Developing a Client-Centred Abortion Counselling Training Course for Healthcare Providers: An Action Research Project

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YAMINI KALYANARAMAN

0000-0002-5993-7362

Supervisor: Distinguished Professor Catriona Ida Macleod

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ABSTRACT

The Choice on Termination of Pregnancy (CTOP) Act was passed in South Africa in 1996, drawing from both a public health and rights-based framework. Globally one of the more liberal pieces of legislation, the Act entrenched a woman's right to early, safe and legal abortion, while promoting the provision of non-mandatory and non-directive counselling, both pre- and post-abortion. In 2008, an amendment to the Act allowed for trained registered nurses to provide abortions in order to increase accessibility. Despite this, research indicates that the current rate of illegal abortions remains high, at almost 50%. Almost three decades later, there are still hurdles to implementation and access.

Baseline research conducted by the Critical Studies in Sexualities and Reproduction (CSSR) research unit at Rhodes University shows that pre-abortion counselling provided in public abortion clinics in the Eastern Cape province tends to be directive, with abortion seekers often being coerced into changing their minds and taking up, in particular, long-acting reversible contraception. This is a serious hindrance to reproductive rights, reproductive autonomy and quality reproductive healthcare, since fear of provider judgement may result in those who are pregnant resorting to illegal abortions out of fear, shame or both.

My research aimed to develop, conduct, document and improve an abortion counselling training course for in-service nurses. This study operationalised the Abortion Counselling Guideline (published by the CSSR as part of the baseline study mentioned above) into a training course titled the *Abortion Counselling Certificate Course (ACCC*). Action Research methodology was adopted for curriculum design, course facilitation, evaluation, critical reflection, and refinement. The training course was conducted in partnership with the Eastern Cape Department of Health as a key stakeholder, and accredited as a short course by Rhodes University. The Abortion Counselling Certificate Course (ACCC) aimed to: build nurses' skills in abortion counselling; promote client-centred and contextually relevant counselling based on reproductive justice principles; and dispel myths regarding abortion consequences with evidence-based research, ultimately benefiting the clients who access the service.

Two training courses were conducted with nine nurse participants in each course. The first took place online (via Zoom) in 2020 during the COVID lockdown; the second took place face-to-face in 2021 at Rhodes University. Research data included feedback forms by the nurse participants, reflective journals maintained by the participants and me, recordings of selected sessions of the training course, participants' case presentations, and interviews with nurse participants two months after attending the first course. Data were analysed using a

reflexive thematic analysis. The study was guided by the following questions: how did the reported learnings and reflections of the course participants dovetail with the specific outcomes of the training course; and what elements, whether internal or external to the course, were identified as enabling or hindering nurses' skills in providing abortion counselling services based on reproductive justice principles.

Findings show that several course outcomes were met, as the nurse participants demonstrated the following: enhanced critical thinking skills; deep listening by being attuned to clients' verbal and non-verbal cues; use of evidence-based and non-stigmatising language; and an ability to be reflexive. A concern, however, is the maintenance of these newly acquired skills against a backdrop of staff shortages, infrastructural and resource constraints, lack of managerial support, and abortion stigma; these need to be further explored and overcome.

This study makes a strong argument for a feminist, client-centred approach to abortion counselling grounded in reproductive justice principles. The course feedback was positive, with participants stating that the course enabled them to realise their own value and acquire self-respect as providers, to advocate for their clients, and to form peer support groups that assist with debriefing and sharing resources. Many said that the Rhodes University course certificate was the first formal acknowledgement they had received in all their years of service as abortion providers.

Keywords: abortion counselling, reproductive justice, nurse training, client-centred counselling

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LIST OF ACRONYMS

AC	Abortion Counselling
ACCC	Abortion Counselling Certificate Course
AR	Action Research
CARM	Conversational Analytical Roleplay Method
CMO	Chief Managing Officer
CPD	Continuing Professional Development
CRR	Centre for Reproductive Rights
CSSR	Critical Studies in Sexualities and Reproduction
CTOP	Choice on Termination of Pregnancy
DENOSA	Democratic Nursing Organisation of South Africa
DoH	Department of Health
ECDoH	Eastern Cape Department of Health
FTF	Face-to-Face
HCP	Health Care Provider
HHDC	Humanities Higher Degrees Committee
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICPD	International Conference on Population and Development
IPV	Intimate Partner Violence
IRPQP	Institutional Research, Planning & Quality Promotion
IT	Information Technology
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraceptives
MCWH	Maternal, Child and Women's Health

NGO	Non-Governmental Organisation
NHRD	National Health Research Database
PAR	Participatory Action Research
PHC	Primary Health Care
RJ	Reproductive Justice
RPERC	Research Proposals and Ethics Review Committee
RUESC	Rhodes University Ethical Standards Committee
SANC	South African Nursing Council
SRH	Sexual and Reproductive Health
SRJC	Sexual and Reproductive Justice Coalition
STI	Sexually Transmitted Infections
TA	Thematic Analysis
TEMA	Telemedicine Early Medical Abortion
TOP	Termination of Pregnancy
USA	United States of America
VCAT	Values Clarification and Transformation
WHO	World Health Organisation
WIP	Work-in-Progress

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CHAPTER ONE: CONTEXTUALISING ABORTION COUNSELLING IN SOUTH AFRICA

1.1 Setting the Scene

In 1996, South Africa passed the Choice on Termination of Pregnancy (CTOP) Act No. 92 (1996), entrenching the right of women, including minors, to early, safe, and legal abortion. The Act also promotes the provision of non-mandatory and non-directive counselling, both pre- and post-abortion. The introduction of this legislation positioned South Africa as a leader in sexual and reproductive health and rights (Albertyn, 2015; Pizzarossa & Durojaye, 2019), and demonstrated how abortion legalisation can positively impact morbidity and reduce maternal mortality, with data showing a 91.1% reduction in deaths from unsafe abortion from 1998 to 2001, that is, within the first few years of implementation of the act (Jewkes & Rees, 2005). An amendment made to the Act in 2008 opened the doors for trained registered nurses to also provide abortions in order to increase access to the service (CTOP Act No. 1, 2008).

The World Health Organisation's (WHO) abortion care guideline describes abortion counselling as a "focused, interactive process through which a person voluntarily receives support, information and non-directive guidance from a trained person, in an environment that is conducive to openly sharing thoughts, feelings, perceptions and personal experiences" (WHO, 2022a, p. 37). Counselling is viewed as more than information provision with the former aspect necessitating specialised counselling training (WHO, 2022a).

In legalising abortion, the CTOP Act not only draws from public health and rights-based frameworks (Favier et al., 2018) but also promotes reproductive justice (International Conference on Population and Development [ICPD], 2022), which has gained traction as an approach to abortion amongst feminist researchers (Chiweshe et al., 2017). At its core, reproductive justice simultaneously acknowledges and combines reproductive health rights and social justice principles (Chiweshe et al, 2017; du Plessis & Macleod, 2024). It aims to understand reproductive decision-making through social circumstances that enable or interfere with a woman's right to bodily integrity, access to contraception, and the ability to continue with or terminate a pregnancy (Chiweshe et al., 2017; Chrisler, 2013).

Espousing a reproductive justice framework, my research operationalised abortion counselling guidelines created for healthcare providers (HCPs[1]) into an in-service training

[1] HCP is quite a broad term that can refer to a facility or a person such as a doctor, nurse, or midwife (Davis, 2025). Other terms often used in the literature are health practitioners, health professionals, health workers and primary care providers. In this thesis, different terms may be used based on how they appear in the source. I use

programme called the Abortion Counselling Certificate Course (ACCC). The guideline, entitled *Abortion Counselling in South Africa: A Step-by-Step Guide for Providers*[2] (Mavuso et al., 2018), was developed by the Critical Studies in Sexualities and Reproduction (CSSR) research unit following baseline research discussed in section 1.5, in which providers and users were interviewed about their experiences of abortion counselling, and actual abortion counselling sessions were recorded (du Toit, 2023; du Toit & Macleod, 2024; du Toit & Macleod, 2025; Mavuso, 2018; Mavuso et al., 2017; Mavuso, 2021; Mavuso & Macleod, 2019; Mavuso & Macleod, 2020; Mavuso & Macleod, 2021; Mavuso et al., 2023).

Action research (AR) methodology was used to document the development, curriculum design, accreditation, implementation, critical evaluation, and improvement of the training course. Specific research questions for my study were: (1) How did the reported learnings and reflections of course participants dovetail with the specific outcomes of the Abortion Counselling Certificate Course (ACCC)? (2) What elements, external to the course, were identified as enabling or hindering nurses' skills in providing abortion counselling services based on reproductive justice principles? Lastly, (3) What elements, internal to the course, were identified as enabling or hindering nurses' skills in providing abortion counselling services based on reproductive justice principles?

This project, and the background research that led to it, are situated in the Eastern Cape Province of South Africa. The broader project, run under the auspices of the CSSR, underscores the interactions in abortion service provision between an abortion service provider and a client,[3] and how this exchange can serve to foster or undermine reproductive justice principles. End-term research that replicates the baseline research methodology is currently being conducted by other CSSR researchers to qualitatively assess changes in the practices of providers who have undergone the ACCC.

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the term 'HCP' interchangeably with 'abortion provider' or 'nurse,' as nurses who have undergone the prescribed training in abortion service provision form the sample for this research.

2 This document will be referred to as the CSSR Abortion Counselling Guideline (Mavuso et al., 2018) in this thesis and CSSR AC Guideline for short. This is a separate document from the National Clinical Guideline for Implementation of the CTOP Act, First Edition (DoH, 2019), which I will refer to as the National Clinical Guideline in the rest of the thesis. Although the CTOP Act was passed in 1996, no national guidelines were published until 2019.

[3] In abortion literature, a person seeking an abortion is referred to in multiple ways: patient, client, woman, and service user, among others. Each term has inferences. For example, 'patient' typically fits within a medical model, 'client' suggests a capitalistic interaction, and 'healthcare user' implies that healthcare is utilitarian. Keeping this in mind, I choose to use the terms 'client,' 'abortion seeker' or 'woman' while acknowledging the power dynamics that exist in an interaction between a client seeking an abortion and a nurse. I use 'patient' when so referenced in the original article.

While South Africa has benefited from a robust and liberal abortion law after the election of a democratic government in 1994 (Röhrs, 2012), several authors note that the country has a long way to go to meet its sexual and reproductive health (SRH) developmental targets (Albertyn, 2015; Mhlanga, 2003; Morison, 2013; Pizzarossa & Durojaye, 2019, Stevens, 2019). Marecek et al. (2017) acknowledge how women's agency concerning pregnancy and bodily decision-making is largely influenced by the legal policies of that geographical setting, as well as the cultural, social, and healthcare contexts within which they live. This introductory chapter includes discussion of the aforementioned issues that shape abortion access in South Africa. I also provide an overview of the background research to this project and a breakdown of the chapters in this thesis.

1.2 Abortion Practices and Policies from Past to Present

South Africa's historical and political backdrop has substantially impacted past and current abortion practices. I break down this period into three broad phases. The first phase, before 1975, speaks to customary[4] law which shifted into colonial law, which criminalised abortion. In the second phase, the Abortion and Sterilisation Act of 1975 was passed, allowing abortion only under very stringent conditions. The third phase paved the way for the CTOP Act in 1996. I describe further these three phases.

1.2.1. Phase One: Pre-1975

Abortion has occurred for centuries. Anecdotal descriptions by Sai (2004) suggest that abortion was historically accepted as a practice in several African cultures, especially when maintaining order in society. Zulu women made concoctions from a peppery shrub called 'uhlungughlungu', the Malays from red geraniums, and the Khoi herbalists from a type of thornbush (Hodes, 2016). Other botanical remedies were made from wild celery, rue, wild 'dagga,' aloes, and bracken fern. Inserting sharp objects into the cervix or injecting detergents were amongst other methods used. There was no clear distinction between abortifacients (to induce abortion) and emmenagogues (to stimulate menstruation), and any drugs or remedies used to provoke menstruation were mostly viewed as a method of extended contraception rather than abortion (Hodes, 2016).

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[4] Customary law consists of written and unwritten rules that have been established through traditions, practices, and customs within communities that may be accepted in courts if in line with the South African constitution (Barrett-Grant, 2003). It prevailed in South Africa much before colonisation as an authoritative form of justice (Wall, 2015).

Scholars and activists highlight that the termination[5] of unwanted pregnancies had conventionally been a common approach to managing fertility in the South African setting (Sai, 2004). In pre-colonial times, customary law governed abortion. Ngwena (2004a) refers to this phase in South African abortion history as the indigenous or pre-colonial phase due to the lack of overarching legislation. Within this framework, the use of abortifacients was viewed as a family matter and not meant for the court (Ngwena, 2004b). Elders, traditional healers and family members could consider abortion if a pregnancy was seen as problematic.

The colonial and apartheid governments ignored or criminalised many customary practices, imposing Roman-Dutch law instead. Although no specific law on abortion existed pre-1975 in South Africa, it was governed by two sets of legislation: common law and the Native Territories Penal Code of 1886. The latter applied in the Transkei[6] region. It was promulgated after missionaries in the region raised concerns about abortion amongst the Pedi and Xhosa people, and it allowed for abortion solely in cases where it was necessary to save the pregnant woman's life (Hodes, 2016).

With colonisation and the oppression of indigenous people arose colonial law. Most abortion laws in Southern Africa, South Africa included, adopted the law of the coloniser, which was essentially the criminalisation of abortion (Ngwena, 2004a). The South African common law[7] thus viewed abortion as a common law crime, with the only exception being to save the life of the pregnant woman (McGill, 2006). Thus, customary law and the received systems of common law prevailed alongside each other (Wall, 2015). However, doctors who performed abortions typically took personal and professional responsibility, risking prosecution or fines (Guttmacher at al., 1998). There was a general sense that both doctors and patients required more clarity regarding aspects of the legal permissibility of abortion (Ngwena, 2004a).

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[5] Termination of pregnancy is often used synonymously with abortion and refers to the "separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman" (CTOP Act, 1996, p. 4). Other terms include elective abortion, induced abortion, and therapeutic abortion. There is some ambiguity around the meaning of these terms in the medical and public space, which has implications regarding the nature and scope of abortion practice (Grimes & Stuart, 2010). In this thesis I use the term 'abortion' to mean 'induced abortion' and not 'spontaneous abortion' or 'miscarriage.'

[6] The Transkei was one of ten homelands created in South Africa under the apartheid government whereby black South Africans were separated based on their ethnicity. It was also one of four homelands that become an independent state in 1976 (Beinart, 2012). In 1994, it was integrated into the Eastern Cape Province.

[7] South African common law was mostly influenced by Roman-Dutch law and English law. Common law is applied when a particular matter is not already governed by legislation (South Africa Report on the African Charter, 1998).

1.2.2 Phase Two: Abortion and Sterilisation Act of 1975

Combined pressure from women's organisations (advocating for legalising abortion), medical institutions and doctors (seeking security for the theoretically "illegal" abortions that they were providing), and the general public led to a shift in abortion law (Hodes; 2016; Guttmacher at al., 1998). The Abortion and Sterilisation Act was passed in 1975 to expand and specify the grounds for abortion beyond those necessary for saving the pregnant woman's life. Under the Act, abortion could be procured from a medical practitioner on the following grounds: if continued pregnancy posed a serious threat to the physical or mental health of the women; if there was serious risk that the child born would suffer from a physical or mental defect; or in cases where the pregnancy was a result of alleged rape or incest (Abortion and Sterilisation Act 2, 1975). While the Act appeared to expand access to abortion, in reality, the majority of women experienced marginal changes, if any.

In effect, the 1975 Act created abortion access for only certain groups of women; white women, women who were rich, and those who lived in urban areas were more likely to receive assistance with an unwanted pregnancy (Mhlanga, 2003). Ngwena (2004b) critiques the rigidity of language used in the Act, such as the absence of socio-economic reasons as grounds for an abortion. Other elusive semantics included a distinction between physical and mental grounds for abortion whereby in case of the latter, the pregnancy needed to pose a 'serious' threat or create danger of 'permanent damage' to a woman's mental health (Ngwena, 2004b). Additionally, there were tedious administrative procedures and multiple authority figures (three medical practitioners, state officials, the police, and the magistrate, depending on the circumstance) involved in procuring an abortion (Abortion and Sterilisation Act 2, 1975).

These stringent requirements created a law reform that was exclusive and accessible only to a privileged group, making the 1975 Act both "paternalistic and authoritarian" (Ngwena, 2004a, p. 342). Guttmacher et al. (1998) note how women with employment and education could procure abortions from private doctors or even fly to England for the procedure, on grounds of the continued pregnancy being a threat to their mental health. In contrast, women without resources and means had to resort to illegal and unsafe[8] abortions due to the time-consuming and stringent requirements for a safe and legal one.

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[8] The World Health Organisation (WHO) defines unsafe abortions as those characterised by inadequate skills of the provider, unsanitary facilities or hazardous techniques (WHO, 1992).

1.2.3 Phase Three: CTOP Act No. 92 of 1996

The post-apartheid era in South Africa, ushered in with the election of a new democratic government in 1994, resulted in several reforms including abortion law reform. The African National Congress prioritised women's health and women's right to choose, focusing its efforts on gender equality and new reproductive health policies (Hodes, 2016; Ngwena, 2004a).

Section 27 of the South African Constitution guarantees that "everyone has the right to have access to health care services, including reproductive[9] health care" (Constitution of South Africa, 1996, p. 11). The CTOP Act Preamble drew from the South African Constitution in recognising the value of human dignity and affording each woman the right to choose to have an early, safe, and legal termination of pregnancy (TOP) based on their own beliefs. The Preamble states that TOP will *not* be used as a form of population control or contraception (alluding to the injustices of the apartheid government). The Act's alignment with reproductive justice is underlined in its many references to *access* to safe, affordable, effective, acceptable, and appropriate health services (CTOP Act, 1996). The CTOP Act makes abortion available under the following circumstances:

a) During the first 12 weeks of pregnancy, *on request;*[10]
b) From the 13th to (and including) the 20th week, in consultation with a medical practitioner, under the following circumstances: in case continuing the pregnancy poses a risk to the woman's physical or mental health; there exists substantial risk to the foetus concerning any physical or mental abnormality; the pregnancy is a result of rape or incest; or if continuing the pregnancy would be a significant social and economic hindrance to the woman;
c) past the 20th week if a medical practitioner agrees, in consultation with another doctor or a registered midwife, that continuing the pregnancy would endanger the woman's life, result in a severely malformed foetus, or pose a risk of injury to the foetus.

The CTOP Act specifies that abortions be performed by medical practitioners, while the 2008 Amendment states that registered nurses or midwives who have undergone the required procedural training may also carry out the procedure within the first 12 weeks. With

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[9] Reproductive healthcare is the only form of healthcare that has a special mention in the South African Constitution, underscoring the value of reproductive rights as human rights and how they are essential to full equality.

[10] The fact that women may receive an abortion within the first 12 weeks *on request* implies that they should not have to offer a reason for obtaining the procedure.

regard to a minor, the Act states that a doctor, nurse, or midwife may advise the pregnant minor to consult with a parent, guardian, family member, or friend, but cannot deny the procedure should the minor choose *not* to consult anyone (CTOP Act, 1996). The Act thus legalised abortion on a much broader basis than before, making it "one of the most liberal abortion laws in history" (Hodes, 2016, p. 85). Despite the liberal premise of the Act, several challenges persist in its implementation, many related to the public healthcare system, which I discuss in the next section.

In some countries, limited reproductive rights are a direct consequence of restrictive abortion legislation, as seen in countries like Malawi and Angola. In contrast, South Africa presents a paradox in relation to the CTOP Act. While the law has been lauded globally for its progressive stance over the past three decades, research consistently highlights its limited effectiveness in practice. This gap between legislation and implementation can be attributed to an array of challenges that range from discursive constructions of abortion to entrenched stigma and barriers to access (Favier et al., 2018; Guttmacher at al., 1998; Harries et al., 2007; Macleod et al., 2011; Mokgethi et al., 2006; Varkey, 2000; Vincent, 2012).

1.3 Public Healthcare in the Eastern Cape Province

The health system inherited by the new government in 1994 was a hugely fragmented structure bearing the legacy of apartheid, with racially-segregated health services administered and managed by various health authorities at the local, provincial and national levels, as well as administrations in the former "homelands"[11] (Wadee et al., 2003). Inequities were rampant within the health system: only 11% of total public health expenditure was allocated to primary healthcare, with most funding going to historically 'white' and urban areas, leaving 'black' and rural areas thoroughly underfunded; the 'rich' minority who accessed the private sector through health insurance or medical aids was estimated in 1992-93 to be about 23% of the population with access to 61% of total healthcare expenditure (Wadee et al., 2003).

Such disparities persist today and may be attributed to the maldistribution of resources in South Africa's dual healthcare system, comprising both private and public sectors (Wadee et al., 2003). This structure has been criticised due to its imbalanced nature in which the socio-economic elite access high-quality private care, while the rest of the population are reliant on

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[11] Black South Africans were confined to 10 homelands under the apartheid government. These homelands, also called *Bantustans,* were geographical areas scattered throughout South Africa, and consisted of only a small fraction of total land in the country (Phillips, 2017).

a public sector that is overburdened and under-resourced (Pauw, 2022). The DoH is implementing the National Health Insurance system as a way to overcome these disparities (DoH, 2024) with the end goal of achieving affordable and accessible Universal Health Coverage in the country (Pauw, 2022). (At the time of writing, the National Health Insurance system had not been rolled out.)

The site of this study, the Eastern Cape, is one of nine provinces in South Africa. The Eastern Cape is noted as the poorest province in South Africa with high levels of poverty and illiteracy (Gadu et al., 2024). According to the 2022 census, it has the fourth highest population, estimated at 7.2 million. The Eastern Cape Department of Health (ECDoH) notes that over 85% of its population are[12] black/African, 7.6% are coloured,[13] 5.6% are white, and less than 0.5% are Indian/Asian (ECDoH, 2025). The Eastern Cape province (first level) has two metropolitan municipalities and six district municipalities (second level), which are further subdivided into 31 local municipalities (third level) as shown in Figure 1.

Figure 1

Municipalities of the Eastern Cape

Note. Map of the Eastern Cape with Municipalities Named and Districts Shaded by Htonl is licensed under CC BY 4.0

[12] The use of apartheid-inspired racial classifications persists in post-apartheid South Africa. As noted by Nilsson (2016), it remains a blatant model for social organisation, as racial identities continue to influence the lives of most South Africans.

[13] In South Africa, ‘coloured’ refers to a multi-racial ethnic group with mixed ancestry. Adhikari (2005) notes that this phenotypically diverse group of people held an intermediate status within the racial hierarchy of the white minority and the predominant African population. The category is heavily debated in South Africa but still used in official statistics.

According to the ECDoH Annual Report for 2022-23, there are 775 public healthcare facilities (which includes both clinics and community health centres), with an additional 152 mobile units and 66 district hospitals across the Eastern Cape. Health services are based on the primary healthcare (PHC) model and directed through the District Health System. As elsewhere, the health system in the EC is sharply divided between the public and private sectors, both of which are governed by the Minister of Health (Whyle & Olivier, 2023). A PHC clinic is a patient's entry point into the public health system; this is also the case for an abortion seeker. If the particular facility they visit does not offer abortion services, they need to be referred to a clinic or hospital that does offer the service they need (such as a first- or second-trimester abortion procedure).

The Women's Legal Centre website (n.d.) provides information on accessing safe and legal abortions in the Eastern Cape. There are 19 public facility clinics across seven regions in the province (Nelson Mandela Bay, Sarah Baartman, Chris Hani, Amathole, Joe Gqabi, OR Tambo, and Alfred Ndzo) that offer first-trimester abortions, and four facilities across four regions (Amathole, Sarah Baartman, Nelson Mandela Bay, and Chris Hani) that offer second-trimester abortions.

Some positive changes in relation to abortion access in the Eastern Cape were noted by the ECDoH in their annual report at the end of the 2022-2023 financial year: 38 health providers were trained by a non-governmental organisation (NGO) on TOP services and the Sexual and Reproductive Health and Rights Policy; an action march against illegal abortions led by the Deputy Minister of Health led to the set-up of three new sites providing abortion services. The report also acknowledges the providers who attended the ACCC offered by the CSSR and Rhodes University Psychology Department, referring to the course developed through this project. "This training was intended to capacitate health providers with skills in pre- and post-abortion counselling" (ECDoH, 2022-2023, p. 100).

1.4 Barriers to Accessing Abortion

The passing of the CTOP Act has not been without legal challenges. 29 years later, there are still hurdles to implementation and abortion remains inaccessible to many (Favier et al., 2018), which speaks to a fissure between the state's legal pledge to reproductive rights and the lived experiences of women in obtaining such rights.

Macro-Level Challenges

Research indicates that the current rate of illegal abortions remains high, at almost 50%, though it is difficult to obtain an accurate estimate (Hodes, 2016; Mosley et al., 2017). At a macro-level, hurdles to enactment of the CTOP Act include disparity in access to services between provinces and vying health priorities such as HIV/AIDS (Favier et al., 2018) and, more recently, Covid. Although patients need to enter the public health system through a PHC clinic, the ECDoH report (2022/23) notes that staff shortages limit after-hour services, causing patients (including abortion seekers) to access hospitals directly, without clinic referrals. A study by du Plessis and Macleod (2024) on rural services in South Africa identified a shortage of functioning facilities and a lack of support from facility managers, which caused further shortages in human and material resources at TOP clinics. The study also highlighted the widespread lack of knowledge about abortion legislation; and in instances where participants knew about the law, they were not fully aware of its stipulations, thus underscoring the need for awareness and information on this topic especially among women (du Plessis & Macleod, 2024). The National Clinical Guideline (DoH, 2019) identified a lack of training and mentorship, and a shortage of both medicines and equipment as factors that impede access to safe and legal abortion services. These various hurdles have severe implications for abortion counselling. Mhlanga (2003) highlights the issues of rural access, health workers' attitudes and limited resources for counselling. The rough terrain and poor road infrastructure in deep rural areas delay access to health services (including abortion services) and ambulance services to rural communities (ECDoH, 2022-2023). Thus, women living in rural areas may need to travel longer distances to access the service, while clinics may be short-staffed, resulting in insufficient time for a comprehensive counselling session. Furthermore, women often receive varying levels of counselling, with service providers differentiating between what they deem to be deserving or undeserving cases, and adjusting their practices accordingly (Macleod et al., 2017).

Micro-Level Impediments

A number of barriers operate at a micro-interactional level. The most prominent barrier identified by women in a study within the Eastern Cape province related to confidentiality, as they feared that nurses or community members who saw them accessing the service would pass on that information to others (du Plessis & Macleod., 2024). Such interactions and perceptions exacerbate other obstacles such as negative attitudes towards abortion (Mosley et al., 2017) and women feeling shame and a need for secrecy (Macleod et al., 2017). Several authors have acknowledged the crucial role that abortion providers play in the decision-making

process (Harries et al., 2007; Harvey-Knowles, 2012), including actively dissuading clients from using the service (du Plessis & Macleod., 2024). Furthermore, a large number of HCPs refuse to partake in abortion service provision on the grounds of 'conscientious objection,'[14] and women thus encounter stigma even at facilities (du Plessis & Macleod, 2024; Favier et al., 2018).

Abortion Stigma

Abortion stigma is the discrediting of persons associated with abortion; this, therefore, includes clients, providers, and abortion supporters (Norris et al., 2011). Although the focus of a study by du Plessis and Macleod (2024) was on attitudes towards abortion services in rural South Africa, their data revealed that abortion stigma was the biggest hindrance to acquiring a safe and legal abortion in rural areas. Herek (2009) describes three manifestations of stigma (all apply within abortion services), namely: enacted (prejudices portrayed through negative actions such as avoidance, discrimination, and violence, which exist along a continuum); felt (a person's expectation that stigma will be enacted on them); and internalised (a person's acceptance of the stigma as part of their beliefs). Enacted stigma is also referred to as experienced stigma, as it involves actual experiences of stigma, and felt stigma is also referred to as perceived stigma (Shellenberg et al., 2011).

Kumar et al. (2009) assert that abortion stigma is "a social phenomenon that is constructed and reproduced locally through various pathways" (p. 628), such as the public healthcare system. Abortion stigma might influence a woman's decision to share her intention or experience of having an abortion with friends, family and HCPs (Moore et al., 2011). This could further determine whether a woman seeks out a safe or unsafe abortion, and medical care following post-abortion complications (Shellenberg et al., 2011). HCPs who experience all three manifestations (elaborated on in my findings under section 7.2.4) might be unintentionally enacting their internalised stigma onto clients.

[14] I use the term 'conscientious objection' if it appears in the study under discussion. However, its reference in this study is not a reflection of my acceptance of the term. On the contrary, I understand the critical role of language and discourse in psychology and research. I acknowledge any good intentions behind framing this act of opposition in a way that respects the beliefs of HCPs. Yet, I am also acutely aware of the hindrances to access, the hostile attitudes, and an inevitable denial of abortion services to which it has led. I therefore adopt the terminology of opposition to abortion, obstruction to access, or refusal to care, in relation to the training course and this project.

1.5 Baseline Research and Rationale for the Abortion Counselling Certificate Course

The baseline research of my project stemmed from two doctoral theses (du Toit, 2023; Mavuso, 2018) and subsequent research papers that emerge from them (du Toit & Macleod, 2024; du Toit & Macleod, 2025; Mavuso et al., 2017; Mavuso, 2021; Mavuso & Macleod, 2019; Mavuso & Macleod, 2020; Mavuso & Macleod, 2021; Mavuso et al., 2023). The research data for these papers were collected from three public hospitals and consisted of recordings of pre-abortion counselling sessions, and interviews with abortion providers and abortion-seekers. Mavuso's (2018) study explored women's and providers' narrated experiences of the pre-abortion encounter that included waiting room interactions and counselling. Interviews were conducted with 30 abortion seekers and four healthcare providers, of which two were nurses and two were lay counsellors.[15] The study by du Toit (2023) explored how first trimester pre-abortion counselling is conducted, with a focus on the overall conversational structure of such a consultation. 28 counselling sessions (21 individual and seven group sessions) were recorded and analysed using conversation analysis.[16]

Using narrative-discursive analysis, Mavuso (2018) showed how various discourses seep into narratives of experiences of the counselling encounter. These included 'parenthood,' 'pronatalist,' 'moralisation,' 'foetal personhood,' client 'reponsibilisation,' and 'abortion as risk' discourses. Providers mostly offer information on how to prevent unintended pregnancies and abortion by using long-acting reversible contraceptives and shared that abortion caused infertility, cancer and psychological and physical trauma (Mavuso, 2021).

The various discourses drawn on effectively end up portraying abortion as an awful act that is harmful and disadvantageous to women. As an outcome of such discourses, parenthood may be glorified, and abortion may be associated with immorality, shame, and sin (Mavuso, 2018). Despite some instances of supportive counselling, Mavuso (2021) argued that coercive anti-abortion counselling is predominant in sessions and is fundamentally both an obstruction to access and a form of reproductive violence leading to conflict, stress, fear, hurt, and pain in abortion seekers, either due to or exacerbated by the 'counselling' provided.

Furthermore, Mavuso (2018) discerned the absence of a 'reproductive rights' discourse (also noted by Chiweshe et al., 2017, who explored the South African and Zimbabwean

[15] The two lay counsellors were volunteers at a US-funded Christian-based pregnancy crisis NGO. One of the hospitals in Mavuso's (2018) study had outsourced their 'options counselling' to this NGO.

[16] To my knowledge and at the time of my study, it is the only research that has used conversation analysis in relation to abortion counselling.

contexts) in participants' narration of their experiences. Mavuso (2018) posits that it may have been challenging for clients to draw on a rights discourse in a pre-abortion counselling session, lest it compromise the service or care they receive from the HCPs. Chiweshe et al. (2017) contemplate a reason for this absence: unlike in Western contexts, the notion of rights has not gained as much traction in the South African and Zimbabwean contexts, thereby diminishing how abortion may be viewed in these two countries.

In du Toit's (2023) study, conversation analysis was used to focus on the content of recorded counselling sessions. He identified seven key conversational projects: *context-setting*, *history-taking*, *establishing the reasons for abortion, presenting the options, providing procedural information, obtaining verbal informed consent,* and *discussion of family planning*. He brought to light how these conversational projects enabled problematic positionings of the provider and client within the interaction. Based on these findings, du Toit and Macleod (2024) argue that since abortion is legal *on request* within the first trimester of pregnancy, asking abortion seekers for a reason is unnecessary. It forces women to justify their decision or offer a 'worthy' enough reason to the provider. Through various directive questions, providers tend to establish that poor contraceptive use is the *real* reason for requesting the service and may then proceed to reprimand the client for not having used contraception (du Toit & Macleod, 2024). In the case of younger patients, this is done by involving a parent in the session (despite the fact that no parental consent is required for any person from the age of 12 to be provided contraception may in South Africa) as providers anticipate parental resistance (du Toit & Macleod, 2025). As such, the patient and the parent are coerced to accept and monitor LARC uptake (du toit & Macleod, 2025).

The problem with this approach is that abortion seekers are thus positioned as being irresponsible while repeatedly warning them in a session to adhere to proper contraceptive use (du Toit & Macleod, 2025). This directive approach completely undermines the complexities of contraceptive usage such as various health-related issues, gendered power dynamics within heterosexual partners, distances to clinics for contraception, shortage of supply, family pressure towards childbearing, and stigma attached to certain groups of people (youth and sex workers) accessing contraception (du Toit & Macleod, 2025).

The study by du Toit (2023) also drew on discursive psychology and revealed a cluster of discourses centred around two main themes. The first clustering of discourses, evidenced within the counselling sessions, focussed on *medical-related issues underpinning the abortion procedure* (medical, responsibilisation, risk and support discourses). These discourses primarily positioned women as patients who were responsible for conceiving and in need of medical intervention, and who had to navigate diverse psychological and physical risks

"associated" with abortion. The second clustering of discourses focussed on *women and the foetus* (reproductive choice, religious, pronatalist, and foetal personhood discourses], which positioned women as being responsible for making a choice and bearing the consequences of that decision. For example, a religious discourse served to construct pregnancy and motherhood as God's plan and the foetus as a 'gift from God' (du Toit, 2023).

The problematics that were underscored in counselling sessions from both studies led to the development of two documents from the CSSR.

The first document is a policy brief that outlined the following findings, *inter alia*: an anti-abortion stance emerged from most sessions; counselling is often directive; physical (breast cancer, infertility) and psychological (depression, suicidal ideation) risks are often emphasised; personhood tends to be ascribed to the foetus with a description of the foetal development -- *"It has arms, legs, it breathes, it has a heartbeat,"* (p. 3); HCPs mostly seem to view abortion as a problematic reproductive process (Mavuso et al., 2017).

The second document, the CSSR AC Guideline includes: the basis of a client-centred approach; how to engage with minors; establishing what kind of counselling is needed by the client; the differences between first and second trimester counselling (no counselling, the presentation of options or decision-making counselling, procedural counselling, pre- or post-procedural counselling); basic information to be shared for informed consent; how to manage third parties; steps involved if a client reveals that they were subjected to sexual or domestic violence; how to ascertain reasons for second trimester abortions (as this is required by law); and self-care and support (Mavuso et al., 2018).

The baseline research informs the current study in many ways: it offers insights specifically into the counselling interactions; it offers perspectives of both clients and HCPs (the latter form the sample in the current study); and it forms the basis of the CSSR AC Guideline used in the in-service training of abortion providers that constituted the action research of this study. The discourse analysis enables an understanding of how clients' experiences of their pre-abortion counselling session is often shaped by the manner in which abortion is framed, and how they, in response, frame abortion and their experience of abortion counselling. The baseline research led to the rationale of the current project as it advocates for a feminist, client-centred approach to abortion counselling practice (Mavuso & Macleod, 2020). Within this approach, facilitated by the ACCC, abortion is normalised and constructed as a safe and legitimate reproductive health decision and procedure, the stigma surrounding abortion is challenged, and the counselling offered by abortion providers is empathic and validating (Mavuso & Macleod, 2020).

The current study is novel in recognising pre-abortion counselling "as a practice that is discursively constituted and therefore subject to discursive (re)constitution" (Mavuso, 2018, p. 7). This sentiment implies that if nurses can critically examine their own style of communication and language in a counselling session, then they may be able to reconstruct abortion in a way that is informative,[17] client-centric and based on a reproductive justice framework. This implication also informed the curriculum development for the nurses' training manual in my study, for example, the inclusion of the Conversation Analytic Role-Play Method (CARM) activity (described in chapter five, section 5.3.2) in the course.

Before moving on to the next section, it is important to make reference to two more studies that form a part of the larger project. As part of the current PhD study, Laurah Mogonong conducted her master's research, titled *Nurses' Experiences of an Abortion Counselling Training Course and their Understanding of Quality Abortion Servic*es. She interviewed nurses who had participated in the first ACCC training course, three months post-training, to gauge their experience of the course and analyse whether and how it had influenced their work in the field (Mogonong, 2023).

Additionally, research by post-doctoral fellow Timalizge Zgambo (based at the CSSR) research, titled *An End-term Evaluation of the Abortion Counselling Certificate Course,* is being conducted with the aim of recreating the baseline research in the public hospitals where the nurse participants operate. The main objective is to assess the effectiveness of the ACCC and to determine if there is a change towards a more non-directive approach and less anti-abortion bias in providers' pre-abortion counselling after having undergone the training course.

1.6 Nursing in South Africa

The overall governance of the nursing sector is shared between the South African Nursing Council (SANC) and the Human Resources Division of the Department of Health (Blaauw et al., 2014). The categories for registration as per Section 31 of the South African Nursing Act are: professional nurse; midwife; staff nurse; auxiliary nurse; and auxiliary midwife (Nursing Act No. 33 of 2005). The regulations do not prevent any nurse from setting up their own private practice as long as they practice within their scope (SANC website, 2018–2025).

[17] This research acknowledges a fine line between information provision and counselling. As such, there is ambiguity in discerning basic information from "additional information" in WHO's (2022a) definition (outlined on p. 1). Keeping this in mind, the training course advocated for the principles of person-centred care to extend to the entire nurse-client encounter while providing practical examples of non-directive guidance.

1.6.1 Nursing Education

As South Africa's health system undergoes transformation, one of the challenges identified in providing high-quality PHC is the need for more nurses with adequate skills (Strasser et al., 2005). Anecdotal evidence suggests that nurses may lack competence in areas such as midwifery due to a communication gap in nursing education and practice (DoH, 2013). With nurses being viewed as the "backbone of the health system" (Mekwa, 2000, p. 272), the issue of nurse training has become a high priority (Strasser et al., 2005).

The post-apartheid transformation of nursing and the education sector in South Africa culminated in a revision of nursing qualifications motivated by a need to focus on evidence-based practice, deal with increased complexities in practice, and augment nurses' professional status (Blaauw et al., 2014). The governance of nursing education was transferred from the Health Department to the Ministry of Education (Mekwa, 2000). The main change included the phasing out of the legacy qualifications (which were not aligned with the Higher Education Qualifications Sub-framework) to a nursing qualification that was in line with higher education to create an integrated national education and training framework (Mthembu, 2023). Under the new nursing qualification, the categories of nurses include the following: professional nurse and midwife (four-year Bachelor of Nursing); general nurse (three-year diploma in nursing); and auxiliary nurse (one-year higher certificate in nursing) (DoH, 2019b). Additional one-year diplomas can lead to a specialist nurse registration (DoH, 2019b). These changes aim to enable nursing students to move seamlessly over time from one programme to another (DoH, 2019b).

Individual training institutions and private educators are increasingly playing a role in nursing education and training (Blaauw et al., 2014). A couple of studies have suggested that the governance on nursing education requires improvement (Armstrong & Rispel, 2015; Blaauw et al., 2014). Social accountability is seen as a core element in transformative education and highlights the importance of educator training and responsive curricula, student recruitment and selection, and issues of governance (Armstrong & Rispel, 2015). Educator preparedness also featured as an issue as a shortage of nurse educators has been noted as a key challenge (Armstrong & Rispel, 2015). Rispel (2015) argues for the inclusion of continuing professional development (CPD) to enable nursing managers (not nurses) to offer high-quality and consistency in patient care. CPD is considered an essential component (though currently not compulsory in all provinces) for developing skills, improving competence and enhancing staff morale (DoH, 2013).

The National Qualifications Framework (NQF) was taken into consideration when developing the ACCC to determine the appropriate level of alignment. Mekwa's (2000) study

highlights certain skills that have been identified by the SANC to enhance primary healthcare teaching and learning: problem-based learning, development of critical thinking skills, and strengthening of reflective skills with the intention to creatively manage change. These skill sets also informed the course activities as they overlap with those of an abortion care training framework (described in the next section). In developing a competency framework for PHC nursing in South Africa, Strasser et al. (2005) identified *effective communication and counselling skills* as one of nine core competencies. They recommend offering specific in-service training classes on diverse topics. As the transformative education of nurses is critical in the shift to universal health coverage (Armstrong & Rispel, 2015), a window of opportunity is provided within which to conduct the current study.

1.6.2 Abortion Care Training

In South Africa, the significant shortage of nurses (Breier et al., 2009; Daviaud & Chopra, 2008; Röhrs, 2017; Wyk & Naicker, 2023) has led to public sector nurses shouldering twice the workload, further causing stress, fatigue, burnout and a demotivated workforce (Wyk & Naicker, 2023). The ongoing scarcity of healthcare providers has, inevitably, put a strain on abortion care services (Smit et al., 2009), leading to fewer willing and trained abortion providers (Harries & Constant, 2020; Mavuso & Macleod, 2021).

The implementation of the CTOP Act was accompanied by some healthcare professionals opposing these services (Dickson-Tetteh & Billings, 2002). In order to counter this opposition, workshops were conduction nationwide by the Reproductive Health Research Unit of the University of the Witwatersrand, the Planned Parenthood Association of South Africa, and the Reproductive Rights Alliance. The workshops concentrated on the law's stipulations, providers' feelings about abortion, and ways to approach the service and abortion seekers. After attending a workshop in Cape Town, 70% of participants reported that they felt "quite a bit" or "a lot" more comfortable in interacting with abortion patients (Dickson-Tetteh & Billings, 2002).

Nurses are involved in several different aspects of abortion including pre-abortion care, counselling-related services, performing the procedure, assistance during and after the procedure, and making referrals. Harries et al. (2009) found that most providers were concerned about pre- and post-abortion counselling as well as contraceptive counselling; this led to a research recommendation for quality abortion care that includes counselling and support for women seeking the service as well as sensitivity training for providers (Harries et al., 2009). Smit et al. (2009) recommended that abortion care learning content include pre-abortion assessment of women, counselling and information sessions, and post-abortion care

and contraception. More recently, the National Clinical Guideline (DoH, 2019) recommends the integration of TOP training into the medical and nursing curriculum as part of a comprehensive course in SRH and rights. All managers and healthcare providers at provincial, district, and sub-district levels need to follow the National Clinical Guideline (DoH, 2019) and the standardised and comprehensive TOP Training Manual materials.

1.7 Overview of the Thesis

In chapter one, I introduced the legal backdrop of abortion in South Africa. I discussed the public healthcare system and further contextualised abortion services and its challenges in the Eastern Cape Province. I highlighted the baseline research, thereby offering a rationale to the current project. In setting the scene, I included information on nursing education and training within the country.

In chapter two, I discuss the reproductive justice (RJ) theory as a lens that informs the research project. In order to understand RJ, I first provide a description of reproductive health and its advancement. I then discuss reproductive oppression, and the many ways in which this form of oppression takes place. These include forced sterilisations, inequitable contraceptive access in rural and urban areas, unwanted pregnancies and illegal abortions. Reproductive rights are then introduced as a fundamental human right; however, I show how authors have argued about the limitations of a rights framework. In acknowledging the confines of “choice”, I introduce the reproductive justice framework, its focus on intersectionality, its limitations and how I incorporate it into my research.

In chapter three, I explore different approaches to abortion counselling, such as feminist practice, pastoral counselling, head-and-heart counselling, and decision-making counselling, finally advocating for a feminist client-centred approach to abortion counselling. I examine the types of counselling which feature in both the CSSR AC Guideline and the National Clinical Guideline (DoH, 2019), concluding with a discussion of a few different modes of counselling, including comparisons between group versus individual counselling, and mandatory versus voluntary counselling.

In chapter four, I focus on two perspectives regarding abortion counselling: those of the providers who offer the service and the clients who receive it. In doing so, I engage with presumptions held by abortion-seekers when accessing the service, and the perceptions that providers have of their clients. More often than not, these presumptions and perceptions are both negative, leading to hindrances in service quality.

Chapter five documents the methodology of action research and the different cycles of action research that took place while developing, facilitating, evaluating and refining the course. I discuss what data were collected, the setbacks and changes that occurred due to the overlap with a global pandemic, and my analytical method of a reflexive thematic analysis. This form of analysis was a suitable fit with action research due to the level of reflexivity employed in both.

Chapters six, seven, and eight address my three research questions. Chapter six responds to the first question: how did the reported learnings and reflections of course participants dovetail with the specific outcomes of the Abortion Counselling Certificate Course? Participants demonstrated their development of client-centred counselling skills in multiple ways such as through developing critical thinking skills, deep listening, comprehending the premise of client-centred counselling and reproductive justice principles, learning from and supporting each other, adopting a language of evidence-based practice, and displaying an ability to be reflexive.

In chapter seven, I present findings in relation to my second research question: what elements, external to the course, are identified as enabling or hindering nurses' skills in providing abortion services based on reproductive justice principles? The chapter engages critically with issues raised in the literature such as staff shortages, isolation and burnout of providers, infrastructural constraints, lack of support in the work environment and abortion stigma. Conversely, the emergence of evidence-based practice, instrumental support, and ways to reduce stress were identified as key enablers of client-centred abortion services. Notably, a reproductive rights discourse is visible in providers' talk (lacking in some previous studies) as an element that enables reproductive justice.

In chapter eight, I present findings concerning my third research question: what elements, internal to the course, are identified as enabling or hindering nurses' skills in providing abortion services based on reproductive justice principles? In answering this, I found that several aspects of the course were appreciated by the providers, such as the critical health psychology approach to the training course; the support network that was created amongst providers during training (which has been maintained post-training); the expertise of the facilitators; and the certificates that providers received at the end of the course.

I experienced some uncertainty about the placement of certain themes as internal or external to the course. In concluding, I acknowledge that there is no perfect place, no right or wrong, as many of these elements overlap and influence each other. Thus, my subjective interpretation allowed me to make decisions concerning the analysis while drawing on the reproductive justice principle of what would enable access to abortion. I close the chapter with

a section on how action research allowed me to experiment with two formats of the course – one online and one face-to-face. Action research therefore enabled a comparative analysis of the two formats.

In chapter nine, I present a discussion related to my three analytical chapters, drawing together the findings and highlighting their interconnections. I summarise my evaluations of the course and propose suggestions for its further refinement. I conclude with recommendations aimed at advancing the course, ensuring its sustainability, and identifying directions for future research.

CHAPTER TWO: A REPRODUCTIVE JUSTICE FRAMEWORK

2.1 Preface to the Research Theoretical Lens

The overarching theory underpinning the action research and the training course is *reproductive justice* (RJ). The nucleus of RJ is based on the assertion that all persons who reproduce should be able to achieve this experience with safety and dignity (Ross et al., 2017). RJ scholars argue that the fundamental human right of safety depends on the resources available in a community, which include but are not limited to, education, income, quality of healthcare and housing. They further specify that access to legal contraception and abortions are essential to foster a healthy environment for reproductive dignity and safety. In other words, as described by the Asian Communities for Reproductive Justice (2008), a person experiences reproductive justice when they have the socio-economic and political resources to make an informed decision regarding their sexuality, body or gender for themselves, their family and their community. RJ draws attention to systemic inequalities that render women unable to control their "reproductive destiny" (Ross, 2006, p. 14). It offers a paradigm that foregrounds the experiences of marginalised groups, and, as asserted by Ross et al. (2017), enables a multi-layered approach that strives for "reproductive freedom" (p. 12).

Three frameworks are often discussed in the literature as a means to counter reproductive oppression (discussed under section 2.3). These are: reproductive health, which is concerned with the necessary health services that women require; reproductive rights, which underscores legal protections for women, including access to services, that are seen as a *right*; and lastly, reproductive justice, which moves towards the transformation of systems and services and empowerment of health users to make informed decisions (ACRJ, 2005; Ross, 2006). RJ does not aim to replace reproductive health or reproductive rights, but rather seeks to expand and incorporate them in advancing reproductive dignity, particularly of black[18] women and women of colour[19] (Ross, 2017).

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[18] While I use the terms 'black,' 'white,' 'coloured' and so on to reflect a specific cultural grouping (in much the same way as I refer to Indian, Asian or Hispanic women), I am aware that such groupings foreground race. I do not support the ongoing political racial categorisation, but I recognise the social applicability of categories and their bearings not only in critical health research but more so in the lived experiences of marginalised groups. I also acknowledge that within the framework of RJ, understanding power relations intersectionally is particularly relevant.

[19] Terms allocated to racialised or ethnic groups tend to vary depending on geographical locations. Hence, I may use terms (such as 'women of colour,' 'African American' or 'Latino') in this thesis depending on how they appear in the source. In most cases, the category will be self-explanatory since it will be context-specific. However, when this is not the case, I add a description to avoid confusion.

Drawing on these frameworks, I begin with a brief description of reproductive health, the emergence of reproductive rights in South Africa and the evolution of reproductive justice globally. I elaborate on the developmental trajectory of RJ and its commitment within sexual and reproductive health. This exploratory path traverses: the origins of RJ, rooted in historical and (contemporary) oppression; the global women's movement that aims to prioritise women's rights; and the emergence of the framework as a counter to the 'pro-choice' movement, with an emphasis on incorporating the economic, social, and health factors that impact women's reproductive choices and decision-making abilities. I explain the role of intersectionality in RJ and why an intersectional analysis is integral to understanding RJ. I provide a description of the relevance of this theory within counselling psychology, while justifying its purpose in conceptualising, implementing, and evaluating the abortion counselling training course. I conclude with some critiques of the theory that appear in the literature.

2.2 Reproductive Health and its Progress

Reproductive health is described as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (ICPD, 1994, p. 40). Reproductive healthcare therefore encompasses all techniques, methods and services that enable the health and well-being of individuals by offering preventative measures and solutions to reproductive health problems (ICPD, 1994). This is not limited to providing counselling and care in relation to reproduction and sexually transmitted diseases but rather embraces sexual health to enhance personal relationships and the quality of life (ICPD, 1994). Reproductive health relies on access to various interconnected human rights such as the right to bodily autonomy, privacy, education, and health (Amnesty International, 2023). States are obliged to safeguard these rights and can achieve this through laws and policies that enable individuals to access reproductive health facilities, services, information, and goods (Amnesty International, 2023).

In South Africa, feminist activism and a public health approach led to the inclusion of reproductive rights in the post-apartheid Constitution (Mbali & Mthembu, 2014). In total, there are 243 sections in the South African Constitution, of which the Bill of Rights comprises Sections 7-39 (Constitution of South Africa, 1996). The Bill of Rights explicitly supports reproductive choice and promotes reproductive health. It contains the following provisions: Section 10 states that "Everyone has inherent dignity and the right to have their dignity respected and protected"; Section 12.2 states that "Everyone has the right to bodily and psychological integrity, which includes the right (a) to make decisions concerning

reproduction; (b) to security in and control over their body"; and Section 7.2 says that "The state must respect, protect, promote and fulfil the rights in the Bill of Rights." When rights are limited, the Constitutional Court examines the impact on the most poor and vulnerable in society (Botha, 2009). This is relevant in relation to abortion access; it enables an examination of whether women's rights are being respected, protected, and promoted or whether there delays that hinder their access, which is a breach of their constitutional rights (Kleinsmidt, 2021).

The ICPD took place in 1994, the year that Nelson Mandela was elected the first president of a democratic South Africa. It was also the year that the reproductive justice movement emerged in the USA (Ross et al., 2017). In 1997, women of colour from 16 organisations belonging to four communities – Native American, African American, Latina, and Asian American – cofounded the SisterSong Women of Color [20] Reproductive Justice Collective, known as SisterSong. The mission statement on their official website page speaks to strengthening the voices of women of colour to obtain reproductive justice by challenging and removing reproductive oppression and by safeguarding human rights (SisterSong, n.d.).

There are several other organisations such as the Asian Communities for Reproductive Justice and the African American Women Evolving led by women of colour who are advocating for women's rights and promoting RJ (Gilliam et al., 2009) around the world. In fact, the ACRJ – renamed Forward Together in 2012 – established in 1989, was one of the founding members of the SisterSong, and has been committed to foregrounding the reproductive health of Asian women in the RJ movement (Venkatraman, 2020). Macleod (2018) notes that the concept of RJ has also been echoed in South Africa with the setting-up of the Sexual and Reproductive Justice Coalition (SRJC).

An RJ framework seeks to fight for a person's rights as well as the conditions that support these rights (Ross, 2006). Therefore, to understand RJ, there is a need first to be cognisant of what reproductive oppression and reproductive rights entail.

2.3 Reproductive Oppression

Activist movements have historically fanned the turn to reproductive justice by voicing the ways in which the government, colonisers and even employers have, over time, "*used* reproductive capacity" to further their agenda of supremacy (Ross & Solinger, 2017, p. 13).

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[20] While I adopt British spelling in this thesis, I use the American spelling if it forms part of a proper noun.

What this means is that as a group, reproductive persons have, in many instances, lost their agency in making decisions suitable for themselves based on healthcare, social support, economic resources and personal preferences. Instead, decision-making is imbricated in complex colonialist and hetero-patriarchal power relations, with those in formal power choosing which populations should multiply, and which populations should be curbed, based on the political environment. ACRJ (2005) defines reproductive oppression as follows: "The control and exploitation of women and girls through our bodies, sexuality, and reproduction is a strategic pathway to regulating entire populations that is implemented by families, communities, institutions, and society" (p. 1).

Ross and Solinger (2017) note that as an outcome of immigration restrictions, racism and genocide of native populations in the US, people of colour have endured subjugation and humiliation in matters of reproduction and parenting, because of the value ascribed to a body based on race. What this brings to the fore is that such "values," biases or judgements often predate the enforcement of policies and, in fact, serve as the impetus for policy decision-making, as can be seen in cases of forced sterilisation, one-child policies, and stratified contraceptive access.

2.3.1 Forced and Coerced Sterilisation: Past and Current

Forced or coercive sterilisations seem to be a frequently-used government "intervention" in countries with diverse populations in order to curb the growth rate of certain sectors of the population. For example, Deeb-Sossa (2017) reviewed the film No Más Bebés (No More Babies] which documented a lawsuit (Madrigal v. Quilligan) filed by 10 Mexican women against the State of California and other organisations that included the Los Angeles County Medical Center. The film details how their forced sterilisation abuse in the 1960s and 1970s was strongly influenced by racial, class and ethnic prejudices of being viewed as "hyperfertile," "burdens," "drains to the welfare system" and "pregnant pilgrims" who wished for "anchor babies" in order to gain USA citizenship (Deeb-Sossa, 2017, p. 164). Healthcare provider biases had been reinforced by population control debates (Deeb-Sossa, 2017) as well as a general public perception that Latina women were more fertile than women of other ethnicities and wanted large families (Gutiérrez, 2009).

Similarly, Wilson (2018) highlights the violence embedded in India's current population policies that regulate and control bodies while constructing certain beings as unsuitable to reproduce. The wombs of Dalit, Adivasi and other women in religious minorities became sites of violence in 2016 and 2017 based on the notion that the fertility of poor women would impede the country's path to progress; this led to coercive sterilisations of women followed by a

startlingly high number of their deaths (Wilson, 2018). Also, despite a ‘basket of choices’ of five official contraceptive methods that include male sterilisation, female sterilisation, oral contraceptives, condoms and intrauterine contraceptive devices (Pachauri, 2014), the sterilisation of women (since the late 1970s) remains the main method in India’s policies and the predominant form of contraception that is available in the country (Wilson, 2018).

When considering reproductive oppression in a country like South Africa, it is not difficult to draw parallels between the instances described above and that of the apartheid government that aimed to enforce policies for their benefit. A formal classification under the apartheid era saw all South Africans classified into four categories: white, African, coloured, or Asian (Norling, 2019). The aim of racist apartheid population control policies was to reduce the fertility rates of Africans, sometimes through forced or coerced sterilisations, while promoting white births (Essack & Strode, 2012). In the post-apartheid era in South Africa, it appears that several challenges remain.

Many women struggle to access services and experience discrimination with regard to sexual, reproductive and sterilisation rights (Strode et al., 2012). A 2012 study conducted in two provinces in South Africa (KwaZulu-Natal and Gauteng) exposed the experiences of 22 HIV-positive women who reported being sterilised between 1996 and 2010 without their informed consent or knowledge (Strode et al., 2012). 48 women lodged a complaint, and as per an open letter to the President of South Africa by Her Rights Initiative, many others stepped forward about forcibly being sterilised in public hospitals, placing the number at 85 HIV-positive women (Heinrich Böll Foundation, 2022). The legal framework that is intended to protect women often fails them, as healthcare providers exert pressure on women to sign complicated consent forms, disrespect their autonomy, and withhold adequate information necessary for informed consent (Strode et al., 2012). The women are further failed again by the Government’s continued inaction to redress this violation in totality, even seven years after the original complaint was filed (Heinrich Böll Foundation, 2022).

A key example of socially-embedded power relations that find legal and policy traction is visible in China’s history. Whyte et al. (2015) challenge the myths surrounding China’s one-child policy, stating that authoritative birth-planning control was already enforced in rural and urban areas, even before the policy was launched. In their paper, they report that certain factories provided women with quotas for reproduction, and how any employee who conceived without birth allotment permission was often subjected to harassment and persuaded to get an abortion. Women in rural areas giving birth to a third child were coerced into being sterilised or having an intrauterine device (IUD) inserted, although urban women were trusted to use contraceptives effectively (Whyte et al., 2015). This demonstrates how reproductive

oppression is fuelled by prejudices against *certain* socially-located groups of people. In addition, families faced threats of being denied household registration which would in turn deny them access to schooling, ration coupons and other essentials (Whyte et al., 2015). This is indicative of the absence of reproductive justice, as a person's reproductive dignity as well as the resources that could create a safe environment were threatened. Between 1971 and 1975, there was a dramatic increase in female sterilisations (217%), induced abortions (130%) and IUD insertions (270%) in China (Whyte et al., 2015). The policy, though launched only later in 1980, has been viewed as "one of the costliest lessons of misguided public policy making" that has caused irrevocable harm in its 35 years of enforcement, including abnormal sex ratios, female infanticide and sex-selective abortions (Feng et al., 2016, p. 84).

2.3.2 Stratified Contraceptive Access

Several studies from around the world highlight how patterns of contraceptive use are linked to various demographic variables such as social location, age, rural or urban residence, education, and wealth. Sheoran's (2015) study around the emergency contraceptive pill in India lays bare women's differential experiences. While some women achieve a level of control by having information and access to contraception, other women are shamed for not taking charge of their reproductive health. This draws focus to the concept of stratified contraception as outlined by Sheoran (2015), who describes how women's contraceptive options are not limited to a binary understanding of being privileged or not privileged, but that rather that women can express their contraceptive practices and experiences in nuanced ways. The contraceptive responsibilities placed on women of a lower socio-economic status are in sharp contrast to the expectations (and experiences) of upper- and middle-class women. The availability of over-the-counter contraceptives to privileged groups occurs "in close proximity to 'contraceptive ghettos' where information about, access to and the ability to purchase contraceptives, and to nutritionally support these contraceptives is restricted" (Sheoran, 2015, p. 244). As Pachauri (2014) asserts, emergency contraceptive pills are mostly available in the private sector and offered in urban areas. Although there is a demand for sterilisation, it is a demand created falsely due to lack of other long-term options, inadequate access to information and insufficient counselling regarding sterilisation information. Hence, poor women actively seeking contraception inevitably resort to sterilisation (Wilson, 2018).

Carole Kaufman (2000) contends that the mistrust of family planning programs stemmed from white fears of an increasing black population. Although the government endorsed these services (which officially commenced in 1974) with the intention to improve women's and children's health, accusations that spoke of "genocidal undertones" and control

persisted against family planning programmes. This led to inquiries into the ways in which the larger political and social context of racial domination in South Africa influenced reproductive control (Kaufman, 2000, p. 105). Depo-Provera (a contraceptive injective taken every three months) was introduced in South Africa in the 1970s. Along with oral contraceptives and IUDs, it was distributed and administered on a schedule largely to black women through thousands of clinics and mobile family planning vans as part of the apartheid government's population control agenda (Green, 2018; Norling, 2019). In contrast, a campaign was launched by the Minister of Bantu Affairs that encouraged white women in South Africa to increase their fertility through tax relief and other benefits (Moultrie, 2001). Thus, an uneven distribution of contraceptives was visible in the government's strategies. The vestiges of these policies and programmes are still evident. Dr. Tlaleng Mofokeng, an expert and activist in sexual and reproductive health and rights, notes that the practice of injecting women, especially those who are poor, black and accessing public health, with long-acting reversible contraception without their consent is taking place even today (Green, 2018).

2.3.3 Reproductive Coercion

The term reproductive coercion is said to be relatively new, having first been used in Pike's (2023) study on intimate partner violence (IPV). It is understood to include any deliberate attempt to influence or control a person's reproductive choices or interfere with their reproductive autonomy (Tarzia & Hegarty, 2021, p. 1). These attempts may relate to pregnancy coercion, interference with contraception, or control over pregnancy outcomes, achieved through verbal pressure and threats (Miller & Silverman, 2010). Pike (2023) asserts that coercion may vary in its severity and may be committed by intimate partners, family members or others. Some patients have experienced contraceptive coercion from healthcare providers at the time of accessing an abortion, evidenced in several ways: lack of contraceptive options being offered; lack of time to consider contraceptive selection; and pressure to choose a particular type of contraceptive (Brandi et al., 2017).

A recent news report revealed the plans of Gauteng Province's Health and Wellness Council to roll out Implanon implants amongst schoolgirls in an attempt to curb and prevent teenage pregnancy (Moatshe, 2025). Nomantu Nkomo-Ralehoko, a Member of the Executive Council stressed the importance of parental consent, stating that once this was received, all learners would need to undergo the implant procedure (by inserting Implanon on the arm of the child so she did not have to take any pills). She clarified that it would be compulsory as long as the mother or father sign the form (Moatshe, 2025). Section 134 of the Children's Act (No. 38 of 2005) affords children over the age of 12 access to contraception on request by the

child, without parent or guardian consent. In response, an open letter was drafted by Section27 (and endorsed by various stakeholders including the CSSR) to the Member of the Executive Council voicing the ways in which such a strategy is misguided and unlawful; it stated, moreover, that an attempt to forcefully administer contraceptives to children threatens bodily integrity and autonomy, and is a violation of a child's constitutional rights (Section27, 2025).

It is acknowledged that research on reproductive coercion is complex due to certain behaviours that may not be intentionally aimed at influencing reproduction. For example, the intent of 'stealthing'[21] may be driven by sexual pleasure with little regard to the possibility of pregnancy, which could end with a coerced abortion (Pike, 2023). Furthermore, while the term typically reflects a form of psychological manipulation, some authors argue that it also takes on a form of structural violence, as state policies that make contraception and abortion inaccessible are basically inflicting reproductive coercion at a structural level (Tarzia & Hegarty, 2021). In this light, Pike (2023) argues that coerced sterilisation is also a form of reproductive coercion.

What is evident in the above review is how women of colour, globally, have been at the forefront in the fight against reproductive oppression (Deeb-Sossa, 2017). Change may be slow but it is inevitable with women's groups (such as Her Rights Initiative, SRJC, and Section27) advocating for RJ and becoming catalysts for social justice. For example, new legislation has ensued in Mexico that remains in place today. It includes: translated sterilisation consent forms; the use of clear and comprehensible language; and a 72-hour waiting period between the granting of consent and the performance of the procedure, to minimise the potential of coercion by HCPs (Deeb-Sossa, 2017; Gutiérrez, 2009). The ACRJ (2005) argues that for RJ to occur, transformation is needed at all levels to end all forms of oppression, so women can gain bodily control by enjoying access to a full range of reproductive choices.

2.4 Reproductive Rights

The ways in which reproductive bodies have undergone abuse in the past gave rise to RJ activists outlining the welfare and reproductive dignity of women in terms of human rights (Ross & Solinger, 2017). In the 1970s, a global women's movement arose, placing human rights at its very centre; this international human rights discourse influenced early RJ activists

[21] Stealthing occurs when a person removes their condom during intercourse without the knowledge or consent of the other person. It violates the partner's reproductive health and autonomy.

(Price, 2020). Simultaneously, women's reproductive rights began to be recognised as basic human rights (Chrisler & Garrett, 2010).

The United Nations-sponsored International Conference on Population and Development held in Cairo in 1994, also known as the "Cairo Conference" was a critical event in the transnational women's movement, as it officially declared women's reproductive rights as basic human rights (Chrisler & Garrett, 2010). Implicit in this declaration was the right for women to make reproductive decisions without experiencing coercion, violence or discrimination. The declaration acknowledged that reproductive health excludes many groups of people due to lack of quality reproductive health information and services, discriminatory social practices, negative attitudes towards women and girls, and the limited power that women often have over their sexual and reproductive lives (ICPD, 1994).

Reproductive rights encompass certain human rights that are recognised in national and international laws (ICPD, 1994). The World Health Organisation (WHO) draws on the ICPD definition to describe them as the "basic rights of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health" (ICPD, 1994, p. 40). In other words, each individual is entitled to reproductive rights, which are embedded in already-existing fundamental human rights guarantees or obligations (Center for Reproductive Rights [CRR], 2009). The CRR, a global legal advocacy organisation based in the USA, is focused primarily on advancing reproductive freedom and rights as fundamental human rights, by using legal frameworks that governments are obligated to uphold (CRR, 2009). The CRR has developed a publication titled *Reproductive Rights Are Human Rights* with the intent to foreground women's reproductive rights within a legal framework. Amongst the twelve rights put forth in the document are the right to privacy, the right to equality and non-discrimination, the right to be free from practices that harm women and girls, the right to be free from sexual and gender-based violence, and the right to access sexual and reproductive health education and family planning information.

This legal framework created a shift within international organisations like the United Nations, who began to recognise abortion as a human right (Ngwena, 2010). The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa was adopted at Maputo, Mozambique in 2003; Article 14 of the Protocol was aimed at shifting the basis of African abortion laws from a criminal paradigm to a reproductive health paradigm (Ngwena, 2010).

Bolstered by the progress made in human, welfare and reproductive rights, new developments in the USA in the 1960s and the 1970s strengthened the prospects for women's

sexual and reproductive wellbeing (Ross & Solinger, 2017). Important Supreme Court decisions led to the decriminalisation of contraceptives, which was an outcome of the Griswold v. Connecticut case in 1965, and the legalisation of abortion, which was an outcome of the Roe v. Wade decision in 1973 (Ross & Solinger, 2017). The former led to birth control being viewed as a private matter, while the latter provided women with choice – though not rights or justice – since a woman's decision was still bound by other restrictions including permission from a doctor (Ross & Solinger, 2017).

Devastatingly, in June 2022, the US Supreme Court overturned *Roe v. Wade* and thereby eliminated the federal constitutional right to seek a safe abortion in the USA (Coen-Sanchez et al., 2022). More recently, in his first week as the president of the USA, Donald Trump made a few executive orders that target reproductive healthcare access that include: rolling back efforts that protect and expand access to abortion and birth control; and reinstating the *Global Gag Rule* thus prohibiting the USA from supporting foreign organisations across the world that offer abortion services (National Women's Law Centre, 2025).

Following South Africa's first democratic election in 1994, the ANC government brought together various stakeholders (anti-apartheid health activists, civil society organisations, women's health groups, and theorists) to develop solutions for equitable health access and distribution of resources (Cooper et al., 2004). Simultaneously, the DoH adopted the primary healthcare approach with a focus on addressing the neglected needs of poor black women and children. The key areas of sexual and reproductive healthcare intervention included maternal health, contraception, abortion, breast and cervical cancer, gender-based and sexual violence, HIV/AIDS, sexually transmitted diseases, and infertility (Cooper et al., 2004). The National Contraception Policy and Fertility Planning Policy and Service Delivery Guidelines (DoH, 2012) and the National Clinical Guideline on TOP (DoH, 2019) have been developed over the years to provide a comprehensive framework for care.

While there has been substantial progress, several hurdles remain that relate to a lack of implementation strategy and planning, limited financial and human resources, the legacy of inequities in healthcare provision across locations, and even barriers specific to particular areas of reproductive care such as a lack of nurses willing to train in and provide abortion (Cooper et al., 2004).

2.4.1 The Choice Rhetoric

The 'choice' rhetoric within a reproductive rights discourse surfaced strongly in the USA following the Roe v. Wade ruling (Solinger, 2013), with the right to privacy being the key argument in the proceedings. Reproductive choice was referred to as the "watchword" of that

era, predominantly by white feminists (Ross & Solinger, 2017, p. 54). However, the assumption linking choice with empowerment (Liddell, 2019) was challenged in the 1990s by women of colour who argued that acquiring reproductive dignity did not depend entirely on personal choice (Ross & Solinger, 2017). In analysing the adoption of a rights framework in reproductive health movements, Spade (2013) argues that within an empowerment discourse, there is a shift of responsibility for health from the state to the individual. In a similar vein, Macleod (2016) asserts that the challenge within a public health approach to a topic like unintended pregnancy is that the woman's *right* to bodily control ends up becoming a *responsibility*, with that responsibility being situated at the individual level. However, a variety of socio-economic considerations such as scanty information, (in)access to medical care, poverty, and gendered power relations all influence the sexual and reproductive health of women (Morison, 2013). The consequence in using the language of "choice" is that individual women are held accountable for poor sexual and reproductive health outcomes (Morison, 2013).

As previously highlighted, only certain women (typically middle-class and white) are afforded choice – whether in relation to abortion, motherhood or adoption – while women (of colour) without resources, lack access to such options (Ross & Solinger, 2017). Public health programmes are critiqued for assuming that "choice" has any meaning to women outside of a middle-class grouping (Macleod, 2016). As has been pointed out by women of colour activists, the notion of choice conceals the political and economic climate of lived experiences: policies and the law respond differently to different groups of women by creating varying degrees of healthcare access for women to manage sex and reproduction (Ross & Solinger, 2017). In fact, institutions conveniently cover up the ways in which inequality is perpetuated and access to resources is minimised, by drawing focus to individual choice (Spade, 2013).

Researchers in South Africa have noted that the framing of the CTOP Act within a "choice" and reproductive rights approach has fallen short in its agenda to advance reproductive health services and gender equality (Chiweshe et al., 2017). The public-private healthcare divide in South Africa is a clear example of how "choice" overlooks social inequality, with 85% of South Africans utilising under-resourced public healthcare (Morison, 2013) and less than 20% of the population having access to private care (Cooper et al., 2004). This shift in responsibility to the individual becomes visible when one examines the ways in which reproductive choices are presented to women (Liddell, 2019). The emphasis is steered to the woman's preference for contraception or abortion, while ignoring her social location or any conditions that hinder her ability and access to resources to make such a decision (Macleod, 2016; Spade; 2013).

