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Understanding the violation of directive anti-abortion counselling [and cisnormativity]: Obstruction to access or Reproductive violence?

Introduction

> [W]hile the notion of providing abortion counselling appears at face value to be an innocuously sound idea, it is by no means politically innocent… abortion counselling practices can easily be founded on problematic assumptions about women, their bodies, their sexuality and their choices. What is called 'abortion counselling' can be anti-abortion counselling, which deploys the assumption that abortion causes psychological harm to win support for a political programme aimed at restricting recourse to abortion in practice (Vincent 2012, p. 126)
>
> [W]hat makes the possibility of a happy abortion, at best, transgressive and, at worst, unspeakable?... As long as motherhood remains the only authentic and 'happy' choice for pregnant women, abortion will manifest as a fundamentally unacceptable choice that women need to justify to or hide away from others (Millar 2017, p. 278)
>
> even though we have witnessed the development of new technologies that challenge our beliefs about human reproduction, the latter seems to remain within an exclusively cis domain…In other words, it is understood that pregnancy is an experience unique to women and that women are women because they get pregnant- a feedback loop that keeps the gears of the repronormative order in motion (Radi 2020, p. 5)

Abortion is legal in South Africa, enshrined in the Choice on Termination of Pregnancy Act (hereafter CTOP Act) 92 of 1996. The CTOP Act allows for abortion on demand during the first twelve weeks of pregnancy and thereafter on various, increasingly restrictive grounds (Pizzarossa & Durojaye 2019). It constructs abortion as a fundamental part of reproductive healthcare, and the decision on whether to have an abortion as a necessary part of "women's" right to have control over their reproductive lives and their bodies. The CTOP Act responsibilises the State to ensure that reproductive decisions are exercised without fear or harm. Concerning abortion counselling, the Act only stipulates that voluntary and *non-directive* pre- and post-abortion counselling be made available. Finally, the CTOP Act states that it is a criminal offence for anyone to obstruct access to legal abortion services.

Millar (2017) argues that liberalisation of abortion law does not ensure that abortion *will* be *accessible*. Instead, the (in)accessibility of abortion relies on how abortion is constructed and understood within local and national imaginations. And in much of the world, the dominant story about abortion is one that is fundamentally *anti*-abortion. Despite South Africa's liberal CTOP Act, legal abortion remains largely inaccessible in South Africa. This is due to abortion stigma, observed through: anti-abortion attitudes and beliefs (Mosley et al. 2018); healthcare workers' refusal to become involved in abortion work, resulting in designated facilities that never functioned to begin with, have since collapsed, or function but only intermittently (Harries et al. 2014, Hodes 2016); and a thriving and well-advertised illegal abortion industry (Trueman & Magwentshu 2013) paired with a lack of government-led and -sustained information campaigns that advertise the legality of abortion, the conditions of the Act, and which facilities are designated and functional.

The dominant narrative on abortion constructs abortion as essentially immoral, harmful and dangerous, irresponsible, a decision which is agonised over, an awful experience, and a last resort to be avoided until *absolutely* necessary (Lee 2003; Hoggart 2015; Millar 2017). As the second epigraph

attests to, this anti-abortion narrative is socio-culturally produced through patriarchal ideas that construct motherhood as self-sacrificing and child-centred, joyful, the only meaningful purpose to "women's" lives, and a sacred duty. It simultaneously naturalises and essentialises motherhood (biological and gestational motherhood especially) as a condition for womanhood (Millar 2017; Tamale 2014). Through this, abortion is constructed as 'anti-motherhood' such that a happy, dignified abortion seems a contradiction, or to signify a deviation from the 'natural', 'normal' gendered order of things. However, often overlooked, including within feminist writings and activism on abortion, is that this patriarchal anti-abortion story is simultaneously cisnormative[1] and repronormative[2]. This is because it relies on a patriarchal construction of pregnant people and their bodies, and therefore abortion seekers, as cis female and cis women. In turn, motherhood is constructed as both a biological duty and the 'natural', 'obvious' and 'good' choice (Millar 2017) for those *presumed* to be cis women and who are deemed to be 'desirable reproducers'[3] (Ross 2017; Weissman 2017). Also, because it simultaneously erases the sex and gender diversity of abortion seekers and people with the capacity to gestate, more generally (Radi 2020), which includes intersex people, trans masculine people and trans men, non-binary people, and gender non-conforming women (Moseson et al. 2020). When the imagining of abortion seekers as cis females and cis women is used to inform the design, implementation and content of abortion services, the resultant care may be harmful for cis, trans and non-binary, and gender non-conforming people with uteri (Moseson et al. 2020).

