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FEATURE

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Contradictions in womxn's experiences of pre-abortion counselling in South Africa: Implications for client-centred practice

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Abstract

Pre-abortion counselling may play a key role in abortion seekers' understanding of their decision to terminate a pregnancy and the subsequent emotions that they feel. In this paper, we report on a study conducted in the Eastern Cape province of South Africa concerning womxn's experiences of the pre-abortion counselling offered as part of the implementation of the Choice of Termination Act that governs the provision of legal abortion in the country. Using a narrative-discursive lens, the analysis revealed four micro-narratives in which participants appreciated non-directive and empathic counselling, as well as being provided with information. They also indicated that the counselling was upsetting and hurtful, particularly when providers drew on the awfulisation of abortion discourse to suggest that abortion leads to terrible consequences, and foetal personhood discourse to intimate that terminating the pregnancy is wrong and other alternatives (adoption, parenting) are better. The connection between these broadly positive and negative responses may lie in the dominance of anti-abortion discourses coupled with the powerful positioning of healthcare providers as experts. The attendant disempowerment of clients within the health clinic setting may constrain pregnant people's ability to question such 'expert' information. The implications for feminist client-centred pre-abortion counselling are discussed.

KEYWORDS
abortion, client, counselling, discourse, experiences, narratives, qualitative research, South Africa

1 | INTRODUCTION

Experiences of abortion counselling have generally been explored as part of studies focusing on womxn's[1] abortion experiences in general. Few studies (e.g. Baron, Cameron, & Johnstone, 2015; Birdsey, Crankshaw, Mould, & Ramklass, 2016; Ely, 2007; Moore, Frohwirth, & Blades, 2011; Tong, Low, Wong, Choong, & Jegasothy, 2012; Vandamme, Wyverkens, Buysse, Vrancken, & Brondeel, 2013) have treated womxn's experiences of abortion counselling as the main problematic of the research. Given the key role that pre-abortion counselling may play in womxn's understanding of their decision to terminate a pregnancy and the subsequent emotions they may feel, in-depth research on pre-abortion counselling is indicated. In this article, we report on a study that was conducted in the Eastern Cape province of South Africa in which womxn accessing abortion

[1]We use 'womxn' (and the possessive form 'womxn's') here to foreground the social construction of sex and gender, and to foreground how these terms historically, and often still continue to, exclude some womxn-identifying persons, including trans womxn and intersex persons, and black womxn both in everyday discursive practices and feminist praxes. We do note, however, that the term is not inclusive of gender non-conforming and non-binary persons.

services were interviewed about their experiences of pre-abortion counselling.

Results from the studies that have been conducted on abortion counselling are varied, specifically in terms of whether womxn experience the counselling positively or negatively. This variability partly has to do with the different contexts within which the counselling is conducted, and partly with different theoretical approaches to abortion counselling (e.g. pastoral (Baloyi, 2012), feminist (Ely, 2007) and psychotherapeutic (Joffe, 2013) approaches, each of which is founded on assumptions about abortion, what counselling is or should be, what the roles of the counsellor and counsellee/client are or should be, and what womxn need from counselling).

In addition, abortion seekers may experience the same counselling approach differently depending on their needs, the circumstances of their pregnancy and sociocultural understandings of abortion within their context. For example, Birdsey et al. (2016), in their study on womxn's experiences of pre-abortion counselling sessions in KwaZulu-Natal, South Africa, found that some womxn found the information provided to be insufficient, some felt it was irrelevant to their circumstances, and others were pleased with the informational aspect of the counselling.

The needs of the clients may also be different from those anticipated by the counsellors. For example, in Moore et al.'s (2011) study conducted in the United States, among the 49 participants who received counselling, 45 were not seeking options counselling (i.e. discussion of options regarding resolving an unwanted pregnancy), having already decided on termination of pregnancy (TOP) prior to presenting at the clinic. They did not appreciate being prompted by counsellors to engage in further thinking over their abortion decision.