2.4.2 Choosing Between Pro-Life or Pro-Choice

Within the abortion debates, individuals tend to or are required to vocalise whether they are pro-choice or pro-life. Of course, it has long been recognised that the politics of abortion is far more complicated that this bifurcation suggests. Nevertheless, the descriptors persist despite problems with both. "Pro-choice" is premised on the idea of "choice." However, the assumption that choice dovetails with *access* to a legal abortion encapsulates neither the diverse needs of women nor their reproductive experiences (Liddell, 2019). Pollitt (2014) draws focus to the propaganda infused in the terms pro-life or pro-lifer that goes beyond notions of how a fertilised egg and a woman's life have the same value, and how the criminalisation of abortions can save foetal lives. She argues that the movement to ban abortion is based on a desire to curb women's independence, restrict sexual and reproductive freedom and further the agenda of the "organised political movement" called pro-life (Pollitt, 2014, p. 13). In the USA, pro-life lawmakers have eliminated abortion-funding, lowered insurance cover for abortions, and created challenges at abortion facilities that include ultrasound imaging and long waiting periods (Solinger, 2013).

The CTOP Act in South Africa has, over the years, had to deal with its own share of legal cases that have opposed abortion. These include: the First Certification Case in 1996; Christian Lawyers' Association of South Africa v. Minister of Health in 1998, and again in 2005; Doctors of Life International v. Speaker of the National Assembly in 2006; and the African Christian Democratic Party (ACDP) Private Members' Bill in 2008 (Kleinsmidt, 2021). Across these cases, the challenges to abortion rights ranged from efforts to afford the foetus legal rights, to requiring parental consent for minors, to mandating ultrasound and counselling, to contesting the Act on procedural grounds, and imposing additional steps during the process – all strategies commonly used to limit access (Kleinsmidt, 2021). Thus, the legal strategies of pro-lifers shifted from directly targeting the core right of the foetus to limiting women's reproductive choice (Albertyn, 2015). All cases were lost in court and the ACDP Bill was rejected by the National Assembly (Kleinsmidt, 2021).

Jarman (2015) asserts that all these varying restrictions under the "hollow rhetoric of protecting life" inevitably isolates (and also depoliticises) the foetus from the woman concerned, her (un)available support network, her living conditions and her access to reproductive services. In South Africa, legal and women's rights activists have typically understood reproductive choice within a broader understanding of equality (Albertyn, 2015). In such an environment, a pro-choice stance is limited due to an assumption that there is choice.

The ideologies of mainstream feminism are grounded in 'choice' and 'rights' with regard to legalising and accessing abortion (Marecek et al., 2017). While several RJ activists remain advocates of the pro-choice campaign, they also acknowledge that the existing tension between "rhetorical reproductive choice" and "actual reproductive justice" is, in essence, their main critique of the choice framework (Liddell, 2019, p. 102). Despite this, many feminists argue that these concepts need to remain at the crux of abortion advocacy (Ferree, 2003). RJ is distinguishable from the pro-choice movement, however, in that the focus is not limited to abortion (Ross, 2006) but speaks to the broad suite of reproductive issues while encompassing inequities and disempowerment as strong influencers of reproductive health outcomes (Morison, 2013) and social justice (Liddell, 2019).

2.5 Reproductive Justice

Merging reproductive rights and social justice gave rise to reproductive justice (Ross, 2017). An RJ framework incorporates and extends the rights framework, as it considers the intersecting social dynamics that promote or hinder women's access to services as well as their capacity to decide the outcome of their pregnancies (Macleod et al., 2017). RJ entails three core principles: (1) the right to have a child; (2) the right to not have a child; and (3) the right to parent a child or children in safe and healthy environments (Ross, 2006). Elaborating on this at a lecture titled *Reproductive Justice 101* (Snakegrrl Sociology, 2008), Loretta Ross emphasises that every woman has the human right to decide *if* and *when* she will have a baby and the conditions in which to give birth; to decide if she will *not* have a baby and her options for preventing or ending pregnancy; and to parent a child with the necessary social support, in a safe environment and a healthy community, without any fear of violence from individuals or the government. This provides a refreshing outlook in advocating for reproductive issues. It underscores that women of colour need to fight equally for a right to parent or *not* parent; and this includes fighting for an environment that enables the realisation of these rights (Ross, 2006).

In expanding the rights and reproductive health movement, RJ offers an intersectional lens to the politics of reproduction with the aim of protecting women (Ross, 2017). It also extends beyond choice and addresses the historical and socio-economic issues that disempower women (Gilliam et al., 2009). As Ross and Solinger (2017) assert, "individual choices have only been as capacious and empowering as the resources any woman can turn to in her community" (p. 16). How context plays a key role is evidenced in South Africa: even though South Africa's legal framework for abortion may be rights-based and liberal, other

structural and socio-cultural aspects have interfered with how this service has been offered and taken up by abortion seekers (Macleod et al., 2017).

Additionally, “choice” may not feature in abortion seekers’ understandings of their decision. A comparative study related to abortion decision-making in two countries (South Africa and Zimbabwe) revealed a strong need in participants to defend their abortion decision (Chiweshe et al., 2017). Despite differing political contexts and legal stances of abortion in each country, women in both places spent considerable time offering a variety of justificatory narratives even though the researchers did not query their reason for abortion. In neither case were rights or choice deployed as a reason. “Shame and hiding” featured, but only in the Zimbabwean context where abortion legislation is more restrictive than in South Africa (Chiweshe et al., 2017).

RJ vocalises the needs of women of colour, young girls, women with disabilities, immigrant women, imprisoned women, poor women and those who have been victims of discrimination (Gilliam et al., 2009). As a contemporary lens that deliberates on the experiences of reproduction (Ross & Solinger, 2017), it embraces the “complete physical, mental, spiritual, political, social and economic well-being of women and girls” enabled and safeguarded through women’s human rights (Ross, 2006, p. 14). Ross (Snakegrrl Sociology, 2008) asserts that, in short, RJ describes the key problem as reproductive oppression, foregrounds human rights, connects an individual to their community, and adopts an intersectional analysis.

2.5.1 Intersectionality and Reproductive Justice

Intersectionality is a concept closely tied to RJ. The intersectional ways in which freedom and opportunities are distinctively constrained for women due to interlocked structural inequalities are prioritised in RJ. Examples of these constraints effected through reproductive oppression and disparities in women’s lived experiences are cited earlier in this chapter (Deeb-Sossa, 2017; Ross & Solinger, 2017; Sheoran, 2015; Strode et al., 2012; Whyte et al., 2015). While the provided list of reproductive oppressions is in no way exhaustive, it draws focus not just to the secondary status of women in society but also to the hierarchy that prevails within groups of women; this limits the decision-making capacities of certain groups due to unequal opportunities. Intersectionality highlights the diverse ways in which reproductive oppression occurs, thereby enabling a systematic study of how different categories such as race, gender, class, ethnicity, sexuality and other socio-political and cultural groupings relate to each other (Fotopoulou, 2012) and create unique lived experiences.

As a theory, intersectionality came to the fore in the late 1980s and underscores the complexities around 'differences and sameness' within social movements (Cho et al., 2013). This theory has meaning within the RJ movement because of its acknowledgement of inequities in society *amongst* women and the acknowledgement of *certain* women's oppressions based on their social location. One of the goals within feminist knowledge has been to respond to differences between women; hence, an integral part of intersectionality is to understand how each category of inequality marginalises women and renders them vulnerable (Davis, 2008). Carbado (2013) stated that the growth of intersectionality as a theory depended on how it could be utilised. The relevance and adoption of intersectionality in the RJ movement have led to the mobilisation of both theories, with each complementing the principles of the other.

2.5.2 An Intersectional Analysis in Reproductive Health

Intersectionality expands the understanding of what the "problem" is within the public health system (Hankivsky, 2012) and this intention overlaps with an RJ framework. For example, within HIV research, this theory enabled the focus in a study to move beyond the individual and deliberate on their lived experiences within broader and inter-connected aspects of unemployment, poverty, state policies and the economy (Browne et al., 2011). Within reproductive health, Ngwena and Durojaye (2014) highlight that the criminalisation and stigmatisation of abortion that inevitably create a market for unsafe abortions, particularly affect women with no means. In other words, women living in rural areas, black women, poor women, women with disabilities, and women living with and affected by HIV/AIDS are more adversely impacted than their wealthier, urban, white counterparts. Each year, tens of thousands of women die; and millions risk their health and lives to be able to terminate pregnancies where abortion is not legal or safe (Hindin, 2007).

Wilson (2018) maintains that coercive sterilisations in India are a type of violence against poor, "lower" caste, rural women committed at a state and global level. A study involving Black and Latinx women's perceptions of abortion in Georgia, USA, highlighted the repercussions of intersectional oppression, intersectional stigma and lack of diverse clinic staff as barriers to accessing the service (Mosley et al., 2022). These studies are valuable in reframing health issues, as they not only contribute to the development of primary health services that address these issues, but also to a deeper understanding of their causes (Hankivsky, 2012). For example, Mosley et al. (2022) recommended diverse clinic staff, flexible fee schedules, and the integration of abortion at a community level to offer a holistic model of care.

The various articulations of RJ and its objectives highlight the importance of analysing and responding to health problems through an intersectional lens as an essential pathway to achieving health equity. In other words, RJ implores an intersectional analysis that always considers the historical context of oppressions (such as apartheid in South Africa) while considering two main components: how individual and social processes are interlocked; and how various axes of discrimination (age, class, ability, sexual orientation and so on) interact in complicated and nuanced ways (Macleod, 2018). RJ has, thus, emerged as a critical lens and a social movement that strives for reproductive agency by acknowledging that issues of sexual and reproductive health (SRH) are intertwined with social and economic injustices, racism, heteronormativity and other such forms of oppression (Grzanka & Frantell, 2017). Adopting an RJ framework means first engaging with reproductive injustices so as to contribute to an understanding of elements that will enable reproductive justice. An RJ framework used for research purposes and for the provision of healthcare, can benefit and empower clients (more so than other models) because of the framework's consideration of intersectionality and social justice issues (Liddell, 2019).

2.6 Responding to a Call for Action

The RJ movement has influenced policy, advocacy, scholarship and activism while aiming to redefine the features of reproductive dignity and what constitutes safety (Ross & Solinger, 2017). In this research project, the nurses' training course – designed to provide and improve quality abortion counselling services – responds to two calls for action.

Firstly, in adopting a RJ theoretical lens, this research responds to a paper by Gilliam et al. (2009) titled "A Call to Incorporate a Reproductive Justice Agenda into Reproductive Health Clinical Practice and Policy" where the authors stress the value of healthcare providers' education in increasing access for marginalised groups of people, which would positively influence family planning, abortion care and other preventative healthcare services.

Secondly, the paper responds to the principles of counselling psychology as encouraged by Grzanka and Frantell (2017), who urge counselling psychologists to work with other health professionals to fight reproductive oppression. In their paper titled "Counselling Psychology and Reproductive Justice: A Call to Action," Grzanka and Frantell (2017) draw links between individuals' SRH, individuals' mental health and the role of counselling psychologists in advocating for SRH rights. The authors note that mental health is not auxiliary but central to RJ, and highlight how it is foregrounded in the definition of RJ, which emphasises the physical, mental and spiritual wellbeing of women (ACRJ, 2005; Ross, 2006). By

integrating RJ principles into counselling psychology research, training and practice, psychologists can contextualise healthcare problems using intersectionality theory, and destigmatise reproductive justice practices within the healthcare system (Grzanka & Frantell, 2017). In fact, the values of counselling psychology specific to South Africa include incorporating a social justice agenda to help overcome apartheid's legacy of inequality (Bantjes et al., 2016).

2.7 Reproductive Justice and its Limitations

RJ developed as a response to some of the critiques of mainstream feminism that did not focus on women of colour or poor women, and the notion of 'choice' (Ross, 2006) that claimed to recognise women's rights but did not provide concrete ways to achieve such rights (Liddell, 2019). Some criticisms of RJ have surfaced over time. These include concerns around its usage by mainstream feminist and reproductive health organisations without adequately incorporating its principles into the programmes and policies (Luna, 2011). For example, Luna's (2011) study with a national reproductive justice coalition in the USA found that leaders of women's organisations (who were part of the coalition) were more likely to acknowledge issues that affected the relatively advantaged members and assume that these problems affected all members, instead of noting issues that impacted disadvantaged sub-groups. Luna (2011) asserts that the gaps between the lens' ideologies and practices pose a challenge to advancing the movement, with several mainstream organisations still needing to address issues of race. This calls for an exploration of personal identity for individuals with more privileges (Luna, 2011).

There is also an acknowledgment for further articulation of this theory depending on the issue being discussed and the context in which it is taking place. For example, in relation to the prejudices of an unsupportable or unwanted pregnancy, it is relevant to study the legal and social contextual elements that advance or restrict reproductive justice with regard to pregnancies (Macleod et al., 2017). Similarly, the discourses surrounding abortion decision-making may overlap and/or diverge in nuanced ways across different politico-legal contexts (Chiweshe et al., 2017). This observation highlights that while RJ endeavours to enable access to reproductive health services, the ways in which this may be achieved in a Western context cannot be viewed as a blanket solution across countries and across various injustices. Thus, building client-centred counselling skills in nurses via a training course may carry different implications when facilitating the course in South Africa due to the narratives, experiences, and challenges experienced by a particular group of abortion providers (in this case public health, in-service nurses).

Another limitation of the RJ framework is its focus on cisgender women with regard to their reproductive abilities (Liddell, 2019). An expansion of the concept to engage in issues such as transgender parenting or heterosexual bias could strengthen the theory (Liddell, 2019). Similarly, topics such as disability, immigration status and sexuality all need traction, although Luna (2011) cautions that the co-optation of this theory in other areas should not lead to its dilution. In contrast, Morison (2022) acknowledges RJ's limited use in psychology due to its positivist bias. Although RJ offers a comprehensive framework, it tends to lack clarity in application, with limited guidance on analytical concepts and their implementation (Morison, 2022). One way proposed to overcome this setback is to deeply consider the theoretical assumptions upon which the chosen research study operates and whether the chosen methodology truly advances reproductive justice (Morison, 2022).

There are some methodological challenges to using RJ in feminist psychology due to the latter's allegiance towards mainstream psychology's postpositivist epistemological position that typically values an outsider researcher objectivity (Avery & Stanton, 2020). This appears to stand in contrast to RJ's emphasis on community-based interventions which acknowledge that individuals are rooted in the communities where they experience systemic vulnerability (Avery & Stanton, 2020). Nurses play a dual role in the health system: as providers of abortion services, and as users of the same health system. It is beneficial to recognise the limitations of this framework and to understand its implications on the research and the training course. As research participants, nurses' experiences are grounded in personal subjectivities and broader institutional knowledge.

In needing to engage with such complexities, I embrace the qualities of being a feminist and a critical psychologist who is "uniquely trained to interrogate phenomena at intrapersonal, interpersonal, and structural levels" (Avery & Stanton, 2020, p. 7). Based on the analyses of the authors in the previous paragraph – one key takeaway is to understand the need for developing a *contextual* training course that is underpinned by the fundamental principles of reproductive justice (the right to have a child; the right to not have a child; the right to raise a child in a conducive environment) and client-centred principles (deep listening, non-judgement, and empathy, amongst others). The learning outcomes of the ACCC have been developed to dovetail with these principles, further facilitated by action research methodology that comprises continuing cycles of critical reflexivity (detailed in the methodology chapter).

2.8 Conclusion

The assertions made by Ross and Solinger (2017) in their book on reproductive justice underscore its vision to protect reproductive rights. The authors highlight that implicit within the understanding of fertility, reproduction and maternity (or parenthood) is a need to understand the social context within which these experiences occur. Therefore, in order to assess the reproductive health of a group, due consideration must be given to the extent of a community's access to affordable reproductive services. This further emphasises the interconnectedness of "health, health care, poverty, community empowerment, and the experiences of individuals" (Ross & Solinger, 2017, p. 12).

In concluding this chapter, I acknowledge the expanse of the Eastern Cape in South Africa, the health inequities prevalent across the province, the divide between the private and the public health sector, and the under-resourced public health facilities. Within this setup is the added stigma attached to abortion that is faced not only by women seeking the service, but also by healthcare providers who offer the service (Norris et al., 2011). This research works towards a collective goal of understanding RJ; and the training course for nurses strives to advance the RJ movement and enhance the theory. The training course space has the potential to enable abortion healthcare providers to become critically conscious agents of social change, who then have the capacity to transform policies and institutions, thus positively impacting the reproductive lives of women.

In this chapter I traced the development of reproductive justice (RJ), the main theory that underscores my research. I described how RJ considers the socio-political climate and health hindrances (such as forced sterilisations, restricted family sizes and stratified access to contraception) that constrain women's reproductive choices and their ability to make decisions. RJ through a feminist lens highlights women's agency, which complements feminist abortion counselling approaches (Ely, 2008) that are embedded in the CSSR AC Guideline used for the training course. Quality abortion services remain at the crux of this research, in terms of elaborating on what constitutes it, what hinders it and what transformations are being made from the viewpoint of healthcare providers to promote it.

CHAPTER THREE: ABORTION COUNSELLING

3.1 Laying the Groundwork

Contemporary research into quality abortion services globally indicates that the inclusion of objective and evidence-based counselling is considered good practice (Birdsey et al., 2016). Furthermore, counselling and education are rated as the most important aspects that influence overall client satisfaction with regard to an abortion procedure (Breitbart, 2000). This chapter focuses attention on research related to abortion counselling. It includes the different approaches to, types of, and modes in abortion counselling. An approach refers to the philosophical underpinnings of the process, which include a deliberate and intentional method that can be applied in various environments (California Learning Resource Network, 2024). The different types of counselling are dependent on a woman's requirements, and whether she requests counselling. If she does not, then it may be limited to obtaining informed consent and the procedural type of counselling. Lastly, I describe modes as the format in which the counselling takes places, which is often predetermined by the clinic staff.

I also highlight the advantages and limitations of the approaches to abortion counselling that have been put forward by authors over the years; these invariably shape the experiences of abortion seekers. These approaches (which include feminist practice, the head-and-heart approach, pastoral counselling, a framework for decision-making, and the client-centred approach) guided the analysis. I considered the participants' reported demonstrated praxis, post-training, against all the beneficial aspects of abortion counselling (as noted by abortion seekers) highlighted in chapters three and four. In discussing the different approaches, I contend that a client-centred approach based on reproductive justice (RJ) principles is well-suited as a framework for empathetic and empowering abortion counselling.

3.2 The Emergence of Abortion Counselling

Joffe (2013) asserts that abortion counselling began during the 1970s abortion rights movement in the USA. After the legalisation of abortion throughout the USA in 1973, abortion counselling began to be considered an intrinsic part of the procedure, so much so that in a mid-1980s journal publication, it began to be referred to as "a new component of medical care" (Landy, 1986, p. 33). In her paper, Landy (1986) describes how the aim of offering such counselling services is three-fold: firstly, to assist women with making an informed decision;

secondly, to offer emotional support for a medical procedure that had been illegal up until then; and thirdly, to offer professional help to women at the crucial moment of abortion decision-making – one that *could* bear the possibility of psychological harm. Hence, the medical procedure, along with provision of information, support, and guidance from a trained health professional, is said to constitute quality abortion services and is considered exemplary practice (Landy, 1986).

Findings from studies within the first couple of decades point towards patients viewing abortion counselling favourably (Bracken et al., 1973; Landy, 1986). Bracken et al (1973) observed that women who had experienced a group orientation to abortion counselling notably experienced less guilt and more relief about the procedure, despite all participants displaying a preference for individual counselling. Other benefits of pre-abortion counselling were that women reported experiencing lower levels of isolation, depression, guilt and anxiety as compared to cases where no counselling was given (Steinberg, 1989). In contrast, inappropriate or inaccurate counselling (such as when women felt that their consent to abortion was not informed or that the counsellor failed to provide adequate information) was found to cause potential harm to women by increasing the risk of post-abortion trauma (Steinberg, 1989).

In Britain, abortion counselling has undergone changes against an everchanging socio-political-legal backdrop partly because it is not a legal requirement (Hoggart, 2015). After the Abortion Act of 1967 was passed, there was initial ambiguity about the purpose of abortion counselling. In the 1970s, the Lane Committee proposed that abortion counselling should include informed consent and equality of access. In the 1980s, a distinction was made between counselling solely for an informed decision and therapeutic counselling, which could be offered to women who were uncertain about their decision (Hoggart, 2015). A significant observation from earlier findings is that several women felt they were being over-counselled, as many of them had already made a decision based on their personal circumstances (Allen, 1985). Additionally (and relevant to this research), Allen's (1985) study also noted the need for *horizontal support systems* for frontline staff who offered counselling services to abortion patients.

The benefits of this recommendation become clear in my analysis, with peer support featuring as an important component that enables abortion providers to critically evaluate their own counselling skills (chapter six), and as a form of informational and emotional support (chapter eight).

3.3 Abortion Counselling Approaches

In their doctoral dissertation that examined healthcare counselling encounters pre-abortion, Mavuso (2018) noted that knowledge about abortion counselling has mostly covered two domains: approaches *to* it; and experiences *of* it. I elaborate on both domains in this chapter. Feminist social work practice (Ely, 2008), head-and-heart counselling (Joffe, 2013), and pastoral counselling (Baloyi, 2012) are some of the frameworks that fall within the first domain, with different models of counselling being presented over time. Based on the studies that I have come across that speak to models for abortion counselling, I make a distinction in this research between *approaches to* and *types of* abortion counselling. An *approach* incorporates a more theoretical orientation and attitude towards abortions, clients and the counselling service, whereas the *type* of counselling comprises the more practical aspects of a counselling session (such as the steps involved in pre-abortion counselling and in acquiring informed consent).

An example of the former is the risk- or harm-reduction approach that started in Uruguay and is now espoused in other Latin American countries with restrictive abortions laws such as Peru. This strategy aims to provide medical and informational support to women before and after an illegal abortion (Grossman et al., 2011). In this literature review, however, I concentrate on abortion counselling in the context of liberal legislation. Below, I highlight some of the approaches mentioned in the literature and draw together certain commonalities that exist across the approaches. These similarities essentially amalgamate into a client-centred approach, which is what is espoused in the nurses' training course of this research project – the ACCC.

3.3.1 Feminist Practice Approach

Joffe et al. (2004) assert that in the 1960s and early 70s, the role of USA-based feminists in abortion work was twofold: to advocate to make it legal; and to enable safe access to illegal abortions during the interim phase. The work of these first-generation abortion activists helped solidify what to include during pre- and post-abortion counselling (Joffe et al., 2004). Despite the development of several counselling styles over time, three aspects remain constant across them all: gaining informed consent; offering procedural information; and providing decision-making support, if necessary (Singer & Ostrach, 2017).

In fact, several reproductive health clinics in the US espouse a feminist lens and therefore their counselling services are typically grounded, whether formally or informally, within a feminist counselling framework (Ely, 2008). A feminist approach entails the following:

normalising the abortion experience, enabling the client to lead the session, taking the political climate – that often negatively influences a woman's access to reproductive care – into consideration, and promoting the client's self-determination (Ely, 2008). At its core, it upholds a client's reproductive autonomy (Mavuso & Macleod, 2019). Historically, some feminist abortion counsellors had argued against an otherwise paternalistic approach in counselling and the addition of aspects apart from informed consent (Singer & Ostrach, 2017). In line with this, Mavuso and Macleod (2019) specify the importance of excluding discourses that awfulise abortion, and these include religious discourses (unless introduced by the pregnant person), while constructing abortion as a safe and legitimate healthcare practice. The authors assert that normalising abortion has the potential to challenge abortion stigma, while Ely (2008) stresses that much of this, including addressing anti-abortion rhetoric, may be achieved during a pre-abortion counselling session.

Indeed, a feminist approach seems especially advantageous for a model of abortion counselling since this area of reproductive health carries a high level of stigma. A consideration of the cultural, social, and political climate can enable HCPs to offer a service that is contextual to the client's lived experience. Additionally, this approach can help empower nurses themselves as they are deeply aware of and experience several challenges related to such work. As Norris et al. (2011) note, abortion stigma affects not only abortion seekers but also those who work in facilities that provide the service, as well as those who advocate for abortion, thus negatively impacting providers by association. However, there is some research that alludes to the limitations of adopting a solely feminist approach; this realisation emerged approximately a decade after the legalisation of abortion in the USA (Joffe, 2013). The limitations and ways to counter them are addressed in the next approach.

3.3.2 The Head-and-Heart Counselling Approach

Created by Charlotte Taft,[22] the head-and-heart counselling model acknowledged a disjuncture between the counselling offered and the abortion experiences of women: many women knew that abortion was the right decision for them, yet their heart felt broken (Joffe, 2013). In her paper about the evolution of abortion counselling, Joffe (2013) describes the reasons behind the development of the head-and-heart model in the USA. Counselling in the

[22] Joffe (2013) notes that one of Taft's earliest editions of the head-and-heart approach was a 1991 booklet used at a women's clinic where Taft was the director. Subsequently, Taft distributed an unpublished paper in 2010 delineating the head-and-heart process to members of the Abortion Care Network as an additional resource to a Pregnancy Options Workbook. Sections of this approach were then integrated into a textbook on abortion provision in the USA. I have thus relied on Joffe's (2013) description of this approach.

early 1970s was overtly political and revelled in the glory of abortion being legalised. Several feminist activists (especially in the state of New York) were amongst the initial people to join this new and emerging occupation of “abortion counselling.” They identified as advocacy-oriented counsellors, who foregrounded their work on promoting women’s rights and safety, often also protecting clients from facilities that were high-priced and escorting patients from the airport to clinics for the procedure.

The role of the abortion counsellor was still developing, and this began to include centering and accentuating the client’s feelings about the experience. By the mid-1980s, the anti-abortion movement began to gain in strength both politically and culturally; this shift visibly began to shape clients’ responses to the procedure. Counsellors found it challenging to recognise the ambivalence in some of their clients, which even led to a sense of cynicism about conventional therapy methods (Joffe, 2013). It soon became clear that much of the focus had been on access but not necessarily the quality of experience. The head-and-heart approach, therefore, aims to support a client in integrating her cognitions and emotions for a healthy response post-procedure (Joffe, 2013).

Taft stated that there are not only medical contraindications to abortion provision but also attitudinal contraindications, and that the latter may be resolved through counselling (Joffe, 2013). Taft viewed patients’ ambivalence as a sign of an attitudinal contraindication to abortion and stressed that it was the counsellor’s job to identify those women who were so ambivalent that they would be unable to come to terms with the procedure (Schoen, 2019). The new method also created a framework to screen clients who appeared to be in a state of high conflict regarding their decision (Schoen, 2019). This took the form of a checklist questionnaire to be filled out during check-in, and it asked about whether the patient was against abortion but felt she had no other choice, whether anyone was pressuring the patient, whether she believed the foetus was a person, and so on (Schoen, 2019).

This model had certain ramifications (Joffe, 2013; Schoen, 2019). Schoen (2019) raised a criticism of this technique as a protracted and cumbersome process, exacerbated by funding cuts that compelled a shift to less rather than more counselling. It was also seen as politically incorrect, and even manipulative to discuss killing, murder and sin. It was described by Beresford[23] – who had trained several abortion counsellors – as an approach that negated the basic premises of women’s health philosophy in which the client is understood to be in charge (Schoen, 2019).

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[23] This is drawn from Johanna Schoen’s 2012 interview of Terry Beresford.

Yet, an increase in stigma around the topic of abortion in the 1980s and 1990s in America led to the likelihood of abortion being framed in religious terms, with women expressing anguish over their decision, fearing God, and hoping for forgiveness (Schoen, 2019). As more patients began to raise religious concerns, Anne Baker – who had been an attendee at Beresford's training workshops – foregrounded a rationale for addressing matters related to spirituality with abortion clients (Joffe, 2013). Baker welcomed local clergy to talk to clinic staff, most of whom were secular in their approach, and help them address religious concerns. This rationale is echoed in Baloyi's (2012) approach discussed below.

3.3.3 Pastoral Counselling

Baloyi (2012) recommends a 'narrative hermeneutical' approach as one possible pastoral approach since most clients are from diverse backgrounds, and hence their counselling needs must be met in different ways and at an individual level. The author's context-specific study is based in the Limpopo Province of South Africa, which has one of the highest levels of poverty and unemployment in the country, and is also overpopulated due to immigrants from neighbouring countries like Zimbabwe and Mozambique (Baloyi, 2012). The study indicates that women's reasons for having an abortion include birth control failure, inability to care for the child, fear of informing their parents, fear of not being able to marry after having a child, and fear that the pregnancy would hinder their education and career plans. As each woman has her own reason(s) for seeking an abortion, Baloyi (2012) argues that the counselling session should predominantly consist of *listening* because the foundation of a narrative approach is to listen, to hear, and to interpret stories from clients.

Baloyi (2012) embraces various pastoral care techniques while counselling. These include being respectful of different perspectives, cultures and language metaphors; and practising a skill-set comprising a non-judgemental attitude, unconditional positive regard, and acceptance towards the client. The author maintains that while the research does not dismiss other counselling methods offered by social workers and nurses, a Christian approach can be beneficial to women who seek an abortion and who believe in God. Baloyi (2012) highlights the benefits of a narrative hermeneutical method, stating that it offers clients the time they need, thus enabling self-help, without the counsellor prescribing what needs to be done.

Such an approach may also have value for healthcare providers who experience any moral conflict about this service provision. A policy brief from the Western Cape Province in South Africa revealed nurses' religious biases when counselling. For example, one nurse stated that she preferred to advise patients against the service unless it was for financial reasons or interruption of studies, since "it's a sin to kill" (WHO, 2010, p. 3). Another nurse,

who identified as a practicing Catholic, shared that in spite of being ostracised by her church, she had reconciled with her decision to be involved in abortion provision (WHO, 2010). The fact that a nurse finds a need to make peace with such a decision lays bare similarities in the experiences of both clients and service providers alike, due to societal norms, religious discourses, stigma and ethical or moral constraints. In such instances, Baloyi's (2012) Christian approach may have something to offer persons who hold a similar belief system as the author himself. Yet, certain limitations about this approach need to be addressed.

Baloyi's (2012) approach is based on the premise that abortion is a sin and will most certainly negatively impact the woman and those close to her. He claims that the woman's life will never be the same without 'proper' counselling. Referring to clients as 'victims' of abortion, and assuming that there will be 'consequences' post-procedure are problematic for a number of reasons. Firstly, it ceases to truly acknowledge a woman's agency in the decision process, thereby contradicting some of the features of a narrative approach that prioritise clients' lived experiences and how clients make sense of their world. This emerges in Baloyi's (2012) description of how some women might prefer to shun their responsibility and instead rely on the expertise of the pastor. This appears to contradict his own suggestion that a counsellor should spend most of the session listening, and his emphasis on how the central facet of narrative therapy is that it views individual people as the experts of their own lives.

Pastoral counselling can be directive and prescriptive with counsellors feeling that they need to create responsible and good (God-fearing) citizens; this came to light in a paper that explored contraceptive counselling techniques (Macleod, 2006). A format that assumes or induces guilt and shame (I highlight certain words below that could have this effect) may actually cause harm to the woman (Mavuso, 2018). Baloyi (2012) argues that the paper's aim is to enable patients to 'cope' with their 'trauma'. Once again, the assumption is that abortion is complicated and necessarily traumatic instead of merely being a common gynaecological procedure. To quote, "it may be allowed, yet sometimes it is committed without any specific reason" (Baloyi, 2012, p. 1), insinuating that a woman may be "committing" an error or a crime, without any thought or purpose, which seems incongruent to his suggested approach.

Lastly, referring to clients as 'abortion sufferers' who 'struggle' post-procedure as they had not been informed of the 'consequences' precludes research that highlights that (a) it is not uncommon for many women to have already made a decision prior to accessing the service (Brown, 2013; Kumar et al., 2004; Vandamme et al., 2013), and (b) several women experience relief post-abortion (Breitbart, 2000; Brown, 2013; Steinberg, 1989). Mavuso (2018) observes that the approach supposedly prioritises how clients make sense of their lives but negates the possibility that women experience abortion in vastly different ways. Thus,

while pastoral care techniques may cater to certain women, the approach remains limiting, as it perpetuates the negative emotional and spiritual consequences it assumes are an outcome of the procedure itself (Ely, 2008; Mavuso, 2018).

3.3.4 Framework for Decision Counselling

Perrucci (2012) presents an approach emphasising the practice and philosophy of abortion counselling, while engaging with common dilemmas faced by clients, and encouraging self-reflection from the provider. Her manual covers a broad range of patient issues, case examples, and training techniques for counsellors to become adept at offering compassionate decision-counselling in family planning and abortion clinics across the USA. In her book, the author offers several self-awareness exercises that enable providers to acknowledge their own feelings and beliefs about the topic of abortion, so that when they are faced with a client's conflicted emotions and spiritual or moral dilemmas, the provider can distinguish between their own sentiments and the client's (Perrucci, 2012).

As the philosophy behind it is firstly (and essentially) *humanistic* and patient-centred (Perrucci, 2012), this approach ties closely to the principles of person-centred therapy,[24] which I discuss under the next heading. Secondly, Perrucci (2012) advocates for a *phenomenological* style of inquiry as a good fit for decision counselling. The method enables a nurse[25] to explore and investigate the client's world from a bottom-up perspective, meaning that the client is given the space and freedom to reveal their experiences without the provider making any assumptions about their needs or desires (Perrucci, 2012). Lastly, the philosophy is *existential* in that a person's freedom is seen as central in their decision to terminate a pregnancy, which affords them agency and autonomy (Perrucci, 2012).

Perrucci's (2012) decision framework comprises three levels: Level 1 is about *validating and normalising* what the client shares, as this can reduce any shame or judgement that they may be experiencing from within or externally. The author observes that stigmatising

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[24] Person-centred therapy, initially termed client-centred therapy, was developed by Carl Rogers in the 1940s, and this approach continues to evolve with present-day developments in theory and research (Murphy & Joseph, 2016). I use person-centred, patient-centred and client-centred synonymously in my research for two reasons: firstly, depending on the literature, any one of these three terms is typically utilised but in essence share the same principles; and secondly, a person seeking an abortion service is also a client or patient within that interaction with a healthcare provider, whether they avail of the abortion procedure or not.

[25] I acknowledge that abortion counselling guidelines are not always used by or targeted at nurses as providers. In this research, however, I use nurse and healthcare provider (HCP) interchangeably and I may, at times, replace terms such as 'counsellor' or 'therapist' with the term 'nurse.' My aim is to contextualise the approach or skillset relevant to my research topic and underscore the interaction between a nurse and a client.

is a ploy often used by anti-abortion groups who aim to alienate or isolate persons seeking this service, which can further lead to feelings of guilt and regret in clients. Normalising, on the other hand, can help clients realise that they are not alone. Level 2 aims to *seek understanding* by acknowledging what the client is communicating, both verbally and through their body language. When a client expresses an emotion, there are different ways to respond, which include either opening the space to share more (by asking open-ended questions) or closing the conversation. The healthcare provider's response to what is being shared reveals how they feel about what is being said. Therefore, a nurse needs to choose the right words to respond, since that nurse may be the first, and perhaps only, person to whom the client talks.

Level 3 involves *reframing* the way clients think about themselves, which helps dispel myths about abortion. This shift can transform self-directed negative emotions into a sense of empowerment, potentially challenging anti-abortion rhetoric. As an example to demonstrate the importance of listening and clarifying, providers should not assume what a client means if they use the word regret. The regret may not pertain to the abortion itself, but rather about having become pregnant, or not having used contraception, or about having had sex with a particular partner, or about being in a situation where both options are undesirable. Thus, understanding exactly what is meant by regret is important. Once this clarity is obtained, then other insights can be brought to the fore. Ultimately, several patients experience immense relief when listened to in an empathetic and supportive manner (Perrucci, 2012).

3.3.5 Client-Centred Therapy

While traditional client-centred therapy is known to be a non-directive approach, the term *person-centred* can refer to a range of contemporary approaches (Renger, 2021). Early descriptions of client-centred therapy tended to focus on technique as though it was merely a method that needed to be adopted by a counsellor; however, effective client-centred therapy occurs when a counsellor holds a particular set of attitudes and utilises techniques that are consistent with their beliefs and personal organisation (Rogers, 2012). In other words, a counsellor who merely uses a method may not be as effective as one who uses a method that is in sync with their own developing attitudes (Rogers, 2012). Similarly, possessing a set of attitudes that facilitate change is inadequate if appropriate methods are not applied (Rogers, 2012).

The latest edition of Carl Roger's 1951 book puts forward a few arguments advocating for client-centred therapy (Rogers, 2012). While the approach mainly relates to a psychotherapeutic setting, I highlight certain elements here because the nurse's abortion counselling training course in this research promotes a client-centred approach.

Firstly, although the concept of nondirective counselling began as a process of verbal exchange to counsel individuals in a *one-on-one* setting, it is now applied in a range of activities that include *group therapy* with diverse groups such as school students, veterans, interracial groups and parent-child groups (Rogers, 2012). Group work has led to the adaptation of P-CT principles into the field of education, and – although less researched – in group settings dealing with poor morale or organisational administration and evaluation (Rogers, 2012). P-CT is, therefore, neither rigid nor static but influenced by culture and time, which broadens its applicability to industrial, social, and religious work (Rogers, 2012). Although Rogers (2012) makes no specific reference to healthcare provider groups, it is not implausible to extend the applicability of these principles into the nursing profession. In fact, the code of ethics for South African nursing practitioners, which guides nurses in ethical decision-making – is premised on respect for human dignity, and upholds the principles of beneficence, non-maleficence, and the autonomy of patients to make their own decisions (SANC, 2013). These values are embedded in Roger's description of P-CT that epitomises a non-directive approach and an attitude of unconditional positive regard and empathy (Renger, 2021).

A second motivation for this approach concerns the 'testability of its hypotheses,' which can be proved or disproved with empirical evidence, and therefore can enable change, reformulation, and development of the approach (Rogers, 2012). While a language of 'validity' is less embraced in qualitative research, the notion of credibility through iterative refinement has value in my study, due to the adoption of action research cycles. Though this aspect has not been explicitly explored in the context of client-centred abortion counselling, the literature highlights key features, such as client-led sessions and non-judgemental clinic staff, that reflect the core values of P-CT. These features include: (1) How HCPs' conceptualisations of abortion impact the extent to which they wish to be involved in the procedure (Harries & Constant, 2020); (2) how their attitudes play a role in encouraging or discouraging a client from having an abortion (Chiweshe, 2016); and (3) the experiences of clients who access abortion services and which aspects of service are described as helpful (Ely, 2008; Mavuso & Macleod, 2020).

Moore et al. (2011) conducted a study of women accessing abortion in which a "cafeteria-style" or individualised approach was used, referring to how women have diverse concerns and needs; rather than feeling compelled, clients should receive care tailored to their unique requirements.

A client-centred approach to abortion counselling emphasises both the patient and the counsellor, while also considering their environment. Cain (2012) asserts that P-CT rests on

the assumption that optimum growth occurs when it is self-directed by clients themselves, and that all persons have the potential to resolve their own problems and develop psychologically in an environment that supports transformation. As it is understood that an individual may only engage in this process within certain pre-existing conditions, the main role of the counsellor is to create such a space for their client (Cain, 2012). In other words, an individual must want to effectuate change in their life in some way, and the environment, facilitated by the counsellor, must support this desire. In relation to a client's reproductive health experience (which includes abortion services), a client-centred approach would enable nurses to have an awareness of their influential role in a TOP setting. In fact, research related to pregnancy supportability[26] in South Africa has pointed to the interconnectedness of a pregnant woman with not only her micro- but also the macro-environment (Macleod, 2016; Kalyanaraman, 2019). Therefore, framing client-nurse interactions within the macro-environment has relevance in client-centred abortion counselling, as it offers a nuanced understanding of the larger socio-political climate within which this service is both offered and constrained.

Other research in South Africa shows how abortion attitudes and decision-making for nurses around abortion provision are shaped by health systems and the environment at institutions (Harries & Constant, 2020). Some abortion-care manuals, such as those published by Ipas, incorporate values clarification as part of nurse training for abortion provision, and include exercises that discuss barriers to accessing abortion-related care (Ipas, 2013; Turner & Page, 2008). Rogers (1957) postulates six essential conditions for constructive personality change using client-centred therapy: (1) the therapist and client must be in psychological contact; (2) the client must be in a state of incongruence, feeling anxious or vulnerable; (3) the therapist must be congruent in the interactions; (4) the therapist must show unconditional positive regard towards the client; (5) the therapist must be empathetic towards the client's frame of reference; and (6) the client must be able to perceive, even marginally, the therapist's empathic understanding and unconditional positive regard. As this research adopts a client-centred approach, I apply these conditions to an abortion counselling interaction to demonstrate how they may apply to and promote, not personality change, but quality reproductive healthcare.

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[26] Macleod (2016) theorises the term 'supportability' to refer to a person's emotional, cognitive, and physical capabilities in having positive pregnancy outcomes which are either enabled or hindered by various micro-interactions (which typically include a partner, family, friends, healthcare providers and work colleagues) and macro-structures (which include religious and cultural norms, socio-economic policies, the healthcare system, and social and gendered discourses). This description succinctly elucidates the two-fold nature of person-centred therapy, meaning that although it is centred around the individual, the role of the healthcare provider is just as important in creating a safe environment for change, in this case, a positive experience of the abortion procedure.

The afore-mentioned conditions would present, firstly, as the establishment of contact between a client and a nurse, and, secondly, as the client being in a state of incongruence. Cognitive dissonance occurs when a client experiences conflict between their behaviours and their thoughts or beliefs (Perrucci, 2012). While this state aligns well with abortion-decision counselling, it could also occur in a situation where a client has already made a decision, yet experiences apprehension and concern due to other reasons such as perceived negative judgement from others. In fact, Joffe (2013) stresses how the strengthening of the anti-abortion movement in the late 1980s played an important role in creating stigma about the procedure, which led to several patients arriving at clinics "visibly conflicted" (p. 61). A client may thus be distressed, confused, and overwhelmed. The next three conditions are, therefore, particularly important and relevant as they relate directly to the skillset of the HCP. The nurse must offer empathy, demonstrate positive regard and remain congruent in the interaction. Research on clients' experiences of abortion counselling shows that empathy, kindness, gentleness, presence, and emotional support from healthcare providers are viewed as positive aspects of care (Mavuso & Macleod, 2020). The final condition is that the client perceives the counsellor's positive regard. A patient must see the nurse as a person who is empathetic, non-judgemental and genuine in the interaction (Cain, 2012).

3.3.6 Similarities Across Models

There are several overlaps between the skillsets recommended for abortion counselling across various approaches. Ely's (2008) paper explored the satisfaction levels reported by patients of their pre-abortion counselling sessions and noted that the patient-directed characteristic of feminist abortion counselling is highly valued. A pastoral narrative hermeneutical approach (Baloyi, 2012) also sees value in a patient guiding the session. Encouraging two-way communication, listening respectfully, inviting a client to ask questions, and acknowledging a client's challenges are some recommendations for client-provider interactions in post-abortion care counselling (Tabbutt-Henry & Graff, 2003). Similarly, Breitbart (2000), who offers general guidelines for any kind of abortion counselling, emphasises that patient-centred healthcare requires excellent communication, which involves validating the client's emotions, encouraging their questions, looking at non-verbal cues, and utilising 'if-then' statements. Although neither of the authors' (Tabbutt-Henry & Graff, 2003; Breitbart, 2000) research relates specifically to an approach to abortion counselling, many of their recommendations align with Perrucci's (2012) framework for decision counselling in which she emphasises normalising the experience and seeking to understand the client through effective communication. Furthermore, Perrucci's (2012) primary philosophical orientation of being humanistic is grounded in client-centredness, an approach driven by the

individual without generalising the client's problems, by considering the client's context (Baloyi, 2012; Ely, 2008). As Rogers (2012) notes, client-centred therapy has evolved from a counselling method to a broader philosophy for human relationships, a shift reflected in its widespread applicability and practice.

3.4 Types of Abortion Counselling

Based on research conducted in South Africa on current abortion counselling practices as well as global academic literature, the CSSR AC Guideline prescribes a client-centred approach, and outlines various steps for nurses to follow, such as: what must be done in the case of minors; how to establish the type of counselling to be offered; what basic information must be provided to gain consent; and how to conduct different types of counselling. It thus forms a substantial component of the training course for nurses that was developed in this study (the ACCC). The CSSR AC Guideline outlines four different types of counselling, namely: options counselling, procedural counselling, pre-procedural counselling, and post-procedural counselling. While describing the four types, I incorporate relevant literature that relates to each, including information from the National Clinical Guideline[27] for implementation of the CTOP in South Africa (DoH, 2019).

3.4.1 Options Counselling

In the initial stages of legalised abortion and counselling in the USA, feelings and options were not considered a formal feature of medical consultations, as the decision was ultimately seen as the physician's responsibility (Landy, 1986). Abortion counselling models have since shifted from being paternalistic[28] to one that prioritises the patient's choice. In options counselling, the focus is clearly on the patient's autonomy to make a choice of whether to accept or reject a particular health service, alongside the right to be well-informed in order to make such a choice (Sandman & Munthe, 2010).

The aim of options counselling is to provide support to a woman who is undecided about her pregnancy, and the alternatives that she has. It offers her the necessary information

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[27] These are currently being revised. IPAS has been conducting online meetings with the subject, "Alignment of National Clinical Guidelines for the Implementation of the CTOP Act 2019 to the WHO Abortion Care Guideline 2022" (July 2024, email correspondence).

[28] A paternalistic model (or 'doctor knows best') is one where the professional makes the decision based on their understanding of what is in the patient's best interest; this contrasts with informed choice, where the patient makes the decision based on information received from the professional (Sandman & Munthe, 2010).

regarding the alternatives available to her, and it can assist with clarifying her values and feelings about these various options (Mavuso et al., 2018; Singer, 2004). This type of counselling has value because research surrounding pregnancy intention shows that almost half of the pregnancies in the USA (Singer, 2004), and approximately 40% of pregnancies globally (Sedgh et al., 2014) are unintended. The role of the counsellor, therefore, is to create space for the client to self-explore so she can understand her feelings and options, and accordingly take action (Joffe, 2013).

Singer (2004) notes that counselling people with unplanned pregnancies can be challenging for HCPs, firstly, due to their own beliefs about topics like unplanned pregnancy, adoption and abortion, and, secondly, because the situation may be experienced as a crisis in the client's life. In order to address these challenges, Millner and Hanks (2002) recommend that counsellors start by examining and reflecting on their own ethics about the topic of abortion and any biases that they may have about the various reproductive choices available. The authors put forward a set of questions to enable a self-examination for counsellors, which include, for example, their thoughts about which situations would make abortion morally acceptable or warranted, and their feelings about women who have repeat abortions. This process of self-reflection overlaps with Perrucci's (2012) decision-making approach (section 3.3.4). If unbiased counselling is challenging for HCPs to effect, the self-inquiry process can help them to acknowledge their prejudices, refrain from letting these prejudices creep into a counselling session, and maintain a level of "healthy detachment" from a patient's decision (Singer, 2004, p. 236).

The principles of options counselling are listening actively, providing accurate information, offering support and helping clients to assess the options of abortion, adoption and parenting (Singer, 2004). Options counselling is different from informed consent, which essentially provides information about the procedure and its risks and benefits. Lastly, options counselling is not intended to resolve all the challenges that make a client feel undecided, but rather to assist the client in coming to a decision about the pregnancy. The emphasis is therefore on a single decision (Singer, 2004).

Although limited, the literature on options counselling mainly covers the process of decision-making about whether or not to have the procedure (Mavuso et al., 2018; Singer, 2004). The National Clinical Guideline defines this as decision-making counselling, but also includes information on different abortion methods such as manual vacuum aspiration (MVA) or medication (DoH, 2019). This element may fall under procedural counselling, highlighting how the different types of counselling can intersect and overlap. For example, provision of information may cover alternatives to abortion, social grants and government assistance, or it

could be procedure-based, which is the next type of counselling discussed. The best practice, therefore, is to follow the client's cue and clarify what they want to talk about (Mavuso et al., 2018).

3.4.2 Informed Consent

Once a client has come to a decision about having an abortion, the individual has a right to information concerning the procedure (CTOP Act No. 92, 1996). This step is mandatory, and it is the duty of the HCP (from whom the client first requested the service) to provide certain basic information to establish consent from the client. It is important to note that not all abortion seekers want *counselling* pre- or post-procedure, since receiving counselling is voluntary (Mavuso et al., 2018). Thus, irrespective of whether a client requests counselling or not, a provider then proceeds to explain the basic information to gain informed consent. This must be done prior to the procedure and falls under the "right to information" in the National Clinical Guideline (DoH, 2019).

Consent is obtained once the client: is informed that only their consent is necessary for the procedure, understands the method of termination, is aware that non-mandatory and non-directive counselling is available pre- and post-procedure, knows their rights under the CTOP Act, and is offered appropriate referrals if necessary (DoH, 2019). The CSSR AC Guideline also outlines practices to avoid.[29] These include not providing graphic details of the procedure, not emphasising unsubstantiated psychological and physical consequences (such as trauma, infertility and cancer), not asking a client in their first trimester to justify their decision, and not asking whether they were using contraception.

Woodcock (2011) highlights the "the informed consent dilemma" (p. 495), stating that there is a fine line between sharing information that may provoke anxiety, and withholding information that could assist with decision-making, as this can be seen as highly paternalistic with regard to the provider-client relationship. While this predicament may create certain challenges in establishing fixed professional guidelines for abortion counselling, it underlines the need for HCPs to hone their practical judgement skills (Woodcock, 2011). In essence, a process of informed consent that is collaborative, context-sensitive and responsive to

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[29] These actions are evidenced in the recordings of abortion counselling sessions taking place in public health TOP clinics in the Eastern Cape. Thus, the informed consent section in the CSSR AC Guidelines includes what information to provide and also what *not* to do when providing basic information to establish consent.

individual client requirements, offers a more nuanced understanding of client autonomy (Woodcock, 2011).

3.4.3 Procedural Counselling

The purpose of procedural counselling is to offer additional information about the procedure beyond what is covered while acquiring informed consent , should the client request it (Mavuso et al., 2018). Breitbart (2000) states that if a client decides to have an abortion, discussing procedural options is critical because a surgical abortion can be completed in a single visit, while a medical abortion (though less invasive than surgery) requires the client to engage in a longer process that takes place mostly outside the clinic, but offers more privacy and control. The National Clinical Guideline states that procedural aspects may even be discussed during the decision-making phase, as a client may require such details to make an informed decision (DoH, 2019): what will happen during and after the procedure, the duration of the procedure, the associated potential risks and complications, pain management, and follow-up care. This ensures that clients have clarity on all aspects of both surgical and medical abortion protocols, including the degree of engagement required from them (Breitbart, 2000).

3.4.4 Pre-abortion Counselling

Pre-procedure abortion counselling occurs specifically prior to a surgical abortion with clients who have decided not to continue their pregnancies (Singer, 2004). The main purpose of pre-procedural counselling is to provide emotional support before the procedure by inquiring about the client's thoughts and feelings, addressing any questions they may have, and offering affirmation, reassurance, and normalisation of their emotional state (Ely, 2008; Mavuso et al., 2018). Ely's (2008) best-practice recommendations for pre-abortion counsellors include the need for counsellors to address any anti-abortion rhetoric that can negatively influence the client. The National Clinical Guideline (2019) states that if the client expresses an interest in information that did not surface during decision-making counselling, then the pre-abortion phase can be used to cover such aspects.

A key debate in pre-abortion counselling is whether it should include information on contraceptive use. The National Clinical Guideline (2019) suggests initiating a discussion about future contraceptive needs and offering the relevant information about contraceptive options during pre-abortion counselling. I discuss contraceptive counselling under section 3.5.3.

3.4.5 Post-Procedure Counselling

Post-abortion counselling occurs after the procedure, if requested by the client, and is aimed at providing any support that the client requires, perhaps in adjusting to their non-pregnant status (Mavuso et al., 2018). Tabbutt-Henry and Graff (2003) advocate for the incorporation of counselling into post-abortion care in four ways. First, policies should be established at the highest healthcare level to integrate counselling into post-abortion care, including guidelines for implementation through staff training and orientation. Second, family planning counselling must ensure informed choice and be voluntary, meaning that clients have the right *not* to receive a contraceptive method after post-abortion care. Third, the authors stress the importance of incorporating counselling into training programmes alongside clinical training, as counselling is often overlooked in this context. Fourth, supervisors need to monitor HCPs' performance by conducting routine measures and client satisfaction surveys to assess providers' counselling skills (Tabbutt-Henry & Graff, 2003).

In South Africa, the National Clinical Guideline (2019) and the CSSR AC Guideline integrate the first two suggestions made in the previous paragraph. The former advocates for offering a contraceptive method, prescription, or referral if requested by the client, and specifies that "this should be encouraged, but not imposed by the provider" (DoH, 2019, p. 10). The latter offers similar points regarding post-procedure counselling, which include: normalising any emotion that the client feels; reassuring the client that they made the best decision; offering a referral if the client expresses such a need; and providing information about contraception, if requested by the client (Mavuso et al., 2018). If a policy mandates that a client must leave the clinic with contraception, usually a long-term or permanent method, it could violate her rights and deter other clients from seeking post-procedural care (Tabbutt-Henry and Graff, 2003).

This is part of the reason why the third and fourth steps suggested by Tabbutt-Henry and Graff (2003) are equally crucial as a means to ensure post-abortion quality services. Mavuso and Macleod (2019) argue for a reframing of pre- and post-procedure counselling as "a small-scale, social strategy to combat abortion stigma" (p. 12). This approach includes avoiding suggestions that clients were at fault in their previous contraception usage, and refraining from coercing clients into taking particular methods post-abortion.

3.5 Modes of Abortion Counselling

In this section, I discuss a few modes of counselling mentioned in the literature, either as part of a particular type (for example, pre-abortion counselling may be prescribed as

mandatory in certain countries); or as differing slightly in technique (for example, procedural counselling may be offered individually or in a group format). The first two sub-themes compare group versus individual counselling and mandatory versus voluntary counselling, followed by contraceptive counselling. I conclude with a brief description of telemedicine counselling.

3.5.1 Group Versus Individual Counselling

Some studies have utilised a group counselling format without it being the focus of the study (Mavuso, 2018; du Toit, 2023). Mavuso's (2018) study on the narrated experiences of pre-abortion counselling in the Eastern Cape Province of South Africa notes that participants encountered both individual and group formats, though it appeared that they had no say in determining which format they would receive. On the other hand, du Toit (2023) who also noted that both formats were on offer to abortion clients, reported that nurses asked patients about their preference for a format and assigned them accordingly, though it was also dependent on the number of patients at the clinic on a given day.

Literature that specifically explored these formats is limited to an early experimental study by Bracken et al. (1973), who explored three techniques of abortion counselling. Participants, who were abortion clients, were randomly assigned to one of three counselling procedures. The first method, called a *group orientation*, was a predominantly information-giving process lasting approximately thirty minutes, where the abortion procedure, post-procedural care, and birth control methods were discussed. If patients attempted to have any kind of group discussion, it was discerningly resisted by the counsellor. The second technique, called a *group method*, included all aspects of the group orientation but went further by having the counsellor explicitly address various psychosocial issues related to abortion and posed some leading questions to the participants. In the last method, *individual counselling,* the counsellor met with clients individually to discuss aspects such as the procedure, birth control, the client's attitude towards abortion, and any other issues that the client chose to cover. This technique was less structured than either of the group methods, with a time limit of thirty minutes (Bracken et al., 1973).

Although the study by Bracken et al. (1973) is dated, there is value in exploring the possibility of group counselling for abortion provision. Findings show that both sets of women, whether counselled individually or in a group, stated feeling less alone post-counselling. The study also revealed that participants in the group method were more likely to report reduced feelings of guilt, while those in the group orientation reported greater awareness of others' attitudes towards sex. As greater awareness can potentially lead to increased comfort in

discussing sensitive issues, a group format could possibly open up spaces for conversations about stigmatised topics such as sex and abortion. This, in turn, could serve as one way to normalise abortion (Hoggart, 2015; Mavuso & Macleod, 2019).

Other findings from Bracken et al. (1973) show that post-procedure women counselled in the group process felt calm, happy, less depressed, reported the abortion as less painful and expressed fewer doubts regarding the decision to have an abortion. This overall satisfaction level was gauged from their increase in confidence that their medical needs had been met and less dependence on the counsellor as they showed less regret in not being accompanied by the counsellor during the procedure. These are promising findings considering the various challenges identified in South Africa regarding barriers to abortion-service provision (Ipas, 2013). As such, a standardised format for group abortion counselling may be an important aspect to consider for future research.

However, there are certain other aspects to consider. Mavuso's (2018) study from the Eastern Cape noted that some participants who had been subjected to the group format voiced discomfort as they wished to discuss personal and relational aspects of their pregnancy in the counselling session. A paper in the Western Cape Province that put forth a training framework for abortion care in South Africa found that most pre-abortion care took place in a group format and mainly involved information sessions (Smit et al., 2009). While the skills of registered nurses were evaluated as 'adequate in practice' with regard to 'information and advice,' their skills were marked as 'inadequate in practice" with regard to resolution counselling (Smit et al., 2009). Moreover, du Toit (2023) cautions that counselling in a group context can have several challenges due to issues of privacy, confidentiality, and the possibility of minors and adults undergoing counselling in the same group, which may create apprehension.

Having said that, the idea of group counselling need not be ruled out completely. Mavuso and Macleod's (2019) paper found that waiting room conversations amongst abortion-seekers created a form of informal social support in which 'chatting' and 'sharing stories' served to construct abortion as common practice. Some participants found strength, comfort, solace and even a sense of solidarity in exchanging their experiences. Bracken et al. (1973) suggested further research into mediating aspects that make one type of counselling more favourable for some women but not for others, stating that there is value in understanding group dynamics and interpersonal interactions for abortion counselling before prescribing "the most enlightened client-counselling technique." (p. 19).

3.5.2 Mandatory Versus Voluntary Counselling

In the USA, many states have made it mandatory for clients to receive counselling prior to having an abortion; certain states that have waiting periods mandate in-person counselling that requires two in-person visits, with counselling taking place in the first visit and the procedure in the second visit (Guttmacher Institute, 2025). In recent years, several Central and Eastern European countries – who were amongst the first to legalise abortion services across a range of circumstances – have incorporated mandatory waiting periods, and counselling that imposes the type of information to be shared pre-procedure (Hoctor & Lamačková, 2017). Although the information shared must be true and not mislead the patient, there are several debates about what type of information constitutes as misleading with regard to abortion (Woodcock, 2011). Some argue that the purpose is to "protect" women's health, while others note that it simply hinders women's access to legal abortion services (Hoctor & Lamačková, 2017).

Despite mandatory waiting periods and counselling requirements in many European jurisdictions, the counselling, like in the CTOP Act, is required to be non-directive (CTOP Act No. 92 of 1996; Hoctor & Lamačková, 2017). This is linked to the concept of informed consent that emphasises the following: that a woman has the capacity to make a decision about her care; that her participation in the decision is voluntary; and that she receives adequate and appropriate information in order to make the decision (Bain, 2020). Guttmacher Institute (2025) purports that informed consent should render mandatory counselling redundant. Unfortunately, research reveals that the kind of information being offered in these sessions is often *not* non-directive (Bain, 2020; Vincent, 2012); the information thus undermines informed consent by being irrelevant and misleading (Guttmacher Institute, 2025). Thus, informed consent allows elements of mandatory counselling to seep into voluntary counselling sessions by directing the conversation in a particular (anti-abortion) direction.

Some examples of misleading information include links between abortion and breast cancer or future fertility (Guttmacher Institute, 2025) or between abortion and mental illness, despite evidence that refutes such claims (Bain, 2020). Several authors argue that forcing women to receive counselling and information that they do not want challenges their autonomy and decision-making capacity (Hoctor & Lamačková, 2017; Mavuso, 2021) and consequently undermines access to safe abortion (Mavuso et al, 2023). Furthermore, trying to convince a woman to continue with her pregnancy (referred to as anti-choice 'counselling') is a violation of the professional principles of counselling (Allanson, 2007) and must be considered unethical practice (Bain, 2020).

3.5.3 Contraceptive Counselling

Client-centred contraceptive counselling is defined as an intervention in which a woman's thoughts, feelings, wishes, and expectations surrounding contraception are explored in relation to certain external factors, such as the environment and culture (Nobili et al., 2007). The majority of contraceptive counselling literature is linked to peri-abortion. The studies discussed below clearly indicate that one of the main purposes of contraceptive counselling is to prevent future unwanted pregnancies.

Beja and Leal (2010) identified eight components of pre-abortion counselling based on healthcare providers' perspectives, one of which is addressing contraception issues. This component includes discussing prior contraceptive use, raising awareness, providing information, promoting behavioural change by helping with the selection and uptake of a contraceptive measure that aligns with the woman's preference, and referrals to follow-up sessions. Breitbart's (2000) counselling model for medical abortions includes offering contraceptive counselling – which is basically a review of the patient's contraceptive options – when the abortion after-care instructions are issued (post-abortion counselling).

A study from Iceland that evaluated the effectiveness of pre-abortion counselling on post-abortion contraceptive use found that contraceptive counselling before the procedure may not be effective (Bender & Geirsson, 2004). The authors observed that sexual and reproductive health counselling focusing on individual contraceptive use needs to be a two-way communication that requires the client's consent. Although a larger number of clients can be contacted pre-procedure, as they are already present, the disadvantages include a possible overload of information and limited time, since several other aspects of care also need to be addressed. On the other hand, although post-procedure offers more time for contraceptive counselling, the drop-out rate is high as many patients often do not return (Bender & Geirsson, 2004). These findings are echoed in a systematic review of studies published between 1997 and 2007, which found no evidence of contraceptive counselling effecting an increase in use of contraception post-abortion (Ferreira et al., 2009).

Gonzales-Huaman et al (2021) conducted a systematic review comparing randomised control trials to study the effect of enhanced versus standard counselling, where enhanced counselling is a 'new intensified strategy' adopted by the intervention group, whereas standard counselling is the intervention that is typically followed in that study's context (control group). Each study had its own way of enhancing contraceptive counselling, using strategies such as the addition of pre-abortion counselling sessions, personalised contraceptive counselling, the use of audiovisual resources, mobile phone interventions, and motivational interviewing. The results suggest that enhanced contraceptive counselling may improve the effective use of

contraception though it did not appear to affect the occurrence of pregnancies or abortions (Gonzales-Huaman et al., 2021).

Another systematic review compared the effectiveness of different counselling strategies for modern contraceptive methods on contraceptive behaviours and satisfaction (Cavallaro et al., 2020). Studies that examined the impact of provider training and decision-making tools for selecting a contraceptive method yielded no evidence of any significant effect on contraceptive behaviours and satisfaction. However, the authors found that interventions where women initiated the method and received structured counselling about its side-effects typically yielded positive effects on the woman's continued use of contraceptives (Cavallaro et al, 2020).

This type of intervention helps to inform and situate contraceptive counselling within a framework premised on agentic decision-making and bodily autonomy. However, this is often not the case in South Africa, where contraceptive counselling tends to be based on the premise that the pregnancy could have been averted in the first place had a proper contraceptive method been used (du Toit, 2023). A lack of post-abortion contraceptive counselling is, thus, viewed as by some providers as "a missed opportunity for contraceptive initiation" (Harries et al., 2009, p. 9).

The Preamble to the CTOP Act (No. 92 of 1996) includes the following statement: "Believing that termination of pregnancy is not a form of contraception or population control" (p. 2). This implies that the Act neither endorses abortion as a contraceptive method nor as a means to curb population growth. While this statement is, in part, likely rooted in the family planning programmes authorised under the apartheid government in South Africa that contained undercurrents of reproductive control (Kaufman, 2000), it appears to have a bearing on abortion providers. Studies have shown that providers are greatly concerned with poor contraceptive uptake due to the notion that abortion often occurs in lieu of 'responsible family planning' and this perception is heightened in instances when women return for repeat abortions[30] (Harries, 2010; Harries & Constant, 2020). Hence, providers tend to describe the 'problem' as 'failure' to use contraception adequately and/or consistently (du Toit, 2023; Mavuso, 2018). Abortion counselling, thus, becomes a "teachable moment where pregnant people must be made aware of the 'correct information' about contraceptives" (Mavuso & Macleod, 2021, p. 7).

[30] Repeat abortion is a term used by abortion providers to refer to instances when a woman returns for an abortion more than once.

It is relevant then to consider how this topic may be addressed for meaningful outcomes from a public health perspective as well as a woman's perspective that takes into account gendered power relations and other factors (du Toit, 2023).

Annexure A in the National Clinical Guideline (DoH, 2019) is a form to be completed by either a medical practitioner or registered midwife for any TOP procedure, where question 9 is: 'Counselling on contraception' with a yes/no check box and 'method offered' with check boxes for pill/injection/implant/IUD/condom/other. Although the form does not overtly state that a contraceptive choice is compulsory, a practitioner who has not received adequate training in counselling may interpret this question as obligatory, rather than voluntary. The CSSR Abortion Guideline states that a provider may ask if a client would like contraception, and to only provide the information if requested by the client. The aim must be to avoid coercing or forcing a client to accept a contraceptive method post-abortion (Mavuso et al., 2018), which is in line with the National Clinical Guideline, reproductive justice and client-centred principles.

Ultimately, a personalised interactive counselling approach that integrates person-centred communication between a healthcare provider and a woman, built on trust and care, while considering the biopsychosocial aspects that influence her needs and priorities, can enable "a shared transparent decision" (Bitzer et al., 2018, p. 1). It is crucial for abortion providers to acknowledge these various intersecting factors that include cultural norms and stigma surrounding contraceptive use in order to offer a nuanced and empathic approach to discussing contraception (du Toit & Macleod, 2025).

3.5.4 Telemedicine Counselling

Section 3.3 of the WHO revised guidelines (2022b) on self-care interventions for health and well-being addresses the elimination of unsafe abortion. These guidelines recommend early pregnancy interventions at a primary care level and on an outpatient basis, to increase access to care. They advocate for the empowerment of individuals through self-assessment and self-management approaches, which enables healthcare resources to be used more optimally. Furthermore, medical abortions should be made available in instances where a woman has access to accurate information, as long as she has access to a healthcare worker should she need it during any stage of the process (WHO, 2022b).

Upadhyay et al. (2010) explored evidence-based practices in emotional care for sensitive and stigmatised health issues in order to inform abortion counselling. In their study, 'internet-based support' and 'ongoing telephone counselling' were two of the nine identified practices featured as supplemental sources of support (Upadhyay et al., 2010). The authors found that these practices enhanced the counselling services due to the stigma attached to

such services. While this form of counselling aims to improve psychological adjustment, this mode also contains procedural information that may be shared telephonically.

Telemedicine gained relevance under the constraints of the pandemic. Todd-Gher and Shah (2020) underscored the importance of abortion services within the Covid-19 context and argued, in the USA, for women to safely undertake self-managed abortions via telemedicine counselling, as it is a human rights imperative. The authors suggest further ways to facilitate self-managed medical abortions (depending on the legal context) such as waiving mandatory waiting periods, removing bans on telemedicine abortion counselling, and withdrawing criminal penalties for self-managed abortions (Todd-Gher and Shah, 2020).

Ong et al. (2023) conducted a global systematic review globally to analyse the effect of Covid-19 on abortion services. Telemedicine Early Medical Abortion (TEMA) was introduced in several countries, including South Africa, to increase access to medical abortions. TEMA involves a tele-consult with a trained healthcare professional followed by the administration of mifepristone and then misoprostol. In South Africa, TEMA had been previously prohibited except in instances where the provider and patient had a prior relationship; however, this regulation was relaxed during the pandemic (Ong et al., 2023).

3.6 Conclusion

In this chapter I delineated various perspectives, approaches, types, and modes of abortion counselling. Several key aspects have emerged from this discussion. An abortion procedure can be an isolating experience for some women, yet it does not take place in isolation. From my understanding, there are two forces at play in an abortion encounter. At the periphery, the socio-political and legal factors can influence a woman’s access to the procedure and the type of counselling she receives. At the centre, each abortion seeker has unique needs based on which she seeks a distinct service. A critical component intertwined in this milieu is abortion stigma, impacting both clients and providers, limiting their ability to normalise the procedure.

The types of counselling methods and the steps in abortion counselling are not complicated when understood within the South African legal framework. Moreover, the reproductive justice principles discussed in the previous chapter align with the South African Constitution by underlining autonomy, agentic decision-making, and bodily integrity. These values are further embedded in a client-centred approach to abortion counselling by instilling deep listening skills that allows a client to lead a session and the provider to hear what a client is saying.

Finally, a feminist lens to this client-centred approach gives due consideration to the macro-environment while aiming to empower a client. In the next chapter, I discuss the second domain of abortion research, namely, experiences of abortion counselling.

CHAPTER FOUR: ABORTION COUNSELLING PERSPECTIVES AND EXPERIENCES

4.1 Exploring Perceptions

The focal point of my research project is abortion counselling (AC), with the aim of informing, developing and refining a training course in this field. This chapter, the second part of the literature review, sheds light on the experiences of those receiving abortion counselling and those providing it. It begins by setting the context of the clients accessing abortion services – whether it is seen as essential, whether it should be mandatory, what it entails, the reasons for seeking it, how it is typically conducted, and how it should ideally be conducted.

The chapter then moves on to discuss the experiences and attitudes of HCPs regarding abortion service provision. It focuses exclusively, therefore, on studies that explore and problematise experiences of abortion *counselling*, from both the clients' and the providers' perspectives, in order to inform the current research project and meet its goals.

4.2 Abortion Counselling Research

In focusing on counselling-specific research, it became evident to me, as a counselling psychologist, that this is an inadequately researched field. Research studies have explored experiences of abortion and abortion decision-making (Alex & Hammarström, 2004; Brown, 2013; Chiweshe, 2016; Kimport et al., 2012; Lie et al., 2008; Orner et al., 2011; Purcell, 2015; Vodopivec et al., 2019; Tong et al., 2012), but few studies have focused solely on the counselling aspect (with the exceptions being Ely, 2008; Hoggart, 2015; Mavuso, 2018; Singer, 2004; du Toit 2023). These studies about general experiences of abortion care have been conducted in countries with diverse legal and cultural environments, making it a challenge to draw direct comparisons about the role of pre-abortion counselling (as attested to by Vandamme et al., 2013).

There has also been a tendency for studies that *are* about AC to be conflated with contraception research. A possible reason is that studies on contraceptive use often purposively sample clients who have undergone an abortion, as post-procedure is often seen an opportunity to include contraceptive information (Beja & Leal, 2010; Ferreira et al., 2009; Kilander et al., 2018; Purcell et al., 2016).

In South Africa, Harries et al. (2009) discerned a paucity of information regarding the personal and professional attitudes of those working in abortion services. Studies were subsequently conducted to explore nurses' attitudes towards abortion service provision

(Harries & Constant, 2020), nurses' subjective experiences, their decision-making processes in the provision of SRH services (Müller et al., 2016), and how their norms and values shape the provision of abortion services (Röhrs, 2017). Yet, over a decade later, a stark dearth of research on abortion *counselling* persists in South Africa (Mavuso & Macleod, 2021).

