Paradigma: Jurnal Kajian Budaya

Volume 12
Number 3 *Vol 12 No 3 tahun 2022*

Article 6

12-31-2022

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Franceline Anggia
Universitas Gadjah Mada, franceline.anggia@gmail.com

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Cover Page Footnote

I would like to thank all the counselors and health workers for their willingness to participate in this study. My deepest thanks to my thesis supervisor from Universitas Gadjah Mada, Mbak Elan Lazuardi, PhD., for her invaluable comments on my thesis back then. This article would not have been possible without the guidance from my thesis supervisor from University of Agder, Associate Professor Margit Ystanes, who had patiently given fruitful advices throughout the process of writing my thesis.

Paradigma Jurnal Kajian Budaya Vol. 12 No. 3 (2022): 311–333

"IT IS HER DECISION, NOT MINE" THE PROBLEM OF CHOICE IN ABORTION CONSULTATION SERVICES IN NORWAY[1]

Franceline Anggia
Fakultas Ilmu Budaya, Universitas Gadjah Mada; franceline.anggia@mail.ugm.ac.id

DOI: 10.17510/paradigma.v12i3.1037

ABSTRACT

Since 1978, women have been granted legal rights to self-determined abortion, from which the idea of women's right to choose achieves its victory in the current Norwegian abortion law. Behind this notion of choice lies an assumption that perceives women as subjects of choice who should personally decide whether or not having an abortion would be the proper way to overcome difficult decisions on their pregnancies. Women's right to choose is celebrated as an ideal concept in consultation services for women who face difficult decisions on whether or not to have an abortion. Counselors and health workers I interviewed used the notion of women's right to choose to describe the professionalism of their work; that is, to create distance from a woman's decision-making process. By employing engaged listening to collect ethnographic data, this study explores limitations encountered with the idea of women's right to choose as applied to care practices for women who are uncertain about their pregnancies. This inquiry examines care relations formed under conditions where the notion of individual choice is not ideal in practice. This study shows how individual choices are socially bound. Women's status as subject of choice is not predetermined but enacted through emotional labor performed by healthcare professionals, which could affect clients' openness and self-efficacy to enact a choice. Emotional labor challenges the claim of neutrality which was described as being emotionally detached from clients, as emotion itself is often deemed insignificant for making rational decisions.

KEYWORDS

Abortion; women's right to choose; care; neutrality; emotional labor; Norway

ABSTRAK

Sejak 1978, undang-undang aborsi di Norwegia melegalkan aborsi berdasarkan permintaan maksimal dalam dua minggu pertama kehamilan. Legalitas ini menandai kemenangan atas gagasan "hak perempuan untuk memilih" (*women's right to choose*). Hak perempuan untuk memilih dalam konteks aborsi dianggap ideal dalam layanan konsultasi untuk perempuan yang mengalami kesulitan memilih antara melanjutkan kehamilan atau aborsi. Perempuan dianggap sebagai subjek pilihan yang selayaknya memutuskan sendiri apakah aborsi

1 This article is a summary of the author's master's thesis.

merupakan cara yang tepat untuk mengatasi kesulitan kehamilan yang tidak diinginkan. Wacana "hak perempuan untuk memilih" secara umum diterima oleh tenaga kesehatan profesional yang saya jumpai. Wacana itu digunakan untuk mendeskripsikan kerja profesional mereka, yakni dengan menciptakan jarak dari proses pengambilan keputusan klien yang mereka tangani. Dengan menerapkan *engaged listening* dalam proses pengumpulan data etnografis, penelitian ini mengeksplorasi keterbatasan "hak perempuan untuk memilih" yang diterapkan pada praktik pelayanan konsultasi untuk perempuan yang mengalami kesulitan memilih antara melanjutkan kehamilan atau aborsi. Dengan mengeksplorasi kondisi "hak perempuan untuk memilih" yang tidak ideal dalam praktiknya, penelitian ini berupaya menunjukkan relasi yang terbentuk antara klien dan tenaga kesehatan profesional yang membantu klien membuat pilihan. Penelitian ini menunjukkan bagaimana pilihan individu terikat secara sosial dan perempuan sebagai subjek pilihan dibentuk melalui praktik relasional yang melibatkan *emotional labor* yang dilakukan tenaga kesehatan profesional. *Emotional labor* memengaruhi keterbukaan klien dan kemampuan membuat keputusan sendiri. *Emotional labor* kontradiktif dengan klaim terhadap netralitas yang diterjemahkan sebagai tidak terlibat secara emosional dengan klien, emosi cenderung dianggap sebagai elemen yang tidak bernilai untuk membuat keputusan rasional.

