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Abortion counselling controversies and the precarious role of social work: Research and reflections from Aotearoa New Zealand

Letitia Meadows, University of Canterbury, Christchurch, Aotearoa New Zealand

ABSTRACT

INTRODUCTION: This article presents debates and controversies about counselling within abortion provision in Aotearoa New Zealand. Formal and informal counselling networks are described, where the role of social workers as providers of counselling services is precarious. Insights consider how service users may be more holistically supported when accessing abortion care.

METHODS: Drawing on findings from a broader qualitative research project involving 52 participant interviews, formal and informal observation of practices, and analysis of service documentation, the concept of boundary objects by Star and Griesemer (1989) is taken up to account for diverse abortion counselling practices that occur in multiple but connected social worlds. Revisiting these findings in the context of current abortion legislation and developments, a Reproductive Justice (RJ) lens is used to inform the implications for service users and social work practice.

FINDINGS: Past and present efforts within legislation, policy, and practice guidelines to standardise abortion counselling have not prevented different versions of counselling from being enacted by social workers, counsellors, nurses, medical practitioners, staff of community agencies, and crisis pregnancy services. This has resulted in the practice and the term *counselling* being contested. Participant accounts and observations revealed that multiple disciplines offer counselling practices while social work remains poorly integrated into service provision.

CONCLUSION: This article employs the concept of boundary objects to account for how variations of counselling have been enacted and disputed. The addition of a reproductive justice (RJ) lens with its attention to social justice is used to appreciate recent advances in access to abortion services alongside arguing for enriched care practices and the value of social work in supporting the integrated well-being and agency of service users.

Keywords: Abortion counselling; social work; controversy; boundary object

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CORRESPONDENCE TO:
Letitia Meadows
letitia.meadows@canterbury.ac.nz

The social work profession has contributed to counselling services in abortion provision in Aotearoa New Zealand for some time. However, counselling is an unregulated space and its presence as part of service delivery is precarious. The term *counselling* is a substitute for a diverse range of practices undertaken by an array of practitioners and lay counsellors who may not have a mental health and well-being background or formal degree in counselling. These practitioners include trained and qualified counsellors, as well as social workers undertaking counselling roles, medical professionals, community-based persons, and laypersons who enact their versions of the counselling. This article accounts for variances in what counselling is, how counselling is included in abortion service provision and the counselling-related practices that sit outside of this structured context. Contextual information follows concerning abortion legalisation and counselling requirements in Aotearoa New Zealand, and the social work and counselling role in abortion provision.

Abortion legislation and counselling requirements in Aotearoa New Zealand

Prior to the Abortion Legislation Act 2020, abortion regulation in Aotearoa New Zealand required that a woman must see two certifying consultants in order to access an abortion subject to legal grounds described in the Contraception, Sterilisation and Abortion Act 1977, and in section 187A of the Crimes Act including: serious risk to physical and mental health. The grounds for abortion were complex and subject to a degree of interpretation, where certifying consultants were required to make a judgment about access and the requests for services (Basset, 2001; Dixon, 2012). Most abortions, 97% from 2019 records, were performed on mental health grounds (Abortion Supervisory Committee [ASC], 2020). A referral from a general practitioner, blood test and swab results, and an ultrasound reading were typically required prior to the first appointment with a certifying consultant.

Concerning counselling, licensed providers of abortion services were required to advise women of the right to participate in counselling under Section 35 the Contraception, Sterilisation and Abortion Act 1977. Under Section 31 of this Act, it was the role of the Abortion Supervisory Committee to ensure access to counselling services that met professional standards (ASC, 1998, 2018). However, the nature and extent of abortion counselling services was mutable and determined by the policies and resources of different localities. The way in which counselling was integrated into service delivery determined the extent of this work, although counselling in abortion provision should comply with the *Standards of Practice for the Provision of Counselling 1998* (ASC, 1998) and updates included in the *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand* (Standards Committee, 2018). According to these *Standards of Practice* (1998), counselling services should be delivered by qualified social workers and counsellors who participate in regular supervision and are affiliated with a recognised professional association, for example the Aotearoa New Zealand Association of Social Workers (ANZASW) or the New Zealand Association of Counselling (NZAC).

