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CALL CENTRES: ANONYMOUS 'SAFE SPACES' FOR WOMEN'S EXPERIENCES OF ABORTION STIGMA

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A MINI-THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS

IN THE DEPARTMENT OF WOMEN'S AND GENDER STUDIES

UNIVERSITY OF THE WESTERN CAPE

SOUTH AFRICA

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JULY 2021

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Declaration:

I, Nonkosi Xaba, declare that "Call centres: Anonymous 'safe spaces' for women's experiences of abortion stigma" is my own work and that it has not been submitted for any degree or examination at any other University and that all sources I have used or quoted here have been indicated and acknowledged by means of complete references.

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Full Name	**Date**	**Signature**

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Abstract

In South Africa, abortion became a right in 1996 in terms of the Choice on Termination of Pregnancy Act, 92 of 1996 (CTOP). However, despite this legal dispensation, debates between pro-life (those against abortion) and pro-choice (those supportive of the law) have continued unabated in liberal South Africa. These debates have resulted in severe stigma for women who choose to terminate their pregnancies. The discourse is shaped by an array of personal, religious, cultural and other social beliefs that differ from community to community. Research shows that access to free post-abortion services is further complicated for women, especially young women, by privacy concerns, the negative attitudes of institutional service providers, and stigma. The constraints associated with access to termination of pregnancy services have forced some women to look for support at call centres. This mystery client study explored the language used to offer anonymity and to create a "safe space" for women experiencing abortion stigma at e-health call centres in the public health sector. The study was conducted using a qualitative feminist lens. Telephonic mystery client interviews were conducted at five identified call centres that offer post-abortion support in South Africa. The data were analysed through discourse analysis. Findings revealed the limited anonymity call centres can offer. Being non-political spaces, call centres become "breathing rooms" and "recuperative spaces" where women can unpack the discourses that influence body autonomy and drive self-imposed stigma.

Keywords

Abortion stigma, safe spaces, call centres, talk lines, body autonomy, social constructivism, feminist approach, post-termination counselling, abortion support, South Africa

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Acknowledgements

Academia is about the ego, Nonkosi…

To my supervisor, Prof. Sisa Ngabaza, I cannot begin to pen the appreciation I have for your unwavering support throughout this MA journey. From the first day I sat down with you, you prepared me for the corrections, critique and even the challenge of being a successful black woman in higher education.

To the Department of Women's and Gender Studies, thank you for the space to grow and experience as well as support while *becoming…*

To my Mother, we did it Sister X! We're one step closer to having a Dr X in the family. You have held this family together and have supported your little girls. I am so happy you are here to see us as successful young women.

To my sisters, I've done my bit and followed my path. I've left no breadcrumbs on this path because I want you to follow your own, it may look nothing like mine, and that's GOOD.

To my best friend, Bongiwe Mphuthi, thank you for everything.

To my Father, I know you're proud, because I am.

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Contents

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CHAPTER ONE

1. INTRODUCTION AND BACKGROUND

In recent years there has been a shift in the healthcare sector towards e-health and the use of information and communications technology (ICT) for healthcare advancement and greater accessibility. Call centres and toll free telephone help lines are currently one of the most efficient and accessible avenues to healthcare services in developing countries where there are barriers to healthcare with respect to socially sensitive health issues due to discrimination and stigma, specifically in the area of sexual reproductive health (SRH) (Ojo, 2018). A report compiled by the World Health Organization (WHO) in 2011 on components of e-health reveals that despite increased call centres and help lines around the world, Africa is still lagging in addressing stigma-sensitive issues such as SRH. This is mainly due to lack of infrastructure (Ojo, 2018).

1.1 Understanding e-health

eHealth is defined as 'the cost-effective and secure use of information and communication technologies in support of the health and health-related fields including healthcare, health surveillance and health education, knowledge and research' (WHO, 2005, p. 121). eHealth is increasingly bridging the gap between medical service providers and clients through categories such as for example mhealth, which refers to public health information dissemination supported by mobile devices such as mobile phones, tablets and the wireless infrastructure (Innovatemedtec, 2018). mHealth care call centres can service a large number of people while avoiding barriers to traditional face-to-face consultation in sensitive areas of SRH where privacy is valued (Yagnik et al., 2015). Marie Stopes International is an example of an

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organization that champions ehealth by means of call centres. The organization has branches globally and provides information on SRH, including abortion. However, its ability to enter a country is as political as it is health-related.

1.2 Abortion legislation: A global view

The global north spearheaded the legalization of abortions, with very few countries maintaining restrictive laws that run counter to the regional trend (Gynmed, 2017). These countries include North-Korea, Poland and Malta. In the first half of the 20th century, abortion was universally illegal, with liberal laws taking shape in the second half of the 20th century (Anon, 2013). In Ireland, Leo Varadkar, prime minster at the time, made headline news when he lifted the abortion ban in May 2018 and called this move the eradication of abortion stigma (Millard, 2018). Research shows that abortion stigma does not exist solely because of legal repercussions but is rooted in community morals, values, and religion. There are often few safe spaces available for women to openly speak about their experiences (Lithur, 2004; Marlow et al., 2014; Payne et al., 2013).

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In Africa, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is the most ratified treaty on the continent (Ngwena, 2013). The treaty includes the African Women's Protocol, which is the first document to explicitly refer to abortion as a human right. Although the treaty has been ratified by numerous countries, few have implemented the principles of the treaty. Most countries still have provisional conditions for the termination of pregnancy. The continued criminalization of a health service only women use, further reinforces the traditional idea of women as reproductive instruments. It also perpetuates the culture of illegal abortions coupled with abortion stigma (Ngwena, 2010).

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Abortion is illegal in all circumstances in 12 of the 54 countries on the African continent and permitted with no restrictions in only four (Remez, Mayall, & Singh, 2020). In Southern Africa – Angola, Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe – abortion laws range from abortion being illegal, to abortions being restricted by set conditions such as to save the life of the woman, and abortion being freely and legally accessible to women (Remez et al., 2020). Abortion is a socially embedded taboo in African countries and although there is a call for e-health call centre advancement in Africa, there are still gendered public health issues barring women from freely exercising their bodily autonomy by enforcing their sexual reproductive health rights.

1.3 Abortion in South Africa

In 1996, the South African government passed the Choice on Termination of Pregnancy Act, 92 of 1996 (CTOP), making abortion services legal and in theory available at approved state hospitals and clinics. Despite government efforts, a study by Malan (2017) reveals that only 40% of state clinics offer abortion services. At these clinics, the pre- and post-counselling is often withheld from the patients or callously administered by service providers (Harries, Gerdts, Momberg, & Greene Foster, 2015). While there is a large body of research on abortion stigma and its manifestation at state health facilities, there is a dearth of knowledge on alternative 'safe spaces' for abortion support, particularly in the form of call centres that offer post-abortion care in South Africa. However, what is known is that a lack of training for agents at call centres (Kimport, Foster, & Weitz, 2011; Kimport, Perrucci, & Weitz, 2012; Yagnik et al., 2015) and a lack of evaluation of call centre services (Upadhyay, Cockrill, & Freedman, 2010; Yagnik et al., 2015) threaten the provision of support spaces where it is safe for women to share their abortion experiences. There is a shortage of literature on post-abortion support

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call centre 'safeness' and on how call centre counsellors in South Africa make the call centre a safe space. This study seeks to investigate the creation of a safe space at call centres that offer abortion support by exploring how the call centres use language to make these spaces safe for women.

1.4 Rationale

In 2016, a friend terminated a pregnancy due to a new job prospect and a recent breakup. Following the termination, she experienced extreme guilt and regret and even though she had my support, she still felt isolated as I could not relate to her situation at the time. A few months later, her workplace gifted each employee with three telephonic counselling sessions for wellness day. She took advantage of these sessions and felt that they were in fact helpful to her. However, after the free consultations, she was still uneasy and fearful of face-to-face counselling. She had cancelled her face-to-face appointments numerous times and would often talk about needing more telephonic counselling.

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Our relationship deteriorated after this. I was the only friend who knew of her termination, and I felt that she could have possibly felt judged by me as well. The entire experience sparked my interest in abortion stigma and post-abortion support spaces for women with a need to share their experiences and to have their autonomy validated. Telephonic counselling appears to be the best anonymous alternative, also referred to as a 'safe space' for women seeking post-abortion support.

Abortion stigma is understood as a social phenomenon embedded in a particular society and shaped by the religious, cultural and personal morals and traditional values of that society (Lithur, 2004). It has become evident that abortion stigma exists regardless of whether a

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woman can access a termination as their legal right or with conditions for the procedure or not at all. Abortion stigma is not dependent on matters of legality but is linked to a perception of the act as a rejection of societal gender norms and ascribed values (Kumar, Hessini, & Mitchell, 2009a). For the purpose of this study, I use the term 'abortion' to speak about the societal stigma and not the procedure of termination of a pregnancy. The women for whom this study advocates do not struggle with the termination procedure itself or the processes thereafter, instead, they battle abortion stigma, a term loaded with societal norms and values. Although this study does not explore the legal framework, I am aware that issues of social justice and reproductive health justice make this study imperative for the continuous work on comprehensive abortion support post-termination.

Safe spaces as a means of post-abortion support are fast becoming a popular way of reducing continued stigmatization (Kimport, 2012). Notwithstanding this trend, there is a shortage of local research on the few call centres that actively offer post-abortion support (Cooper et al., 2005; Meehan & Broom, 2007). Studies confirm the lack of structured psychosocial support post-termination and the underwhelming experiences of women dismissed by healthcare professionals when seeking face-to-face support. Abortion stigma remains an issue for young women, regardless of the legality of the termination of pregnancy in South Africa.

The developments in e-health are necessitating interdisciplinary studies such as this one to better evaluate the experiences of people accessing healthcare. By offering ease of accessing healthcare, e-health protects the identity of the caller, allowing for more open conversation of socially stigmatized diseases and procedures such as a pregnancy termination. However, it is important to ensure that we do not build on flimsy structures – undefined counselling methods

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for post-abortion support or the same dismissive and judgmental tones as women experience during face-to-face consultations.

Call centres are yet to be looked at and understood as a safe space. In my communication with one of the call centre managers I was informed only on caller statistics. There is a need for input from the women with whom they interact. In South Africa, pregnancy crisis centres are not regulated or monitored and they therefore provide 'support' at the possible expense of women.

1.5 Aims and research questions

Research aim

The aim of the study is to investigate how call centres create and facilitate safe spaces for women who need support with their abortion experiences.

The main research question is:

How do call centres create safe spaces for women to discuss their abortion experiences?

Sub-questions

Sub-questions that emerge from the main question are: What is a safe space at an abortion support call centre? How is language used to create safeness in abortion support call centres?

1.6 Outline of thesis

Chapter 1 gave an overview of the current situation in the healthcare industry. ICTs have been introduced in the healthcare sector to offer greater accessibility for the public. Call centres and toll-free telephone lines have become one way of addressing sexual reproductive health

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services such as abortion due that are sensitive to discrimination and stigma. Although legally signed onto the law books as a human right in South Africa, abortion is still a social taboo. This influences public health service providers and affects the quality of the services provided to support seekers. The call centre is framed as a possible safe space. The creation of 'safeness' relies on conversations as hosted by call centre agents. The chapter subsequently states the research question, sub-questions, and the aim of the study.

Chapter 2 critically reviews the body of literature relevant to this study. This includes literature on abortion stigma. The study assumes a feminist lens to begin to understand what safeness means in these mainstream public health support call centres. The chapter also includes an exploration of the characteristics of the available and popular call centres in South Africa, as well as a definition of the 'safe' language women seek when they call.

Chapter 3 discusses qualitative feminist research methods as the methodological framework adopted for this study, as well as the popular public health "mystery client" method of data collection. Due to the transdisciplinary design of this study, ethical considerations and methodological processes and procedures of data collection and recording were thoroughly and duly noted.

Chapter 4 outlines safeness and unsafeness as these concepts relate to the technical call centre process before presenting the discourses that emerged from the mystery client conversations between callers and call centre agents. The theoretical framework for this study allowed me to unpack how certain discourses created unsafeness and safeness for the callers. The discourses are illustrated by means of conversation excerpts. Discourses included taking on motherhood,

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body autonomy, and self-imposed stigma, and the broader patriarchal society to which women who access the call centre are exposed daily.

Chapter 5, the closing chapter, summarizes the findings, the methodological contribution of the study, and the theoretical contribution of the study. The study concludes with recommendations for future studies and the introduction of feminist frameworks for public health SRH contact centres for comprehensive support of stigmatized women.

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CHAPTER TWO

2. LITERATURE REVIEW AND THEORETICAL FRAMEWORK

This chapter reviews the literature on the safe space landscape; the significance of e-health talk lines for the creation of these spaces; the potential shortcomings of voice-only counselling; and women seeking to 'safely' experience these call centres. In this context, it is also important to analyse the availability and quality of call centres at a global, regional, and national level and the experiences of women who access these services seeking the validation of their autonomy. The literature review includes literature from developed and developing countries, although there is a dearth of literature on ehealth and telephonic counselling in Southern Africa. The lack of literature from sub-Saharan Africa leaves gaps in our picture of the topic in the context of the study.

The study uses a multidisciplinary method and a feminist lens to fill some of these gaps in the available research. The conceptualization of abortion stigma as a socially defined taboo and the exploration of how the call centre can become a safe space tows a thin line when being met with service providers who may subscribe to social values that are conflicting with their work. The chapter visits the feminist understanding of ontological 'safeness' at support call centres and how this is constructed through language, granting anonymity (if possible) and confidentiality to callers.

2.1 Conceptualizing abortion stigma

Goffman (1963) conceptualizes stigma as an attribute that is 'deeply discrediting' and changes the identity of an individual. 'Stigma' is not a new phenomenon nor is it a 'natural' one, it

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does, in fact, manifest from the power disparities and inequality that exist in the local society (Kumar et al., 2009). Abortion stigma, as defined by Kumar et al. (2009, p. 628), is 'a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood'. Abortion stigma is both a social and political process that perpetuates and normalizes the patriarchal 'essential nature' of women (Kumar, Hessini, & Mitchell, 2009). Scholars on abortion stigma across disciplines have gravitated to this definition of abortion stigma. It has fed into the conceptualization of abortion stigma as not only country law specific, but located in the societal moral grounding that cuts across the individual, community, institutional structures and society as a whole (Hoggart, 2017; Marecek, Macleod, & Hoggart, 2017).

In an attempt to identify the effects of abortion stigma on women, Vincent Rue in 1981 coined the term post-abortion syndrome (PAS) (Siegel, 2008). PAS was conceptualized as a form of PTSD and although the 'condition' itself is not recognized by any professional psychology/psychiatry group (Rowlands, 2011), anti-abortion lobbyists have since based numerous studies (Boulind & Edwards, 2014; Frelich Appleton et al., 2011; Wasielewski, 1992) on Rue's work. However, in his systematic literature review article, Rowlands (2011) illustrates how secondary analysis of study surveys claiming PAS in fact lack vital information such as information on prior mental health issues, the woman's life circumstances and prior exposure to violence. This makes the studies particularly suspect when other scholars fail to replicate them even when making use of the same data. Siegel (2008) notes that Rue not only pathologizes abortion regret, but furthermore describes it as inevitable and part of 'women's nature' because of their attachment to pregnancy. Rue's claims have since been challenged by

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scholars who call for a broader analysis of women's individual experiences of 'abortion regret' and the claim of PAS (Kimport, 2012).

Abortion stigma and its weight on women is now understood as multi-layered. It is with this in mind that this study seeks to broadly think about women's individual experiences of abortion stigma, but more so to look at spaces offering support or counselling. The study is interested in the way in which women's experiences and feelings are handled at these safe space call centres.

2.2 Safe spaces

Safe spaces are commonly characterized by 'physical safety', authors (Brady, 2005; Press & York, 2018) use the example of sports as a mechanism for social network building and introducing adolescent girls into the public space which they are often excluded from as adolescent girls, and later women, in developing countries. Brady (2005, p. 5) compares the public space and the safe space; calling the public space 'a space where citizens can go for recreation, education, entertainment and participation in political life …'. Brady (2005) speaks about safe spaces, but these safe spaces are also redefined public spaces held by NGOs who act as gatekeepers for the girls. The call centre as an abortion-support safe space is held and redefined in the same way by the agents.

Unlike in Brady's (2005) article, abortion-support call centres are hidden safe spaces removed from the public's consciousness. This can also be seen as a measure of 'safety' for women accessing these services. However, this can further stigmatize or isolate women because although they are getting the counselling they seek, it is still in a hidden space where they leave to return to a society that still harbours the problematic abortion views. In their article, Bullock,

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Truong, & Chhun (2017, p. 3) grapple with the meanings and functions of a safe space for currently and formerly homeless women and men at a farming training site. In the study, special attention is given to 'the dynamics of social exclusion and inclusion'. Bullock et al. (2017) describe safe spaces as 'breathing rooms' and 'recuperative spaces' for marginalized groups and further explain that rather than a solution for the social inequality, safe spaces in fact offer temporary 'respite' in the bigger scheme of things (p. 2). Although Bullock et al.'s (2017) description of safe spaces may be true to a certain extent, in advocating for safe spaces I am more interested in ensuring that women's voices are not silenced while we wait (and work) towards eradicating arbitrary social exclusion in the name of justice and subjective moral society cleansing.

Tapping into Opotow's (2012) conceptualization of justice and moral community provides insight into the social psychological dynamics of exclusion. He notes that "those seen outside the scope of justice are vulnerable to harm because the norms, values, rules, and laws that ordinarily govern social relations among those within our scope of justice do not apply to them" (Opotow, 2012, p. 74). Cultural and religious stereotypes of people who have terminated a pregnancy hold that these women are unnatural. This view is based on the idealization of motherhood (Sibley, Huang, Davies, Sibley, & Osborne, 2016) and becomes a pivotal facet of "othering" and exclusion (Bullock et al., 2017; Truong & Museus, 2012). Ultimately, the "us" versus "them" distinctions contribute to social distancing, dehumanization, and violent silencing of women. Moral exclusion positions women as "ready" targets of "various forms of defamation and harassment by those who see them as objects of fear and loathing" (Wachholz, 2005, p. 1).

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In her work with young women, Harris (2005) stresses the necessity of spaces "where 'subjugated knowledges'… can be voiced [and] where surveillance and appropriation are minimized" (p. 41). "Safe spaces" are socially constructed and dynamic (Bullock et al., 2017). When callers call into the call centre, call centre processes, agents, language, and the callers begin to construct safeness together to openly discuss their experience.

Tucker (2010) discusses safe spaces for mental health service users. In his article, he aims to analyse how mental health service users create safe spaces for themselves in facilities, paying attention to the repeated activities in a given space. Tucker (2010) draws on the theorists Deleuze and Guattari (1987), who unpack 'spaces' as not just physical environment, but as territories that are transformed by audio and visual markers. Deleuze and Guattari (1987) refer to the everyday activities in a space as milieu; coding the safeness using audio and visual markers. Termination centres are constantly coding their 'safeness' with the public through social media advertisements and posts or with particular signage or posters. The call centres, which are branches of the termination clinics, become the testing ground for the 'safeness' of the organization because language (audio markers) is the single milieu when the agent and client communicate. The call centre agent's language use is thus vital in creating a safe space as it is the only instrument used in maintaining the space. Coding or 'language use' for the sake of the study is not static, instead it is in a constant state of recoding to maintain safeness, create safeness or guard safeness for the women entering these spaces.

Safe spaces as 'breathing rooms' and 'recuperative spaces' allow marginalized groups an environment to counter dominant stereotypes. However, these spaces are not a solution to social exclusion issues but are spaces of 'temporary respite' (Bullock et al., p. 2). In their 2017 article Bullock et al. discuss discrimination and anti-homelessness ordinances that contribute

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to exclusion and the meaning and function of safe spaces in such circumstances. It is only in recent literature, which is limited, that call centres are being seen as safe spaces, particularly in the digital age where access to support is being made easier and more convenient for the user.

The notion of safe spaces has for a long time been an accompaniment for social movements during civil rights protests (Ali, 2017). At the time, safe spaces were real spaces but also valuable tools in the advocacy for social justice. The term safe spaces as defined by Adams (2018) is embodied by comfort and fear; '[safe spaces] can offer persons with marginal and stigmatized identities a sense of security'. Lewis, Sharp, Remnant, and Redpath (2015) also explore the idea of safe spaces for women's experiences. In their expansion of the term, they refer to 'ontological safety' where being misrecognized, or having one's views devalued or made to seem 'irrelevant', is 'unsafeness'. In looking at safe spaces, one should also recognize 'unsafe spaces' as environments where women may be exposed to 'triggers' of reinforced stigmatization as relevant in post-abortion support (Lewis et al., 2015).

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'Safe spaces' as adopted by this study are spaces free of triggers. Triggers are things that cause a negative emotional response (Dearing et al., 2014). A call centre embodying 'safe spaceness' has agents or counsellors who are trained to make use of relevant language free of unsolicited or invasive questions and supportive utterances with open-ended questions. A safe space further makes use of counselling techniques such as active listening, validating language, attentive silences and it is non-directive (LaRoche & Foster, 2015). Safe spaces in this study are understood as spaces where women can freely discuss their experiences, exercise their body autonomy and be made to feel secure in their choice.

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2.3 Termination stigma and support

A study by Ludwikowski, Vogel, and Armstrong (2009) examined stigma, particularly societal (public) stigma, personal stigma and self-imposed stigma. Stigma at the societal level has received the most attention in the literature (Harries, Stinson, & Orner, 2009; Holcombe, Berhe, & Cherie, 2015; LaRoche & Foster, 2015; Ngwena, 2004). Societal stigma refers to the societal views that tend to have negative attitudes towards those who have had a pregnancy termination and those who provide abortion services. Both clients and service providers may therefore avoid counselling to avoid this negative societal label. It is important to know that counsellors themselves in the eyes of women seeking help are everyday people of the public.