KATA KUNCI

Aborsi; hak perempuan untuk memilih; *care*; netralitas; *emotional labor*; Norwegia

1. INTRODUCTION

> *"I Høyre deler vi KrFs (Kristelig Folkeparti)[2] sterke bIekymring for en utvikling mot sorteringssamfunnet, og ønsker et samfunn med muligheter for alle. Vi må legge til rette for et samfunn som tar godt vare på personer med utviklings- eller funksjonshemninger, og at familiene får hjelp. Vi er ikke enige om alt, men har forståelse for at KrF har behov for å sette sitt verdipreg på en eventuell regjeringsplattform."*-Solberg, 2018.
>
> ["In the Conservative Party, we share the Christian Democratic Party's strong concern for development towards the sorting society[3] and want a society with opportunities for all. We must facilitate a society that takes good care of people with developmental or physical disabilities, and that families receive help."][4]-Solberg 2018.

In Norway, women's right to choose abortion is regulated by the Act Relating to the Termination of Pregnancy of 1975. It is not until 1978, women have been granted legal rights to self-determined abortion within the first twelve weeks of pregnancy. After the first twelve weeks, pregnant women who wish to terminate their pregnancy must apply through a medical assessment board which will decide on the approval (or disapproval) of the termination of their pregnancy (Helse Norge 2020; Løkeland 2004, 168). Based on this account, women's bodily integrity and choices over reproductive lives are part of citizenship rights, thus, it becomes an essential element of being a Norwegian citizen. Nonetheless, the abortion debate still touches on tricky ethical questions, even in Norway where the state has legally protected individual rights to abortion for more than 40 years. The victory of women's right to choose in the current Norwegian abortion law should not veil the contentious debates around rights that have long existed in the Norwegian history of abortion rights.

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2 English: Christian Democratic Party.

3 This concept expresses the fear that selective abortion (i.e. abortion on the grounds of fetal malformation) would sort human life, especially those with mental and physical disabilities as an undesirable group in society.

4 Special thanks to my thesis supervisor from University of Agder, Margit Ystanes, who helped me translate this statement into English.

The statement introduced at the beginning of this chapter was an expression of view written by Erna Solberg, Norway's former Prime Minister (2013–2021) from the Conservative Party, when the heated debate around abortion rights re-emerged in 2018 at the center of the Norwegian political arena. That statement was Solberg's argument concerning Norway's current abortion law which she deemed discriminatory. Echoing the human rights discourse that is employed by many anti-abortion activists around the world, Solberg, in line with Christian Democrats, emphasized the idea of discrimination towards a fetus with Down Syndrome. Solberg proposed to remove the clause that allows abortion if there is a high risk that the fetus may be severely ill as the result of hereditary conditions, illness, or harmful influences during pregnancy (The Abortion Act 1975, §2c). This clause is known as the 'Downs paragraph', although there is no explicit statement in this clause that mentions Down Syndrome as a special condition for having an abortion. The so-called 'Downs paragraph' was considered discriminative because it renders a group of people into the secondary status and, at the same time, implies that people with mental and physical disabilities are less worthy in society.

Solberg's aim to tighten Norway's abortion law gained strong reactions because it threatens women's right to choose abortion which has achieved its victory in the current Norwegian abortion law. Some said that Solberg's voice to tighten the abortion law was her political maneuver to gain votes in the 2021 election from the Conservative and Christian Democratic Parties, the two prominent parties that had kept Solberg's government in power. Solberg and Christian Democrats' arguments reveal how the human rights discourse can be used to shape negative perceptions of abortion and, in turn, constrain women's reproductive options. At the same time, the group of pro-choice also uses the language of human rights to secure and expand women's opportunity to choose to have an abortion.

Moreover, the debate around abortion in Norway was not primarily about the women's right to choose versus the fetus' right to life. It also involved long-term contestations on Norwegian medical personnel's right to refuse an abortion based on religious and moral grounds (see Løkeland 2017). Not specific to Norway, the discursive struggles about individual rights and abortion have long been the core of the abortion rights debate across the world. The proponents and opponents of abortion rights may use the human rights justification to support women's right to terminate pregnancies and shape negative perceptions of abortion respectively. Although both the proponents and opponents of abortion rights may use the discourse of human rights to sustain their aspirations, the tensions around 'whose right should be prioritized' in the case of abortion debates disclose the ambiguity of the human rights discourse in its usage.

The firmly held human rights values have played an integral part in building Norwegians' self-understanding. The ongoing production of the image of Norway as a peace-making country and the promotor of democracy and human rights has long been intended to construct the Norwegian national identity, which in turn reinforces Norway's political power in the global arena. The Norwegian education system, through its human rights education, becomes a powerful instrument to influence people's values, norms, and attitudes and to establish a common self-understanding of Norwegian as a highly moral nation (Vesterdal 2019). This self-understanding—which is rooted in the fundamental values of human rights—originates from the social imaginary of cultural homogeneity and the ideal notion of a community, based on universalistic principles (Eriksen 2013, 7; Sümer & Eslen-Ziya 2017, 24). With its central principle of egalitarianism and individual choices, human rights as a set of values have been the underlying force behind the Nordic countries' legal system (Askola 2017).