The Choice on Termination of Pregnancy Act (No. 92 of 1996) (hereafter CTOP Act), which currently legislates abortion in South Africa, came into effect in 1997. Under the Act, a termination of pregnancy is legally permitted upon request from the pregnant person for up to 12 weeks' gestation. From the 13th to the 20th week, an abortion may be permitted in circumstances where the pregnancy is the result of rape or incest, continuation of the pregnancy will threaten the physical and/or mental health of the pregnant person, the 'unborn child' will suffer severe abnormalities, or the pregnant person's social or economic status will be significantly adversely affected by the continued pregnancy. After the 20th week, a pregnant person may be granted a TOP when the continued pregnancy would endanger the life of the pregnant person, would lead to foetal malformation, or would seriously threaten the life of the foetus.

In terms of abortion counselling, the CTOP Act stipulates that voluntary (as opposed to mandatory) pre- and post-abortion counselling must be made available but that it is up to the pregnant person to decide whether to use the counselling services or not.[2] Very little guidance regarding counselling is provided in the Act, except that counselling should 'at the least include sufficient information to assist a woman to make an informed choice regarding the termination of her pregnancy'. She must be informed of '(a) the available alternatives to the termination of her pregnancy; (b) the procedure and the associated risks of the termination of her pregnancy'. As we show below this (information sharing) is the aspect about which womxn experienced the most difficulty.

Concerns have been raised that abortion counselling in South Africa may be directive (Vincent, 2012). However, this conclusion is informed by research documenting womxn's accounts of their interactions with staff while using reproductive health services (Wood & Jewkes, 2006) as well as research documenting healthcare providers' views around and attitudes to abortion (Harries, Orner, Gabriel, & Mitchell, 2007). Our study sought to fill this gap in South African knowledge production by focussing specifically on abortion counselling.

2 | MATERIALS AND METHODS

Guided by Taylor and Littleton's (2006) narrative-discursive method, the following questions animated this study: What micro-narratives do womxn use in describing their experiences of receiving pre-abortion counselling? What discursive resources are drawn on in these micro-narratives? Micro-narratives are localised stories usually constructed in short bursts during question and answer interactions (O'Donovan, 2006), and differ from canonical narratives, which are the focus of Taylor and Littleton's (2006) work. Discursive resources may be understood as culturally specific features of talk, which are made available by and within an individual's sociocultural context or community (Reynolds & Taylor, 2004). These features of talk both constrain how and which narratives can be told but are also taken up (or not) in various ways by speakers in the telling of a narrative. As we are using them here, discursive resources refer specifically to discourses (although in other research they may also refer to images, tropes and canonical narratives). Discourses, as we are using them here, are ways of thinking, speaking and writing about the world, which simultaneously construct it in particular ways, and which act upon individuals by producing/calling up selves which speak and act in particular ways (Foucault, 1969/1972). As a discursive resource, we further understand discourses to be 'acted upon' by individuals who may take up discourses (or not) albeit in a way that is constrained by the availability and dominance of particular discourses (Taylor & Littleton, 2006). Thus, we use subject positions to refer to the particular subjects or selves through which individuals are located and locate themselves through/within discourse (Stanley & Billig, 2004).

2.1 | Data collection

The data were collected in the Eastern Cape province of South Africa in 2015 and 2016, as part of the first author's doctoral thesis

[2]Our experience of being in the clinics during the collection of these and other data has been that womxn are generally not made aware that counselling is optional.

in Psychology (with the second author in the role of supervisor). Feminist researchers have long argued that the identity and social location of researchers impacts upon the research process and that researcher's disclosure of the ways in which they are socially located is a necessary part of assessing research (Edwards & Mauthner, 2002). We, both womxn, are feminists whose activism includes promoting reproductive justice, a stance that informs our position on abortion. The first author is black, and the second white. We are both experienced in qualitative data collection and research more broadly, and qualitative abortion research more specifically having both conducted abortion research.

Interviews were conducted concerning womxn's experiences of waiting room interactions and pre-abortion counselling. Womxn who had undergone pre-termination of pregnancy counselling as part of the abortion service process and were willing to speak about their experiences were recruited for the study. This was done through purposive sampling, a strategy in which participants are selected for the particular qualities they possess, such as having experienced an event or practice, which are of interest to the researchers (Tongco, 2007). Womxn were approached and informed about the study face-to-face and were told that if they were interested in finding out more about the study, they could speak to the researchers after the pre-abortion counselling session. Womxn who approached the researchers were then told details about the study and invited to participate.

