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POLICY BRIEF

Revamping pre-abortion counselling in South Africa

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Graffiti in Belfast, Northern Ireland. Picture: Catriona Ida Macleod

Introduction

The Choice on Abortion (CTOP Act, No.92 of 1996) legalises abortion[1] on demand during the first trimester of pregnancy, on various grounds (including that the pregnancy would threaten the woman's socio-economic circumstances) until the 20th week, and thereafter under very limited circumstances. It stipulates that pre- and post-abortion counselling should be made available to women but that women can choose whether or not to receive counselling. According to the Act, the counselling should be non-directive in nature. The Western Cape Department of Health's (2000) 'Termination of Pregnancy: Policy, Guidelines and Procotols' document provides some basic guidance for counselling, but these are under-described.

Our study

A study conducted by the Critical Studies in Sexualities and Reproduction research programme of Rhodes University explored pre-abortion counselling within the public health sector of the Eastern Cape, South Africa. Data were collected at three public health hospitals that offer abortion services.

1. The terminology to describe an induced termination of pregnancy has recently been in dispute. In this policy brief, we use "abortion" in line with international trends.

Data collection involved:

- audio recordings of 32 pre-abortion counselling sessions;
- in-depth interviews with 30 women about their experiences of waiting room interactions (between healthcare providers and women accessing abortion services, and among women themselves) and receiving pre-abortion counselling.
- in-depth interviews with 4 healthcare providers (2 nurses and 2 qualified counsellors belonging to a Christian organisation that offers their services free of charge to the relevant hospital) about their experiences of providing pre-abortion counselling and their experiences of waiting room interactions.

A combination of discursive psychology and conversation analysis was used to analyse the data, with a specific focus on: the structure/format of the sessions (i.e. how the conversation progressed); the content of the sessions (i.e. what was said and how it was said); the discursive resources drawn on by participants in describing their experiences (including the practices engaged in by healthcare providers).

Findings:

Recordings of counselling sessions

- On average, pre-abortion counselling in the public health sector lasted less than 20 minutes. Pre-abortion counselling was, in most cases, conducted individually (e.g. patient – nurse/counsellor); however, group counselling sessions were also conducted.
- Pre-abortion counselling tended to follow a common format;
  - » **Establishing the reason** for falling pregnant, or rather the woman's failure to prevent pregnancy, as well as her reasoning for wanting an abortion (e.g. unplanned, unsupported)
  - » **Providing procedural information** (medical or surgical procedure, what to expect)
  - » **Discussing possible options** (abortion, continued pregnancy and adoption)
  - » **Obtaining informed consent** for the procedure
  - » **Discussing family planning** (e.g. selecting which one to use in the future to avoid pregnancy, dual-contraceptive use encouraged)
- For the most part, counselling was directive, with a clear anti-abortion position emerging in many sessions, particularly those conducted by the independent counsellors.
- Nurses and counsellors overtly emphasised the individual rights of pregnant women in deciding on the outcome of her pregnancy. However, choice and the decision-making process were often discussed as an isolated event that included only the woman and foetus and seldom addressed the social and contextual realities in which pregnant women are located. In addition much of the talk in sessions undermined abortion as a possible choice.
- Both the physical (e.g. future infertility, breast cancer, death) and psychological risks of abortion (e.g. Post-Abortion Syndrome, depression, guilt, regret, suicidal thoughts) were emphasised. Within this kind of talk to opt for an abortion is to put oneself at extreme risk, whereas to continue one's pregnancy is to avoid risks altogether.
- Both nurses and the independent counsellors ascribed independent personhood to the foetus, referring to the foetus as the 'baby'. Independent counsellors engaged in elaborate rhetorical strategies to

construct the foetus as a 'baby' – a practice referred to as person-making. Counsellors personified the foetus through:

  - » Describing the morphological features and the functionality of the foetus at different stages of development (e.g. it has arms, legs, it breathes, it has a heartbeat, it lives, it survives)
  - » Using the signifier 'baby' almost exclusively when referring to the foetus and thus positioning pregnant women as mothers by virtue of being pregnant
  - » Providing visual representation of the foetus' development through photographs