The notion of human rights perceives humans as equal in rights regardless of gender, class, age, sexual orientation, and other varying aspects of identities. From the view of human rights, all humans have the right to make their own decisions. Individual autonomy and self-determination are two prominent values of human rights (Lottes 2013, 367–391). The reproductive rights movement in the 1960s lies in these values.

In pursuing women's bodily integrity, women can gain control over their reproductive lives if they are given access to adequate information and accessible reproductive health services (Freedman & Isaacs 1993, 19). The Program of Action adopted at the International Conference on Population and Development (ICPD) (2004) asserts reproductive health as a fundamental human right. It includes the right to make decisions concerning reproduction that is free from discrimination, coercion, and violence. From this viewpoint, no one should preclude a person's autonomy over their decisions on the reproductive processes.

Abortion is arguably one of the most debated reproductive issues. Safe abortion and women's opportunity to decide whether or not to have an abortion are the main objectives of the reproductive rights movement. From the perspective of reproductive rights, women are the leading actors of biological reproduction who are most affected by pregnancy. Since it is a woman's body that is involved, thus the right to decide on performing an abortion or not should primarily fall upon a woman's shoulder.

Nonetheless, the widely-celebrated individual choices and autonomy in the abortion rights debate might be problematic and dubious because, as Jaggar puts it, "it is a right whose existence depends on certain contingent features of the social situation in which women find themselves" (Jaggar 1994, 281). Hence, the acclamation of individual choices leaves many unanswered questions regarding the conditions in which choices can and should be made. In practice, there really is no individual choice in any absolute way because choices are structured within certain social conditions (Rothman 1994, 329).

The idea of women's right to choose overlooks social relations, sexual division, or in broader terms, the power networks within which choices are made (Porter 1994). The virtue of egalitarianism and a straightforward attitude towards adolescent sexuality still do not address the complexity and various understandings of intimacy, privacy, and the association between the body and morality. Bartz (2007, 18) noted that not all Norwegian share common backgrounds and values. Tracing the historical debate on abortion rights in Norway, the debate did not revolve around a singular topic. As a Lutheran-dominated Scandinavian country, Christian morality[5] has been a central virtue that has led to criticism against the Norwegian pro-choice-based abortion law. In this regard, the proponents and opponents of abortion rights employ the language of human rights to support women's right to choose an abortion and the fetus' right to life respectively (Stenvoll 2002).

Based on fieldwork in two sexual and reproductive health clinics in Norway, the widely celebrated individual choice seemed intrinsic in care practices offered to women who face difficult decisions regarding their pregnancy. Pregnant women were seen in the best position to judge whether or not having an abortion would be the right choice in their situation. They were also viewed as independent and autonomous. Thereby, they should be given an opportunity to exercise their right to decide for their own bodies. The seemingly ideal concept of individual choice that forms the basis of this care provision contradicts the fact that most pregnant women who come to the clinics are in a state of 'crisis': they are anxious, frightened, and some are embarrassed. In such situations, they do not know what to decide and how they should decide for themselves. These reasons are what prompted them to seek care in the first place.

Ethical questions, the relationship with sexual partners, and conflicting life trajectories with women's significant others, have made the process of enacting a choice deeply conditional, rather than absolute. This life condition is acknowledged, understood, and mediated by the consultation services in which a pregnant woman engages in. In the consulting room, making a decision is not disconnected from relational practices involving the pregnant woman and healthcare providers who guide a pregnant woman to arrive at a decision.

5 Christianity has been the leading religion in Norway since the end of the Viking age. In 1536, when Norway was still in a union with Denmark, the Protestant reformation was enforced, and it transformed Catholic Church into a national Lutheran Church (Mikaelsson 2009, 121). As of 2021, the majority of the population in Norway are members of the Church of Norway, with 65% of the total population belongs to the Evangelical Lutheran Church of Norway (Statistics Norway 2022).

Enacting an individual choice turns out to be a process that is deeply relational, although all healthcare professionals that were interviewed commonly perceived woman clients they met as autonomous deciders.

In thinking about the limit of the general abstract rights of women's right to choose, several questions can be raised: To what extent can 'women's right to choose' be implemented in practice? In what conditions is it not ideal? What kind of care relations are formed when an individual choice is hard to pursue?

To address the abovementioned questions, I begin to explore how the discourse of women's right to choose is employed in care practices for women who experience decisional uncertainty towards their pregnancy. From this discussion, I unravel how the interviewed healthcare professionals define an ideal choice for woman clients they met daily. In exploring how healthcare professionals define an ideal choice for their clients, this study explains conditions where the idea of individual choice is not ideal in practice. These conditions lead to the exploration of the relationships of care when clients' individual choices are difficult to pursue. From this inquiry, I would suggest an alternative understanding of women as the subject of choice that has been widely celebrated in the debate on abortion rights as well as in care practices that address pregnant women as autonomous deciders of their bodies.