The three abortion facilities that were selected are each situated in a government-funded hospital in urban and peri-urban environments. These facilities were selected based on their patient flow (approximately ten to 20 people requesting abortion services per day on average), their relative proximity to the researchers, and the existence of hospital-based general counselling services for referral of participants who experienced any kind of distress because of the research interview discussion.

Data for the study were collected using semi-structured, open-ended question interviews to elicit participants' experiences told from their own perspectives through narrative (Jovchelovitch & Bauer, 2000; Willig, 2008). The interviews took place after participants had received abortion counselling.[3] The interviews were conducted in English and/or isiXhosa in accordance with participants' wishes and were audio-recorded with permission from participants. The majority of the interviews were conducted by the first author, who is experienced in conducting interviews around abortion, while the rest were conducted by co-researchers trained and compensated for their work. All of the interviewers are womxn. Interviews lasted on average 30 min.

[3]The healthcare provider responsible for providing the counselling varied at the three sites. At sites 1 and 3, nurses conducted the counselling and performed the abortion procedures. At site 2, counselling was provided by qualified lay counsellors who volunteered for a Christian-based pregnancy crisis NGO. The counsellors had varying qualifications (including a diploma in Christian counselling and an honours' degree in psychology) and varying years of experience providing counselling for the NGO (e.g. two counsellors interviewed had less than 4 years and more than 10 years of counselling experience).

Data were transcribed and translated into English where necessary, with back translation[4] being used to check linguistic and conceptual equivalence. In the interest of transparency, each of the extracts included here is marked with the language in which the interview was undertaken, and therefore whether the extract has been translated into English (<X>, <E>). Minimal transcription conventions were used owing to the translations (pauses: (.); interruption: =; researcher interlude:/ /). Most of the data were transcribed by the first author, who also translated some of the data. Translations and transcriptions were also conducted by a paid translator.

Ethical approval was granted by the Rhodes University Ethics Standards Committee. As indicated, the facilities were chosen on the basis of available counselling services. Although participants spoke about aspects of the pre-abortion counselling which were distressing, counselling support (during or after the interviews) was not needed by the participants, several of whom expressed gratitude and relief at having their stories witnessed by supportive interviewers, and found the non-judgemental interviewing to be cathartic. To protect participants' anonymity, participants were asked to select pseudonyms that are used in this paper. Furthermore, any information that could be used to identify participants (e.g. references to places of residence) has been removed from the extracts.

2.2 | Participants

In total, 30 black[5] womxn were interviewed for the study. Participants ranged in age from 17 to 39, with the average being 26. At the time of their interviews, 12 womxn were studying (two at secondary level and the remainder at tertiary level), seven womxn were unemployed, five were employed, and information was not obtained for the remaining six womxn. Participants included womxn who had never had children, womxn who were pregnant for the first time, and womxn who had one or two children.

Data were analysed using a narrative-discursive method, which is a two-stage analytical process (Taylor & Littleton, 2006). During the first stage, the researcher identifies patterns in the data by way of micro-narratives. This involved analysing participants' responses to the interview questions for a narrative construction of sequence ('and then') or consequence (causality). As part of this task, and in an extension of Taylor and Littleton's (2006) approach,

[4]Back translation is the procedure according to which an independent person translates a document previously translated into another language back to the original language in order to ensure rigour in the translation process. For example, transcribed data that had been translated into English were translated back to isiXhosa and the two versions compared.

[5]'Black' is being used here broadly and politically to refer to those groups who were previously designated as 'non-white' and were racially and economically oppressed under colonial and apartheid systems. Although there are contestations around its usage, we have used it here as racial identity was not constructed or made relevant by participants in the narratives discussed here, and to acknowledge the contestations, and search for new ways of speaking, around categorisation and meanings of race and racial identity, both inside and outside academic and research spaces, currently taking place in South Africa.

the analysis work involved drawing on poststructural writers' work around power relations (gendered, as well as liberal, pastoral and sovereign/authoritarian) to further analyse the data. In the second stage, the researcher analyses each micro-narrative for discursive resources that have been drawn on to construct the micro-narrative. The first and second authors, both experienced in this method of analysis, separately analysed and discussed the data.