In this article I argue that the construction of abortion as awful is underpinned by the normative construction of pregnant people and abortion seekers as cis women, and also by the attendant patriarchal constructions of womanhood which expect motherhood. With reference to research conducted on (cis) women's and providers' pre-abortion counselling experiences at three public hospitals in the Eastern Cape province of South Africa, I argue that these understandings of pregnancy and abortion, and pregnant people and abortion seekers, enable and underpin state-sanctioned, coercive anti-abortion counselling that devalues and seeks to control the reproductive freedom and decision-making of abortion seekers by attempting to enforce parenthood for those presumed to be cis women (and deemed to be desirable reproducers). For trans, non-binary and gender non-conforming abortion seekers, these understandings of pregnancy and abortion, and pregnant people and abortion seekers, may enable/result in abortion counselling that is violent in cisnormative and repronormative ways. Beyond abortion counselling service provision, the taking up of these ideas about reproductive subjectivity and experiences in (African) feminist scholarship on reproduction is a form of discursive violence that erases the sex and gender diversity of (African) people with uteri. This article proceeds in four sections. In the next section, I describe the research referred to above, as well as the findings which have been published elsewhere (Mavuso & Macleod 2019a, 2019b; Mavuso & Macleod 2020). In the second and third sections, I explore the possibilities and limitations for understanding coercive anti-abortion counselling as obstruction to access to counselling that *should* be non-directive, and for understanding this counselling as reproductive violence. In the fourth section, I use an afro-feminist perspective to understand the involvement of US-funded pregnancy crisis centres in South African public sector abortion counselling service provision as an example of US imperialist reproductive geo-politics. and for situating coercive anti-abortion counselling service provision within cisnormative patriarchal/colonial constructions of sex, gender and reproduction . Ultimately, I argue that an Afro-feminist informed language of reproductive violence that *decentres* cis women from reproductive experiences, including abortion and reproductive violence, whilst *visibilising* cisnormativity, is productive for understanding the violence of coercive and dehumanising anti-abortion counselling. It also enables robust theorisation about reproductive experiences that: reflects diverse African realities and experiences, recognises the connections running through and that make possible various forms of reproductive violence perpetrated against people with the capacity to gestate, and that will enable us to eradicate these violences.

[1] Used here to refer to the privileging of cisgendered people (people who identify with the gender they were assigned at birth) in a variety of ways and spheres.

[2] Used here to refer to the regulation of reproduction based on the normalisation and privileging of reproduction (compared to not reproducing) (Franke 2001) and based on ideas about 'normal' reproduction and who *should* and should not (be allowed to) reproduce (Weissman 2017).

[3] Of course, systems of power interact in ways that mean that parenthood is not encouraged nor enforced for all cis women, and that the enforcement or denial of parenthood is based on the categorisation of individuals, groups and communities into 'desirable' and 'undesirable' reproducers (Ross 2017)

Pre-abortion counselling experiences in the Eastern Cape public sector

In 2015 and 2016 interviews were conducted with 30 abortion seekers, all black (cis) women, and four healthcare providers. Of the providers, two were nurses and two lay counsellors. The two nurses (both black) were employed at two different hospitals. The lay counsellors, both white, volunteered for a US-funded, Christian-based pregnancy crisis NGO to which the remaining hospital had outsourced the 'options counselling' component of abortion counselling (nurses employed at this hospital conducted the history-taking and contraceptive counselling components of the abortion counselling session, and conducted the abortion procedures). Recent investigations by Open Democracy have revealed a global network of US-funded Christian-based pregnancy crisis centres, and that South Africa alone has about 70 operating, some with similar arrangements with public abortion facilities (Kahn 2020). Elsewhere (Mavuso & Macleod 2019a, 2019b; Mavuso & Macleod 2020), myself and a colleague have published the findings of the research on abortion seekers' and providers' experiences of pre-abortion counselling referred to here. Below, I limit myself to describing the findings so as to give room for the kinds of discussion I would like to advance about how we might understand the violence of coercive anti-abortion counselling.