However, du Toit's (2023) study on pre-abortion counselling in the public health sector in South Africa is noteworthy for its use of conversational analysis and discursive psychology, and forms an intrinsic part of the baseline research for this project. One of the study's key foci was the overall conversational structure of a pre-abortion counselling consultation, with a micro-level analysis that systematically examined the interactional level of talk. Thus, it specifically analysed turns and sequences of turns within provider-client interactions to perceive how clients interpreted an utterance, their response within that context, and the subsequent proceeding talk (du Toit, 2023). The study identified seven key components of the interaction, referred to as "conversational projects," which is understood as the main objective that participants work towards when interacting. These are: context setting, history taking, establishing the reasons for abortion, presenting the options, providing procedural information, obtaining verbal informed consent, and discussion of family planning. The study demonstrated how the goals of each project enabled problematic discourses that ultimately awfulise and delegitimise abortion, which further led to counselling that was biased and directive (du Toit, 2023). These practices are inconsistent with both the CTOP Act and the principles of reproductive justice.

4.3 Client Perspectives of Abortion Counselling

Given the numerous approaches and types of AC as outlined in the previous chapter, it is likely that the counselling referenced in different studies on counselling experiences ae distinct in nature. Mavuso (2018) advises consideration of this aspect when making any comparisons across studies, as research has indeed shown diverse results in terms of women experiencing AC positively or negatively. It is, therefore, recommended to inquire into the type of counselling models that clinics use, followed by a comparison of the variation in patient satisfaction levels across models (Ely, 2008). Having said that, even a single study may generate varying responses regarding how clients experience abortion counselling (Birdsey et al, 2016; Mavuso & Macleod, 2020). This variability, along with the unique nature and different needs of each client, are important considerations (Vandamme et al., 2013) that have implications for a feminist client-centred pre-abortion counselling model (Mavuso & Macleod, 2020). It is beneficial to study the perspectives of both provision and reception of AC, while keeping in mind the numerous variables that affect this interaction.

4.3.1 Researching Clients' Experiences of Receiving Abortion Counselling

Researchers have used different methods to explore clients' experiences of abortion counselling. Ely's (2008) study,[31] conducted in the USA, adopted a five-item Likert type scale to measure the satisfaction levels of patients with their pre-abortion counselling session. The satisfaction scale included five statements about the information provided, the counselling session, and the counsellor's knowledge, support and responses. All questions were based on the feminist counselling goals stated in the clinic's mission statement, demonstrating that the questionnaire aimed to measure the satisfaction levels of a particular counselling model. Only questionnaires that had responses to at least four of the five statements were considered complete. Results from the study suggest that the majority of the patients who responded to the survey expressed satisfaction with their counselling experience, which led the author to argue for the adoption of feminist counselling philosophies in pre-abortion counselling.

While Ely's (2008) paper is beneficial in providing client feedback to help develop a counselling model, it is not without limitations that also need to be considered. Ely (2008) argues that the measuring instrument lacked the intricacy required for the study, suggesting that the use of a more sophisticated instrument may have yielded more favourable results. Additionally, some questionnaires were excluded from the study because they were incomplete, raising the question about why certain statements may have remained unanswered in a presumably short questionnaire (Ely, 2008). Furthermore, the rating scale does not necessarily highlight what specific aspect led a patient to strongly disagree with any statement on the scale. One recommendation from the study was for future research to focus on acquiring both quantitative and qualitative feedback from patients on the pre-abortion counselling experience with larger sample sizes and more sophisticated instruments (Ely, 2008).

A qualitative study in the USA exploring women's expectations of AC used in-depth interviews with participants either on the day of the abortion procedure or at the client's follow-up appointment, which took place around two weeks after the procedure (Moore et al., 2011). The data were collected from three clinics in three different states, all of which conducted pre-abortion counselling. Two of the states did not have state-mandated counselling, while the third state mandated a 24-hour wait period between the counselling session and the procedure. The counselling included state-mandated content regarding foetal development,

[31] In the earlier chapter, I discussed the counselling model that this study adopted and argued for, which is based on a feminist practice approach.

amongst other information. The study's interview questions included whether the participants had made a decision before speaking to a healthcare professional, what the content of the discussion involved, whether it covered what they had wished to discuss with the counsellor, whether they had any concerns about the procedure, and if so, where those might have originated from (Moore et al., 2011). In this way, the study produced the kind of rich data Ely (2008) advocated for.

Findings from Moore et al. (2011) indicate that most women seeking abortion services have already made a decision prior to their appointment and do not wish to undergo options counselling. Participants reported being hesitant to discuss their emotions with abortion counsellors, saying that their emotional needs were met elsewhere. With regard to patient-provider interactions, women anticipated that the counsellors would attempt to dissuade them from obtaining the procedure and feared that sharing their emotions might, in fact, prevent them from accessing the procedure. Clients also assumed that other women might need support and would benefit from counselling to make a reasonable decision. Moore et al. (2011) argue for a cafeteria, individualised, or tailored approach to AC (see discussion in 3.3.5), as not all women in need of an abortion require the same counselling.

The authors acknowledge some of the study's limitations, such as the inclusion of a state with intense mandates about what the counselling had to include and two states that did not impose any state-level mandates. In answering the interview questions, some of the women did not have clarity about what was or was not mandated. This made it difficult to separate responses to state-mandated versus non-mandated experiences (Moore et al., 2011). Nevertheless, a study by Rowlands (2008) asserts that many women are clear that they do not want mandatory options counselling, and any attempts to include it into government policy must be scientifically challenged. Thus, several authors agree on the undesirability of mandatory counselling as viewed from the perspective of clients (Brown, 2013; Hoggart, 2015; Rowlands, 2008; Mavuso & Macleod, 2020).

A recent study in Mexico and Colombia explored women's concerns regarding AC, highlighting the contrasts in different contexts (Keefe-Oates et al., 2020). The study conducted in-depth interviews with women post-abortion to examine their feelings about abortion stigma and any other fears prior to accessing the service, and to assess whether AC had helped alleviate their concerns. Although both countries have liberal abortion laws, findings revealed that the women in Colombia were worried about the social and legal implications of having an abortion as opposed to the women in Mexico, who seemed more aware of their legal rights to access the procedure. Yet, participants from both places spoke about feelings of guilt and of concerns around judgement by community members or even themselves. The majority of

women in the study said they felt heard, supported, reassured, and unrushed in their interactions with HCPs, leading to high satisfaction levels with the counselling session.

Keefe-Oates et al. (2020) acknowledge some limitations of the study, two of which relate specifically to counselling. First, the study did not aim to evaluate the impact of counselling on support but rather to understand the ways in which AC can assist with providing support and information to clients. Secondly, the role of counselling may have been conflated with other clinical aspects, and so the results may not be an exact description of the counselling experience alone (Keefe-Oates et al., 2020). Despite these limitations, the study demonstrates the ways in which abortion-service delivery – specifically counselling – plays a crucial role in supporting clients by offering accurate information about the safety of the procedure, the law, and emotional support where necessary (Keefe-Oates et al., 2020). In Mavuso and Macleod's (2019) study, the normalisation of abortion as a common procedure helped lower anxiety in clients, leading some to describe their abortion experience as healing and beneficial while voicing gratitude towards the providers. Expectedly, managing stigma is known to positively influence the safety and well-being of clients (Seewald et al., 2019).

An individualised approach with tailored content would benefit women seeking abortion services. In South Africa, Mavuso's (2018) doctoral study – which formed part of the CSSR baseline research that informed my study – explored clients' and HCPs narrated experiences of the pre-abortion encounter. In the study, women's views of their counselling session were varied, with contradictions emerging in their experiences. These included the session being described as informative, doubt-inducing, emotionally hurtful, beneficial and even healing (Mavuso & Macleod, 2020). In terms of content, the following topics during the session led to distress in the client: misinformation linking the abortion to the risk of infertility; the offering of options (when not requested), including the suggestion to put the child up for adoption; and a general tendency to overstate any psychological and physical risks of the procedure. The exaggeration of risks is possibly an attempt by HCPs to dissuade women from having an abortion, hence an 'awfulisation of abortion' discourse is deployed. Consequently, not 'adhering' to long-term family planning or long-acting reversible contraceptives (LARC) tends to be viewed by HCPs as 'defaulting' which further positions abortion seekers as 'failed' or 'bad' women (Macleod et al., 2019). These interactions with HCPs were emotionally troubling, leading to some of the clients feeling hurt as a result (Mavuso & Macleod, 2020). One of the main findings in Mavuso and Macleod's (2020) study highlights the directive nature of the counselling.

These various findings indicate that some women may be ambivalent about the value of AC. Some women feel pre-abortion counselling is unnecessary due to the certainty of their

decision, while others may fear judgement from clinic staff. In spite of experiencing some distress (due to uncertainty about what to expect from clinic staff) prior to the procedure, women are often still resolute about their decision to have an abortion. Depending on how women experience an abortion counselling session and whether they are satisfied with it, clients are likely to feel less negative and more decisive post-counselling. The session can, thus, enable clients to better understand their decision and emotions surrounding the process and reduce any internalised stigma.

4.3.2 The Whether, What, Why, and How of Abortion Counselling

In this section, I discuss the debates around whether abortion counselling should be mandatory, what content should be included, and how the interaction should unfold. These discussions are based on research into women's experiences of abortion counselling. Whether women seeking an abortion should receive counselling remains a contentious topic (Hoggart, 2015). A study based in Edinburgh, Scotland, where the need for compulsory pre-abortion counselling was being debated (in 2011, the bill was *not* passed in Parliament) found that 85% of women who did not access counselling services chose not to do so as they had either already made a decision prior to receiving an abortion or because they expected to receive insufficient information (Baron et al., 2015).

Interestingly, among women who had accessed pre-abortion counselling, a higher number indicated that they would consider post-abortion counselling as compared to women who had not accessed any counselling services at all (Baron et al., 2015). This indicates a positive experience of the pre-abortion counselling session. Unsurprisingly, thus, none of the women in this study mentioned experiencing pressure from the counsellor about whether or not to terminate their pregnancy. The benefits of counselling may lie in the support and reassurance that it can offer women rather than assisting in a (presumed) decision-making process. The authors conclude that policies aimed at mandatory pre-abortion counselling would go against the wishes of most clients and would be a waste of resources. Instead, counselling should be directed towards women who may be at risk for any psychological complications post-procedure.

The value that women ascribe to pre-abortion counselling seems to lie in the session's content (or as stated in the sub-heading, the 'what'), and whether it aligns with their needs.

A study conducted in the KwaZulu-Natal province in South Africa that aimed to explore client experiences of the pre-abortion counselling process, conducted interviews with its participants based on a semi-structured questionnaire (Birdsey et al, 2016). The women seeking abortion services reported being respectfully treated during the counselling session.

Yet, clients also described that the session was not individualised and did not necessarily cater to their lived experiences, many of which included IPV (Birdsey et al, 2016). This highlights the uniqueness of each woman's experience and therefore *what* a provider includes in a session needs to align with a client's narrative – what is being said and what is not being said.

A study in Flanders, Belgium, used two questionnaires to survey women's experiences of pre-abortion counselling: one administered before the session and one just after (Vandamme et al., 2013). Amongst other objectives, the study sought to understand clients' perceived value of a session and their preferred content. In other words, what do clients seeking an abortion want to discuss and to what degree is this mirrored in the session? Methodologically, one of the study's strengths lay in a pre- and post-measurement design that assessed clients' responses just before and immediately after their counselling session. The responses were classified into 11 themes. The analysis revealed firstly, which content or themes were most and least frequently dealt with in pre-abortion counselling sessions, and secondly, which themes showed greater or lesser variance between what was actually discussed and what the clients wished to discuss (Vandamme et al., 2013).

Amongst the themes discussed, *information about the procedure* received the highest rating. This theme also revealed good congruence between the discussed theme (89%) and the number of women who wished to discuss it (82%) (Vandamme et al., 2013). The value of precise procedural and legal information in counselling was discussed earlier in the chapter (Keefe-Oates et al., 2020). *Feelings of guilt* and *religious aspects* received the lowest rating with regard to both what was discussed and what women needed. Predictably, two particular themes indicated poor congruence. The first was *contraceptive use*, which featured in 83% of the content discussed as opposed to a mere 34% of women who wished to discuss it. High variance in this theme likely links to research findings that argue against merging contraceptive counselling with pre- or post-abortion care (Bender & Geirsson, 2004). The second theme was *reasons for the abortion request*, which emerged in 75% of the content discussed versus only 36% of women who wished to discuss it (Vandamme et al., 2013).

Reasons for seeking an abortion, the 'why,' is the focus of many studies and debates. Pike (2023) suggests that the nature and extent of coerced abortion can be understood from research that explores women's reasons for accessing abortion. Kirkman et al. (2009) claim that "knowledge of women's own reasons is an essential aspect of understanding of abortion" (p. 365). While I engage with literature on this topic, I also underline why and in what circumstances this query can be problematic from a feminist client-centred approach. In countries such as South Africa, Portugal or Slovenia where abortion is available *on request*

up to 12 weeks (South Africa) and 10 weeks (Portugal and Slovenia), such a question may (or should) be pointless. The negative congruence in Bender and Geirsson's (2004) *reasons for the abortion request* theme in the previous paragraph ties in with research that underscores the importance of a client-centred approach to AC, wherein querying the reason for wanting an abortion may be experienced as judgemental, though talking about the reasons is acceptable if the person brings this up themself (Mavuso & Macleod, 2020). This claim has further validity since findings in a study in South Africa showed that reasons such as socio-economic hardship, poverty, rape and incest are likely to elicit a sympathetic response in providers (Harries et al., 2009). In other words, if reasons other than these are cited, clients may become concerned about their access to abortion.

Finer et al. (2005) assert that understanding women's reasons for seeking abortions can help inform policy and public debate about unwanted pregnancy and abortion. Additionally, a general understanding of women's complex reasons for requesting an abortion can also help providers engage empathically with women in the counselling space. Economic and housing problems were the most cited reasons from a study in Slovenia where abortion is offered on request (regardless of age and without a waiting period) up to 10 weeks (Vodopevic et al., 2019). Although a later gestation legally necessitates a reason to terminate, a study in Australia by Hayes et al. (2020) found that women seeking 'late' abortion (18 to 24-week gestation period) revealed 'psychosocial' reasons due to system delays and obstruction to access by health providers. In other words, some of the later-trimester abortions could have been avoided had the service been timely. A USA study revealed that the most cited reasons for seeking abortion included interruption in education, work, ability to care for dependents, finances, single parenthood, and relationship problems, underscoring that the reasons are often multiple, interlinked, and diverse (Finer et al., 2005).

A systematic review by Kirkman et al. (2009) in 'high income' countries that explored why women had an abortion revealed similar results. Three main categories stood out: 'woman-focused' reasons such as *wrong timing, age, family complete, does not want children*; 'other-focused' reasons such as *intimate partner, influence of others, existing children*; and 'material reasons' such as *housing and financial limitations,* though they were not exclusive. Additionally, two categories, namely 'multiple reasons' and 'ambivalence' fell under a broad thematic heading that captures the essence of this topic: women's reasons are 'contingent and complex,' leading the authors to conclude that abortion is rarely the outcome of a single reason. Similarly, a synthesis of findings from 14 countries noted that the most frequently cited reasons for seeking abortion were women's socioeconomic concerns and a need to limit childbearing (Chae et al., 2017). Thus, locating reasons within broader socio-economic

contexts can shift providers' perspectives – from ascribing individual blame due to lack of or poor contraceptive usage (du Toit & Macleod, 2025) to understanding abortion requests through a reproductive justice lens.

Some studies have shown that women's decisions to have an abortion are situational, and not a rejection of motherhood, but rather are influenced by a decision to become or remain a good parent (Finer et al., 2005; Jones et al. 2008). In cases when a woman already has children, seeking an abortion may be viewed as a means to assist in protecting children already born, as was seen in a study in Zimbabwe that explored abortion decision-making (Chiweshe, 2016). However, even in the absence of a previous child, women who are seeking out an abortion demonstrate a serious consideration of the responsibilities of motherhood, reflecting on their readiness to parent, their financial capacity, whether they prefer to avoid giving birth to a child that is not completely wanted by both parents, and whether their own needs overlap with those of the potential child (Kirkman et al., 2009). Notably, most of these findings often indicate that women have more than one reason for having an abortion (Chae et al., 2017).

Purcell (2015) contends that focusing on women's reasons for abortion stems from a public health approach aimed at preventing abortion, but this focus often restricts counsellors from exploring other important lines of inquiry. Other possible questions that can help inform services could relate to the choice of a particular procedure. Vodopevic et al. (2019) examined women's reasons for choice of method (surgical or medical), pain reported during each procedure, and the side effects. These types of questions revealed that the majority of women chose a medical abortion (83.4%) and did so mainly on the advice of a gynaecologist, while those who chose a surgical one (16.6%) did so because it was a faster procedure. Women in the latter group reported higher satisfaction levels with their method.

In two of the previously mentioned studies (Baron et al., 2015; Vandamme et al., 2013) women indicated being satisfied with counselling despite their initial apprehension. On closer examination, the sessions in which women expressed satisfaction were those in which counselling that was mostly tailored to individual needs (the *how* of counselling). Findings from Vandamme et al. (2013) show that despite some distress prior to counselling, women were mostly decisive about having an abortion and indicated that the non-directive attitude of the counsellor was greatly appreciated. Thus, if counselling is offered in a non-directive manner with no pressure or perceived judgement from the provider, it can help alleviate stress.

The findings from the studies mentioned above (Baron et al., 2015; Mavuso & Macleod, 2019; Moore et al., 2011; Vandamme et al., 2013) highlight certain aspects regarding how women perceive AC and how the counselling is conducted, which offer valuable insights. Two

of the studies (Baron et al., 2015; Birdsey et al, 2016) conducted at around the same time but on different continents, share some common features. In both countries, the United Kingdom and South Africa, abortion is legal, and there is no mandatory counselling. Findings from both studies referred to the information shared as lacking in some way, despite clients' positive responses of feeling respected (Birdsey et al., 2016) and supported (Baron et al., 2015). For example, nearly one-quarter of the women in Baron et al.'s (2015) study said they were unaware of the availability of pre-abortion counselling services. Birdsey et al. (2016) highlighted that the biomedical and health promotion content did not accommodate the varying needs of clients, such as in instances where women needed support due to IPV. Qualitative research concerning clients' experiences of abortion within the United Kingdom indicate that most women approach HCPs to acquire information and support regarding access to the procedure. When such support is offered, the women report positively about the experience; but they feel judged when questioned about their decision (Beynon-Jones, 2012).

In another study, women who went through a group-based counselling format expressed discomfort as the group dynamics were experienced as constraining (Birdsey et al, 2016). Another study highlighted that women tended to prefer face-to-face counselling rather than phone or online counselling (Baron et al., 2015). Keeping in mind the individualised needs and preferences regarding which format is ideal for which client, providers need to provide an overall supportive stance that can be elaborated on to include non-judgement (Beynon-Jones, 2012) while also being non-directive (Mavuso & Macleod, 2019; Vandamme et al., 2013) and respectful (Birdsey et al., 2016). Acceptability of abortion method and satisfaction with the procedure has been shown to be higher in women who reported higher satisfaction with their counselling prior to the procedure (Vodopivec et al., 2019). These features may be key in *how* to approach abortion counselling.

4.4 Abortion Provider Perspectives of Abortion

Studies exploring providers' points of view have focused on HCPs' overall experiences of and attitudes towards abortion service provision (such as Beynon-Jones, 2012; Harries et al., 2009, Harries et al., 2012; Harries & Constant, 2020; Mokgethi et al., 2006; Röhrs, 2017), providers' constructions of abortion seekers (Chiweshe & Macleod, 2017) and the ethical challenges faced by providers in abortion service (Harries et al., 2014; Millner & Hanks, 2002; Müller et al., 2016). Beja and Leal (2010) acknowledge the role that HCPs play as both witnesses and active participants in the abortion process. To my knowledge and at the time of this research project, there appear to be only a few studies centred around HCPs' experiences of abortion counselling (Beja & Leal, 2010; Nguyen et al., 2010; Mavuso &

Macleod, 2019; Mavuso & Macleod, 2021). Those that emerge from South Africa are based in the Eastern Cape province and form part of the baseline research that informed my study. In this section, I highlight some literature that relates to HCPs' attitudes towards abortion service provision, which directly influences abortion counselling and quality abortion service provision. I include discussions of the research focused on services followed by more limited research that is focused on counselling.

4.4.1 Nurses' Experiences of Abortion Service Provision

Exploring the aspects that influence providers' levels of (dis)engagement in abortion provision can help inform improvements in these services (Harries & Constant, 2020). Research shows that abortion providers' conceptualisations of abortion are embedded in their personal contexts (such as what motivates them to do abortion work), institutional contexts (such as legislation and organisational policies), and discursive contexts (which contributes to understandings of what abortion is and hence, what abortion counselling is) (Mavuso & Macleod, 2021). This is further intertwined with their moral, religious, and personal views (Harries & Constant, 2020). Personal views range from seeing abortion as a sin to considering it a crucial aspect of women's reproductive agency (Harries & Constant, 2020). The institutional context takes into consideration law and policy (such as the CTOP Act in South Africa) and includes shortages of staff willing to partake in abortion training and provision (Mavuso & Macleod, 2021). Teffo and Rispel (2017) also acknowledge that a lack of management support and prioritisation of abortion services, health system inadequacies, human resource challenges, and feelings of loneliness amongst providers are pervasive in several designated abortion facilities, which further speaks to the institutional context. Discursive contexts include public health discourses that range from problematising unintended pregnancies and abortion to constructing unsafe abortion as a risk to public health, thereby reframing legal abortion as moral work (Mavuso & Macleod, 2021).

Nurses who are uncomfortable with the procedure either refuse to partake in it entirely or tend to limit their participation to pre- and post-abortion contraceptive counselling (Harries & Constant, 2020). Other nurses may restrict their services to pre-abortion care such as conducting ultrasounds to determine the gestational age, setting up surgical trays, or providing referrals (Harries et al., 2009). It is disconcerting, however, that a mere acknowledgement of intra-personal conflict could lead to a removal of oneself from this service altogether. Societal, legal, and ethical stances about abortion are complex issues that are often in conflict with each other, which already make this area of reproductive health susceptible to prejudices. Chiweshe and Macleod's (2017) study found that Zimbabwean providers are themselves

trapped in a sociocultural climate that offers limited scripts that they can draw on to describe abortion and abortion seekers. Restricted gendered, cultural and religious discourses thus served to construct women who had undergone an abortion in a negative light – as irresponsible, manipulative and ignorant (Chiweshe & Macleod, 2017). This can lead to more barriers to access, which can put a strain on the public healthcare system in unexpected ways. As noted by Mokgethi et al. (2006), a lack of willing HCPs can push clients towards accessing illegal or backstreet abortions, which can further lead to morbidities and mortalities in spite of the procedure being legal.

Mavuso and Macleod (2021) delved into nurses' motivations for abortion service provision. Their findings uncovered that despite the country's liberal law, abortion is often delegitimised instead of being viewed as a responsible, safe, and beneficial reproductive health procedure (Mavuso & Macleod, 2021). Additionally, in South Africa, 'conscientious objection' is often situated between two conflicting stances: women's rights to reproductive autonomy, and nurses' rights to freedom of beliefs, thoughts, and religion (Harries et al., 2014). Unfortunately, CO is often used by providers to avoid being involved, even peripherally, in abortion care, despite ambiguity surrounding how it must be implemented. Due to a lack of institutional protocols, this process frequently remains undocumented (Harries et al., 2014).

When providers exercise their rights to refuse to perform a responsibility, this action can negatively impact their patients' health and access to reproductive services (Shanawani, 2016). Findings from a study by Harries et al. (2009) that examined HCPs' attitudes towards abortion found that trying to accommodate different providers' varying levels of involvement in abortion service provision leads to "complex patterns of service delivery… and fragmented levels of service provision" (p.4). For example, overall refusal can lead to a shortage of trained and willing service providers (Röhrs, 2017). Overcrowded services make it harder to recruit and retain staff, further weakening the CTOP Act's stipulations by limiting places for legal and safe abortion services (Harries et al., 2009).

Mavuso and Macleod (2019) suggest that transitioning away from a narrative where HCPs merely 'volunteer,' towards a narrative where they feel morally responsible for abortion service provision can help reframe abortion providers and their work in a positive light. The benefits include lessening the stigma and judgement for providers, which would, in turn, directly influence clients' experiences too.

Interestingly, clients' reasons for abortion also influence HCPs' attitudes towards the service making them more willing or less agreeable to offer it. A pregnancy due to rape, incest, or foetal impairment may receive a compassionate response (Mokgethi et al., 2006; Harries et al., 2009). HCPs also seem willing to offer support to younger or unmarried clients with

socio-economic challenges while (once again) emphasising contraceptive use and family planning measures (Harries & Constant, 2020). These findings replicate Beynon-Jones' (2012) stratified reproduction approach (elaborated on in the next paragraph) that categorises abortion requests into acceptable or unreasonable. Failing to use contraception is problematised by providers (Mavuso & Macleod, 2021). Second trimester abortions also emerge as a highly disputed issue for several reasons, including visuals of a more developed foetus (Harries et al., 2012). Harries and Constant (2020) assert that the physical and emotional impact of second trimester abortions on HCPs creates resistance to offering this service, which in turn has severe repercussions for the sustainability of late trimester abortions in a country like South Africa.

Beynon-Jones's (2012) study based in Scotland drew on semi-structured interviews with HCPs to understand their experiences and roles in providing abortions when there was no foetal impairment diagnosis. This exclusion criterion was used because previous healthcare practice literature pointed to an acceptance or normalisation of 'rejecting motherhood' in such an instance. Yet, abortion statistics from a report in England and Wales revealed that a mere 1 per cent of abortions were performed under a foetal impairment condition (Department of Health and Social Care, 2014). Assuming that the same applies in Scotland, this meant that most abortions were taking place due to other circumstances (Beynon-Jones, 2012). The author applied the concept of 'stratified reproduction' as a tool to analyse the interview data. The stratified expectations that HCPs carry regarding motherhood result in abortion requests being categorised as either understandable or problematic. While this article does not focus on AC as the main problematic, it is evident that the views held by HCPs strongly influence the interaction prior to the procedure. 'Young' women, 'older' women, and 'class' are explicitly drawn on by abortion providers to position reasons for abortion requests as rational, irrational, legitimate or problematic.

While providers may perpetuate abortion stigma in circumstances where they see the requests as illegitimate or irrational, they are also subject to stigma themselves. Mavuso and Macleod (2019) analysed HCPs' accounts of the pre-abortion counselling encounter with a focus on abortion stigma. Although there are limited interventions, such as debriefing spaces, to help providers alleviate any feelings of shame and isolation concerned with providing abortion, the authors found that providers resist abortion stigma in social ways (Mavuso & Macleod, 2019). This is done by deploying a hero narrative in which abortion service provision is framed as a public health good that saves lives. Participants described their work as heroic as they saw themselves as saving women from illegal abortions (Mavuso & Macleod, 2019).

The research studies above (Beja & Leal, 2010; Beynon-Jones, 2012; Harries & Constant, 2020; Mavuso & Macleod, 2021; Nguyen et al., 2010) indicate that the personal and professional factors that influence providers' roles in abortion service provision are numerous, intertwined, and complex. For the most part, HCPs describe abortion services through a public health approach that problematises unintended pregnancies and abortion, which ends up framing abortion as awful, and as a failure on the part of both the client and the provider.

4.4.2 Nurses' Experiences of Abortion Counselling

Moving onto research that focuses on the counselling aspect from providers' perspectives, studies reveal that HCPs hierarchically assign value to different aspects of AC. A study conducted in Portugal, where abortion is legal on request from 10 to 24 weeks gestation on certain grounds, showed that while all HCPs in the study conveyed the usefulness of AC, they ascribed varying levels of value to different aspects of counselling. Providing information and addressing contraception issues featured high on the list (similar to findings from Mavuso and Macleod, 2021; and Sullivan et al., 2018). The counselling dimension that dealt with clients' future plans regarding their pregnancy and screening for previous pathology were the least mentioned aspects in the study (Beja & Leal, 2010). All respondents voiced that most women had decided on the procedure prior to approaching the clinic. Thus, the study revealed how "counselling was considered of no use to change the woman's abortion decision" (Beja & Leal, 2010, p. 326). The authors conclude that there is room for improvement with regard to providers' counselling and communication skills (Beja & Leal, 2010).

A study by Nguyen et al. (2010) examined providers' talk about youth pre-abortion counselling in Vietnam, which has a liberal abortion policy, making it available on demand. Historically, the government had passed a two-child policy in 1988 with the intention of maintaining the country's population growth at two per cent (Ngo, 2020). Pre-abortion counselling is, therefore, essentially viewed by providers as a space to prevent future unplanned pregnancies and repeat abortions, and to promote safe sex practices (Nguyen et al., 2010). The study identified five pre-abortion counselling topics that HCPs consider in order to minimise unwanted pregnancies, repeat abortions, sexually transmitted infections (STI) and HIV transmissions: the adverse effects of abortion; the rapid return of fertility post-abortion; contraceptive knowledge; behavioural change and prevention of STI/HIV; and sexual and reproductive health (Nguyen et al., 2010). As such, pre-abortion counselling seems to function as a means to lower any "adverse biopsychosocial effects of pregnancy, abortion and STI/HIV" (Nguyen et al., 2010, p. 60).

In interviews with abortion providers in Mavuso and Macleod's (2021) study, a participant's emphasis on the word 'push' to describe their approach to contraceptive counselling, indicates the manner in which clients are often coerced towards the uptake of LARCs. HCPs view 'no repeat abortions' as a sign of successful pre-abortion counselling, envisioning their role as "the last line of defence for unintended pregnancies and future abortions" (p. 6). Contraception is viewed as the ideal, which is replicated in other studies that focus on AC (Beja & Leal, 2010; Nguyen et al., 2010).

In fact, a study from the Western Cape of South Africa (Sullivan et al., 2018) reveals that the focus in pre-abortion counselling is often on regulating contraceptive usage. While for some clients, the interaction may be their first knowledge of LARC (which potentially creates a sense of control over their own reproductive health), the interactions are marked by inadequate information, inconsistency in providers' responses across different facilities, and general misinformation. This gives rise to a contrasting sense of empowerment and disempowerment for clients (Sullivan et al., 2018).

In Mavuso and Macleod's (2021) study, the authors specifically looked at how third parties are included during counselling and found that in cases of minors, some providers prefer to involve parents as it enables the provider to hold the parents accountable for the pregnancy. In other instances, third parties are viewed as beneficial as they may enable a 'breakthrough' which (in their study) refers to ensuring an abortion is avoided.

A provider in Beynon-Jones' (2012) study stated that should a middle-class, educated, and successfully employed woman want to have an abortion because the pregnancy is inconvenient (timing or otherwise), then they "would make a significant effort to get her to think through and make it clear… to her that although I would sign the form, I wasn't [in] myself particularly supportive of her decision. Again, that's a judgement and some people might argue that I shouldn't be doing that, but that's... that's the way I work" (Beynon-Jones, 2012, p. 519). The HCP, thus, is aware of their judgement towards the client, yet validates it as being the way they work. These kinds of narratives are guided by how abortion requests are categorised: rational, irrational, legitimate or problematic (as identified in Beynon-Jones, 2012).

From a critical health perspective, a few aspects emerge in light of the various findings listed above. Abortion in Africa is frequently framed within a public health framework (Macleod et al., 2018). In certain countries such as South Africa and Portugal, despite abortion being available on request during the initial weeks of pregnancy, providers still sometimes require reasons for abortion (Beja & Leal, 2010; Mavuso & Macleod, 2020). While, within a client-centred approach, understanding the context in which the pregnancy occurred and the meaning ascribed by the client is useful, there is a distinction between such understanding

and demanding the reasons for terminating the pregnancy. While the former may create a trusting space and rapport, the latter can easily shift the tone of the abortion counselling experience to a negative one. As previously stated, providers' willingness to offer an abortion tends to depend on the reason (Beynon-Jones, 2012; Harries et al., 2009; Mokgethi et al., 2006). Paradoxically, the majority of clients do not wish to be asked their reason for abortion (Vandamme et al., 2013) and often feel judged by this query (Mavuso & Macleod, 2020).

4.5 Conclusion

In this chapter, I examined studies that foreground the experiences of health users and of healthcare providers. Women who seek abortions end up (more often than not) experiencing blame, shame and fear. While providers' attitudes have been critiqued in the literature, much of the research points to the limited resources (even discursive ones) and lack of support available to them. Within institutional constraints, nurses attempt to minimise the number of abortions via contraceptive counselling. This has implications for abortion counselling practices in which providers use their judgement to stratify clients' reasons for abortion, their own levels of engagement in this area of work, and the value ascribed to different aspects of counselling.

What becomes evident is that abortion counselling is akin to information provision, particularly in relation to birth control. Clients' experiences mostly centred on unmet counselling needs – either because they did not require counselling at all or because the counselling did not seem relevant to them. In some instances, a preference for information stood out, but overall, what mattered most was the manner in which counselling was offered: it had to be non-judgemental, individualised, non-coercive, non-mandatory, and contextual. In providing accounts of both providers and clients' perceptions of their abortion experience, this chapter shed light on the extent to which providers are fully able to gauge their clients' needs and offer an individualised service.

CHAPTER FIVE: METHODS IN DEVELOPING AND DOCUMENTING THE TRAINING COURSE

5.1 Establishing the Methodology

The aims of action research (AR) are twofold, namely, action and research. McNiff and Whitehead (2011) explain that the ‘action’ is about what a researcher does, and it includes a refinement of their practice; the ‘research’ comprises the manner in which a researcher learns and describes what is done, which in turn enables the production of new knowledge. In other words, the crux of AR is about a process of change (Kemmis & McTaggart, 2005), and the knowledge created is about the knowledge of practice (McNiff & Whitehead, 2011). The purpose of this chapter, therefore, is to elucidate the various actions that I took to develop, conduct, and refine the training course and to document or research the entire process via this thesis.

Born out of social change movements, AR attempts to converge academic investigation and practical interventions (Kagan et al., 2008). While the actions that I describe fall mainly under the domains of two cycles of AR, I hope to demonstrate the ongoing convergence of academic rigour and practicability within the process. As such, AR was both the driver and the vehicle that carried the project through.

I begin by introducing and explaining the nature and cycles of AR. I then describe the different steps of the project: the partnership formation, the course development, research aims, course goals, means to gather data and determine the research sample, amendments to the course and budget, method for data analysis, ethical considerations in AR, and steps taken to ensure the credibility of this research.

5.2 Facets of Action Research

Kagan et al. (2008) define AR as an orientation towards inquiry, rather than a definite method. This definition lends itself to a malleability that can often steer the research in unexpected ways. Change is not an added benefit but rather the core of AR (Davis, 2004); and it is precisely this quality of AR that enabled the project to reach its fruition.

5.2.1 Historical Roots of Action Research

Social psychologist Kurt Lewin is often credited with coining the term AR (Cordeiro et al., 2017; Kemmis & Taggart, 2005; Williamson et al., 2011) and pioneering early work within

the Northern tradition (Wallerstein & Duran, 2008), which is discussed in section 5.2.2. Lewin's (1947) study focused on group and social practices, which he noted could lead to social action – a type of action research. He argued that research studies that only produced books were insufficient (Lewin, 1947). In line with his argument, my project took the baseline research a step further by operationalising the CSSR AC Guideline into a practical in-service training course. Kemmis and McTaggart (2005) describe AR's trajectory in generational terms whereby the first generation's impetus was Lewin's work followed by Corey's AR in education (discussed below); both took place primarily in the USA.

Corey (1954) asserted that AR in education was typically taken up by practitioners to improve their practice with the aim of overcoming future problems. Corey (1954) argues that there are two ways to achieve improvement: one is based on subjective impressions of people's problems, which people are inclined to change; the second involves a professional investigator studying the problem and offering an intervention. The latter poses some challenges: firstly, an outside investigator may lack the insight of those within the organisation; and secondly, practitioners may find it difficult to incorporate any recommendations into their behavioural patterns (Corey, 1954). I paid careful attention to these points, as my project's baseline research (du Toit, 2023; Mavuso et al., 2017) had identified problematic abortion counselling practices, and the aim of the training course was to enable providers to offer client-centred skills through shifts in their attitude and behaviour. As an external facilitator (not part of the DoH), I needed to understand their context based on their experiences to see whether the newly imparted skills *could* and *would* be incorporated by them in practice. The external and internal elements (dealt with in chapter six and chapter seven, respectively) hindering abortion service provision address these concerns.

Kemmis and McTaggart (2005) state that the second-generation momentum in AR occurred in Britain and centred on organisational development. Subsequently, and moving away from the 'practical' nature that had been the status quo, a third generation of 'critical' engagement developed in Australia and other parts of Europe. Later, advocates of a fourth generation, such as Paulo Freire, Fals Borda, Rajesh Tandon and Swantz, emerged from an amalgamation of participatory action research (PAR) and critical emancipatory AR within the contexts of social movements (Kemmis & McTaggart, 2005).

Other authors have argued that tracking AR's roots poses challenges due to its varied conceptualisations that have predictably been dependent on the different contexts and researchers' positions. Kemmis and McTaggart (2005) recognise that 'action' approaches have been alluded to in community development literature as far back as the early 1900s, such as in the work of Jacob Moreno (who is considered the father of psychodrama and

sociometry). In a similar manner, and with regard to PAR, Swantz (2008) argues that no single perspective can stake claim as the authority. Highlighting its various origins, Swantz (2008) references Molano's opening speech at the *World Congress on Participatory Convergence in Knowledge* held in Cartagena in 1997 in which he stated that "nobody discovered it, it was the result of an atmosphere rarefied by the clash between clear-cut scientific explanations and a rough reality" (p. 31). This was the first ever international symposium on AR and Scientific Analysis, and the participants were predominantly from countries outside of the USA (Wallerstein & Duran, 2008).

5.2.2 Northern and Southern Traditions

AR can be challenging to define as it has developed differently depending on its usage (Tripp, 2005). In aiming to shed light on its different applications, several authors (Brown & Tandon, 1983; Cordeiro et al., 2017; Ferreira & Gendron, 2011; Wallerstein & Duran, 2008) have acknowledged the presence of two traditions of applied action-based social research – the Northern tradition and the Southern tradition. Depending on the authors, these traditions have also been referred to as action research and PAR, respectively (Brown & Tandon, 1983).[32] Ferreira and Gendron (2011), however, claim that PAR actually developed in both traditions independently of each other with a focus on education, research, and social change. These deliberations highlight the evolution, merging, separateness, and growth of both traditions.

The Northern tradition is viewed as a practical and effective approach based on the Lewinian model that critiqued the gap between theory and practice, and is aimed at improving the system (Wallerstein & Duran, 2008) by resolving any internal organisational problems *within* the existing environment (Cordeiro et al., 2017). The Southern tradition emerged around the 1970s in countries in Latin America, Africa and Asia, motivated by "the structural crises of underdevelopment, Marxist critiques by social scientists, liberation theology, and the search for new practice by adult educators and community developers among populations vulnerable to globalisation" (Wallerstein & Duran, 2008, p. 28).

This type of emancipatory research openly challenged the dominant colonial, political and historical practices in research. Within this paradigm, Paulo Freire's influential writings led

[32] Although dated, I include the seminal work of Brown and Tandon (1983) as several methodological discussions have stemmed from the distinctions in traditions made by these two authors.

to marked shifts in research relationships whereby community members became participants *in* the inquiry rather than objects *of* it (Wallerstein & Duran, 2008).

Notwithstanding the array of contexts within which AR is espoused, four underlying principles remain pervasive: its participative and collaborative nature, its continuing cycles of self-reflection (plan, act, observe, reflect, and revise), the generation of knowledge, and transformative practice (Cordeiro et al., 2017). Depending on the tradition, these core principles have varying levels of weight. Cordeiro et al. (2017) therefore suggest that clarifying how the philosophical foundations in each tradition influence the 'method' and 'methodology' can be beneficial. To do this, the authors focus on two analytical categories, praxis and emancipation, and how each relates to method and methodology. Their reasoning for selecting these two concepts lies in the notion that, although frequently viewed as analogous, they are conceptually interpreted differently within the two traditions. Cordeiro et al. (2017) argue that the ways in which categories are conceptualised influence the aims of AR, which is further indicative of how AR is adopted as a *method* in the Northern tradition, and as a *methodology* in the Southern tradition.

As the focus of my research was on praxis (course development and development of client-centred counselling skills in providers), I discuss further the notion of praxis (and not emancipation). With regard to location, I situate the Abortion Counselling Certificate Course (ACCC) as research that stems from a region in the global south. However, the basic application is that of Lewin's utilitarian approach which places an emphasis on applied and practical knowledge. Implicit in its trajectory is the notion that AR is not a fixed method or paradigm. Rather, AR is representative of a "family of practices" (Reason and Bradbury, 2008, p. 3); this facilitates an integration of multiple methodologies and embodies an "umbrella process" (Erro-Garcés & Alfaro-Tanco, 2020, p. 8). The Abortion Counselling Certificate Course is an example of such an umbrella process that linked academics, research and policy within a university setting to providers and practice within a healthcare setting. This was further enabled by the values that inform the practice of counselling psychology in South Africa as discussed by Young (2013) which include: promoting social justice; acknowledging the sociocultural and developmental contexts; and emphasising equitable access to health and social care.

As a counselling psychologist, my role as a PhD action researcher in this project aligned with Young's (2013) "contentious consideration… that the commitment to social justice implies activism outside of the consulting room to change the social contexts that perpetuate many social ills" (p. 430). He argues further that if counselling psychology were to remain committed to social justice, it would align with the Bill of Rights embedded in the South African

Constitution that safeguards human rights. This resonated with the research study's theoretical underpinning of reproductive justice that aims to increase women's access to their reproductive rights.

Praxis (within the Northern tradition) involves *reflective action* that includes engaging with a problem and finding a practical way to resolve it (Cordeiro et al., 2017). Coghlan and Shani (2008) refer to this as 'praxis-reflection' whereby attention is paid to any personal dilemmas related to the political dynamics of an AR project. In AR, praxis underscores the following: building inquiry skills through practice; making decisions collaboratively; improving practice locally; and all of this is achieved by focusing on the *process* specifically (Cordeiro et al., 2017). These skills may be fostered through journaling; recording experiences, thought processes, and gaps in knowledge; and through discussions with a mentor or academic supervisor (Coghlan & Shani, 2008). In relation to the ACCC, the course activities fostered: critical thinking through role play activities; self-reflection via journalling; and identifying gaps in knowledge through case presentations that included peer and facilitator feedback. In addition, regular supervision sessions with my research supervisor fostered both critical and practical skills, which in turn enabled me to design the project with greater confidence and a reflective, compassionate approach.

Kemmis (2008) employs both terms, practice and praxis, to underscore the importance of having an external or outsider perspective (objectivity) alongside an internal or insider perspective (subjectivity) in AR. In other words, practice can be understood in a dialectical fashion while navigating the tensions between observer and participant perspectives. This relates to my study, as all ACCC participants were in-service nurses who offered their subjective experiences of working in abortion services, while my co-facilitator (Esona) and I were both psychologists from an academic setting who offered the outsider perspectives. If any differences in opinions arose, the facilitators were guided by a feminist, client-centred approach that drew on the legal framework of abortion in South Africa and reproductive justice principles, while remaining sensitive to the institutional constraints within which the nurses were working. Thus, a dialectical transformation occurred (via group discussions) as described by Kemmis (2008) because each perspective *influenced* and *was influenced by* the other.

5.2.3 Principles of Action Research

AR typically involves the following steps: (1) *planning* (developing a strategic action plan), (2) *acting* (implementing the plan), (3) *observing* (gathering evidence), (4) *reflecting* (engaging in critical reflexivity) and (5) *evaluation* (revising the plan based on insights gained). This completes one cycle of AR, which is then repeated (Kemmis & Taggart, 2005; Koshy,

2005). However, several authors note that AR is rarely a straightforward process with self-contained cycles (Davis, 2004; McNiff and Whitehead, 2011); a conceptual model with planned progression does not guarantee that the project will follow that sequence (Koshy, 2005). In fact, the “pathway may be linear and can also be branching” (McNiff & Whitehead, 2011, p. 10). This was indeed my experience, as my research proposal submission at Rhodes University coincided with the South African government’s announcement of a lockdown for 21 days as a precautionary measure against Covid-19. This shift at a macro-level necessitated a change in the course format from face-to-face (FTF) to online (in the first cycle) and back to FTF (in the second cycle). The research, therefore, did not follow a linear path. It instead aligned with what Davis (2004) described as being cyclic in two ways: firstly, it consisted of a series of iterations, and secondly, it comprised a series of activities within an iteration. As an outcome, stages often overlapped, and the plan changed even prior to the completion of an entire cycle.

The continuing cycles of self-reflection (Cordeiro et al., 2017) helped facilitate the training course in two formats; each one required slightly different skills, with the online format posing more challenges. I drew on skills emphasised by Thornton and Yoong (2011) who stress the role of a blended action learning facilitator. Action learning and blended action learning are both approaches to professional learning. Skills include actively listening, being empathetic while challenging participants’ thinking, managing emotions, modelling listening and questioning skills, and enabling group reflection (Thornton & Yoong, 2011). I unpack the skills development in chapter five. As such, AR was an appropriate and timely methodology for the abortion counselling project in the face of a global pandemic, aligning with the second principle of ongoing self-reflection, which involves planning, acting and observing.

Koshy (2005) suggests that despite a degree of uncertainty, having a project overview with an understanding of the necessary actions at different stages remains beneficial, as it fosters insight and awareness. Before I unpack Cordeiro et al.’s (2017) third principle – generation of knowledge (outlined in my analytical chapters) – it is important to delineate the steps taken that led to the knowledge production. McNiff and Whitehead (2011) assert that methodology can facilitate the emergence of new theory, and the process typically involves steps along a path. The authors reference the 1990 book by Paulo Freire and Myles Horton titled *We Make the Road by Walking: Conversations on Education and Social Change*, and reiterate how the pathway is created by walking it. Keeping these features in mind, I created a model of suggested progression – in conversation with my research supervisor – that eventually created a pathway for this research project.

The number of iterations (even within a single iteration) created a challenge in reporting the process in a manner that captured the ‘messiness” while still being cohesive and coherent. I followed the work of McNiff and Whitehead (2011) who elaborate on the various steps that are adopted in most kinds of action research, such as: outlining research aims and research questions; devising a research design; taking action; collecting data; describing the potential implication of the research; generating theory from the research; refining practice post-evaluation; and writing up a report and disseminating the findings. These steps provided a scaffolding to outline my methodological process in the sequence in which it took place and thereby shed light on the pathway created by this project.

5.3 Taking Action – Cycle One

In piloting the course in abortion counselling, the focus has been on the process and the outcomes of the training course, or the *action* (Meyer, 2000), as AR emphasises the process of inquiry just as much as the findings (Winter & Munn-Giddings, 2001). McNiff and Whitehead (2011) suggest that a systematic monitoring of practice is essential for generating data that reflects the project’s progression. Having this information makes it possible to refer to moments that shifted the trajectory or created insights about the practice. I now draw on my research journal, email correspondence with different entities, presentations made to the project stakeholder, supervisory meetings with my research supervisor, and the research proposal, to provide a step-by-step description of the project’s progression from start to finish. I describe the process in a narrative manner with “I” at the centre of action, though most decision-making happened in conjunction with my supervisor. Minutes from project meetings between April and June 2019 demonstrate the planning and progression that initially took place, which I elaborate on in the steps below.

5.3.1 Stakeholders and Partnerships

The Eastern Cape Department of Health (ECDoH), the Sexual and Reproductive Justice Coalition (SRJC), and the South African Nursing Council (SANC) were identified as possible stakeholders for the project. Any research conducted within the public health sector first requires clearance from the region’s provincial DoH. For this, an application is submitted online using the National Health Research Database (NHRD) website.[33] We decided that the

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[33] The NHRD functions as a repository of past and present health-related research in South Africa and the website is used to apply for ethical clearance from the Eastern Cape Health Research Committee. I created a new account by registering with an email and password to login, and then clicking the ”submit new proposal” tab at the top of the page. I chose the provincial DoH option since the project was being piloted in the Eastern Cape. The

best approach would be to first meet with personnel from the ECDoH, present the findings and recommendations from the baseline CSSR research (Mavuso et al., 2017), propose plans for the nurse's training course, and gauge their interest in partnering with our research unit, and if so, in what capacity.

Kemmis and McTaggart (2005) recommend that university researchers remain cautious during the AR process, and critiquing the tendency of 'facilitator' shifting to 'process consultant' (an outsider who consults) while assuming expertise about the 'method' of AR. The authors posit that 'facilitation' is actually a neutral term – which maintains the positivist paradigm – but ends up being regarded as a technique. This perpetuates a gap between theory and practice, academics and community members, and researchers and workers (Kemmis & McTaggart,2005). Keeping this in mind along with the participative and collaborative nature of the project (one of the four principles described by Cordeiro et al., 2017), contact was made with the Deputy Director of the Maternal, Child and Women's Health (MCWH) unit, which oversees sexual and reproductive health and rights, as well as with the person in charge of Research and Epidemiology.

The first meeting[34] took place at the regional head office in Bhisho, the capital of the Eastern Cape, in August 2019. The initial meeting was productive, with the ECDoH voicing their interest in joining as a stakeholder and offering support in the following ways: they recommended targeting all facilities that render TOP services, rather than limiting the focus to a single district, which meant access to clinics across the province; they offered to assist with circulating information about the training course amongst all facility managers; they confirmed that they would provide permission for nurses to participate in the course and provide transport for nurses to commute to and from the course venue; and they suggested conducting a 'train-the-trainer' course for their staff in the future, so that they could offer this course internally to healthcare providers. Based on the meeting outcomes, our research team decided not to approach other stakeholders[35] at that stage as there appeared to be sufficient resources

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application included information such as research design, time frame and funding. I included the project team members' names in the 'researchers' tab and attached all project appendices as support documents. This approval could only be applied for after the academic proposal had received clearance from the university ethics committee. I included the Rhodes University ethics clearance under the 'ethics approval' tab.

[34] While minutes of all meetings were recorded by myself and my co-researcher, I do not mention every detail regarding each meeting, as several project changes occurred over time. Wherever necessary, I highlight relevant alterations made to the project to demonstrate how the constant "change" feature and flexibility of AR methodology influenced and enabled project development.

[35] With regard to partnering with the SANC, Circular 3/2018 of the SANC (2018, March) states that, in line with the Nursing Act (Act No. 33 of 2005), a process to develop a CPD system for nurses commenced in 2013. In 2017, the SANC stated that it is not ready for a full roll-out of CPD and hence, the implementation will be staggered. This

between the CSSR and the ECDoH to pilot the training course. Also, adding other partners could potentially increase organisational time and administrative work. This decision did not rule out the possibility of partnering with additional stakeholders in the future, as explained in footnote 34. Ultimately, as suggested by Kemmis and McTaggart (2005), we aimed to conceptualise a shared space that allowed for the complexities of social practices like health and education "to become the object of critique and the subject of enhancement" (p. 570).

The current research project, while stemming from an academic setting and moving into the community, aimed to work collaboratively with the project stakeholders and participants in the research. Yet, the participation was not inclusive across the development of the project, as the impetus (and power) rested with the academic researchers to a larger degree. It was crucial to remain cognisant that academics have access to resources and knowledge (perhaps through funding opportunities and subject-matter expertise) in ways that the community does not, and hence collaborative relationships are often shaped by underlying power dynamics (Wallerstein and Duran, 2008). For the purpose of a reflexive mode of inquiry, it was valuable to have an outsider perspective and a dialectical perspective in terms of mutual agreements and frictions amongst observers and participants (Kemmis, 2008). In my project, I refer to Esona and myself as facilitators of the training course. I, however, remained cognisant of the problematics of this term as highlighted by Kemmis and McTaggart (2005), given that my role extended beyond facilitation (see appendix 1 on project roles and responsibilities). I was actively engaged in the transformative praxis of improving the course, and by extension, providers' counselling practices, in line with reproductive justice principles, through action research.

5.3.2 Training Course Development

Planning for the training course involved two main components: designing the schedule and curriculum; and applying for its accreditation from Rhodes University (RU). The first part occurred between April 2019 and April 2020. The second part took place in the latter half of 2020, after the research proposal had been submitted, the Rhodes University ethics and ECDoH approval acquired, and before the first round of data collection started. Below, I describe the first phase of the training course, elaborate on the research proposal process, describe certain shifts that occurred with regard to the course format, and end with an explanation of the accreditation process. This sequence would best elucidate the

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process is yet to commence in the Eastern Cape province and SANC will be a potentially valuable stakeholder in the future of this project development.

chronological progression of events. In addition, I have phrased the four steps in this section to start with a gerund – a verb with the intention of stressing the ‘doing’ or action in the entire process.

Step One: Creating the Training Course and Planning the Research

Initial project planning included designing the training course, for which I incorporated a dialogic pedagogy. Paulo Freire is credited with creating this theory through his influential work, *Pedagogy of the Oppressed,* published in 1970 in English. According to Freire (2005), dialogue is epistemic and must be understood as a way of knowing rather than a tactic to make students do a task. Hence, to engage in dialogue is to recognise the social (and not individualistic) characteristic of the process of knowing (Freire, 2005). This approach is based on the premise that a teacher must be able to talk *with* and not *at* students, while acknowledging that learners have minds of their own (Skidmore & Murakami, 2016).

Closely following the CSSR AC Guideline as a core document, I incorporated activities that would introduce the background of the training course and the relevance of the research component to participants. I engaged deeply with recommendations in the CSSR policy brief that were counselling-specific, such as “counselling guidelines should be based on patient-centred and reproductive justice principles” (Mavuso et al., 2017, p. 5). Based on this, I created and included PowerPoint presentations titled: ‘*Person/Client-Centred Approach: Listening Skills,’ ‘Counselling Guidelines,’* and ‘*Reproductive Health and Reproductive Justice*.’

The ACCC training course manual (see appendix 2) contains three anonymised transcripts extracted from du Toit’s (2023) study that were based off audio-recordings of actual counselling sessions conducted in the public health sector of the Eastern Cape (du Toit, 2023; du Toit & Macleod, 2024; du Toit & Macleod, 2025). These were incorporated into the Conversation Analytic Role-Play Method (CARM) activity. Role-play is a common method in work settings for training and assessing communication skills but is also used as a pedagogical tool in education (Stokoe, 2011); du Toit’s (2023) adaptation of it focused more on the counselling content than the role-play. However, in the context of the ACCC training course, both were emphasised. First, participants read through a transcript. Then the audio track was played for them to engage with in order to create an audio-visual aid (while reading the transcript). Ryan du Toit provided a set of critical questions (appendix 3) to guide the discussion that followed (R.d. Toit, personal communication, May 16, 2021). Participants’ reflections related to this activity are elaborated on in section 6.2.1 that underscores how this activity contributed to the training and development of client-centred and critical thinking skills.

In the foreword to Freire's (2005) book, Professor Donaldo Macedo says that several educators claiming to have a Freirean pedagogical orientation have unfortunately reduced dialogical teaching to a method, which detracts from its fundamental principle to "create a process of learning and knowing that invariably involves theorising about the experiences shared in the dialogue process" (p. 18). I needed to understand the participants' thinking processes to adjust my facilitation practices to be able to dually develop the course *and* the nurses' critical thinking and consciousness in a way that would meet the course goals (Skidmore & Murakami, 2016). I appreciated the richness of my research data and engaged with it with continued curiosity to deepen my comprehension of how the training course influenced, and was influenced by, its participants.

The training course curriculum underwent several iterations from April to June 2019 between my supervisor and myself. As part of AR's observation and critical reflexivity stages (Koshy, 2005), I did the following: (1) presented the project aims and training course programme at a CSSR work-in-progress (WIP) colloquium in July 2019; (2) included the outline alongside course outcomes and assessment criteria at the second meeting with ECDoH in March 2020; and (3) e-mailed and requested feedback from an expert panel in April 2020. The panel included a diverse group of individuals united by their interest in abortion work. Amongst those that responded from the expert panel were two research associates with doctoral degrees (one of whom co-authored the CSSR AC Guideline and policy brief), a clinical psychologist, and a counselling psychologist.

Underscoring the importance of critical reflexivity, feedback from the various discussions mentioned above helped with course refinement from different perspectives such as research, logistics, and language usage (Kemmis & Taggart, 2005). For example, suggestions from the WIP comprised: rethinking 'what' research data would best respond to the research questions and add value to the course refinement process during analysis; and deliberating the ethics with regards to 'research coercion,' as it was possible that a nurse may wish to participate only in the training course and not necessarily the research component, but feel compelled to agree to both. To safeguard the nurses' decision-making regarding their willingness to participate in the research, an annotation[36] was added to the course pamphlet

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[36] The following footnote appeared in the course flyers that were shared with facility managers at the time of recruiting participants for the course: "Participation in the research component is voluntary and will not affect participation in the course." In addition, at the start of each training course, this information was verbally shared with the nurses, and I specified that "not affect" meant that it would not impede their full participation, nor hinder their learning, nor prevent them from successfully completing the course. In this regard, we elaborated on the criteria that had to be met to receive a certificate.

to assure participants of the course intent. Following the various discussions, the course was finalised as a three-day face-to-face (FTF) training course that incorporated a two-week fieldwork period in between day two and day three of the course. The purpose of the fieldwork was to help nurses with the following: to integrate new counselling techniques acquired from the course into their workspace; reflect on any positive shifts perceived and challenges, if any; and prepare a case presentation to share with the group on their return.

Step Two: Drafting the Research Proposal and Gaining Approvals

I drafted my research proposal while simultaneously carrying out the steps described above. Literature that informed the proposal helped to inform the training course (such as topics related to the theoretical lens, Rogerian principles of client-centred counselling, and experiences of healthcare workers in abortion service provision). To receive clearance to conduct my research, the proposal was first submitted to the Rhodes University Department of Psychology's Research Proposals and Ethics Review Committee (RPERC) in March 2020, and two reviewers within the department provided feedback[37] with detailed reports a week later.

Though the reviews were mixed (see footnote 36), we decided that I should use the opportunity to rethink aspects of the research and re-submit the proposal to meet the *next* RPERC submission deadline, rather than expedite the process. As AR plays a crucial role in developing practice (Williamson et al., 2011), I reflected on the importance of taking time to refine aspects of the research and course, while clarifying queries raised by the reviewers. Most of the feedback focused on the need to add appendices that would clarify aspects such as: the roles and responsibilities of the different individuals involved; recruitment procedures and flyers; the gatekeeper permission request letter; samples of feedback forms; and samples of participants' reflective journals. Elaborating on these aspects not only provided the committee with clarity but also deepened my understanding of distinctions between the course and the research. For example, I had not specified any research questions in my first proposal, instead only highlighting the goals. Hence, I formed a clearer distinction between the *course* goals and the *research* goals by including research questions that would evaluate the course

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[37] The RPERC review form contains feedback related to the coherence, context, goals, method and ethics of the proposal, with a final recommendation for one of the following: (1) Accept as is; (2) Accept with comments conveyed to the supervisor and researcher; (3) Re-submit for expedited review (to satisfaction of supervisor and nominated RPERC reader); or (4) Not accepted - re-submit proposal to RPERC. One reviewer checked the second option, while the other reviewer checked the third option.

outcomes and the course process specifically; this would help improve the course for the second cycle of AR.

Towards the end of April 2020, I re-submitted the proposal to RPERC and included a cover letter[38] that acknowledged the reviewers' contributions of critical reflexivity and evaluation as part of the AR cycle (Kemmis & Taggart, 2005). Around the same time, President Cyril Ramaphosa announced a 21-day hard lockdown in South Africa to contain the spread of the coronavirus (Parliament of the Republic of South Africa, 2020). Ongoing lockdown would create substantial changes to the project data collection, in particular, from a face-to-face format to an online course.

The proposal was passed by RPERC in May 2020 and by the Humanities Higher Degrees Committee (HHDC)[39] in June 2020 without any further obstacles. An important aspect of the research proposal is the ethics protocol. At the time of the HHDC submission, I also submitted the ethics protocol form to the Rhodes University Ethical Standards Committee (RUESC). The project received ethical approval from RUESC in June 2020 (appendix 4). Lastly, I applied for clearance from the ECDoH via the NHRD website (refer to footnote 32) and received approval (appendix 5) in August 2020, for a period of one year. Having received approval from RPERC, HHDC and RUESC, this final clearance from the ECDoH meant that the courses could be conducted, and research data could be collected.

Step Three: Converting the Course Format

With the President alerting the country to the start of a monumental struggle that would require every resource, it seemed unlikely that a training course for in-service nurses would be plausible, firstly because the lockdown was undergoing indefinite extensions, and secondly, due to the added pressures on healthcare workers as frontline responders during the pandemic. Following my second presentation at a CSSR WIP in mid-July 2020, we decided that although a 'pre-service course for nurses in training' had been initiated with the ECDoH as an alternative, it would still be beneficial to conduct the course for in-service nurses,

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[38] An excerpt from the cover letter read, "I appreciate your comments and have incorporated various changes in order to respond to your queries and concerns. I have achieved this by expanding on my methodology, adding literature related to Nursing Training and a Validity section to my proposal. I have also added appendices to clarify aspects related to confidentiality, sampling, and feedback. Your valuable inputs have contributed to refining the course and have formed part of the action research methodology of the project."

[39] At the HHDC level, reviewers from two departments (one from Sociology and one from Anthropology) evaluated the proposal and provided positive reviews, while accepting the proposal "as is," with references to it being well-articulated, motivated, and excellent. This was a significant milestone in the project taking shape.

rather than as a pre-service training course. However, travel restrictions had been enforced in South Africa to curb viral transmission (Barbieri et al., 2020), and many universities had undergone shifts from FTF learning to remote instruction via Zoom[40] as a delivery platform (Serhan, 2020). Hence, an online course for in-service nurses seemed to be the next best option. We noted that Zoom meetings can also be recorded, which made it a convenient option for research data that would be needed for future reference (Serhan, 2020).

I enrolled in an online course titled *Take Your Teaching Online* conducted by The Open University to understand the principles of this format. In engaging with theories relevant to pedagogical aspects of online education, I found the 'Blending with Pedagogical Purpose Model' to be a good fit, as it is flexible and can be modified to incorporate components from other theories to fit the requirements of the course (Picciano, 2017). The approach is driven by course objectives, activities, and online technology that is used as a mode of instruction. It contains some basic pedagogical goals with approaches to achieving them, which include the following: content; dialectics or questioning; reflection; collaborative learning; and evaluation (Picciano, 2017). This model aligned with the pedagogy of the FTF approach and also guided learners in selecting technologies for online teaching and accessibility (Coughlan et al., 2017).

Supervision meetings with my supervisor took place online – mostly on Zoom – which helped to improve familiarity with engaging in online discussions. The course outline was changed to incorporate activities that would be feasible in the new online format. For example, the FTF course involved a collage-making ice-breaker activity, which was changed to a personal narrative in which nurses could share a picture or item that was symbolic of their journey to becoming abortion providers, as a means to introduce themselves to the group. Other changes included shifting the timeframe from a three-day to a five-day course. We also included an hour-long pre-course session to familiarise participants with various online tools and the Zoom app features.

We presented the online course format to the ECDoH in August 2020 via Zoom, along with the rationale for the new format for delivery. In essence, an online training course afforded in-service nurses the opportunity to participate from their place of work and limit the amount of travel involved. The shift accounted for the social distancing protocol and the physical safety

[40] Serhan (2020) elaborates on Zoom, which is a web-based collaborative video conferencing tool. Facilitators are able to adopt different features of Zoom to enable an interactive online learning space, such as audio, video, and screen sharing options. The features include breakout rooms to allow for smaller group work, and chat to facilitate discussions.

of participants, researchers and facilitators. This alternative approach was also chosen keeping in mind the research timeline. The ECDoH approved the online course, and it was decided that the online training would take place in the afternoon so that HCPs could attend to their routine work in the morning. Mobile data was provided to participants to attend the course, in case they worked in a clinic that did not have WIFI.[41]

I submitted an addendum to RUESC to inform them of the changed format of the training course. I stated that synchronous online teaching and learning would occur, and that the mode for data collection would take place online via Zoom. The research forms for informed consent were updated to reflect this change. In September 2020, the Institutional Ethics Coordinator responded, stating that as the purpose and fundamental principles of the research process remained the same, the amendment to allow for an online approach was approved (appendix 6).

Step Four: Accrediting the Short Course

The Institutional Research, Planning & Quality Promotion (IRPQP) division at Rhodes University coordinates all planning and institutional research. Any learning programme not already listed as a university programme qualification that results in a certificate with the Rhodes University name, shield or crest is considered a short course (Rhodes University Short Courses and Accreditation, January 2022). The IRPQP functions as a quality control measure to ensure that courses do not overlap in terms of content, are of high quality, and meet the Rhodes University short course policy requirements.

I applied for course accreditation to the Institutional Planning Unit. I included the short course application (appendix 7) that contained all updated information, including the budget, curriculum, mode of delivery, critical cross-field and specific outcomes, assessment criteria, notional hours and credits.[42] We titled the course *Abortion Counselling Certificate Course (ACCC) 2020*. The application received a unique number for record-keeping purposes (SCA 5520) and was then sent to different units on campus for input on its various sections. For example, Section C of the application, which relates to the curriculum development, was sent

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[41] Of the nine participants in the first training course, only two had access to WIFI at their clinic, albeit with poor network connectivity. Hence, the CSSR provided all nurses with mobile data to attend the course.

[42] As explained in the guide to the short course application, notional hours can include contact time, independent learning time which may involve preparing for presentations or reading time and any work (such as the fieldwork component) on which reflections are based. 10 notional hours of learning is valued as 1 credit. The estimated notional hours for ACCC 2020 were 60, with 6 total credits.

to the Centre for Higher Education Research, Teaching and Learning (CHERTL) for input on the pedagogical aspects. Approval from CHERTL was acquired in September 2020 (appendix 8) and from the IRPQP at the end of October 2020 (appendix 9). ACCC 2020 was thus accredited, and once the course was completed, we followed the protocol[43] to print the certificates (appendix 10) for the participants.

As part of the second cycle of AR, the next training course was conducted the following year, after receiving approval from IQPRP at the end of March 2021 (appendix 11). One of the main differences between the two courses was in the mode of delivery. ACCC 2021 (SCA 4221) took place on campus at Rhodes University as an FTF course. The reasons for the shift included: a request from the ECDoH to conduct the course in person; feedback from the ACCC 2020 participants (discussed further in chapter eight, section 8.4.1); and the facilitators' own experiences of the online course not being optimal. Certain changes were made to cater to the logistics of a FTF course. I discuss these later in the chapter in section 5.6.

McNiff and Whitehead (2011) make a distinction between 'descriptions' and 'explanations,' where the former indicates activities that are conducted, but are inadequate, in and of themselves, in enabling someone else to perceive and learn from this content. On the other hand, research-based work necessitates an explanation, which sheds light on the 'what,' 'how' and 'why' of action, through the process of reflection. In section 5.3, I attempted to portray the events (or actions) chronologically, for the most part. However, this was not always possible, as several steps occurred simultaneously but lasted for different lengths of time. A key characteristic of AR is its representation as a spiral that consists of continuous and overlapping cycles of planning, acting, observing, reflecting and critical analysis (Koshy, 2005). In explaining the methodology of developing ACCC 2020, I aimed to establish this continuing and interrelating process.

5.4 Research Design

A research design is an overall plan that justifies the 'why' behind a project and how it is conducted. In other words, it states the rationale and the method for the study. This may occur as a fixed set of steps with the aim of finding a solution and conclusion, or it may develop in a transformative way where new issues are addressed as new questions emerge. The latter

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[43] For printing, the course co-ordinator sends the course details and participants' names to the data processing unit. From there it is sent to the printing unit, after which the course co-ordinator checks and signs the certificates. Lastly, they are sent back to the data processing unit for processing on the system, and cresting.

involves a greater level of uncertainty and risk (McNiff and Whitehead, 2011), which was evident in my study due to its AR design and its timing during the pandemic.

5.4.1 Research Issue

The research issue that underpins this AR (current inadequate abortion counselling practices) was identified in a study that explored pre-abortion counselling conducted at three public hospitals in the Eastern Cape, South Africa (du Toit & Macleod, 2024; du Toit & Macleod, 2025; Mavuso, 2021; Mavuso & Macleod, 2019; Mavuso & Macleod, 2020; Mavuso & Macleod, 2021; Mavuso et al., 2023). The findings indicated that current pre-procedural abortion counselling is a far cry from a process that promotes reproductive justice.

As I have already addressed this aspect in the introductory chapter, I do not elaborate further except to stress that the need for nurses' training in abortion care and counselling has been acknowledged, both by researchers and nurses themselves, as a key step in the provision of quality abortion services (Favier et al., 2018; Grossman et al., 2011; Harries et al., 2007; Harries et al., 2009; Harries et al., 2014; Harries & Constant, 2020; Röhrs, 2017; Vincent, 2012).

5.4.2 Research Aims and Questions

With regard to research aims and questions, McNiff and Whitehead (2011) make a distinction between traditional social science research questions that aim to find out what a group of people is doing or what is occurring in a place, and AR questions that are focused on the researcher and ask what the researcher is doing or how the researcher may improve their work. In the former scenario, the researcher often takes on an outsider perspective, whereas in the latter, the emphasis is on the enhancement of self-learning. AR is two-fold in nature, where improvements at a personal level (or self-development) have the capacity to effect changes at a social level.

McNiff et al. (1996), in their first edition of the book *You and your action research project* shared certain "powerful claims, not to be made lightly" (p. 8). They argued that AR, when conducted in a thorough fashion, can lead to a researcher's personal development and practice, to improvements in the institution where they work (which in this case are the clinics and hospitals that offer abortion services), and to a positive impact in society (which in my project is a contribution towards quality reproductive healthcare by improving the quality of abortion care). In the third edition of the book, McNiff and Whitehead (2011) reiterate how the goals of AR are both personal and social. The personal aim is for the practitioner to acquire a deep understanding and improve their learning so that they may improve their behaviours and

interactions. As an outcome, the practitioner is then able to facilitate the learnings of other people to enable them to improve their behaviours and interactions, which is the social aim. The authors add that while both goals share a symbiotic relationship and carry equal weight, it is important for the practitioner to report how their own learnings have or have *not* influenced the learnings and behaviours of other people. Though I address this aspect only in the discussion chapter, it did influence the type of research questions that I asked.

Koshy (2005) offers similar reflections for framing the research question(s) such as: thinking through what type of question seems appropriate to ask, for example, whether specific or open-ended; and deliberating on the expected outcomes. To construct the research questions, I therefore first scripted the project aims and then worked backwards to highlight what questions would (a) underline my learning and the participants' learning, and (b) assist in gauging whether the course had influenced the situation, i.e., nurses' counselling skills and their behaviours towards abortion service provision.

Research Project Aims. The purpose of this AR project was to operationalise the CSSR AC Guideline. The research's aims, therefore, are to develop, conduct, document and improve an abortion counselling training course for nurses based on reproductive justice principles. In critically documenting the processes and content, I intended to improve: my skills as a research practitioner and course facilitator; my understanding of nurses' challenges in abortion counselling in order to create and offer a course that is contextually relevant; our (the facilitators and participants') comprehension of the wider reproductive healthcare system in South Africa.

Research Questions. To phrase the research questions, I concentrated on key words such as 'develop,' 'facilitate,' 'training course,' 'client-centred,' 'healthcare providers,' and 'reproductive justice.' Specific research questions were: (1) How did the reported learnings and reflections of course participants dovetail with the specific outcomes of the Abortion Counselling Certificate Course? (2) What elements, external to the course, are identified as enabling or hindering nurses' skills in providing abortion services based on reproductive justice principles? (3) What elements, internal to the course, are identified as enabling or hindering nurses' skills in providing abortion services based on reproductive justice principles?