The Abortion Legislation Bill was passed in March 2020, removing abortion from the Crimes Act (1961). The oversight of abortion services shifted from the Ministry of Justice to the Ministry of Health (MoH). Abortion access became legislatively unrestricted in early pregnancy and services were streamlined for those seeking abortion services. The national abortion telehealth service, DECIDE, was initiated in November 2022 providing early medical abortion (EMA), a pill-based early abortion method via telemedicine responding to the need for improved timely and equitable access to abortion services (MoH, 2023). While service provision became more straightforward concerning a pathway of care, social support for those engaging with services remains precarious.

In the Abortion Legislation Act 2020, health practitioners must advise service users of the availability of counselling, although counselling is not a condition of service access. The *Standard for Abortion Counselling in Aotearoa New Zealand* (MoH, 2022) outlines what abortion counselling is, who can provide abortion counselling, and sets out the rights of people receiving abortion counselling (MoH, 2022). Specifically, those who provide counselling must be a supervised, qualified, and registered professional who has knowledge of this area of practice and does not hold any conscientious objection to abortion (see MoH, 2022, p. 2, and Appendix 2 for detailed information).

It is important to highlight that pre- and post-Abortion Legislation Act 2020, the translation of guiding documents into practices has not been, nor is it now, without its challenges and variations. Against the backdrop of the formal networks and guiding documents that frame the supervised, qualified and registered professionals involved in the provision of abortion counselling services, counselling is an informal and unregulated space. It is these informal practice variations within and beyond abortion provision and associated controversies that are the focal point of the research findings offered in this article.

Social work and counselling in abortion provision and beyond

Controversy about the place, presence and practices of social work and counselling as part of an abortion trajectory is longstanding and part of the politics of multidisciplinary care and social work efforts for professional inclusion (see Meadows, 2016). An ANZASW webinar by Whitcombe and Norton (2020) identified changes in the social work role following the Abortion Legislation Act 2020. They noted a reduction in the number of women engaging with social work services in the Canterbury region and raised concerns about holistic care and support for service users. The Abortion Services in Aotearoa New Zealand: Annual Report (MoH, 2023), stated that 21 of 31 abortion services provide in-house counselling while all services offer pre- and post-abortion counselling that is "generally accessible both in-person and virtually" (p. 44). There is scope to explore this further.

In sanctioned settings, social workers and counsellors are involved in the provision of abortion-related counselling. The provision of counselling as part of multiskilled social work practice is a controversy in itself. In Aotearoa New Zealand, Booysen and Staniforth (2017) found that there were related and complementary practices between social work and counselling where social workers identified counselling practices as part of their work, alongside tensions concerning role boundaries between these disciplines. Indeed, as Booysen and Staniforth (2017) discussed, there is limited insight and guidance about the competency of social workers doing counselling as part of their practice. Thus, it is important to highlight the distinction between counselling as a profession and counselling as a diverse set of practices within and beyond abortion provision.

While the legitimacy of counselling as part of social work practice is complex, this complexity multiplies in abortion networks with regard to what counselling is and who provides it. Informal and unregulated counselling and support practices are also part of sanctioned service provision in intentional and ad hoc ways by medical professionals who have amalgamated counselling practices into their existing roles (Meadows, 2016). For example, Hannah et al. (2019) argued that, in women-centred abortion care, while formal counselling is valued from a nursing and midwifery perspective, providers should have the communicative capacities to engage in comprehensive "holistic dialogue" that responds to social, emotional and spiritual matters alongside clinical aspects of care (p. 5).

Outside of sanctioned settings there are multiple, competing, and contradictory ways in which counselling in abortion and pregnancy networks are practised. Varied forms of counselling are offered and provided by qualified counsellors, healthcare professionals, staff in social caring roles, and laypersons (Meadows, 2016). Community services offering counselling, information and/or support concerning pregnancy, as well as broader women's issues, also vary in their perspectives and responses to abortion. The differences concerning who performs abortion counselling and what form this takes are entry points for understanding controversies and disputes about counselling practices.