All the discussions in this study are based on my interviews with healthcare professionals whose job titles are counselors and health workers. All healthcare professionals I encountered are not direct providers of abortion. Counselors are responsible for facilitating a pregnant woman to make a choice around abortion, while health workers provide clinical examinations for pregnant women. All of my interlocutors have no involvement in the operation of abortion. This study does not provide pregnant women's experiences and perspectives in regard to abortion and pregnancy. My exploration of the problem of choice is based on the stories of healthcare professionals who guide women who experience decisional uncertainty towards their pregnancy.

2. CONDUCTING FIELDWORK IN CLINICAL SETTINGS

I visited two sexual and reproductive healthcare clinics in Norway for the duration of this study. These two clinics are referred to here as Dronningens and Kirkegata[6]. Dronningens is a family clinic owned by a municipal authority[7] in Southern Norway. Dronningens provides free health and care services for pregnant women and children between 0-18 years old[8][9]. In 2021, Dronningens had 271 pregnant women as their clients.

Dronningens offers prenatal and postnatal care and family consultation concerning breastfeeding, family planning, contraception, and motherhood. By the time I conducted research in Dronningens, there were 28 health workers consisting of four midwives, four physiotherapists, seventeen public health nurses, and three physicians. When I visited Dronningens by the end of autumn in 2021, I spoke to three health

6 The names of the two clinics I use in this article are pseudonyms.

7 Norway has two systems of local government: the municipalities and the county authorities. The municipalities and county authorities have the same administrative status–meaning that the central government has the supervisory authority of both municipal and county administration. There are 428 municipalities and 19 county authorities in Norway. The main difference between the municipalities and county authorities is linked to the distribution of tasks and responsibilities. The main representative of the central government supervising local authorities is the County Governor (Norwegian Ministry of Local Government and Modernization 2014, 8).

8 In Norway, however, healthcare is not by all means free. According to Helse Norge (2019), although residents of Norway are entitled to medical services, they must pay a user fee for accessing these services. This fee refers to an annual deductible medical expense equivalent to roughly 2,040 Norwegian Krone (NOK)/ 214 USD. After a person pays this fee, they will get an exemption card if they are member of the Norwegian National Insurance Scheme. This insurance will start to cover the cost of healthcare services. However, medical examinations during pregnancy and after giving birth are free in Norway (Norwegian Ministry of Labor and Social Inclusion 2022, 19).

9 In Norwegian legal term, child means every person under 18 years old (Norwegian Ministry of Children and Equality 2016).

workers. The term 'health worker' used in this study refers to interlocutors who work at Dronningens as their task involves performing clinical examinations for their clients. Although Dronningens does not specifically offer services related to abortion, I still consider this clinic an important field site to support and deepen my understanding of the reproductive healthcare system in Norway.

The second clinic I visited was Kirkegata. Kirkegata is a nationwide free health service specializing in abortion guidance. By specializing in consultation for abortion, Kirkegata does not provide abortion services on its own. In addition to consultation around abortion, Kirkegata offers various services that cater to not only women but also couples and men, including consultation around contraception, family planning, and pregnancy that could affect the life of the man whose partner is pregnant. In addition to this, Kirkegata also provides consultation for women who face difficulties in taking care of their children alone and those who experience emotional and relational dilemmas after having a spontaneous or self-determined abortion. Kirkegata's primary mission is to reduce individual and societal burdens when a pregnancy is experienced as challenging. In the case of pregnancy and abortion, counselors at Kirkegata are responsible for guiding women to arrive at a decision that feels right to the women themselves.

Kirkegata had 4.710 clients in 2021. Within the same year, the percentage distribution of clients based on gender showed that 87,5% of Kirkegata's clients were women. Data categorized based on age groups showed a higher percentage of women between the ages of 20–39 visiting the clinic to consult about abortion. Unlike Dronningens, Kirkegata is privately owned and mainly financed through grants over the state budget. On several occasions, Kirkegata ran projects in cooperation with municipal authorities and government-owned institutions, which also have concerns regarding sexual and reproductive health, especially for people from minority backgrounds who reside in Norway. In addition to the grant scheme from the state, Kirkegata receives project-based funds from its cooperation with non-governmental organizations. These projects are not only limited to counseling practice but also dialogue groups and education regarding sexual and reproductive health and rights, which mainly target people from cultural minority backgrounds.

Kirkegata has seventeen counselors spread across eleven branch offices throughout Norway. During fieldwork, I interviewed four counselors with various educational backgrounds, ranging from midwifery, public health nursing, and social work, to child welfare. Unlike the interlocutors from Dronningens, the title 'counselor' refers only to interlocutors who work at Kirkegata as their work primarily focuses on counseling practices, not medical examinations. Aside from counselors, I interviewed a manager at Kirkegata who is also the supervisor of the counselors.

From the two clinics, Kirkegata was my main field site. What I present in this study focuses more on the counseling practice at Kirkegata, given its expertise in guiding clients to choose between pregnancy and abortion. Nonetheless, I still consider Dronningens as an important field site since my encounter with health workers from Dronningens has provided me with invaluable insights into how the issue of abortion and reproductive health, in general, is framed in Norway.