In their interviews with me, none of the providers framed abortion as a reproductive right to which abortion seekers were entitled (Mavuso 2018). And while the two nurses framed legal abortion service provision as necessary to save lives from the threat of backstreet abortion, all four providers constructed abortion as problematic in some way and described abortion counselling as serving the purpose of *preventing* future abortions and the one being requested. The two nurses also described abortion counselling as serving the purpose of preventing unintended pregnancy which was framed as a public health problem. To varying degrees and in various ways, all four providers framed abortion as immoral and shameful. Lay counsellors particularly constructed abortion as sinful and against Christian values and morals; and as dangerous, risky, and harmful to both the foetus/child[4] and the abortion seekers who they positioned as cis women and as mothers.

From interviews with the abortion seekers and healthcare workers, providers' gave information on how to prevent future unintended pregnancy and abortion through the use of long-acting reversible contraception; that abortion 'causes' infertility, cancer and psychological trauma; that abortion (including legal abortion) is life-threatening (at the facility where counselling was conducted by the lay counsellors);and information on the development of the foetus, including showing 'life-size' models of foetuses (again, at the facility where counselling was conducted by the lay counsellors). Thus, abortion emerged overall (with moments of resistance) as immoral/problematic, shameful, irresponsible, dangerous and harmful, a non-option, while parenting and adoption placement were framed as beneficial (joyful, meaningful), moral, responsible and preferable. Abortion seekers were positioned as (cis) women/mothers.

Abortion seekers described some instances of supportive counselling (see Mavuso & Macleod 2019a). I focus here on their experiences of coercive anti-abortion counselling. Several participants described confusion, hurt and pain, fear, and shame as a result of providers' discussions of abortion as wrong, dangerous, damaging and harmful to themselves and their foetus/child, and therefore risky and an irresponsible thing to do; adoption placement as an option that is inherently preferable to abortion; and the process of medical abortion as being 'like birth' and inherently traumatising because this birth would end in abortion and abortion seekers would be expected to observe the products of conception to ascertain that the abortion was successful. At two of the hospitals, some participants also spoke about their stress at having to leave without receiving the abortion, having to continue being pregnant for another two to three weeks, and then having to return for the procedure (Mavuso 2018). At one of these sites, participants were told that delays were being imposed for them to 'think seriously' about their decision. Importantly, several described these various practices as having the effect of introducing doubt and conflict, and making them want to change their minds about the abortion. However, for all except one who did change her decision including but not only because of the counselling itself (Mavuso 2018), continuing the pregnancy was simply not a possibility. Lastly, some abortion seekers at two of the facilities described nursing staff as harsh, unkind and unsupportive in their interactions, and one participant described how abortion seekers would be shouted at for the littlest things (Mavuso 2018).Thus, as a result of the counselling, the

[4] I use "foetus/child" to recognise that abortion seekers (and pregnant people more generally) have different relationships to their pregnancies. Also to resist against both 'pro-life' and 'pro-choice' movements' tendencies to prescribe how pregnant people *should* relate to their pregnancies.

abortion seekers were left to deal with conflict, hurt and pain, stress, fear, and shame that had in fact been created or worsened by the counselling.

Coercive anti-abortion counselling as obstruction to access

Coercive anti-abortion counselling may result in forced pregnancy and subsequent parenthood or adoption placement or forced illegal and unsafe abortion. Even when the abortion seeker eventually obtains an abortion, however, directive counselling likely produces or at the very least exacerbates psychological harm by stigmatising unintended pregnancy and abortion, and by framing motherhood/parenthood as the preferred, responsible/safe, ethical/moral 'option' for (cis) women.