The first question purposefully related to the training course with a focus on the potential learnings and critical reflexivity of the nurses. In addressing it, I aimed to analyse the data related to their demonstrated praxis against the learning outcomes. The second and third questions interrogated where change was feasible or hampered. For example, following the training, providers recognised the relevance of an individualised and contextual approach for each client, yet this was less practical in a time-sensitive clinic setting that was understaffed

and overburdened with clients. This insight helped me to deliberate on the possibility of creating guidelines for a client-centred group format for abortion counselling, as further refinement of the course, in the future.

5.4.3 Training Course Aims

There are both short-term and long-term expected outcomes of the ACCC. Espousing two sets of guidelines – the CSSR AC Guideline and the National Clinical Guideline (DoH, 2019) – the training course aims to: promote client-centred abortion counselling that is based on a reproductive justice framework; dispel myths regarding abortion consequences with evidence-based research; provide contextually relevant[44] counselling and training; and ultimately benefit clients who access the service.

I further make explicit the ways in which the training course aims to help in-service nurses. The course will equip nurses with listening skills, which will assist nurses to identify what kind[45] of counselling is required on a case-by-case basis. It will offer nurses an understanding of the distinction between reproductive rights and reproductive justice. Embedded in this comprehension is an intention to acknowledge and applaud the role that nurses play in the country's reproductive healthcare system by highlighting the historical, socio-economic, and political complexities of abortion service provision. The training course will also function as a debriefing space for nurses to share and reflect on their experiences and challenges of abortion service provision.

The course will ultimately afford nurses a high level of competency to provide client-centred abortion counselling that is based on reproductive justice principles, by building their expertise and confidence in face-to-face abortion counselling. As a short course that is accredited by Rhodes University, each participant will receive a certificate of competency when they complete the necessary coursework and fieldwork. A long-term goal is to partner with SANC and apply for CPD points that nurse participants from the Eastern Cape may receive after successfully completing the course.

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[44] The term "contextually relevant" applies both to designing a training course that is context-specific to in-service nurses (who have undergone procedural training for CTOP), and to inculcating nurses with the competency to provide counselling that is specific to the client's context. The former implication gauges my abilities and learnings to develop the course, while the later gauges the participants' learnings and their ability to offer such counselling to their clients.

[45] By acquiring attentive listening and basic counselling skills, nurses will be able to assess whether a client requires options or decision-making counselling, procedural, pre-procedural, or post-procedural counselling.

In concluding this section concerning the research design, I underscore my commitment to actions of AR that are informed, intentional, and purposeful (as put forward by McNiff & Whitehead, 2011) where the starting point is "a felt need to do something, which transforms into intent, which in turn transforms into action" (p. 40). We identified and acknowledged a *need* to improve the access to and reputation of abortion services in the Eastern Cape (described in the research issue), which transformed into an *intent* to offer quality abortion counselling services (described under research aims), which transformed into *actions* of designing and facilitating training for nurses within this area of service provision (described by the research questions and training course aims).

5.5 Gathering Data

Data in AR are the information collected about research as the project proceeds, which responds to the research question, and demonstrates the "transformation into action so that the question becomes a claim" (McNiff & Whitehead, 2011, p. 42). McNiff and Whitehead (2011) encourage a systematic method to maintain records, such as a research diary, without discarding any of the material, as insights often form over time. Claims in AR involve how a researcher influences new learnings through new actions (McNiff & Whitehead, 2011); therefore, my data can be found in both the actions and learnings of myself and those of the participants. The data I acquired needed to demonstrate the *transformational relationships,* and accentuate whether and how my learning informed the action of the nurse participants. I illustrate this by adopting the diagram by McNiff and Whitehead (2011).

In response to McNiff and Whitehead's (2011) argument for action that is committed, informed and intentional, I maintained my actions (ACCC 2020 and ACCC 2021) at the centre of this project by ensuring the following: that my actions were *informed* by my learnings from the CSSR policy brief, the CSSR AC Guideline, my literature review and data; that I was *committed* to these actions due to my role as a post-graduate researcher and my professional identity as a counselling psychologist;[46] and that the work and research conducted was *intentional* and conducted in order to achieve the goals of this project. What these points highlight for me is the importance of the 'type' of data that are collected.

Koshy (2005) states that while data may be collected in a variety of ways such as field diaries, systematic observation, interviews, and questionnaires, it is important to choose

[46] There is a call for counselling psychologists in South Africa to contribute meaningfully to the public health and education systems by building evidence-based community interventions (Bantjes et al., 2016).

methods that are most suitable to the particular task. Kagan et al. (2008) identify certain methods of AR data collection that they categorise under the three E's: experiencing, enquiring and examining. Participation, self-reflection, story-telling, intentional conversations and dialogue or discussions fall under the first E. Interviews, questionnaires, focus groups and events fall under the second E. Texts, photographs, audios and videos, narratives, field notes of observations, feelings and reflections fall under the third E.

5.5.1 Experiencing, Enquiring, and Examining

The data collected from the project falls under all three E's. I now explain what comprised data for the project and how they can be categorised. Research data included: (1) Feedback forms collected from participants after Session 5 and Session 6 of ACCC 2020 and on Day 2 and Day 3 of ACCC 2021; (2) Reflective journals maintained by the participants (as part of the assessment for the course); (3) Reflective journals maintained by the two facilitators; (4) Observations made by the co-researcher during ACCC 2020; (5) Recordings of selected sessions of the training course; (6) Participants' case presentations (PowerPoint or written presentations). An additional method of data collected was included in ACCC 2020, which was (7) Interviews of the nurse participants by the co-researcher, conducted two months after the course (appendix 12). The interviews conducted by the co-researcher after ACCC 2020, the video recordings (on Zoom) from ACCC 2020, and the audio recordings from ACCC 2021 fall under an enquiring method. A useful feature of my research journal was that although only certain forms of data were listed as research data, I was able to include dialogues or discussions from any moment during the course if I had reflections of these in my research journal. Hence, my reflections that arose from discussion with my research team and my self-reflections fall under both experiencing and examining methods of data collection.

The feedback forms functioned as questionnaires. This method may be described as a method of enquiring. These forms contained open-ended questions such as "What stood out for you in relation to this course?" and "What elements do you think require revision?" In addition, participants were asked to provide written feedback[47] on the strengths and limitations of the following: course materials; facilitators' input; role play sessions; the fieldwork

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[47] Although the feedback forms contained a rating scale, this did not form part of the analysis as there was no quantitative component to the data analysis. Rather, the scale worked as a tool to facilitate written feedback and to help participants hone in on their experiences. Similarly, a number provided me with an initial visual of a high to average rating or alerted me to a stark difference in any particular aspect, which I could then investigate further, qualitatively.

assignment; feedback from facilitators and colleagues; facilitators' time management; journal assignment; the location of the course; and the support buddy system.

5.5.2 Sampling

Data are one of the most crucial aspects of research as it contributes to comprehending theory (Etikan et al., 2016) and, in the case of AR, also generating new theory (McNiff & Whitehead, 2011). Purposive sampling or judgement sampling is a deliberate choice of participants – based on their qualities, knowledge, or experience – that a researcher decides is appropriate for the study (Etikan et al., 2016). In identifying a sample for the training, I took into consideration a group of individuals who would be "proficient and well-informed with a phenomenon of interest" (Etikan et al., 2016, p. 2) which in this case were healthcare providers who were trained in abortion provision. I also considered their interest in participating in (a) the training course and (b) the research, as two separate decisions. Hence, purposive sampling helped me gauge their availability for the course as well as their willingness to participate in the research (Etikan et al., 2016) to ensure they fit the purpose of the research (Terre et al., 2006).

In critically reflecting on the sampling during the first cycle of AR – which in itself went through various shifts due to Covid-19 – we considered three possibilities for groups of nurses: healthcare providers (HCPs) who had undergone abortion training; HCPs who wished to undergo training in abortion services in the future and hence would benefit from counselling skills in this area; and nurses-in-training at a training college.

The third option had been suggested in my proposal as an alternative method for data, with the intention of conducting the course at a training school and then having students shadow nurses in the field who were trained abortion providers, gaining experience only in the counselling part of the service (since they would not have undergone procedural training yet). The idea was vetoed as it would change the course outline itself. For example, one of the initial activities involved participants interviewing each other in pairs about their current counselling practices, followed by a group summary. It would not have been possible for pre-service nurses who had never experienced abortion provision to offer any case experiences.

Similarly, assessing whether the counselling training had been beneficial would have been challenging. The second option posed a similar concern. Hence, purposive sampling helped to narrow down the group to registered nurses who had undergone the prescribed training to perform a termination of pregnancy as per the CTOP Act, and who wished to acquire or deepen their counselling-related skills. From these, the HCPs who provided consent to participate in the research component formed the sample for my research. We

considered a sample size of approximately 10 to 15 participants per workshop as a size conducive to smaller group discussions, role-plays and working in pairs. As research participants, the nurses contributed to the development of the training courses and their feedback formed an integral part of the cyclic process of AR. Although the course was conducted in English, the bilingual co-facilitator functioned as an isiXhosa translator as and when required.

5.5.3 Registrations and Recruitment

A similar method was followed to market ACCC 2020 and ACCC 2021, encouraging nurses to register for the training course. I contacted the Deputy Manager of the Maternal and Child Health Unit at the ECDoH via email (in November 2020 and then again in 2021) and shared the following documents: facility manager (gatekeeper) permission letter (appendix 13); advertisement flyers (appendices 14 and 15); specific course-related and research-related flyers (appendix 16); registration form (appendix 17); informed consent form (appendix 18) and the research ethics approval letters. The deputy manager forwarded these documents to facility managers in eight districts, and also sent me their contact numbers.

Email and WhatsApp became the modes of communication, with the latter being the preferred and most frequently used method. Enrolment for both courses took place on a first-come first-served basis. Although several nurses made enquiries and showed interest, their place on the course was reserved only once they had submitted a completed registration form. Although 10 nurses registered for each course, only nine participants were present at the start of each training. Tables 5.1 and 5.2 include some details of the participants from each course.

ACCC 2020

The online course took place between 13 November 2020 and 09 December 2020. Ten nurses registered and several more enquiries of interest were made. Once the registrations were complete, I informed the remaining nurses who had shown interest that a second course would be conducted the following year. One of the registered participants did not join the first online session, but we decided against inviting a nurse from the waitlist as the pre-course session presented us with several network connectivity issues. Keeping the final number a manageable one at nine helped with online time-efficiency. At the end of the course, participants' letters of attendance and course certificates were sent to them by post.

Table 5.1

Registration Details of ACCC 2020 Participants

	Sex	Age	Facility	Date of TOP Training	District
Nurse 1	M	35	Provincial government-funded hospital	2013	Alfred Nzo District
Nurse 2	F	48	Public health community centre/ Provincial government-funded hospital	Oct 2019	Buffalo City Metropolitan
Nurse 3	F	56	Healthcare clinic/ Provincial government-funded hospital	Mar 2005	Buffalo City Metropolitan
Nurse 4	F		Provincial government-funded hospital	Oct 2019	Hewu District
Nurse 5	F		Provincial government-funded hospital	Nov 2019	Alfred Nzo District
Nurse 6	F		Reproductive health clinic	2018	Amatole District
Nurse 7	F	27	Provincial government-funded hospital	Oct 2019	Sarah Baartman District
Nurse 8	F	55	Public healthcare organisation/ Community health centre	Oct 2019	Nelson Mandela Bay Metropolitan
Nurse 9	F		Provincial government-funded hospital	Oct 2020	Chris Hani District

Table 5.2

Registration Details of ACCC 2021 Participants

	Sex	Age	Facility	Date of TOP Training	District
Nurse 1	M	34	Provincial government-funded hospital	2017	Amathole District
Nurse 2	F	31	Provincial government-funded hospital	2019	Chris Hani District
Nurse 3	F	60	Provincial government-funded hospital	1998	OR Tambo District
Nurse 4	F	34	Public healthcare organisation	Nov 2019	Sarah Baartman District
Nurse 5	F	35	Provincial aided hospital	2018	Nelson Mandela Bay Metropolitan
Nurse 6	F	36	Provincial government-funded hospital	Nov 2019	Chris Hani District
Nurse 7	F	34	Provincial government-funded hospital	2012	Amathole District
Nurse 8	F	48	Provincial government-funded hospital		Amathole District
Nurse 9	F		Provincial government-funded hospital	2015	Buffalo City Metropolitan

ACCC 2021

The FTF course took place between 17 May 2021 and 07 June 2021. Nine nurses registered for ACCC 2021. At the end of the course, participants received their course certificates in person, in the presence of ECDoH managers and CSSR members.

5.6 Revisions and Refinement – Cycle Two

While I have addressed the recruitment of participants for both courses in the section before, in this section I wish to highlight some of the reflections and actions that occurred in between the two courses and the reason behind the change in the mode of delivery. In doing so, I emphasise the democratic and collaborative nature of AR, which is more about research *in* action rather than *about* action (Williamson et al., 2011). Active participation involved not only the course participants, but also the stakeholders, who are managers within the reproductive health field, and whose experiences of the situation were valuable and could contribute towards solutions.

With its roots in humanistic psychology, a variant of AR is 'cooperative inquiry,' which involves finding collaborative ways to effect change by working with people with shared concerns (Williamson et al., 2011). The authors argue that this action and reflection occurs in four phases: when research propositions are first identified; when the practices must have applicability to daily work and life; when researchers gain new insights due to engaging with the project; and when the original proposition is reconsidered and adapted. I describe below how cooperative inquiry occurred prior to ACCC 2021 (Williamson et al., 2011).

In April 2021, we shared an interim report with the ECDoH (our project stakeholder) that contained the following: feedback from ACCC 2020; tentative dates (03 May 2021 to 31 May 2021) for ACCC 2021; and some changes that we planned to incorporate into the next online course. We received news that the manager had retired, and were advised to contact the new director of the MCWH unit, whose contact details were shared. In this regard, a fourth consultation[48] took place with the ECDoH, at their head office in Bhisho. I once again presented the foundation of the research, the course and research aims, and a summary of

[48] As we had not anticipated this additional step, this meeting took place barely two weeks prior to the start of ACCC 2021. All course materials had already been printed, samples of which were distributed at the meeting.

the Cycle 1 process of AR with some critical reflections from participants, general feedback on the course, and plans[49] for ACCC 2021.

The new deputy manager responded positively and spontaneously requested that the course be conducted face-to-face. While they offered support to enable this shift, my immediate reaction was one of doubt, since the course had been refined to suit an online format. In retrospect, this meeting was the quintessence of cooperative inquiry AR. The manager stressed that the technical difficulties of online work were comprehensible, and comparable to challenges faced in the simultaneous and ongoing process of online registrations[50] for Covid vaccines. Her concerns seemed to be raised from a critical examination that illuminated ”how AR links insights from participants' real-world experience with a drive to change social situations” (Williamson et al., 2011, p. 16). She expressed empathy for participants attending an online course as it could be an isolating experience. She reasoned that in an environment where abortion providers already experienced seclusion and stigma, the importance of engaging FTF and sharing experiences in real time would be highly valuable.

In effect, the ECDoH provided permission for registered participants to be relieved from work to participate in ACCC 2021. The course took place on the university campus and was delayed by two weeks to accommodate some of the changes and allow for bookings of venue and catering. Due to the shift to a FTF course, we increased our participant numbers back to 10. Our stakeholder expressed a wish to meet with the nurses during the course. We offered them some time on the third and final day of training before closing, so that it would not interrupt the flow of the module. Two of the managers from the ECDoH and the course-coordinator (also my research supervisor) were invited to the venue and engaged in a

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[49] The planning involved a refinement of ACCC 2020 with most of the changes being made to the structure of the course and not the content. This was to account for the various technical glitches and network connectivity problems that we had experienced during ACCC 2020. We decided to reduce the number of participants in order to offer ample time for discussions and peer and facilitator feedback, without having to increase the overall time for each session by more than 30 minutes. Too much of an increase in the duration could lead to fatigue, especially in an online setting.

[50] The government launched the Electronic Vaccine Data System (EVDS) in South Africa to allow qualified persons (based on priority and age) to register for a Covid-19 vaccine. The website https://vaccine.enroll.health.gov.za/#/ was to assist with the management and surveillance of the vaccine. The manager anecdotally shared that, while this systematised the process, many found the registration process challenging and several needed assistance, as it was not straightforward or simple for all age groups to register with ID or passport and provide personal and contact details.

discussion with the participants, who spoke about their experience of the training and some of their workplace challenges. All participants were then presented with their certificates.

5.7 Funding and Budgeting

Kagan et al. (2008) identify certain dilemmas in trying to secure funding for AR projects, which include: the open-ended nature of projects that may seem less boundaried must be considered, as AR may not always have a set time frame; some form of sustainability may be difficult to assume within a backdrop of constant change in AR; grant proposals involving AR may appear vague; and academic publishers or conference organisations may not wish to fund projects unless the data collection and analysis are complete. Related to the last point, while many institutions often depend on publications for funding whereby presenting a paper at a conference can earn credibility (McNiff & Whitehead, 2011), an AR project that is in progress can create a conundrum.

These arguments raised by Kagan et al. (2008) hold true for this project with regard to finding funders. During the course of the project, I applied for two grants, both of which were unsuccessful: the first grant[51] in August 2019 (rejected in November 2019) and the second grant[52] in April 2020 (rejected in September 2020). The time frame underlines the duration of budget planning, which in itself underwent several iterations. The process of completing these grant applications did help to develop thoughts around the project in a slightly different way than to that of an academic proposal. It helped to think through the broader project and its sustainability, which are also important ethical aspects to consider.

In effect, ACCC 2020 was funded completely by the CSSR, and the main costs included printing, couriering of course materials and certificates, payment of the co-facilitator, and mobile data for all research participants. As the format shifted for the next course, the budget was modified. The ECDoH covered transport and accommodation costs for ACCC

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[51] In September 2019 we were informed that our grant application had been shortlisted, but that due to their own limited funding, only a certain number of organisations were invited to submit a full proposal. They mentioned that should they receive more funds, which they expected towards the end of the year, they would contact us. Unfortunately, in November 2019 they informed us that they had not received more funding to support more grants, in spite of the strength of our proposal.

[52] Our second grant proposal reached round two of the selection process. In their feedback, the reviewers appreciated the way in which our proposed innovation considered the local context to develop contextually relevant feminist training and stated that a training course with a feminist approach would likely help to reduce stigma and improve the care received. The weakness they stated was that it seemed one-dimensional, and that more progress would be possible if the counselling could also be geared towards women in the community, to help alleviate their anxiety about seeking care.

2021. They provided transport for each nurse, who was brought to Makhanda and taken back to their residence at the end of the training. During the training course in Makhanda, the nurses were provided accommodation at a hotel close to the university campus. This process was repeated when the nurses returned for their case presentations after their two-week fieldwork period. Local transport and catering during the course were organised by the CSSR research unit. In this way, although the budget was higher for ACCC 2021, costs were shared between the stakeholder and our research unit.

5.8 Analysis and Interpretation

To interpret the various forms of data acquired, I adopted a thematic analysis (TA), defined broadly as a method to help identify, analyse, and interpret meaningful patterns or themes in the data (Clarke & Braun, 2017). TA is used for inductive (data-driven, or 'bottom-up') and deductive (theory-driven or 'top-down') analyses, and can capture both semantic (explicit) and latent (underlying) meanings during coding (Braun et al., 2016; Braun & Clarke, 2020). Additionally, deductive and inductive processes are not necessarily dichotomous, as the latter is never fully devoid of "paradigmatic, epistemological and ontological assumptions" (Braun & Clarke, 2021, p. 331). However, there is much diversity and flexibility within TA (Terry et al., 2017) which lends itself to various research designs and methods but also epistemological confusion (Braun et al., 2016). Following these authors' suggestions, it was important, therefore, to situate my TA in relation to theory and elaborate on how I implemented a TA in my thesis (Braun et al., 2016).

5.8.1 Approaches Within Thematic Analysis

Braun and Clarke (2021) state that TA is not a singular approach but consists of many, at times conflicting approaches, that differ in their method and underlying philosophy but are similar in their shared interest of finding patterns in the data. They describe three approaches, namely: coding reliability; codebook; and reflexive TA, each with its own paradigm, methodology and epistemology (Braun et al. 2019; Braun & Clarke, 2021). If the three approaches existed along a continuum, coding reliability would sit at one end due to its positivist assumptions and structured stance, reflexive TA would sit at the other end with an emphasis on qualitative researcher subjectivity, while a codebook approach would exist somewhere along the middle. The codebook approach shares some features with coding reliability, such as conceptualising themes as domain summaries, but is not overly concerned about *measuring* coding reliability, which is a more positivist inclination. Codebook

approaches are similar to a reflexive TA in its orientation towards a philosophical and paradigmatical stance (Braun et al., 2019).

My first analytical chapter sits somewhere on the continuum between a codebook and a reflexive TA, in that it vaguely follows a coding frame, such as in a template analysis (King & Brooks, 2017). A template analysis allows (though this is not necessary) themes to be defined prior to the analytical process, which are referred to as 'a priori' themes (Brooks & King, 2012). Though pre-defined, these themes remain tentative and may be removed or refined if they do not represent the data appropriately (Brooks & King, 2012). As I needed to assess how effective the training course was in meeting its objectives in order to evaluate and refine it, it seemed practical to review each course outcome (as *a priori* themes) against participants' reported learnings and the facilitators' observations. This idea stemmed from evaluation studies that have utilised *a priori* themes based on the evaluation criteria or on the theoretical framework guiding the evaluation (King & Brooks, 2017). To this extent, the first analytical chapter drew on certain aspects of a codebook approach to TA, though I am acutely aware that this approach does not constitute Braun and Clarke's (2019; 2021) approach to TA. Yet, my approach diverged from a thorough template analysis as I neither subscribed to the suggested four or more levels of sub-themes nor created theme definitions at the initial template stage for further coding and template development (as described by Brooks et al., 2015).

I also consider my analytical method in the first analytical chapter a deductive reflexive TA: deductive, because existing research (such as du Toit, 2023; Mavuso et al., 2017) and theory (such as Ross & Solinger, 2017) informed my data coding process, and reflexive, because my subjectivity remained at the core of my analytical lens. The *specific course outcomes* of ACCC were primarily conceptualised using reproductive justice and Rogerian client-centred principles. Course outcome 2, for example, was to *comprehend the premises of client-centred abortion counselling and therefore what to include and what to avoid in a session*. So, this outcome encompassed an understanding of non-judgement, empathy, and so on alongside an acknowledgment that language can steer an abortion seeker away from the service, thereby impeding access to the service. When I began coding, my work was informed by a pre-determined course outcome, but it was also theory-driven, as I coded phrases like, "create a safe space," "don't decide for the client," "normalise abortion," "learnt not to be coercive." These were ultimately highlighting a feminist client-centred approach that underlined reproductive autonomy and agentic decision-making. Braun and Clarke (2021) also stress that in reflexive TA, coding is a precursor to theme development; themes are the end result of coding. In this regard, I did not start my analytical work with themes in mind. I

developed and titled one of my sub-themes as *Un'problematising' the Patient* based on prior research that showcased a tendency for providers to place blame on the individual woman for an unwanted pregnancy through semantic and latent coding.

5.8.2 Reflexive Thematic Analysis

My second and third analytical chapters followed a reflexive thematic analysis, which is an approach that underscores the subjectivity of the researcher as an important resource in the analysis, and the necessity of reflexive engagement with the entire process (Braun & Clarke, 2021). This form of analysis provided a systematic means to develop codes (described as the smallest units of analysis) that featured important and interesting characteristics that related to my second and third research questions. Codes or building blocks helped to develop themes while emphasising a key organising concept. Themes, ultimately, provided a scaffolding to organise and report this study's analytical data (Clarke & Braun, 2017).

Clarke and Braun (2017) assert that a mere summary of the data is insufficient, rather the aim of a thematic analysis is to underline features of the data that speak to the research question. Connected to this is the notion that the research question is not rigid and may evolve during the process of coding and thematic organising. As such, my research questions did undergo refinement as I generated codes to better align the questions with the developed themes. For example, my first research question initially was, "how did the processes followed prior to implementation contribute to the development of the training course?" The coding and themes did not suitably respond to this question, and I acknowledged that the enquiry was in fact addressed via this methodology chapter in describing the progression of the course development. The question shifted to, "what changes are evidenced in nurses' skills in providing client-centred counselling based on reproductive justice principles after participating in the course?" I realised this could not be explicitly answered from the data I had generated, as this would require additional data, perhaps interviews with abortion clients. The final question (listed as the first question under 5.4.2) made it feasible to review the demonstrated practices and reflections of participants (as reported by them) against the course outcomes and assessment criteria, thus organically linking the analytical themes to the research aims.

Braun et al.'s (2016) method of thematic analysis involves six phases:

Phase One. The first phase involved becoming familiar with the data though critical engagement (through reading and rereading), making notes, and generating meaning by searching for ideas that respond to the research questions (Braun et al., 2016). With regard to my process, certain data – such as the research journals and feedback forms – were already in a transcribed format since participants had written down their responses. I therefore began

by listening to all audio and video recordings of selected sections of the course and transcribing these data, broadly drawing on Ian Parker's (1992) transcription conventions[53] (appendix 19). I moved on to reading all feedback forms, recordings, observations and research journals. I returned to the feedback forms (in line with the familiarisation process) but found myself forgetting the material that were in the research journals and so on. I thus decided to start coding before moving on to a different set of data. I found it unhelpful to continue reading all my data collected without making sense of it in smaller bite-sized portions. Perhaps this is what (Braun et al., 2016) described as an indirect path that can move forward and at times backward. Although they described this feature as unfolding across different phases, in my case it occurred even within individual phases.

Phase Two. Phase two involved coding, which helped to identify and label interesting data which were relevant to my research questions (Braun et al., 2016). I printed out all my data and manually coded each transcript (at semantic, latent, inductive and deductive levels) using different colours. I began with participants' reflective journals by rereading each of them (course wise). I made analytical notes in the margin of the transcripts to refer to during the next round of coding, as I knew my codes were not final and would change and evolve as I read more transcripts. As I progressed from one journal to the next, I found that codes were repeated and easy to identify, and I also developed new codes as I went along. When necessary, I reprinted transcripts to maintain a level of tidiness and coherence during this step. At times, I linked coded excerpts to relevant literature I had read. Since it might have been premature in the analytical process, I documented these connections on my laptop for later reference.

Phase Three. The main analytical work occurred over the next three phases (Braun et al., 2016). In phase three, I began to organise and group codes together to develop themes. Theme development occurs by clustering codes together that capture broader meanings or higher-level patterns (Braun et al., 2016). For example, while coding deductively, I examined participants' abilities to outline deep listening skills (which I wrote down on a flipchart) based on their own understanding. My codes included "nodding," "leaning in," "maintaining eye contact," "I repeated some of what she said," "if I hear you correctly, it seems…," and "I told her I understood her feelings." On closer examination of my codes, I noticed that when

[53] Ian Parker's (1992) transcription conventions were adopted by Laurah Mogonong (course observer during ACCC 2020) while transcribing her research interviews, which formed part of my data. Hence, to maintain consistency, I adopted the same for data that required transcribing (such as group discussions). However, other data were handwritten or typed by participants and thus appears as such, with only minor editing to increase comprehension (such as correcting a spelling error), while ensuring that the meaning remains the same.

participants described their listening skills with clients, two characteristics stood out noticeably: data segments that referred to non-verbal cues (the first three codes) and those that involved paraphrasing (the last three codes). This led to me splitting and grouping the codes into two cluster codes, namely "body language" (in green) and "verbal communication" (in orange), as higher-level patterns (as described by Braun et al., 2016). The sub-themes that developed from here related to client-centred therapy skills that highlights a counsellor's role in being 'attuned to their client' through keen observation, and 'clarifying information' to ensure that they have understood the client properly. I was actively involved in identifying and formulating these patterns, as suggested by Terry et al. (2017). In other words, my prior knowledge and subjective interpretation led me to comprehend these patterns as 'demonstrated deep listening.' I named these two features a*ttending listening skills* and r*eflective listening skills*, which formed two sub-themes under the broader theme of d*eep listening*.

Phases Four and Five. Phase four involved theme refinement, where I reviewed my themes by first examining my entire coded data set (Braun et al., 2016). Phase five included defining and naming the themes (Clarke & Braun, 2017). I found I needed to make several decisions in these two phases particularly (frequently going back and forth), and have clubbed them together due to the overlap. During these two phases, I found various data that were left out because it was either not substantial[54] enough to form a theme by itself or did not relate to the research question being addressed (at least not directly). For example, when nurses shared experiences about some of their challenging cases during the introductory session, they spoke about instances with clients who had been through sexual abuse, which – from my analytic understanding – alluded to reproductive coercion or violence and transactional sex. I was unsure about how to engage with these points without digressing from the research aim of course development. Upon further thought, I perceived that while such issues are indeed systemic problems, they clearly seeped into provider-client micro-interactions, negatively influencing the quality of counselling. A thematic map helped me to re-organise my candidate themes and place this topic under a central organising concept of c*hallenging cases*. I then moved it to e*lements hindering abortion service provision* (also one of my research questions) since providers described these scenarios as "challenging." I faced a conundrum about whether to include this theme in chapter seven (elements outside of the course) or chapter eight (elements within the course). After all, participants encountered such problems *outside*

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[54] There have been coded data that I have had to eliminate entirely, which created a dilemma in me about whether I was doing justice to my data set. However, for the sake of chapter cohesion and flow, I made a decision in conjunction with my supervisor that certain data could be set aside for now. It is my intention to revisit and possibly publish these findings in a separate paper at a later stage.

of the training space, yet the course had not engaged enough with the ground realities of their work to help them find ways to navigate counselling in such cases. These insights proved to be rich data that could contribute to improving the course (which was the research aim) in the future by incorporating such scenarios into classroom discussions or role-play practice sessions. I, thus, placed it under internal elements, while keeping in mind the “relationships, interconnections, and boundaries between the themes” (Braun et al., 2016, p. 199).

Phase Six. Phase six involved a collation of all the existing and edited analytical work, since the ‘writing-up’ had been an ongoing process since the start of the analysis (Braun et al., 2016). The authors caution that writing a TA involves a few crucial decisions, such as finding balance between two analytical elements – data extracts and analytical interpretations. Too much of the former can lead to a surface-level commentary, whereas a more critical analyses can lend itself to a more analytical narrative (Braun et al., 2016). I had found that deciding which extracts to include and exclude was often a daunting task. Where several participants shared similar sentiments pointing to a particular theme, I had to prudently select a few and find a balance between letting their voices be heard and emphasising my subjective interpretation of why the selected extract was relevant to the theme. Following Terry et al.’s (2017) instruction, this phase was my last opportunity to make edits that strengthened my analysis and conveyed the narrative of my data (Terry et al., 2017). In this step, as suggested by my research supervisor, I also aimed to draw a thread through the research, from the first chapter to the last, and pull everything together. Once I had written up these links and created a common thread, the research was complete.

5.9 Ethical Considerations and Dilemmas in Action Research

There is some discord about the benefits of traditional concepts such as validity, reliability, and methodological objectivity within AR; nevertheless, rigour and research quality are important considerations for action researchers (Buskens & Earl, 2008). Reason and Bradbury (2008) argue for different ways of engaging with validity and quality in AR, where knowledge creation is based on purpose, collaboration, effort, practical outcomes, a variety of ways of knowing, and sustainability. With regard to knowledge generation, in which knowledge is developed on the diversity of experiences (Reason & Bradbury, 2008), I argue that the data generated through multiple means (class discussions, reflective journals, feedback forms, journal entries, etc.) allowed for the voices of the participants, facilitators and the co-researcher to be heard. I have yet to engage in depth with regard to the sustainability of this project. Yet, this consideration and the effort made over the past six years motivate me to promote this training course even after the submission of my thesis, while also taking into

account requests from the ECDoH to create a train-the-trainer manual, and requests from participants to offer such a course to their supervisors.

A paper from the late 1990s highlighted some of the ethical dilemmas that a practitioner researcher can face (Fraser, 1997). As the developer, facilitator, and evaluator of the training course, I related to some of the author's concerns. Fraser (1997) argues that a practitioner may be partial when assessing the effectiveness of a programme for which she is responsible. I evaluated the course semantically and latently. Furthermore, the reflexive nature of the thematic analysis implored me to draw on my subjectivity. So, when reviewing my data in chapter one, for example, I ended up generating sufficient "evidence" to highlight how all the course criteria had been met. Yet, this very bias is often eschewed in traditional research when creating an empirical evidence-based training course.

I attempted to offset this conceivable bias through my professional responsibilities (as suggested by Fraser, 1997). As an action researcher who was advocating for reproductive justice, I had a responsibility to ensure that the training course would ultimately have a positive influence in meeting the needs of abortion seekers. Furthermore, an evaluation of the project necessitated a personal evaluation of my own practice, based on which my judgement of the quality of my actions needed to be subjected to "the critical scrutiny of others" (McNiff & Whitehead, 2011, p. 133). As such, I endeavoured to demonstrate accountability for my research claims by presenting my work at three conferences and periodic work-in-progress colloquiums at the CSSR, where I shared my analytical findings with peer researchers. To share an example, in one of these sessions, a colleague raised a critical point related to the possibility of nurses producing "correct" and "right" answers and questioned whether participants' responses were indeed a true reflection of their learnings. I welcomed such input and subsequently included literature on how to perceive social desirability bias in qualitative research (Bergen & Labonté, 2020). Furthermore, as the data analysis took shape, I shared my three analytical chapters with the course co-facilitator, Esona. I requested her to share (however briefly due to her tight schedule) some feedback about any aspects of the findings. She responded positively, stating that it was great to see it put together and that she was in agreement with my analysis (E. Bottoman, personal communication, April 18, 2025).

I also drew from Thornton and Yoong's (2011) description of the role of the blended action learning facilitator who functions as an *enabler of learning* as well as a *trusted inquisitor*. The former focuses on motivating and encouraging participation, and offering resources and support, while the latter focuses on building trust and relationships with and amongst participants, offering expertise, challenging and questioning the participants, and role-modelling. With these insights, I aimed to find a balance between these two roles and fostered

a relationship with course participants (supported by the use of WhatsApp during training) and simultaneously evaluated them and my own practice. I do not claim to have eliminated all my bias in evaluating the course; however, I did re-examine the data for incongruities within each participant's data that could point to social desirability bias. I thus studied participants' possible bias in course engagement and my own bias in course evaluation.

Munten et al. (2010) assert that there is no universally accepted criteria for appraising AR. However, a process of triangulation – in which data from more than one source are studied and where data are explored from various perspectives – can contribute towards what counts as evidence (McNiff & Whitehead, 2011). I engaged with triangulation by comparing journals from both facilitators and participants, alongside co-researcher observations, to view an instance from different perspectives (visible in the analysis).

Other validating procedures as described by McNiff and Whitehead (2011) include academic validation (the proposal itself underwent revision after reviewers' feedback and the process of course accreditation also served this purpose) and peer validation (initial course revisions were shared, and input from research colleagues and stakeholders were taken into consideration) that this project diligently pursued. My unavoidably subjective claims thus carry rigour through instances of external social validation from fellow researchers (McNiff & Whitehead, 2011), while remaining resolute and loyal to the reflexive TA process.

5.10 Reflexivity in Research and Practice

Reflexivity is the ability to be self-critical and ethical while fostering good practice-based learning (Dallos & Stedmon, 2009). Though my reflexivity extends beyond this section, I have nevertheless included a brief outline here to stress its relevance and the ways in which I engaged with it in this project. Firstly, as an action research cycle in itself incorporates critical reflexivity, it formed a core component of the course development and refinement (highlighted under sections 5.2, 5.3, and 5.6 in this chapter). Secondly, a reflexive thematic analysis underscores the importance of reflexivity and subjectivity in the development of themes and so I was able to naturally weave it into the analytical process (highlighted in section 5.8 in this chapter and also in my analytical chapters, through the addition of journal entries).

Feminist ideas of reflexivity show a concern for any unexamined power of the researcher and aims to reframe power imbalances between a researcher and participants in the study (Finlay, 2002). At its core, reflexivity aims to make interpersonal dynamics explicit, as a researcher can exercise power when interpreting, perceiving, and communicating about the participants (Reason & Bradbury, 2008). Therefore, a third way that I engaged with

reflexivity was focused on my own positioning: how my training as a counselling psychologist influenced my experience as a facilitator. During the courses, I would have been perceived as being an outsider, an academic from the university. The fact that I was doing my doctoral study seemed to gain some level of admiration in how participants responded when I introduced the research component and myself.

At the same time, as I engaged with their reflective journals, their concerns about whether they would pass the course and being evaluated, emerged. This highlighted “the power of the researcher in the position of expert” (Macleod, 2002, p. 19) not only because I would be appraising their work so they could receive a certificate at the end, but also because my interpretation of their case presentations, group discussions, and journals would carry legitimacy (due to my role as a facilitator and researcher). However, I was also a learner in the space and gained insights from participants about procedural information as well as certain protocols (such as what a J88 form was). At such times, I stressed my ignorance and gratitude for acquiring new knowledge from them.

My counselling psychology background informed my role as a course facilitator in how I understood and approached participants’ concerns about the course and challenges in their work, and I endeavoured to alleviate their fears while validating their experiences and emotions. Of course, I also remained cognisant of not falling into the role of a therapist as I found myself naturally empathising with their plight, especially when they spoke of the ways in which they experienced stigma, and the lack of support in their environment. What helped me here was the relevance of locating myself as an ethical researcher and practitioner within the broader social, political, and cultural landscape that influences the narratives we engage in with others (Dallos & Stedmon, 2009).

As their reflective journals included questions about why they became abortion providers, some participants shared personal narratives of their own obstacles in seeking an abortion that then motivated them to pursue this path. I acknowledged, reflected on and extended their difficult experiences to those of abortion seekers. I incorporated discussions on the political landscape of abortion, globally and within South Africa, moving from the political climate to cultural and religious norms to interpersonal gendered power dynamics. In discussing how these interwoven factors create several hurdles for ‘us’ women, I shifted from an outsider to an insider position (as described by Collins, 1990) to create a connection with the participants. Of course, two of the participants were male nurses; however, the majority were women, and such deliberations mainly generated a collective empathy within the group towards each other and towards abortion seekers.

5.11 Conclusion

It can be difficult to explain the various stages in AR before the research commences as these stages usually become apparent as they develop during the process (Holloway & Galvin, 2016). In this chapter I endeavoured to reveal the 'messiness' of the methodology (or inquiry) while demonstrating the rigour that continuously challenged and enabled the project development. In situating my research, I first offered an overview of the roots, traditions, and principles of action research. As noted by various authors (Atkinson, 1994; Davis, 2004; Meyer, 2000) the steps of AR involved iterations within an iteration. Thus, I aimed to describe the two cycles of action research in a coherent (and to some extent chronological) enough fashion. Within these sections, I demonstrated how I devised a research design and underlined the research issue, aims and questions. I described the actions that I took to gather data and implement this plan, which included aspects related to budget and funding. I then elaborated on my analytical process and the ethics of this project. I ended with a section on reflexivity, which occurred simultaneously throughout the project, at times inadvertently and at other times, intentionally. This was enabled by the methodology and type of analysis. The credibility of my research is tied not only to the method delineated in the chapter but also to the claims made in the following three analytical chapters.

CHAPTER SIX: DEMONSTRATING CLIENT-CENTRED ABORTION COUNSELLING PRAXIS

6.1 Establishing Course Outcomes

In this chapter, I respond to my first research question, which is: How did the reported learnings and reflections of course participants dovetail with the specific outcomes of the Abortion Counselling Certificate Course? This question simultaneously merges and interrogates the aims of the research (specifically the aim of evaluating the training course) and the aims of the training course (specifically to build providers' skills in abortion counselling and their ability to dispel abortion misinformation). In order to do this, I examine the nine specific course outcomes against the assessment criteria (appendix 7, page 275) for each outcome, with the objective of refining these components as part of the course development.

The themes that developed illustrate various client-centred counselling skills based on reproductive justice principles that were demonstrated by nurses in both courses. While this analytical chapter primarily aims to address whether and how the course outcomes were met, it also exemplifies alterations in providers' thoughts, behaviours, and approaches towards abortion service provision and towards abortion seekers.

6.2 Critical Thinking Enhancement

The first specific course outcome was *to critically explore case studies to learn effectively*. The discussion of cases arose through formal activities such as the case presentations and the CARM activity (in which recordings from the baseline study were discussed) as well as through informal discussions amongst participants. Thus, the peer dialogue played a key role in the progression of critical skills alongside the scheduled activities outlined in the course. The following sub-themes exhibit the ways in which participants' critical thinking skills developed. This became visible to the facilitators via participants' abilities to engage in peer supervision, and to identify both problematic and positive practices (in baseline research transcripts of audio-recordings of pre-abortion counselling sessions).

6.2.1 Identifying Problematic Practices

Alongside learning about client-centred counselling practices, participants were also introduced and exposed to scenarios that were not client-centric. Thus, they developed proficiencies not only in how to respond, what to say, and what to do but also what *not* to say and what *not* to do. This promoted self-reflection after observing peers' practices and making

notes about what worked well and what did not, with regard to the principles of client-centred pre-abortion counselling and reproductive justice. The extracts below (all responses to the CARM activity) illustrate how participants, having understood the premise of person-centred counselling, began to reflect on aspects that need to be avoided in a pre-abortion counselling session.

> ***Extract 1**: The counsellors were **leading the counselling session which was wrong.**[55] One **even introduce religion** into the counselling when he/she mentioned "God" which was also wrong to do.*
>
> *[Phillani, Reflective journal, 2021, p. 10]*

> ***Extract 2**: It is the **judgement** that was given to the client during the interview that made me angry, the client was not given the opportunity to state how she feels, the provider was trying to **make the client change her mind** about abortion.*
>
> *[Ziyanda, Reflective journal, 2021, p. 10]*

> ***Extract 3**: I was surprised with the way nurses are **directive, judgemental** when handling these clients. The nurses **are guilt tripping the client to reconsider TOP** which is wrong. As a provider you do not, in any circumstance, **convince the client to change their mind**. It is really shocking what is being done here while they are helping them to their (own) satisfaction.*
>
> *[Thandi, Reflective journal, 2020, p. 5]*

Some fundamental observations that participants made were that providers invariably led the session (intentionally or unintentionally) by introducing topics and their own views about abortion, which likely create confusion in clients about the procedure. The three extracts underscore various learnings in participants' reflections: pre-abortion counselling should be led by the client whether it relates to the client's decision to abort or a discussion about their faith (extract 1); a client's decision needs to be respected and must not be questioned (extract 2); and a provider must not be directive or judgemental ("guilt-tripping") and should not try to change a client's decision based on the provider's own preference (extract 3).

Ziyanda's anger (extract 2) and Thandi's shock (extract 3) in reading the CARM transcripts reveal a deep level of engagement with the course material, as their own emotional arousal likely helped contribute to their growing empathy for abortion seekers. This type of critical reflexivity aided providers in acknowledging that while they may have their own beliefs and values about abortion services, their role as a provider is to help the client by neither imposing their own views nor leading the session.

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[55] In the extracts, I highlight certain phrases in bold to underscore the reasoning behind my coding and theme development and to augment my analytical arguments.

The deliberations in extract 1 align with the CTOP Act's stipulation (which states that counselling should not be directive) and the CSSR AC Guideline,[56] which cautions against providers introducing religion into the counselling session. Extracts 2 and 3 specifically underline an important person-centred counselling principle – that of non-judgement, as well as the second core principle of reproductive justice, which is the right not to have a child ("make the client change her mind"). Furthermore, a key learning that emerged from participants' discussions was to prioritise the client's need by encouraging the client to talk.

6.2.2 Identifying Positive Practices

In the extracts that follow, I show how participants' evaluations of counselling interactions helped them to critically reflect on their own cases and approaches. During their fieldwork, they put their learning into practice and eventually presented a case to their peers and course facilitators during part two of the training course. The nurse participants thus recognised and commented on the improvement in their own proficiencies.

> ***Extract 4****: [Response to case presentations] Made me listen more to clients so can give feedback.*
>
> *[Beauty, Feedback form 2, 2020, p. 22]*

> ***Extract 5****: [It] was exciting to present my case and I learnt more. They [case presentations] were very helpful, they helped me to apply the steps that I received here for counselling.*
>
> *[Ziyanda, Feedback form 2, 2021, p. 29]*

> ***Extract 6****: Role plays assisted me to identify gaps I had. Case presentations and the comments of colleagues helps me to identify the falls.*
>
> *[Iviwe, Feedback form 2, 2021, p. 28]*

In extract 4, Beauty reflects on how she began to listen more attentively to her client as she had to gather data from her counselling sessions to inform her case presentation. Ziyanda (extract 5) refers to the practical component of applying the steps (outlined in the step-by-step guide for providers) and learning from it. Iviwe (extract 6) found the identification of her shortcomings by colleagues helpful in rectifying them.

As far as theme development goes, there is a transference of focus amongst participants from the external environment to their internal environment. In section 6.2.1, the

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[56] The CSSR Abortion Counselling Guideline (Mavuso et al., 2018) states to follow the lead of the client in terms of what they bring up, to ask them to elaborate on issues that they present, and not to bring in issues that are not raised by the client. Of course, this does not relate to procedural and legal information whereby a provider needs to ascertain certain information to assess a person's eligibility for abortion.

focus is on observations and evaluations of *other* providers' interactions with abortion seekers. In section 6.2.2, providers scrutinise *their own* behaviours and shortfalls. Thus, the study of cases encouraged an evaluation of the self and a consolidation of theory and practice (as described by Williams, 2005). In other words, participants honed their practical skillset to align with theoretical underpinnings of client-centred counselling and reproductive justice.

Of course, these positive shifts also overlap with course outcome five, which is about the building of nurses' skills and expertise. However, I have chosen to place these extracts within this theme as they speak directly to the assessment criteria for case studies, which is the ability to provide a reflection of learnings from case presentations, clearly visible in the extracts above.

6.3 Deep Listening

Course outcome two was *to develop the ability to listen deeply*. Several features of deep listening overlap with the premises of client-centred counselling (course outcome four), so this theme is guided by the course assessment criteria for deep listening, which is to gauge participants' abilities to outline deep listening skills based on their own understanding. I took into consideration two aspects: first, how providers developed their ability to listen deeply, and second, how this was communicated to their clients.

Sub-themes generated within this outcome centred around providers' proficiency in empathetic listening (understanding what the client is saying from the client's perspective) and supportive (or non-directive) listening. Listening skills rely on the link between verbal and non-verbal communication (Martin & Hodgson, 2006), so these abilities were appraised by observing nurses' *attending listening skills* and *reflective listening skills*.

6.3.1 Attending Listening Skills

The crux of this sub-theme is non-verbal communication, or cues from the client as well as the body language of the provider, as a means of conveying empathy. The following excerpts show how the course participants responded to this topic over the duration of the course.

> ***Extract 7****: I didn't know that non-verbal words can be used.*
> *[Nondumiso, Feedback form 2, 2021, p. 28]*

> ***Extract 8****: I showed my listening skills by using non-verbal words "mmmhhhhhhh."*
> *[Nondumiso, Case presentation, 2021, p. 1]*

__Extract 9__: On arrival, my client __appeared a bit anxious and uncomfortable__, because [when] I asked her how may I help her, she paused(.) Then said after a while she wants to do abortion. As I asked her if she had anything she'd like to discuss further or receive more information, on when __she started becoming relaxed and maintained eye contact__. She began opening up more. I made sure that I showed the client that I was listening to her by __nodding my head__… I __maintained eye contact__ and I didn't speak more than her, I allowed her to tell me more.

[Sethu, Case presentation, 2021, p. 2]

__Extract 10__: I __was nodding__ during our conversation and asked her open-ended questions… I was __leaning slightly forward__ made appropriate __eye contact__ so that I can observe her non-verbal cues.

[Ziyanda, Case presentation, 2021, p. 1]

__Extract 11__: I remember when we were talking about to __make those gestures__ when the client is talking so that they see that you are listening and that you are supporting them.

[Thandi, Interview post-ACCC 2020, p. 1]

Visible in the first two extracts are Nondumiso's range of responses to non-verbal communication, from being unaware of this form of communication (extract 7) to confidently portraying deep listening in-session with a client (extract 8). Extract 9 emphasises various observations made by Nurse Sethu of her client's non-verbal cues ("anxious" and "uncomfortable"). Sethu observes that her own gestures to show her client that she was tuned in ("nodding" and "eye contact") had a positive impact on the client (who became "relaxed" and began to make "eye contact"). This ultimately improved the interaction as the client was able to open up. Ziyanda (extract 10) highlights an important learning, which is the benefit in adjusting her own body language to better observe the client's state, as she remarks that she leaned forward slightly and maintained eye contact *so that* she could observe the client's non-verbal cues. Lastly, Thandi (extract 11) recollects the aspect of body language ("gestures") as a form of attending skills to demonstrate supportive listening to an abortion seeker. As Thandi's extract 11 is from Laurah's (co-researcher) interviews that were conducted two-month post-training, this indicates that the participant's learnings from the course were carried forward into abortion counselling sessions.

6.3.2 Reflective Listening Skills

These skills include the ability to express the essence of the contents and feelings shared by the client, as well as being able to summarise what was said. Reflecting feelings thus involves combining *feeling* and *content*, i.e., "you feel (feeling word) because (content)." This falls within the domain of deep listening, as it is through reflective listening that a provider

is most receptive to a client's emotional and mental state and can respond accordingly. This feature can be seen in the following conversation between Nurse Ruth and her client:

> ***Extract 12:***
> *Client: I feel,* ***ashamed*** *as if I'm doing something wrong, u [you] know sister I have not told anyone about my problem, not even my husband… Will I be forced/ or do I have to tell my husband about the procedure because I don't want him to know and I feel* ***bad*** *about not telling him as I always confide in him when I have a problem.*
>
> *Nurse Ruth's reflections (during the session): She feels if she tell anyone she might be* ***judged*** *and* ***misunderstood****.*
>
> *Nurse Ruth's reflections (post-session): The client had my undivided attention. I maintained eye contact with the client. I nodded while the client was speaking, to show her that I was listening. The client was leading and I was* ***listening attentively****. I also* ***repeated*** *some of what was said by the client back at her and also* ***paraphrasing*** *what was said by the client e.g.* ***If I hear you correctly it seen [seems] to me*** *that you do not want your husband to know about the abortion.*
>
> *[Ruth, Case presentation, 2021, pp. 4– 6]*

Ruth's case presentation (extract 12) outlined the steps followed in her counselling session and included a verbatim account of the conversation between herself and her client. The extract showcases Ruth's active listening that leads to open communication between herself and the client, who appears comfortable enough to reveal her vulnerability to the nurse (as the client had not spoken to anyone else about her problem). Ruth responds appropriately and her reflective listening skills are evident in her understanding that the client might be feeling ashamed and "bad" due to a fear of being judged and misunderstood (the "feelings") and relates it to the client's hesitancy to share the news with her husband (the "content"). Ruth's deliberations were facilitated by her ability to listen to her client. Similarly, the extracts below reveal how listening skills assisted with paraphrasing what the client felt and said.

> ***Extract 13****: I* ***felt great empathy*** *for her and she herself felt let down and also confused by what happened to her. I* ***had to listen to her*** *as she expressed her feelings. On my part I tried to help her understand that there was no reason for her* ***to feel ashamed or guilty*** *as the decision she took was the right thing. The client felt reassured and supported, as such, she was able to open up to me and ask questions about the CTOP procedure… During the procedure, I made use of local analgesic as* ***she expressed fears of pain <u>previously</u>****.*
>
> *[Thato, Case presentation, 2021, pp. 4–5]*
>
> ***Extract 14:*** *I assured her that I've heard what she was telling me and told her that I understand their feeling.*
>
> *[Sethu, Case presentation, 2021, p. 2]*

In extract 13, Thato was empathetic to her client's plight. Her active listening skills helped to reassure and support the client. She also applied a local analgesic during the

procedure having carefully recollected that the client had expressed a fear of pain earlier in their session. Sethu (extract 14) not only understood how her client felt but made it a point to let her client know that she had heard and understood her. It is through deep listening that providers were able to pick up on clients' emotional states. More importantly, this was reflected back to their clients, which is echoed in extracts 12–14.

This theme underscores how participants' comprehension and demonstration of deep listening extended to observation. Nurses developed their listening skills by being attuned to verbal and non-verbal cues (both their own and those of their clients). Active listening entails encouraging the client to talk, listening carefully to the client's request, clarifying one's own understanding, and being present and in attendance (Nemec et al., 2017) as evidenced in the extracts above.

6.4 Different Problems Necessitate Different Types of Counselling

Providers' responses to course outcome three (which was *to identify what kind of counselling is needed on a case-by-case basis*) were weighed on their ability to engage with a variety of counselling types. The assessment criteria were twofold: the ability to outline at least two kinds of counselling, and to identify the kinds of clients who will benefit from different forms of counselling. Apart from thematically coding data that spoke to this outcome, the following two reflective journal questions helped evaluate nurses' competencies in this area: (1) From the different types of counselling scenarios,[57] which might you be most comfortable with providing and (2) What scenario might you find challenging and why? Tables 6.1 and 6.2 compile some[58] nurses' responses to these questions.

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[57] While evaluating data post-ACCC 2020, I noted that using the word "scenario" elicited a response that did not fit with what I needed to gauge. Its usage likely conflated the *types* of counselling with *micro-interactions* in counselling. For example, participants described particular scenarios as being easy or difficult, such as, "a nurse being judgemental would be challenging." Providers' responses necessitated a change in the construction of the question itself, which was not clearly articulated. In the second course manual, the word "scenario" was omitted in the first question and replaced with 'type of counselling' in the second question.

[58] Some participants' names are not listed in the tables for one of two reasons: either they left the answer blank or offered a response that did not fit under a specific heading (such as describing a scenario, see footnote 56). While all their responses undoubtedly offered insight into an acquisition of Rogerian principles of client-centred counselling, some answers did not specifically highlight providers' comfort levels with different *types* of counselling, and hence those answers have been excluded in this particular table. After the course refinement was made in ACCC 2021, all participants' responses were applicable in appraising course outcome three, demonstrating the value of critical reflexivity and evaluation within action research cycles.

The tables reveal that nine participants reported being comfortable with providing pre-procedural counselling against two who stated that they would find this type difficult, and five participants reported that they were comfortable providing post-procedural counselling against one who stated that they would find this type difficult. Although only eight participants said that they would be comfortable with providing procedural counselling, none said they would find it difficult. This is not surprising, seeing as this was the predominant type of counselling they reported offering prior to the training course (described in section 6.4.1). These figures sway the overall result for these three types of counselling towards a favourable outcome.

Table 6.1

Counselling Types that Participants were Comfortable with Providing

Participant	Pre-procedural	Procedural	Post-procedural	Options
1. Peter		1		1
2. Jane	1	1	1	1
3. Mary	1	1	1	1
4. Lilly	1			
5. Faith	1	1		
6. Phillani		1		
7. Ziyanda	1		1	
8. Ntombi	1			
9. Nondumiso	1		1	
10. Ruth	1			
11. Sethu		1		
12. Casey		1		
13. Iviwe				1
14. Thato	1	1	1	1
TOTAL	**9**	**8**	**5**	**5**

Table 6.2

Counselling Types that Participants found Challenging to Provide

Participant	Pre-procedural	Procedural	Post-procedural	Options
1. Lilly			1	
2. Phillani				1
3. Ziyanda				1
4. Ntombi				1
5. Nondumiso				1
6. Ruth				1
7. Sethu	1			
8. Iviwe	1			
TOTAL	**2**		**1**	**5**

A qualitative analysis offers insights into reasons behind some of these numbers. Only one provider reported that she would find post-procedural counselling challenging to offer and this was in instances when a client required a referral to another staff member [Lilly, Reflective journal, 2020, p. 4]. The concern about referrals relates to systemic issues, which are discussed further in chapter seven. The two participants who reported that they would be least comfortable with providing pre-procedural counselling cited reasons such as having to engage with a client who is feeling anxious and stressed [Sethu, Reflective journal, 2021, p. 21] or having to answer difficult questions from a client [Iviwe, Reflective journal 2021, p. 21]. This finding relates to a previous study (Beja & Leal, 2010) which found that the provision of emotional support was the least stated dimension of counselling by providers. This led the authors to determine that some providers did not feel capable of or comfortable with engaging with any emotional or psychological aspect of abortion care; they concluded with a recommendation for continued training for providers to master counselling skills. The tables offer a cross-sectional overview and, overall, reflect positively with regard to providers' capabilities in providing emotional support, indicating that the training course did lead to skill development while alleviating provider-discomfort with counselling.

Options or decision-making counselling emerged as the type of counselling that most participants found challenging, although an equal number reported that they would find options counselling easy. Not all participants stated why they found a particular type of counselling

difficult. However, the figures in the tables do indicate the need for further practice sessions (through role-plays and discussions) during training, so that nurses can acquire competence and confidence in an array of scenarios (under each counselling type) that their clients may present with.

The participants' engagement with course outcome three emerged in several ways: by showing an awareness of and indicating their (dis)comfort levels with different types of counselling; by accepting when a client declined counselling and then progressing to *Basic information to establish consent* (as outlined in the CSSR AC Guideline); by expressing gratitude for the above Guideline as a useful resource to outline the types of counselling; and by acknowledging clients' diverse needs and subsequently alluding to the importance of an individualised approach for each abortion seeker.

I have placed these findings under two sub-themes, which largely lie on a continuum of participants' increasing awareness and comfort levels with various types of counselling. Hence, the first sub-theme relates to providers' cognitions and includes their thoughts and reflections (critical reflexivity) about this topic. The second sub-theme is behaviour-oriented and portrays their actions.

6.4.1 "We Weren't Really Doing Counselling, Rather it was More of Information Giving:" Cognitive Shifts

Closely linked to deep listening (theme three) is the ability to identify a client's need for counselling, and if so, then identifying what kind of counselling. As the different kinds of counselling were introduced in the training, participants were able to make these connections, as is evident from the extracts below:

> ***Extract 15****: It is* ***very important to have listening skills****. It will help us to know what type of counselling client will need*
>
> *[Thato, Reflective journal, 2021, p. 9]*

> ***Extract 16****: I've noticed that most of the time, when doing counselling to our CTOP clients* ***we assume they need the same counselling*** *forgetting that they may come for one procedure but may need different types of counselling depending on their problems* ***and I've also learnt the importance of active listening*** *and letting the patient lead.*
>
> *[Ziyanda, Reflective journal, 2021, p. 8]*

> ***Extract 17****: We weren't really doing counselling, rather it was more of information giving****. We would give the client information and at times it was not organised****. It was haphazard because we would give the client information about contraceptives, which is contraceptive counselling, on its own is a counselling session. So now,* ***after the training now, I understand is that counselling is when the patient do more of***

> ***the talking**. And the whole issue of non-coerciveness. Because **we would give counselling and be directive in doing so**.*
>
> *[Peter, Interview post-ACCC 2020, p. 5]*

Thato's reflection (extract 15) indicates an understanding of the importance of deep listening as well as an awareness of the different types of counselling. The latter is a noteworthy shift in their learning process, as some participants said they had been unaware of additional types of counselling apart from procedural counselling, which is what many of them tended to focus on (see extract 17). Thato recognised the value of being attentive to better identify a client's need. Ziyanda's reflection (extract 16) builds on this observation as she comments on how providers' own assumptions may create barriers to active listening. She alludes to how a client may not know what type of counselling they need, but in allowing the client to lead the session, a provider can help assess the situation and offer an appropriate fit with regard to what type of counselling is necessitated.

In extract 17, Peter reflects in his interview (three months after the course) that prior to the training, his technique or approach was "not organised' and "haphazard." He pinpoints his current understanding that contraceptive counselling is its own entity, which is also notable since the tendency (especially from a public health perspective is to conflate pre-abortion counselling with contraceptive information provision (Beja & Leal, 2010; Bender & Geirsson, 2004; Kilander et al., 2018; Purcell et al., 2016). Being introduced to different types of counselling seemed to bring to the fore two main points for providers: firstly, the value of listening deeply (extract 15) and actively (extract 16), and secondly, critical reflections on their counselling approach *prior* to training, which included the realisation that it tended to be based on assumptions that all clients need the same counselling (extract 16), that it was primarily focused on contraceptive information, and that it lacked structure (extract 17).

While moving along the continuum from gaining an awareness of different types of counselling to gaining confidence in providing those different types of counselling, participants acknowledged the CSSR AC Guideline as a useful resource that enabled their transition and provided structure to counselling interactions.

> ***Extract 18**: They [CSSR Guideline] are good, equipping the nurse how to support their clients more for whatever support they might need be it basic information or emotional support and helping them with decision-making.*
>
> *[Ruth, Reflective journal, 2021, p. 20]*

> ***Extract 19**: The Guideline helps me to know that the women can choose whether or not to receive counselling.*
>
> *[Faith, Reflective journal, 2020, p. 11]*

The CSSR AC Guideline was well-received for various reasons (elaborated on in chapter eight, section 8.2.4) and the extracts above point specifically to the particular course outcome that enables a provider to remain respectful of a client's decision should they decline counselling, and to identify which client would benefit from what type of counselling (extract 18). Interestingly, in extract 19, Faith mentions that the Guideline document has taught her that it is the woman's choice whether to receive counselling or not, although the CTOP Act states the same thing. The ways of establishing which type of counselling should be provided to the client in Step 2 of the CSSR Guideline seems like a necessary elaboration that helped providers gain clarity on what *non-mandatory* counselling means (as described in the CTOP Act) and what exactly to do when a client accepts or declines the offer.

6.4.2 "Those 'Types of Counselling' Will Make Me Do Counselling Differently:" Behavioural Changes

The extracts below highlight how providers took up the types of counselling and introduced them in sessions with their clients.

> ***Extract 20****: I informed the client that* ***counselling is available*** *at our facility, and* ***we have different kinds to choose from****. Decision-making, procedure, pre-procedure and post-procedural. Client agreed that she wanted counselling… during types of counselling when asking for permission from my client, she elaborated that she's sure about her decision because she's unemployed and has 3 kids already from her previous marriage.*
>
> *[Sethu, Case presentation, 2021, p. 1]*

> ***Extract 21****: I've explained to the client that* ***counselling is voluntary*** *and explained to her the* ***types of counselling that we offer,*** *and she opted for pre- and post-procedural counselling.*
>
> *[Ziyanda, Case presentation, 2021, p. 3]*

> ***Extract 22****: Course session was useful to me* ***because I learnt about types of counselling*** *on a case****, therefore it built my confidence*** *related to face-to-face counselling… Those types of counselling will make me do counselling differently.*
>
> *[Bonga, Feedback form 1, 2020, pp. 1–2]*

Extracts 20 and 21 are taken from participants' case presentations, which are reflective of their fieldwork sessions. Evidenced in both extracts are an explanation of the voluntary nature of counselling conveyed to clients, along with a description of the various types being offered, indicating providers' increased comfort with the counselling steps and process. This comfort can be linked to a building of confidence expressed by Bonga (extract 22) in her feedback form where she acknowledges that knowing about the types of counselling has enabled her to conduct her counselling "differently." Additionally, notable in Sethu's presentation (extract 20) is her client's certainty of wanting an abortion ("she's sure about her

decision"), which ties to previous research that indicates that most abortion seekers have made a decision prior to arriving at the facility (Moore et al., 2011).

Ultimately, embedded in these shifts (cognitive and behavioural) is a recognition that each client is unique, with distinct needs that necessitate an individualised approach to counselling. This ties in with research from Moore et al. (2011) who promote a 'cafeteria-style' approach to abortion counselling, meaning that each individual can choose what they need depending on their preference and requirement.

> ***Extract 23****: Different kinds of counselling gives the provider a service that is client-centred and according to their [clients'] presenting problems.*
> *[Bonga, Reflective journal, 2020, p. 6]*

> ***Extract 24****: [Peter responding to what types of counselling he might be most comfortable providing] Options counselling and procedural counselling because I believe in offering my clients choice and giving them power through information-giving to make a decision that best suits their needs.*
> *[Peter, Reflective journal, 2020, p. 6]*

Bonga (extract 23) indicates that the types of counselling are beneficial not only to the client but also enables a provider to promote client-centric counselling based on each individual client. Peter (extract 24) appreciates the fact that he can offer choices as a means to empower his client to make an informed decision. Providers thus responded to course outcome three by acknowledging the distinctiveness of each client's need and subsequently vouching for a tailored and personalised approach to counselling.

6.5 The Crux of Client-Centred Counselling

This theme lies at the very core of the research and speaks to course outcome four which was for participants *to comprehend the premises of client-centred abortion counselling and therefore what to include and what to avoid in a session*. The assessment criteria for this specific outcome comprised critical discussions of client-centred counselling principles. I have structured the first two sub-sections under this theme to include a few excerpts that highlight participants' practices prior to attending the training course. I then juxtapose these against their reported counselling sessions post-training, with the intention of illuminating alterations in their approach and behaviour.

The first sub-theme is broad in that it speaks to an overarching shift in a counselling session from an emphasis on documentation and forms (pre-training) to a centring of the client (post-training). The second sub-theme showcases that the providers have ceased viewing abortion and abortion seekers as problematic, and instead concentrate on guiding a client to

problem-solve while offering reassurance. The third sub-theme highlights the ways in which client autonomy is prioritised and enabled by providers' choice of language that underlines reproductive justice principles.

6.5.1 From Paperwork to Person-Centred

At the start of the course, participants paired up to discuss their current counselling practices (Activity 1) and a summary was shared with the larger group. This activity was recorded. Below are some extracts that shed light on what the participants' counselling sessions entailed prior to attending the training course.

> ***Extract 25****: I lead more by the consent form. So* ***the consent form is leading us*** *when we talk to the patient. We* ***explain what CTOP is about****, and also we* ***give the counselling on the family planning****, all the types of family planning. So we include everything in once, in the individual counselling.*
>
> *[Group discussion, 2021, lines 7–9]*

> ***Extract 26****: In our group neh, when we were discussing the current counselling session, we found that there's no formal counselling. When the people come there's no formal counselling, there is no individualised counselling, it's the same across the board with every client that comes in,* ***there's no formal counselling session, it's just paperwork****. Papers that come from the Department of Health where it's mostly history taking, take the name of the patient, how many pregnancies she's had, how many live babies and how many abortions the client has had.*
>
> *[Group discussion, 2021, lines 3–9]*

The discussant in extract 25 talks about consent forms, while in extract 26, reference is made to paperwork. The commonality across these two extracts is that the counselling is dominated by a bureaucratic form, which invariably has consequences for provider-client micro-interactions. In extract 25, the participant states that they explain the CTOP to clients and this is immediately followed by "family planning." The topic of contraception is thus introduced by the provider quite early on in a pre-abortion counselling session, showing how this narrative – that contraception use *must* be an outcome of seeking an abortion – filters through all layers of the public healthcare system. Additionally, the nurses state that there is no formal counselling (extract 26), which could mean that the counselling aspect has not been "formalised" per se at their clinic due to lack of guidelines or training in this area. In the absence of any formalised counselling, the session is directed (and dictated) by DoH paperwork,[59] such

[59] The Patient Assessment Record is not fully in line with the CTOP as identified by nurses themselves. "Reason for TOP" is one of the questions on the form, although this is not necessary when the pregnancy is < 12 weeks' gestation, as abortion is legal *on request* within that time frame.

as the consent form. This is then followed by information regarding all types of "family planning."[60] These practices link to prior research which has highlighted that abortion providers ascribe high value to information provision and contraception (Beja & Leal, 2010; Mavuso & Macleod, 2021; Sullivan et al., 2018). However, it seems plausible now that one reason for prioritising these aspects in pre-abortion counselling is a lack of training and direction in client-centred counselling, which would typically enable two-way communication, amongst other skills. Nurses, thereby, create their own protocol for what transpires in a pre-abortion counselling session. These sessions end up lacking an individualised approach (emphasised by the provider in extract 26) and the "counselling" sessions devolve into a process of list-checking.

After the training, the counselling sessions were not limited to procedural-based information and contraceptives. The extracts below reflect an overall person-centred nature of interactions, as reported by the participants:

> ***Extract 27****: The client was* ***promised a safe space, privacy and confidentiality*** *was assured to the client. Also told the client* ***she came to the right place****. The CTOP legalises TOP and it is* ***her choice and her right****. Also explained the consent to the client for the procedure. I then explained to the client that counselling is offered and is also optional.* ***Client has the right to accept or refuse counselling*** *and opting not to take counselling does not mean the abortions services will not be provided to her, and basic information will be given to her.*
>
> *[Ruth, Case presentation, 2021, pp. 1–2]*

> ***Extract 28****: A 33-year-old female G3 P1 A1*[61] *came in requesting CTOP. Client didn't want the procedural counselling as she was saying she knows about the counselling, and she didn't want decision-making counselling****, I respected her option*** *and* ***didn't ask the reason for the TOP****. The* ***client was the one who led me*** *that she is not ready to be a mother again by having the second child, I also* ***didn't ask why she didn't use contraceptives to avoid unplanned pregnancy****, I continue with our conversation by asking if she had any questions and she said no, consent form signed by both client and nurse.*
>
> *[Nondumiso, Case presentation, 2021, p. 1]*

> ***Extract 29****: Pre-procedural counselling given as per client agreed, to* ***provide emotional support*** *before we start procedure. Our counselling room was quiet with no*

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[60] I acknowledge the controversial nature of the term family planning within feminist circles, especially when historically, family planning programmes have not always been pro-women. For example, as noted by Sreenivas (2021), government efforts at family planning did not alleviate women's oppression, and their rights and reproductive autonomy remain disregarded. I thus use the term only when referenced as such by nurses, and otherwise use the term contraception.

[61] Gravidity (G) refers to the total number of pregnancies regardless of its outcome. Parity (P) refers to the number of births after 20 weeks of gestation. Abortion (A) includes all miscarriages or medical/surgical abortions before 20 weeks of gestation.

distractions, I ensure my client that each and everything that we are going to ***talk is between us****.*

[Jane, Case presentation, 2020, p. 1]

What is evidenced in these three extracts is how client autonomy is emphasised. This is visible in extract 27 in three instances: firstly, by stating to the client that the decision to terminate the pregnancy is their choice; secondly, by informing the client of their right to accept or refuse counselling (as is mandated in the CTOP Act); and thirdly, by reassuring the client that should they decline counselling, the abortion will still be provided.

In extract 28, the provider demonstrates respect towards the client's chosen option and allows the client to lead the session. Such affirmations from the nurse can go a long way in mitigating the power dynamic between a provider and an abortion seeker, as the client is unlikely to feel compelled to respond from a place of fear.

In extract 29, the client picks pre-procedural counselling even as the provider ensures that the environment is conducive and the interactions remain private, thereby emphasising client-centred principles of informed consent and confidentiality. Specific reference is made to "emotional support," showing an increased level of comfort (for both the provider and the client) in engaging with the client's thoughts and feelings surrounding the procedure. This is notable as prior research has shown that abortion seekers may hesitate to discuss their emotions with abortion counsellors due to the perceived notion that providers may try to dissuade them from accessing the procedure (Moore et al., 2011).

Extracts 25 and 26 indicate procedural and information-based sessions with no "formal" counselling, while extracts 27, 28, and 29 reveal more comprehensive interactions that entail welcoming the client, assuring confidentiality, being respectful, and offering emotional support alongside information. In analysing extracts 25–29, an overarching shift is demonstrated: from a pre-training focus on the paperwork to a post-training focus on the person.