In this inquiry, I employed qualitative methodology inspired by ethnography for primary data collection. Upon writing this section, I kept questioning and feeling inadequate about whether I had done 'proper' ethnographic research due to the several limitations I encountered during fieldwork. In specialized clinical settings, I could not participate in ongoing clinical activities and could not observe while maintaining and balancing both intimacy and distance with the research subjects.

Having been trained in anthropology, I am familiar with participant observation, which is the gold standard for doing proper ethnographic research. Unfortunately, I could not conduct participant observation in a specialized clinical setting as I could not follow activities in the consulting room. This is because the

consulting room is considered a private space for clients, not to mention the duty of confidentiality that each clinic has to maintain.

I had all interviews with interlocutors through appointments. Most of the time, we had time constraints during interview sessions since some of my interlocutors had a consultation session with their clients directly after being interviewed. It was extremely difficult to have extended conversations with the interlocutors outside our appointments. Sometimes I could sense the gesture of restlessness when the interview session occurred longer than the expected time. To sum up, the field is time-bounded, in which having an extended conversation outside the set time was not really possible or even desired by the research participants.

My experiences remind me of Gitte Wind (2008) who stated that the lack of possibility to participate in an immersive capacity is intrinsic to most clinical or hospital ethnography, which happens to be the same case as mine. Doing research in clinical settings made me realize that I had never been in a situation where I had to ponder the limitations and impossibilities of performing participant observation in ethnographic research. In conducting this study, the social and physical arrangements in the clinics were not conducive for me as an 'outsider'—in a professional and ethical sense—to be immersed in the ongoing clinical activities. In this kind of situation, doing research in clinical settings has much to do with trust.

Considering these particular characteristics of the fieldwork, I thought that interview-led research might be a culturally and ethically appropriate method for this study. At first, this choice evoked a feeling of apprehension in me. However, this feeling has left room for reflections on how to do ethnographic research without placing participant observation as the main, if not, the only, orbit of the data collection process. Such self-doubt was distressing not until I read Martin G. Forsey's work in which he proposed *engaged listening* as "an equally valid way of gaining ethnographic knowledge" (Forsey 2010, 567) other than participant observation. Forsey suggested focusing ethnography on its purpose rather than seeing it as a mere method. For Forsey, ethnography aimed to provide an understanding and explanation of the cultural context of lived experiences. One way to achieve this is to listen deeply to interviews with 'ethnographic imaginary'—meaning asking questions beyond the immediate concerns of the research questions.

As Forsey puts it, privileging participant-observation at the center of producing ethnographic data may result from the prolonged domination of using visuals as the core method of knowing and understanding, particularly in Western and scientific culture. It increases the risk of experiences of other senses, namely smelling, tasting, and listening, to be placed at the bottom of the methodological pyramid in ethnographic research. What I present in this study is based more on what I listened to people I met rather than on what I observed them do.

Three interviews were carried out at the clinics where my research participants worked. Simultaneously, four interviews were conducted online because some research participants did not work at the office located in the same city where I stayed. In other words, my research was not bounded by geographic or administrative borders but was more tied to the idea of human rights and women's right to choose used by healthcare institutions, and how these notions are employed in the work of healthcare professionals when guiding women who experience decisional uncertainty towards their pregnancy.

English was the language used for the interviews. Nearly all of the interlocutors I met did not speak English as their first language, nor do I acquire English as my first language. Norwegian is the primary language of all interlocutors I spoke to, except for one interlocutor who grew up in an English-speaking country. Though all conversations were enacted through a language that was not the primary language of both mine and the interlocutors, I acknowledge that the genuine meaning is otherwise spoken through the mother tongue. There are things that translation cannot give justice to.

3. ABORTION AND THE CONTESTATION OF RIGHTS: THE CASE OF NORWAY

In Norway, women have been entitled to the right to self-determined abortion since 1978. Different regulations apply if a woman aims to have an abortion beyond twelve weeks of pregnancy: a woman must apply for permission to a medical assessment board consisting of two medical doctors who will assess the application and decide whether a woman can have an abortion or not. After applying for permission, the woman will be called for a preliminary medical examination and be invited to a meeting with the board to explain her situation. If the application is denied, it will automatically be referred to the Norwegian national appeals board, which serves as the only national board that considers all applications for abortion throughout Norway.

Within the first twelve weeks of pregnancy, women can submit an abortion request to a gynecology department at any public hospital and make an appointment for abortion directly. Public hospitals with a Department of Obstetrics and Gynecology are obliged to provide abortion services. Only medical doctors are entitled to perform abortions in Norway, although the law does not prohibit delegations under the supervision of health professionals (Løkeland 2015). Abortion in Norway is free of charge unless a woman is not a resident of Norway or a member of the Norwegian National Insurance Scheme[10]. For those who request an abortion, there will be no periods of reflection to reconsider their decision, and they do not have to state the reasons for the pregnancy termination. If a woman is under 16 years old, parents or guardians will be given a chance to share their opinions if there are no particular reasons why they should not be given the opportunity (Helse Norge 2020).