Section 10 of the CTOP Act describes offences and penalties related to the Act. Sections 10(1)(a) and (b) relate to non-medical practitioners unlawfully performing abortions referred to in section 2(a), (b) and (c) of the Act (gestational limits and designated providers). Section 10(2) relates to notification of records. Of relevance to this discussion is section 10(1)(c) which makes it a criminal and therefore punishable offence for anyone to "prevent the lawful termination of a pregnancy or obstruct access to a facility for the termination of a pregnancy".

Coercive anti-abortion counselling deploys and seeks to produce fear, guilt and shame in order to persuade abortion seekers to not have an abortion and to parent or opt for adoption placement instead. This violates the Act's stipulation that abortion counselling should be "non-directive". Providers who conduct coercive abortion counselling may, it would seem, further be guilty of preventing a lawful termination of pregnancy, at least where directive abortion counselling results in: (1) abortion seekers having no choice but to continue with the pregnancy and parenting, placing the child up for adoption or abandoning the child, or (2) abortion seekers being forced to seek an illegal and unsafe abortion instead.

Framing coercive anti-abortion counselling as a violation of the CTOP Act and a criminal offence that results in the prevention of legal abortion, may enable us to appreciate the gravity of coercive abortion counselling. It may also disincentivise directive abortion counselling through the possibility of taking action against individual abortion providers who conduct such counselling, facilities where such counselling is provided, and possibly at higher levels as well. Such action may be enabled through the reporting of complaints to the Health Ombud..

These possibilities notwithstanding, there are two possible limitations of using Section 10(c) to understand the harm of coercive anti- abortion counselling. Firstly, a reliance on Section 10(c) *may* mask the various ways that the *State* may not be (fully) committed to ensuring access to non-directive abortion care, The lack of state-led, nation-wide information campaigns to normalise abortion and to inform the public about the legality of abortion, the conditions of the Act and which facilities should be providing abortions, may point to this. Furthermore, both the CTOP Act and the Regulations under the Choice on Termination of Pregnancy Act, 1996 (hereafter, "the Regulations") may themselves use an awfulisation of abortion discourse to frame abortion. Thus, the CTOP Act states that abortion is "not…a method of contraception". I argue that in doing so, it reproduces what Tietze (1974: 148) refers to as "an often vague and generalized anxiety…about the 'problem' of repeat abortions", where constructs abortion *should* be rare/used as an 'emergency measure' only. Concern may therefore centre on normative understandings of abortion in which using abortion (services) more than *once* stretches the socio-cultural limits placed on the normative low tolerance for abortion (Millar 2017). The use of abortion to manage pregnancies may therefore be seen as evidence of 'exceptional deviance'. Indeed, research documents that this framing of abortion may result in abortion seekers who have more than one abortion being especially stigmatised (Stone & Ingham 2011), including during counselling itself. Alternatively, providers may understand their role as gate-keepers tasked with preventing abortion services from being 'abused', with coercive counselling on long-acting reversible contraceptives post-abortion being understood as an acceptable strategy (Mavuso 2018).

Also to be considered is that in the Regulations require abortion providers to inform a "woman" seeking abortion about "(i) the available alternatives to the termination of her pregnancy; [and] (ii) the procedure and the associated risks of the termination of her pregnancy". As such, abortion is arguably constructed within/by the Regulations as "an exceptional and unhealthy procedure" (Pizzarossa & Durojaye 2019, p.60). Consequently, factual and evidence-based information about the *safety* of abortion (including when compared to continuing a pregnancy to term and childbirth) is ignored to frame parenting or adoption placement as inherently preferable (Pizzarossa & Durojaye 2019).

Secondly, while there may be scope within the Act to understand coercive anti-abortion counselling as obstruction to access to termination of pregnancy *and* non-directive counselling (including where abortion seekers are successful in obtaining a legal abortion), . using obstruction to access as a strategy to eliminate coercive anti-abortion counselling may depend on knowledge about the stipulations of the Act (including criminal offences) as well as knowledge about the reporting mechanisms which may be used. Thus, there may be difficulty in achieving this. Indeed, a search using "Choice on Termination of Pregnancy Act" in the Southern African Legal Information Institute (SAFLII) database did not reveal any legal cases that have been tried where directive abortion counselling is framed as obstruction to access (the search did reveal few legal cases that have been tried against illegal providers).