3 | ANALYSIS

Echoing the literature cited above, participants' experiences of the pre-abortion counselling varied. Moreover, there were some inconsistencies within individual accounts. While several womxn reported experiencing the counselling in positive ways, they also described being subjected to information provision practices that, we argue, delegitimised abortion. In the following, we use extracts that exemplify four interlinked micro-narratives. The first micro-narrative, 'the counselling was healing/beneficial', shows the positive aspects of counselling. The second, 'the counselling was informative', speaks to the information-sharing aspect of the counselling. The third and fourth micro-narratives, 'the counselling made me have doubts', and 'I was so hurt', are responses to the information-sharing aspect of the counselling.

3.1 | The counselling was healing/beneficial

Some participants experienced the counselling as a healing or beneficial process. Within this micro-narrative, participants described non-directive, balanced, supportive and empathic counselling. Womxn indicated that they moved from negative emotions when they arrived at the facility to positive emotions as a result of the pre-abortion counselling. They, thus, deploy a psychotherapeutic counselling discourse, in which a healing process is expected to be facilitated through counselling following a difficult event.

In extract 1 below, for example, Thamie describes a change in emotions as a result of the counselling she received.

Extract 1 [site 3] <E>

I: […] if you can just tell me:: um (.) what you experienced in that consultation room how was that experience for you?

Thamie: (.) well [laughs] when I came here /mm-hm/ (1) uh how can I put it (.) I was very heavy (.) neh /mm-hm/ but after the:: (.) session /mm-hm/ in the consultation room I feel very light (.) I'm sure of what I want to do and (.) *ja* (.) that's how good it was /ok ok/ *ja*

…

Thamie: […] first of all yoh (.) she's good /mm/ cause I wasn't expecting that /mm/ she's a very nice person she's gentle /*ja*/ (.) polite /mm/ (2) *ja* (.) the the way she:: she talks and explains it just (1) someway somehow I can say she's a psychologist for God's sake /ok (.) ok/ […]

For Thamie, an effect of the counselling she received is that the burden of doubt and emotional conflict she had been experiencing is relieved and replaced by certainty: 'I'm sure of what I want to do'. Like several other womxn in the study, the counselling had the effect of affirming her decision to terminate the pregnancy. Drawing on a psychotherapeutic discourse, Thamie lists certain qualities that, for her, are necessary for and constitute 'good counselling', and eventually exclaims: 'she's a psychologist for God's sake'.

Thembakazi (extract 2 below) describes a similar emotional transition, an easing of a burden.

Extract 2 [site 3] <X>

Thembakazi: then you will find support; at least the sister is supportive /mm/ (1) she knows how to (1) feel make you feel (.) like you came here holding on and then she chats (.) /ok/ she removes this tension that you are going to do something (.) you see

Explaining what she means by 'support', Thembakazi talks of a transition from a state of tension and stress (i.e. 'holding on') to the removal of this tension. Crucially, this sense of 'holding on' is linked to the sense that abortion is a (morally) profound or significant 'something'. Importantly, in Thembakazi's description, the healthcare provider's counselling practices have the effect of (temporally) disrupting this notion, thereby (temporally) normalising termination of pregnancy.

3.2 | The counselling was informative

Within this micro-narrative, participants gave accounts of the usefulness of information on: (a) pregnancy outcome options (abortion, parenting, adoption); (b) the abortion procedure[6]; and (c) the so-called risks of abortion Womxn spoke of the counselling as an educational or learning experience, with the healthcare provider being positioned as an educator providing useful information.

Extract 3 [site 2] <E>

Mpho: what I think is that it was very informative because she:: she:: (.) well (.) the way she did it (.) she didn't judge us /ok/ and stuff (.) she was just basically informing us on like what was gonna happen /ok/ and like (.) the:: long-term effects not like the medical effects but like psychological effects /ok/ and u::m (.) well she did tell us about the long-term effects which was like (.) increase chances of breast cancer (.) and (.) other like psychological disorders after this and like um (.) reduced chances of having (1) having a child […]

[6]In South Africa, both medical and surgical abortion methods are used, with medical abortion being used as much as possible in the public health context. Medical abortion is where a medication regimen of mifepristone and misoprostol is used to terminate the pregnancy. Surgical abortion terminates the pregnancy through manual vacuum aspiration (MVA) or dilation and curettage.