Reproductive justice

This article is anchored in the context of abortion provision including pregnancy decision-making, post-abortion counselling, and brief intervention. However, the social work and counselling input in this area of practice extends beyond this to include contraceptive matters, parenthood, support networks, issues related to interpersonal and/or structural violence, financial and practical resources, and indeed, the broad array of life challenges that people encounter. In this way, social work practice in abortion provision may be appreciated via a reproductive justice framework. Reproductive justice (RJ) has three core tenets that include: the right to have a child; the right not to have a child; and the right to nurture children in safe and healthy environments (Ross, 2007; Ross & Solinger, 2017). Further, the appreciation of social justice (Ross, 2007; Ross & Solinger, 2017) is relevant to social work and to abortion provision concerning how service users might be further empowered to navigate the conditions that impact their capacity to enact and participate in decisions about their own health care.

Related to RJ is a reproductive rights framework that advocates for the right to choose and the legal freedom to decide about one's own body. For example, The Abortion Legislation Act 2020 secured reproductive rights by shifting abortion from crime to care. However, what a rights-based framework does not attend to is that a decision to have an abortion (or pursue other reproductive trajectories) does not occur in isolation from a broader physical, social, cultural, material, and interpersonal context (see Chiweshe et al., 2017; Marecek et al., 2017). This is where a reproductive framework with its attention to social justice, (neo)colonial influences and intersectionality progresses the advancement and protection of rights by being responsive to the nuances of service users' circumstances, in particular, those most impacted by systems of oppression (Ross, 2007). As Ross (2017) stated, "the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community—and these conditions are not just a matter of individual choice and access" (p. 4). Social work is well placed to progress RJ imperatives and continue the commitment to improving the reproductive lives of service users that a right-based approach has attained.

While this article does not go into detail about abortion counselling and social work practice with service users, the role of social work is addressed as a space for increased presence and accessibility and features in relation to RJ because of its person-in-environment approach and commitment to social justice. While there is ambivalence of social work to advocate for reproductive justice and reproductive rights (Younes et al., 2021), as Beddoe (2021) has argued, there is a need for reproductive justice to be prioritised as a key social work issue in order to address health inequalities. Reflections on the potential of an RJ lens are offered in the discussion section.

Roadmap

This article offers a specific account of how both sanctioned and informal practices of counselling were negotiated at a stand-alone South Island abortion service and beyond this setting in wider, informal, but related, networks. Understanding the controversies of abortion counselling and the contribution of social work is important for theoretical and practical reasons. First, this knowledge illuminates the relationships between disconnected practices at both local and national levels. Second, this knowledge may also support the development of care practices that respond in a holistic way to the service users who engage with abortion services.

The use of language is important to clarify. Within abortion provision the phrase "termination of pregnancy" (ToP) is common; however, as the study that this article draws from follows practices within and beyond health settings, the word *abortion* is used to reflect the combination of professional and lay language to do with abortion. For an in-depth account of language practices to do with abortion, see Meadows (2016). Further, to use inclusive language where those who have a pregnancy may not identify as woman/women, this article uses the term *service user*.

The following section considers selected literature. Then the research approach is outlined, and a description of the study is provided. The section thereafter presents a snapshot of relevant findings from research conducted before the 2020 change in legislation. The final section considers these findings in the current context and, as noted, employs a RJ lens to discuss the theoretical contributions and practical implications for social work practice and research moving forward. A case is made for reviewing the term *counselling* and its function. Further, for a proactive embedding of social work services in abortion provision as a means to enhance integrated care and culturally responsive service provision.

Literature review:

There is limited literature that specifically addresses abortion-related counselling practices in Aotearoa New Zealand (see Kirk et al., 2018). Moreover, attention to abortion controversies tends to address *the* abortion controversy or debate that relates to the moral, ethical, and legal status of elective abortion rather than a specific conceptual lens through which to follow diverse counselling practices. Selected literature considers abortion counselling controversies with an emphasis on counselling instabilities and practice variations.

The controversial status of abortion counselling and its variability are argued by Hoggart (2015) as fundamentally political and mirror political positioning about abortion and competing agendas about what service users need. This includes abortion service providers and pro-choice communities where there is a lack of consensus about the scope of abortion counselling (Hoggart, 2015).

Tensions about the place and fit of counselling in service delivery are discussed by Kirk et al. (2018) in the Aotearoa New Zealand context, in that abortion counselling may be poorly integrated into the care pathway of abortion provision. An older source but relevant argument is made by Simonds (1996) who accounts for the mismatch between the scheduling of medical aspects of abortion provision and the contrasting longer duration of counselling sessions.