A study by Martin, Debbink, Hassinger, Youatt, Eagen-Torkko and Harris (2014) takes a look at stigma as experienced by medical professionals in pregnancy termination care and the effects of this stigma on their personal lives and perceptions of the work they do. Sociology scholars bemoan that this kind of work is considered 'dirty work' – referring to occupations that are socially necessary, but viewed as 'physically disgusting, socially degrading or morally dubious' (Kimport et al., 2011; Payne et al., 2013). It is important to note that women increasingly depend on an admittedly small number of abortion providers for this common procedure (Martin et al., 2014). The study goes further to explain how approximately 50% of medical professionals trained to provide abortion ultimately do not do so (see also, Dehlendorf, Diedrich, Drey, Postone, & Steinauer, 2010; Upadhyay, Cockrill, & Freedman, 2010).

Abortion counselling research primarily focuses on pre-abortion counselling and not post-abortion counselling. The studies on post-abortion counselling or care instead unpack the contraception uptake or the provision of medical treatment as a result of unsafe abortions

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(Adinma, Ikeako, Adinma, Ezeama, & Ugboaja, 2010; Kumbi, Solomon, 2008; Tesfaye & Oljira, 2013). This study explores the one-on-one non-contraceptive focused post-termination counselling interaction between counsellor and client. The study stresses the conversation in the post-termination counselling session as important beyond contraceptive uptake and medical procedures.

In line with the focus of this study, Mavuso, Du Toit and Macleod (2017) explored the pre-abortion counselling in the public health sector of Eastern Cape, South Africa. Their study used a combination of discursive psychology and conversation analysis to analyze the data, focusing on service providers and their at times problematic views on abortion procedures (Chiweshe, Mavuso, & Macleod, 2017). According to the CTOP act, pre- and post-abortion counselling should be made available to women. However, it is not mandatory for women to undergo counselling if they do not want to (Chiweshe, Mavuso, & Macleod, 2017). Telephonic counselling, the focus of this study, provides safeness in that women can call into call centres as they feel it necessary and can 'leave'/ hang up whenever they feel unsafe in the space with the call centre agent. Chiweshe et al. (2017) describe the Western Cape Department of Health's (2000, p. 2) 'Termination of Pregnancy: Policy, Guidelines and Protocols' as 'basic' and 'under-described'. The study findings reveal how 'counselling was directive, with a clear anti-abortion position emerging in many sessions, particularly those conducted by the independent counsellors'. In this study, the selected call centres were liberal in their abortion stance, leaving room for women to discuss it openly.

In an explorative study, Ely (2007) focused on pre-abortion counselling in the context of a feminist counselling framework and the patient's reports on their experience. It is important to note that at the time of publishing, the authors stressed the dearth of knowledge on client

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satisfaction of abortion counselling. Ely (2007) was the only published author working on client's experiences of abortion counselling processes at the time. A decade later, studies researching post-abortion counselling primarily focus on contraceptive education uptake, post-abortion (Boulind & Edwards, 2014; Frelich Appleton et al., 2011; Loeber & Muntinga, 2017). In the United States, many outpatient reproductive health clinics operate based on feminist perspectives, so their counselling services are often formally or informally based on a feminist counselling framework. However, no research has been conducted to examine client perceptions of a feminist post-abortion counselling.

2.4 Feminist abortion counselling

In the United States, the feminist counselling approach naturally compliments the social work profession by emphasizing the self-determination of the client, a concept that is also emphasized in the National Association of Social Workers Code of Ethics (Hebenstreit, 2017). Social work practice with a feminist inclination is described as a 'philosophy of therapeutic intervention as opposed to 'techniques' (Ely, 2007). Feminist clinical social work focuses on the social context of the client's difficulties as jointly determined by clients and the practitioner (Land, 1995; Ely, 2007). Ely (2007) further describes the feminist approach as allowing 'the practitioner to focus on the normality of the client's experience, rather than framing the experience in the context of deviance; it allows the practitioner to value the position of the client; it allows the practitioner to validate the social context in which problems occur; it allows for greater client empowerment; and, it allows the practitioner to recognize how the personal is political' (p. 71).

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Feminist abortion counselling as described in Alzate (2009) seeks to normalize an experience that is commonly framed as deviant by mainstream society. The client guides the counselling process based on their individual needs while acknowledging the political climate, which is difficult to remove from the personal experience of reproductive healthcare. This allows for an emphasis on self-determination (Ely, 2007).

Mavuso et al. (2017) documented the common conversation format in South Africa's public hospitals where counselling sessions lack a feminist characteristic. The counselling sessions were typically less than 20 minutes in duration, with the aim being to establish the reason for 'failure' (p. 3) on the women's part to prevent a pregnancy. Women in these counselling sessions are subliminally required to provide reasons for wanting an abortion, yet they are provided with basic procedural information on abortion. In the pre-counselling sessions, abortion was undermined as a choice over adoption and continued pregnancy. In closing off the sessions, service providers stressed choosing contraceptives that would prevent falling pregnant again. Mavuso et al. (2017) frames this as problematic even in feminist discourses as abortion is seen as something that should be kept at a minimum and not recognized as a valid contraceptive method.

The feminist counselling framework addresses stigma through conversations that emphasize the validation of autonomy and personal circumstances are understood. This benefits both service providers and counselling clients. In addition to societal effects, stigma can influence a person through the direct personal reactions of those with whom we interact, and this is termed personal stigma (Lannin, Vogel, Brenner, & Tucker, 2015; Vogel, Wade, & Hackler, 2007). Personal stigma is stigma we perceive from those closest to us. It is common for people to be less open to making use of services if they receive negative reactions from their families

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(Ludwikowski et al., 2009). Personal stigma to post-abortion support can be separated from the effects of public stigma and has been found to act separately from public stigma on individuals' willingness to pursue counselling.

Wyndolyn et al. (2009) looked at career guidance help-seeking (counselling), and indicated that public and personal stigmas were linked to self-stigma (Goetsch et al., 2010). Self-stigma is the perception held by the individual that it is personally unacceptable to seek counselling. Stigma can therefore play a role in counsel-seeking decisions when it is internalized (Vogel et al., 2006).

There are numerous things that prevent people from seeking professional help even from medical practitioners. The perception of stigma has been recognized as an important barrier to seeking personal counselling (Vogel et al., 2007). Although numerous factors influence whether or not people seek support, it is important to explore unique interventions that allow individuals to confidently seek help. Societal beliefs are difficult and slow to change. However, factors closer to the individual, such as personal stigmatization by close others and the potential mediator of self-stigma, may improve the effectiveness of direct interventions. Therefore, instead of solely focusing on perceptions of post-abortion support, it would be more beneficial to reframe how we talk about post-abortion support away from damned and shamed women counselling to self-empowerment support for women and their decision. Public stigma is more strongly associated with self-stigma than personal stigma. This could be because individuals may be more likely to experience both positive and negative messages from those close to them, while public stigma may be more pervasive and represent clearer negative/non-supportive messages about women seeking help post-termination (Wyndolyn, Ludwikowski,

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Vogel, and Armstrong, 2009, p. 7). Therefore, changing the personal and self-stigma of post-termination counselling may be more direct routes to increasing service confidence and use.

eHealth is largely driven by the need to be hidden, to lessen the self-imposed stigma and to substitute possible stigmatizing personal circles. However, e-health has its own shortfalls in completely granting a safe space, especially in the context of South Africa where support centres are few and not necessarily tailored specifically to post-abortion support seekers.

2.5 Autonomy and women's body autonomy

When clients' personal circles, the public at large and service providers deny them validation and acceptance of the choice to have an abortion, it is important for women to learn to grant that to themselves. DeRobertis and Bland (2018) reviewed numerous quantitative articles, including the work of Wichmann (2011), revealing a correlation between autonomy (self-determination) and wellness/ well-being. Similarly, Sheldon and Bettencourt (2002, p. 34) noted that , "people may have a stronger need for a sense of choice and self-ownership than for a sense of distinctiveness or uniqueness". These findings support the hypothesis that there is a relationship between autonomy and well-being. The United Nations Human Rights Declaration as published in 2015 named personal autonomy as a human right. Autonomy is not just freedom to choose, but for those choices to be validated as true to yourself. If the choices are the best in the individual's circumstances, they are more likely to experience a greater sense of well-being (DeRobertis & Bland, 2018). Nienaber and Bailey (2016) in their legal study of patients' body autonomy site the South African Constitution section 12(2)(b) and the Health Professions Council of South Africa (HPCSA), which gave expression to the aforementioned law. In these two statutes, bodily autonomy is stressed as a human right to

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practice self-determination and health professionals, family members, societal leaders etc. cannot unduly interfere with this decision. The women entering the call centre and the way in which we characterize a safe space is primarily linked to this thought, the validation of women's bodily autonomy and choice for their wellness and wellbeing.

Whichmann (2018) explores the current literature on the relationship between autonomy and well-being across diverse cultures, drawing on self-determination theory (SDT). SDT researchers have found a relationship between autonomy and well-being in both western and non-western societies. Encouraging client autonomy is therefore fundamental to the practice of humanistic counselling, a practice which according to their web page, acknowledges "the responsibility of human beings for their own destiny, having within themselves the answers to improving their own lives" (Organisation for Humanistic and Development, n.d.).

2.6 Counselling and validated autonomy

Acting autonomously is not always easy or obvious. Individuals may be so driven by extrinsic rewards or by relief from external pressures that they make decisions that do not reflect their true values, thus diminishing their overall sense of happiness (Ryan & Deci, 2008). Counsellors may be able to help clients improve their sense of well-being by encouraging them to identify and explore their values. Recognizing a discord between their values and behaviours may be enough to prompt client change, either in attitude or behaviour, thus reducing their distress and improving their sense of well-being.

Although counsellors are ethically obligated to provide services that help clients make culturally appropriate decisions (Strang & Ager, 2003), this in no way diminishes the importance of individual differences or of universal psychological needs. Women who call in

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to the call centres are guided through the process of understanding how their decision to terminate a pregnancy, although 'against their cultural norms', was necessary to remain true to their needs at the time and therefore should be validated for the choice regardless of the views of their social circle.

Myers and Sweeney (2008) note how counsellors use wellness-enhancing interventions to encourage wellness and an overall positive state of well-being. This study focuses on how language use creates safeness, wellness, or well-being. Well-being is defined simply as a person's level of happiness as the person perceives it.

In the book, '*Good Practice in Promoting Recovery and Healing for Abused Adults*' Hoffman (2013) discusses body autonomy in the case of recovering and healing of sex-trafficked women. Hoffman reiterates body autonomy as a 'fundamental right for all' (p. 112) and points out that it is diminished through restricted self-determination. Women making use of the call centre 'safe space' most likely experience body autonomy restriction through condemnation of their pregnancy termination by people in their social circles. Hoffman (2013) details the role of allies in providing support through counselling. In this instance, the call centre agents are more than counsellors, they can be understood as allies helping women understand the body autonomy, they fundamentally have the right to exercise.

In her 2017 study, Holtzman revisits the 2015 Reproductive Freedom Accountability, Comprehensive Care and Transparency (FACT) Act bill signed in California, United States, to protect women's bodily autonomy when seeking counselling at crisis pregnancy centres (CPCs) (Holtzman, 2017). In the article, she traces CPCs' memorandum of Incorporation and its infringement on bodily autonomy. Mandatory disclosure requirements are crucial because

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the conduct and practices of CPCs reveal public health concerns, infringe upon women's reproductive rights and bodily autonomy, and contribute to inequality with regard to healthcare access. The bill, in line with body autonomy, states "[a]ll women deserve medically accurate and unbiased information when facing an unintended pregnancy, in order to ensure autonomy in decision-making and personal integrity," because "[w]hen a woman is coerced to continue an unwanted pregnancy through misinformation or lack of access, she loses control of her body, education, finances—her future" (Holtzman, 2017, p. 343).

Undoubtedly, autonomy, particularly body autonomy, is a core value of feminism framed by gendered self-determination and the individualist arguments (Ferree, 2003). Autonomy can be viewed as what an individual can choose to do or refrain from doing. Cooper (2018), however, argues that autonomy is not simply making a choice but adds that 'autonomy and rights arguments... do not appeal to many women who have had abortions because...women are not choosing at that moment to "exercise their rights", but are doing the best they can at the time and given their circumstances' (p. 21) and this is what makes a simple termination taxing for women; the social need for justification of women's body autonomy. Downie and Telfer (1971) grapple with the term autonomy, arguing that it is not just about being individualist, it is also framed by external influences as abortion is framed by stigma. In this outdated but very relevant article, Downie and Telfer outline two kinds of autonomy; freedom of choice and autonomy of action. Downie and Telfer (1971) early ideas on 'thinking' autonomously highlight the difficulty individuals have managing social norms and embodying autonomy. For example, an individual can be influenced by another person to put the social norms above autonomous decision making. This study understands self-imposed stigma from this social constructionist view. It is linked with social environments and the beliefs we hold as learnt

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through our socialization. When women enter the call-centre hoping to discuss their experience, they are quite possibly judging and talking about themselves from a particular moral point of view they hold or have been held to by family, friends, or a partner. It is therefore important to pay attention to the agents' response to the moral position a client holds themselves to and to analyze the possible moral judgement shift that the agent might introduce to the client.

When the state denies or grants the right to body autonomy, it dismisses or acknowledges women's moral competency to make abortion decisions and therefore denies or recognizes women's full personhood (Ferree, 2003; Vincent, 2012). South Africa's Constitution avows women the right to body autonomy and self-determination. Yet the South African legal framework has not addressed the need for post-abortion support or delineated how it should be framed in ways that would respect personal autonomy of women and the decision they make around abortion, as per the secular constitution (Katz, 2017; Vincent, 2012). Currently, post-abortion support can serve as continued surveillance and colonization of women's bodies by patriarchal norms and societal expectations (Vincent, 2012).

Research (Ells, Hunt, & Chambers-Evans, 2019) in healthcare has begun focusing on relational autonomy in the era of patient-centred care. Earlier, Elles, Hunt, and Chamber-Evans (2011) discuss the feminist formulation of (relational) autonomy, emphasizing how, in addition to respecting a patient's capacity/right to make informed choices, health professionals must attend to the patients' sense of identity (that is, the self that is self-governing). Women entering the call centre have already made the choice to have an abortion. It is the role of the agent to help the client reconcile her choice with her moral judgement of herself. It is in this space that women's process claiming of autonomy is strengthened, exercised, and realized in a

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[conducive] social context like a call centre. It is therefore important to create spaces that can provide this, making them 'safe'. A call centre offering a fair and supportive social context (safe space) will ensure that service providers build relationships that allow individual clients to ask questions and voice their feelings and concerns (Dodds, 2016). Conversely, when social contexts prevent individuals from making decisions, refuse to allow people to voice their feelings or concerns, or regard people as unable to make decisions, people are denied opportunities to develop and exercise their autonomy, making this space unsafe (Dick & Arnold, 2018; Dodds, 2016; Zontangos & Anderson, 2004).

Denying women opportunities to act autonomously not only reinforces the stereotype that they are incapable of being autonomous, but also inhibits their autonomy by not allowing them to develop autonomy skills. Safe spaces in post-abortion support call centres should, therefore, be created to celebrate body autonomy and validate women's choices (Collective, 2014).

Post-abortion support

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2.7 A global overview

'When society shames us for our abortions, it affects how we mourn, discuss, and accept them.' – Eve Kushner (1997, p. 9). Anti-abortion activists use numerous strategies to ensure that the termination process is stressful and stigmatized for women. Patients are badgered with comments of how they are 'baby-killers' and how the foetus experienced pain (Rubin, Russo, & Russo, 2008). Over and above stigmatizing and threatening women, these activities undermine feelings of adequacy for coping with a pregnancy termination, deter social support, foster shame and guilt and create barriers that inhibit access to important means for coping with the stress of an unwanted pregnancy (Rubin et al., 2008).

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Understanding unwanted pregnancy and abortion from a stress and coping perspective, Rubin et al. (2008) conceptualize post-abortion support as working through "situational (social, economic and cultural considerations) and intrapsychic (personal traits and resilience and coping strategies)" factors as a way to determine mental health outcomes (p. 71). Tabbutt-Henry and Graff (2019) further define post-abortion support in the medical space as 'two-way communication conducted to help clients make decisions and to deal with their feelings about their circumstances' (p. 2). In their study Major, Appelbaum, Beckman, Dutton, Russo and West (2009) echo the sentiments of Rubin et al. (2008) that if women do not receive emotional support with a change in the emotional script post-abortion, they will be vulnerable to manipulation by anti-abortion organizations seeking to advance an anti-abortion political agenda (Major et al., 2009; McBride & Keys, 2018). Rubin and Russo (2014) emphasize the importance of abortion support providers being aware of their own viewpoints and values before engaging with clients. Therefore, effective post-abortion support provides clients with skills and knowledge to make their own personal decisions free from manipulation and coercion (Rubin, Russo, & Russo, 2008; Tabbutt-Henry & Graff, 2019).

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Post-abortion support need not be mandatory counselling, but it should be available when needed. The limited accessibility of abortion support safe spaces makes for substandard counselling, with few women willing to face secondary trauma and stigmatization by biased counsellors. Post-abortion support spaces in South Africa are scarce or exist as subcategories of other support spaces such as the South African depression and anxiety group (SADAG), which works closely with The Connect Network, a Christian organization (Meehan & Broom, 2007).

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2.8 Crisis pregnancy centres as abortion support centres in South Africa

Crisis pregnancy centres are organizations whose main objective is to support women with unintended pregnancy. In most cases these centres are non-profit organizations that offer free services such as free pregnancy tests, ultrasounds, testing for sexually transmitted infections, providing maternity or baby items, and telephonic counselling on "post-abortion stress". These centres have also been described as anti-abortionist with the intention of persuading women to consider adoption or parenting as options above abortion (Rosen, 2012; Bryant & Swartz, 2018).

CPCs in South Africa have been around from the late 1990s. They are more often than not affiliated with Christian networks and national anti-abortionist organizations. CPCs are usually NPOs and are typically staffed by volunteers and employees who lack medical and counselling training or are not licensed professionals in the area of work. Although pro-choice lobby groups have raised awareness of the misinformation provided by these organizations and their anti-abortion agenda, literature on CPCs in the field of public health and gender studies is limited.

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It is through websites, telephone counselling, in-person visits and advertisements in women's toilets all over the country that crisis pregnancy centres disseminate medical information on the risk of abortion. These often lack any scientific validity (Rosen, 2012). CPCs are known to inform women of the adverse effects of abortion on long-term mental health, making reference to 'post-abortion syndrome', which numerous studies have disproved as a trauma (Rowlands, 2011; Siegel, 2008; Stotland, 2011).

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The abortion support spaces in South Africa created by the CTOP act have been described as 'problematic' because they leave room for inefficient normative counselling to lead in the public health. There is no counselling content framework and no obligation, by law, for service providers to give counselling pre/post-abortion (Vincent, 2012). A lack of regulation or clear policy in relation to abortion support in South Africa has denied women a holistic pregnancy termination process and aftercare.

Scholars (Kimport, Foster, & Weitz, 2011; LaRoche & Foster, 2015b) emphasize the importance of the client–service provider relationship when providing abortion support. They outline how post-abortion support should foundationally be non-judgemental, nondirective, non-politicized and confidential. Although there is a dearth of research on the call centre space for post-abortion support, several scholars have brought to light the need for investigating the training or credentials necessary for counselling in an environment highly stigmatized, with few support alternatives for women (Kimport, 2012; LaRoche & Foster, 2015a; Vincent, 2012).

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It is undeniable that post-abortion support is an unmet need. Not only has the need for support been pathologized by Rue (1981) as a mental illness, but there is no opportunity for women to holistically work through societal, institutional and self-imposed abortion stigma (Esia-Donkoh, Darteh, Asare, & Blemano, 2015). Post-abortion support has been recognized to help women to come to terms with lost relationships, cope with stress and reconcile the decision to have an abortion. This support also helps in instances where a lack of any other form of social support further compounds an already strenuous abortion experience for women (Kimport et al., 2011; Upadhyay et al., 2010).

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2.9 Digitalizing support: Call centres and talk lines

Telephone interventions in the health sector have been praised for their effectiveness in bridging consultation between service providers and patients. Clear successes in reducing mortality, hospitalization and office visits in primary healthcare (Wasson et al., 1992), increasing knowledge dissemination on medical conditions (Rondinelli, McCullough, & Johnson, 1989) and minimizing stress, anxiety and depressive symptoms in medical patients (ACSW & MSW, 1982) have further boosted the rapport of telephonic social support from way back.

The late 1990s brought a turn in traditional views on counselling. Courtland Lee, the president of the American Counselling Association in 1998 noted 'to think clients in the new century would not expect to access [web] counselling services is probably foolish and short-sighted' (Beattie, Cunningham, Jones, & Zelenko, 2006, p. 2). Australia's Kids Helpline (KHL) opened its lines in 2000, where individual counsellors and clients interact online and using other forms of digital media (Beattie, et al. 2006). KHL in 2000 was the only free, anonymous, 24-hour phone counselling service available to the youth in Australia. They recorded over one million calls annually and over 10 000 online counselling sessions (Beattie, et al., 2006). In 2009, KHL recorded over 14 000 online counselling requests (Rawson & Maidment, 2011) and although this is a growth from the 10 000 in 2006 (Beattie, et al. 2006), online counselling has undeniable limitations for the counsellor and client because voice pitch, pace of speech and tone is absent, making it difficult to assess and express emotions. This creates a loss of discursive cues.

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In the early 1990s, help lines became popular in public healthcare because of the recognized anonymity, the non-threatening setting and telephone conversations that further allow the client to maintain some control in an unfamiliar area of knowledge. Beattie, Cunningham, Jones, and Zelenko (2018) acknowledge how interactive help lines are better suited in healthcare and education because counsellors are able to facilitate a client's planning of their course of healing and how they want to move forward (Manhal-Baugus, Ed, & Way, 2001).