> and she (.) told us about like other options besides abortion /mm-hm/ because she (.) um she said that there are other women out there who don't have children (.) um who can't have children /mm/ who would like to have children /mm/ and then like if you go through with the pregnancy and then (.) just give birth to that child and like you know (1) give that child a home [...]

Mpho indicates that she experienced the information provision part of the counselling as non-judgemental and factual. She implies that the counselling was educational, as she received information of which she was previously unaware. She does not question the content of this knowledge, in which the 'consequences' of terminating a pregnancy are depicted as highly risky and harmful, both psychologically and physiologically.

This kind of overstatement of the risks of (legal) abortion is part of what feminist scholars have termed the 'awfulisation of abortion'[7]—the normative understanding of abortion as an invariably 'awful' experience with little to no significant benefits, a necessary evil at best, and consequently a decision that is agonised over and therefore only ever made as a 'last resort'. Within this discourse, abortion is constructed as traumatic to abortion seekers, with so-called post-abortion syndrome, mental ill-health or emotional duress being part of the trauma of abortion (Hoggart, 2015; Sparrow, 2004; Wahlström, 2013). This is despite a body of research that demonstrates that legal and safe abortion does not, in and of itself, cause or lead to mental ill-health (Major et al., 2009) and that emotions such as grief, loss and regret, while experienced by some, are not inevitable (Charles, Polis, Sridhara, & Blum, 2008). Abortion is also constructed as always already medically dangerous and highly risky (Wahlström, 2013), even when conducted legally and safely in healthcare facilities by trained healthcare providers, and despite the fact that abortion generally poses fewer health risks than taking a pregnancy to term (Gerdts, Dobkin, Foster, & Schwarz, 2016).

Despite receiving such (mis)information, Mpho describes the counselling positively, as non-judgemental and informative. This suggests that within the healthcare context, interactions such as pre-abortion counselling, may be seen, and possibly conducted, as an opportunity for information sharing and education. When this happens, questioning the accuracy of the information received is difficult if not impossible from the subjective positioning of both learner (as opposed to educator) and layperson/client (as opposed to healthcare worker). The power relations between educator and learner, and healthcare professional and layperson, mean that Mpho receives the information as *information*, that is, as factual and necessarily as value-neutral.

[7]First used by Australian feminist scholars in the 1990s (See Sparrow (2004) and Wahlström (2013)), it has since been used by feminist scholars to describe a defining feature of abortion politics outside of Australia, including the UK and the United States. Feminist scholars note that this feature of abortion talk is taken for granted even among abortion and pro-choice advocates.

3.3 | The counselling made me have doubts

Within this micro-narrative, participants described how aspects of the counselling, such as pregnancy resolution 'options', information around the 'risks' of abortion and/or details of the abortion procedure (usually medical abortion) resulted in conflict around their decision to terminate the pregnancy. Thus, womxn tended to describe wanting to change their decision. For most of the womxn who constructed this micro-narrative, however, this conflict was unresolvable as abortion was the only course of action for them.

In extract 4 below, for example, Thombulelo describes the discussion around pregnancy options as directive and persuasive.

Extract 4 [site 1] <X/E>

Thombulelo: =that part of the options? */ja/* (.) it was u::m (4) it was like u::h (3) they don't wanna, they don't want me to do the termination (1) /ok/ *ja* it was like she didn't want me to do it /mm/ and I have no reason for me to do it /mm/ and I can just keep the baby /mm/ and give it out (.) give it up for adoption /ok/ (and u::h just like make it ok) /ok/ *ja* so the option was like (.) she was trying to do that

I: ok (.) and h- how did you experience that? What, what, how did you feel about that?