Kirk et al. (2018) highlighted the variations in counselling practices and processes in abortion provision within and between different localities. These variations involve poor alignment between legislation, policies, and practice including the quality, consistency, and availability of abortion counselling services (Kirk et al., 2018). Moreover, variations concerning access to counselling, particularly access in rural localities and in addressing complex needs, are signposted in research following the Abortion Legislation Act 2020 about the skills and willingness New Zealand of clinicians to provide abortion services in primary care (Macfarlane et al., 2023).

Macfarlane et al. (2023) highlighted the important role of Te Tiriti in ensuring the rights and safety of Māori in Aotearoa in service provision. They argued that abortion care should employ an equity lens that is safe and acceptable for Māori and Pasifika people. Moreover, that care should be personalised rather than folded into a business model (Macfarlane et al., 2023). Staying with the Aotearoa New Zealand context, Le Grice (2017) discussed that for some wahine Māori, there may be a mismatch between the notion of individualised decision-making and a reproductive decision-making as nested in a wider whānau context (Le Grice, 2017). "Given the pressures Māori have faced throughout colonisation, and the impact this has had on the relationships and whanau life of many (Le Grice, 2014), centring an individual Māori woman's perspective—her vantage point, circumstances and context, desires, dreams and reasons for having an abortion in context—is crucial" (p. 157). The Standard for Abortion Counselling in Aotearoa New Zealand (MoH, 2022) locates the counselling role in response to these concerns clearly indicating the continuing presence of institutional racism, and emphasising culturally responsive practice and Te Tiriti o Waitangi obligations.

Counselling outside the provider contexts includes services by crisis pregnancy centres and/or anti-abortion pregnancy counselling services. These less regulated crisis services may be perceived as less credible by abortion providers (Allanson, 2007), and may include practices of misinformation, deception, and efforts to dissuade pregnant persons from pursuing abortion services (Bryant & Swartz, 2018; Cannold, 2002) and/or delay access to health care (Rugrum, 2022). A distinction is made here between women/person-centred community agencies and services that support pregnant persons while upholding their reproductive rights, that is, service delivery that considers a full range of choices and evidence-based information concerning a pregnancy outcome.

Mainstream healthcare sites are not excluded from anti-abortion activism and further practice variances. Mavuso et al. (2023) examined anti-abortion counselling practices in three hospitals in South Africa. These authors challenged the meagre engagement with counselling as part of the World Health Organisation's (WHO) (2015, 2019) understanding of safe and unsafe abortion. Mavuso et al. (2023) argued that the quality and safety of legal abortion services are undermined by the emotional and psychological harms that anti-abortion directive counselling can incur for service users.

Given the limited literature available and the expressions of diverse and mutable counselling arrangements, further attention to understanding the nuances of abortion counselling and responding to concerns about potential harm is needed.

Theoretical approach: Boundary objects

This analysis of counselling engages the concept of "boundary objects" (Star, 1991, 2010; Star & Griesemer, 1989) as a site of collective action that gathers together different but intersecting social worlds or mediates, as Bowker and Star (1999) discussed, "multiple communities of practice" (p. 286). To break the term down a little, the word *boundary* as Star (2010) defines it, does not refer to a border per se but to a "shared space" and "object" refers to what is enacted rather than an object in a material sense (p. 603). Star (2010) stated that "[b]oundary objects are a sort of arrangement that allows different groups to work together without consensus" (Star, 2010, p. 602). In this way, the concept of boundary objects is useful for following the counselling that is connected to abortion provision and its differences.

Given that different groups may each hold and retain their own representations of an object, counselling can be treated as a boundary object that connects diverse actors (social workers, nurses, doctors, crisis pregnancy counsellors, and feminist health agencies) despite their differences in practices and perspectives. The insights of boundary objects allow various and but related counselling arrangements in abortion provision and different but connected counselling practices enacted in the abortion and pregnancy networks beyond service provision to be considered together. This approach allows a move beyond abortion pro-life and pro-choice dichotomies, and beyond the boundaries of the social work discipline to trace and account for diverse counselling practices that emerge in and through broader abortion networks.