Coercive anti-abortion counselling as reproductive violence

Obstetric violence has been conceptualised as degrading, dehumanising and disrespectful care that birthing women are subjected to in obstetric healthcare settings and facilities (Chadwick 2016). Practices and behaviours traditionally conceptualised as obstetric violence include neglect and the use of treatments that are harmful and/or not medically necessary nor indicated, care that is characterised by or that includes the misrepresentation of risk, a lack of privacy, and consent not being sought at all or being coercively sought for a range of practices (Pickles 2015; Sadler et al. 2016; Vacaflor 2016). Furthermore, obstetric violence has been framed as a form of gender-based violence and thus also includes verbal violence and/or psychological violence and institutional violence (violence that stems from inadequate conditions in institutions and facilities) (de Bruyn, 2003; d'Oliveira et al. 2002). As a framework obstetric violence therefore understands harmful practices and providers' behaviours as institutionalised patriarchal abuse and reproductive control that seeks to regulate women's subjectivities, experiences and bodies during pregnancy, (Castro & Savage 2019; Diniz & d'Oliveira, 1998).

Acknowledging the framework's potential usefulness and relevance to South Africa, Pickles (2015) makes several criticisms of the mainstream conceptualisation of obstetric violence, including: (1) the normative focus on "women" as victims of this violence, with "women" being implicitly framed as cisgender; and (2) the predominant focus on childbirth. Some recent scholarship employs broader conceptualisations of abusive reproductive care by using terms such as "pregnant people" (e.g. Pickles 2015) and "birthers" (Chadwick 2017), and/or by including abortion care (e.g. Pickles 2015; de Bruyn, 2003; d'Oliveira et al. 2002). This notwithstanding, Pickles (2015) calls for conceptualisations of obstetric violence which overcome these and other normative conceptualisations before it can be applied in South Africa.

In response, I understand reproductive violence as the ways in which interacting policies, institutions, and systems of oppression, and the discourses on which they are founded, seek to control and regulate reproductive experiences, subjectivities, decision-making and futures and to enforce normative gendered subjectivities (Griffin & Woods 2009; Ross 2017). By framing reproductive violence in this way, and by drawing on scholarship on obstetric violence practices, we can understand how several of the practices deployed by providers during coercive anti-abortion counselling constitute reproductive violence.

First, is the misrepresentation of risk. This can be seen through the provision of misinformation that abortion 'causes' or 'leads to' infertility, cancer, and inevitable and long-lasting psychological trauma (with medical abortion being framed as invariably mirroring childbirth and inherently traumatic), thus misrepresenting abortion as risky, dangerous and harmful. The construction of abortion as risky was also achieved by *withholding* information about how continuing a pregnancy to birth carries far greater risk than abortion (Pizzarossa & Durojaye 2019), and sometimes by constructing motherhood/parenthood as inherently blissful and/or by minimising the challenges of parenthood. Constructing abortion as risky contradicts the evidence-base on abortion. Indeed, rigorous scientific evidence does not causally link abortion to cancer or infertility (Brown 2013)-it is even recommended practice for providers to inform abortion seekers about *rapid fertility return post-abortion* (IPAS 2014). Regarding the risk of psychological trauma, critical abortion research has shown that abortion seekers' emotional and/or psychological experiences of abortion vary greatly, depending on various factors which include: past experience with mental ill health; the societal construction of abortion as wrong or immoral and the abortion stigma this produces (which can result in non-disclosure about the abortions and thus limit access to social support); whether abortion seekers have support in their decision-making; whether the decision to abort was their own or was

coerced by someone else; and the relationship the abortion seeker has to their pregnancy (including the terms they use to refer the foetus/child) (Major et al. 2009; Kimport, Weitz & Foster 2011).