Thombulelo: mm (2) I felt (.) I felt like changing my mind at first /mm/ because I it was like I (.) like I (1) some (.) it felt so::me like I so::me how can I put this by the way (2) like it made me want to be sad [feel sorrow/pity] = /=mm-mm mm-mm/ do you understand /mm-mm=/ =as in like (.) to think about what I'm going to do and how wrong it is /o::hh/ *ja* /how wrong it is=/ (that's why *ja*)

Thombulelo here refers to a counselling practice that featured in many womxn's accounts—that of healthcare providers asking womxn for their reason for requesting an abortion. In asking for these reasons, the 'rational reproducer' discourse is drawn on. Within this discourse, womxn (and mxn) ideally plan pregnancies, take precautions to avoid unintended pregnancies, make rational choices concerning the outcome of the pregnancy, and comply with healthcare directives. Notably, Thombulelo's account demonstrates how the requirement for 'rational' reasons for abortion is called for in counselling. Implied within this discourse is that pregnant people may be positioned as 'irrational' and 'irresponsible' reproducers, and consequently as having no 'rational' basis for terminating a pregnancy ('I have no reason', as indicated by Thombulelo).

The healthcare provider emerges in Thombulelo's account as a judge of the validity of clients' decision to have an abortion. As Thombulelo describes, the healthcare provider attempts to guide her decision-making away from abortion. This is achieved through shaming: 'think about what I'm going to do and how wrong it is'. Thombulelo initially feels like changing her mind. For her, however,

as was the case with other womxn who constructed this micro-narrative, adoption is a non-option: 'a::nd I can just keep the baby/mm/ and give it out (.) give it up for adoption'. Her use and emphasis of the word 'just' highlights the *impossibility* of placing the child up for adoption, despite the healthcare provider's assumption about the ease with which this could be done.

For some womxn who constructed a micro-narrative of 'It made me have doubts', the awfulisation of abortion was emotionally troubling:

Extract 5 [site 1] <X/E>

Lisa: another another thing she told me is that (.) that she explained to me (.) she gave me more information about there that is contained in that paper (.) she said other things (1) that are, that physical damages are there for the future (.) I may go without having children /mm/ other people they say (.) because they have seen the child (.) they cannot erase that image (.) the image does not go away and they end up having problems /mm/ in their mind /mm/ yes it is like that so (.) I found that information /ok/ that is what made me like I have doubts [...]

Lisa recalls the two (overstated) risks that made her have serious doubts about terminating the pregnancy: future infertility and the possibility of psychological distress following abortion. Lisa recalls how the counsellor used traumatology talk, implying that having 'seen the child', clients would experience flashbacks. By 'seen the child' Lisa is likely referring to the information some womxn in this study reported being provided: they would likely, depending on their gestation, recognise the foetus as human (they were expected to watch for the products of pregnancy to be expelled after medical abortion).

This kind of traumatology talk is premised on a discourse of foetal personhood, in which the foetus is constructed as an independent rights-bearing person, separate from the pregnant person carrying the pregnancy. Within this discourse, the foetus, its interests and well-being are prioritised above those of the person carrying the pregnancy. But more than that, the person carrying the pregnancy is positioned as mother, and therefore as nurturer and protector. In this case, traumatology talk is reliant on an understanding of the physical harm done to the foetus, and the consequent psychological harm that mothers (and parents) are expected to experience, particularly having been complicit in the harm done to the foetus.

3.4 | I was so hurt

In this micro-narrative, some of the womxn spoke about the hurt they felt during the counselling because of the (overstated) risks of abortion or being encouraged to opt for adoption. Tied to these feelings of hurt or sadness was the sense that abortion could not be avoided, despite perhaps wanting to reconsider their abortion decision as a result of the counselling discussion. In extract 6, Nziweni has been asked by the interviewer to elaborate on her experience of the counselling as having gone well but also as hurtful.

Extract 6 [site 2] <X>

Nziweni: [...] (1) u::h things like (.) when you are twelve weeks (.) and above /mm/ twelve weeks /mm/ it is now a person that has a soul /mm/ you see /mm/ so (.) to (.) if it is done there (.) abortion (.) you are given pills to take /mm/ you expel a person a child (.) what is left is blood but the feet are there /mm/ the hands you see them they are there (.) /mm/ then (1) how will you take the pills and expel it when it is still breathing /mm/ u::h you need to wait even for it to pass out you (.) /you are watching everything/ give birth to it (.) yes you are watching everything (.) so other things like that, that make you feel painful /mm/ but when the decision has already been taken

Nziweni describes the information she received during the counselling concerning foetal development. This information is the reason for her pain and hurt. The emphasis Nziweni places on 'person' suggests that this information was revelatory and shocking for her. Indeed, knowledge around foetal development is a powerful tool in the foetal personhood discourse, transforming the foetus to a rights-bearing person, seemingly independent of the pregnant person who in turn is positioned as a vessel to the foetus (Macleod & Howell, 2015).