The study

I had been employed at Lyndhurst, a first-trimester, stand-alone abortion service in Christchurch, for about a year prior to commencing a part-time PhD research project. I continued in a hybrid practitioner-researcher role at Lyndhurst for four further years, finishing my employment to focus more intensely on the writing up of the research findings. During this time, and following the 2011 Christchurch Earthquakes, Lyndhurst was relocated as part of Christchurch Hospital. Prior to the commencement of the study, I gained Ethics approval from the Health and Disability Ethics Committee and the University of Canterbury Human Ethics Committee. A locality assessment permitted the research to occur at Lyndhurst.

The methodological approach is qualitative and informed by actor-network theory (ANT). ANT is a methodological toolkit that extends conventional notions of the social world by orientating the researcher to how "the social" is relationally assembled as an assortment of people and things—of heterogeneous "actors" (Latour, 2005). The researcher is charged with mapping and following this collective action using description as the means of accounting for this work rather than by way of explanation (Latour, 2005). The focus of a descriptive account is on emphasising the *how*: how actors frame their worlds, how worlds are generated, ordered, and configured.

The overarching method was participant observation, which was suited to my immersion in the research setting and shifting position concerning my shifting participation in abortion provision and observer of complex day-to-day practices (see Law, 2004). Data were generated from the concurrent activities of research fieldwork and social work practice including formal and informal observation of practices within abortion provision, document analysis and 52 semi-structured interviews with service users, staff in abortion provision, health professionals connected to the service, protestors, and crisis counselling staff. Interview participants were invited to talk about their connection to abortion and this was explored in a semi-structured way and shaped by the participants positioning.

Data were analysed manually and thematically (Braun & Clarke, 2006) across the research process from inception to completion (Liamputtong, 2009). I sought to physically engage with the data from interview transcripts, descriptive memos, reflective writing, and key service, policy and legislative documents closely by seeing, holding, (re)cutting and (re)sorting the acquired data. The focus on counselling involved an array of related people, materials and practices that appeared and reappeared in the data yet I could not seem to firm this up. The ANT emphasis on tracing and following mediate action allowed me to see that counselling was not one stable and fixed thing but enacted through diverse actors and practices (see Latour, 2005). Aligned with an ANT sensibility, I did not follow this analytic process through to an explanation but relied on the mode of descriptive writing to "give voice" to research participants (see also Murphy & Dingwall, 2003) and make my case about counselling controversy and mutability. Note that I do not offer generalisations about abortion counselling nor have I sought to be representative about abortion concerns. The descriptive text and quotations provided do not attest to *the truth* about abortion-related counselling but are a capturing of moments and multiplicities.

Hybrid roles, blurry boundaries and multiple identities

It is important to acknowledge the hybridity of the practitioner-research role and the multiple identities that participants embodied. For my part, whilst I had many opportunities from Lyndhurst colleagues as an insider, it was also peculiar and a different dynamic to be researching in and being of this setting (see Meadows, 2016). Of note, care was taken to navigate the role of both social worker and researcher in an ongoing way. For example, I excluded from directly recruiting service users and did not make use of my appointments with individual service users to illicit and record data, although inevitably these experiential insights informed the research. Regular supervision and reflective writing offered a means of continued reflection on my hybrid role and supported accountability regarding the ongoing decision-making undertaken during the research process.

Concerning participants, I did not seek a specific number of participants from certain professional or service user roles nor did I aim to organise participants in this way. Rather, through the methodological activities of "following the actors" and connections between actors (Latour, 2005), it was apparent that many of the interview participants inhabited multiple identities at once, linking into various parts of the assemblage of abortion, past and present. For example, many participants were *composites*—they may have been a staff member at Lyndhurst, held a specific professional role at an alternative setting, may have connected with the position of recent or past service user, and/or be linked to a community agency. I could not always anticipate what interview participants would share; however, I did not seek to "tidy up" this complexity for the sake of order (see Law, 2004) and ultimately referred to particular roles and identities as these were foregrounded during the course of the participant's account. In this way, this ANT-influenced account mirrors a case study of how multiple professions interacted with the *object* of counselling and brought a local and specific version of counselling into being.

Findings

The following section describes some of the dynamic (re)configurations of counselling and *how* counselling is presented in the data. These findings draw from a broader thesis chapter about professional identity and social work where the argument is made that identity is dynamic—assembled, enacted, disrupted, and reassembled (Meadows, 2016). This argument applies to the notion, role and practices of counselling as this was followed in, and through, varying professional interactions and activities within and beyond the clinic setting. In line with the methodological approach of accounting for relational work between heterogeneous actors, counselling attributes include distinctly human qualities, such as empathy and listening, but also a wider range of effects: the way we are guided by training or professional documentation, the way parts of the body are engaged to "do" counselling work, such as ears to "hear someone out" and how counselling is relationally practised through the people, tools, materials and spaces. The concept of the boundary object is employed as a means to express these multiple but intersecting counselling arrangements.