- Nurses and counsellors adopted an educator/expert role during the interaction which primarily involved providing information. When discussing the abortion procedure, nurses generally provided information in a neutral manner with specific references to medication, instruments and physical side-effects patients may experience during and after the procedure, whether surgical or medical. Independent counsellors, when providing procedural information, did so by describing the procedure in exaggerated graphic and explicit detail (e.g. "your baby comes out in bits and pieces", "your child is physically sucked apart, first the head, then the tummy, then the legs"). An image of the foetus was often shown after the procedural information had been shared. The very presence of this sort of information in the interaction highlights the directive and biased form pre-abortion counselling can take in the public health sector in South Africa.
- The above practices work as rhetorical scare-tactics that construct abortion as, firstly, a medical procedure associated with a wide range of extreme consequences and, secondly, as an act that is in contravention of the accepted purpose of 'mothers' (pregnant women) to protect their 'babies' (foetuses). Through constructing abortion in only negative terms and contributing to its 'awfulisation' (Hadley, 1996), women are discursively dissuaded from considering abortion as a legitimate and safe reproductive health option.
- Nurses and counsellors did not consider the exclusive use of male condoms to be an effective method of preventing pregnancy. Nurses and counsellors encouraged dual-contraceptive and long-term methods such as Implanon, Intrauterine Device (commonly referred to as 'the loop') and the contraceptive injection (3-month dosage usually recommended). Contraception was discussed whether women requested this information or not.

Interviews with women

- Women expressed having 'no choice' but to have an abortion owing to their personal circumstances. The decision to have an abortion preceded the visit to the clinic.
- Women expressed shock and sometimes pain over the information provided to them about foetal development, the stated 'risks' of abortion (infertility, cancer and psychological trauma), and details of the abortion procedure provided during the counselling.
- Women described how receiving this information created or reinforced conflict over the decision to have an abortion, a conflict that could not be resolved due to the necessity of having an abortion.
- While several women described their counselling experience overall as informative and even supportive, some women described feeling judged by their healthcare provider.
- Women's waiting room experiences revealed that for some this was an important source of support which allowed them to realise that an abortion is a common procedure, while for others the sharing of past experiences was scary.
- The fact that counselling is optional and not mandatory was only made clear in a few instances.

Interviews with health service providers

- Healthcare providers generally problematised both abortion and unintended pregnancy, seeing both as a failure on the part of the woman.
- Nurses and counsellors saw the purpose of pre-abortion counselling as one of preventing both unintended pregnancy and abortion, in particular through the prescription of contraceptives.
- Healthcare providers positioned themselves as facilitators and supporters of the women's decision-making, with their involvement being limited to providing neutral/factual information. At the same time, they spoke of prescribing the 'correct path' to women by requiring reasons for the abortion request, insisting that women take up contraceptives, and/or discussing abortion as harmful and dangerous to the woman.

Implications

1. Our results point to health service providers actively trying to dissuade women from having an abortion through: (1) the ascription of personhood to the foetus, the presentation of foetal imagery, and graphic descriptions of foetal development; and (2) outlining a number of risks associated with abortion. Both these practices are problematic. In the first instance, deploying a discourse or 'mother/baby', with the implied responsibilities of protection, fails to appreciate the circumstances under which women opt for an abortion, undermines her right to bodily integrity, and potentially adds stress and distress to the decision. In the second instance, the risks are vastly exaggerated. The physical risks mentioned by health service providers are hugely overstated and in dispute in the scientific literature. What IS known is that the physical risks of abortion performed under safe conditions are substantially less than the physical risks associated with taking a pregnancy to term and giving birth. The latter (risks of continuing a pregnancy) were never mentioned in the sessions. The psychological consequences of abortion are also in dispute in the literature. Sound evidence, however, as indicated by the American Psychological Association report, suggests that abortion conducted within the first trimester under safe and supportive conditions does NOT lead to mental health difficulties.
2. Despite the stipulations in the CTOP Act, the counselling provided is in many ways *directive*, stemming from how abortion and unintended pregnancy are understood by healthcare providers as problematic reproductive processes that need fixing.
3. The information provided by counsellors and nurses may contribute significantly to the distress that women may feel at having an abortion. Recent research points to women's emotional responses to an abortion being shaped by the services provided. If abortion is constructed negatively in pre-abortion counselling, it is likely that women will assimilate some of this negativity.

Recommendations

- A set of national standardised guidelines for pre-abortion counselling that would be implemented nationwide need to be developed. These standards need to address the content as well as the process of counselling.
- These guidelines should be informed by an understanding of abortion as a common health procedure and an appropriate method of fertility regulation that women may decide to use or not as their circumstances dictate and/or according to their needs.
- Nurses and counsellors should have to undergo training based on these guidelines before being able to provide counselling in everyday practice.