6.5.2 Un'problematising' the Patient

With participants demonstrating a centring of their clients, providers' learnings were further underscored in how they spoke *about* their clients and *to* their clients. In Activity 1 of the course manual (appendix 2), participants exchanged notes on challenges they encounter, and the following excerpts feature some points that arose in the discussion.

Extract 30: *So, the challenges that we face at our workplace,* ***the attitude of the clients****. Some clients they just come and they say sister you can just see, observe the patient just want the medication and go. Some of them,* ***they don't have patience****.*

[Group discussion, 2021, lines 13–15]

> ***Extract 31****: Then we also give the patient the review date for a scan… in our facility we do them this week and then next week the patient must come back for scan for review to check if their uterus is empty or not…* ***Then the challenges, some patient they are not coming back for (i) scan after a week****. That's the challenges that we're facing. So, we won't know the patient they are fine or not.*
>
> *[Group discussion, 2021, lines 9–16]*

Overall, the tone that emerges in extracts 30 and 31 is one of frustration when nurses talk about client-related challenges. Abortion in the public health sector (and, therefore, amongst its staff) is, for the most part, viewed as a problematic procedure to be avoided (Mavuso et al., 2017). Hence, the very request for an abortion can both trigger and exacerbate nurses' stress levels especially in the context of limited support in this area of reproductive healthcare. In extract 30, the patient is seemingly not patient enough while portraying a couple of *difficult* mindsets: firstly, clarity about the decision to abort; and secondly, a sense of urgency to leave ("just want the medication and go"). With regard to the former, research has shown that most women have already decided to have an abortion prior to arriving at the clinic (Baron et al., 2015; Beja & Leal, 2010). With regard to the latter, despite South Africa's liberal abortion laws, prevailing abortion stigma contributes to clients' negative experiences of service provision (Harries et al., 2014). While this (prior) knowledge has the capacity to inform the interaction, providers appear oblivious towards abortion seekers' perspectives and needs. The *attitude of clients* is consequently problematised.

Furthermore, clients often do not return for their scans (extract 31), which poses yet another challenge, as the success of the abortion procedure remains uncertain. Plausible reasons for clients not returning could include long distances to the clinic, finances, an aversion to the antagonistic clinic environment, and fear of further stigmatisation. Yet, the *client's behaviour* (the "not coming back") is viewed as the problem. Such attitudes and behaviours (of the clients) complicate matters as providers often use the session as an opportunity to educate women about birth control and contraception.

As participants critically evaluated the information presented during course activities (such as the ole-play and CARM), their understanding of how providers' practices influenced clients' experiences deepened, and they began to alter their approach. Lilly noted that in her experience of being an abortion seeker in the role play, "being a client and being treated as a dignified human being… gave me comfort as a client, as I was warmly welcomed by my provider" [Bonga, Reflective journal, 2020, p. 7]. She experienced the responsiveness of the

"nurse"[62] as comforting. Reflections such as this were guided by a client-centred approach that enables dual emphasis on the counsellor and the client (Cain, 2012), which further fostered a collective empathy for abortion seekers and a desire to advocate for women's rights. Providers' perspectives thus began shifting from problematising the client (as seen in extracts 30 and 31) to helping a client problem-solve (as seen in extract 32).

> ***Extract 32****: The client-centred approach where the* ***counsellor needs to prioritise the client****, let them talk and lead the conversation and that* ***you're not there as a problem solver****/give clients solutions to their problems but* ***you are there to help them****/guide them to* ***find their own solutions*** *to their problems.*
>
> *[Ruth, Reflective journal, 2020, p. 9]*

Ruth recognises her role as that of a guide, not necessarily to solve a client's problem but to assist a client in making their own decision. Hence, the focus really is on a client-led session. The two extracts below are from participants' case presentations that indicate their discernment and implementation of various Rogerian client-centred counselling skills.

> ***Extract 33:*** *The client had already made up her mind.* ***My role as a provider was to give her support, understanding and reassurance and not adding more stress****. I felt great empathy for her and she herself felt let-down and also confused by what happened to her****. I had to listen to her as she expressed her feelings****. On my part I tried to help her understand that there was no reason for her to feel ashamed or guilty as the decision she took was the right thing****. The client felt reassured and supported****, as such she was able to open up to me and ask questions about the CTOP procedure.*
>
> *[Thato, Case presentation, 2021, p. 4]*

> ***Extract 34****: [Client requested pre- and post- procedure counselling] She was* ***asked about her feelings*** *about the whole procedure and expressed that she was afraid of pain and was reassured that she was going to be given analgesics and antibiotics…* ***Reassurance was done throughout the process of counselling*** *and affirmation of understanding by way of* ***maintaining eye contact, nodding*** *at some point was also done. The client has been allowed express her emotions by crying at some point she would be quiet. In concluding the counselling session* ***more questions were invited****. [Post procedure] The fact that the client has made good decision was re-emphasised.*
>
> *[Ntombi, Case presentation, 2021, p. 2]*

Using these two brief extracts, I relate the provider-client micro-interactions to Rogers's (1957) six identified conditions in a client-centred approach. There is contact between a provider and client (condition one) in both scenarios. In extract 33, the client was "confused," and in extract 34, the client was "afraid of pain." Thus, in both extracts, the clients exhibit a level of anxiety for different reasons, thereby displaying a state of incongruence (condition

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[62] I have placed the word "nurse" in quotes only to denote that a roleplay scenario is being referred to.

two). Both providers, Thato and Ntombi, are congruent in their interactions (condition three), and display unconditional positive regard (condition four) and empathy towards the clients' frames of reference (condition five). This is seen when Thato expresses feeling "great empathy for her" and tries to alleviate the client's feelings of shame and guilt by offering support for making the right decision. Likewise, Ntombi offers reassurance and affirmation of her understanding of her client's state.

It is also evidenced that both clients receive this well and perceive the providers as genuine and non-judgemental (condition six) in how they respond in session. Thato reported that her client felt reassured and supported, leading to open communication for the client to ask questions, while Ntombi reported creating a safe space for her client, enabling her to cry freely and express her emotions.

6.5.3 Enabling Reproductive Autonomy

This sub-theme reflects participants' awareness of what to include and what to avoid in a session. While all three sub-themes encompass providers' client-centred skills, this section underlines proficiencies specific to abortion counselling in South Africa (as stated in the CSSR AC Guideline). Perceiving the role of language in facilitating or stifling communication, providers identified what to avoid in a counselling interaction, as seen in the extracts below.

> ***Extract 35***: *When you are a counsellor, you must* ***not be coercive****, you must* ***not be judgemental*** *too. And if the client does not want counselling, you don't need to do it.*
> *[Linda, Interview post-ACCC 2020, p. 3]*

> ***Extract 36***: ***I shouldn't decide for the client****, the client comes first and needs to be listened to. The focus should be on a pregnant woman needing a service, not foetus.* ***The foetus shouldn't be labelled*** *to mother when scanned* ***as human being*** *to reinforce guilty* ***and gift****.*
> *[Sethu, Reflective journal, 2021, p. 17]*

> ***Extract 37***: *The provider was* ***not supposed to bring her personal beliefs in the counselling****. It is about what the client wants at the end of the day. She should not have made the client to feel guilty about what she wants to do.*
> *[Ziyanda, Reflective journal, 2021, p. 17]*

> ***Extract 38***: *Basically, what we discussed was very similar. It was very interesting because what* ***we've decided to stop****; there are two things that we decided to stop. One was ehh,* ***asking the reason for request (of abortion)*** *because that's what was in the guideline, that* ***if the patient is less than 12 weeks****, it is not mandatory to ask why the patient is requesting a termination of pregnancy…Uhm the other thing was, the contraceptive issue, uhm again the form at the end has got a question there that a patient's choice of contraceptive. Now,* ***we've decided to stop forcing or coercing***

> ***amaPatients (Patients) to choosing to contracept**. But rather, if a patient decline contraceptives, will go to that section and say patient declined contraceptive.*
>
> *[Group discussion, 2020, lines 3–7 and 14–18]*

Extracts 35 to 38 bring to the fore a client-centred approach based on reproductive justice principles. Linda (extract 35) and the group discussant (extract 38) stress the importance of non-coerciveness; Sethu (extract 36) asserts that she should not decide for her client; and Ziyanda (extract 37) remarks that the provider must not introduce their own beliefs. All these points are especially crucial in abortion counselling, considering that previous research has pointed to the influential role of providers in the counselling interaction (Chiweshe, 2016; Harries et al., 2007; Harvey-Knowles, 2012; Mavuso & Macleod, 2019) alongside clients perceiving that providers may try to dissuade them from having an abortion (Moore et al., 2011).

In safeguarding a client's right to choice, providers' behaviours align with the reproductive justice principles of autonomy and integrity, enabling the clients to decide their pregnancy outcome. This further upholds Section 12 (a) of the Bill of Rights, which is the right to make decisions concerning reproduction (Constitution of South Africa, 1996). Sethu (extract 36) reflects on how the language used can be guilt-inducing, and cautions against using words such as "gift" that can reinforce guilt. Her remark about focusing on a pregnant woman and not the foetus also alludes to Section 12 of the Constitution that grants persons control over their bodies without limiting these rights in favour of the foetus.

As such, two aspects unanimously emerged that providers decided to stop: asking the reason for TOP (within 12 weeks), and questioning why the client did not use contraception (seen in extracts 38 and 28). The discussant in extract 38 shared his group's resolution to state that the "patient declined contraceptive" as a way to respond to the DoH form that queries contraceptive roll-out for public health statistics. Thus, through discussions, the participants were able to resolve any dilemmas concerning protocol and demonstrated a clear sense of what to embrace and eschew in a session henceforth.

> ***Extract 39**: It has quite improved now cause **I know what to do and what not to do, what to ask and what not to ask**. Uhm they [clients] now feel free as long as you don't ask the reason and what not. They are fine now to tell you everything. And sometimes the client is the one that tells you the reason even though you don't ask because of the way I portray myself.*
>
> *[Thandi, Interview post-ACCC 2020, p. 1]*

Extract 39 emerged in the two-month follow-up interview, which is gratifying for a couple of reasons: firstly, to note that the learnings are being carried through into the work place, which is a further nod to the contextual nature of the course offered (that the learnings

are implementable in the field); and secondly, that the provider is able to see the positive influence of her new approach on a client, who now feels free to volunteer information even without being asked.

6.6 Advancement of Proficiencies

Providers' skill sets advanced through the duration of the course and are evidenced in a variety of ways such as: their acquisition of strategies to be used in deep listening (sections 6.3.1 and 6.3.2); their increased awareness of different types of counselling (sections 6.4.1 and 6.4.2); and their developing attitude towards a client-centred approach (sections 6.5.1-6.5.3). As course outcome five was *to build skills, expertise, and confidence related to face-to-face counselling*, it is certainly interwoven with all of the aforementioned sub-themes. The coding that informed this theme, therefore, involved codes such as "gained," "improved," "increased," "developed," and "boost" when participants referenced their counselling skills, knowledge and confidence. The first sub-theme focuses on providers' own acknowledgements of their improved confidence and expertise. The next sub-theme highlights how participants accredited their colleagues and group work as essential in their skill development process. The last sub-theme underscores how providers' enriched competences – via course elements like the CSSR AC Guideline and their colleagues – had a far-reaching effect on their morale by equipping them to counter stigma and stand tall.

6.6.1 Confident Confidants

The following extracts showcase improved self-confidence levels for all providers after the various course activities and curriculum with the support of the CSSR AC Guideline.

> ***Extract 40****: I am* ***now confident enough*** *to provide the counselling to my clients, especially after the role plays.*
>
> *[Course participant, Feedback form 1, 2021, p. 1]*

> ***Extract 41****:* ***Now*** *I am able to* ***refer to client/person centred approach****. I stick to my counselling guidelines. I'm familiarised myself with reproductive health and reproductive justice. My knowledge has been improved and* ***gained a lot****.*
>
> *[Jane, Feedback form 2, 2020, p. 22]*

> ***Extract 42****: It has* ***increased my confidence*** *helped me develop better understanding of my clients.*
>
> *[Beauty, Reflective journal, 2020, p. 6]*

> ***Extract 43****: [The course] brought a* ***new sense of confidence*** *in my work.*
>
> *[Mary, Feedback form 2, 2020, p. 21]*

In extract 40, the course participant[63] asserts that she is "now confident enough" and acknowledges the beneficial function of the role play activity in the course. In extract 41, Jane acknowledges the CSSR AC Guideline and information acquired around reproductive health and justice as contributing to her improved knowledge ("gained a lot"). Beauty (extract 42) notes that her increased confidence has enabled a better understanding of her clients, and Mary (extract 43) states that the course, in itself, contributed to her newfound sense of confidence. The extracts demonstrate how increased knowledge led to enhanced skills and greater confidence, and how the information acquired during the training course informed future counselling sessions.

It is also gratifying to note that some providers noted the benefits of the training beyond abortion services, as seen in the two extracts below.

> ***Extract 44****: I have gain confidence in during counselling. CTOP is not only about the procedure but is client centred and* ***we deal and treat the client holistically****. I will be able to* ***counsel other people*** *– not necessarily CTOP clients.*
> *[Course participant, Feedback form 1, 2021, p. 1]*

> ***Extract 45:*** *Now I am using my counselling skills in all aspects of my work as a professional nurse not necessarily to CTOP only.*
> *[Phillani, Reflective journal, 2021, p. 24]*

Extract 44 speaks to an ability to engage with clients more holistically while being able to extend counselling skills to people other than abortion seekers. Both extracts (44 and 45) underline their ability to transfer the learnings into other spheres of their role as a nurse. The overall outcome in section 6.6.1 is constructive, with participants reporting a sense of assurance in their work. These are positive responses to several calls made by authors for the training and transformative education of nursing staff (Armstrong & Rispel, 2015; Harries & Constant, 2020; Mavuso & Macleod, 2019; Röhrs, 2017; Strasser et al., 2005) as these findings indicate the transformative value that the training has had in promoting quality abortion care.

6.6.2 Peer Supervision and Support

The camaraderie that developed during the course helped create an environment that was conducive to learning, and *who* was offering feedback or input mattered as much as *what* was being presented and discussed. Participants acknowledged the informative role that their

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[63] Providers had the option to include or omit their names in the feedback forms. Where names are not mentioned, I include their data by merely stating "course participant."

colleagues played in their own skill development. The extracts below showcase how group exchanges enabled learning in a constructive manner.

> ***Extract 46***: ***Group interaction is possible*** *and more learning from each other makes one to have an insight.* ***Information sharing*** *is a continuous process.*
> *[Ntombi, Reflective journal, 2021, p. 19]*

> ***Extract 47***: ***Working as a group has helped me a lot*** *because (a) My* ***confidence has improved****. (b) I was able to identify my mistakes and do corrections. (c) Seeing that other people are trying by all means to help and even putting themselves in your shoes, that encourages me to do more for my clients. (d) I have realised that* ***we all need other people's views*** *and opinions.*
> *[Lilly, Reflective journal, 2020, p. 5]*

> ***Extract 48***: *My peers were prepared, and they done their presentation very well. They did their research step by step and exhausted every detail of the counselling. Their cases were very interesting.* ***I have learnt a lot from them****.*
> *[Nondumiso, Reflective journal, 2021, p. 24]*

In extract 46, Ntombi discusses the benefits of the course as enabling group interactions which facilitates learning as well as the ability to self-reflect. Lilly (extract 47) describes the many ways in which she benefited from working collaboratively in training, which included improved confidence, an ability to self-assess, receiving encouragement, and recognising the value of feedback. In extract 48, Nondumiso is appreciative of her colleagues' efforts as she observes the manner in which they conducted their case presentations and affirms that she "learnt a lot from them."

Reviewing peer presentations was beneficial in several ways. It made participants cautious when offering feedback (elaborated upon in the next extract) and open to receiving comments from each other, and as Lilly stated, it helped to "identify and correct mistakes" (extract 47). It also enabled a collegial space that was not led solely by the facilitators. As psychologists conducting the course, we were able to avoid taking on a "teacher" role for the entire duration of the course and, instead, focus our efforts on facilitating dialogue amongst the participants. This provided an opportunity for vertical (facilitator-participant) and horizontal (participant-participant) learning (Williams, 2005). I share a reflection from my own journal during the first training course.

> ***Extract 49***: *They [participants] seem to be learning from each other. Thandi's reflection was insightful when she shared that she learnt [from her peer] that it is ok to apologise to a client. They also seem appreciative of each other. Perhaps they are careful to be kind so that they receive kind feedback?! They also seem more self-critical and other-complimentary. But that is ok! After all, how often do they receive compliments for the work they do? I'm sure it helps to boost their confidence and esteem.*
> *[Yamini, Main course facilitator, Reflective journal, 2020]*

I showed doubt about whether it was helpful if participants were offering predominantly positive feedback to each other with regard to their learning. However, reflecting on my own reflections,[64] I notice there is synergy between the sub-themes in sections 6.2.2 and 6.6.2, where the former underscores participants' abilities to critically evaluate themselves, while the latter focuses on their admiration and recognition of each other. Additionally, constructive comments were offered by the facilitators during the course. Thus, the process became a 'triadic feedback mechanism' where observations made by oneself, peers, and facilitators were integrated and presumably balanced each other out.

Keeping in mind the sensitive nature of abortion work and the level of burnout associated with stigmatised professions, one of the secondary course goals was for the course to function as a safe space for providers to debrief. This aspect became visible as nurses identified similarities and difference in their experiences, not limited to case studies but also their environment. This invariably aided in critical reflection as can be seen in the following extracts:

> ***Extract 50***: *Each provider experience* ***different personalities*** *[referring to clients] and even though we use step by step guidelines, the* ***same booklet, we handle counselling differently in a way****.*
>
> *[Sethu, Reflective journal, 2021, p. 24]*

> ***Extract 51***: *Despite our* ***different approaches*** *to our clients, we all strive for* ***a common goal****. We should be more accommodative, inclusive and open minded to different race, religion, age, prejudice.*
>
> *[Peter, Reflective journal, 2020, p. 11]*

> ***Extract 52:*** *I evaluated that we have* ***different cases*** *and interested [interesting] cases.* ***We have done counselling the same way*** *touching or* ***prioritising different things.***
>
> *[Ruth, Reflective journal, 2021, p. 24]*

> ***Extract 53:*** *The other thing that I have learnt from my peers is that* ***we are in the same situation in terms of infrastructure.***
>
> *[Nondumiso, Reflective journal, 2021, p. 24]*

Both Sethu and Peter (extracts 50 and 51) note that different providers have different approaches to counselling with clients having distinct personalities and characteristics. Ruth (extract 52), on the other hand, comments that although their cases are different, the

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[64] This feature is what Dallos and Stedmon (2009) term *personal reflexivity* which they see as "a conscious cognitive process whereby knowledge and theory are applied to make sense of remembered reflective episodes" (p. 4). They assert that the focus here is to reflect *on* action retrospectively rather than to reflect *in* the moment of the action.

counselling is done the same way but that they may prioritise different things during counselling. Though the meaning is not fully clear, Ruth might be referring to different principles of client-centred counselling that each provider highlighted in their presentation. Additionally, noting that they are in the same situation infrastructurally (extract 53) likely built empathy, as providers identified with each other's challenges. What these reflections do emphasise, are providers' inclinations to compare their style to that of their colleagues' which potentially creates a learning curve and increased confidence in what they do.

6.6.3 Boosted Morale: A Ripple Effect of Abortion Counselling Training

While the main focus in developing this training course has been to impart counselling skills to providers and enable them to dispel myths about abortion consequences, there are certain findings that indicate a ripple effect caused by the positive outcomes of the training course. The first observation is the unintended outcome of helping to combat stigma.

> ***Extract 54:*** *It did help me a lot. It* ***boost*** *my spirit. Yeah! It did* ***uplift me a lot****, you know,* ***as a result I'm walking tall*** *uhm, yeah.* ***I just close my ears and eyes to whoever might be talking bad*** *about my service.*
>
> *[Faith, Interview post-ACCC 2020, p. 3]*

> ***Extract 55****: So, when* ***I have people in my corner that understands*** *and give me tons and tons of advices, it helps because it broadens my mind and it has been one thing that has also been motivating me to continue with TOP. Because* ***a lot of times there are a lot of things that can be discouraging in terms of providing TOP*** *services because* ***it is stigmatized to start*** *with* ***as a nurse you are stigmatized*** *for starters, working for public services or sector is further degrading you in these current times we are living in. And even worse,* ***when you are going to terminate pregnancies people will judge you****, people will stigmatize you. So having people in my corner who are facing challenges similar to mine have helped so much to* ***have confidence to continue soldiering on****.*
>
> *[Peter, Interview post-ACCC 2020, p. 7]*

Extract 54 indicates that the skills and confidence acquired during training likely helped Faith to shut out and ignore any negative comments about her work and stay uplifted. Similarly, Peter (extract 55) remains motivated to continue providing TOP as he feels understood and heard by other abortion providers amidst discouragement, stigma, and degradation. The fact that the course would boost the morale and spirit of providers was unexpected. Yet, these sentiments were shared by several providers who detailed the nature of their work as stigmatising and discouraging. This is not surprising, seeing as providers' identities are entwined with abortion work and ongoing stigma is hypothesised to contribute to stress, difficulties with colleagues, and burnout (Harries, 2010). Faith's reference to "whoever might be talking bad" and Peter's work analogy of "soldiering on" are both suggestive of conflict

in their work environment. Providers thus acquired skills not only in counselling and dealing with difficult client cases, but also in how to engage with their workplace challenges and attitudes of other non-provider colleagues.

The courses functioned as debriefing spaces that ultimately afforded nurses a space to connect with each other and bond.

> ***Extract 56****: I'm gratefully [grateful] to find out* ***we are not alone as providers of CTOP****, they are people who cares about us and who are willing to help and assist us…I'm glad now to find out* ***I have siblings like you in CTOP*** *to advocate form women's lives and respect their rights and decisions and to provide non-judgemental services.*
>
> *[Jane, Feedback form 2, 2020, p. 22]*

Jane (extract 56) displays gratitude as she realises that she is not alone, even referring to other providers as her siblings and thus signalling deep affection towards them. The implications of these bonds that have developed appear to directly influence abortion service provision as all three extracts make references to their future behaviours – Faith is walking tall, Peter has confidence to soldier on, and Jane displays the will to be an advocate for her clients. These extracts demonstrate how this study created a safe space for participants to talk about various aspects of abortion, which helped to both address and challenge stigma (also seen in a study by Bloomer et al., 2023).

The connections made with other providers were not the sole reason for participants' newfound sense of purpose. The CSSR AC Guideline was once again appreciated, as is evidenced in the following extracts:

> ***Extract 57****: Those guidelines* ***gave light and boost my self-esteem*** *on how to deal with different situation professional.*
>
> *[Iviwe, Reflective journal, 2021, p. 20]*

> ***Extract 58****: Guidelines will be helpful because* ***we will be able to have backbone*** *when our managers want us to do things their way.*
>
> *[Lilly, Reflective journal, 2020, p. 4]*

The CSSR AC Guideline was intended as a resource for providers about the abortion counselling protocol. It proved to be a key component not only in building their competence with clients (extract 57), but also their confidence when engaging with their managers at work (extract 58). Lilly's reference to "being able to have a backbone" reveals some level of anticipated tension that she foresees when she and her colleagues return to work, possibly with regard to pressures from their supervisors around forms and statistics (these aspects are elaborated on in the next chapter).

6.7 Evidence-Based Language and Practice

A crucial goal of the course, and course outcome six, was for providers *to dispel myths regarding abortion consequences with empirical evidence-based research*. This aspect was a compelling part of the training due to the amount of abortion misinformation present in the public domain. On completion of the course, an embracing of the phrase “evidence-based” was observed in class discussions, with nurses sharing their understanding of the divergence between beliefs and empirical research.

> ***Extract 59****: On the other side* ***people have their own beliefs (negative) about abortion*** *e.g. if you terminate you will have bad luck… If you had an abortion you might not conceive in future, you can/will have post abortion stress e.g. experience nightmares guilt and so on.* ***I believe that these might not be true*** *because* ***there is no evidence proving the truth about these myths****.*
>
> *[Casey, Reflective journal, 2021, pp. 18–19]*

> ***Extract 60****: I was emotionally aroused today when the counsellor told the client “What if this was your last egg/only egg” I believe that* ***people should not mention things they are not sure about****/ things that have not been* ***scientifically proven****.*
>
> *[Ruth, Reflective journal, 2021, p. 18]*

> ***Extract 61****:* ***False beliefs*** *are not up to date with* ***current science****, and create many barriers, which are preventing women from accessing safe services.*
>
> *[Peter, Reflective journal, 2020, p. 5]*

Extracts 59 and 60 highlight providers’ reflections around practices that can be misleading for clients. Casey and Ruth demonstrate their engagement with the CSSR AC Guideline that cautions against introducing and discussing ‘risks’ of abortion, as research has not established causal links between safe abortion and infertility or psychological trauma (Mavuso et al., 2019).

Peter (extract 61) recognises that information which is not evidence-based can become a barrier to women accessing safe and legal reproductive health services. The extracts below underscore an important shift in the choice of language used by providers to help normalise an abortion procedure.

> ***Extract 62****: Abortion is* ***not killing*** *but the* ***removal of the products of conception*** *on the choice of the woman to do it.*
>
> *[Phillani, Reflective journal, 2021, p. 19]*

> ***Extract 63****: I will tell them abortion is a* ***clean medical procedure****, just like any other medical procedure. And it is* ***every woman’s right****.*
>
> *[Faith, Interview post-ACCC 2020, p. 4]*

> ***Extract 64****: Her concern was that will she be able to conceive again after abortion. I reassured her that as long* ***she did it in a legal place it is safe*** *and no research that approved of future infertility.*
>
> *[Lilly, Case presentation, 2020, p. 4]*

Phillani (extract 62) offers what Perruci (2012) describes as a 'reframing' and alters his language to describe an abortion procedure in medical terms as the removal of the products of conception. Similarly, Faith (extract 63) emphasises medical language while also drawing on a rights perspective. In Lilly's excerpt (extract 64), she provides assurance to her client by stressing the importance of having a safe and legal abortion (as opposed to a backstreet, illegal one). Furthermore, the goal of offering contextually relevant counselling is visible via Nondumiso's reflections below:

> ***Extract 65****: Decision-making counselling because the client doesn't want to continue with her pregnancy, so by providing information about the adoption I think* ***I am violating client's right to abortion****. As for government assistance, I will introduce the client and her baby to poverty because the government's assistance will not be enough to provide for the child because there are many children depending on government's assistance.*
>
> *[Nondumiso, Reflective journal, 2021, p. 21]*

Nondumiso's reasoning is reflective of her engagement with a client's context and the consequences of taking an unwanted pregnancy to term. Her reference to violating a client's right underlines the core values of reproductive justice that works to counter any form of reproductive oppression (Ross & Solinger, 2017).

What stands out in these extracts are the ways in which language serves many purposes. Using exaggerated language (extract 59) or offering procedural information combined with an ultimatum ("what if this was your last egg?" in extract 60) can apply undue pressure and stir emotions alongside instilling fear or guilt in an abortion seeker. A provider's choice of words can help challenge beliefs (extract 61) and subsequently help to normalise a procedure (extract 63).

The revelations from extracts 59–65 are evidence of providers' learnings of how a client-centred language that is guided by reproductive justice principles offers an alternate way to communicate, in a manner that is sensitive, unimposing, and mindful of a client's mental and emotional state.

6.8 "My Counselling was Effective Because My Client Came Back"

Course outcome seven was *to conduct effective person-centred abortion counselling.*[65] As this aspect overlaps with nearly all the previous themes that have been discussed in the chapter, there are some questions that I specifically address in this section. Firstly, what demarcates an abortion counselling session as being effective, and is it (in any way) different to client-centred counselling?

The extracts from Nurse Iviwe's case presentation below offer some insight into these queries.

> ***Extract 66***
> *Client: I am ready for procedure now.*
> *Iviwe: **Do you think you will need** contraceptives after procedure. We have all types of contraceptives **if** you need them.*
> *Client: No, I will condomise until I will be ready for next baby.*
> *Iviwe: Perfect you can get more condoms if you want. Also, I can assist you if you still have bad feeling about the relationship you had….**Maybe refer to psychologist** if it's fine for you.*
> *Client: No after the termination of this pregnancy I will be fine.*
> *[The provider then described her interactions, which were indicative of active listening, maintaining eye contact and nodding, asking questions, paraphrasing, picking up on the client's cues and ended the presentation with her own reflections]*
> *Iviwe: Client made me feel emotional too with the history she experience. Challenges we are arising when doing termination (TOP) is the form. Some of questions are not necessary during counselling. My counselling was effective **my client came back and appreciate the way I treat her**.*
> *[Iviwe, Case presentation, 2021, pp. 3–4]*

Iviwe demonstrates various client-centred principles (outlined in brackets in extract 66). The counselling interaction is also guided by reproductive justice principles that enable agency in her client – this includes the decision regarding her preferred choice of contraception and the decision regarding a possible referral to a psychologist. Iviwe thus effortlessly includes post-abortion care into the session. It is no surprise that her sensitivity and non-judgement is well-received and appreciated by her client.

One aspect that was previously reviewed as a problem by participants seems to have improved for many of them post-training. This relates to a client returning for their scan (see extract 31).

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[65] This aspect will be fully explored in the larger project through an end-term study that aims to repeat the baseline study. The research project is already underway and will include recordings of abortion counselling sessions conducted by the participants.

> ***Extract 67****: Her follow up after a week for scan.* ***She came back after a week****, I asked how is she feeling after the procedure,* ***she said she is happy that it's all over*** *and the scan shows her uterus is now empty, I was happy that she said she decided to take oral contraceptives.*
>
> *[Casey, Case presentation, 2021, p. 1]*

> ***Extract 68****: She said to me, because you said that you are going on leave* ***I did not want to miss you because I don't want to be attended by someone else****, you were very nice to me, so that is why I brought my daughter so that you can attend her also. The daughter requested the same option which was opted by the mother. They thanked me and said will come to me for family planning.*
>
> *[Bonga, Case presentation, 2020, pp. 1–2]*

The fact that clients are putting in an effort to return for their scan is telling of the quality of care they received during their first visit. In extract 67, Nurse Casey is relieved to see that her client's uterus is empty and they both state being happy with the outcome. Indeed, Casey's happiness is also due to her client's decision to take oral contraceptives; however, based on her description of the interaction, this does not seem to have been coerced. Similarly, in extract 68, Bonga's client returns the following morning with her daughter who is also in need of an abortion. The client appears keen to have the same service that she received for her daughter, and ascribes the positive experience to the provider, as she states that she did not want her daughter to be attended to by anyone else.

Once again, we see the issue of contraception raised, with the mother and daughter stating that they will return for "family planning." The pressure on providers about an appropriate way to engage with contraception evidently remains, as they grapple with an approach that is in line with client-centred and reproductive justice principles that emphasise agentic decision-making alongside facing some pressure from the public healthcare system for contraceptive roll-out. I engage with this topic further in the next chapter.

What is clearly visible in extracts 66–68, however, is the contentment of the clients. While this is, of course, based on providers' reports, the participants did include some feedback that they had received.

> *Extract 69: In my clients uhh I did receive uhm a message from one of my clients was recommending me because of the good service that I gave, because uhh one of my supervisors sent it to me. Also, you see it when they go out, they smile, it makes you feel good that you have done something good for your client.*
>
> *[Faith, Interview post-ACCC 2020, p. 3]*

> *Extract 70: So my clients now, I'm seeing a lot of clients. Some clients now are referring me. Letting people know that go see Peter, he is amazing, he gives out quality information. He's open, his [he's] non-judgemental. And for me that has boosted a lot of my morale because I see that me going through the course learning how to do proper counselling that is recommended and actually implement it, it has*

made my clients more free to talk. It has made my clients more comfortable in coming to my clinic, and actually talking about their problems. Not only limited to abortion but generally you know.

[Peter, Interview post-ACCC 2020, p. 6]

Faith (extract 69) mentions receiving positive feedback from a client via her supervisor, which reinforces her own perceptions that clients leave her clinic with a smile. Peter (extract 70) echoes similar sentiments about being referred for his superlative service. Peter reflects on certain features that have improved his practice such as quality information, his openness and non-judgement, and adopting a “proper” counselling method. He relates these changes to clients being more comfortable with visiting his clinic and discussing their problems.

These shifts are massive, in that it epitomises a core need behind developing the training course, which was to increase access to legal abortion services. Figures 2 and 3 contain pictures of the notes I made while facilitating the course to strengthen the finding.

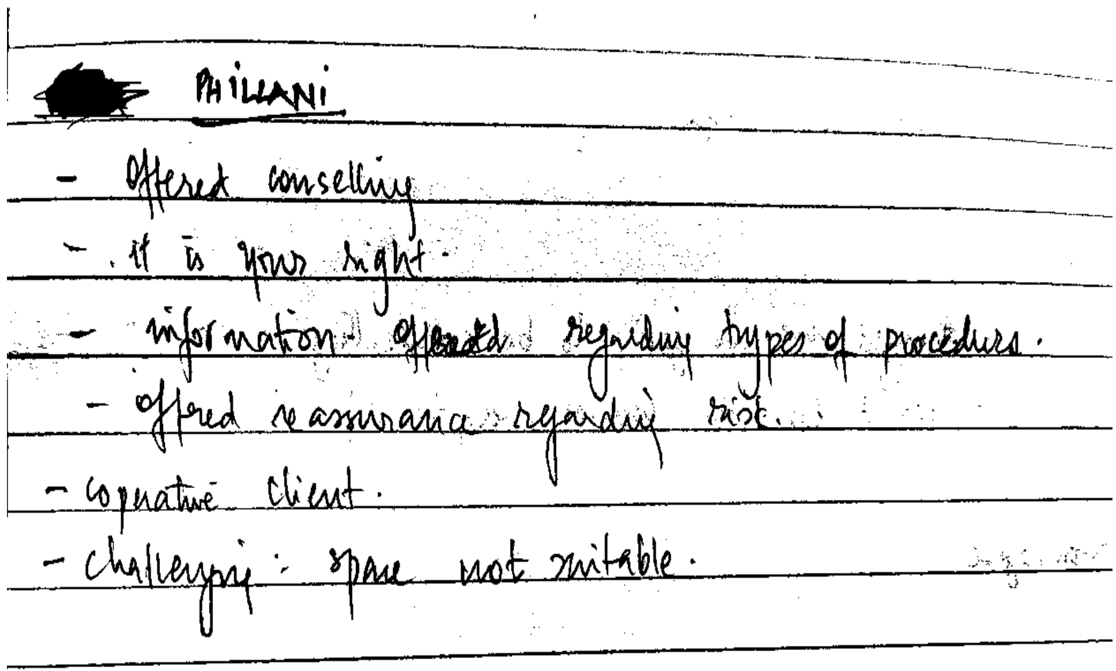
Figure 2

Facilitator’s Notes during the Introductory Session

PHILLANI
ToP not taken as a contraceptive
- we have to probe
- how many times have you done it?
- didn't go for family planning?
- educatee them
- "I don't want to see you again"
- some women don't know it's their right.
- so I have to teach them

Figure 3

Facilitator's Notes on the Case Presentation at the End of the Course



Both photos relate to Nurse Phillani. Figure 2 relates to his comments at the start of the course regarding how he conducts abortion counselling. He first states that TOP must not be taken as a contraceptive. He continues that it is the nurse's duty to probe ("we have to") if a client went to "family planning" and how many times they have had an abortion previously. He also conveys that it is their role to "educate" and "teach" the client and thereby takes on a predominantly paternalistic role. Sandman and Munthe (2010) note this stance in the medical field, where health professionals often lead the session based on what they believe will best suit the patient, as opposed to informed choice where the patient decides for themself.

Phillani also states that some women are unaware of their rights. He shares that he ends his session by telling his client that he does not want to see them again. Afterall, pre-abortion counselling has been shown to be successful when abortion seekers do not return for another abortion (Mavuso & Macleod, 2021). He also (verbally) stated being proud of his "stats" as the number of women visiting his clinic are low, possibly implying that the "family planning" programme at his facility is a success. Of course, this is not indicative of whether fewer women are needing abortions, only that his clinic receives fewer abortion requests.

Moving forward, Figure 3 shows my observations of his approach at the end of the course, highlighting a non-directive, client-led exchange. Counselling is offered, instead of

probing, which is a stark contrast to his approach at the start of the course. He also provides reassurance to his client who is viewed no longer from the perspective of success or failure but rather as a "cooperative client" accessing a reproductive right.

These extracts all point to client satisfaction. After declining the suggestion for a referral (in extract 66), the client stated that she would be fine after the termination. The clients in extracts 67 and 68 returned; Casey's client for a scan and Bonga's client with her daughter. In extract 69, Faith described how clients left her clinic with a smile on their face, and the number of Peter's clients increased (extract 70) due to an increase in the number of referrals. These examples are crucial in normalising the narrative around having an abortion, while also challenging its construction as difficult and traumatic (Mavuso & Macleod, 2019).

A final facet of effective client-centred abortion counselling relates to third-party involvement. The extract below describes such an encounter and demonstrates the ability of the provider to engage with the third party without losing sight of the client.

> ***Extract 72****: Client was accompanied by her mother. I asked the mother to give me a minute with the client alone and I asked her if she wants her mother to be present during the session and if her mother did not force her to come and she said she will be comfortable with her mother present because she is here to support her and she is not forced to do this.*
>
> *[Ziyanda, Case presentation, 2021, p. 3]*

Ziyanda diligently follows the steps outlined in the CSSR AC Guideline under *What to do if there are third parties present* and calmly asks to speak to the client alone to ensure that there is no coercion from the client's parent to abort. To Ziyanda's relief, the client confirms that her mother is supportive, and the provider thus moves forward with the session while ensuring that her focus is on her client for the rest of the interaction.

Through this theme, what stands out is that the effectiveness of a counselling session can be measurable to a large extent by the patient-satisfaction outcome. This is indicated in three ways: when clients return for their scans; when clients refer someone they know to a particular abortion provider by name; and when a supervisor offers positive feedback to a provider from a client.

Additionally, managing third-party involvement during a session and managing referrals equally fall under abortion care. Thus, effective client-centred abortion counselling not only comprises client-centred counselling but is a more comprehensive term that might involve engagement with other allied health professionals such as a social worker or a psychologist, or effectively navigating third-party involvement.

6.9 Reflexive Providers

The last theme in this chapter relates to course outcome eight, which was for providers *to be reflexive about their roles in promoting client-centred counselling*, and therefore to assess their ability to understand how their actions influence the counselling encounter. Some nurses specifically spoke about their ability to reflect and what that enables. For example, Ntombi noted in her feedback on the training course that it “improves the reflection on oneself and provides an insight on what went wrong or right that needs to be done” [Ntombi, Feedback form 2, 2021, p. 28]. Other providers engaged in the process of reflecting, as can be seen in Thato’s reflections in which she observes of her own behaviour that, “I do have a tendency to maybe impose on the clients. I have learned that I must learn to listen and work with the client in finding solutions to her problems, because after all, it’s her decision at the end of the day” [Thato, Reflective journal, 2021, p. 16].

Such reflections were indeed spearheaded by the dialogical pedagogical approach of the courses that emphasised self-reflection and critical reflexivity. As critical reflexivity featured in section 6.2 of this chapter, this sub-theme accentuates self-reflection and, more importantly, providers identifying themselves as part of a problem that needs change.

> ***Extract 73****: Reading of Conversation Analytic Role Play made me realise that* ***as Healthcare Provider we fail our clients****. And we also judge them for doing abortion instead of using contraceptive.*
>
> *[Lilly, Reflective journal, 2020, p. 3]*

> ***Extract 74****: I’m quite* ***surprised*** *at the manner* ***we*** *as CTOP providers conduct our pre-abortion counselling. I feel* ***we are very descriptive and directive*** *in our counselling.* ***Prioritise our values*** *and pry on our patients personal affairs, assumptions.*
>
> *[Peter, Reflective journal, 2020, p. 4]*

> ***Extract 75****: I* ***felt uncomfortable*** *with the questions from health service provider. I felt like if I was the patient I was going to ask the provider to* ***skip the counselling because it’s creating problems other than helping the women*** *to cope.*
>
> *[Casey, Reflective journal, 2021, p. 18]*

Alluding to the (problematic) practices that surfaced in pre-abortion counselling, Lilly and Peter (extracts 73 and 74) use the terms “we” which suggests a process of self-evaluation and reflexivity. There is no othering of the providers that they read about in the CARM transcripts. In other words, they do not place blame on “those” providers but rather accept mutual responsibility for the crucial role that all providers play in enabling or preventing access. The providers analysed how descriptive and directive counselling (extract 74) can be distressing and potentially end up creating a problem rather than helping a client, ultimately

suggesting that it may be altogether better to "skip" the counselling part (extract 75). The tone in these reflections is sympathetic and even apologetic. Interestingly, in extract 73, Nurse Lilly reflects on how *providers* fail their clients. This suggests a shift in attention from what a client did or rather did *not* do (use contraception) to what a provider *can do* in session to either support or silence an abortion seeker. Finally, the last two extracts emphasise providers' acknowledgements of their own frame of reference and how they decide to manage this aspect in relation to their work.

> ***Extract 80:*** *We as counsellors* ***have our own cultural and religious beliefs*** *and so does our clients. We* ***must be aware not to talk about culture or religious topics*** *in our counselling session.*
>
> *[Phillani, Reflective journal, 2021, p. 16]*

> ***Extract 81****: At work you don't bring your beliefs and cultural practices, you have to put them aside (leave them at the gate and take them when you are going out). Cultural beliefs must not interfere with your work.*
>
> *[Casey, Reflective journal, 2021, p. 16]*

A unanimous acknowledgement emerged that imposing personal beliefs on clients was a disservice, which motivated the participants to put aside their cultural and religious beliefs. Casey does not suggest altogether discarding their beliefs but rather to leave them at the gate and to take them when they leave work, thus portraying how providers could potentially offer quality abortion services, while prioritising their clients and maintaining a work ethic and professional identity (even if that is separate from their personal beliefs or values).

I end this section with three interconnected reflections. To provide some context, the situation relates to Nurse Thandi's case presentation following her fieldwork. In it she reported an interaction with an abortion seeker whom she recollected as having accessed abortions services twice in the past two years. The client promised to return in six weeks to "insert loop" (IUD) but instead returned for another abortion. Thandi reported that she felt "angry" and "chased her out of the office." She then used some "self-calming techniques" while recollecting the importance of non-judgement and reminding herself that it was the client's choice. Thandi called her client back into her room, apologised for how she had portrayed herself, provided her with the service, and lastly "referred her to a social worker for further management" as she felt a bit worried for her client. The first extract is from Thandi regarding her fieldwork highlights, the second is my co-facilitator's response to her after her case presentation, and the last is a reflection from my journal.

> ***Extract 82****: It had* ***made me improve*** *even more on the way I was handling my clients. I have also discovered that in order to cope I should use coping mechanisms if I'm faced with a difficult situation.* ***This has increased my self-awareness*** *thus*

> *helping me develop a better understanding of others. It has* ***helped me to develop creative thinking skills*** *when handling my clients. It* ***encourages me to have an active engagement in my work*** *process.*
>
> *[Thandi, Reflective journal, 2020, p. 11]*

> ***Extract 83****: I like* ***the fact that you went and apologised to the client*** *and still offered her a safe space to talk, and still listen to what the client wanted, and still did what the client wanted anyway.* ***That must have taken a lot from you*** *considering your feelings around the matter seeing that you had just seen this client, and this was the third time…so your feelings, they came and overwhelmed you. But you apologised and* ***you gained some sort of self-awareness****. And* ***you allowed the client to talk and feel safe****.*
>
> *[Esona, Co-facilitator feedback on Thandi's case presentation, 2020]*

> ***Extract 84****: It takes a level of confidence to show vulnerability. I was moved during Thandi's presentation today when she disclosed her initial reaction and anger, how she chased her client out, and then how she navigated that. She was brave enough to share it with the group. We all learnt something from her today… that we aren't going to always get it right and we needn't be scared to admit when we have made an error and apologise. Some solid unlearnings and relearnings today!*
>
> *[Yamini, Main course facilitator, Reflective journal, 2020]*

The process of triangulation is enriching in research as it helps improve the credibility of the research findings (Noble & Heale, 2019). Bringing together extracts 82–84 helped me to analyse a scenario from three perspectives – that of the participant, my co-facilitator, and myself, while checking for any overlaps in our observations. The reflections took place at different times during ACCC 2020, but all relate to the same participant's experience. Thandi (in extract 82) acknowledges how the course has helped her improve her engagement with clients and her skills when faced with a challenge. She reports that her increased self-awareness has helped her to understand her clients better, to improve her creative thinking, and to be actively involved in her work.

Her reflections overlap with the co-facilitator's (Esona's) comments about Thandi's case presentation. Esona notes how Thandi's self-awareness guided her through a situation that was overwhelming. The co-facilitator is appreciative of Thandi for apologising to the client [for chasing her out of the room initially after realising it was a "repeat abortion"] while also commending the client-centric service that she went on to provide despite how she felt. This overlaps with my own notes in my reflective journal maintained during the course. I comment on how I was impressed with Thandi's bravery to choose a complicated case; a case that started out with her being seemingly punitive towards a client. This necessitated an unlearning and discarding of old practices and a relearning and enacting of client-centred abortion counselling in the moment, which she displays.

These reflections are helpful in gaining skills, expertise, and confidence while recognising that learning is not a clear, linear process and often includes moments of uncertainty. On the contrary, learning from mistakes is just as helpful. Interestingly, Thandi's sense to apologise was also something she learnt during the course from another colleague (refer extract 49).

Before concluding this chapter, I acknowledge that assessing participants' learnings likely posed a challenge with possible pressure on participants to produce a socially acceptable answer, considering the critically inclined discussions taking place. To reduce this bias, I observed participants' response styles to check for consistency over time, as suggested by Bergen and Labonté (2020) in their paper on detecting and limiting social desirability bias in qualitative research. I therefore explored the extent to which similar or conflicting sentiments featured in a participant's engagement across the duration of the course, through their fieldwork, case presentations, and interviews.

I also gave due consideration to what was being shared as a precursor to or following their learning, as this offered insight into the *process* of change rather than just the content. For example, while summarising a group discussion, a discussant shared their group's consensus which was to "stop asking about reason and contraceptives and how many times, rather ask if they are interested in contraceptives and give them a choice." The discussant, therefore, does not limit the statement to what to stop. Rather, she offers a solution based on their group's dialogue about *how to engage* during a conversation surrounding contraceptives so that clients may make informed choices.

Similarly, Nurse Phillani in his reflection stated, "To me, counselling was about me, the counsellor, doing the most talking, and concentrated more on procedural counselling. Now that I have attended the Abortion Counselling Course, I have learned that the counselling session should be led by the client." He, thus, courageously admits to having been more directive and less client-oriented pre-training, thereby demonstrating a level of honesty in his assertion and self-evaluation. In this way it is discernible that although there may be bias in participants to produce "correct" answers, many of these responses are offered with deep reflection, insight, and critical evaluation.

6.10 Conclusion

The main purpose of this chapter was to assess how the in-service abortion counselling training course outcomes were met, based on participants reported learnings and observations. This analytical chapter achieved the main objective by reviewing the course

outcomes against the assessment criteria and participants' reflections. I took into consideration providers' cognitions, emotions, and behaviours at the start of the course, during the training and at the end, thereby revealing the transitions across the course duration.

The training courses enabled introspection into what the terms non-coercive, non-directive, and non-mandatory mean at a semantic level but also at a behavioural level (during role plays). The transformative and beneficial value of training for providers is underscored throughout the chapter. Noticeable in these findings are the ways in which abortion providers deeply benefited from the training workshop as a safe space to discuss their work. They developed new ways of engaging with their experiences and those of their clients (Mavuso & Macleod, 2019). The findings from this chapter inform the refinement of course activities and outlining of course outcomes, which is discussed in the final chapter of this thesis.

CHAPTER SEVEN: EXTERNAL ELEMENTS ENABLING AND HINDERING ABORTION SERVICE PROVISION

7.1 Framing External Aspects

In the previous analytical chapter, I looked at which course outcomes were met and how they were able to contribute towards quality abortion services based on reproductive justice principles. My second research question engages with the following question: What elements, external to the course, are identified as enabling or hindering nurses' skills in providing abortion services based on reproductive justice principles? Therefore, I explore whether the client-centred counselling skills, acquired and demonstrated by abortion providers in the previous chapter, can be sustained in their work environment. If so, then what aspects (outside of the course) reportedly makes this possible, and if not, then what are the recounted obstructions, and what does this mean in relation to offering the course?

From the literature review, it is clear that abortion services in the country are substandard in terms of quality and accessibility, despite provisions of the CTOP Act. Only a small portion of the course was allocated for discussing the challenges (as the primary focus was on developing abortion counselling skills), yet a wide range of issues emerged. All the challenges identified under section 7.2 in this chapter directly impede providers' abilities to offer client-centred abortion counselling, thereby obstructing abortion access and undermining reproductive justice. Section 7.3 puts forward elements that support providers by enabling them to do their job with confidence and respect, thereby promoting reproductive justice.

7.2 Providers' Challenges Within Abortion Service Provision

In the following sub-themes, I have placed the various identified hinderances under separate headings, although each aspect is clearly intertwined with the others. The source of the problem remains ambiguous, but it is evident that each element maintains and exacerbates abortion (dis)services.

7.2.1 Staff Shortage and its Sequelae

Below are some of the responses to providers' *anticipated* and *lived* experiences of abortion counselling service provision that emerged during the training courses:

> ***Extract 1****: It is the* ***time*** *as we're having* ***more clients a day and less staff*** *to attend the clients. but will try my best to implement all that I have learnt here.*
>
> *[Ziyanda, Feedback form 1, 2021, p. 1]*

***Extract 2**: No challenges **will just make more time** for to engage with my clients.*
[Course participant, *Feedback form 1, 2021, p. 1]*

***Extract 3**: **Time** to do proper counselling with each client.*
[Ruth, Feedback form 1, 2021, p. 1]

The three extracts above are all from a feedback form in which providers related the challenges they *foresaw* (feedback form 1) moving into the fieldwork component of the training course. It is apparent that providers are anticipating "time" to be a challenging factor as they are all too familiar with staff shortages and the high workload at their facilities. In the first two extracts, the providers share their intention to implement the learnings (extract 1) and to make more time for each client (extract 2). In extract 3, Ruth also foresees time being a challenge to providing "proper counselling." *Proper* counselling seems to stand in contrast to the counselling that took place prior to attending the course, which would have likely been provider-led and information-driven (based on previous literature and findings in the previous chapter). Thus, providers demonstrated an awareness that adapting to the new guidelines and implementing person-centred counselling principles would necessitate more time per client, which is unfortunately lacking due to staffing issues.

As predicted by participants, being short-staffed did prove to be a challenge and it most certainly hindered their ability to provide client-centred counselling despite their good intentions shared in extracts 1 and 2.

***Extract 4**: **Working alone** in a facility may cause "**burnout**" because of the workload. **Interference** by significant others in the process.*
[Ntombi, Reflective journal, 2021, p. 17]

***Extract 5**: **Disturbances** during counselling due to **busy facility**. And we work as multidisciplinary team.*
[Sethu, Feedback form 2, 2021, p. 29]

***Extract 6**: **I need a staff nurse also nursing assistant** because one I have is sick and is on dialysis. **Too much workload** as I'm also doing {colonoscopy} on Wednesday. Every time they [manager] always told me **that there is a shortage of staff**. Also, we need to be debriefed at least 3 times a year…**sometime feel having burnout**, but I always controlled myself by taking a deep breath.*
[Nandi, Reflective journal, 2020, p. 5]

The busyness of providers' facilities is exacerbated by the shortage of staff, which leads to time constraints, making it hard for nurses to practice their newly-acquired skills, such as active listening and allowing the client to lead. Apart from being the sole abortion provider at their facility (extract 4), nurses are often part of a multidisciplinary team (extract 5) and hence have other nursing duties. Nandi (extract 6) needs to work in a different department every

Wednesday due to a staff shortage. Abortion providers feel pulled in different directions due to various demands made on them from other departments. This is indicated in their usage of words such as “interference” (extract 4) and “disturbances” (extract 5). The use of the word “interference” suggests an obstruction that is preventing Ntombi from honing her skills. A break – when a provider is called away – during a person-centred counselling session can rupture the process of ensuring privacy, maintaining confidentiality (which is a huge concern for an abortion seeker), and building rapport with a client.

An overly demanding work environment can cause irritability, frustration and exhaustion in providers. These aspects combined with an unsupportive environment (such as extract 6, in which managers acknowledge the staff shortage but are unable to improve the situation) can further lead to burnout in providers. Burnout is, of course, spoken about in abortion literature (Harries et al., 2009) as an area of concern that needs intervention. Several nurses referred to either anticipating (extract 4) or experiencing (extract 6) burnout. Nandi (extract 6) also suggests that providers require debriefing at least thrice a year to alleviate their stress. Sadly, the consequences do not stop with staff burnout.

> ***Extract 7****: Challenges that I am experiencing is the* ***challenge of not having someone who is working with me****…because if I am off sick or I am on leave, there is no one on my service. So, the service programme is closed.*
>
> *[Faith, Interview post-ACCC 2020, p. 4]*

The costs of being short-staffed and the sole abortion provider lie on a continuum of severity. At one end, providers relate that working alone leads to an overload of clients causing less time per client, and at the other end, convey that it can lead to the service closing altogether when the provider is on sick leave (extract 7) as there is no one to take over this role.

From each course (after they were completed), we lost a provider. Nurse Nandi (ACCC 2020) and Nurse Casey (ACCC 2021) passed away in September 2021 and March 2024, respectively. This news was exceptionally difficult for other providers and facilitators to come to terms with. I include one of my reflections about Nurse Casey’s death with the intention to highlight the reality of such possibilities and how the ramifications of these losses must also serve as an impetus for increasing the pool of abortion providers and the quality of their workspace.

> ***Extract 8****: I am shocked and heartbroken to hear of sister’s passing. She was young and a mother of a thirteen year-old girl and four year-old boy. I feel deeply saddened for her children and family. Sr. Ntombi shared that she trained her in 2012, and that Casey had been a provider ever since. I hope Sr. Casey was aware of the incredible*

difference she made in the lives of many women over the past 12 years. This is a huge loss to her family and an even bigger loss to the community.
[Yamini, Main course facilitator, Reflective journal, 2024]

The repercussions of having only one provider at a facility (or for a few surrounding facilities, as is more often the case) are dire. In these cases, it likely leads to the clinics shutting down altogether, until new nurses are trained and assigned to those facilities. Thus, the consequences of being the sole abortion provider at a personal level (causing burnout) and macro level (leading to no abortion service) are clearly visible.

7.2.2 Infrastructural Constraints

Another issue impeding the provision of client-centred abortion counselling is the non-availability of space for abortions.

Extract 9*: I have also observed that in some institutions the CTOP programme is "neglected" eg. No proper set up or a designated area to provide the services.*
[Phillani, Reflective journal, 2021, p. 15]

In extract 9, *not* having a designated area for abortion services leads Phillani to reflect on how the CTOP programme is neglected in some institutions. The neglect is unfortunately rampant across facilities with several participants sharing the piteous state in which they attempt to render the service.

Extract 10*: It is the* ***clinical setting*** *as* ***we do not have space*** *which may make a conducive environment so that we provide the counselling needed by the patient…I can say that* ***I'm trying my best*** *with the challenges that I'm facing of* ***not having space and equipment*** *to work with.*
[Ziyanda, Reflective journal, 2021, pp. 16-17]

Extract 11: Infrastructure is a problem because you have to look for [an] available room.
[Casey, Case presentation, 2021, p. 1]

Nurse Ziyanda (extract 10) has neither the space at her facility to offer confidentiality during counselling, nor the equipment for the abortion procedure. Meanwhile, Casey needs to go in search of an available room when she encounters an abortion client (extract 11). Rather than it being a smooth process for providers and clients alike, the abortion interaction between a provider and a client starts with an obstruction – that of no space.

If a space is found, it is still far from ideal since it is often a shared space: both in terms of being shared by a group of abortion seekers (extracts 12 and 13) or by other hospital staff (extract 14).

> ***Extract 12:*** *I think to me is* ***the space that stood on my way, our institution is too small, hence I end up taking all my clients put them in a same room*** *educate about the services and how to take medication, even though when I scan them, I take them one by one and ask confidential question aside and give them the chance to vent.*
>
> *[Faith, Reflective journal, 2020, p. 6]*

> ***Extract 13****: In the* ***confidentiality*** *side my colleague, she maintained confidentiality because she maintained one on one ehh counselling. In my place nehh [right]* ***there's a challenge of space because I've got a mini theatre and then even my consultant room is so small****. So when I'm going to do education to them****, I must group them…because I've got a challenge of space****. When I'm doing counselling, I'm doing the group counselling. So when I'm reading that consent form for them they are all here, all of them…the* ***only privacy*** *is* ***when I'm doing the procedure*** *because it's one on one but counselling is a group. But* ***if I can get space*** *as I can hear ke [that****] the one-on-one counselling is very important*** *because it's where* ***the client is able to voice her fears or knowledge****.*
>
> *[Group discussion, 2020, lines 32–44]*

In these two extracts, two important client-centred principles are jeopardised – privacy and confidentiality. Participants recognise the disadvantage of conducting group counselling and that it lessens the likelihood of clients freely voicing their thoughts and feelings. Providers shared alternative provisions made by them to afford clients some privacy, such as talking during scanning (extract 12) or during the procedure (extract 13), as this takes place one-on-one. Yet, there are other instances where even a brief individual session is not an option.

> ***Extract 14****: The challenges that we're facing…then a space which Sr. Ruth point on that, in my facility, uh, I'm using a consultation room and if, I'm working in OPD [outpatient department],* ***if the doctor****, we have three doctors in in my facility,* ***then I won't have a space for that day to do a TOP****. Then* ***I have to turn patient away and then come back the next day*** *because there is* ***no space for me to work****.* ***I can't be counselling in the passage****.*
>
> *[Group discussion, 2021, lines 15–19]*

In extract 14, the group discussant shares that she works in the outpatient department and uses a consultation room to conduct abortion counselling and procedures. However, this is a shared space with the doctors. On days when the doctor is present, there is no room available for the nurse to conduct abortions. As she rightly acknowledges, she cannot offer counselling in the passage. A clear hierarchy is evident between a doctor's and a nurse's requirements, and between outpatient services and abortion services. In both cases, the former is prioritised, thus leaving abortion providers and abortion services to bear the brunt.

The consequences of space constraints range from mild to severe, depending on the facility set-up. A lack of a room can result in one of these outcomes: a dip in the quality of the counselling session due to limited individual counselling time (taking place only during a scan

or the procedure itself); or no privacy due to a group format; or no abortion service altogether and a client being turned away for the day. In rural areas of South Africa, large distances to facilities and high transport costs severely impede access (Amnesty International, 2017). In this context, a client being turned away, even if only "for the day," can, in fact, have a grim outcome on their reproductive health and decision-making capacity.

7.2.3 Managerial (Un)involvement

Clinic managers play a crucial role in the functioning of the facility and its staff. The excerpts below highlight providers' experiences with them, revealing a mostly unsupportive relationship.

> ***Extract 15**: The **attitude of managers towards the programme** may make it difficult for the programme to run smoothly.*
>
> *[Ziyanda, Reflective journal, 2021, p. 17]*

In extract 15, Ziyanda reflects on how managers' views of abortion can negatively impact its provision, which indicates that, firstly, many managers do not view the programme in a positive light, and secondly, the pervasive top-down approach in public health can be hugely problematic when managers are not "pro-choice" (as discussed by Peter in the next extract).

> ***Extract 16**: In terms of abortion services, **I still have lot of challenges in terms of support from management** because management is **not really pro-choice**. They really are **not supporting this programme**. And the second challenge is when you have managers that are **not supportive**, whatever problem you are to face, that maybe **directly involved in terms of providing or rendering services**, like the **equipment** for instance, **we are running out of sterile packs**. Human resources, because I am running the clinic all by myself. I have nurses who have been inspired by the services I render but **management is not training them**. There is **no training** that is scheduled, so I am **alone**.*
>
> *[Peter, Interview post-ACCC 2020, pp. 6–7]*

Peter suggests that the challenges regarding abortion services are related to managers' stance on abortion – they are "not really pro-choice." This directly impacts abortion services, including in relation to equipment and staffing: Peter's facility is running out of sterile packs for abortion procedures, and no training of new staff is taking place. Peter indicates that there are other nurses showing interest in becoming providers. This would be a huge asset as it would benefit the health system due to the current shortage of providers and alleviate the problem of current providers being overworked and burned out (established in section 7.2.1). However, no training has been scheduled by the managers for these potential abortion

providers, leaving Peter to be the sole provider at his clinic, functioning with few resources. His usage of the word “alone” portrays himself and his work as unaided and isolated.

> ***Extract 17****: I also have* ***a problem with my management a lot****, cause my CMO [Chief Managing Officer] is not comfortable with CTOP at all, he even suggested that* ***we only do it on Tuesday*** *and not Thursdays too.*
>
> *[Group discussion, 2020, lines 64–68]*

Echoing Ziyanda and Peter’s sentiments, the discussant in extract 17 voices that her CMO’s discomfort with abortions led him to propose that it only be offered on one day of the week. This is, of course, an outright denial of a reproductive right, as any abortion seeker arriving at the clinic on any of the remaining days are forced to turn back. Even the framing “not comfortable with CTOP” portrays a resistance to legislation and the Act itself.

Taking the consequence of unsupportive managers a step further, the discussant in the extract below shares her views that managers ultimately need to be held accountable for any hindrances in access to abortion services.

> ***Extract 18****:* ***Penalties*** *provided in the act* ***for the people now who chooses to be obstacles*** *towards the accessing of the services of…There are some penalties that are there, that are put there. But in many times you find that the* ***managements of all those facilities*** *[another nurse agreeing] are the ones that are supposed to* ***be arrested*** *or even are the ones that are* ***supposed to be liable*** *for, for, what is happening in their facilities, because* ***their lack of interest in the service itself prejudice****, that, that, that the innocent girls or women coming for the termination of pregnancy*
>
> *[Group discussion, 2021, lines 20–26]*

When the discussant (extract 18) shares that there are penalties in place, she is referring to a section in the CTOP ACT that addresses *Offences and penalties*[66] that makes any form of obstruction to access punishable by law. The anger is clear in her words when she suggests that managers should be arrested. When she brings up the word ”management,” there is an overall agreement from other participants in the form of nodding and verbal cues, revealing that this sentiment and experience (of not being supported) is shared by many providers, across facilities. The discussant asserts that clinic managers’ lack of interest is, in and of itself, a prejudice against abortion seekers, who are depicted as “innocent” in contrast to the “criminal” actions of managers. This bias filters through, resulting in lack of equipment,

[66] Section 10(c) states that any person who prevents or obstructs access to a facility for TOP shall be guilty of an offence and liable to a fine or imprisonment for a period not exceeding ten years (CTOP Act, 1996).

lack of support from the human resource department, and lack of training opportunities (extract 16), with the programme running neither smoothly (extract 15) nor daily (extract 17).

7.2.3.1 Supervisors and "Stats"

When it comes to abortion services, an area in which clinic supervisors *do* appear to show an interest is the number of abortions being conducted in the facility. The extracts below reveal providers' views that, overall, managers' sole focus seems to be on statistics or "stats" as they refer to it:

> ***Extract 19****: I was stood up by [what stood out to me was] that we have the same* ***problems*** *when it comes to* ***managers and the doctors not supporting us fully*** *on the different dilemmas we face at CTOP clinic.* ***Managers only care about reports more than the well-being*** *of us as CTOP providers.*
> *[Thandi, Reflective journal, 2020, p. 3]*

When Thandi (extract 19) states that all participants have the "same problems," she highlights how widespread this issue really is. Of course, reporting is a part of the protocol that managers need to follow as per Sections 7(2) and 7(3) of the CTOP Act, which state that the person in charge of a facility needs to be notified of every TOP carried out in the facility, and, within a month of the procedure, collate and share this information with the Director-General (CTOP Act, 1996). Yet, ironically, out of all the values and rights enshrined in the CTOP Act, the section on *Notification and Keeping of Records* appears to take precedence over Section 7(2) in the Bill of Rights, which safeguards the protection, promotion and fulfilment of the rights of people (Constitution of South Africa, 1996). This is indicated in the way providers feel that their wellbeing is neglected (extract 19) and the main engagement with their managers relates to mostly recording and reporting.

> ***Extract 20:*** *The only challenge is…and the fact that* ***our managers wants statistics*** *as to* ***how many TOP done*** *and* ***how many family planning*** *used.*
> *[Faith, Reflective journal, 2020, p. 12]*

> ***Extract 21****: I think also* ***not having support from superiors****. The only thing they know is to get stats. I think that is also another* ***challenge****.*
> *[Faith, Interview post-ACCC 2020, p. 4]*

> ***Extract 22****: The* ***only thing*** *the facility* ***needs statistics*** *at the end of the month, but since what you are doing you like, you keep on doing.*
> *[Jane, Reflective journal, 2020, p. 2]*

"Stats" include not just the number of abortions conducted but also how many, and which contraceptives were prescribed (extract 20). Nurses need to keep track of how many abortions they have performed and submit it to their manager who then shares these records with the Director-General. Faith reflects on this aspect, both during the course (extract 20) and

during a follow-up interview conducted three months after the course (extract 21), where she shares that it is challenging when superiors do not offer support and only want stats. In extract 22, Jane alludes to the fact that providers ascribe meaning and value to their work, which is what enables them to continue to provide the service, despite the lack of support and the attitude of their supervisors.

7.2.3.2 Doctors and Scans

An issue faced by providers in the workplace relates to their dependence on doctors for the purpose of scanning a client to determine the gestation of the pregnancy.

> ***Extract 23: Doctors are against this service*** *to a point* ***they do not want to do scans*** *for us.*
>
> *[Thandi, Reflective journal, 2020, p. 3]*

> ***Extract 24****: There are few who are assisted/supported to their Institutions, most are* ***suffering*** *like me, e.g.* ***For scans you have to request Doctors****, even instruments to work you have to look around yourself.*
>
> *[Jane, Reflective journal, 2020, p. 2]*

> ***Extract 25:*** *Uhm, the* ***managers not being supportive.*** *Right now, since last week* ***I don't have the scanner since it broke****. My manager yho [wow], it's a struggle. They that* ***it should be a problem for the doctors not me****. It's more like mna [me]* ***I am overlooked when it comes to scan use*** *so long as I'm the one who's reporting, they are not going to [be] bothered.* ***They want the doctors to report****.*
>
> *[Thandi, Interview post-ACCC 2020, pp. 1–2]*

> ***Extract 26****: I also have* ***a problem with my management a lot****, cause my CMO [Chief Managing Officer] is not comfortable with CTOP at all, he even suggested that* ***we only do it on Tuesday*** *and not Thursdays too. Because she only allocated* ***one doctor for me*** *to do the CTOP but the problem is when the doctor is on leave* ***no one is available to confirm i [the] scan*** *for me. So it's really difficult working with them.*
>
> *[Group discussion, 2020, lines 64–68]*

The extracts show that doctors, like managers, may be against abortion services (extract 23), making it even more difficult for nurses to provide the service. This is because many nurses are reliant on doctors to perform a scan of the patient and need to "request" (extract 24) it, while assuming (a) that the instruments (extract 24) and scanner (extract 25) are working, and (b) that the doctor is not on leave (extract 26). For the discussant in extract 26, it would also need to be a Tuesday.

All these conditions are extremely unfortunate especially when looking at the following considerations made in the National Clinical Guideline (DoH, 2019): firstly, registered and

trained nurses and midwives can only perform abortions up to 12 weeks and can then only assist a registered and trained doctor, between 13 weeks or beyond (Section 2.1, NGC 2019); secondly, TOP is safer the earlier it is performed, and as the equipment needed for routine and early medical procedure is not sophisticated, it must be offered in basic facilities, in order to increase access (Section 5.4, NGC 2019); and lastly, an ultrasound is not a prerequisite for TOP, as if it is not available, a clinical assessment of the gestational age that coincides with the last menstrual period can be considered (Section 4.2, NGC 2019). If training was prioritised by managers, the challenge stated in the extract below would not be an issue.

> ***Extract 27**: Also we have **the challenge of the scans**. Some of us are **not trained** to do scans so **we depend on the doctors**. And some **doctors they may be very busy**, so we have to be patient and now we, also we have to be patient for the patient because some of them they are very in a hurry or maybe some are staying very far or even because eh like my facility we we accommodate farms [other nurse agreeing]. Some of them they are brought by their bosses and are given about two hours to do everything. So we have to have patience to talk to the doctor. Doctor, can you **please do for me this scan** because this client must go to the farm. She doesn't have transport. So that's a challenge.*
>
> *[Group discussion, 2020, lines 17–22]*

The participants in the above extracts indicate that abortion services are delayed for several reasons: not enough nurses being trained to do scans (extract 27), making them reliant on doctors; doctors not assisting in a timely fashion with conducting scans (extract 23 and 24) or with reporting a faulty scanner (extract 25); or instruments not working (extract 24). This only pushes an abortion seeker's gestation period further to a second trimester abortion, which would be harder to obtain. In extract 7, it was seen how a nurse going on leave can cause the clinic to close. In extract 26, it emerges that when a doctor is on leave, there is no one to do the scan, leading to the same consequence of no abortion service. The group discussant (in extract 27) seems very aware of the challenges faced by abortion seekers living on "farms" and shares how the impatience of "bosses" necessitates them almost pleading with doctors to assist with a scan, as providers sense the urgency of the service required. Other nurses nodding in agreement underline the fact that this is a common scenario.

These extracts under section 7.2 highlight several restrictions related to space, equipment and allocation of time to the service, while underscoring the difficulties with management and how their decisions regarding the functioning of the clinic directly impede access. It is vexing to note that an otherwise routine and safe procedure becomes more unattainable with each level of hierarchy in the clinical setting. These findings tie in with previous literature in South Africa that highlights the problems that nurses encounter when doctors are unwilling to assist (Amnesty International, 2017). Highlighted in this section are

the many ways in which management involvement in abortion service provision is at a bare minimum. Section 7.3.2 engages with instances of some supportive managers and the benefits of this assistance.

7.2.4 Abortion-Related Stigma

Abortion stigma is theorised as a social phenomenon that is locally created and exacerbated through different pathways (Kumar et al., 2009), which thus frames abortion stigma as a social process (Millar, 2020). The data that emerged in the previous sections of this chapter highlight several of these pathways such as the work setting with a lack of staff, space, equipment, and support from managers and doctors. In other words, abortion stigma both constructs and maintains an externally unsupported environment. Kumar et al. (2009) define abortion stigma as a negative quality attributed to an abortion seeker. Norris et al. (2011) assert that it can also affect doctors and nurses, and supporters of women who have undergone abortions (such as friends, family, advocates and researchers). The extracts I include below support these claims as they reveal abortion stigma experienced by individuals belonging to these three groups: abortion seekers, abortion providers, and supporters of abortion seekers.

Several of the participants referred to stigma faced by them and their clients, indicating their awareness and familiarity with this aspect, but also a helplessness and a stoic tone that often accompanies this topic.