Counselling within and beyond the boundaries of social work

At Lyndhurst, the site of this study, counselling services were formally provided by social workers and evolved over time from being routine, then voluntary—routine at the onset of a new medical abortion service in a new format as a psychosocial assessment with counselling available—then optional where women were to be made aware that counselling was available. This latter mode of counselling remains in the current setting at the time of writing this article and under the 2020 Act. Informally, varying counselling-related practices were enacted by a range of Lyndhurst staff. Counselling variations were also enacted outside of Lyndhurst in community settings including crisis pregnancy services.

Counselling as part of this abortion assemblage did not belong merely to the role and tasks of social workers but also to many other actors and practices. Social workers in abortion provision, nurses, and community counselling services assembled different versions of counselling that are shaped by specific professional memberships and configurations. The varying tensions about who should do counselling, what counselling should look like, and where this should occur, relates quite readily to the concept of boundary objects (Star, 1988, 2010; Star & Griesemer, 1989). Referring again to the work of Star and Griesemer (1989), "[b] oundary objects are objects which are both plastic enough to adapt to local needs and the constraints of several parties employing them, yet, robust enough to maintain a common identity across sites" (p. 393). In this way, as a boundary object, mutable versions of counselling unfolded across divergent communities of practice.

Counselling adaptations: "Part of our role is counselling too"

Within and beyond the clinic setting, counselling was loosely structured and often adapted when employed by diverse groups: an abstract object—but more tightly articulated and concrete in its use by specific memberships, such as the social workers who performed counselling tasks at the service with the requirements of employed roles, qualifications, and standards of practice. However, even in these more structured settings, counselling was taken up and adapted by different professional groups. A nurse at the service illustrates this below:

> I1: You know even from the nursing point of view let's face it, the counsellors do a fabulous job, you guys do a fabulous job, but, you know, part of our job is that counselling role as well, on a different level, well not that different, well there is that difference in that we're not trained in that [laughs] but there is a counselling role – it's a real hands-on role and there are times when people need you to just sit with them and just hear them out.
>
> (Interview 1)

The social work identity I held and the role I enacted in abortion provision was expressed by the participant as "counsellor". I held a degree in social work and membership of a social work professional body, yet, a sign indicating "counsellor" was attached to my workplace office door. Moreover, while the work that is undertaken was expressed as valued, and despite the sign on my door, I cannot claim the counselling role nor its practices. As described above, counselling was integrated into nursing practices, "part of our job is that counselling role", and thus, social workers as authorities in counselling in this setting is contested.

Linking back to Star and Griesemer (1989), as a boundary object, the action of counselling in the quote above appears to be located *between* medical and social worlds and is taken up and adjusted by the nurse as part of her nursing activities. As she articulates, the counselling employed is "not that different" except for the fact that nurses are "not trained in that." Nurses do not have the qualification that produces the counselling role at the clinic, as within the counselling network, being trained is imperative to acquiring employment as a social worker who engages (with some professional controversy) in counselling practices.

Role legitimacy: "The right person to do the job"

When counselling is assembled by other actors, such as the nurse above, the backdrop of social work legitimacy falls away. Counselling is reconfigured as something else. The nurse describes this counselling component as a "real hands-on role" where people need you to "just sit with them and just hear them out". However, the nurse wears a uniform, holds different qualifications, carries, and uses various medical tools, and occupies different spaces within the setting at Lyndhurst, and these elements, in turn, configure counselling differently.

For the nurse above, counselling is referred to as a form of engagement—"hands-on" but, instead of hands and medical tools that focus on the bodies of service users, the ears are engaged to listen to women who enter abortion provision. The voice of the woman, her account, her story is what is taking primacy in this "counselling" role that the nurse enacts whilst the social work counselling "toolbox" that is comprised of, not only the voice of women, but a myriad of other actors, is displaced. While talking and listening practices are very much part of integrated care, that medical staff *do* counselling, and occupy this hybrid space, was not agreed upon by social workers.