It is important to acknowledge that telephonic sessions are found to be shorter than face-to-face counselling sessions – 30 minutes or less (Salfi, Ploeg, & Black, 2005; Tremont, Duncan Davis, Bishop, & Fortinsky, 2008). This can raise doubt about the quality of support. However, because these sessions are cost-effective, women can continuously make use of these spaces as opposed to repeated psychology treatments, which are costly as they typically need multiple sessions. They also must find a means to get to and from the centre, and there is the psychological and emotional tax of being seen going into these centres.

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Bullock, Browning and Geden's (2002) study revealed that telephonic psychosocial support on its own reduced the perceived burdens of the callers as this method eliminates 'non-supportive non-verbal cues that may be given even by well-meaning individuals' (p. 7). Kimport et al. (2012) emphasize talk lines as alternative, non-political spaces for women to discuss their abortion experiences. The concept of call centre agents as faceless voices, establishes a space outside of politics, allowing callers to openly share. It is clear from Kimport 's (2012) study that call centres are pertinent alternative spaces for voluntary post-abortion support and that they are by nature fit to facilitate an ongoing process of thinking through the stigmatized abortion experience and counselling abortion regret (Kimport et al., 2012).

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Although developed countries such as Canada and the United Kingdom have highly functional call centres, also referred to as talk lines, there has been a need to look at the evaluation of the services provided. Yagnik et al. (2015) note that there is very little published literature on the evaluation of call centres in both developed and developing countries.

Research on both secular and religiously affiliated support call centres reiterates that call centres linked to clinics are by and large guided by the clinic's philosophy about abortion care (Upadhyay et al., 2010; Kimport et al., 2012). The manner, therefore, of the call centre agents and the language used in the call centre space could be influenced by the training values of the organization, which may alter and taint the interpretation of 'safeness' in the call centre. This is further explored in this study.

The topic of investigation into the training of call centre agents who offer telephonic counselling has also been brought to the forefront. WHO e-health has reported on medical staff being the main providers of talk line services. In cases of abortion support, volunteers and retired social workers are commonly recruited as call centre agents (Hanna, 2010). Various studies (Alarcón & Heyman, 2013; Forey & Lockwood, 2010; Friginal, 2008; 2009; 2013) have looked into language use at call centres, focusing primarily on the English proficiency of agents in mainstream call centres. This is not the focus of this study. There is an overall gap in literature on the agents ability to provide non-judgmental abortion support (Bobevski, Holgate, & Mclennan, 1997), but more importantly for this study, is the language (whichever language) and meaning attached to the words in the dialogue between call centre agent and women seeking support in this space.

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2.10 Digitized support: Privacy concerns in sexual reproductive health support

Call centres at face value are safe and anonymous. However, when calling into call centres, we often ignore the first recorded voice we hear: 'Please note that all calls are recorded for quality assurance purposes'. This pre-recorded message is fairly harmless at any other call centre, except sexual reproductive health support centres and clinics. When entering the SRH support centre, this pre-recorded message immediately makes the caller aware that the conversation may be shared, played back or open to third party listeners. Privacy is an important issue for many users calling into call centres. For clarity, a broad definition of privacy is "the state of being apart from observation [or] freedom from unauthorized intrusion" (Shaffer et al., 2013, p. 4). At support centres and/or crisis centres, the issue of privacy becomes difficult to work around in instances where there is a need for a follow-up. Support centres that work with suicide prevention or SRH often ask for follow-up details (Bambling, King, Reid, & Wegner, 2008) and studies also report patients doubting the safe-guarding of their privacy (Barsom et al., 2020).

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Like e-health, m-health (mobile health) uses mobile devices such as a mobile phone or tablet to support the practice of healthcare. mHealth makes use of wireless communication devices to support public health and clinical practice (Khan Yang Khan, 2010 cited in Mduma & Kalegele, 2015) and improve the delivery of healthcare information to researchers, practitioners and patients (Talking Medicines, 2017). A study in Bangladesh focused on SMS text-based interventions for contraception uptake post-termination. The intervention's mandate was to provide text message reminders based on the contraceptive method the woman selected on the day of her termination procedure (Uddin et al., 2017). The Ministry of Health

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and Family Welfare of Bangladesh recognized the potential of m-health and has used mobile technology to broadcast health messages to all cell phone users (Kay, 2011).

The study yielded varying results. However, privacy concerns were prominent with more than half of the women who participated in the study, responding affirmatively to the statement "someone I did not want to know about the text reminders found out". When participants were asked for suggestions for more effective ways of communication with better privacy, women suggested 'automated voice messages or phone call reminders would be better for privacy' (p. 2). In addition, participants suggested having a number to call to get information. The overall majority of women indicated interest in using a hotline as being able to talk to a counsellor was important to some of the women (Uddin et al., 2017).

2. 11 Digitized support: Anonymous calling and women's privacy

Help lines provide support to individuals in the community who are experiencing a personal crisis. Numerous scholars (Ratele, Shefer, & Clowes, 2012; Vattø, Lien, DeMarinis, Kjørven Haug, & Danbolt, 2019) have revealed the common characteristics of anonymous callers; they are often alone and feel prompted to call in to the support centres because of their loneliness. A sense of loneliness is very common in the instance of women who have pregnancy terminations without telling anyone; the abortion stigma and social and political climate often silence the voices of women seeking an outlet to discuss their experiences (LaRoche & Foster, 2017).

Vatto et al. (2019) in their study '*Caught Between Expectations and the Practice Field*' focused on the experiences of call centre agents who reported that the crisis line primarily served as a broad ongoing support function for loneliness (p.1) as opposed to suicide

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prevention. Dadfar, Lester, Turan, Beshai, and Unterrainer (2019) warn that because the telephone is generally used for conversation, agents must actively ensure they do not fall into conversational mode instead of focusing on crisis intervention. It is very common for clients to become too dependent on the service becoming what Dadfar and Lester (2019, p. 2) term 'chronic callers'. In studying anonymous groups, Dadfar and Lester (2019) further found that anonymous callers were more likely to withhold information when calling in, making it difficult for the agent to connect with them or do a follow-up.

Call centres in South Africa are a mix of crisis centres and support centres where callers have the privilege of remaining anonymous or provide a pseudonym. Due to the nature of the call centres included in the study, namely post-termination support call centres, there is an expectation that the callers would be allowed the space to have a conversation with call centre agents and feelings of 'taking up space' could be managed by the agents.

Feminist scholarship (Allen, 1988; Gilman, 2008; Gilman & Green, 2018) discusses informational privacy. Informational privacy concerns the ability individuals have to control their personal data and limiting access to others. Obviously, an agent/counsellor must ensure that the clients receive the appropriate support, and in creating a safe space, they realize the need for client anonymity.

While many women are uneasy about their privacy in a time of technological transformation, the harms poor women face from privacy deprivations go far beyond unease (Gilman, 2008; Gilman & Green, 2018). Feminist scholar Allen (1988) writes on how 'privacy is essential to moral personhood and self-development' (p. 36). Chiweshe et al. (2017) bring to light how poor women have always had less privacy than wealthy women and are demeaned for this as

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seen in their interaction with civil servants at public hospitals. The call centres contacted in the study are not toll free and although call centres offer to call the client back, this in itself strips a veil of privacy when these women seek support. Women who can afford to be on the call for longer get to keep their privacy.

Second-wave feminism tackled the concept of privacy when addressing the divide in the public/private sphere where government perpetuated gender inequality by their non-interference in the private sphere under the guise of 'privacy' (Gilman, 2008). Domestic privacy, which traditionally shielded domestic violence from legal intervention, is today criminalized. In public health, doctor/counsellor–client relationships are protected by the privacy laws where previously privacy reinforced the power of powerful members of families – i.e., husbands and fathers – over less powerful women. This is particularly relevant when studying sexual reproductive health where in patriarchal countries women still need the permission and/or the accompaniment of husbands/fathers when needing medical consultation and/or SRH consultation (Gilman, 2008).

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Gilman (2008) notes how the second wave of feminism laid the foundations for questioning and problematizing 'too much unwanted privacy', but also how women can greatly benefit from certain forms of privacy. This criticism, however, is largely based on the experiences of white, middle-class women and overall ignores the experiences of poor women who have historically lacked privacy. Black feminist scholar Allen (1988, p. 203) contends that privacy is in fact valuable to women and privacy as a form of "restricted access" offers women a reliable opportunity for "seclusion, solitude, and anonymity" in home and family life (the personal, which for women is also very political). Allen further argues that women's relationship with privacy has been troubled because they have "possess[ed] too much of the

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wrong kind of privacy" (p. 208), usually tainted by hiding private sphere abuse. Kim (2005), picks up this argument, to show how the value of privacy benefits women. This kind of privacy often brews itself into stigma and unspoken shared truths. The study then seeks to understand the idea of privacy for fostering safeness and validating autonomy.

Theoretical framework

2. 12 Social constructionism

This study analyses the subjective reality of safe spaces by analyzing mystery client telephonic conversations at abortion support call centres. A discourse analysis framework grounded in social constructivism was adopted. It is through language analysis and taking into consideration social context that the study can understand how these support call centres begin to create a safe space or how they may make clients feel unsafe.

Constructivism is a movement that focuses on how meaning is created, negotiated, sustained and modified while being aware that the very idea of knowledge and absolute truth is created and not discovered (Andrews, 2012, p. 44). As this study investigates the notion of safe space, it makes use of language and the meaning attached to language in client–call centre agent interaction. Burr, (1995) argues that within social constructivism, language itself can be a problematic means of sharing thoughts and feelings and in fact makes thought possible by constructing concepts such as safe space in this case. Social constructivism explores how language is used in a space to make it safe. This is particularly relevant to this study as interaction is purely verbal at a call centre. Language predates concepts and provides a means of structuring the way the world – or the call centre in the case of this research – is experienced. Therefore, how we speak and the language we use is altered to create safeness even before we

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define a space as safe. Berger and Luckmann (1996) cited in Galbin, (2014) maintain that conversation is the most important means of maintaining, modifying, and reconstructing subjective reality. It is during the call centre agent and client interaction analysis that I explore the language used to create safety for women entering these spaces.

Language, a fundamental aspect of the process of knowledge production, is a way of constructing an ontological safe space thus being a form of social action and co-creation. Language gains its meaning from its use in context (Burr, 2003; Gergen, 1994; McNamee, 2004). The constructivist approach emphasizes the ability to create realities through language in its varied forms of presentation, stimulating a process of continuous creation of spaces with different meaning and interpretation. Scholars (Gergen, 1985; Gergen, 1994; McNamee, 2004) outline the core principles of social constructivism, such as realities constituted by means of language use in spaces. They also emphasize how reflexivity, when interacting in a support call centre space, is particularly important for call centre agents, who are wholly responsible for creating this safe space when engaging with a client. Davis (2013) describes how social constructivism in its weak sense tries to introduce a common-sense approach to thinking about how people victimize individuals unlike them, even using language. This study probes how agents who are tasked with creating a safe space for clients might in their own subjectivity victimize and potentially stigmatize clients. Social constructivism is, therefore, an appropriate overarching framework to understand the use of language in creating a safe space at the call centre.

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2. 15 Conclusion

Abortion has been socially marked as discrediting to womanhood and stigma is understood as a manifestation from power disparities and inequality in the community. Abortion stigma is both a social and political process perpetuating patriarchy's 'essential nature' of understanding mothering as women's sole important role. Studies have further explored abortion stigma as the societal moral grounding cutting across the individual, community, institutional structures, and society. Previous studies used the concept of 'safe-spaces' to describe physical safety, Brady's (2005) understanding of safe-spaces as redefined public spaces is particularly relevant to this study as call centres were redefined as possible safe-spaces. The safeness of these call centres is also in how hidden they are from public consciousness. The hidden nature of the call centres further isolated women seeking counsel, when returning to a community that harbors problematic views on abortion

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CHAPTER THREE

3 METHODOLOGY

3.1 Mystery client method in gender studies

This chapter describes the methodology used to carry out the study. Although underpinned by feminist research, I made use of the mystery client method popularized in public health. The approach was chosen to help understand the subjective experiences of the women who access abortion support call centres in South Africa. The chapter discusses the study site, data collection tools and processes, as well as the researcher's experience while undertaking the study. To ensure the trustworthiness of the study, results are reported as a true reflection of the experiences of participants and of the information gathered from the mystery clients' interactions.

3.2 Qualitative feminist research

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The study was undertaken using qualitative feminist research methods. Feminist research is committed to collecting and representing the untold stories of those marginalized in a particular society (DeVault & Gross, 2012). The idea of call centres as safe spaces that provide abortion support is both a new one, thanks to technological advancements in e-health, as well as a socio-political issue that needs exploration. Call centres as safe spaces are best understood through simulation of the experiences of women entering the call centre for support.

DeVault and Gross (2012) criticize the current way in which research is done, particularly in 'talking with people' and the 'systemizing' of this in research. They instead encourage active involvement and paying attention to 'productive powers of language; the subtle

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shades of meaning conveyed through the nuances of speech, gesture, and expression' (DeVault & Gross, 2012, p. 206). Hesse-Biber (2006) posits that social knowledge is best acquired through the use of qualitative research methods as one's perspectives and choices are informed by experience and context (Hesse-Biber, 2012; Dana & Dumez, 2015). Pascal (1991) concurs with this perspective when she contends that qualitative research is very informative as it is highly descriptive. It contextualizes issues in addition to allowing the researcher to learn and develop. She argues that qualitative methods, unlike the quantitative ones that are hierarchical in nature, strive to reduce the power gap between the researcher and the participants during the interview process. Denzin and Lincoln (2000) also agree with this view, arguing that quantitative methods are not ideal for social research as they silence the already marginalized voices even more due to emphasis on causal relationships and not processes.

In her paper, Davids (2014) quotes Mouton and Babbie's (2001, p. 270) description of qualitative research and its attempt to 'study human action from the perspective of the social beings themselves'. Davids emphasizes the ability of the approach to provide in-depth information and descriptions about people's experience pertaining to the research issue. Aligned with this research, the mystery client method gives us this insight. According to Wellman, Kruger and Mitchell (2005, p. 188), 'qualitative research is concerned with understanding social and psychoanalytical phenomena from the perspectives of the people involved and are concerned with the participants' experiences, beliefs and attitudes.' This is why this methodology has been adopted to explore safeness and how call centre agents provide counselling services to women.

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3.3 Study site

The study was carried out at five identified call centres that offer telephonic abortion support services in South Africa. The call centres represent both international and national organizations known to – primarily or as a subcategory – provide abortion support in South Africa. The call centres are diverse in their approach and stance on post-abortion support. The international organization popularized by their pregnancy termination services has a call centre that offers psychosocial support secondary to their information on post-termination care. The call centre is outsourced and agents are advised to refer clients when they need support beyond what they offer. The call centre is considering the introduction of a pregnancy line to deal with psychosocial support primarily.

To gain access to the call centres, I had to receive approval from the call centres themselves. However, they were not informed of when the study would be carried out, in line with the data collection processes of the mystery client method.

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It is important to note that calls are routinely monitored and evaluated. However, this evaluation takes a quantitative approach. In my meetings with the call centre managers, they reported on caller statistics, lengths of calls and whether they were able to secure a walk-in booking from the caller. There was no mention of the caller's experience of the call, nor was there mention of the telephonic experience they aim to create for women accessing the call centre.

3.4 Method of data collection: Mystery client telephonic conversations

When using the mystery client method (Arullapan et al., 2018; Boyce & Neale, 2006; Fitzpatrick & Tumlinson, 2017; Mchome et al., 2015), a researcher or volunteer mimics the role of a client seeking services at the said institution and thereafter reports on their

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experience (Arullapan et al., 2018; Fitzpatrick & Tumlinson, 2017). The mystery client method is popular in the field of health sciences and is usually implemented with the aim to monitor improvements, evaluate the provision of service, or for in-depth understanding of the client and service provider's real-time interactions (Mchome et al., 2015; Nalwadda, Mirembe, Byamugisha, Tumwesigye, & Faxelid, 2016), which is the focus of this study. Evidence shows that some scholars have used the mystery client method to evaluate the provision of family planning services in contexts where it is plausible for service providers to respond differently when they are aware they were being monitored (Boyce & Neale, 2006; Nalwadda et al., 2006). This study made use of this method to gauge the dynamic interaction between the client and service provider in the continuously constructed safe space of the call centre (Kimport et al., 2012).

This study, and its particular methodology is one of few, granted access to explore the public health space using methodologies uncommon in the humanities, but inevitable for postgraduate students' interdisciplinary work from different academic backgrounds. The unpopularity of this particular methodology rests on administrative and legal repercussions that may arise i.e. the study revealed unflattering conversations in identifiable centres considering that there are only a handful in the country. This was raised to me in the meeting with ethics committee members. As spaces that service communities, support centres should open themselves up more to humanities scholars and view their scholarly work as academic feedback tools. I am grateful to all institutions that opened themselves up for this study.

The study had three volunteers, these were women who run an abortion support private Facebook group. The volunteers and myself used predesigned client profiles (Wilkinson, Vargas, Fahey, Suther, & Silverstein, 2014) when interacting with call centre agents. The

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personal information of the call centre agents was not requested or used in this study and the agents have been anonymized.

3.5 Research procedure

It proved difficult to gain approval from the ethics committee in the Humanities, with the chosen methodology. The proposal was rejected three times and I was only able to gain approval by providing informed consent forms from call centre agents. The requirement from the ethics committee was that the call centre agents should be informed and alerted of the time the study would be done, that is, over two months during the year and they should be allowed to consent. The unscheduled telephonic conversations were between call centre agents and mystery client volunteers, with the researcher in the room taking notes. The conversations were carried out based on pre-designed client profiles and were allowed to end organically or be carried out to a maximum of 45 minutes. Conversations between call centre agents and mystery clients were in English with allowances of Zulu phrases to maintain the authenticity of the mystery client profile. Translations and transcriptions were done with all the necessary attention to minimizing jeopardizing the richness and quality of data gathered. The client profiles are attached as Appendix A and B.

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3.6 Accessing the call centres

As mystery client callers, myself and three research assistants contacted five call centres that were involved with the study. I would often be intimidated by the response before the actual conversation began. The feelings were not focused on not being able to get data, but fear of being dismissed for wanting post-abortion support after a termination. Literature had already suggested that post-abortion counselling was uncommon or done inadequately. Of the five call centres contacted, two would not provide telephonic assistance, although

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their website had mentioned that telephonic support was available. Instead, the caller was urged to make an appointment for face-to-face counselling. The other call centres provided telephonic support as trained. These interactions are analyzed in the next chapter.

3.7 Data analysis: Discourse Analysis

I am primarily trained as a quantitative researcher. I therefore looked to Wellman et al. (2005, p. 211) for the guiding principles of qualitative research to make sense of the information gathered in the field. Firstly, field notes were transcribed to better familiarize myself with the data collected at the time. Secondly, I began discourse analysis as I read through the telephonic conversations, extracting sections from the conversations that spoke to the focus of the thesis. Themes systematically developed as I explored how the discourses were produced, consumed, or opposed and rejected in the abortion support call centres. Finally, I reflected on the data and interpreted it.

Discourse analysis is described as the analysis of language 'beyond the sentence' (Tannen, 2012). Gavey (2011) reflects on their 1989 article that draws attention to language and the context in which it is used to establish and perpetuate power relations (Fairclough, 1994; Gavey, 1989). It is through language that representations and ideologies become dominant and are therefore assumed as common sense. In the case of this study, the dominant language used around abortion in everyday conversation outside the call centre is likely to construct/deconstruct the safeness of the support call centre. Lazar (2007) in his poststructuralist theory explains this concept of discourse as a 'site of struggle' (p. 144). The call centre as a discourse site provides an exploration of the struggle between social (re)production of language around abortion and contestation in spaces providing support. Although the conversational themes are not predetermined, the study pays particular attention to the call centre agents' communication of advice to the support seeker as a way

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of answering the research question: How do call centre agents create safe spaces for women to discuss their abortion experiences?

Guided by discourse analysis, the aim of the study is not to analyse underlying meanings and 'lies'. Instead, the study pays attention to recurring patterns in language during the conversation, that constitute the dominant ideologies in the broader socio-cultural context. The study looks at how these conversations recreate and redistribute abortion stigma or how they challenge it. The study explores the emerging gender ideologies and relationships as they crop up from the conversations in the call centre.

3.8 Validity and reliability

This study continuously sparked debate in the Department of Women's and Gender Studies because of its methodology. In order to maintain validity and reliability (Shenton, 2004), I used the same profile guide and cues in all call interactions with the call centre agents. The interviews with call centre agents were recorded and transcribed as they occurred.

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For transferability, I purposefully diversified the call centres I would be accessing to ensure transferability and examine whether the study would yield similar results if conducted at another call centre. For conformability, I needed to ensure that the results were a true reflection of what goes on at the call centre, and when shared with the call centre managers, they would be able to understand it and be satisfied that it was a true reflection of the information shared with the researcher. In my meetings with call centre managers for signed informed consent letters, all managers were interested in the results of the study. I therefore made it a point to lay out all information gathered during the study in a way that can be understood not only in the context of the university, but for them as well.

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3. 9 Reflexivity

I located myself in the study as a researcher actively involved in the area of addressing abortion stigma and the creation of safe spaces in health for both gender and social justice. As a researcher I undertook this study as an activist and feminist woman. The proposal approval and ethics clearance process proved to be challenging as indicated. The method was criticized for not being feminist and/or not suitable as a method at a Master's level. The method is admittedly more common in public health, but I saw it as a great tool to be used in feminist research to avoid retraumatizing potential participants and ensuring real interaction responses.

With a strong belief in this work, I was offered the opportunity to plead my case in front of the ethics committee. I was accompanied by my supervisor, who along with her brought numerous print-outs of studies that had used the same method. In the meeting there was space to reconcile our views on the method and ethics considerations and we left the meeting with approval on condition that call centre managers alert their agents that I will be conducting mystery client calls to their centres during a specific time frame with the call centre's permission and this was consequently done.