Later, Nziweni explained how she found a discussion on the possibility of adoption placement hurtful.

Extract 7 [site 2] <X>

Nziweni: [...] I was so hurt I don't want to lie /mm/ but I had already taken a decision /mm/ that I want to do this /mm/ you see (1) and I have to /mm/ because of the situation (.) you see (1) /mm mm/ *ja*:: so /*ja*/ getting hurt there (.) I was hurt /mm/ and then I feel bad about (.) what I'm going to do (.) because I never do this before it's my first time to do it /*ja*::/ *ja*:: then (1) *ja* I was so hurt man /*ja*/ cause I even cried and /mm/ u::h (1) can it be that I save this child or /mm/ what do I do /mm/ I didn't have a choice /*ja*/ I can't carry the baby for nine months and give (.) give uh (.) give her or him away (.) no (1)

Although Nziweni at first (not shown in this extract) described her experience of the counselling as 'being advised on the right things', she went on to indicate the hurt she felt: she has no other recourse but to terminate the pregnancy due to her circumstances, but is made to feel 'bad' or guilty through the deployment of the foetal personhood discourse: 'can it be that I save this child'. In constructing the foetus as a fully fledged child or baby, abortion seekers are necessarily positioned as mothers and therefore nurturers and protectors of their children. Implied, then, is that Nziweni's decision to terminate the pregnancy contradicts this positioning. Her use of the word 'save' is particularly notable in its likening of abortion to an act of death and the subject positions that this makes available to her:

she can either rescue the child and be a 'good mother' or participate in its death and be a reproachable one.

4 | DISCUSSION

As we have shown, there was variation across participants' accounts of their pre-abortion counselling experiences. Participants indicated that they experienced the counselling as non-directive, empathic and informative. At the same time, participants spoke about the counselling introducing doubt about their decision and as hurtful. These kinds of contradictions were found *within* some participants' narratives.

These contradictions centred on certain information-giving practices that formed a part of the counselling they received, namely unconfirmed and overstated risks around abortion (infertility, cancer and psychological trauma), descriptions of the abortion procedure and information around foetal development. Importantly, this information was bound up in and constructed through discourses (specifically the awfulisation of abortion, the responsible reproducer and the foetal personhood discourses) that, when deployed in the pre-abortion counselling space, had the effect of delegitimising abortion as an appropriate, responsible and safe way to resolve a pregnancy.

It is important to note that womxn narrated that the counselling was experienced as non-directive and empathic, even as they also spoke to the distress they felt at receiving certain information. That womxn experienced the counselling as positive in some respects cannot be dismissed. Thus, the contradictions in womxn's experiences certainly points to how the counselling was directive but also had positive features which womxn appreciated, such as empathy, kindness, gentleness and emotional support. There are also other possible explanations for this contradiction. All together, these explanations may contribute to the counselling having been experienced as positive *and* distressing. First, research has shown that the South African public in general tends to hold views, which are pronatalist and problematise abortion, allowing abortion only under very specific circumstances (Harries, Stinson, & Orner, 2009; Mvaba & Naidoo, 2006). Given that it is likely that womxn in this study are also caught up in a discursive culture that problematises abortion, such responses might point to participants' own contradictory feelings. Second, this contradiction might point to some womxn's need for information and the need for providing information in a nuanced and supportive way. Third, these responses might also reflect the researcher–participant power relation where participants felt as is if they were expected to give a desirable answer (i.e. that the counselling went well, especially as they were interviewed within the hospital) and felt unable to disagree or depart from this. And finally, they might reflect the power relations, which is understood here as acting upon another's actions (Foucault, 2000), between healthcare providers and clients/patients within clinical and hospital settings where clients may not be/feel able to critique or problematise the content of the counselling, which a negative experience might be interpreted as, due to the authority invested in the healthcare provider within such settings. Importantly, the power relations between healthcare providers and clients/patients may also involve unequal access to information and the knowledge and right (in a discursive, subject positioning sense) to interpret such information.