Unconsented/coerced practices that are harmful and are not necessary nor medically indicated in abortion care is the second set of practices. Making abortion seekers receive information on the development of the foetus/child (including making them view models of foetuses) is an example of this. Although information about the development of the foetus is usually framed as 'necessary' for a 'fully-informed' decision to be made, it is usually imposed to shame, responsibilise and guilt abortion seekers into parenthood (Woodcock 2011). And while some abortion seekers may very well want to receive information about the development of their foetus/child (Fisher & Lafarge 2015), such information should be given only with consent. Imposing delays between first contact with the facility, and the abortion procedure is another example, . When this is done to get abortion seekers to 'rethink' their decision, it serves to create obstacles to healthcare that should be timely. Framing the provision of unsolicited information on the foetus/child and delays in abortion care as serving the 'best interests' of abortion seekers, reflects paternalistic and patriarchal healthcare that undermines pregnant people's decision-making capacity, expertise, freedom and dignity. Furthermore, these practices contradict research (e.g., Brown 2013) that has documented that most pregnant people have already reached a decision by the time they reach an abortion facility. Even when delays between first contact and the procedure are due to long waiting lists caused by a shortage of providers and not enough functioning facilities (Harries et al. 2009), this may be considered institutional violence as it relates to structural challenges that negatively impact on humanised and dignified care. Indeed, the psychological distress caused by delayed care or neglect is recognised as a form institutional violence (de Bruyn 2003).

The possible consequences of coercive anti-abortion counselling may also be understood as reproductive violence. As some of the participants described in their narratives, the most immediate consequences of the content and delivery of the counselling were the hurt and pain, confusion, stress, shame, and fear that they experienced. Care that produces such harm has been described as verbal and psychological violence precisely because it denies abortion seekers their humanity and right to reproductive dignity (Ross 2017). Indeed, d'Oliveira et al. (2002) and de Bruyn (2003) discuss providers' stigmatisation of abortion, and attempts to shame and castigate abortion seekers, as examples of verbal and psychological violence, and Pickles (2015) describes healthcare characterised by shouting, and harsh and unkind interactions as abusive and violent. In this vein, providers' framing of abortion as wrong, and positioning abortion seekers as immoral, is violent in and of itself. Thereafter, forced pregnancy (whether this results in parenthood or not) and being forced to resort to illegal and unsafe abortion practices (which may actually result in infertility, ill health or death) in order to terminate the pregnancy are also forms of reproductive violence since they undermine abortion seekers' right to make decisions about and to have control over their reproduction, bodies and lives (Castro & Savage 2016; Diniz & d'Oliveira 1998).

The language of reproductive violence. enables an understanding of the breadth and depth of coercive anti-abortion counselling and its consequences whilst allowing us to locate it beyond individual providers or facilities, or isolated instances of harm. Indeed, through this language, we can see how the coercive anti-abortion counselling described in this article is part of a patriarchal machinery that constructs certain 'truths' about abortion to enforce motherhood on abortion seekers who are presumed to be cis women. The language of the CTOP Act and its Regulations, and the inaccessibility of abortion are also part of this machinery. Through the language of reproductive violence, then, coercive anti-abortion counselling can be understood as an example of reproductive governance by the State to achieve reproductive control (Castro & Savage 2019), in this case with the aim of preventing abortion and enforcing motherhood (Tamale 2016). Thus, coercive anti-abortion counselling is not only political as Vincent (2012) suggests, but also violent in the State's attempt to produce (cis) women who use LARCs to plan their pregnancies and who parent once they have conceived, thus precluding the need for abortion. Given the State's role in enabling and producing this violence, then, it is the responsibility of the State to urgently address this violence and ensure dignified, humanised abortion care to which abortion seekers are entitled and of which non-directive counselling is an indispensable part.

The possibilities of understanding coercive anti-abortion counselling as reproductive violence notwithstanding, its success in eliminating coercive anti-abortion counselling may require additional legislation and state capacity, as well as awareness campaigns about such legislation and the relevant reporting mechanisms to ensure accountability. Whether or not such legislation is developed,

it is vital that the conceptualisation of reproductive violence decentres cis women as the default and therefore only legitimate subjects of gestational reproductive experiences and violence. It is also important that understandings of reproductive violence as gender-based violence do not anchor cis women to "gender". This is because the normative anchoring of cis women to gestational experiences and to "gender-based violence" has grave implications, even when applied to research where abortion seekers *are* (cis) women. These implications concern, among others, our ability to recognise, respond to and eliminate reproductive violence perpetrated against people with uteri and in all its manifestations. They also concern our ability to fully understand and act against patriarchal systems, including cisnormativity, that produces, justifies, trivialises and obscures this violence and the connections running through them.