> ***Extract 28:*** *No surprises noted. All the challenges are familiar and expected as we were told in TOP training e.g they will call you all sorts of names.*
> *[Casey, Reflective journal, 2021, p. 15]*

> ***Extract 29****: The stigma associated with CTOP makes it difficult for clients to come forward and ask for assistance as they fear to be judged.*
> *[Thato, Reflective journal, 2021, p. 16]*

In extract 28, Casey expresses *felt stigma* (described by Herek, 2009), which is a person's expectation that stigma will be enacted on them: "no surprises noted." Similarly, Thato (in extract 29), refers to this same form of stigma but from the perspective of an abortion seeker. Thato posits that a fear of judgement can be a hindrance for a client in accessing the service. Casey mentions that she was alerted to this aspect during her training, and hence she was prepared for these challenges. The fact that stigma is addressed in training shows the pervasiveness of felt stigma amongst abortion providers. In stating that the challenges were familiar, Casey implies that she *has* experienced name-calling and other difficulties (also known as *enacted stigma*, Herek, 2009), which is echoed in the extract below.

> ***Extract 30:*** *I am not the only one who volunteered herself [to] become CTOP provider (then* ***other colleagues called me killer****).*
>
> *[Iviwe, Reflective journal, 2021, p. 15]*

Despite bravely volunteering to become a provider, Iviwe experiences enacted stigma from other nurses. The word “killer” personifies the foetus, with the aim of inducing guilt in both the provider and seeker, simultaneously undermining reproductive justice. Extracts 28–30 all share a similar undertone of resignation.

The journal entry below is a reflection of my own felt stigma in working in this area of reproductive health over the past six years.

> ***Extract 31****: I’ve come to realise that when I’m asked about what my PhD is about, I reply with caution. I wonder what their stance on abortion is and then typically take on a legal and rights perspective. I launch into a rationale for my research. Is this necessary? And am I being defensive? Maybe both are true! Perhaps it is necessary to open up about this otherwise silenced topic. And I do need to defend my work. Also, it’s made me more considerate towards the plight of providers and what they undergo on a daily basis, though far worse.*
>
> *[Yamini, main course facilitator, Reflective journal, 2022]*

My thoughts relate to conversations with different people over time, their responses to my area of work, and my choices to either engage or not engage in various discussions. I realised that such exchanges took effort, were demanding – often weighted – and rarely easy. I put this down to stigma while acknowledging that my academic engagement with abortion is at the receiving end of only a fraction of the stigma experienced by abortion providers. I can, therefore, only imagine the impact of ongoing stigma on providers’ mental and physical health.

While it is necessary to prepare providers for the environment they will face (as stated by Casey in extract 28), it is equally important to work towards concurrently combatting this stigma using different strategies suggested by different authors (Ely, 2008; Mavuso & Macleod, 2019; Mavuso & Macleod, 2021). If not, the felt stigma very quickly becomes *internalised stigma* (Herek, 2009), which is when a person accepts the stigma as part of their understanding of themself. These self-concepts are further entrenched through cultural and social norms as can be seen in the following sub-sections, which comprise two broad themes. The first revolves around the belief that abortion is bad and, therefore, has consequences. The second comprises notions of a good woman and her duties and responsibilities in society.

7.2.4.1 Christianity, Culture and Cosmology

This sub-theme provides illustrations of how culture may be used in everyday interactions to induce shame and negative experiences. Echoing assertions by Macleod et al.

(2011), the extracts that follow indicate how culture becomes intertwined with African cosmology regarding the role of ancestors[67] and Christianity.

> ***Extract 32: Culturally**, I am aware that some of the **clients are binded [bound] by their culture** on not doing termination of pregnancy because **the ancestors will turn their** (ancestors) **back on them** (the clients) and that is believed to have experience some **bad luck**.*
>
> *[Nondumiso, Reflective journal, 2021, p. 16]*

> ***Extract 33:** The belief system differ across the cultural communities for an example if a client is terminating a pregnancy the belief is that the **ancestors will punish her**.*
>
> *[Ntombi, Reflective journal, 2021, p. 16]*

In extracts 32 and 33, the main view is that a woman who has an abortion will experience bad luck as an outcome of her ancestors turning their backs on her. Evident in these extracts are the ways in which ancestor worship stirs both respect and fear (Bogopa, 2010). The belief that the "ancestors will punish her" implies a need to be rebuked or penalised for committing an offense. In other words, an abortion is being referenced as a crime in cultural terms despite its liberally legal status in the country. Nondumiso's usage of the word "bind," in extract 32, reflects a constraint faced by abortion seekers. Restrictions are typically put in place for people to stay within a legal framework. However, here culture takes on a moral policing role that ironically contradicts the abortion law, thereby limiting access to the service. Religious norms serve in a similar way as indicated in the extracts below.

> ***Extract 34:** We all have different values and cultural backgrounds that develop our beliefs…other people still believe **abortion is killing a baby or human**, others, **because of religion believe it's a sin**.*
>
> *[Sethu, Reflective journal, 2021, p. 16]*

> ***Extract 35**: Some patients and colleagues are **against CTOP** because it is believed to be **against their cultural beliefs, some believe that it is a sin**.*
>
> *[Ziyanda, Reflective journal, 2021, p. 16]*

Having different cultural backgrounds and cultural beliefs is emphasised in these two extracts, while highlighting that abortion is viewed by "others" (extract 34) or "some" (extract 35) as a "sin." This underscores a religious view, which overlaps with Baloyi's (2012) stance (both referred to and critiqued in the literature review, see section 3.3.3), which mainly conceptualises abortion as a sin that negatively impacts the life of an abortion seeker and

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[67] Bogopa (2010) states that in South Africa, a central tenet to the world view for several cultural groups is the notion of ancestor worship. Viewed as the 'living dead,' ancestors are believed to play a pivotal role in influencing the lives of those alive, through blessings or curses.

those close to her. This premise places abortion in a negative light rather than being viewed as a reproductive right.

Extract 36 below shows how religion is put to work to underpin an overall discrediting and demeaning of abortion providers by other nurses in their facilities.

> ***Extract 36****: Most of the nurses have* ***negative attitude*** *towards CTOP and towards us as providers. They see the programme as* ***waste of time****, they* ***call us by names****, the other one even say did you go to school to do what you are doing,* ***how do you sleep at night, are you a Christian****, all those sorts of behaviours, but now when their relatives wants the programme that is then they realise how important and useful is the programme…Yes, most nurses always states that their* ***culture and religion does not allow them to work as CTOP providers****.*
>
> *[Faith, Reflective journal, 2020, pp. 5–6]*

> ***Extract 37****: She [manager] said to me, "no, they've come to do abortion so it's not [unclear]* ***you must leave them just like that****,* ***you must go to theatre and save lives*** *there in theatre instead of doing these people who have just come to abort.*
>
> *[Bonga, Interview post-ACCC 2020, pp. 12–13]*

In extract 36, abortion services are seen as a "waste of time" and in extract 37, the provider is told to "leave them just like that" (about abortion seekers) by her manager. Abortion does not seem to represent a legitimate medical procedure, especially when provided on request. This ties in with the scepticism suggested in the question (extract 36) about whether the providers were educated in providing abortion ("did you go to school to do what you are doing?"), essentially displaying disbelief that such training could form part of medical training.

Additionally, referring to abortion as a "waste of time" is an ironic way to describe a time-sensitive service: if anything, providing the service can save resources and time, when considering firstly, that second trimester abortions are offered in fewer clinics; and secondly, the possibility of sepsis in backstreet abortions and the added load that would have on the healthcare system. With abortion being viewed as "killing a baby or human" (extract 34), it is pitted against both "cultural beliefs" (extract 34) and the role of a nurse which is considered to "save lives" (extract 37), leading to an overall opposition to the service.

Faith complains that other nurses typically question the beliefs of providers ("are you a Christian?") and suggest that it must be difficult for providers to sleep without a clear conscience. A *moral surveillance* type of interaction style seen between medical practitioners and patients (identified by Nack, 2008) is also visible between non-abortion providers and abortion providers, as a means of enacted stigma (also seen in extract 30). Meanwhile, other nurses do not wish to join this area of work – as shared by Faith – due to the notion that their culture and religion come in the way. This finding aligns with previous research from two studies in particular: the first has shown stigma to be a barrier to participating in abortion

services on religious and moral grounds (Harries & Constant, 2020), and the second underscores how culture can function as a discursive resource to oppose abortion (Macleod et al., 2011). Yet, there is some hope, as Faith shares that when a relative of a non-provider nurse needs an abortion, that's when the usefulness of the programme is highlighted and possibly appreciated by others outside of service provision. This indicates that cultural ways of being are not static.

7.2.4.2 Performing Womanhood by Being Pregnant

A general view and concern that emerged in the data relates to the maintenance of womanhood and preserving the status quo when it comes to a woman's duties and responsibilities in society. Cis-[68] and mater-normative ideas of proper womanhood (as described by Mavuso & Macleod, 2021) typically position all abortion seekers as cisgendered women who are already mothers or who (should) desire motherhood, and so providers may try to direct their reproductive decisions. This, of course, goes against a client-centred counselling process that is client-led and curtails agentic decision-making for abortion seekers. These notions are held by providers and clients alike, as is seen in the following two extracts, which invariably feed abortion stigma making it increasingly difficult for women to access the service.

> ***Extract 38:***
> *Nurse Ruth: Mmm...tell me more*
> *Client: As a wife in our communities and family it is **expected of us** to have a lot of children, more than two. It is our **wifely duty** to expand the family of the in laws by having more children.*
>
> *[Ruth, Case presentation, 2021, p. 4]*
>
> ***Extract 39:*** *It is an **acceptable norm that a woman must bear/produce more children** until all eggs are finished (ovum). Having said that, knowing the cultural context of **the communities we serve** allows us to be sensitive in dealing with issues on the ground.*
>
> *[Ntombi, Reflective journal, 2021, p. 16]*

Ruth's client in extract 38 shares her fears about the many expectations placed on her from not just her husband but her in-laws as well. She speaks of her duty to produce children within a conjugal union that, in this context, sees married women as subservient to the in-law family. Within a patriarchal narrative that normalises women's obligations to expand a family,

[68] Cis-normativity normalises and privileges persons who identify with the gender they were assigned to at birth while viewing this assumption as natural (Robinson, 2022).

an abortion serves as an incident that disrupts and disregards the “natural” flow of progression. Abortion is seen as an act visibly offensive to the societal norms of motherhood (Bloomer et al., 2023). Women who abort are cast as “deviant” from the norm and subsequently linked to a list of undesirable characteristics that create said stigma (Kumar et al., 2009).

In extract 39, Ntombi confirms that for a woman to bear many children is an accepted norm. This aligns with Nandy’s (2017) description of mater-normativity, which is the dominant conceptualisation of an ideal woman as a mother – becoming a mother is both expected and accepted. Ntombi’s assertion “until all eggs are finished” portrays an image of a machine that is expected to churn out as many products until it no longer can.

In both extracts, a woman lacks voice and choice and is referred to only in relation to the family she is part of, and what she can do to serve and fulfil the wishes of her community, which includes her ancestors. This ties in with one of the key discourses identified in Ngqangweni’s (2014) research that identified a familial (or *ukwenda*) norm prevalent in the AmaXhosa[69] culture, which is based on the idea that a woman is "married to the household” and this includes the immediate family, the extended family and the ancestors. This narrative clearly plays out in extracts 38 and 39, with strong connotations of a woman’s obligation and duty to “have a lot of children” and “expand the family” (extract 38) and “produce more children” (extract 39).

There is a pressure to perform womanhood by being pregnant, and hence an abortion is shrouded in secrecy due to the implications of not meeting such expectations. In fact, in cases that end in abortion, being pregnant also needs to be kept under wraps.

> ***Extract 40****: She [the client] feels relieved about her decision [to have an abortion] she’ll be able to sleep tonight because before she come for abortion she was stressed and was worried about her sister and other people in the community where she lives they’ll notice her pregnancy.*
>
> *[Sethu, Case presentation, 2021, p. 2]*

In extract 40, it is indicated how an abortion seeker wishes for both the pregnancy and the abortion to go unnoticed. It is unclear exactly why she wishes for people in her community to *not* know of her pregnancy. It could either relate to stigma associated with having an abortion, or to falling pregnant,[70] depending on her age and social location. Essentially, she

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[69] AmaXhosa are Xhosa-speaking people who are an ethnic group native to the Eastern Cape in South Africa.

[70] I acknowledge Kumar’s (2013) caution against grouping abortion stigma with stigma related to unwanted or mistimed pregnancies as it may limit the ways in which interventions are designed to combat abortion stigma. My focus in analysing extract 36 is thus on abortion-related stigma.

expects to be judged for both occurrences, and anticipates that if community members find out she was pregnant and aborted, her actions will not be condoned. A study in southern Cameroon found that although condemned in society, there is greater tolerance for abortion than a mistimed pregnancy, meaning that an abortion carries less shame than an early entry into motherhood (Johnson-Hanks, 2002).

Interestingly, the client shares her relief emphasising that she will be able to sleep at night. The former likely stems from having had the procedure and having avoided stigma. The latter lies in contrast to the sentiment in extract 36 that questions how providers actually sleep at night. It also challenges previous research that only highlights negative emotional and mental outcomes of abortion on the abortion seeker. Extract 40 indicates a client content with her decision and happy with the outcome. In fact, the only aspect that was stressful related to stigma and what others would say or think about her. The extracts also reveal an element of fear being instilled, as can be seen in the phrases “fear to be judged” (extract 29), “bad luck” (extract 32), “punish her” (extract 33), and “stressed” and “worried” (extract 40).

Prior literature has highlighted that two characteristic demonstrations of internalised abortion stigma are guilt and shame (Kumar et al., 2009), and the extracts in this section portray how cultural, ancestral, religious and familial narratives function to induce these feelings in abortion seekers and providers. Bloomer et al. (2017) showed that adult abortion education in community settings could generate resistance to anti-abortion norms and silencing through the creation of dialogical spaces. The ACCC offered such a space to providers, yet most (if not all) of their communities, have yet to engage in such workshops.

7.2.5 “Failure” of Repeat Abortions and Contraceptive Uptake: Providers’ Conundrums

In clinics and provincial hospitals, there is a push for contraceptive roll-out and emphasis on record-keeping related to the number of abortions conducted. This was indicated in section 7.2.3.1 related to supervisors and stats. Many providers, thus, end up as gatekeepers for abortion services, more so when a client requests one for the second or third time. The extracts below convey this argument.

> ***Extract 41****: I noticed that some of my colleagues do* ***have a problem or question the decisions*** *of client when they come for* ***CTOP more than once****.*
> *[Ruth, Reflective journal, 2021, p. 16]*

> ***Extract 42:*** *I was* ***surprised*** *that there are* ***still providers*** *who* ***deny woman CTOP services*** *just because* ***they have done it before.***
> *[Zintle, Reflective journal, 2021, p. 24]*

In the case of a returning abortion seeker, Ruth (extract 41) observes that some of her colleagues question and problematise this trend, while Zintle (extract 42) expresses being surprised by the fact that some of her colleagues refuse to provide the service altogether. This is an unequivocal denial of a reproductive right, given that the only apparent reason is that it is a second abortion. The time frame of Zintle's reflections relate to a fieldwork journal entry, indicating that she had already attended the training course and was attuned to both client-centred and reproductive justice principles. This may explain her "surprise" that there are "still providers" who deny clients access. While this analysis underscores the value of such training in improving access, it also highlights decisions made at an institutional level that inevitably places pressure on providers, as is evidenced in the extracts below:

> ***Extract 43:*** *I was just surprised that there are* ***facilities that don't allow client to do TOP for the second time.***
>
> *[Casey, Reflective journal, 2021, p. 16]*

> ***Extract 44****: And also, they are now saying, it seems like they are now spending more money on me, on the pills that I use. So, I must try to* ***minimize the people coming in for TOP*** *of which I don't understand cause now, they are saying if someone is coming for the* ***second or third time, I shouldn't do it*** *yet. The record when I was practicing this, they were saying they can do as much as they want. So, I don't understand how I'm going to go about it.*
>
> *[Thandi, Interview post-ACCC 2020, p. 2]*

Casey (extract 43) is surprised by the fact that "facilities" do not allow a client to have a second abortion. Providers problematise, question, and deny access (as seen in extracts 41 and 42) most likely because they are following instructions given by their supervisors. Extract 44 is taken from Thandi's two-month follow-up interview with Laurah (co-researcher), demonstrating her attempt to utilise the learnings from the course and the subsequent challenges she faced in implementing them. Her managers note that more money is being spent on abortion services due to an increase in the usage of pills that induce abortion. She is instructed by them to "try to minimize the people coming for TOP" (likely by promoting contraceptive use), and to withhold abortion services if a patient returns for a second or third time. Unfortunately, denying an abortion may paradoxically increase the burden on the public health system. Thandi then refers to her "records" (presumably training course notes) as she recollects hearing that a client may "do as much as they want." The principles of client-centred and reproductive justice approaches to women's health are juxtaposed against the directives received from her facility supervisor, leaving her confused.

The confusion due to external pressure is compounded by an internal conflict for many providers as revealed in the following data extracts.

> ***Extract 45**: [Eh] we talked about the **cases where people come now and again, now and again**. I also **don't force them to use contraceptive**, if they don't want to use them I don't give to them, but I think I should have more time with them to…like to discuss about everything and the CTOP because I think **that part I'm not doing it well that's why they coming now and then**, now and then, because I had a client today whose coming for the third time for CTOP.*
>
> *[Group discussion, 2020, lines 45–50]*

> ***Extract 46**: After seeing that it was her **I got angry** and **chased her out** of my office. I **felt like a failure** or am **not health educating properly**. This client did TOP in 05/2019 again 05/2020 and now. To me it felt like **she is using TOP as a contraceptive method** because the last time she did TOP she promised to come back at 6 weeks to insert loop. I called her back after I was fine.*
>
> *[Thandi, Case presentation, 2020, p. 1]*

> ***Extract 47**: There are **some hiccups** whereby now as you taught us that the client, we **mustn't chase them away** when they come back for termination for the second or third time. Now what I've noticed the **clients didn't want to use contraceptives, they want abortion**. And **I don't want to lie** Laurah, **it's frustrating** because these clients some of them are 13 years, 12 years, they came in December now they came again. So **that is my big problem** that I have noticed. I cannot do anything. **I have to do this abortion as long as she wishes**.*
>
> *[Nandi, Interview post-ACCC 2020, p. 9]*

Extracts 45–47 illuminate providers' own frustrations about repeat abortion clients. Although there are distinct institutional demands made on them, the sentiments conveyed in these extracts highlight feelings of discontent experienced at an intrapersonal level. In extract 45, the group concurs that cases of repeat abortions ("come now and again, now and again") are a common scenario they face. The discussant in extract 45 shares that although she does not force contraceptives on her client, she wishes she had more time with each client. She reckons that if she did "that part" better – convince a client to accept a contraceptive – she could help prevent an unplanned pregnancy.

In extract 46, Thandi describes her anger and sense of failure at a client returning for a third abortion. Where the success of pre-abortion counselling may be measured by abortion seekers not returning for another abortion (Mavuso & Macleod, 2021), the return of a client may likely point to feelings of "failure." Thandi voices self-doubt at her own ability to educate the client "properly." When her client failed to return for contraception after six weeks, Thandi suspected that the client was "using TOP as a contraceptive method." This is a commonly held notion in public health facilities (see Röhrs, 2017) and is also voiced by Nandi (in extract 47), who asserts that clients "didn't want to use contraceptives, they want abortions." After attending the ACCC course, it appears that some "hiccups" arose in Nandi's previous strategy of "chas[ing] them away," in cases of repeat abortion clients, as she is now cognisant of this action being a barrier to access. She describes this issue as "my big problem" and expresses

frustration (especially since some of her clients are 12 and 13 years old) and helplessness (she shares that she "cannot do anything") but has to provide the abortion.

In extracts 45 and 46, the root of the problem is internalised as providers feel personally responsible for not convincing a client to accept a contraceptive (extract 45) or not educating a client well enough (extract 46). Furthermore, in extracts 46 and 47, providers feel torn between refusing the service ("chased her out," "chase them away") versus offering it again for "as long as she wishes." This sentiment is encapsulated in what Peter identified as his challenge in implementing the learnings from the course during his fieldwork. He stated "my personal judgement vs my career responsibility" [Peter, Feedback form 2, 2020, p. 22] thereby suggesting two opposing or conflicting motives. This links with previous research findings where participants' personal norms are in opposition to CTOP stipulations (Hodes, 2016; Röhrs, 2017). Röhrs (2017) asserts that nurses' moral judgment of abortion services can lead them to classify clients into one of two groups - those worthy or unworthy of support, which then almost necessitates a client to justify their abortion. Based on the literature and findings, clients who use abortion as a contraceptive method, who return for a second abortion, and who are younger in age are likely to be viewed as less worthy of the service. This contradicts the rights-based framework revealing how personal norms can negatively influence abortion-service provision.

For several other providers, their anticipated challenges related mostly to contraceptive uptake.

> ***Extract 48****: The challenging aspect is the part of the client leaving without contraceptive after termination of pregnancy.*
>
> *[Beauty, Reflective journal, 2020, p. 4]*

> ***Extract 49****: That the client will forget to use any contraceptive to prevent unplanned pregnancies.*
>
> *[No name, Feedback form 1, 2021, p. 1]*

Extracts 48 and 49 highlight a key concern for providers, which is a client refusing a contraceptive. There is an overlap with previous findings suggesting that nurses do get cross and frustrated with clients who return for repeat abortions, and expect that responsible women would use contraceptives (Röhrs, 2017). Providers have an added responsibility of providing contraceptive statistics to their managers (see extracts 20 and 22); hence, they find it challenging when a client leaves the facility after an abortion without a contraceptive (extract 48). As providers fear that a client will "forget to use" (extract 49) a contraceptive, they see the next best option as ensuring that some form of contraceptive is administered to a client before she leaves the facility. They view this as a preventative solution, within their control, to prevent an unplanned pregnancy that may end in another abortion.

Learnings from the course seem to have dually created and partially resolved the predicament. The extracts below indicate how some providers reconciled this struggle:

> ***Extract 50****: The session ended well, [and] the client reported that she is happy that she is getting help.* ***I was not comfortable with her decision about the contraception,*** *[she just wanted to finish the procedure and then afterwards she would go to the clinic for contraceptives] but I had to respect her decision. A**t least she was not saying she is not going to take contraceptives at all** Her follow up after a week for scan, she came back after a week. I asked how is she feeling after the procedure, she said she is happy that it's all over and the scan showed her uterus is now empty. I was happy that she said she decided to take oral contraceptives.* ***I find the contraception part challenging*** *because I am used to offer [it] and then the client will decide, the same time, what type she is using, and not leave the facility without getting contraception. I did well on respecting her decision. I didn't enforce her on taking contraception.*
>
> *[Casey, Case presentation, 2021, p. 1]*

> *Extract 51: After giving them the care I used to force them with contraceptives of which I learn is their right to use contraceptives or not, my duty is to counsel them in a way that they must see the difference and make their informed choices.*
>
> *[Jane, Reflective journal, 2020, p. 6]*

In essence, providers dread clients leaving without contraception and returning for another abortion. Within the constraints of being short-staffed and over-worked, repeat abortion clients can seem unwarranted and preventable, from their perspective. As Casey states (extract 50), she "is used to" offering contraceptives at "the same time" (as the abortion) and the client does "not leave the facility without getting contraceptive." But forcing contraception goes against bodily integrity, while undermining a reproductive right. In extract 50, the client left without a contraceptive. Nevertheless, the client reported being happy with the service and returned for her scan, and at that stage agreed to take an oral contraceptive. In this case, the positive relationship built in the first interaction clearly enabled the client to return and accept a contraceptive method, without the provider needing to "enforce" it. As suggested by Jane, in extract 51, one way to navigate this challenge is to counsel clients in a way that the client can make an informed decision without coercion.

Conversely, respecting a client's choice about whether they wish to receive contraceptive information does not always have the outcomes anticipated by providers, their managers, and the public health system.

> ***Extract 52****: We used to force them to take contraceptives neh [right]. But now after the course if the client wished to get contraceptive, we don't ask them now.* ***It's their right to have it and it their right not to have it*** *as long as we have talked about the contraceptive because as a TOP provider, I have to give them the options of contraceptive to choose from. So,* ***it's their choice to choose****. Most of them just*

> *say* ***ohh sister I will come back but you find that they come back again pregnant****.*
>
> *[Nandi, Interview post-ACCC 2020, p. 9]*

In extract 52, Nandi conveys that contraceptives are no longer forced on the client and a client receives it only if they wish for it and choose it. She reflects on how several clients claim that they will return for contraceptives only to find them returning pregnant, much to her dismay. Indeed, several women in South Africa are unable to make decisions about their use of contraceptives due to gendered power dynamics (Varga, 2004). Additionally, du Toit and Macleod (2025) assert the need for providers to fully understand the complexities of contraceptive usage ranging from structural hurdles to familial pressures to personal health issues (such as contraceptive side effects or mental health problems).

However, the incessant nature of this problem does seem to result in a need to place the blame somewhere, and no one is spared. Many providers deem themselves at fault for not educating a client well, managers for their lack of support towards the programme, clients for refusing contraceptives, and even the ACCC course facilitators for not viewing the problem from their lens.

> ***Extract 53****: I assumed that the psychologists will ask us why are we correcting other's mistakes by performing TOP, and I believe that the* ***psychologists fail to understand*** *that we as nurses need to give full information and be transparent when giving information.*
>
> *[Nondumiso, Reflective journal, 2021, p. 18]*

In extract 53, the frustration and possible anger that Nondumiso experiences is conveyed in the tone of her message. She refers to unplanned pregnancies as “mistakes” and the act of providing an abortion as “correcting other's mistakes”. While providers seem to feel like a failure when a client returns for a repeat abortion, Nondumiso asserts that the psychologists (course facilitators) fail to understand the need to be open with clients and provide them with adequate information. What she means by “full information” is unclear though it may well include enough information to convince a woman to agree to contraception, thereby preventing another abortion.

My own failure to account fully for the nurses' contextual realities offers a valuable insight, prompting a reconsideration of how this element is addressed in the course – one that fully acknowledges the complexity and gravity of this situation, including the intrapersonal and interpersonal tensions between supervisors and providers, all within the constraints of a strained healthcare system. I engage with this further in the course refinement section in the next chapter.

7.3 External Elements Enabling Reproductive Justice

After examining in detail the elements that hinder reproductive justice, it is equally important to identify the elements that enable nurses in their roles as abortion providers, and to recognise how these contribute to service provision and accessibility. They include the following: evidence-based research that asserts abortion as a safe medical procedure when done in a legally sanctioned setting; support from clinic supervisors, managers and other providers as a means to counter various challenges in the work setting; spaces that help alleviate providers' stressors; and South Africa's legal framework that safeguards reproductive rights.

7.3.1 Abortion as a Common and Safe Medical Procedure

The idea of abortion as a routine and medically safe procedure is not a commonly heard narrative. Instead, a misinformed overemphasis on the risks, with the intent of dissuading a client from seeking the procedure, is discernible (as seen in the baseline research). The following extracts demonstrate how a matter-of-fact explanation of abortion by providers, along with the availability of tools and medication, make the abortion process a smooth and easy one:

> ***Extract 54****: For surgical abortion MVA (manual vacuum aspiration) has* ***a success rate of 98%*** *with* ***only a 2% rate of complications****.* ***Pain management is also available at our hospital*** *e.g. ibuprofen, diclofenac & paracetamol client can also use nonpharmacological approaches such as hot water bottle to treat pain…I further emphasised that* ***medical abortion is generally a very safe procedure****.*
>
> *[Phillani, Case presentation, 2021, p. 3]*

> ***Extract 55:*** *The procedure itself i.e. manual* ***abortion no one has ever come back septic ever since I became a provider*** *from November 2019.*
>
> *[Bonga, Reflective journal, 2020, p. 2]*

The providers in extracts 54 and 55 both emphasise the safety of a medical/surgical abortion conducted at a health facility. Phillani draws on his statistical knowledge of the procedure's high success rates, while Bonga draws on her applied experience, having encountered no complications since she became an abortion provider. Additionally, in extract 54, Phillani is able to offer a variety of pain medications to his client only because they are available at his facility.

The following two extracts highlight that the availability of resources enables providers to offer assurance with confidence and sincerity.

> ***Extract 56:*** *[Client] expressed that she was afraid of pain and* ***was reassured that she was going to be given analgesics and antibiotics.***
>
> *[Ntombi, Case presentation, 2021, p. 2]*

> ***Extract 57****: I informed the client that* ***safe instruments are used and in our facility, abortion is legal, medically safe*** *and that it won't affect-her fertility in future…Assuring the client and giving information when client is asking about future fertility that termination of pregnancy is safe and safe medically,* ***equipment that is safe is used****.*
>
> *[Sethu, Case presentation, 2021, pp. 1–3]*

Ntombi (extract 56) is able to reassure her client – who expresses a fear of pain – that she will receive analgesics pre-procedure to manage pain, and antibiotics afterward to prevent infection. Sadly, the availability of medication is not always a given, as Nandi too had alerted Laurah to their ongoing challenges due to unavailability of Petogen, stating “It’s a problem everywhere” [Nandi, Interview post-ACCC 2020, p. 10]. In a similar vein, the availability of instruments cannot be taken for granted. Sethu (extract 57) reassures her client by emphasising the safety of the instruments and equipment used, while highlighting the legality of the procedure. The key finding in these extracts is that the safety of an abortion procedure is enabled and assured by the availability of medications and medically safe equipment.

7.3.2 Instrumental Support from Managers and Other Providers

A few of the participants shared having supportive managers. This was an encouraging but uncommon description of the working relationship (following the findings in section 7.2.3) with clinic supervisors. The ways in which service delivery changes as an outcome of a supportive manager are noteworthy.

> ***Extract 58****: At my workplace they [managers] try by all means that* ***I must get the equipment that is needed for CTOP****, and* ***they do offer space*** *for me to do counselling, so that my clients are confident in me when I am providing the counselling sessions. T****hey also recruit more nursing staff*** *to [who would] find it in their hearts [to become providers and make them see] that CTOP is not a bad programme, they must apply for the training.*
>
> *[Nondumiso, Reflective journal, 2021, p. 24]*

> ***Extract 59****: My manager is so supportive like, very supportive. As a result, I had a query because* ***I was short-staffed****. So, on the coming change-over in April,* ***I will be getting a sister and also a staff nurse****.*
>
> *[Nandi, Interview post-ACCC 2020, p. 10]*

In extracts 58 and 59, both providers refer to the assistance they receive from managers, and the benefits are clearly visible. Nondumiso’s supervisor (extract 58) ensures that she has a physical space to counsel her clients. This likely enables an intimate counselling interaction affording privacy and confidentiality which, as she observes, immediately instils a

sense of confidence in her clients. Once again, this availability of space is juxtaposed against the findings in section 7.2.2 where a lack of a designated space can lead to the service being shut down. Moreover, there appears to be a plan to recruit and train more nursing staff, as Nondumiso implores for more staff to appreciate this service as "CTOP is not a bad programme." In extract 59, Nandi requested assistance due to being short-staffed. Having a supportive manager enabled the recruitment of not one, but two additional staff members.

In addition to managerial support, peer support holds equal value, and the extracts below showcase the different ways in which providers help other providers.

> ***Extract 60****: Also, when it comes to infrastructure we support each other by* ***giving each other work instruments****.*
>
> *[Thato, Reflective journal, 2021, p. 20]*

> ***Extract 61****: When I'm experiencing problems, Sr. Mary's door always open for me* ***to guide and even to educate me more*** *and support.*
>
> *[Jane, Reflective journal, 2020, p. 2]*

In extract 60, Thato received tangible support in the form of equipment from another provider. In extract 61, Jane received information support from a senior nurse, Sr. Mary, who had initially trained her to be a provider. A fellow-provider at the same facility keeping their door open creates an amicable and supportive working relationship. This setting serves to educate but also likely lessens the isolation commonly experienced by abortion providers (Harries et al., 2009; Teffo & Rispel, 2017). While a lack of resources such as equipment, medication and sterile packs (see extract 15) directly disrupts services, the availability of all of these together enables providers to guarantee quality services.

7.3.3 Reducing and Combatting Stressors

The participants shared how they managed some of the challenges identified in this chapter; these may be a useful starting point when considering recommendations at the end of this project.

> ***Extract 62****: VCAT[71] helped me to deal with those challenges.*
>
> *[Lilly, Reflective journal, 2020, p. 2]*

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[71] The Values Clarification for Abortion Attitude Transformation (VCAT) process and toolkit was designed by Ipas (a global NGO) as a workshop to help foster support, acceptance, and advocacy in participants towards comprehensive abortion care. The workshop aims to help healthcare providers explore, interrogate, and clarify their personal beliefs and values surrounding abortion with the intention to increase awareness and comfort in client-centred abortion care (Turner & Page, 2008).

> ***Extract 63****: Seek psychotherapy intervention when experiencing burnout in the working environment in particular abortion environment.*
>
> *[Ntombi, Reflective journal, 2021, p. 23]*

Lilly (extract 62) credits the values clarification for abortion attitude transformation (VCAT) workshop with managing “those challenges” tied to the cultural context in which she works. Ntombi (extract 63) attributes “burnout” to multiple challenges such as limited space, staff shortages, lack of support, and stigma, sharing that therapy can be beneficial in alleviating distress. These two options are most certainly effective strategies for providers, when accessible. However, these appear to be band-aid fixes that target the symptom.

A systemic approach to overcoming these challenges are interventions at the source, such as recruiting more nursing staff and facilitating workshops to combat stigma in clinics and communities.

> ***Extract 64****: No major challenges because in my facility we don’t have lots of numbers (clients) so I am able to provide individual counselling and concentrate to 1 client.*
>
> *[Casey, Reflective journal, 2021, p. 17]*

In extract 64, Casey shares that she does not experience any major difficulties, which is a refreshing outlook in comparison to the many grievances expressed in this chapter. It is unclear what leads to lower numbers of clients at her facility; however, she is able to focus individually on each client while experiencing all other challenges as minor.

7.3.4 The Deployment of Reproductive Rights and Justice

Several extracts highlighted support for women’s choice and abortion as a reproductive right, showcasing how the CTOP Act can benefit not only abortion seekers but also abortion providers, depending on how it is used.

> ***Extract 65:*** *I ensure confidentiality, I then explain to the client that it is* ***her right to terminate pregnancy in South Africa Act No 92 of 1996.***
>
> *[Phillani, Case presentation, 2021, p. 3]*

> ***Extract 66:*** *Reminded Her that It is Her right to decide* ***if and when*** *to become pregnant and* ***weather she wants to continue or terminate her pregnancy****.*
>
> *[Ziyanda, Case presentation, 2021, p. 6]*

> ***Extract 67: The choice of abortion (CTOP Act, No. 92 of 1996) legalises termination of pregnancy*** *and it is* ***her choice and her right****…never forget that it is your reproductive right to have an abortion.*
>
> *[Ruth, Case presentation, 2021, p. 1–5]*

All the providers featured in extracts 65–67 refer to the CTOP Act as one that affords the client choice and rights. The tone in the extracts is explicit. It seeks to uphold the dignity of the clients and provide assurance by explaining (extract 65) and reminding (extract 66) the clients to "never forget that it is your reproductive right" (extract 67) to have an abortion. The confidence with which the providers engage with their clients around their (the clients') rights would most certainly influence the interaction while promoting client-centred counselling. Additionally, reference is made to reproductive justice principles when Ziyanda (extract 66) asserts that it is a client's right to decide "if and when" to become pregnant.

These excerpts are all taken from participants' case presentations, which took place at the end of the training course. Having trained in abortion service provision, all of them would have been well-versed with the Act's stipulations from the outset. Yet, the concept of rights did not emerge in any of the initial group discussions. Instead, the focus was on their more challenging cases, problems with clients, and other shared difficulties. Reproductive rights discourses began to surface in their discussions and reflections only later in the training, as a technique that enabled client-centred counselling. For several providers, adopting a language of choice and rights also led to the realisation that these two aspects do not equate to access, as seen in the extracts below:

> ***Extract 68****: I think I am violating client's right to abortion, as for government assistance, I will introduce the client and her baby to poverty because the government's assistance will not be enough to provide for the child because there are many children depending on government's assistance.*
>
> *[Nondumiso, Reflective journal, 2021, p. 21].*

> ***Extract 69****: The legalisation of abortion gave the women choices to do CTOP but not justice. Because some women in the* ***lower class*** *or for example in the* ***rural areas*** *have the choice to do CTOP but may* ***struggle to access the services eg long distances to travel, no money, no food****.*
>
> *[Phillani, Reflective journal, 2021, p. 18]*

> ***Extract 70:*** *The women still experience* ***challenges in accessing the TOP in our facilities due to infrastructure, less personnel providing the service, less facilities providing the services,*** *it might be legal in SA but women are still having challenges. Especially if they are second trimester there are only* ***2 hospitals in Eastern Cape doing second trimester.***
>
> *[Casey, Reflective journal, 2021, p. 18]*

In extract 68, Nondumiso displays an understanding of the challenges in carrying an unwanted pregnancy to term, showing sensitivity to the social location and context of her client. In extracts 68 and 70, an understanding of reproductive justice emerges, which inevitably leads to a growing empathy among providers and a need to protect clients' rights and advocate for their choices. Phillani (extract 69) also acknowledges the social location of

clients, recognising that limited access to transport facilities, money and food can make it extremely challenging for clients to access clinics. Casey (extract 70) emphasises the challenges created by infrastructural constraints and staff shortages, compounded by the fact that only two facilities offer second trimester abortion services.

Although intersectionality was *not* theorised during the training, participants' journals revealed the relevance of inequalities amongst women and the impact of social isolation on access to services (highlighted in bold text in the extracts). Providers' understanding of how reproductive justice extends the rights framework to improve access may thus be viewed as an enabling factor that promotes client-centred abortion services.

7.4 Conclusion

This chapter shone light on the different challenges faced by providers in delivering quality abortion services. These points are not new and merely support existing literature on staff shortages, infrastructural challenges, stigma, and adversarial interpersonal dynamics with other staff, doctors, and unsupportive managers. In addition, culture, religion and notions of motherhood feed abortion stigma. Within the constraints of their work environment, providers are left conflicted between feminist ideologies that advocate for women's reproductive rights and concerns about "repeat abortions" with low contraceptive uptake by clients. Despite these hurdles, there are visible instances of camaraderie between providers (as brothers and sisters who support each other), as well as ways they mitigate stress, and new narratives they use to frame abortion.

CHAPTER EIGHT: INTERNAL ELEMENTS ENABLING AND HINDERING ABORTION SERVICE PROVISION

8.1 Identifying Internal Aspects

This third and final analytical chapter engages with my last research question, which is: What elements, internal to the course, are identified as enabling or hindering nurses' skills in providing abortion services based on reproductive justice principles? It provides a glimpse into the role of action research in developing the course to support its overall goal of improving abortion access.

Sections 8.2 and 8.3 in this chapter highlight elements within the course that were identified as fostering nurses' abilities to provide client-centred abortion counselling while drawing on reproductive justice principles. The themes that developed point to aspects that were specifically conducive to learning while strengthening providers' approach to and investment in abortion work. The extracts showcase the ways in which participants demonstrated their deepened engagement and intention to be promoters of women's reproductive health services. Section 8.4 uncovers course elements that restricted providers' engagement with the course and therefore limited their adoption of client-centred counselling skills. This section lends itself to considerations for improvements made feasible by action research's focus on refinement and change.

8.2 Facilitating Changes in Abortion Practices

The providers identified several elements of the course that they found useful for various reasons. ACCC 2020 and ACCC 2021 were conducted using different formats; the former was conducted online, and the latter was conducted face-to-face (FTF). It was expected that each course would present distinct advantages and limitations. The four sub-sections in this section address both courses, revealing that regardless of the format, several objectives were achieved. The sub-themes illuminate specific features of the course, namely: a WhatsApp group created for the participants of each course; the theoretical approach to the course; certificates and praise received as an outcome of comprehensive participation in the course; and course material that worked favourably to achieve the course goals while being steered by action research methods.

8.2.1 Buddy System: Informational and Emotional Support

A WhatsApp group was set up for the course participants on day one of each training course. The reasons for creating the groups were twofold: firstly, so that I could communicate with the group and clarify their doubts, and secondly, for the participants to connect with each other during the course, with the hope that it would extend into their fieldwork. The participants unanimously acknowledged its usefulness as a support buddy system. In both courses, providers independently created their own WhatsApp group (one without me) as a space to engage on matters unrelated to the course but likely connected to professional roles as providers. This set-up proved beneficial and the extracts below demonstrate the different ways in which these WhatsApp groups served them:

> ***Extract 1****: I contact my colleagues by phoning them or via WhatsApp if it's something* ***I'm not clear on****.*
>
> *[Sethu, Reflective journal, 2021, p. 20]*

> ***Extract 2****: Support buddy system* ***boost our strength*** *in working environment.*
>
> *[Jane, Feedback form 2, 2020, p. 21]*

In extract 1, Sethu explains that she connects with other providers via phone calls or messages, and implies that her primary usage of these interactions is as an information resource for clarification. In extract 2, Jane reports that the support buddy system works to boost "our" strength, including not just herself but all the other providers too. Here, "strength" is more likely to refer to mental strength or self-esteem rather than physical strength, thus referring to the *WhatsApp group support buddy* element as a means of mental health support. Furthermore, when Lilly shared that the support buddy group "boosts our morale and quality of work," [Lilly, Feedback form 2, 2020, p. 21] she underlines how an improved psychological state contributes to improved work performance, and thus improved services.

In the two extracts below, we also see how informational and emotional support effortlessly merge, leading to an overall sense and approval of social support amongst providers.

> ***Extract 3****: Buddy system is* ***very useful and very good****. There are sometimes days that you are dull and [inaudible] as the provider. By having buddy system, you can be able to* ***share whatever burden*** *you have for* ***support and encouragement****. Also, buddy system assist when you want some* ***advice and clarity*** *about something that you don't understand.*
>
> *[Faith, Reflective journal, 2020, p. 15]*

> ***Extract 4**: It is **very helpful**, when **I need some clarity** on something my colleagues are always there to **support** and I also do the same, **sharing what I know** with them. It's either I call or WhatsApp but it is **very helpful**.*
>
> *[Ziyanda, Reflective journal, 2021, p. 20]*

Faith (extract 3) reflects on the uplifting support and encouragement she receives from other providers on challenging days when she feels dull or burdened. The feeling of isolation experienced and voiced by many providers is thus alleviated due to the support buddy system. She reaches out on the group when in doubt or for advice, highlighting the dual purpose it serves. Ziyanda (extract 4), too, indicates how useful the other providers are when she lacks clarity on any issue. She alludes to this system as a "very helpful" two-way process of offering and receiving assistance. Faith expected that the support buddy system would "also help for future purposes" [Faith, Feedback form 2, 2020, p. 21]. It does, therefore, appear that the WhatsApp groups formed during the training courses certainly extended into their fieldwork component, with an intention to retain the connection post-fieldwork as well. The support system functioned by encouraging communication and, in doing so, decreasing the level of isolation experienced by providers (often the sole provider in their facility and facing stigma from non-provider staff). Beauty affirmed that "knowing that you have support from someone helps a lot," [Beauty, Feedback form 2, 2020, p. 21] which highlights the importance of *perceived support,* whether or not a provider actually reaches out for assistance. Simply knowing that she is not alone is, in itself, a comforting thought.

8.2.2 Critical Health Psychology Approach in Training

All participants acknowledged the training course as beneficial to their skill development. While they commended specific aspects that stood out to them, they also emphasised the importance of this type of training, and its particular relevance to their line of work.

> ***Extract 5**: I feel that TOP does provide a different approach to nursing as a whole because of **the support we get from academics** like you, **from NGO's** like SRJSC and more like IPAS. It's **so informative, so inspiring** because you **get to meet scholars, you get to meet researchers**, and that helps because this is a direction that we all want to take in nursing where we have nurses that are researchers, you know, that are open-minded and that can be able to **solve problems using empirical and academic efforts**.*
>
> *[Peter, Interview post-ACCC 2020, p. 8]*

> ***Extract 6**: To be able **to correlate theory with practical** on the ground by assimilating all the presentations and by imagination.*
>
> *[Ntombi, Reflective journal, 2021, p. 18].*

In extracts 5 and 6, participants refer to the underpinnings of a critical health approach in psychology that uses (a form of) action research to pursue transformation and change (Chamberlain & Murray, 2009). Peter, in extract 5, appreciates the combined effort of academics, NGOs, and scholars in abortion-related work, stating that this involvement is both "informative" and "inspiring." For him, the idea of nurses as researchers is compelling, and aligns with DENOSA's (Democratic Nursing Organisation of South Africa) position statement on nursing research, which advocates for strengthening research within the nursing curriculum as an integral part of professional development. DENOSA maintains that since nurses constitute a significant portion of South Africa's health workforce and operate across all areas of care, they are uniquely positioned to contribute to wider research through collaborative work. This ties in with Peter's appreciation for the collective support he has received via this training course as well as from other stakeholders (such as IPAS and SRJC). His gratitude for empirical and academic efforts is shared by Ntombi, in extract 6, who emphasises the value of connecting theory (presented during the course via presentations) to their clinical practice. This reflection links to previous research highlighting the role of action research methodology in bridging the gap between theory and practice (Munten et al., 2010).

The critical health approach also served to counter abortion stigma as identified by participants in the courses.

> ***Extract 7****: It is more interesting because we get to discuss and share knowledge and experience. It makes you* ***understand much better what our women go through in their communities****, it is more* ***equipping and encouraging*** *so that we can* ***provide better services*** *in our respective communities, you get to* ***ask question*** *if you don't understand.*
>
> *[Ziyanda, Reflective journal, 2021, p. 19]*

> ***Extract 8****: The fact that termination of pregnancy is* ***no more stigmatized*** *because today we are having some short courses that are specifically directed at* ***empowering the health providers****.*
>
> *[Ntombi, Reflective journal, 2021, p. 15]*

> ***Extract 9****: With the stigma that is attached,* ***I'm not worried, due to the training that you guys have given me****, so I don't bother myself a lot about it.*
>
> *[Faith, Interview post-ACCC 2020, p. 4]*

In extract 7, Ziyanda emphasises that the course enabled a socio-cultural sensitivity towards women in the community and an understanding of the plight of an abortion seeker. She asserts that the course prepared and motivated her to improve service provision. This can be viewed as an advancement from merely being "told" about what to expect in the workplace (view chapter seven, section 7.2.4, extract 28) to being actively "equipped" with strategies to navigate the negative attitudes prevalent in abortion work. While Ziyanda valued

being able to ask questions, it is gratifying to note that providers viewed the course as a space to "share knowledge and experience," as this was precisely the aim with regard to course facilitation: to stimulate an exchange of knowledge rather than create a top-down, teacher-learner approach to training.

Extracts 8 and 9 accentuate how the course addresses stigma amongst abortion providers. Ntombi (extract 8) credits short courses like the ACCC for helping to combat stigma and empowering providers. Faith (extract 9) acknowledges her stigmatised setting and feels less bothered by it due to the training she received. Although Faith does not specify which aspects of the course helped her to develop this attitude toward addressing stigma, she does, in her other data, refer to abortion as "a clean medical procedure just like any procedure" and a "woman's right" [Faith, Interview post-ACCC, 2020, p. 4]. She also expresses her goal to be an "advocate" for "vulnerable" clients who come for assistance [Faith, Reflective journal, 2021, p. 11], thus drawing on evidence-based research and a rights perspective, both of which were underscored during training. It appears that these tenets of the training course enabled an attitude shift that equipped providers with tools to navigate the stigmatised work terrain.

Here, we see in action the relevance of advocacy and how programmes that aim to normalise abortion within public discourse (as suggested by Norris et al., 2011) can actually benefit abortion providers and eventually seekers, alike. The ACCC functioned as a safe space that enabled providers to acquire a different approach to engage with and discuss abortion experiences, both their own and those of their clients (as recommended by Mavuso & Macleod, 2019).

8.2.3 Formal Acknowledgement of Abortion Providers

Drawing on the findings from the first analytical chapter, in which providers demonstrated attitudinal shifts to become advocates for their clients by enabling reproductive autonomy (section 6.5.3), and the second analytical chapter, in which the *language* used to talk about abortion was identified as enabling abortion access (sections 7.3.1 and 7.3.4), it becomes evident that providers bridge these aspects, emerging as bearers of insights, knowledge and practices acquired during training. Providers began to speak about abortion in new ways: by espousing evidenced-based narratives that normalise an abortion as a safe and routine medical procedure; by adopting a human rights perspective that included reproductive rights as every woman's right; and by articulating reproductive justice principles and an understanding of how choice does not equate access. Providers are, thus, revealed as a key tool in facilitating access to abortion services, and given the enormous number of challenges they encounter, their wellbeing needs to be prioritised.

One grievance that was collectively shared by participants was the lack of governmental recognition, remuneration or certification to endorse their training as abortion providers, which is seen in the following extracts:

> ***Extract 10: Government promised*** *us years back that we would get* ***bonus of R10000 and laptop. Never fulfilled that promise.***
>
> *[Mary, Reflective journal, 2020, p. 6]*

> ***Extract 11****: Our* ***department promised to give us a once-off incentive*** *for the service that we provide* ***but they haven't done so****. Secondly, we haven't received any certificates for our training as abortion providers, something to refer. But at least we do have the certificate that we got from you guys. We* ***don't get a direct answer*** *from our superiors, we are just* ***sent from pillar to post****.*
>
> *[Faith, Interview post-ACCC 2020, p. 4]*

> ***Extract 12****: I have been trained and been working as an abortion provider for the past seven years.* ***I haven't received my certificate*** *because, I remember back then when we were trained, they said most of TOP providers tend to open their own private clinics, so* ***they will hold our certificates*** *until we're done with our practical.* ***I did my practical. I submitted all my documents, but I haven't received my certificate until to date****. And now I wonder will I ever have a document that states that I have been trained and found to be competent as an abortion provider.*
>
> *[Peter, Interview post-ACCC 2020, pp. 6–7]*

Mary was one of the senior nurses on the course, having undergone her procedural training in 2005, 15 years earlier, and has since contributed to training several new providers. Her dissatisfaction (in extract 10) is justifiable, particularly given the amount of time that has elapsed, and the unfulfilled promises made to her cohort regarding financial incentives and laptops. Faith (extract 11) alludes to another false promise made and a futile follow-up process, being sent "from pillar to post" with supervisors evading providers' questions about their one-off incentives. Extract 12 offers some insight into why the Government (extract 10) and the department (extract 11) may be evasive when it comes to incentives. Peter (extract 12) shares that "they" (presumably referring to management) are concerned about providers leaving to set up their own private clinics. So, it appears that their certificates are intentionally withheld. Providers are led to believe that they will receive their certificates after the practical portion of their assessment is complete, but this expectation remains unfulfilled, which leaves Peter wondering whether he will "ever" have a document endorsing his competency as a trained abortion provider.

While the department may temporarily succeed in retaining providers using this tactic, it seems neither sustainable nor healthy. The main outcome is, regrettably, that the work of abortion providers remains unnoticed, which only feeds the negativity and stigma they encounter.

8.2.3.1 Documented Recognition

As such, the ACCC proved to be a space that offered providers some well-earned recognition, as is indicated in several extracts. Faith (extract 11), who did not receive any certificate after her procedural abortion training, requested us, the ACCC facilitators, to "refer" this matter forward. It is possible that providers are exhausted from their repeated appeals going unheeded, and are willing to enlist any potential intermediary who can advance their concerns to management. Faith is relieved that she "at least" has the certificate from the ACCC "guys." Her reference to us as "guys" portrays a casual tone and reflects a level of comfort and trust in speaking about this aspect, demonstrating the possibility that she views us as allies who can speak on her behalf. Her gratitude for the ACCC certificate is echoed by other participants too.

> ***Extract 13****: Because the course will give me a certificate.*
>
> *[Iviwe, Reflective journal, 2021, p. 15]*

> ***Extract 14****: Am excited because I will be learning new things from this course and also gaining new knowledge, will also acquire a certificate.*
>
> *[Thandi, Reflective journal, 2020, p. 2]*

Extract 13 is Iviwe's opening line in her reflective journal, which reveals her strong desire to acquire some form of documented proof of her role as an abortion provider. Thandi (extract 14) shares her motivation to learn new things, gain new knowledge, and receive a certificate. It is therefore revealed that, whether a certificate is the primary reason for registering for the counselling course or not, it has a bearing and meaning for all participants.

> ***Extract 15****: It all came to a close today. We presented them with their certificates amidst applause and photographs. The DoH managers and Catriona's presence made it ceremonial and festive, different to 2020, where we had to post them their certs. I didn't get to see their faces then. But today it felt real. I could touch the certificate, a fruition of the Abortion Counselling Certificate Course, and they could hold (onto) these certificates, a symbol of the culmination of the course, and the fulfilment of a long-term wish.*
>
> *[Yamini, Main course facilitator, Reflective journal, 2021]*

My journal entry on the final day of our second training course brings to the fore the sense of elation and relief that I felt as I relived those moments of celebration. Just as I felt supported by the presence of Catriona, my supervisor, I presume that the participants too felt bolstered by the presence of the DoH managers who cheered them on. The providers all wore looks of accomplishment as they received their certificates. In my reflections, it dawns on me that I had not fathomed the gravity of the certificates for the ACCC 2020 (online) course participants, as they had received the certificates by post. Seeing the ACCC 2021 (FTF)

course participants receiving them in person, therefore, made it more "real." The value ascribed to the certificates by the participants was layered. The certificates were awarded to acknowledge the skill set acquired and to authenticate that participants had successfully met the course criteria, yet the certificates represented this and so much more to the recipients. It was, for all participants, the first documented recognition of their training and work as abortion providers. It was encouraging and affirming in nature, which stands in stark contrast to the felt and enacted stigma they had encountered in their (mostly) unsupportive work environments. This formal recognition of providers was facilitated by the ACCC, and had the added benefits of boosting their morale (identified as a ripple effect of the course, see chapter six, section 6.6.3) and encouraging them to continue being advocates for women's reproductive health, thereby enabling reproductive justice.

8.2.3.2 Expert Input and Recognition

Another feature that the providers seemed to appreciate and benefit from was the feedback they received from the course facilitators as a form of ongoing acknowledgement of their developing skills. This feedback stands separate to the feedback they received from their peers (featured in section 6.6.2, *Peer Supervision and Support*), as it seems to carry particular significance, possibly due to the notion of being evaluated.

> ***Extract 16****: The feedback I got made me so happy, as one of our presenters said "I have never seen anyone smiling the way they are smiling from the beginning of this role play" that makes me realise that the technique I use is superb (good).*
>
> *[Bonga, Reflective journal, 2020, p. 7]*

> ***Extract 17****: I'm feeling positive, as we have qualified people (psychologists) who will help us with counselling our clients (pre- and post-counselling) for termination of pregnancy.*
>
> *[Ruth, Reflective journal, 2021, p. 15]*

In extract 16, Bonga describes how hearing the feedback from one of the presenters (referring to one of the course facilitators) brought her much happiness, along with the self-realisation that her method was "superb," which was likely a massive confidence booster. In extract 17, the focus shifts from *what* feedback is offered to *who* is offering it. In other words, Ruth expresses optimism because the course is being conducted not just by psychologists but by "qualified psychologists," indicating her appreciation for the facilitators' experience and competency, which fuelled her enthusiasm at the start of the training course. A similar sentiment was shared by Peter earlier in this chapter, when he described his interactions with researchers and academics as "informative" and "inspiring" [extract 5, p. 5], highlighting his

gratitude for such expertise. Descriptive words such as “happy,” “smiling,” “superb,” and “positive” are notable, as they generate new attitudes towards abortion work, shifting from feelings of hopelessness and stress to those of hope and interest.

The two extracts below are inter-connected: the first is an excerpt from the feedback provided by Esona to Peter on his case presentation; and the next extract comprises his reflections regarding her feedback. This affords some insight into the type of feedback that participants received from facilitators and why it mattered to them.

> ***Extract 18****: I felt like I was in the room with Peter when he was doing his counselling for his client and I’m sure the client really felt comfortable. I mean not everyone feels comfortable the first time to actually tell you what’s going on with them. So you setting the scene and allowing her to voice out what is* ***exactly*** *going on must have been really helpful that she felt she can trust you, she felt contained. So well done on that. Kudos. The case was amazing, I’m glad.*
>
> *[Esona, Co-facilitator, Case presentation feedback to participant, 2020, p. 1]*

> ***Extract 19****: Esona said she felt like she was “there”, part of the counselling as we were presenting. That surprised me and boosted my confidence as a provider. It is always important to measure yourself so as to improve.*
>
> *[Peter, Reflective journal, 2020, p. 9]*

Esona observes that Peter set an earnest and inviting tone to the counselling session, which made the client feel comfortable enough to “voice out” exactly what she felt. Esona also perceived his ability to instil trust and contain the abortion seeker. Furthermore, as this session took place online in 2020, it provides valuable insight into the quality of online interactions. Despite network glitches, it was possible for facilitators to gauge and comment on nuanced features of the counselling session, leading Esona to state that she felt transported to the counselling room. Her statement stuck with Peter, who reflected on it in his journal, noting that it both surprised him and helped to build his confidence. This illustrates how positive feedback can lead to increased morale. This sentiment was echoed by Bonga in extract 16. It is gratifying to note that the participants took the feedback to heart, found it beneficial during the training, and are taking these inputs forward with them.

8.2.4 Training Course Resources

The training course materials included the ACCC course manual, the CSSR AC Guideline, PowerPoint presentations, and information pamphlets. As stated in the literature review, no official guidelines had been published since the passing of the CTOP Act in 1996, up until 2019, when the National Clinical Guideline was circulated by the DoH. It was the same year this research project began, aiming to operationalise the CSSR AC Guideline. Thus, for

many providers, the CSSR AC Guideline (though focused on abortion *counselling)* was the first set of guidelines with which they engaged.

During training, a participant noted that "Guidelines are provided to promote uniform and quality abortion counselling in all facilities that offer abortion services" [Ntombi, Reflective journal, 2021, p. 20], underscoring its value as a means of quality control. Other participants shared similar reflections:

> ***Extract 20****: As providers* ***we needed the guidelines*** *in order to make sure that we* ***do our work according to the set policies and standard*** *as things changes all the time. We must make sure that* ***rights of women*** *who come to our institutions are* ***protected*** *all the time and that they are* ***treated with dignity*** *and* ***empowered****.*
> *[Thato, Reflective journal, 2021, p. 20]*

> ***Extract 21****: The guidelines helps me to know that the* ***woman can choose whether or not to receive counselling****.* ***Not to judge the client if how many times*** *to come for abortion, it's the* ***woman's medical right****, I must just offer the services. It's their choice to* ***choose whether she wants contraceptive or not****.* ***Not to personalise the foetus****.*
> *[Faith, Reflective journal, 2020, p. 11]*

In extract 20, Thato offers her perspective of why the guidelines were necessitated. She, like Ntombi, views it as a resource that monitors providers' work ethic. She sees a benefit in having "set policies and standard" amidst changing times and notes its value in safeguarding the rights and dignity of abortion seekers. She, thus, offers an overarching view of the usefulness of the CSSR AC Guideline (Mavuso et al., 2018). Faith (in extract 21) focuses on certain non-mandatory aspects featured in the CSSR AC Guideline, such as an abortion seeker's right to accept or refuse counselling and contraceptives. It appears she was not fully cognisant of these stipulations previously, or perhaps she was under pressure to function within institutional constraints that devalued these rights. The CSSR AC Guideline reinforces key elements that enable reproductive autonomy, for example, practising non-judgement even in cases of repeat abortions, employing a rights perspective ("woman's medical right"), and avoiding ascribing personhood (likely what Faith means when she says "personalise") when referring to the "foetus" (the Guideline suggests following the language used by the user).

Extracts 20 and 21 emphasise the benefits of having guidelines. The following two extracts indicate the ways in which providers utilise them.

> ***Extract 22****: They are helpful, they* ***give me/us directions*** *on* ***how to speak properly*** *with our clients and* ***to make them feel comfortable****, so they can open up on their own. They are* ***helpful*** *because* ***they guide me*** *not to be judgemental.*
> *[Sethu, Reflective journal, 2021, p. 20]*

> ***Extract 23**: The CSSR Guidelines are **helpful and guiding on how to offer counselling to my clients**. I have gained more skills through the guidelines and am confident in my counselling skills now.*
>
> *[Nondumiso, Reflective journal, 2021, p. 20]*

Sethu (extract 22) and Nondumiso (extract 23) refer to the helpful and guiding nature of this resource. They also state that the Guideline taught them *how* to speak, *how* to make a client comfortable, and *how* not to be judgemental (extract 22) and essentially *how* to offer counselling (extract 23). The Guideline is generally perceived as an all-encompassing resource that covers the "what," "why," and "how" of abortion counselling, and principally viewed by participants as a resource that was "assisting a lot and guiding to provide quality counselling sessions" [Phillani, Reflective journal, 2021, p. 20].

Lastly, other course materials also featured in the research data as contributing to effective teaching and learning, as identified by course participants:

> ***Extract 24**: The **course manual carried substantial information** about the course, also reminds me what to do and not to do when dealing with the client who comes for TOP.*
>
> *[Nandi, Feedback form 1, 2020, p. 18]*

> ***Extract 25**: Everything was on point, even the **study material was clear** enough to read and understand.*
>
> *[Thandi, Feedback form 1, 2020, p. 18]*

> ***Extract 26**: **English used is simple and understandable**…we are provided with manuals and data. Even if we start late with the course but 16h00 is 16h00…**facilitators stick to the content of training**, sent to us on emails, whatsapp, through post. **We did have different options**, zoom, whatsapp, email.*
>
> *[Linda, Feedback form 1, 2020, pp. 19–20]*

> ***Extract 27**: It's **focussing on student success** because I was getting handbooks through Postnet and also email. Being better if not the best because there is no physical contact, everything went well.*
>
> *[Mary, Feedback form 1, 2020, p. 18]*

All four extracts are from ACCC 2020 (online), where course materials were sent via post to participants, ahead of the course. Nandi (extract 24) notes that the manual carried ample information, while Thandi (extract 25) and Linda (extract 26) comment on the intelligibility of the study material and language used. Linda also shares her appreciation for receiving the course manual and mobile data,[72] and for the course not running overtime. Both

[72] Data here refers to mobile data that was purchased and sent to providers so they could connect online, as most of the facilities did not have Wi-Fi connectivity.

she and Mary (extract 27) commend the different means of communication implemented such as "WhatsApp," "email," "zoom," and "Postnet" (a private postal service within South Africa) with Mary noting that this emphasis reflects the priority placed on "student success." She reflects that owing to the Covid lockdown ("no physical contact"), this was the next best alternative.

8.3 Empowering Nurses as Enablers of Reproductive Justice

This theme highlights nurses' personal qualities that direct them to a service-oriented profession. It is important to, firstly, appreciate their commitment and the constraints under which they provide services. Secondly, with a supportive environment, like that of the ACCC, it is possible to build on their personal motivations and foster providers' skills, attitudes, and narratives related to abortion. This can ultimately help to improve abortion access, as seen in the extracts below.

8.3.1 Self-Motivated and Other-Directed

Several participants shared similar sentiments of wanting "to gain more knowledge and improve my standards" [Lilly, Reflective journal, 2020, p. 1] and hence registered for the course. However, it extended beyond personal growth as they also intended to help improve the services in their communities.

> ***Extract 28: Being a provider*** *inspired me a lot because* ***I like helping people,*** *seeing that the clients have a trust on [in] me* ***motivates me to love being a provider****…I sign up for the course because* ***I want to help my community on TOP****, more especially those in need of it e.g., incest, rape cases and those who find themselves pregnant and unable to take care of the kid.*
>
> *[Bonga, Reflective journal, 2020, p. 1]*

> ***Extract 29: What motivates me is helping women to make their own decision*** *concerning their* ***reproductive health.*** *I wish to give the adequate information and how to make correct decisions concerning having kids or not.* ***The difference I make in women's lives motivates me to keep on supporting the programme.***
>
> *[Thato, Reflective journal, 2021, p. 15]*

Both Bonga (extract 28) and Thato (extract 29) allude to their "helping" nature as an influencing factor in being providers. Bonga says that witnessing her clients' trust in her inspires her, while Thato says she is motivated by seeing the difference she makes in women's lives. Thus, they both indicate a personal quality that is bolstered by positive micro-interactions with clients. They indicate wanting to make a difference in the world by helping the "community on TOP" (Bonga) and "supporting the programme" (Thato). Additionally, Bonga shares her

awareness about unintended and unsupported pregnancies, and Thato highlights her targeted interest in reproductive health, thereby demonstrating their contextual knowledge and a desire to be responsive towards "those in need."

Jane also shares her inclination to develop her skillset to improve the service, in the following extract:

> ***Extract 30:*** *I want to l**earn more about the abortion counselling** and to know more about **what is expected of me when attending to these clients** on a day-to-day basis. To also **learn new ways to improve the service of abortion.***
>
> *[Jane, Reflective journal, 2020, p. 1]*

Jane is curious to learn about both what to expect with regard to abortion counselling and what is expected of her when providing this service. She views the course as an opportunity that enables a reciprocal process of improving herself to enhance her daily interactions with clients. Phillani shares an observation while noting his intention to persevere in this line of work:

> ***Extract 31****: What I have observed from the others during the session is that **most of us got the passion for CTOP**… I **saw the need for the CTOP services**. **I didn't listen to the negativity** that was said by others about the CTOP services.*
>
> *[Phillani, Reflective journal, 2021, p. 15]*

Phillani witnesses that several providers are passionate about their work and this sentiment resonates with him. In noting the "need for CTOP services," he is able to look past the "negativity." Thus, despite the many challenges in this line of work, providers showcased a self-motivation to develop their skills, an inclination to help others in need, and a shared commitment to improve the service.

8.3.2 Keeping the Service Open and Functional

With their personal qualities and growing skillset fostered within the ACCC, many providers voiced a commitment to improve abortion services (such as the extracts under 3.1) and, in some cases, to essentially prevent them from shutting down, as is indicated in the following extracts:

> ***Extract 32****: Professional nurses who were doing CTOP in [name of hospital], i.e. women's health were about to retire. So, the CEO of our hospital approached me to go at women's health. In 2017 I started, and **I was willing to do TOP to help my community** at large to avoid and minimize septic abortion that are being done by the [unclear] doctor's on the street.*
>
> *[Nandi, Reflective journal, 2020, p. 1]*

Abortion provision would have closed at Nandi's hospital (at least temporarily) had she been unwilling to undergo procedural training after the retirement of the provider at the time. When the CEO requested her to transfer to the women's health department, she promptly agreed, motivated by her desire to assist her community while reducing the rates of septic abortions caused by backstreet procedures.

In Bonga's case below (extract 33), she was already providing abortions but was pulled away from her work by her operational manager to work in the theatre instead. The excerpt below shares her conflicted interactions with the manager and how she overcame it.

> ***Extract 33****: I said to her, "but I do have a patient with me here who came here for my help". She said to me, "no, they've come to do abortion so it's not [unclear] you must leave them just like that, you must* ***go to theatre and save lives there*** *in theatre* ***instead of doing these people who have just come to abort****. So, I decided to go there but I think* ***I'm rectifying the mistake****. If this clinic is not essential to this institution* ***I'd rather quit****. And I rather close women's clinic totally and go to assist in theatre. So,* ***I think they heard me because since then no one has asked me to go and assist in theatre*** *and leave my clients behind… It helped me so much, the SRJ [sexual and reproductive justice] came in together with the area manager and I raised the question, "****Am I supposed to leave my clients*** *to go and assist in other wards?" And I could see that the manager was shocked that I asked that question and since then she has not asked me to assist in any wards.*
> *[Bonga, Interview post-ACCC 2020, p. 12–13]*

Bonga's agency as a provider shines through in this brave interaction with her supervisor who tells her to focus her effort to "save lives" instead of working with people "who have just come to abort." While she is initially pressured into working in the theatre, she appears to experience a shift in her thinking and decides to rectify "the mistake." This may have been facilitated by her participation in the course and the subsequent visit (unrelated to the course) of a sexual and reproductive justice (SRJ) representative along with the area manager. She seized the opportunity to raise her concerns with them, to which her own manager reacted with shock, highlighting the complete unexpectedness of Bonga's challenging stance. Her actions portray Freire's central tenet of conscientisation, which when applied in nursing education necessitates a critique of existing conditions and the ability to identify existing hurdles with the aim of effecting change through reflection and action (Mooney & Nolan, 2006). Bonga was subsequently allowed to stay clear of other wards, and has since been able to focus solely on abortion provision. This symbolises a win for Bonga, personally, and an overall victory for reproductive rights and justice.

With vying health priorities, it does appear that abortion services bear the brunt, as several other providers also shared similar experiences. Thandi needed to manage the women's clinic at her hospital in the afternoon, while undertaking Covid vaccine training and

provision during the morning. In another case, it appears that the abortion clinic was closed altogether.

> ***Extract 34****: Happy because they [other participants]* ***motivated me to stand up for my clients*** *and* ***fight for my hospital to open a space*** *where I can be able to provide CTOP services and because of that,* ***I will make sure that happens*** *and will always keep in touch with them so that when I encounter problems, I [can] ask them…I did my fieldwork at [name of hospital] as my Hospital does not provide CTOP services.*
>
> *[Ziyanda, Reflective journal, 2021, p. 24]*

Ziyanda (extract 34) asserts that in evaluating her peers' case presentations, she felt inspired by them to make a difference at her hospital. Following the training, she felt determined to open a space for CTOP services and vowed to follow through while remaining in contact with other providers should she encounter any challenges. She, thus, highlights the value of shared experiences and camaraderie that were nurtured during the training course, in her gaining the courage to "stand up" for her clients and "fight" for her hospital to open a space for abortion provision. She was unable to conduct her fieldwork assignment at her own hospital and was, fortunately, able to work out of a different hospital during that time. Her displacement during that phase may have also incited empathy towards clients who visit a clinic and are referred to another clinic due to the unavailability of abortion services.

Iviwe (extract 35) shows how intent needs to be followed by action. Both extracts are taken from her data but are written at different stages during the training course.

> ***Extract 35:***
> *I think our institution may recognize reproductive health as a whole including TOP. From now I need to motivate my managers to re-open women's health clinic.*
>
> *[Iviwe, Reflective journal, 2021, p. 24]*
>
> ***It's had an impact*** *in my institution to reopen Women's Health Clinic since it was closed from 2020 April.*
>
> *[Iviwe, Case presentation, 2021, p. 5]*

Iviwe's clinic was affected by Covid, following which the women's health clinic was closed. In her reflective journal, she contemplates asking her managers to reopen the women's clinic, considering that comprehensive reproductive health services include abortion services. After her fieldwork and during her case presentation, she proudly declares that the training has "had an impact" and the women's clinic has since reopened as an outcome of her attending the course. Though the training may have motivated her to raise the matter with her managers, it is ultimately her personal effort and commitment that led to the clinic reopening.

8.3.3 Patient Satisfaction: Perceived and Conveyed

This sub-theme reinforces the notion of providers being (or becoming) enablers of reproductive justice after attending the ACCC, as we see access being made possible through client-centred counselling interactions. While a new research project (similar to the baseline research) assessing the ACCC is already underway, participants' accounts offer some insight into how their altered practices have filtered through to their clients.