> I52: ...it comes up often in multidisciplinary teams, "why don't I do the social assessment, I've got the information here" and what I say to nursing staff is "look, it's exactly the same, I can read the instructions and I can take blood pressure and I know how to draw up a syringe and I can give injections, I can do those things, the point is that I can do those things but I'm not trained to do those things. I don't have the certificate that says I'm the right person to do those things, it's not my role to do them".
>
> (Interview 52)

Informal counselling networks: "counselling is a bit of broad term"

Linking again to the idea of counselling as a boundary object (Star & Griesemer (1989), counselling may be thought of as a common object that sits between groups, like in the example of the nurse who employed her articulation of counselling as part of her work. However, because abortion counselling lacks durability as a fixed professional practice that has authority only within certain spheres of work, other groups can pick this up and tailor counselling for their own needs whether they are medical or social actors, professionals, or laypersons. An actor from a women-focused community agency offers her account of this below:

> I3: I mean here we don't have a formal set up, you know we don't have someone come along formally to I guess enter into a counselling-type relationship, it's more an on-the-spot thing so it's a, probably a smaller version of what you do but you can do quite a bit in a small time to help people examine where they're at.
>
> (Interview 3)

Outside of the formal counselling set up that the above actor refers to, this agency employs its own version of counselling: a "counselling-type relationship". Other community settings, offer further variants within a particular structure and context that is tailored by this group. An example of this is articulated below:

> I4: We're a 24-hour counselling service, counselling is a little bit of a broad term because we are not trained counsellors, but we've done a comprehensive 12 session course on pregnancy counselling.
>
> (Interview 4)

The language shifts here from abortion to pregnancy. As Allanson (2007) argued, pregnancy counselling that is conducted independently of abortion provision is often considered less credible by abortion providers (Allanson, 2007) or as a strategy employed by "anti-choice" actors to dissuade prospective service users from pursuing abortion as a pregnancy outcome (Bryant & Swartz, 2018; Cannold, 2002).

At Lyndhurst, and among several long-standing community women-centred organisations, this specifically concerned a distrust of community groups with 'pro-life' or religious associations. The term *false providers* is one of the ways that these latter groups are described in that they are thought to provide false information, block access to, and perpetuate myths about abortion provision (Allanson, 2007). The ascribing of this notion of *falsity* is an effort to secure a specific reality or *purity* about the nature of counselling that those in abortion provision uphold. At the same time, this notion refutes the lay efforts of those whose enactments of counselling conflict with abortion providers.

Counselling contrasts and contested practices

As became evident during this local study, the counselling at Lyndhurst acquired its own sceptics and there were other modes of counselling beyond the clinic, and counsellors who contested Lyndhurst practices. The following quote, part of an interview with a community pregnancy counsellor, draws attention to this:

> Letitia: I wondered if there were some similarities, like my role is a social worker/counsellor at Lyndhurst and there must be some similarities with what we do and some contrasts as well.
>
> I4: I think there would be many contrasts. We are there never to make up clients' minds for them and we like them to be fully informed, so when people ring us and say "I want an abortion", really, we would, if they were willing, give them the alternatives.
>
> (Interview 4)

The lack of consensus between groups is one of the elements of the boundary object (Star, 2010; Star & Griesemer, 1989). The lack of consensus between groups who enact the object of counselling (Lyndhurst and the pregnancy counselling service) was revealed in this arrangement. Whilst Lyndhurst social workers would argue that they, in fact, did not make up clients' minds for them and that they sought to fully inform clients, the community counsellor implies disagreement with this.

Indeed, as Law (2004) explained, laypersons, like the actor above, may be sceptical of the expertise that is claimed by those who hold authority and may question the interests that sit behind expertise. The community counsellor in the interview above makes it clear that the mode of counselling at this service contrasts with that which Lyndhurst provides. Moreover, we are alerted to the tailoring of the counselling that takes form in this setting, the localised adjustments that groups make for their specific needs (Star, 2010). When a client calls on the telephone and says they want an abortion, the othering of abortion is brought into presence. Not by stating that an abortion trajectory is made absent, but by saying, "really, we would, if they were willing, give them the alternatives" (Interview 4). The contrast between counselling at Lyndhurst and that provided in the pregnancy counselling service reveals these services as quite different objects. Likened to a boundary object, counselling in the pregnancy counselling service may not be enacted as a professional process according to the aims of social workers at Lyndhurst, but it proved to be adaptive as far as it mediated "talking work" across different communities of practice that, aligned or not, linked into abortion networks.