My research training has been mainly quantitative. Therefore, for my Master's thesis I found it necessary to gain the experience of qualitative research with my employment prospects focusing on qualitative research. This study has helped me grasp the skills of engaging with people through interviews, mapping volunteers for field work, interacting with stakeholders for insights, learning about ethics applications, information sheet/consent form write-ups, interacting with people as volunteers and organizations as study sites. I focused on issues of reflexivity, positionality and power relations in the field in order to undertake this research ethically. The rights of all the study participants were respected and

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protected for the duration of the study. I did my best to guard against the unequal power relations between the researcher 'mystery clients' and the researched 'call centre agents' as this is one of the key principles of quality, feminist research.

3. 10 Ethics considerations

It is the nature of a call centre to record all calls. All recordings and notes acquired by the researcher during the study have been kept confidential and will be destroyed five years after the study has been completed. The call centres will be informed of the results of the study after the project has been completed.

After receiving ethics approval and call centre managers had given permission, it was still important to remember and understand my responsibility as a researcher to ethically carry out this research, keeping in mind that participants, although not being a vulnerable group, were to be treated in a human and sensitive manner.

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CHAPTER FOUR

4. DATA ANALYSIS AND DISCUSSION

During data analysis, I made use of discourse analysis, carefully paying attention to binary oppositions, identifying discourses and key themes emerging from the telephonic conversations. The initial themes centred on the safeness and unsafeness of the call centre space and how it is dressed and addressed. Multiple discourses as the products of multiple ideologies about womanhood, mothering and children emerged as well. Although this thesis focused on the language used to construct safeness at call centres, the competing discourses were mobilized by the agents in giving support and creating certain discourses of safeness. As I focused on how the agents facilitated and created safeness for the callers while tackling these discourses, it became clear how the call centres as hidden spaces functioned as buffering spaces for women away from the stigma, yet very much aware of the social climate for these women. Key discourses that emerged from the mystery client conversations include bodily autonomy, gender inequality, SRHR, motherhood, self-imposed stigma, mental health post-termination, societal values rooted in culture and religion and its contribution to abortion stigma. These discourses are unpacked in this chapter.

4.1 Constructing safeness at an abortion support centre

As physically hidden spaces, e-health call centres are able to host stigmatized conversations with their clients by providing anonymity for open discussion of their experiences. eHealth call centres' employees are knowledgeable on sexual reproductive health, understand the societal stigma associated with the procedure, and are presumably equipped to counsel callers.

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When women seek post-termination support at reproductive health centres, nurses and consultants often assume they are referring to the post-termination surgical aftercare. Support that addresses personally experienced abortion stigma, self-imposed stigma and abortion regret is not offered at the clinics. Abortion stigma also makes it difficult for women to seek this support face-to-face. Abortion stigma as experienced by women forces them into these hidden call centres for support. As hidden spaces there is no conclusive data to show how safe or unsafe, they are for women seeking non-stigmatized support and counsel. I would like to stress that the focus here is not on the counselling techniques and qualifications of the agents (although this is important too) but on the safeness created by providing anonymity, validated autonomy and how language is used as an indicator of care, sensitivity, understanding and therefore safeness. Phillips (2007) emphasizes that:

> *"Care is fundamental to our individual identity as this is played out in our social interactions and relationships … Care is fundamental to who we are and how we are viewed in both public and private spheres of life. (p. 1).*

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Care at post-abortion support centres involves helping women reframe ideas around abortion choices to help alleviate public and self-imposed stigma (Rubin & Russo, 2008).

The call centres contacted in the study vary and include public and private sector sexual reproductive health medical centres, sexual reproductive health support centres and secular psychosocial support centres. Using the mystery client method, five women called into the above outlined call centres needing 'someone to talk to about [their] abortion'. What follows is a critical discourse analysis of the language used during these interactions.

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4.1.1 Discourses of femininity, care work and call centres

Across the public and private sector, women are primarily employed as social workers, nurses and caregivers because they are seen as 'natural nurturers' in society (Reddy, Meyer, Shefer, & Meyiwa, 2014). As spaces of care work particularly focusing on women's reproductive health concerns, it is expected that these call centres would primarily employ women. It was therefore not surprising that the first line of attendance to callers, a pre-recorded welcome message, was in the voice of a woman.

→ *Women's voice pre-recorded audio: Welcome to the *** client services centre...*

The first voice the caller hears is the pre-recorded welcome message in the voice of a woman. Although most customer service lines make use of female voices, at a pregnancy termination support clinic this can be seen to create safeness. Literature reveals that female clients prefer female therapists in mental health and primary healthcare settings. Numerous studies (Garcia, Paterniti, Romano, & Kravitz, 2003; Landes, Burton, King, & Sullivan, 2013; Pikus & Heavey, 1996) report that the preference has to do with the safety and comfort clients experience when receiving counselling from female therapists, particularly when presenting problems of a 'personal nature'. Pikus and Heavey (1996) report that female counsellors are perceived to have the ability to be more empathetic and are described as being "warmer", therefore making it easier for clients to speak openly. *"You called wanting to speak to a counsellor … you can continue from [there] cause I got a bit of the details..."*

On initial contact with the call centres, all but one caller was met by a woman agent. At the call centre where initial contact was with a man, the caller was later transferred (without the caller's knowledge) to a woman agent.

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In healthcare, specifically reproductive health, support care is socially gendered precisely because most of the work done by women is for the social welfare and care of other women. Aligning care to women's morality effectively locks women into care tasks and in turn locks men out as we see the male agent redirecting the call as soon as he hears the client's concern. Such responses overburden women in that space as they must take on more work than their counterparts.

In the same breath, the interaction with women agents ushered in a layer of safeness where care is not only an expression of an underlying commitment to relationality, it also contributes to the establishment of specific interpersonal relationships needed when seeking abortion stigma support (Reddy et al., 2014). This is not to resubscribe the gendered ideas of care work, but to understand the comfort and reassurance created in experiencing the likeness of 'womanhood' by accessing these support centres as everyday women in a gendered society.

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While a layer of safeness is created by a woman's voice, the voice is then married to 'call centre processes', which threatens this safeness. Call centres by nature record all incoming calls. Depending on the size of the call centre and its technical advancement, call centre agents can see the personal details of the caller. In order to connect with agents working at the call centre, clients/callers must comply with the call centre's first requirement, which compromises the caller's privacy. The breach of privacy is justified as being for 'quality assurance' purposes, which forms part of the everyday monitoring and evaluation of call centre performance.

As heard here:

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*Welcome to the *** client services centre, please note that all our calls are recorded for quality purposes...*

The study of Yagnik et al. (2015), one of the most recent to explore the client experience when accessing e-health at call centres, made use of the mystery client method as done in this study. They noted that call centre monitoring and evaluation studies have previously reported on simple data fields such as age, gender, the province of caller and the reason for the call. The compromising of the callers' safety for simple monitoring functions brings attention to the need for a mechanism to protect privacy that does not impose limitations on the services or the quality of care the system offers (Milutinovic & De Decker, 2016).

Although inevitable and necessary for the daily functioning of the call centre, the following statement further compromises anonymity:

I have just given your contact number to somebody, you can expect a call shortly, ok?

The excerpt is an example of the information accessible to advanced call centres in addition to recording conversations. The caller was asked to hold the line and when the agent returned to her, she was informed that her contact details had been shared with a third party. A layer of safety, callers rely on when making use of call centres is anonymity, which in this case, while promised by the nature of calling in as compared to walking in to a support centre, is compromised by the technical operational processes. This makes the call centre appear to be an unsafe space for women seeking to discuss their experiences anonymously. The complexity lies in that for support call centres to efficiently carry out their work, there is a need for agents to have this information readily available in cases of suicide or disconnected calls. Murphy et al., (2019) in her piece addressing confidentiality for clients as a counsellor at a call centre stressed the unsafeness of these policies.

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The women calling into these centres are often dealing with societal prejudice surrounding abortion stigma. When people call into these centres they are sharing secrets. These women may fear losing their livelihoods if their experience becomes public. The initial recording prompt and instances of sharing client details without consent will cause callers with privacy concerns to hang up, and this indirectly denies these women safety. Unlike face-to-face counselling, callers are still afforded the 'masquerade aspect' (Gwinnell, 2003, p. 331), that is the luxury of choosing false names and personas similar to wearing a mask. This is for self-protection. Self-disclosure only takes place when the caller is comfortable, or it does not take place at all. This scenario further plays out as shown in the following extract:

Mbali, can I quickly get your number just in case our line cuts cause the line is quite bad?

At another call centre it is not clear whether the agent has the caller's information readily available, but the agent asks the caller for their contact details to better connect with them and gives the caller an opportunity to self-disclose. Although this discourse peels away a layer of safeness, the caller is given the opportunity to self-disclose as opposed to being 'exposed'. The request for contact details even if you can readily access them creates safeness for the caller, who may already feel vulnerable speaking to a stranger. The agent making the request even with access to this information aims to put the caller in a position to decide whether they will forego anonymity in order to receive assistance.

Infrastructure and connectivity to these call centres continue to be an issue for young women in rural and urban peripheral areas. Because of the lack of clear connectivity, callers are disconnected and they must call back in to the call centre numerous times. There is an issue of increased cost of access (depleting airtime) for support services, although theoretically it should be cheaper to phone in to call centre support centres. In order to

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receive cost effective counselling in the case of this study's call centres, you must share your contact details which, due to the RICA laws in South Africa, can be traced back to your identity. Seeking anonymity as a cloak of safeness in this case becomes what may prevent the caller from receiving support.

It is not uncommon for clients to assume that they will be speaking with clinic staff when calling into the call centre. However, one of the reproductive health clinics selected for the study subcontracts its call centre services and the call centre receives instructions from head office. The gap and lack of counselling services and readily available professionals on the line makes the space feel unsafe and as if it lacks the range to assist clients who are more than likely calling to seek counselling support. Evidence of this is noted in the following extract, where the agents emphasize the lack of counselling services in the space where it is expected:

> *Agent: All right ma'am… we don't have counselling services at *** ok? Unfortunately not, but if there is something I can help you with, I'll try my best… you're more than welcome to speak to me. If there is something I can assist you with then I will… I will try my best, ok?*

Hanna (2010) reveals the lack of professional qualifications at support call centres with volunteers commonly recruited as call centre agents. In this excerpt the caller requested to speak to a counsellor and the agent attempts to remedy the lack of professional counselling with *'If there is something I can help you with, I'll try my best'*, reassuring the caller, who may be feeling isolated and lonely. Women calling into support call centres have been cited as feeling alone, which is common in the instance of women who have pregnancy terminations without telling anyone. The abortion stigma, social and political climate often silence the voices of these women seeking an outlet to discuss their experiences (Laroche

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& Foster, 2017). The agent further adds that the caller is 'more than welcome' to speak to her, creating a space of safety to share what she may be struggling with and attempting not to scare the caller away with the initially mentioned lack of counsellors. The agent also offers a disclaimer for her potential shortcomings 'I'll try my best', and manages the expectations about the help she will be able to give.

There are elements of unsafeness in the above excerpt – a lack of counselling services at a reproductive health support call centre is a grave shortcoming. An aspect of trust includes competency (Milutinovic & De Decker, 2016), which is missing in this particular context. There is a difference between peer support and professional counselling. Peer support is support provided by people who have the same experience (Hoey, Ieropoli, White, & Jefford, 2008). Information centres give an opportunity to connect with someone who has gone through the same experience or someone with whom the caller shares sameness through sex/gender/experience. Professional counselling goes further to provide reassurance and hope, knowledge and understanding of abortion stigma, and self-help-strategies to decrease feelings of isolation (Kinnane, Waters, & Aranda, 2011).

Some call centres hire volunteers, while others outsource their services to commercial call centres. This ties in with the findings of this study and the fact that the literature reveals the lack of sufficient counselling training. These volunteer-based and outsourced centres take employees through two- to three-day training sessions (South African Depression and Anxiety Group, 2018) where volunteers have reported not having adequate training once being put on the line. In feedback sessions some have suggested that their training programmes should be adapted for future peer support volunteers (Kinnane et al., 2011). If a woman calling into the centre is seeking to anonymously share their experience, the call centre should provide that safeness by having an agent available to answer the line and

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listen. However, in the case where women are calling into the centres for professional advice and counsel for coping with guilt and self-imposed stigma and so on, simple peer support and the training of volunteer agents over three days create grave gaps in safeness and professional support.

The Mental Health Service Administration (2000) discusses therapeutic issues for counsellors, stressing how some women feel *safe* with female counsellors. For women calling into secular support call centres, the male voice may be a trigger if the woman is struggling with a male partner. Conversations with male counsellors can be uncomfortable and cause women to be wary of opening up. Conversation can be slow and unfold awkwardly:

Caller: Uhmmm can I speak to somebody about my termination?

Agent: Is that what you did?

*Caller: *delayed response*... yes*

Agent: Ok what do you, what do you want to speak to somebody about?

Kinanne et al. (2011) report on male and female counsellors at a support centre, noting how male counsellors did not acknowledge or respond to emotional cues from the patient. This may not have been the intention of the agent, but Kinanne et al. (2011) support the idea that male counsellors at support centres have a different approach to patients because they are male. In the case of abortion support seeking, speaking to someone of the same sex creates safeness. Failing to connect with the call centre agent pushes the caller back into her social circle as a place to source help:

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I think it is a good idea that you speak about it openly…. Find either a group of people or a close friend that you can speak about it uhmm quite openly and honestly and divulge all your feelings about it, all your doubt….

Although the call centre specializes in psychosocial support, the male counsellor fails to recognize that the client is seeking support from a hidden place such as a call centre and that it means that she might not have support or someone to speak to in her own circle. This points to a gap in common experience. The client's social circle and community at large is described as being able to openly offer support and healthy discussion of the client's feelings. The public domain is a space characterized by discourses of blame, discourses of morality, and the agent is inadvertently pushing the caller back into that space. Herold, Kimport and Cockrill (2015) discuss public discourse around abortion and how this can privately stigmatize women who have abortions, making it difficult to openly discuss their experience with those around them (Herold, Kimport, & Cockrill, 2015). The call centre as a safe space with a unique feature of anonymity makes it easier for clients to enter and discuss their experience. The agent in this situation displays lack of understanding of the public abortion stigma discourse the caller may have been exposed to prior to accessing the call centre. It is part of counselling to remind clients of the power of social support, but in this case the client is consciously avoiding this power source, seeking hidden support instead.

However, at another call centre the helpline is acknowledged as a safe space:

Don't ever hesitate the call centre helpline psychosocial structure of support was mainly designed for you guys, this is your space where you need to feel free to ask me anything, anytime, anyhow... you're protected, your protection comes first before anything else. So don't ever hesitate. This is your space.

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The agent encourages callers to use telephonic support centres and characterizes them as anonymous safe spaces available to the youth. *'You're protected, your protection comes first before anything else'.* The agent understands the need for privacy when discussing socially sensitive issues.

4. 2 Discourses of safeness in anonymity vs conventional face-to-face counselling

The bias towards conventional face-to-face counselling by professionals denies women seeking anonymity access to professional support (Wong, Bonn, Tam, & Wong, 2018). Psychosocial support is traditionally given face-to-face. Some centres advertise telephonic support, but when clients phone in they are offered bookings for face-to-face counselling. There is no flexibility to accommodate clients who require telephonic counselling, even though callers' express discomfort with coming into the offices as seen here:

This is how we operate. You must come to [the office]. Do you know where our offices are?

Such rigid institutional practices and systems make connecting with counsellors difficult and keep women from seeking telephonic counselling. The interviews in this study were conducted before the Covid-19 pandemic, so women opted for telephonic counselling even though face-to-face counselling was readily available.

At two call centres the calls were cut short for Mbali and Nozipho when they indicated that they were unwilling to come into the centre. These centres happened to be crisis pregnancy centres (CPCs) that have been reported to be anti-abortionist and preferred directive counselling (Alblas, 2020). It was important to include CPCs in this study as they are the most visible pregnancy support centres, some even working with universities and clinics around the country (Mavuso, Chiweshe, & Macleod, 2018). The National Abortion Federation Report (2006) comments on the deceitful physical appearance of CPCs that pass

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as healthcare clinics by locating themselves close to clinics that offer abortion to 'increase their legitimacy' (Suite & Dc, 2006, p. 4). A university campus clinic came under scrutiny when outcries on social media revealed it to be an anti-abortion space where women were being referred to for 'unbiased advice' and support (Wiersma, Kerridge, & Lipworth, 2020). When calling in to one CPC, the caller seeking telephonic counselling said, '*may I please speak to a counsellor about my abortion',* and the call was redirected. The National Abortion Federation's (NAF) 2006 report *'Crisis Pregnancy Centers: An Affront to Choice'* exposes CPCs for misleading advertising practices, advertising under categories such as 'women's organizations'. They urge women to book and honour appointments to meet in person to 'talk', but evade questions about their services:

So when are you willing to come?... Should I give you a date…

No, no it would be much better if you could come in and see us… if possible come tomorrow morning, we open at 10 o'clock.

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These discourses of manipulation of women seeking support create unsafeness.

In the process of seeking consent for this study, I had a conversation with a volunteer at one of the CPCs. My interest was to find out their thoughts on telephonic counselling. She advised that the CPC would prefer face-to-face, one-on-one counselling as to better connect and 'bond' with the young women coming in. Bonding with clients would mean sharing the same values and beliefs. Clients often walk in to face-to-face counselling sessions unclear of the values:

"...I have to say that I was disgusted to find one of those 'Caring' Pregnancy Centre advertisements in my mail last week! Most of what it said was a bunch of lies. It says things like: "Free Pregnancy Test," "Friendship and Emotional Support," "Medical

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Referrals," and "Aid in Obtaining Community Resources." None of these were true, and the ad mentions NOTHING about religion, church, and being anti-contraceptive, and anti-choice." NAF CPC Patient Partnership Participant (National Abortion Federation, 2006, p. 3).

Literature (du Plessis, Sofika, Macleod, & Mthethwa, 2019; Mavuso, Chiweshe, & Macleod, 2020; Nkosi, Mulaudzi, & Peu, 2020; Parker, 2019) describe crisis pregnancy centres as providing face-to-face anti-abortionist counselling with misleading information and advice on services and post-abortion experiences. For this study the mystery caller did not go in for face-to-face counselling after being redirected.

4.3 Drawing on discourses of gender and motherhood in making sense of safeness

Women are ascribed saint-like status when adhering to traditional gendered roles of motherhood (Huang, Davies, Sibley, & Osborne, 2016). The politicized public abortion debate is in essence a debate about the role women should be playing in the society and when women reject this role by choosing abortion, they are criticized for not fulfilling an essential component of womanhood (Huang et al., 2016; Osborne & Davies, 2009).

The abortion debate is often seen as binary, pro-life vs pro-choice, when there are in fact grey areas where the circumstances of the abortion can garner support. 'Elective' abortion (financial insecurity, unplanned pregnancy) and 'traumatic' abortion (when a woman's health is in danger, pregnancy as a result of rape or impaired foetus) are the two categories for abortion. Notably, women who experience a traumatic abortion receive more support than woman who have an elective abortion (Bahr & Marcos, 2003; Huang et al., 2016; McKinney, 2019). The culture of secrecy due to stigma has left many abortion stories untold and those that are told, are told with a recourse of tragedy to morally recuperate

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women (McKinney, 2019). The stories of women having had elective abortion and being shamed by society further necessitates hidden safe spaces to discuss their experience post-abortion.

The second edition '*Woman-centred Post-abortion Care Reference Manual'* (2013) defines a women-centred approach to care as 'service providers identifying their own values and beliefs and separating them from that of the clients in order to focus on the clients' needs (p. 9). At the SRH centre that is non-CPC affiliated, this approach was used to support creating of safeness. SRH centre agents broadly address motherhood as a complicated decision. In the conversation, agents communicated layered ideas of motherhood and parenting post-abortion. When a caller described having a hard time reconciling having an abortion when she sees her friends raising children as single mothers, call centre agents used language to describe an abortion as an escape from the burden of motherhood and its social expectations: '*Children are a long-term commitment and we always say the child always belongs to the mother…'*

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The agent translated an African saying *'the child belongs to the mother'* to refer to the social norm for and parenting experiences of most women in South Africa and other similar contexts. Women as mothers in our communities are positioned as solely responsible for raising children, even in cases where the fathers are alive. Women's position as sole providers makes them more susceptible to poverty (De Roure & Capraro, 2016; Kamuren, Kamara, & Ntabo, 2017). At one secular call centre an agent personally related with the caller instead of formalizing their consultations: '*I am a firm believer and my philosophy…'* the agent shares her 'beliefs and philosophy' for bringing a child into a home with *functional parents*. The agent is aware of the social climate in South Africa and the plight of women in everyday social interactions and the frustration to follow if the home

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environment is dysfunctional with an unsupportive partner and/or unplanned child. As an insider and outsider, the agent shows and shapes how guilt can arise from being a single parent: *'Why am I allowing to put another human being in struggles*.' As the agent visited these scenarios, the societal norms and her language speaks to raising children in the context of South Africa and the dominant discourses shaping this process.

Voluntarily childlessness has been problematized in literature (Lynch et al., 2018; Shapiro, 2014) and women who make the decision not to have a child are denied support. This punishes women for 'rejecting nature', *'To deny the authority of nature … is not natural'* (Macleod, Feltham-King, Mavuso, & Morison, 2019, p. 205). Motherhood is seen as reaching higher levels of spiritual stature and natural fruition. Women's personal development and adult identities are rooted in choosing motherhood (Macleod et al., 2019; Woollett & Boyle, 2000). The discourses of gender and womanhood here are also linked to the agents' own values. The fact that dominant societal discourses shape how agents construct meanings here, creates the space as not value free and therefore not so safe.

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The language agents use when describing the decision to have an abortion unintentionally reveals their understanding of the broader social values and beliefs on motherhood:

> '*… in reality a child requires you to be selfless and I'm sure also you took that decision on, 'Mbali also has goals for herself'... cause once you become a parent it becomes about them and not about you.'*

Voluntary childlessness research is often shaped by ideas of women being unfit to mother (Kelly, 2012; Macleod et al., 2019), thus choosing not to be mothers. Women are seen as potential 'bad' mothers and as selfish if they are career women (Woollett & Boyl,

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2000:309). One agent led the caller to see an abortion as the best decision considering how her own career-centred selfish desires would make her an unfit mother.