> ***Extract 36****: So, my clients now, I'm seeing a lot of clients. Some* ***clients now are referring me****, letting people know that "go see Peter, he is amazing,* ***he gives out quality information****, he's open, he's non-judgemental". And for me that has boosted a lot of my morale because I see that* ***me going through the course, learning how to do proper counselling*** *that is recommended, and actually implement it, it* ***has made my clients more free to talk****.* ***It has made my clients more comfortable in coming to my clinic*** *and actually talking about their problems.*
>
> *[Peter, Interview post-ACCC 2020, p. 6]*

> ***Extract 37:*** *Yes,* ***because I've applied the Abortion Counselling Steps, and I noticed a change in my clients*** *that how* ***they're able to freely ask questions.*** *[in response to her experience of the fieldwork component]*
>
> *[Sethu, Feedback form 2, 2021, p. 29]*

In both extracts, the providers are cognisant of a shift in their clients' demeanours after their participation in the course. Peter (extract 36) affirms that after attending the course and implementing what he learnt ("how to do proper counselling that is recommended"), his clients are now "*more* free to talk," alluding to them being *less* free previously. Sethu (extract 37) observes that applying the abortion counselling steps led to "a change" in her clients as they now freely ask questions. The clients in these extracts do not appear passive or scared, rather they are perceived as autonomous individuals who are comfortable with going to the clinic as well as attending the session. The power relations between the provider and abortion seeker that typically dictate what kind of information is exchanged (see Mavuso & Macleod, 2019) are thus mitigated, while enabling clients to receive information pertinent to their needs rather than insufficient or irrelevant information (as noted in pre-abortion counselling by Birdsey et al., 2016).

Positive feedback was not limited to providers' discernment of their clients' behaviour, as is visible in the next extract:

> ***Extract 38****: In my clients,* ***I did receive a message from one of my clients*** *[who]* ***was recommending me*** *because of the good service that I gave. Because one of my supervisors sent it to me. Also, you see it* ***when they go out, their smile*** *it makes you feel good that you have done something good for your client.*
>
> *[Faith, Interview post-ACCC 2020, p. 3]*

In extract 38, Faith's observations are based on her perception of her clients leaving the clinic with a "smile" as well as definite feedback ("a message from one of my clients") conveyed to her by her supervisor. Her clients' smiles are indicative of their satisfaction with the service. Furthermore, both Faith and Peter highlight being recommended (extract 38) and referred (extract 36) by their clients. This makes Faith feel good and boosts Peter's morale, while also reflecting the quality of the counselling services. As prior research (Mokgethi et al., 2006) has indicated that some clients resort to backstreet abortions to avoid stigma and judgement, it is noteworthy that positive shifts have been noted in provider-client interactions by providers and abortion seekers alike.

8.3.4 Abortion Providers as Human Rights Defenders

Several participants in this study took up the stance of advocating and defending the rights of women, in line with Amnesty International's global campaign that frames abortion providers as human rights defenders (Amnesty International, 2023). The extracts below underline the ways in which providers aim to safeguard reproductive rights and what prompts them to do so:

> ***Extract 39****: My belief is that if a woman has taken a decision to abort her pregnancy* ***her rights should be offered to her****. She took a decision at home and came to the provider. The provider should help her and listen to the client's story.*
> *[Sethu, Reflective journal, 2021, p. 18]*

> ***Extract 40: The women's health****, especially young women****, to give them the chance to continue with their dreams****. The community level of education that is low,* ***our people need the information and services.***
> *[Casey, Reflective journal, 2021, p. 15]*

Sethu (extract 39) believes that when a woman has already decided to have an abortion, then a provider's role is to listen to her and help her by affording her that right. There is practically a shift in focus from the provision of an abortion to the provision of a *right*. Casey (extract 40) feels strongly about young women's health as it opens up the possibility of a different future, one in which they can pursue their dreams. She notes that as the education level in communities is low, there is a pressing need to provide accurate information. Thus, to both providers, affording abortions equates to affording women their rights, and in doing so, giving them a chance to dream by equipping them with knowledge.

Extracts 41-43 (below) highlight some motivators for providers that orient them towards a line of work focused not only on service but grounded in social justice and reduction of health inequities.

> ***Extract 41:*** *My family motivates me, and* ***women in leadership positions and women fighting social injustice*** *inspire me to do what's right for our women in SA…****I signed up for the course so that I can help women*** *who want to do TOP to not feel judged, and to counsel them about their choices.*
>
> *[Ruth, Reflective journal, 2021, p. 15]*

> ***Extract 42****: I was introduced to CTOP programme in 2019, since* ***then I fell in love with it as it advocates for woman's rights*** *and tried to* ***do away with backstreet abortion*** *which is endangering their lives. I* ***love to do health talks*** *especially to young women and their reproductive problems,* ***so this course is very relevant****, not only to my work but out in my community at large****, to also do away with stigma*** *attached to abortion.*
>
> *[Ziyanda, Reflective journal, 2021, p. 15]*

> ***Extract 43: To help teenagers not to do back street abortion*** *to* ***prevent unnecessary deaths,*** *and so that they must know* ***their rights*** *and options.*
>
> *[Jane, Reflective journal, 2020, p. 1]*

In extract 41, Ruth shares that she is inspired by women in leadership roles who fight for social justice. In extract 42, Ziyanda declares her love for the CTOP programme due to its advocacy stance, and for conducting health talks with young women. Ziyanda and Jane (in extract 43) both feel strongly about backstreet abortions. Ziyanda sees its role in "endangering lives" and Jane wishes to prevent "unnecessary deaths;" they both underscore the high risks this illegal activity poses to women. Their views also reflect their sensitivity towards the social context that acts as a deterrent from accessing an abortion at a legal facility. Ruth (extract 41) wishes to eliminate the judgement faced by abortion seekers and Ziyanda (extract 42) hopes to eliminate the stigma attached to abortion. Here, they both acknowledge the role of the course in helping them achieve their goals, as Ruth shares that she signed up for the course "so that I can help women" and Ziyanda shares that partaking in the course is "very relevant" to her own work and would also have a far-reaching effect in her community.

As defenders of human rights, abortion providers are positioned in a positive light. This reframing of their work is voiced by Nandi in response to Laurah's (co-researcher) interview question, "What would you say to other nurses who are thinking of undertaking the training?"

> ***Extract 44****: I will tell them that* ***we are saving our country****. Like for instance the young teens, they need to further their study. So that's why they came for TOP, because once they give birth to that child, the time is moving on, so* ***we are saving the nation****.* ***It's not like we are devil worshippers****. Like for instance, me, myself I'm a preacher in my church, so there's nothing,* ***there's no sin on my side*** *that I've made a sin by terminating a child, because it's not even a child that we are terminating, it's a clot, just a clot.*
>
> *[Nandi, Interview post-ACCC 2020, p. 10]*

Nandi's labour in promoting the service to potential abortion providers is discernible. She provides the example of an unplanned pregnancy and notes that giving birth and raising a child demands effort and time. The phrase "time is moving on" may imply a delay or inability for the "young teen" to (return to) pursue her studies. Nandi markets her job profile by emphatically stating that "we are saving our country" and "we are saving our nation" further implying that providing women with what "they came for," an abortion, is better than having uneducated and possibly unemployed young mothers. As if pre-empting a religious or moral conflict, she asserts that, far from being "devil worshippers," she herself is a preacher in her church. She reiterates that she is not committing a sin and concludes with a cautionary argument against personifying the foetus, stating, "it's a clot, just a clot."

Participants thus reframed abortion as doing something good such as helping teenagers, giving women an opportunity to dream, and improving the community (also seen in O'Donnell, Weitz & Freedman, 2011) while positioning themselves as heroes (referenced in Mavuso & Macleod, 2021). However, Mavuso and Macleod (2019) caution against the tendency of a hero narrative that tends to construct legal abortion as a solution to preventing deaths due to backstreet abortions, rather than affirming it as a reproductive right. While participants did draw on the hero narrative in describing their efforts to do away with backstreet abortions, prevent unnecessary deaths, and save the nation, the construction of abortion as a right is certainly visible within this theme. Moreover, the usage of reflexive pronouns by some of participants in the extracts is telling. Casey (extract 40) refers to "our people," Ruth (extract 41) refers to "our women in SA" and Ziyanda (extract 42) refers to "my community," all implying a level of identification with the people in their community rather than an othering of those in need of reproductive services. This personal sentiment has the capacity to strengthen their advocacy efforts to become "a promoter of reproductive health for women" [Iviwe, Reflective journal, 2021, p. 23] and a defender of human rights.

8.4 Hindering Participants' Skill Development and Course Engagement

I now explore elements within the course that interfered with participants' abilities to immerse themselves in the course, thereby hindering their capacity to fully acquire client-centred abortion counselling skills. This section includes participants' feedback as well as my own observations on the components that require changes. As each course took place in a different format, this also allows for a comparative analysis.

8.4.1 Comparing Course Formats: Lessons and Learnings

Table 8.1 covers difficulties experienced by participants within and during the course. The data in this sub-section were from participants' feedback forms and lent itself to semantic coding. In the table, two columns (ACCC 2020 and ACCC 2021) provide a summary that encapsulates various concerns raised by participants during training. The extracts in brackets signify participants' direct quotations to substantiate the summary offered.

Table 8.1

Course Comparison

ACCC 2020 (Online Course)	ACCC 2021 (FTF Course)	Course Refinement Considerations
Lack of technology (no laptops or desktops at clinics) No Wi-Fi service	N/A	Ensuring all participants have smartphones for online courses Providing mobile data for participants
Unfamiliarity with technology by some nurses and lack of training in technology ("the training was not easy because of the network and technology")	N/A	Including more information and practice time in the pre-course session to familiarise participants with various apps and their features
Course materials were not received or did not arrive in time	N/A	Consider extending the time between participants' registration and the start of the course, for courier services to reach more remote locations
Network connectivity problems Time management – dragging due to network issues ("time + network is a barrier")	N/A	As network connectivity was not within our control, little can be done. The shift in Laurah's (co-researcher) role from observer to online administrator mitigated time delays, showing that an administrator for each online session is beneficial
"Environmental factors due to loadshedding[73]"	N/A	As the online format requires full attendance for successful completion of the course, the FTF course would appear to be a current and feasible solution
Course duration is too short ("time is short, extra time needed")	Course duration is too short ("It must be extended to one week;" "training Is not enough as we feel we need more time to share")	Consider increasing the duration of courses, whether online or FTF

[73] Loadshedding refers to the ongoing controlled power outages or planned electricity supply interruptions carried out by Eskom (the national and primary power generator in South Africa) to balance out the demand and supply of electricity.

Several points raised within the online course are not applicable to the face-to-face course, The table instantaneously provides a comparative overview of the disadvantages and advantages of the two formats.

1) The first observation was that eight of the nine providers registered for the course did not have computers or laptops to access an online course. While one facility did have a computer, most of the clinics did not have internet connectivity. As all providers owned smartphones, mobile data was provided to all participants (by the CSSR) for the duration of the course, thus overcoming this obstacle. However, even in my own experience, joining a Zoom session via the desktop app and the mobile app are two very different experiences. While a computer or laptop has a larger screen whereby it is possible to view multiple participants on a call, the mobile app only allows for four faces on the same screen at a time. This feature likely limited the group setting experience for participants and might have potentially added to their sense of isolation (as the sole provider in their facility). However, as all participants were being introduced to Zoom features for the first time, it is likely that they did not have a separate experience to compare their connectivity to.

2) As the use of technology for engagement in an online course was new to several participants, it did necessitate extra time to introduce and familiarise participants with the app features, along with continuous reminders. This requirement reduced the amount of time available that could have been allocated to the specific course outcomes.

3) Two of the nine participants did not receive their course materials in the post on time. This prevented them from being fully prepared or knowing what to expect and do during the first online session. On receiving this feedback, alternate arrangements were made to immediately share the material with the participants via email and WhatsApp. It would be beneficial for course facilitators to enquire about this aspect in advance or even share soft copies of all course materials pre-emptively to avoid such a situation.

4) Internet connectivity caused major problems during the course, creating audio disturbances, frozen screens, and participants losing connectivity. This led to them missing out on what was being shared by different speakers as well as being interrupted when they were trying to speak. It impeded their ability to fully participate in group discussions. From a facilitator’s point of view, this also created a lag in the training session as participants had to be brought up to speed once they reconnected, though they often rejoined only to lose connectivity again. The following extracts underline these difficulties:

> ***Extract 45**: Yeah, **I'm a little down today** because from the onset **I was struggling**, even now **I didn't hear anything** from Peter. But I will continue with my presentation, nehh [ok].*
>
> *[Bonga, Case presentation, 2020, p. 2]*

> ***Extract 46**: **Tired and stressed, overwhelmed** by technical aspects (who has joined, people getting disconnected and messaging me to rejoin) …Participants are helpless during technical glitches. And it takes away from facilitation/ observation [for me].*
>
> *[Yamini, Main course facilitator, Reflective journal, 2020]*

The two extracts offer perspectives from a participant and a facilitator. Both Bonga and I describe how the network disruptions impacted us personally and professionally. Bonga shares being "down" because she could not hear much from the start. This prevented her from listening to her colleagues' presentations as well as offering feedback, if any. She then tentatively attempted to present her case. I, too, reflect on my fatigue and stress caused by network problems as it prevented me from noting down my own observations as a researcher and doing full justice to my role as a presenter and main course facilitator. I also observed the effect this has on participants, as they appeared helpless, which may have led to a feeling of being inept.

5) The issue of loadshedding (power outages) does pose a hurdle to any online training course. This aspect did not impact the FTF course as Rhodes University has provision for generators.

6) The issue of the course duration being inadequate was raised within both courses and was experienced by both participants and facilitators. The irony lies in the severe time constraints that participants experience in their role as providers. Apart from needing extra time to compensate for lost time due to network problems, I noted that the FTF course feedback also requested for a longer duration, alluding to it being rushed. My analysis ties in with their sentiments, but more so for reasons noted in the next sub-theme.

8.4.2 Further Contextualisation and Extended Duration of the Course

This section covers aspects of the course that need revision to create a context-specific abortion counselling course for providers. The extract below is a reflection following an impromptu decision for Esona (my co-facilitator) and I to present a client-centred abortion counselling role play to the nurses during the second course.

> ***Extract 46**: Esona and I conducted a role-play in which I was the provider, and she was the client. At the end of the session, I felt quite content since we had neither practiced nor previously discussed on the type of case we would put forward to the group. For a spur of the moment decision, I felt pleased. However, nurses shared*

that it was not realistic enough since often clients hardly speak and offer mono syllabic responses. This was an important learning for me and offers scope for improvement for the types of scenarios or clients portrayed in future workshops.

[Yamini, Main course facilitator, Reflective journal, 2021]

In our role play, I aimed to create a safe and non-judgemental space while asking open-ended questions. In response, Esona offered a fair amount of information about her background and her concerns. The providers felt that this was not what they typically encountered during a session. While the focus of the role play was on presenting a client-centric interaction, it would have been beneficial to showcase how to elicit communication, especially from a passive client who is apprehensive about sharing information. It is commendable that the participants felt comfortable enough to share this constructive criticism with the facilitators.

Several other scenarios from group discussions brought to the fore providers' lived experiences with counselling clients, including their challenging cases. While the challenges in these cases emphasise numerous systemic problems that are external to the course, I have chosen to include it in this section to highlight two main considerations: firstly, to acknowledge that the course did not offer practice-counselling opportunities with context-specific challenges and extra time allocation for honing counselling skills; and secondly, to underscore the relevance of refining the course (going forward) to reflect cases that providers relate to, thus demonstrating the advantage of action research in identifying course shortcomings to enhance it.

8.4.2.1 Reproductive Coercion

Reproductive coercion is a deliberate attempt to interfere with a person's reproductive decision-making and hinders their reproductive autonomy, which can include controlling their pregnancy outcome through forced abortion or pregnancy continuance (Pike, 2023). Instances of pressure from family members is visible in the following extracts:

Extract 47: *The fact that it seemed we had all similar difficult counselling cases of mothers pushing their children to terminate.*

[Peter, Reflective journal, 2020, p. 2]

Extract 48*: The girl came fast saying that she's coming to do termination of pregnancy. The mother quickly gets in, and she was shouting the girl, "Why are you fooling me? Because you said to me you have irregular menses and tenderness of the breasts, now you just quickly run into this clinic requesting termination of pregnancy. Do you know that I'm a Christian and I'm saved?" Ehh! She was shouting [at] the girl.*

[Nandi, Case presentation, 2020, p. 4]

Peter (extract 47) reflects on the similarities that he and his colleagues face and notes that a commonly-occurring challenging scenario is that of mothers "pushing" their children to have an abortion. The word "push" denotes a level of compulsion in the interaction between an abortion seeker and their mother. Similarly, in extract 48, Nandi witnesses the mother of her client barging into the clinic room shouting at her daughter for "fooling" her, indicating that the client had concealed from her mother the real reason (that of abortion) for her visit to the clinic, possibly out of fear. The mother's religious affiliation as a Christian who is "saved" indicates that, in this case, the pressure is likely to *not* have an abortion. Thus, reproductive coercion functions as verbal pressure or threats either way – to continue with or to terminate a pregnancy (Miller & Silverman, 2010). The extract that follows speaks to the latter:

> ***Extract 49:*** *A case whereby a pastor came with an 18-year-old girl to do termination because she falls pregnant while she's in church and the provider **tried to convince the pastor that it must be the child's choice** to do the termination not the pastor. But the pastor was having a problem that the congregation is going to look at him with negative eyes that he impregnated the child in the church, and **the child was convinced by the pastor that she wants to do it**, although it's supposed to be her choice not the pastor's choice to do it. Unfortunately, he gave her two days to decide, but the child came back to do it. So, it was very interesting to me.*
>
> *[Group discussion, 2020, lines 5–12]*

In extract 49, the group discussant shares a case of an 18-year-old who was impregnated by a pastor at her church. The provider attempted to safeguard her client's autonomy by emphasising to the pastor that the decision to continue or terminate the pregnancy was not his to make. A sense of coercion is discernible in the encounter as the pastor fears backlash and stigma should his congregation find out. Although the nurse "tried to convince the pastor" that it was the client's choice alone, it appears that "the child was convinced by the pastor" to have an abortion. "He gave her two days to decide" does not sound like choice was actually afforded to the client, considering the power dynamic in their relationship. Both extracts 48 and 49 have religious connotations but the intimidation in each encounter is, ironically, towards different reproductive outcomes. This shows how a religious view about abortion is not rigid, rather it sways towards an outcome that is viewed as the lesser "evil" within that context.

8.4.2.2 Transactional Relations

Male dominance (as seen in the interaction between the pastor and the abortion seeker in extract 49) is one of the characteristics visible in transactional sex encounters alongside increased availability of resources like fashionable clothing, social inclusion and even just survival, as shown in a study in a peri-urban community in South Africa (Zembe et al., 2013).

Yet, these encounters prove to be more nuanced than a mere exchange of sex for access to resources:

> ***Extract 50**: She was like, "You know what? I have to talk about this because I have a problem. **I was impregnated by my stepfather**, and I now fell in love with him"…the stepfather actually said to her [the client] **if she wants to continue receiving money from him, for clothes and for school, she needed to do something in return as a favour**…As I was listening to her, she was like, she's not interested in talking to the police or opening a case because this was consensual, according to her. But uhm, she did request that I could refer her to a social worker.*
> *[Peter, Case presentation, 2020, p. 1]*

In Peter's presentation, he highlighted the complexity surrounding the case due to the interplay of transactional sex (for school, clothes and money), the type of relationship (stepfather and stepdaughter), and the emotions of the abortion seeker (that she "fell in love with him"). The extract reveals the nuanced nature of reproductive coercion as external pressure – often occurring within an intimate relationship – that can quite naturally be internalised by the abortion seeker due to the gendered power dynamics of the relationship. Thus, in instances where a daughter is reliant on her mother (extracts 47 and 48) or pastor (extract 49) or stepfather (extract 50), an understanding of reproductive rights as "it's supposed to be her choice" (offered by the group discussant in extract 49) might be rather simplistic. Or, as noted by Pike (2023), "a simple commitment to always respect reproductive autonomy and avoid any kind of pressure fails to appreciate the complexities of relationships" (p. 88).

8.4.2.3 Disabled Persons

Abortion providers from both courses deliberated on their interactions with disabled[74] abortion seekers and the discussions underlined challenges at a macro- and micro-interactional level.

> ***Extract 51**: I've got a challenge with a disabled child, unable to talk, but she can hear, and she can write. When she came with this child, with nine weeks pregnant and then the mother said that she can't take care of this child because this one is*

[74] There remains ambiguity around the semantics of language, more so with different disability categories, about the preference of identity-first (disabled person) versus person-first (person with disabilities) usage (Sharif et al., 2022). The authors make three recommendations: to ask individuals for their personal preference; to refer to the intended demographic using their self-identified preference; and to remain up to date with ongoing discussions surrounding preferences over time, as this may change. I did not interact directly with the disabled abortion seekers referenced in the extracts and each extract has a different usage by each provider. I, therefore, have chosen to use identity-first language as the article indicates this slight preference for disabled persons, while recognising the importance for flexibility and respect in the language used.

disabled and unfortunately the disabled lady is 22 years old and then ***she said she can't take care of this baby, so she must do a CTOP****.*

[Group discussion, 2021, lines 57–60]

Extract 52*: The difficult (case) challenges, I had the patient who was disabled, she couldn't talk, she can't hear. So she was accompanied by her sister. Sister said they don't have parents they are alone at home, so she can't take care of the baby because if she will continue with the pregnancy, she won't hear the baby crying, she can't talk with the baby.* ***So there's no other choice but to do termination****.*

[Group discussion, 2021, lines 23–26]

Extract 53*: As far as abortion counselling challenges, I experienced a challenging case today. I had a client who could not speak. She could not write. She could not read. She only knew sign language****. I couldn't offer her counselling*** *because she was above 12 weeks. I wanted to give her information.* ***I wanted to give her counselling support, but I had no interpreter in the premises*** *of this hospital.*

[Peter, Interview post-ACCC, 2020, p. 7]

Visible in extracts 51 and 52 are signs of pressure and third-party involvement, from the mother and sister of the client, respectively. I am uncertain whether to even refer to the clients as abortion seekers as it is unclear whether they are interested in the procedure, or if they have been brought to the clinic against their will. The discussant in extract 51 later revealed that she requested the mother to go out, but she objected. Yet, the provider managed to hand over a pen to the "disabled child" who then conveyed in writing that she wanted to have the baby and would take care of her baby with her disability grant. The provider went on to include a doctor and social worker in the discussion, and the disabled person gave birth to the child. This case had an encouraging outcome despite the initial barriers. The provider's presence of mind, incorporation of the Act ("I just take out my Act and educate her (the mother) according to my ACT," lines 61–62), and involvement of support from other staff lent itself to enabling reproductive justice, while functioning as a good example for other providers. Extract 52, on the other hand, ended in an abortion and "a bilateral tubal ligation, which is the closing of the tube that she can't have kids again" [lines 32–33] and is unclear whether it was indeed the disabled person's decision. These findings tie in with previous literature that has highlighted how the reproductive agency of disabled patients is often undermined by both formal and informal support networks (Pacheco et al., 2024).

In extract 53, Peter tries to engage with a disabled client, which proved to be challenging due to the unavailability of a sign language interpreter at the clinic. Unlike in extract 51, where the disabled person was able to hear and write, Peter's client could not speak, hear, or write. At a macro (institutional) level, it imperative to afford such services to improve the quality of abortion care, as it prevented Pater from offering her counselling and providing her with information since she was over 12 weeks pregnant.

8.4.2.4 Sexual Abuse

The three extracts within this sub-section aim to underscore the nature of complex cases that providers deal with that are often a combination of various issues:

> ***Extract 54****: She's* ***a known HIV patient on treatment****. She came in requesting TOP…I talked to the social worker before saying I referred the client and then the social worker was like, no, she needs to see her* ***maybe she's got an abusive boyfriend that doesn't want condoms at all, maybe that's why she's getting pregnant time and again****, so she needed to see her.*
>
> *[Thandi, Case presentation, 2020, p. 6]*

> ***Extract 55****: Our challenge ne[no] is the rape cases. They come they say they are raped but then they have not reported the rape. And then when you do the scan you find that they are second trimester. Obviously, those ones they can't be helped by us. Then we have to advise them. They must report…..they come and look for beds. If there are beds, they are done, if there are no beds, they are not done.* ***So if it's a rape case, they have to report so that they can get their prioritised****, ne [no]! Also, some, they will say they are raped, mostly if the client says she is raped, you must know now the law is involved. So, you take the proper information about the rape event.*
>
> *[Group discussion, 2021, lines 46–51]*

> ***Extract 56:*** *When the sister spoke with the client itself, the client said, "No, he was my boyfriend, I was not sexually abused".* ***It's just the family members who claimed that she was abused****. Yes, it was a case of statutory rape where she was young, and* ***this guy is like 45 and she's 17****, but it was* ***not a case where she came to the unit and said she was raped*** *or anything because products of conception would have been taken for evidence purposes.*
>
> *[Group discussion, 2021, lines 50–55]*

The difficulty in the case in extract 54 is that the client has repeatedly accessed abortion services coupled with being a HIV-positive patient, which led Thandi to refer her client to a social worker. The social worker suspected that the client may have an abusive partner, thus alerting the provider to some form of coercion, leaving the provider uncertain of how to best assist the client long-term. Referring the client to the social worker seems to have been a step in the right direction. It would be beneficial if providers themselves felt adept at engaging directly in such cases (in case there is no social worker available at the time).

Extract 55 brings to the fore more challenges in such cases, including instances when the client is past the first trimester. This necessitates an additional referral to a hospital offering second trimester abortions, alongside deciphering the grounds for abortion. There appears to be a level of ambiguity ("they say they are raped but then they have not reported the rape") thus leaving the provider feeling stuck as she states that reporting the case as a rape would

help to hasten[75] the process, as the client would get prioritised, and a bed could (hopefully) be made available.

The relevance of "reporting" following a rape case is amplified in extracts 55 and 56, as it appears that the very access to an abortion is dependent on it. Extract 56 reveals an instance in which the client stated that the relationship was consensual, while the family insisted that it was rape. In such an instance, the provider was left navigating third-party involvement, possible sexual abuse, coercion, and the possibility of litigation as the provider was informed by another staff member to fill out a J88 form (which is written evidence of the medical indications pointing towards rape that may be required to obtain a conviction in an assault case).

The CSSR AC Guideline contains sections on what to do in cases when there are third parties present or if a client reveals that they were raped, and aspects related to second trimester abortions. Yet, the training course did not factor in sufficient time for providers to practice counselling while navigating the complexity of a case with multiple and interlocked challenges (such as encountering third party pressure in addition to assisting an alleged rape case or a disabled client).

While the course cannot resolve systemic problems highlighted under section 8.4.2, it can aim to alleviate the stress that providers experience in such counselling interactions. A takeaway from extracts 47–56 is for the course to consider a provider's role in a variety of scenarios and how to develop their skills specific to decision-making abortion counselling while helping an abortion seeker navigate reproductive terrain taking into account short-term and long-term implications of the choices afforded to them. These examples are beneficial in informing role play scenarios for practice in future courses.

As stated in the introduction to this chapter, sections 8.2, 8.3 and 8.4 responded to my third research question and detailed various internal elements of the course that aided and limited providers' engagement with the course and their subsequent provision of client-centred counselling skills. I now progress to my final section that shifts focus from the research question to the overall research project and highlights the undertaking of action research in this project and how it contributed to course development.

[75] The National Clinical Guideline (DoH, 2019) states that one of the conditions that a pregnancy may be terminated between 13 weeks and 20 weeks + six days is if it resulted from rape or incest. It also states that, "it is important that the pursuit of legal recourse in such cases does not detract the provider from offering the TOP services that the individual needs" (p. viii).

8.5 The Role of Action Research in the Course Development

Developing the course using action research (AR) methodology allowed for deeper engagement and introspection by going beyond relying solely on feedback forms to improve the course. The cycles of AR (observe, reflect, act, evaluate and modify) began while conceptualising the research project, and continued through curriculum design and course accreditation, to course implementation and refinement. Action researchers have understood the process to be untidy and evolutionary as it progresses, with the intent to bring about change in the environment where it is conducted (Davis, 2004). In my own experience, while this project did aim to bring about change in abortion healthcare services, the project also encountered much change internally (through its own cycles) as well as externally (due to its collaborative nature and reliance on Rhodes University and the Department of Health, and the restrictions during Covid-19). AR enabled the continuation of the project even during a global pandemic and subsequent lockdown in the country, as it allowed for the format to be adapted from a face-to-face course to an online course and back to a face-to-face course again. Against this backdrop, this project has accumulated a lot of data due to my ongoing reflections, analysis and need to refine the course. I share a couple of these deliberations in the following two sub-themes.

8.5.1 Potential for a Dual Format Course Design

As the course was held remotely, intra-covid, as well as in-person, post-covid, it highlighted that some aspects of the course are better suited to being conducted in person whereas other parts of the course *can* be adapted to an online medium with some components conducted asynchronously (during the fieldwork components where participants worked on their case presentations and reflective journals in their own time with input from the facilitator via email or WhatsApp). Section 8.4.1 highlighted the disadvantages of each course identified by participants, creating the potential to improve those aspects. However, it also emerged that, within the constraints of the pandemic, several participants from ACCC 2020 (the online course) appreciated the opportunity to attend a training workshop and improve their skills amidst their restrictions.

Tables 8.2 and 8.3 cover the benefits experienced by participants of each course. The data in this sub-section were from participants' feedback forms and reflective journals and (like Table 8.1) lends itself to semantic coding. The tables provide extracts from participants that underline aspects that they appreciated about the course.

Table 8.2

Advantages of the Online Course (ACCC 2020)

Online Course (ACCC 2020) Advantages	Summary
"It has been a nice experience of me as I did not know anything about zoom to begin with. Learning online is good thing for me especially in this era of Covid. We get to do things online without meeting up." *[Thandi, Reflective journal, 2020, p. 6]*	Appreciation for online format during Covid No prior knowledge of Zoom, thus, appreciated learning about it
"It is my first time with the online. I feel it does work." *[Beauty, Feedback form 1, 2020, p. 18]*	First experience with online technology; found it positive
"Online training is the best to me, more especially during this pandemic disease Corona." *[Bonga, Feedback form 1, 2020, p. 18]*	Appreciation for online format during Covid
"This was my first online class, and it does work. It has been very engaging and informative for me." *[Peter, Feedback form 1, 2020, p. 18]*	First experience with an online course Found it engaging and informative
"To me it is so interesting since it's my first time and it is very clear as if I'm in a classroom." *[Jane, Reflective journal, 2020, p. 3]*	First experience with an online course Compared it to being as clear as in a classroom

Elements of the online course that were appreciated include: the opportunity to learn online with an introduction to Zoom; identifying the benefits of joining an online course; recognising that even in times of uncertainty such as a pandemic, it is still possible to advance their skill development; finding the course engaging and informative; and seeing it as an opportunity that helped to improve not only their counselling skills but also their IT skills, which were necessary to engage in the course. Despite participants facing multiple challenges during the online course, it appears that the online format was well-received and appreciated. The ACCC 2020 course, implicitly and explicitly, had guided participants in developing the informational technology (IT) skills necessary to successfully engage online, both interpersonally (using the break-out room feature on Zoom) and pedagogically (through note taking, reflective journals and peer supervision). Thus, even though various setbacks (identified in section 8.4.1) existed during the online course, findings suggest that there are added benefits with the acquisition of new technological skills. As participants did not have a face-to-face course for comparison, their focus was centred on their experiences of only the online format within external constraints. Thus, this contextual feedback is valuable as it highlights the positives of the online format, which can be extrapolated when considering the

facilitation of a future courses that may need to take place within similar or other external constraints (such as limited resources, time, or funding).

In engaging with the participants, their contexts and requirements, it is clear that there are some benefits to the course being conducted remotely (or as asynchronously as possible) due to budget constraints and because communities rely on them as their sole abortion provider. The time providers spend away from that setting is detrimental to those community members seeking abortion services. Yet, providers need time to debrief and engage face-to-face with facilitators and colleagues without the concern of needing to attend to work, alongside training. This would lessen the isolation and burnout experienced by providers.

Table 8.3

Advantages of the FTF Course (ACCC 2021)

FTF Course (ACCC 2020) Advantages	Summary
"It's great because we are able to physically see the facilitators, to concentrate more on the learning activities and not being disturbed by colleagues or family like visual training, to be able to discuss activities as groups, and discussing our challenges as colleagues." *[Nondumiso, Reflective journal, 2021, p. 19]*	Meet facilitators in person No disturbance from colleagues or family = better concentration Face-to-face discussions with peers
"I feel like it was a good idea to come for face- to-face because it also gives us, as providers, to debrief and socialise and vent our feels in a comfortable environment without interruptions." *[Casey, Reflective journal, 2021, p. 19]*	Debrief in-person and socialise Increased comfort in a face-to-face environment with no interruptions
"Face to face allows us to communicate with each other freely and discuss topics further, sharing of ideas where one can be able to ask questions immediately for clarity purpose, so by the time one leaves the session, everything is clearly understood. It gives us a chance to discuss topics freely without having to worry about network or data finishing, so it's cost effective." *[Thato, Reflective journal, 2021, p. 19]*	Improved communication Ability to ask questions and clarify doubts with immediate feedback No network glitches = improved communication
"I find it good and exciting as we can share our experiences when it comes to CTOP and also we can engage on a personal space as a group." *[Ruth, Reflective journal, 2021, p. 19]*	Engage at a more personal level due to meeting in person
"It's easily accessible to receive information, read, and write. It's easy to ask questions and easy to enquire about what we want to know. I find it easy to talk about the topics we engage in and to talk about our experiences at work as providers." *[Sethu, Reflective journal, 2021, p. 19]*	Face-to-face enabled better facilitation, learning, clarifications, and discussions

In summary, elements of the face-to-face course that were appreciated include being able to: engage with facilitators in person; socialise with other providers; debrief and vent; communicate freely; have more in-depth discussions; share ideas; clarify doubts with the added benefit of immediate feedback; engage in a more personal way; access information easily; ask questions; and talk about shared experiences as providers – all this without the stress of network and connectivity issues and without disturbances from other colleagues or family. Some providers compared the benefits of the face-to-face course to those of the online course, suggesting that they had prior knowledge of the online course conducted the previous year and had received some feedback from the participants of that course.

In viewing providers' acknowledgements of the online course format and the time and budget constraints, one consideration would be to decrease or remove the elements of the online course that hinder course engagement while considering a dual format where Part One of the course is conducted face-to-face giving providers an opportunity to meet, and Part Two is conducted online (after their fieldwork) with providers presenting their case presentations in an online format while additionally developing their IT skills. While an entirely face-to-face course is, of course, the most ideally suited, the capacity to compare and learn from each course format through action research has created an opportunity to consider and design a dual format option of the course. Thus, the potential for online abortion counselling courses for providers, and even managers, doctors and other professionals in healthcare settings, must not be ruled out entirely.

8.5.2 Mentalisation in Nurses Training

Mentalisation is a concept that relates to a nurse's ability to demonstrate empathy towards their patients as well as an awareness of themselves (Satran et al., 2020). The benefits of this skill in a healthcare context is gaining momentum with nursing-related research studies acknowledging the value of mentalisation abilities (Morenon, 2024; Satran et al., 2020; Warrender, 2015; Welstead et al., 2018) for providers and their patients, thus improving the quality of service.

The extracts that follow present an awareness in participants about the interactional dynamic of their exchange with a client, with a focus on not only the client but also themselves:

> ***Extract 57****: Also to help me through debriefing because it is not only about a client alone, also CTOP providers. My self-calming techniques: breathe and inhale calm and exhale stress; admit that I'm anxious or angry; release the anxiety or anger; visualise myself calm; must change my focus and focus on what's right.*
>
> *[Mary, Reflective journal, 2020, pp. 1, 5]*

> ***Extract 58****: I have learned how first I am very nervous but as time goes [by] I gain confidence and it is what I need to be more confident, also towards my clients.*
> *[Phillani, Reflective journal, 2021, p. 22]*

Mary (in extract 57) speaks about the critical value of debriefing, and then rightfully adds that “it is not only about a client alone, also CTOP providers,” implying that it is just as important to address the needs of a provider as it is to assist a client. In fact, reference to the need for debriefing was made by nearly all participants in both courses, underlining an acknowledgement of their difficulties and the value in lowering their cumulative stress. Mary highlights her strategies to remain calm, which include first recognising that she is feeling angry and anxious, thus drawing awareness to her own emotional state, which then enables her to alleviate her stress and focus on what is right (for the client). Phillani (extract 59) has a similar reflection by drawing his attention inward, towards himself and then outward, towards his client. He observes that he first tends to feel nervous and then his anxiety is replaced with confidence over time. Phillani shares that building his self-confidence enables him to provide the same level of assurance to his clients.

Mentalisation skills can enable nurses to deal with complex and emotionally demanding situations (Satran et al., 2020). This is channelled through an awareness of the mental states of oneself and that of a client (Allen et al., 2008). The findings in the three analytical chapters clearly point to high pressure, a variety of emotionally charged scenarios with clients, and a demanding work environment faced by abortion providers. Their ability to focus on the client while being self-aware appears to create more sustainably empathetic exchanges with clients than when only focusing on the client. The extract below points to a win-win situation:

> ***Extract 59****: I think my client will benefit as I also have benefitted from the course. If someone receives support from the managers at work, I think she is also able to support her client in a proper way.*
> *[Bonga, Reflective journal, 2020, p. 7]*

In extract 59, Bonga offers some critical insight into an aspect of the course that was not envisioned at the outset. Bonga acknowledges the course as a supportive space, one that she has “benefitted” from. She considers that her client may ultimately reap these benefits as it is in receiving support from her manager that she would be able to pass it on to her client. The link that she makes – receiving support facilitates providing support – is vital, as it points to the role of the training courses in building mentalisation skills. In other words, the course supported her by creating a space to de-stress, debrief and vent (through group discussions on workplace challenges, difficult cases, etc.). She now perceives being able to create the same supportive atmosphere for her client and allowing her to vent. As stress interferes with the ability to effectively mentalise (Holmes, 2008), in the absence of the course, having a

supportive manager could mitigate Bonga's stressors, enabling her to be more present and mindful in her counselling practice.

Warrender (2015) noted that staff nurses who had undergone mentalisation-based training found it to be an empowering skill that further facilitated a change in attitude towards patients while promoting empathy. Extracts 57-59 showcase shifts in providers' behaviours and attitudes. Empathy is a cornerstone of client-centred counselling, as it is of mentalisation. Yet, it is only one side of the coin in mentalisation; the other being self-awareness (Allen et al., 2008). The next two extracts showcase moments during counselling micro-interactions when providers demonstrated self-awareness, enabling mentalisation abilities:

> ***Extract 60****: I felt the difference and I could notice it on my session with my client that now I was no longer imposing my views, no matter if I met a case that* ***I felt it was tapping on my other types of, you know, feelings****. But I could like, you know,* ***control the situation*** *because of the course itself… So, this moment was for me, a moment where I felt all these* ***sudden arousal of emotions****, you know.* ***I was angry*** *at this man,* ***but I did not display it.*** *Instead, I displayed a non-judgemental approach.*
>
> *[Peter, Case presentation, 2020, p. 1]*

> ***Extract 61****: Then after seeing that I know this client, I'm sorry, I chased her out of my office.* ***I was very much angry****. I chased her out, cause she was coming last year, 2019. She was here in May this year again, she was here for the second time. And then now is the third time.* ***I couldn't hold myself, I chased her out. Then I thought to myself, I used the self-calming techniques*** *to calm myself yho [wow] just to try and make myself understand, not to be judgemental and keep in mind that it's her choice to do termination of pregnancy, at the end of the day. Even if she wants to do it for the twentieth time you have to do it. So, after calming myself* ***I called her in again and then I apologized for the behaviour that I portrayed****, and then uhh I told her that there will be confidentiality. It will stay between us, and I welcomed her. I introduced myself and all that.*
>
> *[Thandi, Case presentation, 2020, p. 6]*

In extracts 60 and 61, the nurses display a few characteristics of mentalisation. Firstly, they both focus their attention inward as they aim to understand their own thoughts and feelings. Peter and Thandi experience anger, though at different people. Peter's anger is towards the man who impregnated his client (see extract 50), as he senses an injustice within their relationship with the partner coercing his client to abort. Thandi is angry at her client as it is her third abortion (see extract 46, chapter six, in which she questions herself and experiences a sense of failure due to repeat abortions). They both also make reference to the fact that self-awareness helped them to manage their emotional state (Peter could "control the situation" and Thandi used "self-calming techniques") and subsequently assist their clients by effectively using a client-centred approach.

Allen et al. (2008) support Carl Roger's argument that non-directiveness of a counsellor does not equate passivity; rather, it is precisely this aspect that makes the role of a counsellor (or abortion provider) so challenging. Since the nature of client-centred counselling focuses intensely on the needs of the abortion seeker, it can conversely almost "invisibilise" the thoughts and feelings of the abortion provider. This is fundamental from a reproductive rights perspective, since the opinion and beliefs of anyone other than the abortion seeker are inconsequential as long as the abortion seeker meets the legal criteria for the procedure. The challenge lies in the lived experiences of providers who face multiple interwoven stressors, making it tough to continuously be empathetic. Thus, for nurses, "holding the mind in mind" while "seeing yourself from the outside and others from the inside" (Allen et al., 2008, p. 3) can be a fundamental component in finding a balance between managing their clients' needs against their own mental states, more so when facing a challenging case. Peter and Thandi demonstrated these abilities in how they evaluated their own psychological states, recalibrated themselves, and approached the situation differently. They reiterated their case presentation observations in their reflective journals:

> ***Extract 62****: To control my emotions, even if I feel strong about something [on the] subject that my client might be raising…I have learnt to cope/ control my emotions on different cases.*
>
> *[Peter, Reflective journal, 2020, p. 11]*

> ***Extract 63****: I have also discovered that in order to cope, I should use coping mechanisms if I am faced with a difficult situation. This has increased my self-awareness thus helping me develop a better understanding of others.*
>
> *[Thandi, Reflective journal, 2020, p. 11]*

Once again, in both extracts, the providers display an ability to think about their feelings and a cultivation of their mental skills (as described by Allen et al., 2008). Peter is now able to manage different cases as he is more aware of when he becomes emotionally charged ("feel strong about something"), and Thandi admits that an increased self-awareness has enabled her to be more considerate and empathetic towards her clients. Participants' capacities to mentalise appears to have created a buffer for providers that functions as a protective factor with the potential to safeguard them from fatigue and burnout in the long run. Although not termed 'mentalisation skills training,' it does appear that providers felt empowered from their training, as Peter and Thandi discovered and learnt ways to cope in situations that were demanding.

Previous research has described that mentalisation-based training is like common sense (Bateman & Fonagy, 2010) and that due to its implicit nature, the technique is quite natural (Warrender, 2015). This led to nurses in Warrender's (2015) study stating that prior to

gaining mentalisation, they probably followed a similar practice. Extracts 60 to 63 reveal a similar sentiment with participants indicating mentalisation abilities without labelling them as such.

The capacity for mentalisation was not set out in the course outcomes; however, the themes that I developed through my own frame of reference as a counselling psychologist and reflective action researcher led me to note this skill development as participants began to allude to various features of mentalisation. I posit that the creation of a space for nurses via the training course is now being mirrored in their interactions with their clients as they foster safe, non-judgemental spaces for abortion counselling.

Allen et al. (2008) view mentalising as refining (rather than creating) an approach to counselling, and they highlight ways in which these skills can enhance client-centred counselling. This is beneficial to note as the client-centred approach to abortion counselling can therefore remain central to the course, with the addition of mentalisation as a topic to augment the benefits of training for clients and providers. This also highlights the relevance of using action research to refine the course, as the theme was generated from the research data.

8.6 Conclusion

This chapter shows that the “support buddy” WhatsApp group served as a source of informational and emotional support to providers during and after the course. Participants valued the certificates they were given, with most stating that this was the first time they had received any form of formal recognition as abortion providers. This served to boost their morale while voicing their commitment to enabling women’s reproductive rights. The notion of abortion providers as human rights defenders is a strong motivator for nurses, and this concept has already begun gaining traction in feminist research. This chapter offers some pleasant counter-narratives related to providers, who have typically been perceived in the literature as shaming, blaming, and punitive. This chapter has examples of providers relating to their clients respectfully, while going out of their way to keep abortion services up and running. Evidenced in these sub-themes are the ways in which microlevel changes influence abortion service provision enormously (such as the act of one provider standing up to her manger to keep her clinic open, with a threat to stop work otherwise). This step will have impacted the lives of so many women. Also evidenced are systemic issues and how intersectionality highlights various inequities that disservice women who are disabled, who have been sexually abused, and who are in gendered power relationships and experience reproductive coercion.

CHAPTER NINE: DISCUSSION AND CONCLUSION

9.1 Final Reflections

The main aims of this research were to operationalise the CSSR AC Guideline titled *Abortion Counselling in South Africa: A Step-by-Step Guide for Providers*. This was done by developing the Abortion Counselling Certificate Course (ACCC) based on reproductive justice principles, evaluating whether and how the course met its learning outcomes, and refining it based on feedback from participants and research analysis.

In this final chapter, I summarise the problems surrounding of abortion counselling highlighted in prior literature and the CSSR baseline research that led to the need for the training course. I highlight the successes of the training courses and the outcomes that they met. I then speak to areas of improvement in the course based on participant feedback and researcher evaluation. I underline the core components of this project, namely: the reproductive justice principles and the dialogical pedagogy that underpinned the course; action research methodology that guided the training course; and the reflexive thematic analysis that offered a rigorous analytical process. I view each component as a strength in this project due to the manner in which they complemented and enhanced each other. I conclude with a section on suggestions for future research.

9.2 Problems Revealed in Abortion Counselling

South Africa's Choice on Termination of Pregnancy (CTOP) Act of 1996 embeds a woman's right to an early, safe, and legal abortion. The Act makes abortion available: up to 12 weeks of pregnancy, *on request*; under specific circumstances from 12–20 weeks; and on particular medical grounds, after 20 weeks. The Act promotes non-mandatory and non-directive counselling pre- and post-procedure. An abortion within the first trimester may be offered by a registered nurse or midwife who has undergone the prescribed abortion procedural training.

In traversing the historical and theoretical landscape of abortion counselling literature, several persistent difficulties emerged. While I included global literature in chapters three and four – due to limited abortion counselling research in South Africa – my focus in this concluding chapter will relate specifically to the South African context. The aspects most relevant to this project relate to the prevalence of directive pre-abortion counselling practices within public health clinics in the Eastern Cape province, as evidenced in the CSSR baseline research (du Toit, 2023; du Toit & Macleod, 2024; du Toit & Macleod, 2025; Mavuso; 2018; Mavuso et al.,

2017; Mavuso, 2021; Mavuso & Macleod, 2019; Mavuso & Macleod, 2020; Mavuso & Macleod, 2021; Mavuso et al., 2023). With most nurses essentially viewing abortion as a problematic procedure, their efforts tend to centre on dissuading women from using the service, instead of neutrally supporting and respecting a client's informed decision (especially in first trimester cases when it should be available on request). Nurses tend to impose their personal or societal beliefs on clients, resulting in judgmental undertones towards abortion seekers. Some providers see their role as "saving lives" while creating responsible women. Such paternalistic attitudes can manifest in tactics like emphasising the negative outcomes of abortion (e.g., exaggerated health risks or future infertility) or describing the foetus in emotive and personified detail ("it has arms, legs, a heartbeat") that further instils fear, guilt and shame in women. These practices directly undermine the non-directive counselling mandate of the CTOP, which calls for counselling that is voluntary and unbiased.

Another central issue is the conflation of abortion counselling with the provision of contraceptive information (Beja & Leal, 2010; Bender & Geirsson, 2004; Kilander et al., 2018; Purcell et al., 2016). Providers often attribute a woman's abortion decision to improper contraceptive uptake and, through a series of leading questions, use the counselling session to reprimand her. This directive, one-size-fits-all approach ignores the complex realities that contribute to unplanned pregnancies, such as power imbalances in relationships, contraceptive supply issues, or societal pressures on women to bear children. Such "counselling" negates a woman's immediate needs and erases her context, which might include contraceptive coercion or lack of access. Thus, rather than providing emotional support or relevant information about the procedure, the interaction devolves into shaming or scolding, leaving the client feeling unheard and unsupported.

Other hurdles that were revealed relates to the mandatory versus voluntary nature of abortion counselling (Brown, 2013; Hoggart, 2015; Rowlands, 2008; Mavuso & Macleod, 2020). In South Africa, even when abortion is available *on request* within the first trimester, and even though counselling is optional, in practice, clients may feel it is obligatory. The literature reviewed indicates that counselling can be a gatekeeping step as clients often feel like they must comply and appear remorseful to secure the service, which can distort the counselling encounter into a perfunctory ritual.

Empirical insights into abortion counselling from the viewpoints of abortion seekers and providers reveal a disconnect characterised by mutual mistrust and negative preconceptions. The literature highlights negative assumptions that are two-sided: abortion seekers presume they will be treated poorly, and providers presume clients are irresponsible, leading to an interaction clouded by stress and stigma (Harries & Constant, 2020; Macleod et al., 2019,

Mavuso & Macleod, 2020; Mokgethi et al., 2006; Röhrs, 2017). This mutual negativity clearly undermines the therapeutic potential of abortion counselling as a space that can be informative and containing.

Additionally, many providers face external pressures, a lack of support from their managers, unavailability of resources, and a lack of training and space to debrief (du Plessis & Macleod, 2024; Harries et al., 2009). Providers report frustration with systemic issues like staff shortages and high demand, which leave them with little time for each client. Some nurses experience difficulty reconciling their personal beliefs with their professional duties. This can result in counselling that is procedure-focused and institution-driven. For instance, providers might focus on paperwork and informed consent rather than engaging empathically with the client. Negative provider attitudes, feeling isolated at work and burnout (often from being overworked or socially ostracised for performing abortions) can translate into a detached or harsh "counselling" style.

The findings discussed in chapters three and four reveal that women's needs vary; a one-size-fits-all counselling approach is inadequate. Quality abortion counselling needs to be individualised (cafeteria-style), judgement-free, voluntary, and with the potential to function as a de-stigmatising space. Positive client experiences occur when counselling focuses on providing clear information and reassurance about the procedure, thereby alleviating any fears. Conversely, negative experiences often involve clients feeling shame, stigma or that their voices are unheard, reinforcing their initial concerns of judgement.

Furthermore, inconsistent counselling models and a lack of standardised training for abortion providers mean that the quality of abortion counselling varies greatly. This inconsistency means that clients' experiences can range from supportive and informative to hurtful and shaming, indicating a lack of clear guidelines and accountability in counselling practices. These problems collectively hinder the quality of abortion care by compromising the support, information, and respect that clients should receive in counselling. The baseline research argued for the importance of a feminist client-centred counselling approach, thereby advocating for an intervention like the ACCC training to help providers reflect on their biases and improve their counselling approach, and to ensure that clients' voices and rights are better acknowledged in the counselling setting. This is what is addressed in my research.

In my study, a reflexive thematic analysis helped respond to the following questions: whether the reported learnings and reflections of the course participants dovetailed with the specific outcomes of the training course; and what elements, whether internal or external to the course, were identified as enabling or hindering nurses' skills in providing abortion counselling services based on reproductive justice principles. The former question delved into the demonstrated

praxis of nurse participants during and post-training. This helped to re-evaluate the course content, specific course outcomes, and course assessment criteria. The latter question was broken down into two parts and were dealt with across two analytical chapters. Chapter seven engaged with external elements to the course and chapter eight engaged with internal elements of the course.

9.3 Evaluating the Effectiveness of the Abortion Counselling Certificate Course

Evidenced in the data (from chapter six) is the success of the ACCC in achieving many of its goals. Participants demonstrated their critical thinking skills via case studies (outcome one) by noting differences between problematic and positive abortion counselling practices. They showcased both *reflective* and *attending* listening skills in staying attuned to clients' verbal and non-verbal cues and adjusting their own body language to display a welcoming attitude. They, thus, exhibited their capacity for deep listening (outcome two). Having been exposed to different kinds of abortion counselling in the CSSR AC Guideline – pre-procedural, procedural, post-procedural and options – participants expressed varying comfort levels in providing each of these (Tables 1 and 2 in chapter six) with a developing ability to identify which client would benefit from what type of counselling. This was visible in a couple of ways: firstly, through cognitive shifts in appraising that their previous practices with abortion seekers were mostly information-led and lacking structure; and secondly, through behavioural changes by structuring the flow of the session to follow the CSSR AC Guideline while informing clients about and offering them different kinds of counselling. Providers, thus, demonstrated their capacity to identify what kind of counselling is needed on a case-by-case basis (outcome three) and put forward the idea of a tailored and individualised approach to abortion counselling.

I then showed how participants came to comprehend the premise of client-centred abortion counselling and therefore what to include and avoid in a session (outcome four) by highlighting client interactions prior to, during and post-training. This comparative analysis provided some insight into their thinking and actions over the duration of the course and demonstrated how their focus shifted in the following ways: from a focus on documenting the process to a focus on centring the client; from seeing a client and their abortion as problematic to helping a client resolve their problem; and from concentrating on clients' reasons for abortion (related to first-trimester abortions) and non-usage of contraceptives to enabling reproductive agency and bodily integrity. The next theme underlined their building of skills and confidence in abortion counselling (outcome five) and revealed how this was distinctively facilitated by peers with the added advantage of an overall improved morale for all participants

in the course. The findings from chapter six helped to inform the refinement of course activities and outlining of course outcomes (section 9.4).

Furthermore, the ACCC addressed a significant gap in pre-abortion counselling practice by promoting a non-coercive and non-judgemental engagement with clients. This aspect provides clarity to providers on the CTOP Act's stipulation of what "non-mandatory" and "non-directive" counselling looks like. I say this because, in giving providers the benefit of the doubt, it is possible that some participants may have been unaware that behaviour can be pressurising while inducing shame and guilt in abortion seekers. During and following the training, participants reported an increased awareness of how implicit biases, personal values and systemic pressure shape their abortion counselling interactions. This came through in their reflective journals, highlighting that the ACCC was valuable in promoting a rights- and justice-based approach to abortion counselling. Yet, as revealed in chapters seven and eight, the sustainability of their newly acquired skills is precariously dependent on various external and internal elements that either enable or hinder their implementation in clinical settings.

9.4 Refining the Course Outcomes and Course

While the ACCC has shown much potential in achieving its outcomes, it is important to consider certain refinements to enhance its ability to equip providers with client-centred counselling skills. The data and findings (mainly from chapter eight but also informed by chapter seven) suggest key areas where modifications to the course design and outcomes would help to better align the training with the lived realities of abortion providers, thereby improving client engagement. I offer alterations to the course and its outcomes, which are based on my analysis and the reflections and experiences of the nurses.

9.4.1 Deepening the Emphasis on Active Listening

Nurses demonstrated considerable growth in attending and reflective listening skills; however, further reinforcement of these skills through practice and supervision (peer or facilitator) is indicated. Participants themselves suggested more time for practice, which indicates the benefit of additional applied exercises that focus on non-verbal listening and client-mirroring. Future iterations of the course could include more structured experiential learning through recorded role plays with feedback, and peer-reviewed counselling transcripts. For example, the CARM activity can take place as a group discussion (and not just individual engagement), firstly, to enable deeper reflection due to the benefits shown through peer-

supervision; and secondly, to remain responsive to providers' feedback, thereby ensuring that the curriculum evolves in alignment with the realities of their context and the setting.

9.4.2 Expanding Training on Diverse and Specific Counselling Needs

Participants remarked on how different clients' needs necessitate different counselling strategies. The course addressed various types of abortion counselling – decision-making, pre- and post-abortion, and procedural. However, the findings show that providers would benefit from a nuanced understanding of how to tailor their approach to specific client needs. Further course refinement can, therefore, engage in content- and context-specific cases introduced in session by course participants themselves. This would better equip nurses to deal with more complex cases that link more closely to their lived experience.

9.4.3 Enhancing Reflexivity and Self-Awareness Training

The course helped to foster reflexivity while prompting participants to critically explore their practices and biases related to abortion and abortion seekers. The findings suggest that further reinforcement is needed to ensure these insights translate into sustained practice of client-centred abortion counselling. Some providers continue to struggle with discomfort, particularly in cases of repeat abortions or clients with complex social circumstances. Strengthening structured self-reflection exercises such as guided journalling, group debriefings, and moderated discussion on ethical and moral dilemmas would enhance providers' abilities to maintain non-judgemental interactions.

9.4.4 Reinforcing the Application of Reproductive Justice Principles

During the course, nurses recognised the relevance of considering socio-economic and political structures and barriers to reproductive autonomy. The data do indicate instances where its application in day-to-day practice remains inconsistent, such as chasing a "repeat abortion client" out. Although this instance served as a good example for growth and critical self-reflection, it also reveals that such reactions continue to occur (clearly exacerbated by external elements). There may be some use in operationalising RJ principles in client interactions by refining the outcomes to include specific competencies related to advocacy, systemic awareness, and client empowerment. This may help providers to integrate RJ principles more effectively into their practice. In order for providers' practices to be nurtured and maintained, it is crucial to give due consideration to suggestions made by participants themselves. Nurses recommended involving managers and clinic supervisors in the training or offering separate training for them. This would foster support for abortion providers. As was

visible, nurses who expressed having a supportive manager expectedly had a better work experience.

9.4.5 Strengthening Peer Support and Supervision Structures

One of the most impactful elements of the course was the sense of peer connection and shared learning. Nurses frequently commented on the value of engaging with colleagues (who understood their point of view) to exchange experiences and seek advice when necessary. However, there is a need to institutionalise and formalise these support structures beyond the duration of training. The course manual could include recommendations that equip participants with ideas for ongoing peer supervision, case consultations, and informal mentorship networks. An annual meet where providers from across the Eastern Cape partake in a case conference (where each nurse may present on a client's case – challenges and successes) may be a motivating factor for continuing best practice. This would further align with nurses' Continuing Professional Development.

9.4.6 Embedding Ethical Decision-Making into Everyday Practice

My research findings indicate that providers encounter ethical dilemmas that challenge their ability to maintain a client-centred approach, particularly in cases of third-party involvement and reproductive coercion. Although the ACCC introduced ethical principles, the data show a need for greater practical guidance on navigating such dilemmas in real-time counselling sessions. Refinement could therefore include practice related to scenarios on ethical decision-making following reflective discussion on any provider distress.

9.5 Strengths of the Study

This study provided several notable strengths, especially in its critical baseline research, methodological approach, analytical framework, and theoretical underpinning of reproductive justice. By integrating action research methodology and a reflexive thematic analysis into this framework, the study provides a rigorous and contextual exploration of abortion counselling training. I speak to each of these elements and how their interwovenness strengthened my study.

Firstly, a strength in this project was the baseline research as a pre-existing benchmark for comparison. Although the main aim was to assess participants' demonstrated and reported counselling skills against the course objectives, I also noticed changes in participants' attitudes and behaviours post-training. One of the themes (section 6.5) offered a comparative

analysis of providers' practices prior to participating in the course, which overlapped with findings from the baseline research. Post-training, their focus shifted from mere information-giving to enabling reproductive autonomy, from completing paperwork to centring the client, and from viewing the client's request as a problem to approaching the client with an intention to problem-solve.

Secondly, the iterative cycles of action research (AR) were well suited for designing a course, as it allowed for direct and ongoing engagement with participants, continuous feedback, and the adaptation of training based on real-world experiences. Although this was not PAR, the course positioned participants as co-creators of knowledge, since providers could reflect on their experiences and articulate their challenges while proposing context-sensitive solutions (such as deciding to "scratch out" reasons for abortion within the first trimester from the old form during client intake administration). The flexibility of AR enabled an easy enough transition from a course that was designed for a face-to-face format to an online format and then back to a face-to-face course. While this was arduous during implementation, it was made manageable due to the choice of methodology. Overall, this method proved to be dynamic by enabling real-time learning and responsiveness to quality abortion services. The feasibility of conducting the course in two formats offers insight into the applicability of online training and peer supervision for abortion providers, while also highlighting its challenges with network connectivity.

Complementing the nature of action research that facilitated feedback, reflection and refinement was the course pedagogy which was dialogical (inspired by Paulo Freire's educational philosophy). Learning took place through critical dialogue and mutual knowledge exchange rather than a one-way lecture for the entire duration. In practice, it meant that as a facilitator, I *talked with and not at* the participants, while acknowledging the nurses' own experiences and insights. Training sessions were interactive – including group discussions, role plays, and reflective exercises – creating a space where participants could share their challenges and discuss cases that they managed well. This dialectical learning helped to develop nurses' critical consciousness about abortion care. Nurses' on-the-ground experiences in abortion work (such as constrained resources and their difficulties with "repeat" abortions, to name just a couple) and the facilitators' broader feminist and reproductive justice approach were exchanged. This collective reflexivity reinforced key course principles – for instance, when legal facts and RJ principles were introduced in dialogue, nurses began to reconsider institutional norms and their own practices in the light of those principles.

Fourthly, my adoption of a reflexive thematic analysis bolsters this study's contribution to the field. It allowed me to confidently move away from positivist notions of validity,

objectivity, and generalisations, thus emphasising the development of a context-specific training course. This does not mean that the research lacks rigour. I convey the study's credibility through my own journal entries across the duration of the course, while emphasising the theoretical underpinnings of my data and findings. These reflections prioritise the subjective experiences of providers and facilitators while acknowledging the complexity of our professional identities. For example, I was a course facilitator evaluating providers' skill development while also being a researcher who was evaluating my own practice of facilitation and course development. It allowed me to engage deeply with my data and to incorporate insights as they evolved over time and across courses. As an outcome I did not shy away from my own professional identity. My subjective lens, as a counselling psychologist and critical health researcher, led me to naturally empathise with providers (whose behaviours towards patients are typically criticised) in viewing their many personal, micro- and macro-struggles. I believe this was valuable given the sensitivity and stigma surrounding abortion, as it provided a nuanced understanding of how providers (and myself) navigate roles in this field of work.

A combination of the action research methodology and a reflexive thematic analysis enabled a deeper analysis of the personal aims (to understand and inform my learning to improve my behaviour and practice) and social aims (to facilitate the learning of participants to enable them to improve their behaviour and practice) of AR.

Lastly, the reproductive justice framework is a further strength in this study due to its considerations of the systemic structures that shape individuals' access to abortion services. The lens informed the course content by broadening the scope of abortion counselling beyond a narrow "choice" narrative. For example, the curriculum addressed how factors such as rurality, poverty, gender dynamics, and access to resources shape clients' reproductive decisions. The course encouraged nurses to enable clients' autonomous decision-making and dignity in abortion care, rather than imposing their own personal or moral judgments.

I set out to develop nurses' skills by gaining a better understanding of the historical, socio-economic and political context of abortion seekers. Inadvertently, the lens also helped providers to better comprehend their own frustrations and restrictions in service provision (creating a space to "vent"). It thus ended up being a particularly relevant framework in contextualising providers' own experiences by illuminating the intersectional challenges they face from institutional constraints to broader societal stigma. By embedding RJ within the research design and the training curriculum, this study extends beyond individual-level counselling techniques to advocate for structural change in abortion service provision.

Several nurses spoke of a newfound sense of purpose as advocates for women's rights. A highlight was the instance where one nurse stood up to her manager to ensure that

the women's health clinic would stay open. This shows that the study not only contributes to academic discourse but also has practical implications for improvement in access to quality abortion counselling, even if it is just one provider at a time.

9.6 Limitations of the Study

I have included the limitations of this PhD study that I identified or that have been highlighted to me over the progression of this project. Some challenges were difficult to overcome due to the university-based nature of the study. Time and resource constraints also stemmed from clearance processes (from Rhodes University and the Eastern Cape Department of Health) and short-course accreditation, which was valid for one year. This allowed for only two cycles of action research to be completed within the PhD timeline. A longer project might have conducted additional cycles to further refine the course while overcoming identified setbacks.

The scope and sample size were relatively limited: the action research was conducted via two iterations of the course with a total of 18 nurse participants (nine per course). While a small-group approach was appropriate for an in-depth action research study, it does limit the generalisability of the findings. The participants were all from a specific context (public-sector abortion providers in one province), so the results and course design insights may not directly transfer to different regions or to providers with different profiles (such as doctors or counsellors outside the nursing profession).

External circumstances such as the Covid-19 pandemic introduced more limitations. From a training course perspective, I have previously highlighted the difficulties with network connectivity and how this impacted teaching and learning. From the perspective of research, each iteration of the action research cycle was conducted in a different format. Thus, a precise comparison within each format was not possible. It would have been useful, for example, to note how changes made to improve online participation (following ACCC 2020) would have influenced the demonstrated learnings in a second online course. This could not be evaluated as the second course was conducted face-to face.

Another important limitation involves constraints that relate to the data collected and the perspectives from where it was generated. The evaluation of course outcomes relied heavily on participants' self-reported reflections (through journals, feedback forms, and interviews) and the researcher's observations of training sessions. Direct evidence of changes in actual counselling practice or client outcomes was not obtained within the project's timeframe. As noted in the thesis, determining whether, post-training, nurses truly provided

feminist client-centred abortion counselling based on reproductive justice principles, would require follow-up data from abortion clients themselves and recordings of actual sessions. This was beyond this study's scope, although it is being taken up by other CSSR researchers. Therefore, the conclusions about improved counselling practices remain somewhat provisional, as I cannot ascertain how sustained or effective the changes are in real-time counselling interactions.

Researcher involvement presents another potential limitation. As a PhD researcher, I was involved in the course design, facilitation, data collection and evaluation of the participants praxis and the course itself. Having these multiple roles raises the possibility of observer bias. Additionally, my own enthusiasm for the RJ framework and counselling techniques might have unintentionally steered interactions, shielding me from viewing any other approach that may have been advantageous (such as a reparative justice framework). However, this is somewhat counterbalanced by the reflective nature of the methodology – as I did maintain a reflexive journal, and sought peer and supervisor feedback to illuminate my blind spots and challenge my prejudices.

Related to my own bias is the notion of social desirability bias amongst nurses (discussed under *Ethical Considerations in Action Research,* section 5.9). This speaks to the tendency of participants to respond in a manner they believe is expected or acceptable to the facilitator. Participants knew that I was evaluating the course, which may have influenced them to give "right answers" or overly positive feedback to please the facilitator, as they were aware that they were also being assessed. I attempted to mitigate this by firstly allaying their concerns about their performance and fostering trust. I also checked for inconsistencies in participants' responses (discussed in the last paragraph under *Reflexive Providers,* section 6.9) but some bias is inevitable.

9.7 Implications and Suggestions for Future Research

The study offers valuable insights into the complexities of abortion counselling training, highlighting both its strengths and areas for improvement. While the findings reveal a strong foundation for the enhancement of client-centred counselling practices for in-service nurses based on reproductive justice principles, it also uncovers several avenues for further exploration.

9.7.1 Longitudinal Evaluation of Training Outcomes

This study captured immediate and short-term shifts in knowledge, attitudes, and skills of nurses. However, it remains unclear if these changes will be sustained over time. A long-term evaluation of the impact of the ACCC on providers' counselling practices will be extremely informative. Timalizge Zgambo (a post-doctoral fellow at the CSSR) is currently conducting an end-term qualitative evaluation of the ACCC intervention with the initial research providing the baseline for comparison. This study could potentially offer insight into whether the initial enthusiasm and skill development observed during the course perseveres in the face of institutional constraints and possible professional burnout.

9.7.2 Peer Support and Supervision Models Research

Findings from this study showed the crucial role that peer support and supervision play in promoting client-centred counselling. However, the mechanisms through which such networks operate with their capacity to enhance professional resilience remains underexplored. Research into structured peer support groups for abortion providers, mentorship programmes, and case conferences can contribute not only to nurses' professional growth but also their psychological wellbeing. This could include a comparison of different supervision models or strategies to understand which type is most operational and sustainable through the year, and to gauge their effectiveness in mitigating provider fatigue while reinforcing client-centred and ethical abortion counselling practices.

9.7.3 Expansion of Training Course Focus

The course promoted a feminist client-centred approach based on reproductive justice principles, and achieved several of its goals. Its focus centred around first-trimester abortion counselling. This was important due to the problematic practices uncovered despite the CTOP Act's stipulations that allow for abortion *on request* during the first 12 weeks of pregnancy. As an outcome, scenarios that included second-trimester abortions (e.g., due to foetal genetic abnormalities) were missing. Of courses, nurses not only provide first-trimester abortions but may also be involved in assisting a doctor in later trimesters. The guidelines for provider support of women facing a late termination of wanted pregnancies owing to foetal abnormalities developed by Dr Angie Vorster of the CSSR could be form a useful resource in this instance (Vorster, 2022; Vorster & Macleod, 2025).

Moreover, the inclusion of transgender pregnant persons in training course material and scenarios also needs due consideration in future iterations, as the language in this thesis

and the training course remained limited to women and abortion seekers. While the latter is indeed a broader term, specific mention of trans persons was missing in this current project.

9.7.4 Institutional and Policy-Level Interventions

This study highlighted numerous structural barriers, such as staff shortages, managerial disengagement, and abortion stigma that hinder a thorough embracing of client-centred counselling by abortion providers. Nurse participants suggested the need for supervisor training programmes so that their clinic managers' perceptions and attitudes towards abortion service could also align with providers' new learnings. Instances of supportive managers in this study demonstrated the effectiveness of such assistance in acquiring resources such as an extra staff member when there was a shortage. Thus, further research could examine institutional reforms, policy advocacy and training aimed at supervisory and managerial positions. A combination of this suggestion along with point 9.7.1 (long-term evaluation of training programs) can generate information on the ways in which the integration of the National Clinical Guideline (2019) on TOP and the CSSR AC Guideline have had an influence in abortion care.

9.7.5 Integrating Mentalisation-Based Skills Training

Through my study, mentalisation emerged as a valuable skill that holds promise in nurses' training and particularly for abortion providers. The ACCC showed that nurses are better able to manage any complex feelings that might arise in abortion contexts when equipped with mentalisation skills. This element enhanced providers' capacity for empathy while cultivating self-awareness. Their capacity for self-regulation, a core aspect of mentalisation, not only benefited clients but also acted as a buffer for nurses against burnout. Against the backdrop of numerous challenges in public health nursing, further research and integration of mentalisation into abortion counselling training holds much promise. This would contribute to sustainably empathetic exchanges even when under high stress and trying to navigate emotionally charged client-interactions.

9.8 Conclusion

My action research offered an intervention that aims to increase the quality of, and hence potentially access to, reproductive services by advancing person-centredness, non-directiveness and consistency in the services rendered. This was enabled through various course activities and outcomes such as: developing critical thinking and deep listening skills; understanding the principles of client-centred counselling; fostering empathy and non-

judgement; and building support amongst providers. The in-service training course thereby strives to promote quality abortion services.

The findings of this study and the outcomes of the training courses contribute to the literature on feminist client-centred abortion counselling training based on reproductive justice principles, by identifying both its successes and ongoing challenges. Several critical areas necessitate further investigation, such as the sustainability of this training course, the long-term impact of training, the role of peer support for abortion providers, institutional and policy-level changes, client perspectives, and what it means to apply reproductive justice in practice.

These elements in my research combined to effect change in provider training and abortion counselling practices. For providers, the course inadvertently offered a space to debrief that served to counter anti-abortion discourses while co-creating new narratives on ways to engage with abortion. For abortion seekers, the course has enabled nurses to foster reproductive autonomy, bodily integrity, and agentic decision-making for pregnant persons who want or need to have an abortion. Thus, the abortion counselling session itself can be converted into a space that challenges abortion stigma and promotes reproductive justice.