From the perspective of self-determined abortion, women are seen as subjects who have the ability to choose between alternative courses of action. The opportunity for self-determined abortion gives women greater autonomy and control over their reproductive decisions. On a substantial note, the victory of women's right to choose in the current Norwegian abortion law is the result of long-term contestations of rights that also characterise abortion rights debates worldwide. The debates on abortion have frequently revolved around two issues: women's rights to choose as opposed to the right to life of the unborn fetus (Løkeland 2017, 194). Such is also the case in Norway. When the law of self-determined abortion was passed in 1978, this issue split the Norwegian Parliament into two factions. The first faction consisted of members of the Labor Party and the Socialist Left Party. They were the proponents of abortion on demand. On the other side, the opponents were all members of Parliament from the Christian People's Party, the Liberal Party, the Center Party, the Conservative Party, and the Progress Party (Stenvoll 2002, 288–289).

The Labor Party and the Socialist left support self-determined abortion. Allowing women to choose was seen as a crucial precondition for women to gain control over their reproductive lives. Strongly emphasizing their arguments on class perspectives, the defenders of women's rights choose to argue that a restrictive abortion law will mainly disadvantage women from lower economic backgrounds. They may resort to finding unsafe and illegal abortions, whereas well-off women may find abortion abroad (Stenvoll 2002, 291).

Meanwhile, members of Parliament from the Christian People's Party were quite vocal in supporting the rights of the unborn fetus based on theological perspectives. They contend that the fetus should be seen

10 A guideline published by the Norwegian Ministry of Labor and Social Inclusion (2022) provided categories of who are compulsorily insured under the Norwegian National Insurance Scheme. This document states that "as a general rule, all persons who are either resident or working as employees in Norway or on permanent or movable installations on the Norwegian Continental Shelf, are compulsorily insured under the National Insurance Scheme" (p. 4). Persons who are not compulsorily insured by this insurance scheme may apply for voluntary insurance, if certain conditions are met. Persons insured by the National Insurance Scheme are entitled to several benefits, including cash benefits and medical benefits in case of maternity. Excluded from compulsory insurance are "foreign citizens who are employees of a foreign state or of an international organization. The same applies to persons with a short-term employment in Norway and persons exclusively receive pension from abroad" (p. 5). In general, full employment is the basic principle of being compulsory insured by the Norwegian National Insurance Scheme.

as a human being with its own rights from the moment of conception. The fetus is viewed as holy and closer to the divine being (Petchesky 2000 337), regardless of the development stage of the fetus. In contrast, pregnant women are viewed otherwise: sinful, irresponsible, and selfish. Conservative Christians, whose arguments are based on theological perspectives, tend to equate abortion with the taking of human life. This argument stresses the human characteristics of the fetus and the inhumanity of pregnancy termination. This kind of view reflects Christian arguments based on theological concepts, such as a man being created in God's image and the sanctity of human life. Religious ethics, as represented by Christian People's Party, has shaped the landscape of the abortion rights debate in Norway although Norway has been generally recognized as a rather secularized country, where religion is thought to play a minor role in Norway's public life and politics (Markkola & Naumann 2014).

When the Norwegian Parliament passed the law of self-determined abortion in 1978, the state church of Norway (Evangelical-Lutheran denomination of Protestant Christianity) was the strident opposition to self-determined abortion. At that time, some state church priests felt they could no longer be agents of the state church and started questioning their relationship with the state. The new abortion law conflicted with the common notion of the value of human beings and Evangelical-Lutheran Christianity as the state religion (Hassenstab 2014). However, it is important to note that Christian arguments on the right to abortion are not uniform and do not merely reflect complete disapproval of abortion. For example, in 2021, the Lutheran Bishop's Conference acknowledged the church's lack of commitment to women's liberation and rights which has placed an additional burden on women in their difficult situations. This conference ended up with a statement: "a society with legal access to abortion is a better society than a society without such access", while at the same time emphasizing that the fetus owns life with its own value and thus shall be protected (Den Norske Kirke 2021).

The significant role of theological perspectives in shaping the abortion rights debate is not specific to Norway. In Norway's culturally-similar neighboring country, Sweden, the notion of human dignity has also been taken by Lutheran theologians when it comes to debates on abortion. The church of Sweden is now more open towards the legitimation of abortion despite the Catholic Church and some more conservative Lutherans expressing clear opposition to abortion (Da Silva 2009).