Religious and cultural society frown upon the rejection of motherhood and CPCs have received a backlash worldwide from pro-choice activists, reporting on the support provided by CPCs as lined with misinformation, discourses on motherhood rejection and linking this with post-abortion syndrome diagnosis (Mavuso et al., 2020). Post-abortion syndrome, which counsellors at CPCs liken to posttraumatic stress disorder, is an unfounded psychological condition said to be a result of an abortion. Research has disproven it (Steinberg et al., 2018). Although recommended and most visible, calling in to these centres may create unsafeness as they are misleading with a biased anti-choice position (Malan, 2017; Wiersma et al., 2020). When women phone in, the force to self-disclose to receive support, and the lack of alternatives such as being referred to other telephonic support centres when women request that, keeps women out from receiving support in South Africa. The one CPC's response to callers seeking telephonic consultations was dismissive and non-accommodative. At other call centres that offer abortion-related services and not post-termination support, similar to CPCs, safeness was created by being accommodative and flexible in their support offering, as seen with this agent:

> *Agent: If ever you need to talk again uhmmm you can call into the contact centre and ask for Meegan* I am the manager of the contact centre you can ask to speak to me and we can have a chat again by all means.*

I noticed that in closing the conversation with Mbali, the agent made the caller aware that she may call again.

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The agent describes herself as the manager of the centre and points to her experience at the call centre, persuading the caller to call the contact centre again. At this centre, safeness, unlike at the other centres, is guarded by the contact centre as a whole's willingness to hear the caller out as compared to the requirement to present yourself for a face-to-face session. Ideas of conventional counselling are challenged here as this centre accommodates the caller's need for the telephonic counselling. When saying 'we can have a chat again' the agent makes the caller comfortable enough to seek help once again at the call centre.

However, CPCs cannot be demonized as non-progressive or dismissive merely for wanting to offer face-to-face counselling. Irvine, Drew, Bower, Brooks, Gellatly, Armitage, Barkham, McMillan, and Bee (2020) in their systematic review of telephonic and face-to-face counselling interactions reveal how therapists express reservations about providing telephonic support. The reasons for the reservations include the need to create and sustain a quality therapeutic relationship and being able to read the patient's visual cues (Irvine et al., 2020). Even at call centres where telephonic counselling took place, prior to ending the call agents referred callers for conventional face-to-face counselling at the end of the call:

> *Would you maybe want uhmmm to continue with face to face counselling maybe, you don't have to go now but I can give you the number so that when you are maybe ready to go there …*

The fact that face-to-face counselling is continuously raised in conversation indicates how the method is recognized as the beneficial long-term solution for women seeking to discuss their experience and feelings post-termination. Bee, Lovell, Airnes, and Pruszynska (2016) in their study visit the readiness of therapists to adopt telephonic counselling support and how this may affect the successful implementation of telephonic counselling for the benefit of callers. However, the uneasiness of the agent when suggesting face-to-face counselling:

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'when you are maybe ready', is understanding of the issues of disclosure that callers grapple with and their greater need for anonymity, specifically for the politically sensitive issue of abortion. This creates safeness for clients. The 'newness' of telephonic counselling in a developing country such as South Africa further highlights the need to train counsellors to ensure openness and disclosure from callers, achieve participation in conversation and translating attentiveness to the caller in a much shorter time as telephonic counselling sessions are much shorter in their nature (Irvine, 2020). All these factors and how they are achieved contribute to how agents facilitate safeness or create unsafeness for the caller, as is discussed herein below.

4.4 Discourse of autonomy

Pro-choice activists have cloaked themselves in privatizing discourse, encouraging care providers not to ask the reasons for an abortion and further not judging those reasons (McKinney, 2019). Reproductive healthcare centres' formal and informal counselling methods are based on the foundation on feminist counselling framework (Ely, 2007). Feminist counselling methods emphasize the self-determination of women, therefore recognizing how validating autonomy is a key element of 'safeness'. Although some of the call centre services in this study were outsourced by reproductive healthcare centres, the feminist counselling framework with its emphasis on acknowledging autonomy through language trickled down to external call centre upholding safeness.

> *When you called us for the first time to make the booking and stuff you did it because you did it for a certain reason, you don't have to go over why you did it…*

Women who have abortions are often described as desperate, in crisis and depressed (Rue, 1992; Kimberly & Kirk, 2007; Boulind & Edwards, 2008). Kimport et al.'s (2012) study of abortion support call centres challenge Rue's (1981) claims of women's attachment to

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pregnancy and instead calls for a broader analysis of women's abortion experience. During pre-abortion counselling, there should be no focus on external influences of decision-making 'unless the client requests this' (Ely, 2007, p. 5). However, the decision-making process should be fleshed out and discussed with the caller. The study by Macleod et al. (2016) illuminates how the 'deviant' reproductive decision maker (women who've had an abortion) are made visible and viewed as problematic. The study pays attention to how describing women as 'deviant' reinforces and polices boundaries of 'normal motherhood (p. 3). In this study, the decision making process and reasoning of callers pull numerous discourses into the conversation. The conversations in the study contribute to the feminist research, which challenges the regulatory frame of compulsory and natural motherhood (Chiweshe et al., 2017b; Woollett & Boyle, 2000). The discourses in the conversations also run parallel to the facilitation of, or degradation of safeness in the call centre space.

On the call with Nozipho the agent affirms the caller's autonomy and begins to visit discourses on what is affecting her feelings and thoughts on the abortion, acknowledging different influences on autonomy and decision making. The language to gain trust and understanding of the caller's reasoning builds safeness in the call centre as shown here:

> *Agent: When the baby happened or pregnancy happened you took another choice of saying 'I'm not financially, physically, emotionally, spiritually, in any dimension even a structurally so [ready] to become a mum or to have a baby right now hence the termination happened.*

The agent affirms her reasons as well-considered and logical, '*you took another choice'.* However, at call centre 2 an agent raises discourses on post-abortion syndrome (PAS). Post-abortion syndrome as a 'mental health condition' has been rejected by the American Psychiatric Association (Rowlands, 2011). This pathologized reaction to abortion stigma

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and self-imposed stigma is used as a talking point by agents as well. Agents' language does not refer to the termination as a simple medical procedure, but emotively refers to it as a *'passing',* challenging these discourses of pathology. Referring to an abortion as a *passing* swings in between medical discourse as clear-cut and emotively draws on the human element/emotions to connect with the caller and as necessary for achieving therapeutic goals (Adinma et al., 2010; Major et al., 2009; Rubin et al., 2008).

> *'With every passing lets put it that way there is a mourning period so allow yourself to mourn… allow yourself to feel sad for a little bit but then allow yourself to also realize that you made the decision the best you can.'*

Fear-mongering during abortion support creates unsafeness by making rational unfounded claims and alluding to mental health issues when overthinking:

> *'But don't don't and I'm again going to say don't let it consume you because once you let something like this consume you you going to have a horrible time...'*

The repeated *'don't, don't, and I'm going to say again don't'* brings attention to the agent's position on abortion as a duly guilt-filled procedure and it makes it more difficult for a woman to work through her emotions. The agent's language makes room for unsafe anti-abortionist discourse of understanding a foetus as a 'living' baby, as used by pro-life activists (Huber, 2018). The decision to have an abortion is socially understood as more than a medical procedure. It a surgical procedure resulting in the ending of 'life', and this should be acknowledged and mourned. The guilt that is culturally driven and now taken up by the agent's own positionality is then responsible for the 'death' of something living. The agent alludes to the caller having not dealt with 'guilt' and possibly how she may not have previously had the space (that the call centre now provides) to 'mourn' out of self-

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judgement and uncertainty. One sees how dominant discourses on abortion are promoted and exploited as agents create meaning with clients.

The agent draws on discourses of death/loss and the need for mourning periods, although unclear on how long this period should be. *'Allow yourself to feel sad for a little bit'*, the agent reaffirms the unfounded horrid effects, which are also unclear, of mourning too long *'you going to have a horrible time'*. The agent positions the mourning period as something necessary, but says that it should be short-lived to avoid long-term mental health issues. The agent encourages moving forward, *'take life as it comes'*, keeping away from the warned 'dwelling on' and/or 'wallowing' which, according to her, will affect the caller's health. Agents facilitate a conversation that callers may be having with themselves on whether or not to feel sad about the decision while describing the callers experience from a place of loss: *'allow yourself to feel sad… allow yourself to also realise that you made the decision the best you can'*. Huber (2018) in her work on therapeutic culture and emotional management, discusses how counsellors (in this case agents) themselves inevitably bring their stance on emotional management and emotional discourse to work when advising clients on the line. What needs to be noted is how their reasoning is informed by dominant discourses in their social context. In this instance, the agent is affirming the caller's autonomy, describing the decision as the best decision for themselves. The agent ascribes a non-specific time frame, '*for a little bit*', while warning the caller that prolonged sadness will result in long-term problems: '*You're going to have a horrible time*'. Although hovering on mental health implications brought on by the caller's self-imposed stigma, the agent carries safeness and in essence reminds the caller of their power and autonomy to choose. In all this, the most important aspect is that the agent affirms the client's decision and acknowledges their power to be autonomous, ultimately creating safeness in the call centre. The call centre agent in this case did not explicitly position herself as a professional

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psychologist/psychiatrist, but repeatedly relied on medical discourses, specifically mental health, warning the caller of 'dwelling' not being 'healthy' as seen below;

> *'The thing is you'll never know whether you've done the right decision or not but I don't think its healthy for you to dwell on it. I think you should like be confident in the decision that you made and live with it and then just you know take life and …as it comes take each day as it comes don't wallow or dwell over it because its going to consume you, you know?'*

The agent empowers the caller, reminding them that they had the power to choose and they made a decision that was best for themselves. In encouraging the client by saying that there is solace in coping with a termination by yourself, there is also a word of caution about overthinking by yourself. The agent says: '*you'll never know whether you've done the right decision*'. The agent tells the caller to not get caught up in a binary way of thinking about the termination – wrong decision, right decision. As a remedy to dwelling, the agent persuades the caller to rather be 'confident', encouraging the caller to be accepting of her decision. The agent refers to the caller's termination as a '*decision that [she] made*', reaffirming the caller's agency and making the caller aware of how exercising this agency is her right. Safe spaces are spaces that encourage and stand for the agency of individuals.

4.4.1 Choice in context

As social beings, often our decisions feel solidified and 'right' when affirmed by others around us. The call centre as a safe space and the agent's facilitation of acceptance of the decision to terminate allows the caller 'breathing room' as described by Bullock et al. (2017), a safe space for recuperating. The caller's reasoning for the termination is not regarded as important for debate in that space: '*Don't doubt yourself now'.* This is not out of disregard, but as validation of autonomy and the right to termination, persuading the

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caller to rest in her autonomy and feel safe enough to embrace it in that space. As described by Bullock et al. (2017), safe spaces are in fact places of temporary 'respite' in the bigger scheme social interaction and cohesion when addressing abortion stigma. In the same discussion the agent continues to say:

> *Agent: Ya you know every every female that goes through what you've gone through has a story and has a situation and has a reason why they do what they do and no one is allowed to judge you.*

The agent stresses the universality of the participant's experience, emphasizing that: *'every female that goes through what you went through'*. The language creates inclusivity, and in this way, the agent attempts to make the caller feel less isolated and comforted in knowing that other women have the same experiences. Such an approach to engaging clients creates safeness by rejecting discourses on abortion as social deviancy (Sitzmann, Brown, Casper, Ely, & Zimmerman, 2008). The unframing of the client's experience as deviancy and affirming it as a constitutional right, is further read in the language: *'...has a story and a situation...no one is allowed to judge'*. The agent takes a stand to embrace and create safeness for the client, who is overwhelmed by stigma. The space respects whatever decisions clients have made without passing judgement. The agent continues to use her positionality and space as 'experience'. She has listened to other experiences and therefore locates this experience in the broad experiences of this place. Even though the agent describes the universality experiences, she still alludes to a recognition of uniqueness in the commonality of women's experiences. The emphasis on each story and situation creates this rejection of the universality of women's experiences (Siegel, 2008). While it is true that they are all calling the centre because of abortion experiences, these experiences are not identical. While stigma may be a common response to these experiences, the power of

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safeness in this space lies in how the space recognizes that each woman has a unique story and situation and their experiences should be respected. Speaking about the universal experiences of women further serves as a remedy for callers who feel isolated. Universalising the experiences of women and the decision to terminate a pregnancy while speaking on bodily autonomy and the need to advocate for it, also creates a layer of safeness. Not only is the agent attempting to create safeness with her language, she does so by bringing discourses of motherhood and the sameness of the callers, even with respect to their decision to have an abortion, into the broad discourse of universal rights.

> *'I as a woman, I as a mum, as any woman around the world, in any part of the world, I have a right'.*

The agent can speak as a person and not an extension of a call centre which may enforce its own values on the agent, makes it a safe space and conducive for the caller to have an honest conversation and to relate and connect with women on the line.

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The agent creates safeness in encouraging the caller to have a fulfilling life even after her termination. The caller may have been holding back on things she wants to do because of the guilt about her pregnancy termination and an inability to talk to those around her about it. Acting autonomously is not always easy, and in providing relief from external pressures call centre agents facilitate the creation of the client's own world by encouraging them to identify and explore their own values to go on in their world: *'it shouldn't be the end of your world'*. In their dated literature, Burn (1992) mentions that counsellors are ethically obligated to provide services that help clients make culturally appropriate decisions. The call centre creates safeness in encouraging well-being; a person's level of happiness above the social norms that may exclude them (Myers & Sweeney, 2008).

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4.4.2 Body autonomy in patriarchy

The discourse on patriarchy is always a challenge when issues of bodily autonomy are being interrogated. Relationships, having experienced an unplanned pregnancy resulting in an abortion, may very well be contentious. In conversation with the call centre agent, the caller explains her relationship with her partner falling apart due to the unwanted pregnancy: *'Previous relationship what happened? What made you guys end up breaking up?'* In South Africa, gender-based violence (GBV) is a common response to women exercising bodily autonomy and it creeps up in this space. Motta, Penn-Kekana, and Bewley (2015) in their study to measure the prevalence of domestic violence on women seeking abortions, related the experienced violence to 'limited power of negotiation' (p. 129) in intimate relationships with partners when discussing contraception. Interrogating and destabilizing the norm of patriarchal views stripping bodily autonomy, the agent tells the caller: '*They [Men] would say 'you don't have the right to terminate my seed'...he cannot start beating you around 'ubani othe…' (who said you can)'*. Discourses of unplanned pregnancy as a 'seed planted' takes on a religious understanding of a woman as not having a body that belongs to her, and a woman being unable to make autonomous decisions. Unplanned pregnancy in this scenario is the idea that a woman's body does not belong to her when a man has planted a seed. The planted seed is more valuable than the carrier, who can be violated to keep the seed safe.

Motherhood ties into patriarchal discourses, projecting women as mothers and homemakers. When the caller mentions being unsure of her decision on not to be a mother, the call centre agent introduces narratives of understanding motherhood:

'Agent (mimicking a patriarchal understanding of motherhood by a male partner):... The more I give her kids and kids keep suppressing her she is going to be a home staying

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mother… cause now she needs to raise 2 3 5 kids at once and I'm not there, I'm not there and I'm expecting that when I go back home my kids are clean and neat and healthy and they've eaten, badlile yabo (they've eaten, you know?).'

The agent re-enacts culturally normalised and deemed appropriate conversations between couples, emphasising the patriarchal expectations of women when having children and how child-rearing in the home becomes the responsibility of women. Agents at a safe call centre help women re-evaluate whose opinions rule over their body. In this case, the agent refocuses the caller's opinion to body autonomy: '*[instead say] I decide what comes in this body, what stays in this body.'* This is a solid affirmation of the power the client holds above all discourses that construct and normalise womanhood.

4.5 Discourses of shame: Self-imposed stigma

eHealth is largely driven by the need to be hidden and secure (Samra, 2019), to lessen the self-imposed stigma and to substitute stigmatizing public and personal circles. Public stigma in literature (Beadle-Holder, 2011; Goffman, 1963; Kondylis, Legovini, Vyborny, Zwager, & Cardoso De Andrade, 2020; Melvin, 2021) has been acknowledged as a reason for women seeking hidden spaces post-abortion as respite. Telephonic counselling callers often have not shared their experience and/or feelings with their personal circle (Abrahams et al., 2010). A caller told an agent that she was unsure of the decision to have an abortion and when she heard family and friends crudely talk about abortion, this further exacerbated the self-doubt and self-imposed stigma.

The agent facilitates a safe space by listening and not pre-empting the caller's experience. Previous studies (Barilan, 2012; Eidmann, 2011; Griffin, 2019; Lee, 2003), have shown that pre-empted diagnosis of post-abortion syndrome creates unsafeness for callers. Safe

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facilitation is initially noted when the agent starts a call with Mbali through the effective language of: *'I'm here to listen'*. By allowing the caller to take the lead and express themselves, agents provide support by taking directives from the callers. Agents with this approach can gain insight into discourses to better understand and engage the caller. "... *before you continue, my question to you is, where is your biggest struggle right now? What is it that's hurting you or calling you?"* The agent is seeking connection and sourcing discourses the caller may ascribe to that are making it difficult for her to come to terms with an abortion. Rubin and Russo (2008) emphasize how counsellors must be knowledgeable about the larger social context and its effects on women's understanding of their decision post-abortion. Reconciling agency and conflicting social framings of choosing to have an abortion is a thin line for agents to walk. On the line a caller reveals how she feels guilty about having an abortion, more so because her friends and family do not know about it. Self-imposed stigma does the ostracizing work, setting up a scenario of disapproving family and friends who in reality are not even aware of the termination.

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Self-imposed stigma is caused by the individual's experience of positive and negative messages from those close to them and the broad framing of abortion as a shameful act, making it difficult for the individual to navigate their own feelings and thoughts on the termination and judging themselves based on the social group's morals: "*So I think they will always be that sense of questioning or guilt to say did I make the right decision"*.

Call centre agents in their casual talk with a client can further drive the unsafeness and re-establish the helplessness of the caller to the outside environment as seen in what one agent said:

'We know that females judge females and it should (not) be that way but reality is, it is you know...'

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Reclaiming agency and bodily autonomy are key in creating a safe space for women who have unsupportive social circles and the agent talks to this issue here. However, this language can further drive the loneliness that the callers may be feeling. We should also note that the agent's opinion is informed by the discourses of morality attached to an understanding of women and morals in this broad community: *'Females judge females'...* The agent's language isolates the caller from her disempowered environment, taking power and creating safeness through affirming autonomy: *'it is your business, you don't need to explain yourself to anyone'*. Such an affirming stance would be what the client needs.

4.6 Reproductive health rights vs patriarchy and sex education

South Africa's National Adolescent Sexual and Reproductive Health Rights Framework Strategy, 2014–2019 (2015) stresses the lack of comprehensive material available to target groups for education on sexual reproductive health and rights (SRHR). In May 2017, the former president of the United States, Donald Trump, signed an executive order entitled '*Protecting Life in Global Health Assistance*'. This order, also known as the global gag rule, barred nongovernmental organizations engaging in abortion-related work (services, counselling, referrals, and advocacy) from accessing US global health funding. The inability of government to reach youths and educate (therefore normalizing through socialization) on reproductive options, including abortion, and the crippling of nongovernmental organizations leaves communities, especially women, vulnerable to uneducated opinions and stigma. One agent makes the caller aware of this knowledge gap here:

'People have a right to talk and sometimes lack of knowledge makes us to talk things, blow them out of proportion because there is a lack of knowledge there...you didn't have

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much more of information about termination of pregnancy until you're in that situation then you start researching and finding out more so that you empower yourself...'

The call centre as a safe space inherently functions as a buffering space. It does not ignore the dynamic political discourses on abortion and other issues that callers may see the need to address. The agent uses language to emphasize the power the abortion experience has given the caller as they learned and unlearned their own prejudice and ignorance prior to their abortion. The agent critically but very casually makes the caller aware of the disservice and disempowerment the government, community leaders and elders do to young women. She goes further to highlight sexual wellness topics that are open for discussion in society and are therefore not stigmatized:

'... many people they'll be more informed about sex [and masturbation]in comparison to termination… they have socialised us to bring certain things in the light and certain things under carpet, you know…Now things have changed the generation has changed... How do I say 'termination is illegal'? Who put it under the carpet? Why was it under? On whose decision? There is gender imbalance, there is gender power there, there is power struggle.'

As an agent at this call centre safe space, the agent carries on a frank conversation on reclaiming power in knowledge and then the power to act autonomously with this knowledge. Even at this call centre there is safeness for agents to go against the political power dynamics that muffle the conversations on abortion. The agent's language here makes the caller aware of the change in advocacy and abortion support in hidden spaces and the disadvantages of being a woman in a patriarchal society that has the power to silence 'put under carpet' and dictate unquestionable norms 'certain things in the light'.

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4.7 '*Go back to the high powers':* Discourses of morality, unsafeness, cultural values and religion

Grasi (2020) defines 'unsafe' spaces as spaces where the same values are not shared or the individual does not align with the collective. Grasi (2020) emphasizes that an 'unsafe' space, to be clear, refers to spaces where we are made to feel uncomfortable, or in this case insecure about a decision. Understanding unsafe spaces in this framing makes it clear how agents create safeness by discussing parallel discourses, which in the outside world contribute to feelings of insecurity and discomfort for women seeking to discuss their abortion experiences. Call centre agents bring in the outside world's unsafeness to have deep reflections on why and how the outside world makes us feel unsafe. The opportunity to interrogate 'unsafeness' outside of the call centre is experiencing safeness at the call centre as shown here. Agents are tasked with finding contexts that misalign callers with the collective. We should also note that whenever abortion-related work is hidden from the public, it leaves room for assumptions and ill-informed opinions. This muffled nature of abortion is framed by problematic discourses of culture and religion which uphold patriarchal views of women understanding themselves and their bodily autonomy. These discourses play out in the agents' engagements with clients here.