An afro-feminist perspective on coercive anti-abortion counselling

Afro-feminism(s) is grounded in and seeks to visibilise the diversity of African realities. It understands that interacting systems of power, such as (cis)patriarchy, racism, classism, and neo-colonialism and imperialism, shape and produce African realities (Tamale, 2020). Conceptualised this way, Afro-feminism(s) may, I argue, provide an important, critical and robust framework for understanding the severity, scope and impact of the violence of coercive abortion counselling. It also enables us to comprehend the implications of conceptualising (cis) women as the only legitimate subjects of abortion care, gestational reproductive experiences, and reproductive violence.

An Afro-feminist perspective enables us to understand how coercive anti-abortion counselling in public healthcare facilities creates a racialised and classed burden of reproductive violence and its consequences. This burden is borne out by black, poor pregnant people for it is black, poor communities who largely rely on public healthcare. Psychological services are inequitably distributed and remain largely inaccessible for the black poor majority (Pillay & Barnes 2020). Thus, the support that may be needed to address the psychological harm caused or exacerbated by coercive anti-abortion counselling may be inaccessible, with abortion seekers being left to manage this harm themselves. Coercive anti-abortion counselling may force abortion seekers to resort to illegal and unsafe abortion. As such, black and poor abortion seekers may bear the brunt of the consequences of unsafe abortion. Therefore, an Afro-feminist perspective may help us to see how colonial and apartheid patterns of devaluing the reproductive freedoms of black people (Klausen 2015; Tamale 2016) are continued in a post-apartheid democratic South Africa by restricting access to dignified abortion care through coercive anti-abortion counselling. Coercive anti-abortion counselling results in forced parenthood. Thus, an Afro-feminist perspective allows us to recognise as gender-based violence attempts to reproductively control people with a capacity to gestate based on and in order to enforce compliance with patriarchal constructions of gender and sexuality (not limited to womanhood)(Tamale 2016).

As mentioned earlier, one of the three hospitals where data were collected had outsourced the 'options-based' component of abortion counselling to a US-funded Christian-based pregnancy crisis centre. Using an Afro-feminist perspective, we may understand the involvement of US-funded Christian-based pregnancy crisis centres in South African abortion service provision as perhaps the latest in US neo-colonial and imperialist geo-political attempts to control the reproductive freedoms and futures of black, poor pregnant people in the global South (see Lane, Ayeb-Karlsson & Shahvisi 2020 and Tamale 2016). The outsourcing of aspects of abortion counselling to these centres may in turn be understood as the South African State's own patriarchal investment in a reproductive control, anti-abortion agenda, and/or a result of inequitable and coercive population control-based funding agreements.

The coercive anti-abortion counselling practices and experiences thereof described in this article are underpinned by a cisnormative imagining of abortion service users as cis women. I argue that it is precisely through our patriarchal, cisnormative and repronormative understandings of sex, gender, pregnancy and reproduction that people with vaginas and uteri are imagined as cis women and always already mothers. It is through/by these same systems that motherhood is anchored to biology and is therefore naturalised, normalised and expected of/for cis women. This cisnormative imagining of pregnant people as (cis) women is reflected in everyday, feminist, and legal discourse (e.g. the CTOP Act and its Regulations in South Africa) on abortion. Cisnormativity is also reflected in the imagining of pregnant people as cis women in obstetric violence scholarship, such that obstetric violence is normatively conceptualised to centre on the experiences of (cis) women. As a result, (cis) women are positioned as the only (possible, legitimate) subjects of this violence. What does it do to

centre (cis) women in abortion and reproductive violence scholarship and activism this way? What is lost by doing so?

First, it means that when we do so *as* African feminists and *within* African feminist scholarship, we fail to acknowledge and therefore engage in a violent erasure of the sex and gender diversity of African people, including the diversity of those with the capacity to gestate and of abortion seekers more specifically. When we do so, we are in effect creating a cisnormative and patriarchal account of African people and African realities. As such, we fall into the same trap and perpetrate the same harms for which African feminists (see, for example, Matebeni and Msibi 2015; Tamale 2020) have rightfully criticised African politicians and governments: whether intentionally or inadvertently, we produce narrow and exclusionary representations of "Africa", who belongs and who can claim an "African identity".