In essence, I believe that my integration of action research, a reflexive thematic analysis, and reproductive justice principles supported the study by ensuring that it remains contextually responsive, analytically rigorous, and theoretically grounded. Action research provided the iterative structure to evaluate and refine the course; the reproductive justice framework and counselling psychology provided the guiding content and values; dialogical pedagogy augmented the course facilitation; and a reflexive thematic analysis provided the sense-making tool with which I analysed the data. Furthermore, my role as a counselling psychologist enabled me to empathise with some of the concerns raised by participants as I aimed to alleviate their fears while validating their experiences. I also identified mentalisation emerging organically in participants' learning, even though it was not a pre-defined outcome. The theory of mentalisation appears to be a valuable addition for future course development and research, as it would equip nurses with tools to maintain empathy and emotional resilience in challenging abortion care scenarios.

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APPENDICES

Appendix 1: Project Roles and Responsibilities

PROJECT ROLES

PhD RESEARCH PROJECT TITLE: Developing a client-centred abortion counselling training course for healthcare providers: an action research project.

	Name	Designation	Workplace	Role
1.	Yamini Kalyanaraman	PhD student	CSSR	▪ Main researcher and writing up of PhD study ▪ Primary developer of training course ▪ Primary facilitator of training course ▪ Lead liaison between project stakeholders ▪ Project management (includes planning of budget/ logistics - food, travel and accommodation arrangements/ applying for RU short course/ designing of course certificates) ▪ Documenting all course feedback ▪ Revising training course ▪ Maintaining a reflection/observation diary as part of research data ▪ Co-developing interview schedule for follow-up interviews conducted 2 months after the training course ▪ Co-developer of training course manual ▪ Assistance with grant applications
2.	Catriona Macleod	Supervisor	CSSR	▪ Project lead ▪ Research supervisor ▪ Co-developer of training manual
3.	Laurah Mogonong	Masters student	CSSR	▪ Researcher and observer during training course ▪ Maintaining records of which portion of transcripts require editing (based on participants' consent/non-consent to the research component) ▪ Maintaining a reflection/observation diary ▪ Conducting follow-up interviews 2 months after the first training course.
4.	Phathiswa Esona Bottoman	Clinical psychologist	Fort England Psychiatric Hospital	▪ Course co-facilitator ▪ Maintaining a reflection journal ▪ Translator in isiXhosa, if required (although the medium of teaching will be in English)
5.	Ndileka Gaba	Deputy Manager	ECDoH	▪ Partner at the DoH, EC ▪ Collaborator for in-service training.

Appendix 2: ACCC Course Manual

MAY 2021

ACCC HANDBOOK

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BACKGROUND

About CSSR

The Critical Studies in Sexualities and Reproduction (CSSR) is a research unit at Rhodes University and falls within the Department of Psychology. One of the goals of the research programme is to conduct research that promotes reproductive justice. This training course falls within the broad topics of unsupportable pregnancies and abortion.

About the course

Under the constraints of the global pandemic (Covid-19) the online course seeks to provide nurses with skills to meet the changing and varying needs of clients; and to develop and deepen nurses' skills in face-to-face abortion counselling sessions. In this past year the need for telecounselling for clients has gained importance as well as providing and creating a support network for nurses.

The course aims to benefit nurses and will help to:

- ✓ Acquire skills to provide abortion counselling.
- ✓ Create a space to debrief and reflect on experiences of abortion provision.
- ✓ Contribute towards Continuing Professional Development (CPD).
- ✓ Acquire online pedagogical skills.

The course encourages critical engagement, reflexivity and discussion amongst participants around the current content and process of counselling. The skills acquired from this online training course will ultimately help to promote client-centred and contextually-relevant counselling. The counselling techniques imparted in the course are based on *Reproductive Justice principles* and the *Guidelines* that have been published by the CSSR.

Course schedule

		Day/Date	Time	Duration
Session 1	Week 1	**Monday, 3rd May 2021**	14h00 – 16h30	2.5 hour
Session 2	Week 1	**Thursday, 6th May 2021**	14h00 – 16h30	2.5 hours
Session 3	Week 2	**Monday, 10th May 2021**	14h00 – 16h30	2.5 hours
Session 4	Week 2	**Thursday, 13th May 2021**	14h00 – 16h30	2.5 hours
Session 5	Week 3	**Monday, 17th May 2021** (followed by two weeks of field-work)	14h00 – 16h30	2.5 hours
Session 6	Week 5	**Monday, 31st May 2021**	14h00 – 16h30	2.5 hours

Accreditation

Credit value

Credits are calculated on the assumption of 10 "notional hours" per credit. These notional hours include online sessions, reading time, reflections, case presentations, field work, etc.

Task/ Activity	Estimated Notional Hours
Online sessions	15
Field work (2 weeks)	10
Reflective journal (2 hrs per session)	12
Course manual readings and case-presentation preparation	22
Feedback	1

Total Hours = 60 Total Credits = 6

NQF level

This course is rated as level 6 in the National Qualifications Framework.

Critical cross-field outcomes

- ✓ Identify and analyse issues that require coverage in abortion counselling.
- ✓ Analyse, organise and critically evaluate information in relation to abortion counselling principles.
- ✓ Be culturally sensitive with clients across a range of social contexts.
- ✓ Organise and manage time in the provision of abortion counselling.
- ✓ Communicate effectively with colleagues during fieldwork, and with clients during counselling.
- ✓ Reflect and explore effective counselling strategies.

Specific outcomes

- ✓ Critically explore case studies to learn effectively.
- ✓ Develop the ability to listen deeply.
- ✓ Identify what kind of counselling is needed on a case-by-case basis.
- ✓ Comprehend the premises of client-centred abortion counselling and therefore what to include and what to avoid in a session.
- ✓ Build skills, expertise and confidence related to face-to-face and telephonic abortion counselling.
- ✓ Dispel myths regarding abortion consequences with empirical evidence-based research.
- ✓ Conduct effective woman-centred abortion counselling.
- ✓ Be reflexive about their roles in promoting client-centred counselling.

Preparing for the course

It will be useful to follow these steps prior to the start of the course.

- ✓ Ensure you have access to a room in your workplace with a computer or laptop and WIFI.
- ✓ All online sessions will take place via the Zoom communications app.
- ✓ You do not require a zoom account to attend a meeting. To commence our sessions, you will receive an email with a link. Click on the zoom link to gain entry into the training course.
- ✓ If there is no WIFI, then ensure you have a smart phone. This can be used as a hotspot to connect the computer to the internet.
- ✓ If you are the only participant from your facility, then a set of headphones maybe beneficial to offer you privacy. If not, then ensure the device speaker is clear and the volume maybe adjusted.
- ✓ Consider placing a "do not disturb" sign outside the room, or informing other staff of your requirement, so that you may attend the course without any interruptions.

Case presentation

In preparing your case for presentation, it will help to keep in mind these points.

1. Firstly, choose what format you wish to present your case (word document or PowerPoint).
2. Make sure to include background information about your client (demographic details, gestation, presenting problem).
3. State what the client requested and what was your approach with regards to type of counselling provided. Sometimes it can be more than one type.
4. Add your observations about the client and/ or the situation to make the case interesting.
5. Add your reflections with regards to your thoughts about the case and your feelings towards the client.
6. What did you find challenging? What worked well for you?
7. End with a final reflection on your training.

Meeting the course criteria

It is understandable and common to feel nervous about starting the course and whether you will successfully complete it. Be assured that continuous engagement and participation is key. There is no 'exam' at the end. Rather, view the entire course as a learning process (even making mistakes). There is no 'fail' in the end. The certificate will be provided if you meet the criteria, which is:

- ✓ Full attendance of all sessions.
- ✓ Participating fully in each session (this includes offering suggestions to colleagues/ sharing reflections/ asking questions etc).
- ✓ Completing the Reflective Journal questions after each session and ensuring that you submit it prior to the next session.
- ✓ Submission of case presentations

Environment

Test your network coverage and find the best spot for the remainder of the course. Please avoid driving or being in a crowded or noisy place during the course. This will be very beneficial in ensuring that the course is a success for yourself and your colleagues.

Attendance

We have to monitor your attendance closely in order to award your certificate.

We will open each session 15 minutes before it begins so you can join in good time and we can start on time. Once you join you must mute your sound and you may also switch off your camera until the time the session formally begins. During the session your camera must preferably remain on. However, if there is a network issue, then you may turn it off. But please turn your camera on for your role play and case presentation, or when you are speaking, so we can see you.

Please do not do other work or take cell phone calls etc. (except in case of an emergency) during the session.

We understand that there may be some unforeseen situations where you are late or leave early. In such situations you must inform us either beforehand or as soon as possible afterwards. You can do this by sending an email to Laurah who will be monitoring this: laurahmogonong@gmail.com or send her a WhatsApp at 0791618195.

If you have an unexpected network issue that is out of your control we will be understanding. In such cases, do not panic. Simply disconnect and try re-joining the link when your network has improved.

If you miss time due to an outage or emergency, you can discuss with us (by sending us an email or WhatsApp) whether there is some way to make up what you missed.

SESSION SCHEDULE: 14H00 — 16H30 [2.5 HOURS]

Session 1 [Monday, 3rd May 2021]

S. No.	Activity	Content	Time
1	Introduction	▪ Facilitators ▪ Training course (PPT) ▪ Research	40 min
2	Online learning	▪ Online tools ▪ Familiarising with Zoom features	40 min
15h20 – 15h30 BREAK			10 min
3	Ice breaker	▪ Participant's introduction and a "Narrative about your journey to become an abortion service provider"	45 min
4	Wrap-up	▪ Set up WhatsApp group (support buddy) ▪ Discussion/ Q & A ▪ HW	15 min

Session 2 [Thursday, 6th May 2021]

S. No.	Activity	Content	Time
1	Pair-work (Breakout rooms)	▪ Interview each other (20 min each) about current counselling sessions (your counselling background/ counselling practices/ most challenging case/ a case that you managed well etc.)	30 min
2 **This session is recorded*	Group discussion	▪ Share a summary of your interview with the group	50 min
15h20 – 15h30 BREAK			10 min
3	Basic counselling and listening skills PPT (Screen share)	▪ Identifying what kind of counselling or assistance is required (informed by *Rogerian principles of person-centred therapy*)	50 min
4	Wrap up	▪ HW	10 min

Session 3 [Monday, 10th May 2021]

S. No.	Activity	Content	Time
1	Conversation Analytic Role-play Method [CARM] (Audio share)	▪ Review transcripts ▪ Audio recording of counselling session ▪ Audio of conversation analysis (*by Ryan du Toit*) ▪ Discussion	1 hr
15h00 – 15h10 BREAK			10 min
2	Empirical research PPT (Screen share)	▪ Evidence-based research and practice	40 min
3	CSSR Policy brief	▪ Discussion	20 min
4	Wrap up	▪ Q & A/ HW	20 min

Session 4 [Thursday, 13th May 2021]

S. No.	Activity	Content	Time
1	CSSR Guidelines PPT (Screen share)	▪ Presentation on CSSR Guidelines	1 hour
15h00 – 15h10 BREAK			10 min
2	Pair-work (Breakout rooms)	▪ Discuss the Guidelines with your partner ▪ Reflect on your counselling sessions in relation to the Guidelines (*what to start/ stop/ continue*)	30 min
3 **This session is recorded*	Group discussion	▪ Share a summary with the group (what is helpful/ foreseeable challenges etc) ▪ Q & A	40 min
4	Role-play preparation	▪ Instructions for Role Play	10 min

Session 5 [Monday, 17th May 2021]

S. No.	Activity	Content	Time
1 **This session is recorded*	Role Play	▪ Participants, in pairs, present a short counselling session ▪ Interactive and constructive feedback	1 hour 30 min
15h30 – 15h40 BREAK			10 min
2	Self-care (Screen share)	▪ Suggestions and discussion on avoiding burn out	20 min
3	Wrap up	▪ Discuss field-work assignment ▪ Case presentation preparation ▪ Feedback forms	30 min

Session 6 [Monday, 31st May 2021]

S. No.	Activity	Content	Time
1	Case presentations	▪ Participants present a case from their field-work	1 hour
15h00 – 15h10 BREAK			10 min
1	Case presentations (contd.)	▪ Participants present a case from their field-work (contd.)	50 min
2	Wrap up	▪ Closing discussion ▪ Feedback forms	30 min

ACTIVITIES AND HOMEWORK

Session 3: Conversation Analytic Role-play Method (CARM)

Transcript 1 [Health service provider (P) and Client (C): 27 years, 2 children, unintended]

1 C: .hh and you won't know whether that was your last egg that is coming now (.) are
2 you married
3 (.)
4
5 P: No
6
7 C: Do you plan to get married
8 (1.1)
9
10 P: No::
11
12 C: n:EVER .h you don't want to be married=
13
14 P: =uh uh
15
16 C: You don't want to have someone close to you=
17
18 P: =(I don't want to m:arry)
19
20 C: hehehehe ((laughter)) .hh the thing is neh (1.75) for future (.) if you have happen to
21 maybe .hh
22
23 P: (get) [married
24
25 C: [get married one day and the husband (.)[wants a child]
26
27 P: [wants a child]
28
29 C: and you're struggling to (.) fall pregnant will you be able to tell him the truth
30 (2.0)
31
32 P: °eish° (.)[I'll try my best]
33
34 C: [it is it is it's you can .h say that you're not willing to
35
36 P: [(mh)it might be]
37
38 C: because you don't have to disclose it to anyone (1.5) .h this clinic strictly confidential
39 (.) understand (1.0) .hh okay (.) now::((shuffling paper)) what I'd like to do is read this (.)
40 consent
41
42 P: okay
43 ((paper shuffling))
44 (1.75)
45
46 C: .h with the consent we've got ((paper shuffling)) one (.) for the (.) actual abortion
47 .hh and the other one (1.75) .h for the psychology department meaning that you were
48 totally informed (a)bout everything right .hh and the fact that you are sure-are you sure
49 about this abortion=
50
51 P: =yes I am
52

53 C: .h is there no nothing that I can say .hh is there anything that I can say .h that will
54 change your mind say for instance .hh that there is a (1.0) adoption (.) options [no neh
55
56 P: [(no/mh)
57
58 C: .h that (.) if you carry the baby (.) you can give the baby to someone who
59 desperately wants one
60 (2.75)
61
62 P: °mh° but it won't be easy
63
64 C: .h how
65
66 P: for me to carry the baby for nine months and give it away >uhuh< (.) it won't be
67 easy for me to give the baby away that time
68
69 C: I can under- I can understand that one neh ((phone ringing)) .h I can understand (.)
70 um ((clears throat/PR))you know mos that you h. don't need anyone's consent [to do an
71 abortion neh
72
73 P: [°yes°]
74
75 C: .hh let me read this (1.0)consent form the psychology department .hh I received
76 counselling prior to the abortion procedure .h the session prepared me with regards to the
77 possible pre and post abortion psychological (.) complications .hh do you feel that you will
78 be able to live with (.) .h the fact that .h uh (.) you could feel guilty for the rest of your life
79 (2.0)
80
81 P: °I I'll° think I would live with it .hhhh hhh. ((deep inhale then strong exhale))
82
83 C: is there anyone that you can trust (2.0) that you can talk about this [...]

Transcript 2 [Health service provider (P) and Client (C): 23 years, 16 weeks into pregnancy]

1 P: We've placed eighty four to date, so there is a family that gods also (.) if you not
2 going to do it you know he's got someone that'll have the babies (.) .h but I wanna show
3 you we got these models my girl and just helps you understand and i'm gonna give you a
4 book ((noise over recorder)) see already perfectly form: ↑ed .h and this is twenty so you in
5 between there somewhere are your two:: babas
6
7 P: hehe ((slight sniff))
8 (1.8) ((noise))
9
10 C: Two: (1.5) you carrying so sma ↑::ll Sanele
11
12 P: °Yeah°-
13
14 C: -↑my wor↑::d >(it) doesn't even look like one<
15
16 P: ((sniffing noise)) (I'm sorry)
17
18 C: I have got a little brochure here that you can take home ((sniffing noise/ noise over
19 recorder)) and um at sixteen wee-at thirteen weeks (1) fine hair starts to grow on the head
20
21 P: Mhm
22
23 C: do they tell you the gender >or the sex of the babies<
24 (1.2)
25
26

27 P: n:o h.
28
29 C: no
30
31 P: Mhmh
32
33 C: because you can tell already (.) and at twenty weeks you gonna start feeling
34 movements already the ears are already starting to work .h that's [how quickly it becomes a
35 baby
36
37 P: [(ya)]
38
39 C: that I want you to take that (.) and read [that at home
40
41 P: [(thank you)]
42
43 C: and think about it (.) .h but now I wanna ask how are you feeling (.) with your news
44 (1.8)
45
46 P: ((.sniffs)) (.) I'm feeling just ( ) ((shuffling noise))
47
48 C: ab ((noise)) just absolutely overwhelmed
49 (.)
50
51 P: ((.sniff)) (1.7) I don't even know what to do now
52 (2.1)
53
54 C: You know if you don't know what to do the best thing to do (.) is nothing for a while
55 (1.4) th:ink about it (.) don't rush into decisions you might regret for the rest of your life
56 (.)that's why we here (.) to offer hope (.) to try and hel:p you m:-mal-make your decision
57 your decision remember it's your↑:s ((click noise)) that we maybe can just guide you a little
58 bit to make some wise choices when you feel like you can't cope (.) Like you feeling
59 desperate, confused, anxious <don't know what to do> .hh th:at's why we're here (.) just
60 because we really care (1.6) and I think realising it's twins (.) such a double gift. It's almost
61 like yoh
62
63 P: ((ya?/ .h h.))
64 (.)
65
66 C: can I really do this (2.1) I mean I was given this-these two gifts (.) and it will be
67 double (1) (it'll be) double risk with the procedure as well cause because you're already
68 ((Sanele sniff)) sixteen weeks so you'll be admitted ((noise)) go into labour (.) I explained
69 that (.) uh but with two there will be double the risk (.)
70
71 P: (kay)

<u>Transcript 3</u> [Health service provider (P) and Client (C): 15 years]

1 P: Why do you want to terminate your pregnancy then, young lady?
2
3 C: I was told at home to terminate it because I am still young
4
5 P: And what do you say? Do not say "it is said". How about you?
6
7 C: I also want to terminate it because I am still young, I will not be able to take care of a child
8
9 P: That is why when a young person starts dating, they should use family planning methods,
10 young lady. Do you realize now that you have failed yourself? Eh? What grade are you in?
11
12 C: Grade 10

13
14 P: That is why when a young person realizes that they are interested in dating they need to
15 take themselves to the nearest clinic and do family planning because if not, then you will get
16 pregnant. Do you understand what I am saying? Why did you not go for family planning?
17 Hmm?
18
19 C: ……..
20 P: You are not married, right?
21 ___
22 P: Is this your first pregnancy?
23
24 C: Yes
25
26 HSP: I have searched a date for you, young lady. When a person comes for an abortion here,
27 we book them an appointment, okay? We do not do the abortion on the same day. The reason
28 why we book the first session is so that we can scan you and see whether or not you qualify.
29 We do what is called, counselling as we are doing with you right now, sitting face-to-face,
30 okay? And in this counselling, there is a form that you need to read for me here, okay? You
31 will tell me what you understand from this form, okay? You will tell me. I already know what
32 it says. This form contains all the information regarding the abortion that we will perform on
33 you, okay? Those are the things that, which you can expect. We are not saying that they will
34 happen, They are thing that you need to expect because you will do an abortion in your life,
35 okay? You understand, right?
36
37 C: Yes, Ma'am
38
39 P: We do not want you to be surprised later in life when you experience any of the things
40 that you will read and tell me about. You should not forget that in a particular year you did
41 an abortion. Do you understand, young lady? Just because you do it here, does not mean that
42 it does not have problems. It does have complications; it does have risks. The reason why you
43 do it here at the hospital is so that you can be close to help should anything happen to you.
44 You do understand what I am saying, right? That is why it has been allowed to be done at the
45 hospital. So that a person can be safe and get help in case anything happens. You understand
46 me, right? And here we are not promoting abortion more than we are promoting family
47 planning because had you done your family planning, you would not be here. But it is already
48 done now, right? And we assume that it is a mistake and we will help you to fix the mistake.
49 After that, we will make sure, young lady that we give you a family planning method here.
50 When you come out of you, we would have given you a family planning method. And for
51 each person who does an abortion here, we advise that person to take a long-term family
52 planning method because it shows that you are not reliable for us to trust you on the short-
53 term ones like the pathogen and neristrate. They were there and you failed to use them until
54 you got pregnant, isn't it? So, for someone we have just done we advise that you take the
55 long-term family planning methods. The long-term family planning methods we are talking
56 about here are the implant of 3 years and the loop of 10 years. The implant is the one that is
57 inserted on the arm. You do know an implant, right?
58
59 C: Yes
60
61 P: I will find you a date using this book. I will search for a date that you can fit into here. So
62 today you are what? You are using a family planning method while you are already pregnant.
63 16 plus 6. You see this thing of your, right? Or you do not understand what I am saying? You
64 do not understand it? 16 plus 6, 7 then it becomes 17, then it becomes 18…
65 ___
66 P: You will do an abortion on the 9th of September. On the 9th of September you will be 19+1,
67 still you qualify because our rule says we must stop at 20 weeks. Do you understand? There
68 is a reason why we book, young lady. There are two reasons, okay? And these two reasons
69 are affected by those things which I said you must read and tell me about there. Sometimes
70 a person comes here on the first day undecided, okay? Once we have sat down and discussed
71 this thing, because for instance there is another side from adoption social workers that we
72 work with but they are not here today, okay? They are usually here because sometimes a
73 person comes here having told themselves that they will do an abortion and once we have

74 sat down as we are sitting to advise you, you find out that another person changes their mind,
75 okay? And say, "No, I would like to step down from this decision." Even after you have heard
76 about these things, we give you a chance to go home and decide whether you really want to
77 continue after this procedure after you have heard about all its complications and risks, okay?
78 So, if you still want to continue on the 9th of September you will come back and do the
79 abortion. If you do not want to continue, we will see by you not arriving. Ours is to give you
80 the date because you qualify. Your date is the 9th of September. You understand, right? On
81 the 9th of September there at home if you decide to come back, you will wake up and bath
82 and prepare yourself. You have to be here by 8 o'clock. You pack your bag. What will you
83 carry in your bag? You will put in your toiletries, a nighty and a lunchbox because you will be
84 admitted on the 9th. You will arrive here at 29. Your folder will be here at 29 when you arrive.
85 The doctors will arrive here and admit you. You will not be looking for your folder on that
86 day when you arrive here. Your folder will be there. I will put it in that box, okay? You must
87 be here and ready to be admitted by 8 o'clock. The doctors will arrive and admit you all and
88 then you will go to 27. At 27 that is where the procedure will be done. What happens at 27?
89 At 27 you will arrive and be given two pills. Do you understand? Both these pills you do not
90 drink them with water, you put them under the tongue and suck them until they are finished.
91 It is your duty there, young lady, okay? You will be given the first pills. After being given the
92 first pills, you count 4 hours. After 4 hours, it is your duty to go to the nurse and say, "Sister,
93 the 4 hours has ended, please give me more pills." Do you understand? Until the foetus comes
94 out. You do that every time after 4 hours. If the foetus has come out it is you again who will
95 tell the nurse that, "Nurse, it seems as if something has happened now." Do you understand?
96 Because that is a ward and there are sick people there. The sisters... that is a gynae ward.
97 Some have womb problems. People have very serious sicknesses. You understand, right? And
98 therefore, the nurses focus on that most of the time. Do you understand? You are not sick,
99 right?
100
101 P: So what is the risk about? (Long pause)
102
103 C: A risk maybe... I die
104
105 P: Mhhm
106 *long pause
107
108 C: And in this process there might.... There will be bleeding
109
110 P: Mhhm
111
112 C: (inhaling of air grasping to breath). The process might.... Have consequences of a physical
113 damage
114
115 P: Mh mh. In that womb. And not be able to have children when you want them. Do you
116 understand, young lady? Maybe you might get pregnant, right? You conceive and, on the
117 month, when you did an abortion, you get a miscarriage. Those are the womb damages being
118 mentioned here, okay? They are aftereffects. So you should expect these things when you
119 are older, they will not happen now, okay? Eh eh. You might have womb problems and your
120 womb might occasionally bother you, okay? Although you will be given pills to treat the
121 womb when you come out of there, you can expect that the womb might occasionally bother
122 you. You understand, right? What else does it say? I am trying to add on. What else does it
123 say?
124
125 C: .... *long pause
126
127 P: Is it finished now? You do not understand? Let us help. In that last paragraph, okay? It
128 says that as we were saying, the physical damages to your womb, okay? And it might happen
129 that the foetus does not come out there at 27 as it is supposed to. And that will force you to
130 go to the theatre. That means that by all means, when you come out of this hospital the
131 abortion will be done No matter what happens. Do you understand what I am saying?
132 Because once you start taking those pills that you will be given, there is no going back. So you
133 must make sure on that day that you want to continue with the procedure. You will not step
134 down on your decision when you feel the pain that we are being told about here and that

135 bleeding and say, "Mhmh!" As I have told you, you will give birth there. All that that process
136 of giving birth, your mother knows about it. You will have birth pain but it is just that you
137 will give birth to a baby that is not alive. Do you understand, young lady? There can also be
138 psychological trauma. You understand what psychologically means, right?
139
140 C: Mh
141
142 P: Mh. And we will see you maybe, going around stealing other people's children on the
143 streets and baby talking with dolls. Those are all aftereffects of abortion. Do you understand,
144 dear? We are trying to fix you (put you on the right path) here, my child, okay? One might
145 think that, no since I came to the hospital. No, an abortion is still an abortion no matter where
146 it is done. Do you understand, young lady? So we are trying to prepare you for that day,
147 okay? So that you do not get confused when you start bleeding there. Even though you will
148 be given pain killers, the pain will still be there. You know that birth pain is inevitable, ma'am.
149 It is just that in this case you will go through the pain for nothing. Do you understand
150 everything that is being said here, young lady?
151
152 C: Mh
153
154 P: You understand it? Okay. So after all that you have heard it is up to you to go home and
155 decide okay? We are not saying that these things will happen. We are not saying that. We
156 have no guarantee but you must know that there will be pain. Otherwise I think I am done
157 with you Is there anything that you would like to ask? Ma'am, is there anything that you
158 would also like to ask?
159
160 Mother: Mm mmh (No)
161
162 P: Everything is clear, right? So what did I say your date was?
163
164 C: It is the 9th
165
166 P: It is the 9th. Arriving time?
167
168 C: I should be here by 8 o'clock
169
170 P: There is a reason why we say 8 o'clock because our doctors are busy and they do not only
171 make rounds here because I am at the front of these doctors. So they come and knock at any
172 time so we do not wish for the doctors to arrive while the client is not here. Because if that
173 happens, we will not be able to find that doctor again. That means that if the doctor sees that
174 you are still in the queue… that means that if you are not available on that day you will end
175 up giving birth to that child. Because as you can see these months 19 +1 you are already close
176 to 20 and we book every day. If you arrive on a different day, we will not be having space for
177 you. Do you understand what I am saying? That is why it is important for you to keep the
178 date and time for just one day. Do you understand, my child? That will need you to arrange
179 with the school on what you will do. Thank you. You will also ask for a school letter. Okay

Session 3: CSSR Policy Brief

Viewing these documents from the hard copy (booklet):

If you have a smart phone, your camera app may be able to open the QR codes below. To do this: open the camera app on your phone and hold your device over one of the QR codes so that it is clearly visible within your smart phone screen. This should open the link.

Viewing these documents from the soft copy (PDF):

You can click on the first link of either document or you can type the TINY URL into a web browser.

Revamping pre-abortion counselling in South Africa
https://www.ru.ac.za/media/rhodesuniversity/content/criticalstudiesinsexualitiesandreproduction/documents/20180926_PolicyBrief_PreAbortionCounselling.pdf

Also available here: https://tinyurl.com/yy2n4m9b

Session 4: CSSR Guidelines

Step-by-step abortion counselling guide for providers
http://srjc.org.za/wp-content/uploads/2017/06/Abortion_Counselling_Guide_Version_1-1.pdf

Also available here: https://tinyurl.com/yyddr9er

REFLECTIVE JOURNAL

WHAT IS A REFLECTIVE JOURNAL?

A reflective journal is one way of thinking, in a critical and analytical way, about different aspects of your work and your responses to this training course.

THE JOURNAL CAN INCLUDE

- ✓ Personal comments on my work
- ✓ Notes
- ✓ Quotes
- ✓ Extracts from discussions
- ✓ Sketches
- ✓ Thoughts
- ✓ Feelings
- ✓ Behaviours

REFLECTION SKILLS

General reflection is the ability to reflect on technical skills.

- ✓ What are the basic principles of reproductive justice?
- ✓ What are the basic principles of client-centred counselling?

WHAT CAN I RECORD?

Self-reflection is the ability to reflect on your internal world.

- ✓ How can I make use of my ideas to contribute to the training course?
- ✓ How can I make use of newly acquired skills to develop my work?

Adapted from:

Ash, Clayton, & Moses. (2009). Learning through Critical Reflection: A Tutorial for Service-Learning Students. Raleigh, NC.

CSSR

Session 1

1) What or who motivates and inspires you?

____

____

____

____

____

2) Why did you sign up for this training course?

____

____

____

____

____

3) Was anything (related to others or yourself) from the 'Intro Narrative' session surprising to you?

____

____

____

____

____

4) What are your feelings as you start the course?

____

____

____

____

____

Session 2

1) How do you rate your competence in your work? (What do you do well and what do you find difficult?)

____

____

____

____

____

____

2) In activity 1 and 2 today (interviews and discussions), what kind of differences did you notice in your approach to work from that of your colleagues?

____

____

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____

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____

____

3) What is your awareness of the cultural context in which you work?

____

____

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CSSR

4) What stood out to you about the 'Basic counselling and Listening skills' presentation?

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5) What challenges do you foresee in providing such counselling services?

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CSR

Session 3

1) What were your reactions to reading the anonymised data of counselling sessions?

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___

___

2) Observe your own assumptions & beliefs, especially if you were emotionally aroused at any point today. Comment on this.

___

___

___

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___

___

3) What stood out to you from the evidence-based research presentation on Reproductive Health in SA?

___

___

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___

4) What are some common myths that people hold about abortion? What do you think about these now?

___

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5) How do you find the online space for learning?

___

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Session 4

1) How are you using the support buddy system? In other words, how are you offering to your colleagues and receiving support from them?

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2) What are your thoughts about the CSSR guidelines?

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3) From the different types of counselling, which type might you be most comfortable to provide and why?

____

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____

CSSR

4) What type of counselling might you find challenging to provide and why?

5) What are your self-calming techniques? What do you do to recuperate?

Session 5

1) What was your experience of being a client in the role-play?

2) When receiving feedback on your counselling session today, was there anything you were surprised to learn about yourself or your technique?

3) You will now commence 2 weeks of field-work. Based on everything covered so far in the training, list down what new learnings do want to incorporate into your provision of abortion counselling; what do you plan to avoid; and lastly what have you been doing well all along and that you will continue to do.

WHAT TO START?	WHAT TO STOP?	WHAT TO CONTINUE?

CSR

Session 6

1) What did you learn in evaluating your peer's case presentations?

2) Write down any general reflections from your field-work that stood out to you, which you may want to share with the group or simply highlight for yourself.

FEEDBACK FORMS

As part of the research process in refining the course, we would value your evaluation of the course as well as any suggestions that you have, apart from what is asked in the questionnaire. Thank you!

Feedback Form 1 (after session 5)

WAS SESSION 1 (regarding introduction to online tools) USEFUL? WHY OR WHY NOT.

- ____________________
- ____________________
- ____________________
- ____________________

DID THE COURSE MANUAL CARRY SUBSTANTIAL INFORMATION ABOUT THE COURSE? IF NOT, THEN WHAT DO YOU SUGGEST MUST BE ADDED?

- ____________________
- ____________________
- ____________________
- ____________________

IS THERE ANY ADDITIONAL INFORMATION THAT WOULD HELP YOU PREPARE FOR THE ONLINE FORMAT OF THE COURSE?

- ____________________
- ____________________
- ____________________
- ____________________

WHAT STOOD OUT TO YOU FROM THE ONLINE TRAINING COURSE?

- ____________________
- ____________________
- ____________________
- ____________________

WHAT SUGGESTIONS DO YOU HAVE TO IMPROVE THE ONLINE TRAINING COURSE?

- ____________________
- ____________________
- ____________________
- ____________________

WHAT CHALLENGES, IF ANY, DO YOU FORSEE IN IMPLEMENTING THE LEARNINGS FROM THE COURSE?

- ____
- ____
- ____
- ____

WHAT WILL YOU DO DIFFERENTLY AS AN OUTCOME OF THE TRAINING COURSE?

- ____
- ____
- ____
- ____

On a scale of 1 – 5 (1 being poor and 5 being excellent), please rate the following with regards to the TRAINERS

		1 Poor	2 Below average	3 Average	4 Good	5 Excellent
(i)	CLARITY OF PRESENTATIONS					
(ii)	KNOWLEDGE OF SUBJECT MATTER					
(iii)	ENCOURAGED PARTICIPATION					
(iv)	TIME MANAGEMENT					

PLEASE PROVIDE REASONS FOR YOUR RATINGS HERE. WHAT ABOUT EACH COMPONENT PROMPTED YOUR RATING? IF YOU RATED THE COMPONENT 1 OR 2, WHAT CAN WE DO TO IMPROVE ON IT?

(i)____

(ii)____

(iii)____

(iv)____

On a scale of 1 – 5 (1 being poor and 5 being excellent), please rate the following with regards to the COURSE MATERIALS

		1 Poor	2 Below average	3 Average	4 Good	5 Excellent
(i)	**WELL-ORGANISED**					
(ii)	**PROFESSIONAL APPEARANCE**					
(iii)	**UNDERSTANDABLE**					
(iv)	**CONTENT OF PRESENTATIONS**					
(v)	**CSSR GUIDELINES**					
(vi)	**ONLINE TOOLS** (Zoom/whatsapp etc.)					

PLEASE PROVIDE REASONS FOR YOUR RATINGS HERE. WHAT ABOUT EACH COMPONENT PROMPTED YOUR RATING? IF YOU RATED THE COMPONENT 1 OR 2, WHAT CAN WE DO TO IMPROVE ON IT?

(i)____

(ii)____

(iii)____

(iv)____

(v)____

(vi)____

IF THERE IS ANYTHING IN ADDITION THAT YOU WOULD LIKE TO SAY ABOUT THE COURSE THAT HAS NOT BEEN COVERED IN THE FEEDBACK, PLEASE DO SO IN THE SPACE BELOW. THIS MAY BE SOMETHING POSITIVE OR CONSTRUCTIVELY CRITICAL THAT WOULD ENABLE US TO IMPROVE THE ONLINE TRAINING COURSE.

- ____
- ____
- ____
- ____

Name (optional) ________________________ Date ________________________

Feedback Form 2 (after session 6)

Your feedback will enable us to refine the course so that other nurses may benefit from the training. We highly value your contribution to developing the course and providing us with honest feedback. Thank you!

On a scale of 1 – 5 (1 being poor and 5 being excellent), please rate the following with regards to the course format

		1 Poor	2 Below average	3 Average	4 Good	5 Excellent
(i)	INTRODUCTION					
(ii)	LISTENING SKILLS					
(iii)	ROLE-PLAYS					
(iv)	REFLECTIVE JOURNAL					
(v)	SUPPORT-BUDDY SYSTEM					
(vi)	FIELD-WORK ASSIGNMENT					
(vii)	CASE PRESENTATIONS					
(viii)	DURATION OF COURSE					
(ix)	ONLINE FORMAT					

PLEASE PROVIDE REASONS FOR YOUR RATINGS HERE. WHAT ABOUT EACH COMPONENT PROMPTED YOUR RATING? IF YOU RATED THE COMPONENT 1 OR 2, WHAT CAN WE DO TO IMPROVE ON IT?

(i)____

(ii)____

(iii)____

(iv)____

(v)____

(vi)____

CSR

(vii)____

(viii)_______________________________________

(ix)____

WAS THE FIELD-WORK A GOOD ADDTION TO THE COURSE?

- ____
- ____
- ____
- ____

WERE THE CASE-PRESENTATIONS USEFUL IN PREPARING YOU TO PROVIDE QUALITY ABORTION SERVICES?

- ____
- ____
- ____
- ____

WHAT CHALLENGES, IF ANY, DID YOU EXPERIENCE DURING YOUR FIELD-WORD IN IMPLEMENTING THE LEARNINGS FROM THE COURSE?

- ____
- ____
- ____
- ____

IF THERE IS ANYTHING IN ADDITION THAT YOU WOULD LIKE TO SAY ABOUT THE COURSE THAT HAS NOT BEEN COVERED IN THE FEEDBACK, PLEASE DO SO IN THE SPACE BELOW. THIS MAY BE SOMETHING POSITIVE OR CONSTRUCTIVELY CRITICAL THAT WOULD ENABLE US TO IMPROVE THE ONLINE TRAINING COURSE.

- ____
- ____
- ____
- ____
- ____
- ____

Name (optional) ______________________ Date ____________________

Appendix 3: CARM Guided Discussion Questions

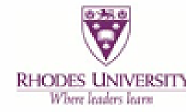
CONVERSATION ANALYTIC ROLE-PLAY METHOD (CARM) Guided questions by Ryan do Toit

Discussion points (How could this be done/said differently? + Conversationally, how can counsellors focus more on the patients?)

- How would you describe the nature of the counselling session so far?
- Compare what is said by the counsellor and what is said by the patient?
  - Who is talking the most?
  - What is being focused on in the talk? Is it the pregnant women or the fetus?
- Identify a section, perhaps something that is said by the counsellor, and describe how you could potentially re-phrase, re-word or present the information differently to the patient.
- What do you think about the inclusion of “God” (line 1) in the counselling session?
  - Is this something that needs to be avoided by the counsellor OR only discussed if brought into the session by the patient?

Appendix 4: Ethical Clearance from the Rhodes University Ethical Standards Committee

Appendix 1



Human Ethics subcommittee
Rhodes University Ethical Standards Committee
PO Box 94, Grahamstown, 6140, South Africa
t: +27 (0) 46 603 8055
f: +27 (0) 46 603 8822
e: ethics-committee@ru.ac.za

www.ru.ac.za/research/research/ethics
NHREC Registration no. REC-241114-045

1 June 2020

Ms Yamini Kalyanaraman

Email: g14K2501@campus.ru.ac.za

Review Reference: 2020-1337-3489

Dear Ms. Kalyanaraman

Title: Developing a women-centred abortion counselling training course for healthcare providers: an action research project.

Principal Investigator: Distinguished Professor Catriona Macleod

This letter confirms that the above research proposal has been reviewed and **APPROVED** by the Rhodes University Ethical Standards Committee (RUESC) – Human Ethics (HE) sub-committee.

Approval has been granted for 1 year. An annual progress report will be required in order to renew approval for an additional period. You will receive an email notifying when the annual report is due.

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 the completion of the research. The purpose of this report is to indicate whether 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 cataloging number allocated.

Sincerely,

Prof Arthur Webb

Chair: Human Ethics Sub-Committee, RUESC- HE

Appendix 5: Approval from the Department of Health

Enquiries: Zonwabele Merile
Email: zonwabele.merile@echealth.gov.za
Tel no: 083 378 1202
Fax no: 043 642 1409

Date: 18 August 2020

RE: Developing a women-centred abortion counselling training course for health providers: an action research project. (EC_202008_008)

Dear Ms Y. Kalyanaraman

The department would like to inform you that your application for the abovementioned research 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 update 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 Eastern Cape Health Research Committee secretariat. You may also 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

TOGETHER, MOVING THE HEALTH SYSTEM FORWARD

Appendix 6: Approval for Change of Course Format

Yamini Kalyanaraman <yamini.arts@gmail.com>

Addendum to review reference 2020-1337-3489

Siyanda Manqele <s.manqele@ru.ac.za> 22 September 2020 at 17:31
To: Yamini Kalyanaraman <yamini.arts@gmail.com>

Dear Yamini

Kindly note that your application has been reviewed for the revision of research approach from face-to-face to online. As the purpose and fundamental principles of the research process remain the same, it has been APPROVED the amendment to allow for an online approach.

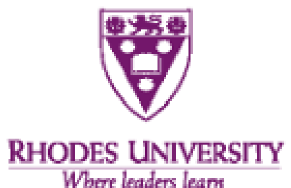
Kind regards

Siyanda Manqele (Mr)
Institutional Ethics Coordinator

Research Office, Rhodes University
t: +27 (0) 46 603 7727 f: +27 (0) 86 616 7707
Room 220, Main Admin Building, Drostdy Road, Grahamstown, 6139
PO Box 94, Grahamstown, 6140, South Africa
Website: https://www.ru.ac.za/researchgateway//

Email: s.manqele@ru.ac.za

Appendix 7: Short Course Application



APPLICATION TO OFFER A SHORT/CERTIFICATED COURSE

SECTION A : GENERAL INFORMATION

A1 Name of course: **Abortion Counselling Certificate Course**

A2 Name and contact details of Course Coordinator:
(*Note: This person must be a Rhodes University staff member and must familiarize themselves with the University's Short Course Policy)*
D/**Prof. Catriona Macleod**
Email: c.macleod@ru.ac.za
Contact Number: +27 (0) 46 603 7328

A3 'Home' Department/Institute/Division: **Critical Studies in Sexualities and Reproduction (CSSR), Psychology Department, Rhodes University**

A4 Has this course ever been offered before? Is so, please indicate when (year/s): **No**

A5 Proposed dates on which the course will be offered:
(Please also indicate how many times per year the course will be offered)
5 week online course offered twice (between 2020 and 2021)
Each course will consist of the following: 1 online pre-course session (1 hour); 5 online course sessions (2 hours each); two weeks of fieldwork.

A6 Will any external partners be involved in the offering of this course? If Yes, please complete Section D.
EASTERN CAPE, DEPARTMENT OF HEALTH

A7 Times and venue at which the course will be offered:
14h00 – 16h00 (5 sessions) and 14h00 – 15h00 (1 session); Venue: Online

A8 Delivery mode (contact / distance / mixed mode): **Distance**

A9 Envisaged enrolment: **Approximately 10 participants are expected**

A10 Is the course available to the general public or restricted to 'in-house' personnel?
This course is being offered to nurses who provide abortions, so it not for 'in-house' personnel.

A11 Is the course recognised by any other organisations (e.g. professional councils or SETA's)? If 'yes' give names: **No**

A12 List any special materials students will require in order to take the course:

Each participant will be provided with a course manuel that includes: Course outline; Learning outcomes; the "Step-by-step abortion counselling guide for providers"; and the policy brief titled "Revamping pre-abortion counselling in South Africa" both published by the CSSR. These last two documents are the companion booklets for the course. They are available in both hard copy and web formats.
Please follow the links below to view the documents online:

https://www.ru.ac.za/media/rhodesuniversity/content/criticalstudiesinsexualitiesandreproduction/documents/20180926_PolicyBrief_PreAbortionCounselling.pdf

https://www.ru.ac.za/media/rhodesuniversity/content/criticalstudiesinsexualitiesandreproduction/documents/Abortion_Counselling_Guide_(Version_1).pdf

A13 List any Rhodes University facilities which will be utilised in offering this course:
(Please note: Course coordinators are responsible for arranging with the relevant managers, in good time, the use of any RU facilities such as computer laboratories or access to the Rhodes Library or Health Care Centre.)
No facilities will be required as the course will take place ONLINE.

A14 Indicate whether the certificate issued will be a certificate of competence or a letter of attendance:
Note:
Certificates of competence are only awarded if the course is formally assessed and participants meet the required standards. Section C of the application form must be completed.
A written motivation must accompany applications to offer letters of attendance, and Section C may be omitted in this case.
Both a Certificate of Competence in Abortion Counselling and a Letter of Participation (attendance) will be offered.

A15 Qualifications and Experience of Teaching Staff:

A15 QUALIFICATIONS AND EXPERIENCE OF TEACHING STAFF			
NAME & POSITION	**HIGHEST RELEVANT QUALIFICATION**	**PROFESSIONAL REGISTRATION (IF ANY)**	**YEARS OF RELEVANT EXPERIENCE**
Yamini Kalyanaraman (Course facilitator for Certificate in Abortion counselling; 2nd year Phd researcher)	M.A in Counselling Psychology (NQF Level 9)	PS 0144240 (Registration with HPCSA)	15 years of experience in facilitating workshops and training in areas of: • Outdoor experiential learning programmes for children (2003-2004) • Soft skills training for corporates (2005-2007) • Drama workshops for the Trinity College of Speech and Drama (2012-2013) • Community engagement group facilitation with The Gender and Sex Project (2016) and the Eluxolweni Shelter for boys (2017)

			• Topics of Mental Health for University students (2018 – 2019) Yamini has made presentations at conferences and colloquiums and lectured to Honours and Masters graduate students.
Esona Bottoman (Course facilitator for Certificate in Abortion counselling; Clinical psychologist at Fort England Psychiatric Hospital)	M.A in Social Work M.A in Clinical Psychology (NQF Level 9)	PS 0139319 (Registration with HPCSA)	Over 12 years of experience in group work and facilitation (for children, adolescents and adults) as a social worker in areas of: • Life skills • Parental guidance • Information programmes aimed at child protection services • Foster care support • Family reunification services • Adoption • Court investigations • TB patients acceptance, adherence, stigma, family reintergration.
Catriona Macleod (Supervisor, co-ordinator)	PhD	10	27 years of experience in the field, including conducting training of counsellors and psychologists.

SECTION C : CURRICULUM DEVELOPMENT

This section MUST ONLY be completed if a Certificate of Competence will be awarded to participants. Please see Appendix 1 for assistance with this section.

C1 General Information

a. Admission Requirements:
What entrance requirements in terms of qualifications, experience, age, etc. have been set for applicants to take the course?
Participants are only those registered nurses who have undergone prescribed training in order to perform a termination of pregnancy, as per the Choice on Termination of Pregnancy Act, 1996.

b. Indicate the **NQF level** at which the course is pegged:

5	6 ✓	7	8	9	10

c. Briefly indicate how the **credit value** of the course has been determined *(add space as required)*:

Task/ activity	Estimated notional hours
Online sessions	11
Field work (2 weeks)	10
Reflective journal (2 hrs per session)	12
Course manual readings and case-presentation preparation	25
Feedback and research interview	2

Total Hours = **60** Total Credits = **6**

d. Is there any duplication or overlap with similar courses offered by Rhodes University (as short courses and/or formal qualifications)? **No**
If yes, comment on if and how articulation with whole qualifications is possible.

C2 Curriculum Design

In this section, please describe the curriculum design. We will be looking specifically at how points (a) – (c) interrelate (see attached guide for more on this). Please include information you think relevant (such as the course handout), so that an informed recommendation can be made. Many applicants choose to submit this in tabulated form.
Please provide:

(a) A **purpose** statement (the aims/ goals/ purpose of the course)

The Certificate in Abortion Counselling course aims to operationalise guidelines for abortion counselling among healthcare providers in the Eastern Cape. With the dialogical approach, the course seeks to encourage critical engagement, reflexivity and discussion around the current process of counselling; and for nurses to undergo training based on the guidelines. The course will work to also create a space for healthcare providers to debrief and reflect on their experiences of abortion provision. The counselling guidelines are based on ***client-centered*** and ***reproductive justice principles***. The purpose will be to:

1) address the *content* and *process* of counselling.
2) create and provide abortion counselling guidelines that are contextually relevant.
3) Equip participants with telecounselling skills.

(b) The **outcomes** (what your students should be able to demonstrate on completion of the course)

As an outcome of the critical dialogical pedagogy adopted in this course, participants will be able to demonstrate generic and specific outcomes.

Critical cross-field outcomes

1) Identify and analyse issues that require coverage in abortion counselling.
2) Analyse, organise and critically evaluate information in relation to abortion counselling principles.
3) Be culturally sensitive with clients across a range of social contexts.
4) Organise and manage time in the provision of abortion counselling.
5) Communicate effectively with their colleagues during fieldwork, and with clients during counselling.
6) Reflect and explore effective counselling strategies.

Specific outcomes

1) Critically explore case studies to learn effectively.
2) Comprehend the premises of client-centred abortion counselling and therefore what to include and what to avoid in a session.
3) Develop the ability to listen deeply.
4) Identify what kind of counselling is needed on a case-by-case basis.
5) Build skills, expertise and confidence in their field of work, related to abortion counselling.

6) Be reflexive about their roles in promoting client-centered counselling
7) Dispel myths regarding abortion consequences with empirical evidence-based research.
8) Conduct effective client-centred abortion counselling, face-to-face and telephonically

(c) How you intend to **assess** your students' learning (the assessment tasks and the criteria you reference and/ or communicate to students when making an assessment).

Assessments will take the form of critically reflective pieces that participants will share from their journal based on all the activities listed above. This will include, in line with the course outcomes, critical reflections on: (1) the principles of client-centred abortion counselling; (2) the strategies to be used in deep listening; (3) different forms of counselling that are required for different kinds of clients; (4) the cases presented during the course in Session 5 and what they learnt from colleagues' case presentations; (5) the counselling they delivered while in the field; (6) evidence about the health and psychological consequences of abortion in relation to taking unwanted pregnancies to term; (7) their role in the abortion counselling sessions; (8) feedback from colleagues and facilitators during the course; (9) how their counselling skills and confidence have changed (i.e. what they might wish to START/ STOP/ or CONTINUE). Reflective journaling will include conceptual as well as practical components regarding abortion counselling. The written pieces will inform the facilitators' feedback to the participants.

Assessment criteria for each of the tasks identified above (1 to 9) will be as follows (all be rated on a scale of 1 to 5):

1. Principles of client-centred abortion counselling
    a. Critical discussion of principles
2. Deep listening
    a. Outline of deep listening skills
3. Variety of counselling
    a. Outline of at least two different kinds of counselling
    b. Identification of kinds of clients who will benefit from different forms of counselling
4. Presented case reflections
    a. Reflection on strengths or weaknesses in the presented sessions
    b. Reflection of learnings from case presentations
5. Fieldwork counselling
    a. Careful outline of cases
    b. Critical reflection on what worked, and what could be improved
6. Evidence of consequences
    a. Outline evidence concerning physical and psychological consequences of abortion in relation to taking an unwanted pregnancy to term
7. Role
    a. Critical reflection on how their actions influence the counselling encounter
8. Feedback
    a. Outline of feedback provided by colleagues during the course
    b. Response to the feedback
9. Change in skills
    a. Reflection on differences in approach (what they have started to do differently, stopped doing and continue to do from previous counselling experiences).

C3 The Evaluation Process

Rhodes University's *Guide to the Evaluation of Teaching and Courses* should assist you in this process. It aims to encourage curriculum designers to engage in a process of 'reflective practice' with evaluation processes as integral to curriculum development.

(a) Please include information on how you intend to evaluate the course and/ or teaching, and most importantly, how such evaluation processes will feed into curriculum review cycles.

This short course forms part of an action research project, conducted by Yamini Kalyanaraman, a PhD candidate, with the assistance of Laura Mogonong, a master's candidate.
The action research methodology in itself will guide the progress and development of the course. Data for the action research will be collected through:

1) Feedback forms collected from participants at the end of Session 4 and Session 5;
2) Reflective journals (maintained by the participants and the two facilitators);
3) Participants' case presentation (in powerpoint or word format);
4) Interviews (conducted by the co-researcher).
5) Recording of activities in Session 1 (Activity 2); Session 3 (Activity 3); and Session 4 (Activity 2).

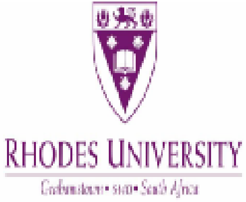
These data will be analysed, and the findings fed back to the facilitators.

In the Feedback forms related to the Certificate in Abortion Counselling, participants will be asked to comment on the following:

- What stood out for them in relation to this course?
- What elements they think require revision?
- Rating of the following (on a scale of 1 to 5): course materials; facilitators' input; role play sessions; fieldwork assignment; feedback from facilitators and colleagues; facilitators' time management; journal assignment; location of course.
- Expanding on each of the elements mentioned above – reasons for their rating; recommendations for improvement.

(b) If this course has been run before, please include discussion here on which aspects were previously identified as areas for improvement, and your approach to improving/ enhancing the quality of student learning in this year's course.
This course will be offered for the first time in 2020/21.

Appendix 8: Curriculum Approval for the Course



CENTRE FOR HIGHER EDUCATION RESEARCH, TEACHING AND LEARNING
Email: chertl-admin@ru.ac.za • Tel: +27 (0)46 603 8171/3 • Fax: +27 (0)46 603 [illegible]

11 September 2020

Institutional Planning Unit

Rhodes University

Grahamstown

Dear Chimwemwe

SCA 5520: Abortion Counselling Certificate Course

This capacity-building course will be offered for the first time to healthcare providers in the Eastern Cape. The course will be offered twice in 2020 and 2021 in a virtual format. The curriculum is aligned and poised to meet participant needs and careful consideration has been given to assessment and course evaluation.

The application to approve the curriculum of this course is granted.

Best regards

Anthea Adams

This Short Course
ABORTION COUNSELLING CERTIFICATE COURSE
.... *(name of Course)*
***has been considered and is supported by*:**

The Course Coordinator:

D/Prof. Catriona Macleod	C A Macleod	15/09/2020
Name	*Signature*	*Date*

The Head of Department:

Prof. Charles Young		
Name	*Signature*	*Date*

The Dean of the Faculty:

Prof. Tom Martin		17·9·2020
Name	*Signature*	*Date*

4. **The Head of Division/Institute**
(in the case of support services and research institutes):

Name	*Signature*	*Date*

APPROVAL GRANTED TO OFFER THIS SHORT COURSE IN 2019

	30/10/2020
Vice-Chancellor or Deputy Vice-Chancellor	*Date*

Appendix 9: ACCC 2020 Accreditation

Institutional Planning Unit, Rhodes University, P O Box 94, Grahamstown, 6140

Tel: +27 46 603 8060. Fax: +27 46 603 7561. Email: registrar@ru.ac.za

30 October 2020

Prof C Macleod
CSSR
Psychology Department
RHODES UNIVERSITY

Dear Prof Macleod

SHORT COURSE APPROVAL

I am pleased to inform you that your application to offer the following short course in 2020 was approved by the Chair of the Institutional Planning Committee on 30 October 2020.

5520 Abortion Counselling Certificate Course

At the conclusion of the course, please provide information on the evaluation of the course. A suggested format is attached for your convenience.

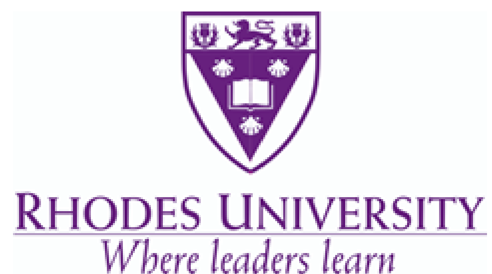
Should you wish to offer the course again in 2021, please submit an application timeously as short course accreditation is only valid for the current year of approval. If you plan to run the course more than once in the year, relevant details must be provided in the application.

Yours sincerely,

Remigius Nnadozie (Dr)
Director: Institutional Research, Planning & Quality Promotion

cc Finance
cc Registrar

Appendix 10: Sample Certificate for ACCC Participants



CRITICAL STUDIES IN SEXUALITIES AND REPRODUCTION

ABORTION COUNSELLING CERTIFICATE COURSE

This is to certify that

Name of delegate

has attended
and demonstrated his/her competence
in the above course.

SARChI Chair – CSSR
Course Co-ordinator

Registrar

Appendix 11: ACCC 2021 Accreditation

Institutional Research, Planning & Quality Promotion, Rhodes University, P O Box 94, Grahamstown, 6140

Tel: +27 46 603 8060. Fax: +27 46 603 7561. Email: r.nnadozie@ru.ac.za

31 March 2021

Prof C Macleod
Psychology Department
RHODES UNIVERSITY

Dear Prof Macleod

SHORT COURSE APPROVAL

I am pleased to inform you that your application to offer the following short course in 2021 was approved by the Chair of the Institutional Planning Committee on 31 March 2021.

4221 : **Abortion Counselling Certificate Course**

At the conclusion of the course, please provide information on the evaluation of the course. A suggested format is attached for your convenience.

Please take note of the attached letter from the Centre for Higher Education Research, Teaching and Learning (CHERTL).

Should you wish to offer the course again in 2022, please submit an application timeously as short course accreditation is only valid for the current year of approval. If you plan to run the course more than once in the year, relevant details must be provided in the application.

Yours sincerely,

Remigius Nnadozie (Dr)
Director: Institutional Research, Planning & Quality Promotion

cc Finance
cc Registrar

Appendix 12: Interview Schedule

Interview Schedule by Laurah Mogonong

Thank you for agreeing to participate in this interview

1. You will remember that as part of the training course, we discussed participants' experiences and understandings of abortion counselling at the time. What is your memory of what you and others said at the time?
2. What are your thoughts about what was said in this session?
3. How did the course alter your practice in relation to conducting abortion counselling?
4. How have clients responded to the changes that you have affected in your practice?
5. What challenges are you still experiencing in conducting abortion counselling and abortion services?
6. Have you managed to continue with the support buddy system? If so, how has this helped, if at all?
7. If you were to talk to nurses who are thinking of undertaking the training, what aspects would you tell them are beneficial? How would the course change how they conduct their practice?
8. Is there anything else you would like to add?

Appendix 13: Facility Manager Letter for Recruitment of Nurse Participants

CRITICAL STUDIES IN SEXUALITIES AND REPRODUCTION

Tel: (046) 603 7329 - Email: cssradmin@ru.ac.za

[Date]

To
The Facility Manager

Subject: Permission to recruit nurses working in termination of pregnancy services for an online training course in abortion counselling and possible participation in research to improve the course.

Dear Ma'am/Sir,

We are from the Critical Studies in Sexualities and Reproduction (CSSR) unit, which is part of the Department of Psychology at Rhodes University. In this letter we ask permission to recruit nurses working in your termination of pregnancy services for an online training course in abortion counselling.

The training course is titled, **Abortion Counselling Certificate Course**. Yamini Kalyanaraman, who is a qualified counselling psychologist, and Phathiswa Esona Bottoman, who is a qualified clinical psychologist, will facilitate the course. Both have experience in the field of reproductive health.

The nurses will be able to participate at no cost to themselves, your facility or the Department of Health. At the end of the course, participants who meet the assessment criteria will receive a Rhodes University *Certificate of Competence in Abortion Counselling* and a *Letter of Attendance*. The goals of course are to: promote client-centred and contextually-relevant counselling based on a sexual and reproductive justice framework, and the *Step-by-step* guide for providers published by CSSR. The training course will aim to benefit nurses by building their skills to provide face-to-face counselling and also eventually contribute towards their Continuing Professional Development (CPD).

The criteria for inclusion in the training course would be for the nurses to have undergone the necessary training in abortion care and to currently be providing such services. Their participation would involve compulsory attendance of five online sessions (2 hours each) over a span of 5 weeks, from 14h00 – 16h00. This will include a two week period of field-work. Over and above this, there will be a 1 hour orientation (14h00 – 15h00) to online learning, prior to the start of the course. Participants will need access to a desktop computer or laptop. If this is not possible then they will need a smartphone, although the former medium is preferable. Mobile data can be provided to the participants by the CSSR. If your clinic can provide the nurses access to a desktop or laptop during the sessions, this will be highly beneficial to the participants and contribute greatly to the success of the course.

Nurses who participate in the training course will have the choice whether or not to participate in the research component. Nurses' non-participation in the research will in no way impact their participation in the course or their ability to meet the course learning outcomes. Two students from Rhodes University will be involved in the action research, which is designed to improve the course, under the supervision of Distinguished Professor Catriona Macleod (email id: c.macleod@ru.ac.za). Yamini Kalyanaraman (student number is G14K2501) is doing her doctoral studies and Laurah Mogonong (student number G19M1795) is doing her master's degree. In partnership with the Department of Health, Eastern Cape (DoH, EC), the aim of this project is to develop, conduct, document and improve an abortion counselling training course for nurses. Research data for the action research project will consist of: feedback forms; reflective journals maintained by the participants and facilitators; participants' case presentations; recordings of selected sessions of the training course; and interviews with participants — conducted telephonically — two months after attending the course, as a follow-up. We will offer the course twice in 2020-2021. The course will be conducted a second time so that it may be revised and refined after taking into consideration the nurses' feedback.

The Rhodes University Ethical Standards Committee (RUESC) has approved the ethics (Review Reference: 2020-1337-3489) of this project on 01. June.2020. Please find attached: the RUESC approval letter; and the clearance letter from the DoH, EC [....].

Attached please find flyers for our training course and research. Kindly grant relevant nurses the permission to attend our online training course. The dates and times of the first course are listed below. The dates for the second course will be provided at a later date.

		Day/Date	Time
Session	Week 1 (Orientation)	Friday; [date]	14h00 – 15h00
Session 1	Week 2	Monday; [date]	14h00 – 16h00
Session 2	Week 2	Wednesday; [date]	14h00 – 16h00
Session 3	Week 2	Friday; [date]	14h00 – 16h00
Session 4	Week 3	Wednesday; [date]	14h00 – 16h00
Session 5	Week 5	Wednesday; [date]	14h00 – 16h00

We would be grateful if you could supply us with the names and contact details of those nurses who have agreed to participate. Please let us know if anything is unclear or if there are other questions you have for us.

Thanking you.

Kind regards,

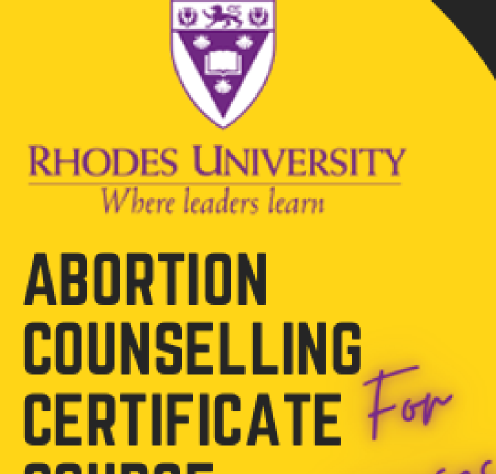
Yamini Kalyanaraman

Laurah Mogonong

Phathiswa Esona Bottoman

Catriona Macleod

Appendix 14: ACCC Advertisement Flyer – 1



2020

WHO CAN REGISTER FOR THE COURSE?

Nurses who have undergone TOP training, but wish to acquire and deepen their skills related to counselling.

HOW MANY PLACES ARE AVAILABLE?

A maximum of 10 places are available on the course. Enrolment works on a 'first come-first served' basis.

IS THERE A COST?

CSSR will cover all costs involved in this course, as there is a research component.

WHEN IS THE COURSE?

13. Nov. 2020	2 - 3pm
16. Nov. 2020	2 - 4pm
18. Nov. 2020	2 - 4pm
20. Nov. 2020	2 - 4pm
25. Nov. 2020	2 - 4pm
09. Dec. 2020	2 - 4pm

CSSR IS OFFERING AN ACCREDITED SHORT ONLINE COURSE IN ABORTION COUNSELLING

HOW DO I REGISTER?

Ask your facility manager for a registration form or you may contact Yamini at yamini.arts@gmail.com for any queries.

CRITICAL STUDIES IN SEXUALITIES AND REPRODUCTION
CSSR

Appendix 15: ACCC Advertisement Flyer – 2

AIM

To train in-service nurses in abortion counselling

To document and improve this training course through action research*

COURSE DETAILS

3-day course consisting of:

- Two-day workshop
- Two weeks of fieldwork
- One-day workshop

PARTICIPANTS

Nurses who wish in future to undergo training in Termination of Pregnancy (TOP) services.

Nurses who have already undergone TOP training, but wish to acquire and deepen their skills related to counselling.

LEARNING OUTCOMES

Identifying what kind of counselling is needed on a case-by-case basis.

Competency in provision of patient-centred abortion counselling based on reproductive justice principles.

Building skills, expertise and confidence in abortion counselling.

Creating a space for sharing, debriefing and reflecting on experiences of abortion provision.

CONDUCTED BY: **CRITICAL STUDIES IN SEXUALITIES AND REPRODUCTION**

ON COMPLETION

You will receive:

Certificate of Competence in Abortion Counselling

Letter of Attendance

** Participation in the research component is voluntary and will not affect participation in the course.*

Appendix 16: ACCC Research Flyer

RESEARCH INFORMATION - ABORTION COUNSELLING CERTIFICATE COURSE

RESEARCH PROJECT TITLE

Developing a client-centred abortion counselling training course for healthcare providers: an action research project

WHAT IS THE PROJECT ABOUT?

The primary aim of this research is to develop, conduct, document and improve an abortion counselling training course for nurses.

PROJECT GOALS

To develop the course, using action research so as to:

- ✓ promote client-centred and contextually-relevant counselling based on a sexual and reproductive justice framework.
- ✓ dispel myths regarding abortion consequences with empirical evidence-based research.

YOUR ROLE

We request your participation in the research as your input regarding the course is crucial to ensuring a quality product. Participation will involve:

- ✓ Giving permission for your contributions in the course (such as feedback forms and reflective journals) to be used as data.

CONSENT AND PRIVACY

- ✓ Participating in this research project is voluntary and will not affect your participation in the course; you may withdraw from the research at any point during the course.
- ✓ Participants will be asked to sign a consent form.
- ✓ Names and personal information of participants in the report, will be kept strictly confidential.

WHO IS RUNNING THE PROJECT?

CRITICAL STUDIES IN SEXUALITIES AND REPRODCUTION

PSYCHOLOGY DEPARTMENT
Rhodes University [RU]
Lucas Avenue
Makhanda 6139

Website: https://www.ru.ac.za/criticalstudies/

CONTACT INFORMATION*

For more info. on the research project, contact:

Yamini Kalyanaraman
(PhD researcher)
yamini.arts@gmail.com

RESEARCH SUPERVISOR:

D/Prof CATRIONA MACLEOD

APPROVALS

This project has received ethical clearance and been approved by:

- ✓ Rhodes University Ethical Standards Committee (RUESC).
- ✓ RU Short Course Approval
- ✓ Department of Health, Eastern Cape.

**For any queries regarding ethical clearance, please contact the RUESC manager Siyanda Manqele @ s.manqele@ru.ac.za*

Appendix 17: ACCC Participant Registration Form

ABORTION COUNSELLING CERTIFICATE COURSE

Application Form, November 2020

RHODES UNIVERSITY CSSR
CRITICAL STUDIES IN SEXUALITIES AND REPRODUCTION

FULL NAME

NAME OF CLINIC

WORK ADDRESS

HOUSE ADDRESS

EMAIL ID

PARTICIPANT MOBILE NUMBER

DO YOU A SMART PHONE?

DO YOU HAVE WHATSAPP?

DO YOU HAVE A DESKTOP/LAPTOP AT WORK?

DO YOU HAVE WIFI AT WORK?

HAVE YOU UNDERGONE TOP TRAINING? AND WHEN?

**Please email the completed form to Yamini at yamini.arts@gmail.com OR take a picture of the completed form and whatsapp it to 0797063020*

CSSR

Appendix 18: Informed Consent Form

DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN RESEARCHERS AND RESEARCH PARTICIPANT

I ____(participant's name) agree to participate in the action research project of Yamini Kalyanaraman, Laurah Mogonong and Catriona Macleod. The aim of this project is to develop, conduct, document and improve an online abortion counselling training course for nurses. The course aims to support nurses in developing skills in the area of abortion counselling.

I understand that:

1. This research is under the supervision of Distinguished Prof. Catriona Macleod in the Psychology Department at Rhodes University, who may be contacted on +27(0)466037329 or c.macleod@ru.ac.za.
2. The researchers are students conducting the research as part of the requirements for a Doctoral/Master's degree at Rhodes University. The researchers may be contacted on
   - Yamini: 079 706 3020 or yamini.arts@gmail.com
   - Laurah: 079 161 8195 or laurahmogonong@gmail.com
3. The research project has been approved by the Rhodes University Ethical Standards Committee (RUESC) [Review Reference: 2020-1337-3489]. For any queries regarding ethical clearance please contact the RUESC Manager, Siyanda Manqele at s.manqele@ru.ac.za.
4. The Abortion Counselling Certificate Course has been approved by the Department of Health, Eastern Cape (EC_202008_008) and the Rhodes University Short Application Course Division (SCA 5520).
5. My participation in the research will enable the development of an online abortion counselling course that will contribute to nurses' professional development; and lead to the development of training manuals for which my expertise input is highly valued.
6. I am participating in a 5-week online course which, if I meet the criteria, will result in my being issued with a *Certificate of Competence in Abortion Counselling*. I am free to participate in the research component or not, without my decision affecting my participation in the course.
7. I agree to a contract of confidentiality amongst the participants, facilitators and researchers in this training course. As a group member, I acknowledge that any information shared about oneself, cases or field-work experience should be considered personal and private information. Information gathered about other participants in this training course cannot be shared, without prior consent, outside of this space.
8. As part of the research, I agree to:

	YES	NO
Allow some sessions of the training course to be recorded. The facilitator will alert me to these sessions.		
Allow my inputs during recorded sessions to be used as data.		
Allow the reflective journal that I submit as part of the course assessment to be used as data.		
Allow my case presentation to be used as data.		
Provide feedback on the course through completing feedback forms.		
The tape recordings may be transcribed by one or more nominated third parties		
The data may be retained after the study for the sole purpose of research and information will remain anonymous.		

9. If at any point I am asked to answer questions of a personal nature for the research study, I can choose not to answer any questions about aspects of my life, which I am not willing to disclose.
10. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. *Should I feel uncomfortable or at risk at any point, details of an appropriate counselling service (telephonic or face-to-face) will be provided to me.*
11. The report on the project may contain information about my personal experiences, attitudes and behaviours, but the report will be designed in such a way that it will *not* be possible to be identified by the general reader. My name will not appear in any research reports or presentations, and all effort will be made to disguise my inputs.
12. I am free to withdraw from participating in the research component (this will *not* affect my participation in the course or issuing of the Certificate) at any time during data collection. However, I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation, which I did not originally anticipate.
13. The nature of the research and the nature of my participation have been explained to me verbally and in writing.

I agree to participate in all or parts of the research component (as specified above) of the training course that I am attending:

Signed on (Date): ____

Participant: ____ **Researcher:** ____

** If you have not agreed to be part of the research component, your voice will be deleted from the recordings taken during the course. Your reflection journal will be used for the assessment of your competence only and not for the research*

Appendix 19: Ian Parker's Transcription Conventions (Adapted)

IAN PARKER'S (1992) TRANSCRIPTION CONVENTIONS (ADAPTED)

Symbol	Meaning
Round brackets ( )	Indicates doubts arising about the accuracy of material
Ellipses ...	To show when material is omitted from the transcript
Square brackets []	To clarify something to help the reader
Forward slashes / /	Indicates noises, words of assents and others
Equals sign =	Indicates the absence of a gap between one speaker and another at the end of one utterance and the beginning of the next utterance
Round brackets with number inserted, e.g. (2)	Indicates pauses in speech with the number of seconds in round brackets
Round brackets with full stop (.)	Indicates pauses in speech that last less than a second
Colon ::	Indicates an extended sound in the speech
Underlining _________	Indicates emphasis in speech