The second widely-debated topic is the right of Norwegian health professionals to refrain from performing or assisting an abortion. Under the current Norwegian abortion law, Norwegian health professionals have the right to consciously object to performing or assisting an abortion based on religious or moral considerations. The term 'consciously object' refers to "the right of medical personnel to abstain from participating in an intervention if the intervention is against the healthcare providers' religious and moral convictions" (Lynöe, et al. 2017, 117). This debate reached its peak around 2011, whereas in 2014, the new coalition government: the center-right Conservative Party and the populist neoliberal Progress Party, needed support for their political legitimation. To achieve their aim, they agreed to defend the right of general practitioners to refuse to refer an abortion in exchange for political support from the Christian Democratic Party (Askola 2017, 28). The proposal was quite controversial and attracted widespread criticism because it threatened women's right to abortion and the lack of professionalism of medical actors. The proposal was dropped in 2014 following a growing protest.

4. BETWEEN THE LOGIC OF CHOICE AND CARE IN HEALTHCARE

I put my study in conversation with theoretical and empirical literature around care practices (e.g. Pols, 2005; Mol, Moser, Pols 2010; Krause & Boldt (eds.) 2018; and Driessen 2018). Within this body of work, I have been particularly inspired by the work of a Dutch ethnographer and philosopher, Annemarie Mol, about the

logic of care and choice in healthcare. In her book 'The Logic of Care: Health and the Problem of Patient Choice' (2008), Mol contrasted two ways of dealing with the disease within the context of treatment and life with diabetes. Mol called these two ways of dealing with the disease 'the logic of choice' and 'the logic of care.'

The logic of choice roots in liberal principles that allow people to make choices so long as they do not harm others. The logic of choice entails emancipation that celebrates individual autonomy and equal opportunities for people to make choices independently. In the healthcare realm, the logic of choice honors the freedom of individuals to answer questions about a better life and the goals of the care practice that an individual engages in. Although the logic of choice is widely celebrated as a strong moral preoccupation in many realms of society, for Mol, the emphasis on individual choice does not always lead to improving patients' well-being. In healthcare settings that treat patients with diabetes, the freedom given to the patients to choose whatever they want for their bodies will not improve their health conditions. Instead, it may lead the patients to serious complications that worsen their condition. Mol suggests that patients' choices and good care may sometimes complement each other, but they often clash in practice (Mol 2008,1).

The emphasis on individual choice in healthcare may seem ideal, but patients with diseased bodies and feelings of confusion and fright can hardly make their own choices. That is also the case for women who seek consultation when they experience decisional uncertainty towards their pregnancy. All research participants I spoke to did not call the woman clients as 'patients' since they do not have a diseased body to be cured[11]. However, many women come to the clinics because, like the diabetes patients in Mol's study, they have difficulty making a choice for themselves. Instead of suffering from a particular disease, most women who come to the clinics feel confused and ambivalent about the pregnancy they go through. They have no idea of the viable options and may not know what and how to choose. In such a situation, pregnant women seek professional guidance to help them sort out their thoughts, acknowledge their feelings, and assist them in weighing the viable options.

To put it bluntly, the logic of choice may clash with the reality of living. The logic of care goes beyond celebrating individual choice as the core idea to improve healthcare and patients' well-being. Mol argues that good care does not mean going along with whatever patients want. Good care makes space for what is not possible for patients. While choosing is confined to specific moments, care is an open-ended process involving continuous adjustments and interactive actions between patients and healthcare providers that unfolds through time. Care is profoundly relational. In doing care, constant negotiations to compromise between what is desired by the patients and the possibilities available to them are crucial. Here, what leads to a better life is continuously shaped by persistently adjusting through frictions and problems to shape 'the good' that is never settled within the logic of care (Mol 2008, 76).

In this light, making an individual choice is not an end. Care does not stop at providing options to women as subjects of choice. Instead, care calls for being attentive to what is relevant and vital to a woman's life, even if it goes beyond the pregnancy. Mol postulates this as the process of *doctoring* that points to "the creative calibrating of elements that make up a situation, until they somehow fit and work" (Mol 2006, 411). In the current study context, doctoring is a matter of attuning and being attentive to each woman's specificities when experiencing a difficult decision during their pregnancy. Women who seek consultation are not homogeneous. Indeed, they might feel confused, anxious, and frightened. Nevertheless, a woman's

11 None of the research participants I spoke to addressed people who came to the clinics as patients. Instead, they called the people 'clients' (Norwegian: *klienter*). I suppose the term 'clients' indicates the logic of choice that suggests people who come to the clinics as the ones who will determine the end of care practices they engage in; they are people who are supposed to make active choices on their own (Mol 2008).

feelings and embodied experience of pregnancy may differ significantly based on, for instance, financial constraints, the relationship (or lack thereof) with the sexual partner, and her mental state at the time of pregnancy.

In attuning to clients' specificities, emotional labor (Hochschild 1983) performed by healthcare professionals is vital in pursuing a desired outcome of a consultation. According to Hochschild, this emotional labor "requires one to induce or suppress feeling to sustain the outward countenance that produces the proper state of mind in others" (Hochschild 1983, 7). Hochschild used the term 'emotional labor' to refer to the management of feeling to create a particular publicly observable facial and bodily display. This labor has exchange value and is sold for a wage. Based on Hochschild's arguments, I would like to emphasize the instrumental role of emotional labor: how this kind of labor is performed to pursue a particular desired outcome in care. The emotional labor performed by healthcare professionals is crucial in enabling woman clients to be active subjects in care.