Although South Africa is a secular state, most of the population identifies as Christian, Hindu, Judaism and some African traditional religions (SAHO, 2019). In Africa particularly, governments hold sentiments of SRHR being un-African or western (Cense, de Neef, & Visscher, 2018). These conservative arguments tabled by some countries at international platforms such as the United Nations, hamper progress towards policy development and programme implementation for women's and girls' rights, reproductive health rights and safe abortion (Cense, et al., 2018). The politics of religion and culture

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often taint the discussion of abortion in public. Religion and culture as social structures prevent women from exercising their bodily autonomy and influences how they themselves and members of the religious and cultural communities see women who have abortions (Dozier et al., 2020; Frohwirth, Coleman, & Moore, 2018). Calling in to one of the centres, Mbali introduced herself as living with her grandma in a township and having no one to discuss her abortion with as her friends and family are largely based in a church community. The agent picks up on Mbali's positionality to draw on discourses of 'higher powers', in making meaning of their exchange. Here the agent believes that women calling into the call centre who subscribe to any higher powers may seek to be vindicated by the power structures against which they have gone:

> '*... if it has offended my culture and my religion I need to go back and find out, especially if its something that not making you to sleep at night… find out that if one does wrong in this aspect of life, according to my culture of religion what is it that I can do to make it right.'*

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What the agent raises here is how the religious and cultural values into which we are socialized act as tools of self-surveillance and in some cases cause self-imposed guilt for exercising reproductive rights:

> *Agent: ... And religion and culture as much as they can talk because they are values that have been instilled in you. There's also, in those values, there's a way that if I do wrong there is a way of correcting my wrongness...*

Speaking to the caller as an insider in culture and religion, the agent's language cements discourses on abortion as a wrong needing to be corrected. As an outsider listening in, the advice of 'correcting...wrongness' creates unsafeness by framing women's body autonomy

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in the bounds of the overseeing culture/religion, something to be repented. Positioning God and ancestors as forgiving and accepting when asked for forgiveness or performing customary rituals suggests that these 'higher powers' have authority which inadvertently compromises body autonomy as well. The agent considers that the termination may be heavy on the caller not only because of a lack of education on her reproductive rights, but the values instilled by religion and culture and how exercising reproductive rights offends the religious and cultural societal values. The agent continues the discourse on inflated guilt and the caller ruling herself as having committed an offense. The agent's language creates unsafeness as it leads the caller to guilt-ridden rituals in order to receive closure for 'wrongness':

> *'Agent; [Ask yourself] Do I call my ancestors to say 'ngiyaxolisa' (I'm sorry) and if I do; how? What's the process? What is at stake, what is it that involves here, if that means I have to 'hlaba inkuku' (slaughter a chicken), I have to call them, I have to 'tshisa impepo' (burn spiritual incense), I have to do whatever it takes because all those things as you practice them they help you to get closure... go back to the high powers.'*

In all the telephonic conversations callers and agents acknowledged that the choice to terminate a pregnancy is personal, but after termination the stigma around abortion is isolating and difficult to reconcile with own personal values. This could be because of culture, religion, social values or even a lack of knowledge of sexual reproductive health rights and ideas of bodily autonomy. The engagement of agents and clients in this study was not value free. Agents were in many instances digging deep into the broad, particularly patriarchal informed discourses on women's bodies, and womanhood to make sense of meaning in discussing abortion stigma with their clients.

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Conclusion

This chapter reported on the discourse analysis used to explore safeness at post-abortion support call centres in South Africa. The agents' language and formal call centre processes during mystery client conversations with callers were analysed. The language of the agents showed how 'safe' these centres can be for women seeking support with their abortion experience. Callers' short encounters with unsafeness was due to call centre processes that cannot be prevented, such as data collection and call recording. Evidence from this study shows how conversations at the call centre intersected with parallel social stigma discourses on which agents drew during the counselling sessions to make meaning of women's experiences.

The discussion considered socially constructed discourses that emerged to see how these created or threatened safeness in conversations with callers. Some of these discourse included, those of femininity and care work as women's work, understanding womanhood, motherhood as socially determined and natural, challenges with culture and religion and the omniscient. This chapter concludes with an understanding of the complexities of the construction of safeness – the multiple parallel discourses that intersect with the main issues complicate the creation of safeness. Call centres do offer a safe space and agents successfully use sensitive language that promote safeness. However, it should be noted that safeness is clearly not linear, straight, or neat. It is complicated and troubled by several factors as raised here. The social constructs on which agents draw revealed how social stigma influences and shapes bodily autonomy, patriarchy, SRHR, motherhood, self-imposed stigma, mental health post-termination, societal values rooted in culture, and religion, even in hidden safe spaces. The discourses emerging in the support centres are anchored in both the participants and agents' socio-cultural contexts. Discourses do not

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operate in a vacuum; they draw on existent ideologies (Fairclough, 1995). It is therefore not surprising to see discourses on religion and culture emerging to threaten bodily autonomy in these conversations. It is apparent that both clients and agents consume these discourses, and they are in tandem, redistributing these discourses to make sense of experiences shared in the support centre. Go back to the higher powers, they all believe in some higher power; hence the agent finds it easy to point the client to these powers.

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CHAPTER FIVE

5. CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The aim of this study was to explore support call centres as safe spaces for women to discuss abortion stigma experiences using mystery client telephone conversations with call centre agents. Mystery clients called into five support centres to discuss their post-abortion stigma experience at anonymous call centre 'safe spaces'. Agents' language introduced intersecting discourses that created and threatened safeness at the call centre.

Chapter 4 gave a short description of the participants and presented the study results. The results were analysed using discourse analysis. What emerged from these telephonic conversations was how procedurally, call centre processes of call recording and sharing contact details do not grant safeness in *anonymity* for women entering the space. However, all call centre conversations explored, to different degrees, women's understanding of bodily autonomy and exercising agency, while interacting with discourses of SRHR, mental health, motherhood, patriarchy, culture, and religion. I also emphasize this study's novelty in theoretical and methodological contributions. I could not find any studies that had used a mystery client approach in humanities, and the initial resistance to the use of this approach by the university's ethics committee is evidence enough to show that such an approach is not common practice in the discipline. I hope more scholars will adopt this method in exploring subjective experiences in 'hidden spaces' such as was done here and I fully recommend the approach to future studies. This chapter summarizes this study's theoretical and methodological contributions and gives recommendations for future studies.

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5. 2 Summary of findings

The literature review revealed that there is a dearth of knowledge on post-abortion support call centres and few studies on safeness at call centres providing counselling on abortion stigma experiences, from a feminist perspective. This made this study a necessary bookmark on call centre support in the increasingly digitized 21st century in the context of South Africa. The context is becoming even more important after the Covid-19 pandemic, which has accelerated the need to make the shift to digitized medical support all over the world. Going into the field, I found that Vincent Rue's 1981 pathologized understanding of abortion stigma fell away at the call centres. The manner in which most of the agents dealt with stigma by addressing the concerns and the way in which they drew upon existing discourses to make sense of their callers' experiences was dynamic. In most cases agents went out of their ways, to create safeness for women callers in call centres. Those callers who indicated how they felt isolated and misunderstood or judged were given space to discuss their experiences. These discussions pushed the callers to interrogate and make sense of their expeiences differently through lens of power, bodily autonomy and sexual reproductive health and rights.

Although previously associated with the social movements during civil rights movements (Ali, 2017), safe spaces as introduced to us by Brady (2005) focused on physical spaces. Drawing on Bullock et al. (2017), this study adopted the broader understanding of safe spaces as 'recuperative spaces' and as autonomy-validating *conversations* in non-face-to-face spaces of respite from social exclusion. In heeding Harris's (2005) call for spaces where young women can speak with little to no surveillance, this study conceptualized the call centre as a safe through adopting the social constructionist lens. Social constructionism allowed call centre agents and callers to co-create and reframe post-abortion stigma by

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visiting numerous discourses that feed into their own understanding of abortion stigma. Unlike what Mavuso et al. (2017) found, the support offered to the women calling into the call centre was non-directive, with agents co-creating or bringing broader understandings of abortion stigma so that the woman could move forward. The agents in this study did not bring in their own moral stance on abortion, in most cases, when in conversation with callers. They advocated for autonomy in their language and stressed the importance of bodily autonomy for the young women calling in, positioning these spaces as safe for women callers. True to the feminist lens (Land, 1995), the agents did not characterize the abortion experiences of callers as deviance, but framed these experiences as exercising of bodily autonomy and sexual reproductive health rights.

Burn (1992) stresses the importance of agents being obligated to provide counselling that is culturally appropriate. However, in addition to this there is the importance of individual psychological need. The agents smoothly carried callers through individual needs with cultural expectations visited for holistic 'healing' and easing of self-imposed stigma, even if these were mostly shaped by the dominant discourses in their socio-cultural setups. As mentioned by Cooper (2018) and evident from numerous discourses during the conversations, the autonomy and rights arguments for abortion was not just about 'exercising their right', but focused on how the decision to have an abortion had been emotionally taxing for women who must justify their bodily autonomy socially.

Similar to Rubin et al. (2008), in conceptualizing the stress of unwanted pregnancy, the agents seamlessly worked through what literature coined as situational (social, economic and cultural considerations) factors to mental health and coping post-abortion.

The CPCs that were included in the study denied callers any telephonic counselling, but their history on pre-abortion counselling has been documented. This study could not

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therefore contribute to the knowledge on post-abortion counselling offered by these organisations.

Although this was not the initial goal of the study, in retrospect the study can pass as a small-scale feminist monitoring and evaluation of support call centre. This is in line with the call of Yagnik et al. (2015), that developing countries should follow the example of developed countries such as Canada and the United Kingdom in adopting highly functional talk lines.

Entering the call centre as researchers, introduced the possibility of service providers responding differently when aware they were being monitored (see Boyce & Neale, 2006; Nalwadda et al., 2006). This made me choose the public health *mystery client* research method. Volunteers and I were the mystery clients at support call centres, entering these hidden support spaces seeking anonymity and non-socio-political resolution of a post-abortion stigma experience. All mystery client scripts expressed feeling alienated and stigmatized for having an abortion, be it self-imposed or by individuals in their personal circle. They also presented the inability to connect with a social circle to openly discuss their abortion stigma, therefore calling in to the call centre. Call centres are not typically recognised as 'safe spaces', nor are call centre agents seen as able to effectively engage in care work, like their face-to-face counselling. Not being able to rely on body language to ensure safeness, call centres adopted care work like practices such as using women's voices on the lines. Women's voices are perceived as more empathetic than male voices. All the call centres contacted in the study were managed by woman call centre agents. As a typically female-dominated industry, call centres embraced traditional care work elements of having female counsellors in support space settings (Garcia et al., 2003; Landes et al., 2013; Pikus & Heavey, 1996; Rodriguez, Power, & Glynn, 2021) giving an element of

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safeness to women callers. Female and male agents made for dynamic interactions with callers and their voices alone could reinforce safeness or cause tension in relatability for callers facing abortion stigma. On the one occasion of reaching a male lay counsellor at a support call centre, the call was quickly transferred to a woman agent. The male voice encountered at the secular call centre had a short conversation with the caller. The transfer to a female agent was presumably to create 'safeness in likeness' for the caller. This raised concerns about the burden on female agents at support centres as abortion stigma remains a women's conversation.

True to call centre fashion, calls at centres are recorded for quality assurance, with some of the recordings being used as training material for future agents (Woodcock, 2016). This study viewed remaining anonymous as safeness for callers. However, the expectation of anonymously accessing telephonic post-abortion support became more unrealistic with every call centre contacted. Call centre technological advancement and the RICA laws of South Africa that allow telecommunications and internet service providers access to users' metadata (State of Privacy South Africa, 2019), make anonymously accessing the call centres unlikely for women wanting to make use of these services. Although anonymity is not guaranteed, agents continuously used reassuring language during the conversations to bolster safeness by offering confidentiality.

When there is a reluctance to seek face-to-face support, alternatives such as telephonic support can help overcome help-seeking barriers related to stigma to encourage access to care for marginalized women (Patel et al., 2016, cited in Wallin, Maathz, Parling, & Hursti, 2018). The main focus of the study was call centres, but face-to-face counselling and support came up in all but two telephonic conversations. The caller was asked to 'call again soon' and reminded that the call centre was their space to discuss anything. As I learned

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during my meeting with a call centre manager, providers prefer face-to-face counselling, especially for abortion support, as they can better connect with 'mothers'. At some call centres callers were denied telephonic support and encouraged to book appointments although the websites said they offered telephonic support. Although the unsafeness of a call centre was noted in being unaccommodating, it was more apparent in denying callers support if they did not disclose their identity in the rigid short-lived conversations on the line if clients refused to come in.

Call centre agents were aware of abortion stigma and acknowledged the uneasiness of callers going through with face-to-face counselling. Post-abortion support call centre studies with a focus on coping with abortion stigma do not exist. The lack of literature on these rising hidden support spaces breeds room for unsafe trial-and-error methods being used by call centre agents for personalized support. Hanna's (2010) work echoes the concerns of the very basic training of volunteers or lay counsellors at some call centres. This gave context and reasons for why agents in this study referred callers to face-to-face sessions as calls ended. The fact that agents advised women to seek face-to-face support even after receiving telephonic counselling, shed light on the agent's perceived ineffectiveness of telephonic support, or rather the strong reliance on and belief in the effectiveness of traditional face-to-face support.

It was also noted that the personalized support offered to clients introduced numerous discourses working in parallel with abortion stigma experiences of women entering the call centre. Bodily autonomy and agency, which intersect with self-imposed stigma and the caller's personal circle, brought to light discourses of blame for rejecting motherhood (Herold, Kimport, Cockrill, 2015). Here we are reminded of how the public debate on abortion is rooted in the role in which society sees women (Cook et al., 1992). We also

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note how the abortion experience conversations primarily involved discourse on motherhood and the rejection of the 'natural calling' to motherhood (Yanshu et al., 2016). In the many untold stories of abortion, the stories that do get told are those of a tragic recourse and negative narratives of the pregnancy experience (McKinney, 2019). By framing abortion as tragic and traumatic experiences women have previously been able to morally recuperate for choosing abortion granting conditional autonomy for exercising reproductive autonomy.

Benevolent sexism (Yanushu et al., 2016) has previously influenced narratives related to motherhood. However, at the call centres in this study, call centre agents reshaped motherhood, or the rejection of motherhood, as an empowering stance. They provided support to women who had elective abortions. Unlike in the Bahr and Marco (2003) and Craig et al. (2002) studies, the language of call centre agents in this study and the call centre space did not subscribe to benevolent sexism and created safeness by providing support for women who had opted for elective abortions as well. Similar to Macleod, Feltham-King, Mavuso, and Morison (2019), agents deconstructed the idea of autonomous choice of abortion as failed motherhood. The call centre agents understood the callers as women who do not have to embrace 'normal' motherhood to fully be accepted by 'womanhood' in the broad spectrum of patriarchy.

Politicized public debates on abortion make exercising sexual reproductive health rights and openly discussing choices difficult. The restrictive reproductive health education on abortion, specifically by governments, and gag rules by NGO funders have created public unsafeness for women. However, this study revealed that call centre agents recognised themselves as providing respite from politicized abortion debate '*this is your space where*

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you need to feel free to ask me anything, anytime, anyhow... you're protected, your protection comes first before anything else'.

5. 3 Theoretical contributions of study

This study contributes to the limited knowledge of support call centres, particularly with a focus on post-abortion support. A keyword in this study, safe space, has not been used to describe the physical call centre, but as a way of describing the safeness of the conversations between callers and agents working at the call centre. Social constructivism as a framework is well-suited to gaining an understanding of the conversation co-created and reframed by the caller's subjective experience when interacting with the call centre agent. During an interaction, agents and callers constructed meanings of their experience drawing on their collective understanding of the external or broader social meanings attached to abortion, giving the clients social stigmatization as well as self-stigmatizing.

Discourse analysis

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Discourse analysis is described as a methodology and a theoretical framework (Anderson & Holloway, 2020). This dual action allowed for multidisciplinary analysis. Discourse analysis begins its claims on the importance of language by acknowledging that our ways of talking do not neutrally reflect our world, identities and social relations but rather play an active role in creating and changing them (Jørgensen & Phillips, 2002). This was evident in how agents drew on dominant sociocultural and political discourses to make sense of women's experiences in the call centre. Through discourse analysis, I was able to interrogate the nature of social action by dealing with how actions and/or meanings were constructed in and through text and talk in the call centres. It was important to note how

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agents drew on the discourses of patriarchy, womanhood, religion and culture, to locate as well as make sense of women's experiences of abortion stigma.

5. 4 Methodological contributions of this study

Due to the non-typical feminist and social science methodology of this study, venturing out into the field was delayed by the ethics committee. However, persistence with this methodology allowed for the study to take a transdisciplinary approach of a feminist perspective on a typically public health study. Authentic discussions between mystery clients and call centre agents at abortion support centres were possible, allowing for rich data on the everyday social discourses.

The principle of feminist qualitative research remained central to the data collection process. The researcher and volunteers calling into the call centre prevented the possible re-stigmatization of women who may have had traumatic pre-counselling experiences with service providers, as is commonly reported (Harries et al., 2009; Mamabolo, 2006; Mavuso & Macleod, 2020). The caller profiles and prompts were representative of the experiences of women outside the call centre who had no one, with whom to openly discuss the stigmatized choice. The mystery client approach was most relevant in this study as it allowed an authentic evaluation of how digitised hidden spaces such as abortion support call centres use language to create safeness/unsafeness for women seeking support with different layers of abortion stigma.

5. 5 Recommendations for future studies and suggestions

As a mini-thesis this study was limited in numerous ways. However, it is still an academic bookmark that can serve as a starting point for other studies to further explore this gendered area of public health and ICTs in the context of South Africa and Southern Africa. I

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identified discourses that emerge from post-abortion telephonic support centres while focusing on the language call centre agents used to discuss and understand stigmatized experiences of having an abortion in South Africa. The call centres in the study, although diverse, were limited to five. Considering the limited call centres in the country, it is recommended that future studies widen their scope by looking at other African countries that make use of e-health call centres for post-abortion support. Due to the ethics committee's conditions for approval of the study, I did not unpack the characteristics of the call centres as some of these characteristics would reveal the identity of the call centres.

I recommend a more comprehensive and gendered approach when researching call centre donor organisations and the morality ethos guiding the support offered. This can tell us more about the safeness of call centres. Whether abortion be accessible in safe or unsafe (illegally) circumstances women who need support are at risk of social stigma and legal prosecution if they pursue face to face counselling in some contexts. Questions around e-health and privacy/anonymity in countries where abortion is illegal remain unanswered, especially when considering the prosecution of women. Gendered research in this area is important, and with the advancement and implementation of e-health call centres in other African countries, there is a need for researchers to be one step ahead in ensuring holistic monitoring and evaluation in abortion restrictive countries. Discourse analysis allowed for in-depth unpacking of social fabrics that perpetuated stigma within conversation. Studies should not shy away from post-abortion support spaces because of restrictions on abortion in some countries, as women are still accessing abortion services and turning to hidden spaces, such as social media, seeking support.

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Appendix

Client profile

Name: Mbali

Age: 18

Educational background: In her matric

Relationship history and status: Dating her boyfriend Sihle for 1 year and he is in his second year at University. The relationship between them was good but has been stressful since finding out about the pregnancy and having the abortion.

Living arrangements: Lives with her grandmother and younger brother in a village. Moved to the village since her mother's passing, previously she stayed in a Johannesburg township.

Family: Mother recently passed away. She is on good relationship with her grandmother do not discuss sexual health and personal/emotional discussions. She has a hard time adjusting to the new community and feels as though she doesn't fit in.

Friends: Mbali has had a hard time making friends since moving to [village] and Mbali sees herself as more mature than the people around her at school. She has made one close friend named Nokuthula who she walks with to school. Mbali feels Nokuthula wont understand because she is still a virgin and loves talking about religion.

Circumstances surrounding pregnancy: Mbali was using the injection contraceptive when she was still staying with her mother in Johannesburg. She missed her last injection because her mother had fallen ill but thought that the hormones would still be in her system because she has been getting the injections for a while. With the stress following her mother falling ill she had thought she missed her period due to stress. Her boyfriend had tried assuring her that she was not pregnant because she was on the injection. She took a pregnancy test and the test was positive. Mbali felt shocked and overwhelmed; she and Sihle had spoken about starting a family one day but now was not the time with her mother being ill and unable to work.

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Other options considered: She considered continuing with the pregnancy but could not handle disappointing her mother whilst she was ill. Sihle had said his family would've helped but Mbali was unsure because their relationship was fairly new and she was still in school. Sihle was ultimately supportive of her decision to have the abortion.

Reasons to terminate pregnancy: She was still in high school, financially unstable, living circumstance unstable.

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Client profile

Name: Nozipho

Age: 25

Educational background: Completed her undergraduate and honours degree

Current occupation: financial advisor (trainee)

Relationship history and status: She had been dating her boyfriend Mandla for 1 year 6months. At the time of the relationship she was happy before the infidelity started and they broke up due to a lack of commitment and emotional unavailability on his end.

Living arrangements: She lives on her own. This is the first time she's been on her own since leaving university residence, but feel she has done well for herself.

Family: Nozipho is an only child to her mother who lives back home in Ladysmith where she was born. She is on good terms with mother but would not raise the pregnancy to her because she feels it was anyway irresponsible.

Friends: Nozipho is a very social person with someone around her constantly but all her close friends are from back home and hold very rigid ideas about sex and pregnancy out of wedlock.

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Circumstances surrounding pregnancy: Nozipho was not on any contraception and trusted Mandla enough to 'pull out' or tell her if a mistake had happened and they could get a morning after pill. When her period was late, she was sure she was pregnant because she has a very regular period. Mandla had brushed of her claims, Nozipho thinks it was because he might have thought she was doing it for attention because their relationship had ended. All of the tests came back positive and Nozipho knew immediately she could not keep the child because she had finally started a new job after numerous employment rejection letters. Nozipho felt overwhelmed and alone, at a time when she should be most happy because of the job she was sad because of she knew a child was a big responsibility.