We argue that womxn's use of 'the counselling was informative' micro-narrative must be situated within the clinic as a site of power wherein healthcare providers' language use is accorded the weight of scientific authority and truth. The connection between the broadly positive and negative responses of these womxn to the pre-abortion counselling encounter lies in their powerlessness to question such expert information, despite it being vastly overstated and lacking in evidence. The healthcare providers' assumption that all options for the resolution of a pregnancy are available to these womxn and the delegitimisation of abortion serves to produce decision uncertainty or to exacerbate it. In the context of limited viable options, this conflict may be irresolvable.

5 | IMPLICATIONS FOR PRE-ABORTION COUNSELLING SERVICE PROVISION

It is important to acknowledge that the participants' responses discussed here were not uniformly shared by all participants in the study. Furthermore, they cannot be taken to be representative of experiences of the counselling offered at the three sites where our data were collected, nor do they reflect experiences of pre-abortion counselling offered at public health facilities in the Eastern Cape province or elsewhere in South Africa. Indeed, further research is needed on whether and how pre-abortion counselling occurs at other facilities in South Africa, and the various ways it is experienced by clients. Nevertheless, we hypothesise that the participants' experiences we discussed here may have several implications for abortion counselling service provision in South Africa, and indeed elsewhere.

The micro-narrative of 'I was hurt' where some womxn spoke about the hurt they experienced in relation to receiving information about the risks of abortion and/or foetal development points to how counselling may produce harm or distress instead of mediating or preventing it. It points to the importance of excluding inaccurate information, such as the overstated risks of abortion, so that pregnant people may have a comfortable abortion experience.

Because womxn's accounts suggested that womxn generally did not have a choice in what kinds of information they were provided with, a micro-narrative of 'I was hurt' also points to the need for the voluntariness of abortion counselling (as stipulated in the CTOP Act) to be understood and emphasised by healthcare providers so that abortion counselling *is* voluntary. Indeed, our own research suggests that counselling may not be voluntary, at least at the facilities where our research was conducted. Given that abortion seekers have varying needs and in order to uphold reproductive autonomy, mandatory counselling is certainly undesirable (Brown, 2013). Echoing Moore et al.'s (2011) argument for a 'cafeteria-style approach' and Birdsey et al.'s (2016) call for client-centred counselling, a model of abortion counselling should be developed that is responsive to the narratives clients tell of their lives. To do so, different kinds of counselling should be

made available to abortion seekers: decision-making counselling (for those who have not yet decided and would like assistance in talking through their options such as they may be), procedural counselling (where clients can elect to hear more details about the procedure), and pre- and post-procedural counselling (where clients may get emotional support prior to or after their procedure) (Mavuso, du Toit, & Macleod, 2017). Indeed, womxn's micro-narratives of 'It was informative' and 'The counselling was healing/beneficial' point, respectively, to the different needs that abortion seekers may have around information provision and supportive (psychological) counselling.

A feminist, client-centred counselling has certain implications for abortion counselling practice, over and above the counselling model we suggest. It would mean that providers: uphold the reproductive autonomy of their clients and therefore do not use discourses, including religious discourses and misinformation, which awfulise abortion; normalise abortion by constructing it as a safe, beneficial, legitimate healthcare practice and reproductive decision and by challenging the stigma around abortion, a stigma with which abortion seekers may themselves struggle; and pay careful attention to the ways in which clients speak about and refer to their pregnancy and adopt those language practices. It would also mean that providers offer counselling that is empathic and is affirming of the abortion decision. Indeed, in some of the narratives shown here participants spoke about how empathy, kindness, gentleness and presence were positive aspects of the counselling.

Given the provider training and resources that would be required to effect this model of counselling, and given the structural and resource constraints in South African public healthcare provision (and in resource-poor settings elsewhere in the world), as well as a global climate of increasing restrictions on abortion access (including limitations to funding for abortion services), imaginative solutions may be required to implement this model of counselling. However, our research suggests that providing feminist, client-centred counselling would make significant improvements to pregnant people's well-being and would improve access to reproductive autonomy.

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