Second, we miss opportunities to contribute to a robust African theorisation that acknowledges, and is able to fully theorise around, the legacies, operations and consequences of patriarchal/colonial binary constructions of sex and gender (Lugones 2007) that imagine pregnant people as (cis) women and female (Radi 2020) and position cis women as always already mothers (Millar 2017). De-anchoring cis women from pregnancy whilst visibilising cisnormativity may enable us to reckon with the ways these assumptions about pregnancy, gender and sex underpin the design, content and delivery of abortion care to harm people with uteri (Moseson et al 2020). We may also be better able to recognise the connections across a range of violent experiences. For example, the violences perpetrated in/through dehumanising abortion counselling that shames abortion seekers for not parenting or that constructs abortion seekers as 'undesirable' reproducers and encourages or pressurises them to *not* parent. We can also understand as reproductive violence the ways in which trans and non-binary people with and without uteri are denied reproductive care or are subjected to care that is dehumanising and undignified (Riggs, Pfeffer, Pearce, Hines & White 2021), including that characterised by misgendering, invasions of privacy, violations of bodily integrity, and transphobia (Luvuno, Ncama and Mchunu 2019). Decentring cis women from pregnancy whilst visibilising the cisnormative foundations of patriarchy may also enable us to further our understanding of abortion counselling practices and experiences, and the ways in which abortion and gender are socio-culturally regulated, in similar and divergent ways, for different abortion seekers. For example, we might ask: How is abortion counselling practised when abortion seekers' gender and sex identities and expression disrupt normative, cispatriarchal assumptions about who pregnant people and abortion seekers are and should be, patriarchal ideas about pregnancy and about gender? What reproductive violences do providers perpetrate and the state enable/support in/through such counselling? Lastly, de-anchoring cis women from pregnancy may enable us to de-couple "cis womanhood" from "gender", thus enabling us to be critically reflexive about and sharpen and expand our understanding of gender-based violence as violence that enacts and enforces patriarchal gender relations and patriarchal constructions of gender, including violence perpetrated against sexually and gender diverse people (Goldscheid 2015).

Conclusion

In this article, I have drawn on research documenting the pre-abortion counselling experiences of four providers and 30 abortion-seeking (cis) women to explore the possibilities of understanding coercive anti-abortion counselling first as obstruction to access and then as reproductive violence, ultimately arguing that the language of reproductive violence may be more productive. For example, for making visible the role of the state in enabling and perpetrating this violence, and its responsibility for eliminating it. Eliminating coercive abortion counselling requires, firstly, the development of regulations and guidelines that delimit who is allowed to provide abortion counselling and that regulate the content of abortion counselling so that it *excludes* instead of being informed by a patriarchal anti-abortion narrative and a cisnormative presumption that abortion seekers are cis women. Secondly, the provider training necessary to effect these regulations and guidelines and to ultimately ensure the CTOP Act's promise of non-directive abortion counselling. These regulations, guidelines and training will need to be underpinned by an afro-feminist and reproductive violence framework that de-anchors cis women from abortion and pregnancy more generally, that understands coercive abortion counselling as reproductive violence, and that understands the ways in which the state perpetrates this violence. Thirdly, it may be useful to develop reproductive violence legislation to govern reproductive care and service provision. Such legislation would need to recognise the sex and gender diversity of people with uteri, and encompass a wide range of reproductive services.

A cisnormative logic that positions pregnant people as cis women is evident in the stories about abortion, pregnancy, and obstetric violence that are circulated by feminist scholars and activists. This means that *we*, too*,* and perhaps especially, must do the work of de-anchoring cis women from pregnant subjectivity and reproductive experiences. Doing so will mean that we are able to contribute to theorisation that expands understandings of reproductive violence, and that reflects the diversity of African people's reproductive realities and experiences. If we do, there is the real possibility that we will create a world in which the words "dignified", "respectful", "compassionate" and "good" characterise abortion care, happy abortion experiences are common, and reproductive violence, in all its many manifestations, is eliminated for all people with and without uteri.

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