Other options considered: She has always wanted children but only after she had married and had a stable income.

Reasons to terminate pregnancy: career was about to take off after a long stall and the break-up between her and the boyfriend at the time.

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Prompt script

1. I know the decision was for the best but I can't stop wishing I did things differently, I just feel so alone.

2. I wish that there were more people that I could talk to about this.

3. I know my boyfriend loves me and supports me, but I feel like he doesn't understand what I'm feeling (Mbali profile)

4. I feel sad because I would ultimately really like to parent, just not now.

5. I know that in time everything will be okay, I'm just having a hard time with it now.

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LIST OF REFERENCES

Abrahams, N., Jewkes, R., Lombard, C., Mathews, S., Campbell, J., & Meel, B. (2010). Impact of telephonic psycho-social support on adherence to post-exposure prophylaxis (PEP) after rape. *AIDS Care*, *22*(10), 1173–1181.

ACSW, R. L. E., & MSW, B. M. J. (1982). Group therapy by phone. *Social Work in Healthcare*, *7*(2), 79–90. https://doi.org/10.1300/J010v07n02_06

Adams, T. E. (2018). Looking out: gay bars, safe spaces, and the pulse massacre. *Qualitative Inquiry*, *24*(5), 338–339. https://doi.org/10.1177/1077800417741390

Adinma, J. I. B., Ikeako, L., Adinma, E. D., Ezeama, C. O., & Ugboaja, J. O. (2010). Awareness and practice of post-abortion care services among healthcare professionals in southeastern Nigeria. *The Southeast Asian Journal of Tropical Medicine and Public Health*, *41*(3), 696–704.

Alarcón, A., & Heyman, J. M. (2013). Bilingual call centres at the US-Mexico border: Location and linguistic markers of exploitability. *Language in Society*, *42*(01), 1–21. https://doi.org/10.1017/S0047404512000875

Alblas, M. (2020). A practitioner's experiences from the Netherlands and South Africa. *Sexual and Reproductive Health Matters*, *28*(1).

Ali, D. (2017). *Safe Spaces and Brave Spaces*. *1*(1), 13. Retrieved from http://files/432/Ali - 2017 - Safe Spaces and Brave Spaces.pdf

Allen, A. L. (1988). *Uneasy access: Privacy for women in a free society*. Rowman & Littlefield.

Alzate, M. M. (2009). The Role of Sexual and Reproductive Rights in Social Work Practice. *Affilia*, *24*(2), 108–119. https://doi.org/10.1177/0886109909331695

Anderson, K. T., & Holloway, J. (2020). Discourse analysis as theory, method, and epistemology in studies of education policy. *Journal of Education Policy*, *35*(2), 188–221.

Andrews, T. (2012). *What is Social Constructionism? 11*(1), 8. Retrieved from http://files/457/Andrews - 2012 - What is Social Constructionism.pdf

UNIVERSITY of the WESTERN CAPE

http://etd.uwc.ac.za/

Arullapan, N., Chersich, M. F., Mashabane, N., Richter, M., Geffen, N., Veary, J., Venter, W. D. F. (2018). Quality of counselling and support provided by the South African National AIDS Helpline: Content analysis of mystery client interviews. *South African Medical Journal*, *108*(7), 596. https://doi.org/10.7196/SAMJ.2018.v108i7.12543

Bahr, S. J., & Marcos, A. C. (2003). Cross-cultural attitudes toward abortion: Greeks versus Americans. *Journal of Family Issues*, *24*(3), 402–424.

Bambling, M., King, R., Reid, W., & Wegner, K. (2008). Online counselling: The experience of counsellors providing synchronous single-session counselling to young people. *Counselling and Psychotherapy Research*, *8*(2), 110–116. https://doi.org/10.1080/14733140802055011

Barilan, Y. M. (2012). Ulysses contracts and the nocebo effect. *The American Journal of Bioethics*, *12*(3), 37–39.

Barsom, E. Z., Jansen, M., Tanis, P. J., van de Ven, A. W. H., Blussé van Oud-Alblas, M., Buskens, C. J., … Schijven, M. P. (2020). Video consultation during follow up care: effect on quality of care and patient- and provider attitude in patients with colorectal cancer. *Surgical Endoscopy*. https://doi.org/10.1007/s00464-020-07499-3

Beadle-Holder, M. (2011). Black churches creating safe spaces to combat silence and stigma related to AIDS. *Journal of African American Studies*, *15*(2), 248–267.

Beattie, D., Cunningham, S., Jones, R., & Zelenko, O. (2006). 'I Use Online so the Counsellors can't Hear Me Crying': Creating Design Solutions for Online Counselling. *Media International Australia Incorporating Culture and Policy*, *118*(1), 43–52. https://doi.org/10.1177/1329878X0611800107

Beattie, D., Cunningham, S., Jones, R., & Zelenko, O. (2018). 'I use online so the counsellors can't hear me crying': creating design solutions for online counselling. *Media International Australia Incorporating Culture and Policy*, *118*(1), 43–52. https://doi.org/10.1177/1329878x0611800107

Bee, P., Lovell, K., Airnes, Z., & Pruszynska, A. (2016). Embedding telephone therapy in statutory mental health services: A qualitative, theory-driven analysis. *BMC Psychiatry*, *16*(1), 1–11. http://etd.uwc.ac.za/

Bobevski, I., Holgate, A. M., & Mclennan, J. (1997). Characteristics of effective telephone counselling skills. *British Journal of Guidance & Counselling*, *25*(2), 239–249. https://doi.org/10.1080/03069889708253805

Boulind, M., & Edwards, D. (2014). Journal of Psychology in Africa The Assessment and Treatment of Post-Abortion Syndrome: A Systematic Case Study From Southern Africa. *Africa*, *18*(4), 539–547. https://doi.org/10.1080/14330237.2008.10820233

Boyce, C., & Neale, P. (2006). *A Guide to Using Mystery Clients for Evaluation Input*. 20.

Brady, M. (2005). *Creating Safe Spaces and Building Social Assets for Young Women in the Developing World: A New Role for Sports*. 16. Retrieved from http://files/423/Brady - Creating Safe Spaces and Building Social Assets fo.pdf

Bryant, A. G., & Swartz, J. J. (2018). Why crisis pregnancy centres are legal but unethical. *AMA Journal of Ethics*, *20*(3), 269–277. https://doi.org/10.1001/journalofethics.2018.20.3.pfor1-1803

Bullock, H. E., Truong, S. V, & Chhun, L. (2017). Combatting social exclusion: "safe space" and the dynamics of inclusion at a homeless farming site. *Journal of Poverty*, *21*(2), 166–192. https://doi.org/10.1080/10875549.2016.1186774

Bullock, L. F. C., Browning, C., & Geden, E. (2002). Telephone social support for low-income pregnant women. *Journal of Obstetric, Gynaecologic & Neonatal Nursing*, *31*(6), 658–664. https://doi. org/10.1177/0884217502239217

Burr, V. (1995). An Introduction to Social Constructionism. London: Routledge

Burr, V. (2003). Social constructionism. London: Routledge.

Cense, M., de Neef, M., & Visscher, W. (2018). *Culture, religion and sexual and reproductive health \& rights*. Utrecht: Rutgers. Retrieved from https://www. rutgers. international/sites

Chiweshe, M., Mavuso, J., & Macleod, C. (2017). Reproductive justice in context: South African and Zimbabwean women's narratives of their abortion decision. *Feminism & Psychology*, *27*(2), 203–224. https://doi.org/10.1177/0959353517699234

Collective, T. R. (2014). Safe space: towards a reconceptualization: safe space: towards a reconceptualization. *Antipode*, *46*(5), 1346–1365.

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

https://doi.org/10.1111/anti.12089

Cooper, D., Dickson, K., Blanchard, K., Cullingworth, L., Mavimbela, N., von Mollendorf, C., … Winikoff, B. (2005). Medical abortion: the possibilities for introduction in the public sector in south Africa. *Reproductive Health Matters*, *13*(26), 35–43. https://doi.org/10.1016/S0968-8080(05)26203-1

Dadfar, M., & Lester, D. (2019). A study of callers to a telephone counseling service. *Illness, Crisis & Loss*, 1054137319833299.

Dadfar, M., Lester, D., Turan, Y., Beshai, J. A., & Unterrainer, H. F. (2019). Validation of the multidimensional inventory for religious spiritual well-being with Iranian samples. *Mental Health, Religion and Culture*, *22*(6), 591–601. https://doi.org/10.1080/13674676.2019.1628194

Dana, L.-P., & Dumez, H. (2015). Qualitative research revisited: epistemology of a comprehensive approach. *International Journal of Entrepreneurship and Small Business*, *26*(2), 154–170.

Davis, L. J. (2013). *The disability studies reader*. Routledge.

De Roure, S., & Capraro, C. (2016). Faith paths to overcome violence against women and girls in Brazil. *Gender & Development*, *24*(2), 205–218.

Dearing, J. A., Wang, R., Zhang, K., Dyke, J. G., Haberl, H., Hossain, M. S., … Poppy, G. M. (2014). Safe and just operating spaces for regional social-ecological systems. *Global Environmental Change*. https://doi.org/10.1016/j.gloenvcha.2014.06.012

Dehlendorf, C., Diedrich, J., Drey, E., Postone, A., & Steinauer, J. (2010). Preferences for decision-making about contraception and general healthcare among reproductive age women at an abortion clinic. *Patient Education and Counselling*, *81*(3), 343–348. https://doi.org/10.1016/j.pec.2010.06.021

DeRobertis, E. M., & Bland, A. M. (2018). Tapping the humanistic potential of self-determination theory: Awakening to paradox. *The Humanistic Psychologist*, *46*(2), 105–128. https://doi.org/10.1037/hum0000087

DeVault, M. L., & Gross, G. (2012). Feminist qualitative interviewing: experience, talk, and knowledge. In *Handbook of Feminist Research: Theory and Praxis* (pp. 206–

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

236). Retrieved from http://methods.sagepub.com/book/handbook-of-feminist-research/n11.xml

Dick, H. P., & Arnold, L. (2018). From South to North and back again: Making and blurring boundaries in conversations across borders. *Language & Communication*, *59*, 17–27. https://doi.org/10.1016/j.langcom.2017.02.005

Dodds, S. (2016). *Social contexts and health*. (February).

Downie, R. S., & Telfer, E. (1971). Autonomy. *Philosophy*, *46*(178), 293–301. https://doi.org/10.1017/S0031819100016934

Dozier, J. L., Hennink, M., Mosley, E., Narasimhan, S., Pringle, J., Clarke, L., … others. (2020). Abortion attitudes, religious and moral beliefs, and pastoral care among Protestant religious leaders in Georgia. *PloS One*, *15*(7), e0235971.

du Plessis, U., Sofika, D., Macleod, C., & Mthethwa, T. (2019). *Assessing the impact of the expanded Global Gag Rule in South Africa*. International Women's Health Coalition.

Eidmann, K. A. (2011). Acuna and the Abortion Right: Constraints on Informed-Consent Litigation. *Colum. J. Gender \& L.*, *20*, 262.

Ells, C., Hunt, M. R., & Chambers-Evans, J. (2019). *Relational autonomy as an essential component of patient-centred care*. 24. Retrieved from http://files/526/Ells et al. - 2019 - Relational autonomy as an essential component of p.pdf

Ely, G E. (2007). The abortion counselling experience: A discussion of patient narratives and recommendations for best practices. *Best Practice in Mental Health*, *3*(2), 62–74.

Esia-Donkoh, K., Darteh, E. K. M., Asare, H., & Blemano, H. (2015). Who cares? pre and post-abortion experiences among young females in Cape Coast Metropolis, Ghana. *African Journal of Reproductive Health*, *19*(2), 43–51. Retrieved from http://files/363/24877769.pdf

Ferree, M. M. (2003). Resonance and Radicalism: Feminist Framing in the Abortion Debates of the United States and Germany. *American Journal of Sociology*, *109*(2), 304–344. https://doi.org/10.1086/378343

Fitzpatrick, A., & Tumlinson, K. (2017). Strategies for optimal implementation of

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

simulated clients for measuring quality of care in low- and middle-income countries. *Global Health: Science and Practice*, *5*(1), 108–114. https://doi.org/10.9745/GHSP-D-16-00266

Forey, G., & Lockwood, J. (2010). G*lobalization, communication and the workplace: talking across the world*. Retrieved from https://books.google.co.za/books?id=Uudzpa2A0v8C

Fairclough, N. (1995). *Critical discourse analysis*. Longman London

Frelich Appleton, S., Frelich, S., Frelich Appletont, S., Davis, A., Hollander-Blumoff, R., Hughes, E., … McGarr, C. (2011). Reproduction and regret. In *Yale Journal of Law & Feminism Article* (Vol. 23). Retrieved from http://digitalcommons.law.yale.edu/yjlf/vol23/iss2/2

Friginal, E. (2008). Linguistic variation in the discourse of outsourced call centres. *Discourse Studies*, *10*(6), 715–736. https://doi.org/10.1177/1461445608096570

Friginal, Eric. (2009). *The language of outsourced call centers: a corpus-based study of cross-cultural interaction*. Retrieved from https://books.google.co.za/books?id=Te05AAAAQBAJ

Friginal, Eric. (2013). Evaluation of oral performance in outsourced call centres: An exploratory case study. *English for Specific Purposes*, *32*(1), 25–35. https://doi.org/10.1016/j.esp.2012.06.002

Frohwirth, L., Coleman, M., & Moore, A. M. (2018). Managing religion and morality within the abortion experience: Qualitative interviews with women obtaining abortions in the US. *World Medical \& Health Policy*, *10*(4), 381–400.

Galbin, A. (2014). An introduction to social constructionism. *Social Research Report*s, 6(26), 82-92

Garcia, J. A., Paterniti, D. A., Romano, P. S., & Kravitz, R. L. (2003). Patient preferences for physician characteristics in university-based primary care clinics. *Ethnicity and Disease*, *13*(2), 259–267.

Gavey, N. (1989). Feminist poststructuralism and discourse analysis: Contributions to feminist psychology. *Psychology of Women Quarterly*, *13*(4), 459–475.

http://etd.uwc.ac.za/

Gavey, N. (2011). Feminist poststructuralism and discourse analysis revisited. *Psychology of Women Quarterly*, *35*(1), 183–188.

Gergen, K. J. (1985). Social constructionist inquiry: Context and implications. In *The social construction of the person* (pp. 3–18). Springer.

Gergen, S. J. (1992). *Therapy as social construction* (Vol. 10). Sage.

Gergen K. J. (1994). *Realities and relationships.* Cambridge, MA: Harvard University Press.

Gilman, M. E. (2008). Welfare, Privacy, and Feminism. *U. Balt. LF*, *39*, 1.

Gilman, M., & Green, R. (2018). The surveillance gap: The harms of extreme privacy and data marginalization. *NYU Rev. L. & Soc. Change*, *42*, 253.

Goetsch, D., Jordan, C., Jung, C., Lampman, L., Nobbs, S., & Ruiz, C. (2010). Students' attitudes, beliefs and plans regarding career planning and post- college life. *St Olaf College*, 1–25.

Goffman, E. (1963). Stigma and social identity. *Understanding deviance: Connecting Classical and Contemporary Perspectives*, *256*, 265.

Griffin, C. (2019). *The truth about crisis pregnancy centres*.

Gwinnell, E. (2003). Unique aspects of internet relationships. *Telepsychiatry and E-Mental Health*, 327–336.

Gynmed. (2017). Countries Where Abortion Is Illegal Under Most Circumstances.

Hanna, S. (2010). Call Centres As Sites of Professional Practice: "Where Old Social Workers Go to Die"? *Australian Social Work*, *63*(3), 266–280. https://doi.org/10.1080/0312407X.2010.497966

Harries, J., Gerdts, C., Momberg, M., & Greene Foster, D. (2015). An exploratory study of what happens to women who are denied abortions in Cape Town, South Africa. *Reproductive Health*, *12*(1). https://doi.org/10.1186/s12978-015-0014-y

Harries, J., Stinson, K., & Orner, P. (2009). Healthcare providers' attitudes towards termination of pregnancy: A qualitative study in South Africa. *BMC Public Health*, *9*, 296. https://doi.org/10.1186/1471-2458-9-296

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

Harris, A. (2005). VII. discourses of desire as governmentality: young women, sexuality and the significance of safe spaces. *Feminism & Psychology*, *15*(1), 39–43. https://doi.org/10.1177/0959353505049702

Hebenstreit, H. (2017). The national association of social workers code of ethics and cultural competence: What does anne Fadiman's the spirit catches you and you fall down teach us today? *Health & Social Work*, *42*(2), 103–107. https://doi.org/10.1093/hsw/hlx007

Herold, S., Kimport, K., & Cockrill, K. (2015). Women's private conversations about abortion: A qualitative study. *Women & Health*, *55*(8), 943–959.

Hesse-Biber, S. N. (2012). Feminist research: exploring, interrogating, and transforming the interconnections of epistemology, methodology, and method. In *Handbook of Feminist Research: Theory and Praxis* (pp. 2–26). Retrieved from http://methods.sagepub.com/book/handbook-of-feminist-research/n1.xml

Hoey, L. M., Ieropoli, S. C., White, V. M., & Jefford, M. (2008). Systematic review of peer-support programs for people with cancer. *Patient Education and Counselling*, *70*(3), 315–337.

Hoffman, K. (2013). Surviving sex trafficking: Recovery and healing. *Good Practice in Promoting Recovery and Healing for Abused Adults*, 117–136.

Hoggart, L. (2017). Internalised abortion stigma: Young women's strategies of resistance and rejection. *Feminism & Psychology*, *27*(2), 186–202. https://doi.org/10.1177/0959353517698997

Holcombe, S. J., Berhe, A., & Cherie, A. (2015). Personal beliefs and professional responsibilities: Ethiopian midwives' attitudes toward providing abortion services after legal reform. *Studies in Family Planning*, *46*(1), 73–95. Retrieved from http://files/353/personal belief and professional responsibilities Ethopian midwives.pdf

Holtzman, B. (2017). Have crisis pregnancy centers finally met their match: California's Reproductive Fact Act. *Northwestern Journal of Law and Social Policy*, *12*(3), 78.

Huang, Y., Davies, P. G., Sibley, C. G., & Osborne, D. (2016). Benevolent sexism, attitudes toward motherhood, and reproductive rights: A multi-study longitudinal

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

examination of abortion attitudes. *Personality and Social Psychology Bulletin*, *42*(7), 970–984.

Huber, K. (2018). *Pregnancy Counselling and Abortion Politics: Exploring the Effects of the Expanding Therapeutic Culture in US Society*.

Innovatemedtec. (2018, July 25). *ehealth - what is ehealth?* Retrieved from https://innovatemedtec.com/digital-health/ehealth

Irvine, A., Drew, P., Bower, P., Brooks, H., Gellatly, J., Armitage, C. J., … Bee, P. (2020). Are there interactional differences between telephone and face-to-face psychological therapy? A systematic review of comparative studies. *Journal of Affective Disorders*, *265*, 120–131.

Jørgensen, M., & Phillips, L. (2002). *Discourse Analysis as Theory and Method*. Retrieved from http://methods.sagepub.com/book/discourse-analysis-as-theory-and-method

Kamuren, L. J., Kamara, E., & Ntabo, M. (2017). Perceptions of high school students on the need for sex education in secondary schools, Eldoret Municipality, Kenya. *European Journal of Education Studies*.

Katz, J. (2017). Advocacy above the fray? Limitations of the pro-voice approach to supporting abortion patients. *Feminism & Psychology*, *27*(2), 243–250. https://doi.org/10.1177/0959353517696514

Kay, M. (2011). mHealth: New horizons for health through mobile technologies World Health Organization Global Observatory for eHealth. *GSMA MHA Mobile Health Summit Cape Town*, (June).

Kelly, K. (2012). In the name of the mother: renegotiating conservative women's authority in the crisis pregnancy center movement. *Signs: Journal of Women in Culture and Society*, *38*(1), 203–230. https://doi.org/10.1086/665807

Kim, S. A. (2005). Reconstructing family privacy. *Hastings* LJ, 57, 557-600.

Kimport, K. (2012). (Mis)understanding abortion regret. *Symbolic Interaction*, *35*(2), 105–122. Retrieved from http://www.jstor.org/stable/symbinte.35.2.105

Kimport, K., Foster, K., & Weitz, T. A. (2011). Social sources of women's emotional difficulty after abortion: lessons from women's abortion narratives. *Perspectives on*

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

Sexual and Reproductive Health, *43*(2), 103–109. https://doi.org/10.1363/4310311

Kimport, K., Perrucci, A., & Weitz, T. A. (2012). Addressing the Silence in the Noise: How Abortion Support Talklines Meet Some Women's Needs for Non-Political Discussion of Their Experiences. *Women & Health*, *52*(1), 88–100. https://doi.org/10.1080/03630242.2011.643348

Kinnane, N. A., Waters, T., & Aranda, S. (2011). Evaluation of a pilot 'peer support'training programme for volunteers in a hospital-based cancer information and support centre. *Supportive Care in Cancer*, *19*(1), 81–90.

Kondylis, F., Legovini, A., Vyborny, K., Zwager, A. M. T., & Cardoso De Andrade, L. (2020). Demand for Safe Spaces: Avoiding Harassment and Stigma. *World Bank Policy Research Working Paper*, (9269).

Kumar, A., Hessini, L., & Mitchell, E. M. H. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality*, *11*(6), 625–639. https://doi.org/10.1080/13691050902842741

Kumbi, Solomon, Y. (2008). *Quality of PAC in public health facilitied in Ethiopia.pdf* (pp. 26–33). pp. 26–33.