- It should be made clear to all women that counselling is not mandatory. In addition, women should be able to choose what KIND of counselling they would like to receive. Specific guidelines should be developed for each kind of counselling:
    - » Options/decision-making counselling (usually taken up by women who have not yet made the decision)
    - » Procedural counselling (usually taken up by those who would like to know more about what the procedure entails and what their options are)
    - » Pre-procedural counselling (for those who would like emotional support immediately prior to the procedure)
    - » Post-procedure counselling
- Counselling should *avoid* the following:
    - » *Requiring* the woman to relate how she conceived;
    - » Shaming the woman for lack of contraceptive usage, or any other behaviour that could be construed as leading to the unintended pregnancy (it must be remembered that across the globe 1 out of 2 or 3 pregnancies is unintended, making this a common occurrence);
    - » *Requiring* the woman to divulge her reasons for wanting an abortion;
    - » Using the word 'baby' to refer to the foetus;
    - » Using graphic descriptions of foetal development or showing pictures of foetuses;
    - » Citing unproven and disputed physical and mental consequences of abortion;
    - » Using religious references unless these are brought up by the woman herself;
    - » Judging the woman on an unintended pregnancy or reason for needing an abortion where the woman does provide this information.
- The counselling guidelines should be based on patient-centred and reproductive justice principles, which emphasise the following:
    - » Counselling should be conducted in an interactive and dialogical fashion in which the stories and narratives told by the woman are foregrounded and respected.
    - » Counsellors should recognise the social context within which a woman is requesting the abortion; counsellors should not demand information from the woman, but should express understanding for her situation where the woman elects to share stories with the counsellor.
    - » Counsellors should normalize abortion as a reproductive health right as well as the *experience* of having an abortion. Negative discourses about abortion should be avoided. For example, if the client does bring up their own religious beliefs, counsellors should try to normalise the abortion (reference can be made to such groups as Catholics for Choice).
    - » Counsellors should only deal with content and topics which patients wish to discuss (this does not apply to *accurate* medical information about the procedure which is required for informed consent to proceed with the abortion).
    - » Information not solicited by the women needs to be limited to the woman's rights under the CTOP

Act (e.g. woman may request an abortion up to 12 weeks gestation; conditions under which 2nd trimester abortions may be performed; no partner consent required; minors encouraged to consult trusted adult, but not required to).

  - » Counselling should not focus on decision-making unless a need to do so is indicated by the woman herself.
  - » Securing informed consent for the abortion procedure should be conducted in a context-sensitive manner that is responsive to the woman's needs.
  - » Counselling must be confidential at all times; women must be informed of this.

- Information on the procedure should include the following:
  - » The choice of method available at the particular stage of gestation.
  - » The side effects and potential complications; symptoms that may be experienced during and after the procedure.
  - » How long the abortion will take.
  - » Pain management.
  - » Any items that the client needs to bring with them (food, change of clothes, blanket etc).
  - » Follow up care, including referrals if necessary and contraceptive discussions and prescription, IF requested by the woman (this should NOT be imposed by the healthcare provider).
- Training of counsellors and nurses should include role play and feedback. One possibility is Conversation Analytic Role-play Method (CARM) developed by Stokoe (2011; 2014). Its key features are as follows:
  - » It is based on the analysis of anonymised data of an actual counselling session (e.g. using the findings from this study). Audio recordings of real-time sessions are used.
  - » The trained facilitator works cooperatively with participants to identify, evidenced based, problematic communicative practices (e.g. providing graphic description of the procedure) and explores alternative means of conversing in the pre-abortion interaction.
  - » It can be used to critically explore the *format/method* (i.e. individual versus group counselling, conversation structure) and the *content* of the counselling.
  - » This training can explore the nuances of patients and counsellors talk (for example, what do pauses mean in the interaction?)
- Standard random exit interviews should be conducted with women concerning their experience of pre-abortion counselling so that problematic practices can be identified and addressed. These interviews should be conducted by people independent of the abortion clinic as part of the public health audit system.
- Where independent counsellors are used, there needs to be a thorough screening of their methods, and they should be obliged to undergo the same training as other healthcare providers.
- Research should be conducted to explore how pre-abortion counselling is experienced and conducted in other provinces of South Africa

- Research should be conducted around how healthcare providers are trained in providing pre- (and post-) abortion counselling (including the values clarification aspect) so that, if needed, this training can be changed to best serve abortion providers in providing counselling that is not directive and harmful to women.

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