Thus, counselling to do with abortion was not contained within the walls of Lyndhurst or its rooms. Counselling was a distributed set of practices that were reworked and taken up by different actors across different sites. This reworking and appropriation of counselling by different groups produced tensions concerning the authenticity of counselling and which actors held the authority to provide this service.

Discussion: Abortion counselling (re)configurations and reproductive justice

The findings illuminate counselling as an unregulated space where counselling within abortion provision and outside of service delivery comprises of diverse set of practices that were contested, mutable and multiple. The consensus between participant contributions illuminated a lack of consensus about what the counselling role was and who should perform its activities. Different participants across professional and lay memberships, such as social workers, nurses, and community counselling services, took this role up and assembled their own version of counselling. The social work role of providing counselling services in abortion provision was shown to be precarious as this concerns role identity and legitimacy. The analytic description and participant quotations support the concept of the boundary object as a means to appreciate counselling as a site of intersecting communities of practice that can be considered simultaneously.

The findings exhibit alignment with arguments of variation and inequity of services where the integration of abortion counselling within service provision is at times at odds with service delivery within and between varying localities (Kirk et al., 2018; Macfarlane et al., 2023). However, these findings sit awkwardly alongside the recent aspirations for counselling practice in abortion provision. The Standard for Abortion Counselling in Aotearoa New Zealand (MoH, 2022) outlines and purpose and scope of abortion counselling including who can provide this, specifically outlining types of practitioners and knowledge and practice expectations. Attention is afforded to how abortion counsellors give effect to obligations under Te Tiriti o Waitangi and there is an appreciation of the intersectional spaces that service users occupy and their interface with a colonial-inflected health system. Guidance is offered concerning the delivery of abortion counselling services, cultural responsiveness and the rights of service users.

Alongside these in-depth and nuanced guidelines for counselling provision, there is a gap between the integration of social work services as part of abortion provision and the aspirations of The Standard for Abortion Counselling in Aotearoa New Zealand (MoH, 2022). Outside of immediate service delivery, counselling is a presence that exists on its own terms. In these spaces, there are versions of counselling that may, as Mavuso et al. (2023) suggested, undermine the efforts of abortion services to provide quality care and via directive anti-abortion practices, induce emotional and psychological harm for service users. Since (and separate from the undertaking of the initial research) the Abortion Legislation Act 2020 has provided impetus for improved and streamlined access to abortion in established abortion services and shifted the status of abortion from crime to health care. However, related to the research findings, counselling controversies continue and the contentious social and political landscape of abortion provision in Aotearoa New Zealand has not been erased. It is important to recognise that the presence and impact of other committed actors in this network, such as crisis pregnancy counselling services, actively advertise their services and seek to disrupt access to abortion provision and care.

There is space for further consideration of the access, availability and framing of social work and counselling services that respond to the political, psychosocial, spiritual and cultural complexities of abortion. There may be value in disrupting the mutability of counselling practices by reviewing the term *counselling* and how this reflects the social work and counselling roles in abortion provision. Further, there is scope to address the mismatch between a medically oriented provision of abortion services and the contributions of social work practice. Revisiting Ross (2017), "the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community—and these conditions are not just a matter of individual choice and access" (p. 4). The recommendations for social work practice include continued advocacy for the presence of social work and counselling services to ensure that these are indeed available so abortion provision does not inadvertently maintain or intensify the disparities or oppressions of care and separate service users from the circumstances of their reproductive decisions.

Conclusion

Abortion counselling has been described as a contested set of practices that have been reworked and taken up by different actors across different sites, within and beyond the social work role. Findings from previous research have been considered alongside current realities that indicate that the peripheral and precarious position of social work in abortion provision is maintained concurrently with the legislative requirement that counselling must still be available. The offering of a counselling service in abortion provision, mutable or otherwise, is not a genuine option when social work is poorly integrated into service provision or off-site from a service where timeliness is key. In this way, social work has a role to play in progressing reproductive justice through continued advocacy to advance quality, skilled, non-biased, non-directive, and culturally responsive holistic care for service users of abortion provision.

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