Kushner, E. (1997). *Experiencing Abortion: A Weaving of Women's Words*. Retrieved from https://books.google.co.za/books?id=YRDpsV73X3sC

Landes, S. J., Burton, J. R., King, K. M., & Sullivan, B. F. (2013). Women's preference of therapist based on sex of therapist and presenting problem: An analog study. *Counselling Psychology Quarterly*, *26*(3–4), 330–342. https://doi.org/10.1080/09515070.2013.819795

Lannin, D. G., Vogel, D. L., Brenner, R. E., & Tucker, J. R. (2015). *Predicting Self-Esteem and Intentions to Seek Counselling : The Internalized Stigma Model*. https://doi.org/10.1177/0011000014541550

Laroche, K. J., & Foster, A. M. (2017). *"I kind of feel like sometimes I am shoving it under the carpet": Documenting women's experiences with post-abortion support in Ontario*. https://doi.org/10.1139/facets-2017-0059

LaRoche, K. J., & Foster, A. M. (2015a). Toll free but not judgment free: evaluating

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

postabortion support services in Ontario. *Contraception*, *92*(5), 469–474. https://doi.org/10.1016/j.contraception.2015.08.003

LaRoche, K. J., & Foster, A. M. (2015b). Toll free but not judgment free: evaluating postabortion support services in Ontario. *Contraception*, *92*(5), 469–474. https://doi.org/10.1016/j.contraception.2015.08.003

Lazar, M. M. (2007). Feminist critical discourse analysis: Articulating a feminist discourse praxis. *Critical Discourse Studies*, *4*(2), 141–164.

Lee, E. (2003). *Abortion, motherhood, and mental health: medicalizing reproduction in the United States and Great Britain*. Transaction Publishers.

Lewis, R., Sharp, E., Remnant, J., & Redpath, R. (2015). 'Safe Spaces': Experiences of Feminist Women-Only Space. *Sociological Research Online*, *20*(4), 1–14. https://doi.org/10.5153/sro.3781

Lithur, N. O. (2004). Destigmatising abortion: expanding community awareness of abortion as a reproductive health issue in Ghana. *African Journal of Reproductive Health*, *8*(1), 70. https://doi.org/10.2307/3583308

Loeber, O. E., & Muntinga, M. E. (2017). Contraceptive counselling for women with multiple unintended pregnancies: the abortion client's perspective. *The European Journal of Contraception & Reproductive Healthcare*, *22*(2), 94–101. https://doi.org/10.1080/13625187.2017.1283399

Ludwikowski, W. M. A., Vogel, D., & Armstrong, P. I. (2009). *Attitudes Toward Career Counselling: The Role of Public and Self-Stigma*. 1–9. https://doi.org/10.1037/a0016180

Lynch, I., Morison, T., Macleod, C. I., Mijas, M., du Toit, R., & Seemanthini, S. (2018). From deviant choice to feminist issue: An historical analysis of scholarship on voluntary childlessness (1920--2013). In *Voluntary and Involuntary Childlessness*. Emerald Publishing Limited.

Macleod, C. I., Feltham-King, T., Mavuso, J. M.-J. J., & Morison, T. (2019). 'Failed'mothers,'failed'womxn: Demarcating normative mothering. In *Intersections of Mothering* (pp. 30–43). Routledge.

http://etd.uwc.ac.za/

Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). Abortion and Mental Health: Evaluating the Evidence. *American Psychologist*, *64*(9), 863–890. https://doi.org/10.1037/a0017497

Malan, M. (2017, August 6). Only 40% of public clinics provide abortions: Study. *SABC News - Breaking News, Special Reports, World, Business, Sport Coverage of All South African Current Events. Africa's News Leader.* Retrieved from http://www.sabcnews.com/sabcnews/only-40-of-public-clinics-provide-abortions-study/

Mamabolo, L. R. C. (2006). *The experiences of registered nurses involved in termination of pregnancy at Soshanguve Community Health Centre*.

Manhal-baugus, M., Ed, D., & Way, W. (2001). *E-Therapy : Practical , Ethical , and Legal Issues*.

Marecek, J., Macleod, C., & Hoggart, L. (2017). Abortion embedded and embodied in social relations: Challenges for feminist psychology. *Feminism & Psychology*, *27*(2), 133–143. https://doi.org/10.1177/0959353517704877

Marlow, H. M., Wamugi, S., Yegon, E., Fetters, T., Wanaswa, L., & Msipa-Ndebele, S. (2014). Women's perceptions about abortion in their communities: perspectives from western Kenya. *Reproductive Health Matters*, *22*(43), 149–158. Retrieved from http://files/355/womens perceptions and abortion in their communities perspective from western Kenya.pdf

Martin, L. A., Debbink, M., Hassinger, J., Youatt, E., Harris, L. H., Martin, L. A., … Youatt, E. (2014). Measuring Stigma Among Abortion Providers : Assessing the Abortion Provider Stigma Survey Instrument Measuring Stigma Among Abortion Providers : *Women & Health*, *54*(7), 641–661. https://doi.org/10.1080/03630242.2014.919981

Mavuso, J. M.-J. J., & Macleod, C. I. (2020). Resisting abortion stigma in situ: South African womxn's and healthcare providers' accounts of the pre-abortion counselling healthcare encounter. *Culture, Health \& Sexuality*, *22*(11), 1299–1313.

Mavuso, J. M. J., Chiweshe, M. T., & Macleod, C. I. (2018). ' Choice ' in women ' s abortion decision-making narratives : Introducing a supportability approach. *Pins*, *59*,

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

20–40.

McBride, D. E., & Keys, J. L. (2018). *Abortion in the United States: A Reference Handbook, 2nd Edition*. Retrieved from https://books.google.co.za/books?id=0tliDwAAQBAJ

Mchome, Z., Richards, E., Nnko, S., Dusabe, J., Mapella, E., & Obasi, A. (2015). A 'mystery client' evaluation of adolescent sexual and reproductive health services in health facilities from two regions in Tanzania. *PLOS ONE*, *10*(3), e0120822. https://doi.org/10.1371/journal.pone.0120822

McKinney, C. (2019). A good abortion is a tragic abortion: fit motherhood and disability stigma. *Hypatia*, *34*(2), 266–285.

McNamee, S. (2004). Social construction as practical theory: lessons for practice and reflection in psychotherapy. *Collaborative Practice in Psychology and Therapy*, 9–21.

Mduma, N., & Kalegele, K. (2015). *An Integrated Mobile Application for Enhancing Management of Nutrition Information in Arusha Tanzania*. Retrieved from http://arxiv.org/abs/1508.03441

Meehan, S.-A., & Broom, Y. (2007). Analysis of a National Toll Free Suicide Crisis Line in South Africa. *Suicide and Life-Threatening Behavior*, *37*(1), 66–78. https://doi.org/10.1521/suli.2007.37.1.66

Melvin, E. (2021). Investigating dramatherapists' experiences of adult clients' stigma in relation to their mental health difficulties. *The Arts in Psychotherapy*, *73*, 101768.

Millard, R. (2018, August 5). Ireland tipped to repeal abortion ban by a landslide. *News24*. Retrieved from https://www.news24.com/World/News/ireland-tipped-to-repeal-abortion-ban-by-a-landslide-20180526

Milutinovic, M., & De Decker, B. (2016). Ethical aspects in eHealth--design of a privacy-friendly system. *Journal of Information, Communication and Ethics in Society*.

Motta, S., Penn-Kekana, L., & Bewley, S. (2015). Domestic violence in a UK abortion clinic: anonymous cross-sectional prevalence survey. *Journal of Family Planning and Reproductive Healthcare*, *41*(2), 128–133.

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

Murphy, P. T., Clogher, L., Van Laar, A., O'Regan, R., McManus, S., McIntyre, A., … Hallahan, B. (2019). The impact of service user's suicide on mental health professionals. *Irish Journal of Psychological Medicine*, 1–11.

Myers, J. E., & Sweeney, T. J. (2008). Wellness counselling: The evidence base for practice. *Journal of Counselling and Development*, *86*(4), 482–493. https://doi.org/10.1002/j.1556-6678.2008.tb00536.x

Nalwadda, G., Mirembe, F., Byamugisha, J., Tumwesigye, N. M., & Faxelid, E. (2016). Young peoples' interface with providers of contraceptive care: a simulated client study in two Ugandan districts. *Contraception and Reproductive Medicine*, *1*(1). https://doi.org/10.1186/s40834-016-0027-0

Ngwena, C. G. (2010). Inscribing abortion as a human right: significance of the protocol on the rights of women in Africa. *Human Rights Quarterly*, *32*(4), 783–864. Retrieved from http://www.jstor.org/stable/40930337

Ngwena, C. (2004). Conscientious objection and legal abortion in South Africa: delineating the parameters. *Journal for Juridical Science*, *28*(1). https://doi.org/10.4314/jjs.v28i1.27128

Ngwena, Charles. (2013). Access to safe abortion as a human right in the African region: lessons from emerging jurisprudence of un treaty monitoring bodies. *South African Journal on Human Rights*, *29*(2), 399–428. https://doi.org/10.1080/19962126.2013.11865080

Nienaber, A., & Bailey, K. N. (2016). The right to physical integrity and informed refusal: Just how far does a patient's right to refuse medical treatment go? *South African Journal of Bioethics and Law*, *9*(2), 73. https://doi.org/10.7196/sajbl.2016.v9i2.472

Nkosi, L. J., Mulaudzi, F. M., & Peu, M. D. (2020). Challenges related to the structure of the choice on termination of pregnancy services in public health facilities in the Tshwane District of Gauteng. *African Journal of Reproductive Health*, *24*(1), 106–114.

NW, 1615 L St, Washington, S. 800, & Inquiries, D. C. 20036 U.-419-4300 | M.-419-4349 | F.-419-4372 | M. (2013, June 8). A history of key abortion rulings of the u.s. supreme court. *Pew Research Center's Religion & Public Life Project*. Retrieved from

http://etd.uwc.ac.za/

http://www.pewforum.org/2013/01/16/a-history-of-key-abortion-rulings-of-the-us-supreme-court/

Ojo, A. I. (2018). mHealth Interventions in South Africa: A Review. *SAGE Open*, Vol. 8. https://doi.org/10.1177/2158244018767223

Opotow, S. (2012). The scope of justice, intergroup conflict, and peace. In *Oxford Library of Psychology. The Oxford handbook of intergroup conflict.* (pp. 72–86). New York, NY, US: Oxford University Press.

Osborne, D., & Davies, P. G. (2009). Social dominance orientation, ambivalent sexism, and abortion: Explaining pro-choice and pro-life attitudes. *Personality Assessment: New Research*, 309–320.

Parker, T. (2019). *Where Do We Go From Here?: Two Key Informants' Perspectives on How to Address Conscientious Objection in TOP Provision in South Africa*.

Patel, V., Chisholm, D., Parikh, R., Charlson, F. J., Degenhardt, L., Dua, T., … others. (2016). Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities. *The Lancet*, *387*(10028), 1672–1685.

Payne, C. M., Debbink, M. P., Steele, E. A., Buck, C. T., Martin, L. A., Hassinger, J. A., & Harris, L. H. (2013). *Why Women Are Dying from Unsafe Abortion: Narratives of Ghanaian Abortion Providers*. Retrieved from http://www.jstor.org/stable/23485926

Pikus, C. F., & Heavey, C. L. (1996). Client preferences for therapist gender. *Journal of College Student Psychotherapy*, *10*(4), 35–43.

Press, T. F., & York, N. (2018). *Creating safe spaces and building social assets for young women in the developing world: a new role for sports author (s): Martha Brady Source : Women ' s Studies Quarterly , Vol . 33 , No . 1 / 2 , Women and Sports (Spring - Published by : The Femini*. *33*(1), 35–49.

Ratele, K., Shefer, T., & Clowes, L. (2012). Talking South african fathers: a critical examination of men's constructions and experiences of fatherhood and fatherlessness. *South African Journal of Psychology*, *42*(4), 553–563.https://doi.org/10.1177/008124631204200409

Rawson, S., & Maidment, J. (2011). Email counselling with young people in Australia: A

http://etd.uwc.ac.za/

research report. *Women in Welfare Education*, *10*(10), 14–28. Retrieved from http://go.galegroup.com.ezproxy.liberty.edu:2048/ps/retrieve.do?retrieveFormat=PDF_FROM_CALLISTO&accesslevel=FULLTEXT_WITH_GRAPHICS&inPS=true&prodId=AONE&userGroupName=vic_liberty&tabID=&workId=PI-1UBW-2011-DEC00-IDSI-14.JPG%7CPI-1UBW-2011-DEC00-IDSI-15.J

Reddy, V., Meyer, S., Shefer, T. & Meyiwa, T. (2014). Towards a critical theory of care. In: Reddy, V., Meyer, S., Shefer, T. & Meyiwa, T. (eds). *Care in context: transnational gender perspective* (p. 1-27). Cape Town: HSRC Press.

Remez, L., Mayall, K., & Singh, S. (2020). Global developments in laws on induced abortion: 2008–2019. *International Perspectives on Sexual and Reproductive Health*, *46*, 53–65. https://doi.org/10.1363/46e0920

Robb, J. E. (1920). Having right and being right. *The International Journal of Ethics*, *30*(2), 196–212.

Rodriguez, L., Power, E., & Glynn, E. (2021). Introduction to domestic violence, abuse, and coercive control for counsellors: An evaluation of the impact of training. *Gender, Work \& Organization*, *28*(2), 547–557.

Rondinelli, D. A., McCullough, J. S., & Johnson, R. W. (1989). Analysing Decentralization Policies in Developing Countries: a Political-Economy Framework. *Development and Change*, *20*(1), 57–87. https://doi.org/10.1111/j.1467-7660.1989.tb00340.x

Rosen, J. D. (2012). *V I E W P O I N T* (Vol. 44). Retrieved from http://www.chsourcebook.com/articles/

Rowlands, S. (2011). Misinformation on abortion. *European Journal of Contraception and Reproductive Healthcare*. https://doi.org/10.3109/13625187.2011.570883

Rubin, L., & Russo, N. F. (2014). Abortion and mental health: What therapists need to know. *From Menarche to Menopause: The Female Body in Feminist Therapy*, *27*(3–4), 69–90. https://doi.org/10.4324/9781315864716-10

Rubin, L., Russo, N. F., & Russo, N. F. (2008). *Abortion and Mental Health Abortion and Mental Health : What Therapists Need to Know*. *3149*(2004). https://doi.org/10.1300/J015v27n03

Ryan, R. M., & Deci, E. L. (2008). A self-determination theory approach to psychotherapy:

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

The motivational basis for effective change. *Canadian Psychology/Psychologie Canadienne*, *49*(3), 186–193. https://doi.org/10.1037/a0012753

Salfi, J., Ploeg, J., & Black, M. E. (2005). Seeking to Understand Telephone Support for Dementia Caregivers. *Western Journal of Nursing Research*, *27*(6), 701–721. https://doi.org/10.1177/0193945905276882

Shapiro, G. (2014). Voluntary childlessness: A critical review of the literature. *Studies in the Maternal*, *6*(1).

Sheldon, K. M., & Bettencourt, B. A. (2002). Psychological need-satisfaction and subjective well-being within social groups. *British Journal of Social Psychology*, *41*(1), 25–38. https://doi.org/10.1348/014466602165036

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63–75.

Sibley, C. G., Huang, Y., Davies, P. G., Sibley, C. G., & Osborne, D. (2016). B*enevolent sexism , attitudes toward motherhood , and reproductive rights : a multi-study longitudinal examination of abortion attitudes*. (May). https://doi.org/10.1177/0146167216649607

Siegel, R. B. (2008). Lectures the right's reasons: constitutional conflict and the spread of woman-protective anti-abortion argument. Retrieved from http://www.operationoutcry.org

SIEGEL, R. B. (2008). The right's reasons: constitutional conflict and the spread of woman- protective anti-abortion argument. *duke law journal*, *57*, 52. retrieved from http://files/440/Siegel - the right's reasons constitutional conflict.pdf

Sitzmann, T., Brown, K. G., Casper, W. J., Ely, K., & Zimmerman, R. D. (2008). A review and meta-analysis of the nomological network of trainee reactions. *Journal of Applied Psychology*, *93*(2), 280.

Steinberg, J. R., Laursen, T. M., Adler, N. E., Gasse, C., Agerbo, E., & Munk-Olsen, T. (2018). Examining the association of antidepressant prescriptions with first abortion and first childbirth. *JAMA Psychiatry*, *75*(8), 828–834.

Stotland, N. L. (2011). Psychiatric aspects of induced abortion. *The Journal of Nervous*

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

and Mental Disease, *199*(8). Retrieved from https://journals.lww.com/jonmd/Fulltext/2011/08000/Psychiatric_Aspects_of_Induced_Abortion.11.aspx

Strang, A. B., & Ager, A. (2003). Psychosocial interventions: Some key issues facing practitioners. *Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict*, *1*(January), 2–12. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc4&NEWS=N&AN=2004-19714-001

Suite, S. N. W., & Dc, W. (2006). *Crisis Pregnancy Centers: An Affront to Choice*. 4–5. Retrieved from www.prochoice.org

Tabbutt-henry, A. J., & Graff, K. (2019). *Client-provider communication in postabortion care stable URL : https://www.jstor.org/stable/3181078 Client-Provider Communication in Postabortion Care*. *29*(3), 126–129.

Tannen, D. (2012). Discourse analysis--What speakers do in conversation. *Linguistic Society of America*.

Tesfaye, G., & Oljira, L. (2013). Post-abortion care quality status in health facilities of Guraghe zone, Ethiopia. *Reproductive Health*, *10*(1), 35. https://doi.org/10.1186/1742-4755-10-35

Tremont, G., Duncan Davis, J., Bishop, D. S., & Fortinsky, R. H. (2008). Telephone-delivered psychosocial intervention reduces burden in dementia caregivers. *Dementia*, *7*(4), 503–520. https://doi.org/10.1177/1471301208096632

Truong, K. A., & Museus, S. D. (2012). Responding to racism and racial trauma in doctoral study: An inventory for coping and mediating relationships. *Harvard Educational Review*, *82*(2), 226–254. Retrieved from http://hepg.org/her-home/issues/harvard-educational-review-volume-82-number-2/herarticle/an-inventory-for-coping-and-mediating-relationship

Tucker, I. (2010). Mental health service user territories: Enacting 'safe spaces' in the community. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *14*(4), 434–448. https://doi.org/10.1177/1363459309357485

Tuli, F. (2010). The basis of distinction between qualitative and quantitative research in

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

social science: Reflection on ontological, epistemological and methodological perspectives. *Ethiopian Journal of Education and Sciences*, *6*(1).

Uddin, J., Biswas, T., Adhikary, G., Ali, W., Alam, N., Palit, R., … Bhuiya, A. (2017). Impact of mobile phone-based technology to improve health, population and nutrition services in Rural Bangladesh: A study protocol. *BMC Medical Informatics and Decision Making*, *17*(1), 1–9. https://doi.org/10.1186/s12911-017-0502-9

Upadhyay, U. D., Cockrill, K., & Freedman, L. R. (2010a). Informing abortion counselling: An examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues. *Patient Education and Counselling*, *81*(3), 415–421. https://doi.org/10.1016/j.pec.2010.08.026

Vattø, I. E., Lien, L., DeMarinis, V., Kjørven Haug, S. H., & Danbolt, L. J. (2019). Caught Between Expectations and the Practice Field. *Crisis*, *40*(5), 340–346. https://doi.org/10.1027/0227-5910/a000573

Vincent, L. (2012). Shaking a hornets' nest: pitfalls of abortion counselling in a secular constitutional order – a view from South Africa. *Culture, Health & Sexuality*, *14*(2), 125–138. https://doi.org/10.1080/13691058.2011.627469

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). *Perceived public stigma and the willingness to seek counselling: the mediating roles of self-stigma and attitudes toward counselling perceived public stigma and the willingness to seek counselling: the mediating roles of self-stigma and attitudes toward co*. (June 2014). https://doi.org/10.1037/0022-0167.54.1.40

Wachholz, S. (2005). Hate crimes against the homeless: Warning-out new England style. *Journal of Sociology and Social Welfare*, *32*(4), 141–163.

Wallin, E., Maathz, P., Parling, T., & Hursti, T. (2018). Self-stigma and the intention to seek psychological help online compared to face-to-face. *Journal of Clinical Psychology*, *74*(7), 1207–1218.

Wasielewski, P. L. (1992). Post-abortion Syndrome: Emotional battles over interaction and ideology. *Humboldt Journal of Social Relations*, 101–129. Retrieved from http://files/364/23262748.pdf

Wasson, J., Gaudette, C., Whaley, F., Sauvigne, A., Baribeau, P., & Welch, H. G. (1992).

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

Telephone Care as a Substitute for Routine Clinic Follow-up. *JAMA*, *267*(13), 1788–1793. https://doi.org/10.1001/jama.1992.03480130104033

Wiersma, M., Kerridge, I., & Lipworth, W. (2020). Status, Respect, and Stigma: A Qualitative Study of Non-financial Interests in Medicine. *Journal of Bioethical Inquiry*, 1–14.

Wilkinson, T. A., Vargas, G., Fahey, N., Suther, E., & Silverstein, M. (2014). "I'll See What I Can Do": What Adolescents Experience When Requesting Emergency Contraception. *Journal of Adolescent Health*, *54*(1), 14–19. https://doi.org/10.1016/j.jadohealth.2013.10.002

Wong, K. P., Bonn, G., Tam, C. L., & Wong, C. P. (2018). Preferences for online and/or face-to-face counselling among university students in Malaysia. *Frontiers in Psychology*, *9*, 64.

Woodcock, J. (2016). *Working the phones: Control and resistance in call centres*. Pluto Press.

Woollett, A., & Boyle, M. (2000). *Reproduction, women's lives and subjectivities*. Sage Publications Sage CA: Thousand Oaks, CA.

Yagnik, P., Gold, J., Stoove, M., Reichwein, B., van Gemert, C., Corby, N., & Lim, M. S. C. (2015). Development and pilot of a framework to evaluate reproductive health call centre services: experience of Marie Stopes international. *BMC Health Services Research*, *15*(1). https://doi.org/10.1186/s12913-015-1064-0

Zontangos, G., & Anderson, A. . (2004). OpenAIR @ RGU The Open Access Institutional Repository at Robert Gordon University. *Qualitative Market Research:An International Journal*, *7*(3), 228–236. Retrieved from http://eprints.qut.edu.au/29653/

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