In addition to Hochschild's arguments on emotional labor, the marked contrast between the logic of choice and care proposed by Mol underpins my study. However, I do not attempt to reemphasize the contrast between these two logics in the context of abortion services in this study. Instead, I aim to explore how the logic of choice and care are situated in the two sexual and reproductive health clinics I visited.

5. PROFESSIONAL NEUTRALITY AND THE WAY AN IDEAL CHOICE IS IMAGINED: HEALTHCARE PROFESSIONALS' PERSPECTIVES

Central to the idea of choice is turning a person into a subject, positioning a client who is a pregnant woman as an autonomous decider who is independent of paternalistic care providers. It means that the responsibility for choosing whether or not to have an abortion should remain in a woman's hands. The vital position of choosing is not exclusive to care practices in the context of abortion guidance. Likewise, it may reflect large-scale health and care services that strive to orient patients as subjects-who-know rather than passive actors in the medical services they engage in (Pols 2005).

All research participants I met held a common view that they should not provide judgment on what a client might feel, think, and decide. When it comes to the question of which option is best and should better be taken by a client, the logic of choice provides no answer. Mol (2008) argues that this is the normativity of the logic of choice.

Another representative of the logic of choice is reflected in Kirkegata's website, which states that the main tasks of Kirkegata's professional staff are helping clients get what they need, providing clients with an opportunity to make a choice, along with conversing about what is important to the clients in making a decision. The statement strongly emphasizes the individualistic character of making an ideal reproductive decision. Helping clients get what they need and providing them with an opportunity to understand what is important to them suggests the central position of their individualism in this care provision. Clients are entitled as subjects of choice who are free to attach their value judgment in deciding for themselves. Central to this statement is the notion of choice which emphasizes clients' autonomy to make a free decision. Meanwhile, healthcare professionals are 'merely' helpers who do not determine the end of a decision-making process. This widely celebrated individual choice suggests a question: What does the notion of individual choice tell us about this care provision?

"It is her decision, not mine" is a statement asserted by all interlocutors I met that best epitomizes their working principle. I heard that statement many times, particularly, in conversations about my interlocutors'

experiences of guiding women who experienced decisional uncertainty towards their pregnancy. On the one hand, that statement sounds evident to me that my research participants tried to express that allowing clients to decide what is best and right for their bodies is, by all means, their professional obligation. Following this statement, professionalism is linked to the ability to distance oneself from clients' decisions–which means counselors and health workers should not let their personal views affect clients' decisions.

The way my research participants described an ideal choice was translated to the notion of 'neutrality'. They suggested neutrality in two senses. First, they described neutrality as not being engaged or aligned with any ideological, political, or religious grouping. They have been striving to create an open space and opportunity for women to exert control over reproductive decisions without affecting the women to choose certain options. Healthcare professionals, I spoke to describe their primary task as helping women clients find a decision they believe is right for them and giving them respectful support. As healthcare professionals, they should not give an opinion and decide if something is good or bad for the clients.

Second, the counselors and health workers I met perceived neutrality as being emotionally detached from the clients. Mathilde's explanation below represents it:

> I think when a woman talks to her family, friends, partner, or ex-partner, they will always have some opinions about what a woman should choose. When a woman comes here [to Kirkegata], we do not have any agenda other than having her reflect on what her thoughts and feelings. Because we are neutral. We are not emotionally involved like maybe the family and friends are. (Interview with Mathilde, a counselor at Kirkegata, November 2021).

Not having emotional ties with clients marks professionality. In explaining neutrality as professional conduct, some research participants contrasted their relationship with clients to clients' relationships with their intimate others, namely family and friends. Professionality is understood as being distant from emotion and familial relations.

From the excerpt above, telling clients what they should or should not choose is unprofessional. Besides the non-judgment endeavor, some research participants argued that being judgmental of clients' decision-making process is not a wise attitude because, as counselor Jorunn put it, 'I am not living her [my client's] life. So, I do not know what is best for her life. She is just presenting a little bit of her life to me, and I can help her reflect on that. But I cannot judge what is better for her life' (Interview with Jorunn, a counselor at Kirkegata, November 2021). Marianne, a counselor at Kirkegata, once explained that she can help a client reflect on various factors that shape viable options, but she cannot tell her clients to do something or choose certain options instead of the other. It is not her job to tell clients the right decision for them, though, on several occasions, Marianne had opinions in her mind toward what option her client should take.

Information and knowledge are key tools to enact an ideal choice. In helping clients exert control over a decision, providing clients with advice and information is crucial for making an informed decision. The information can be about social assistance a woman can obtain if she is pregnant and gives birth to a child, along with information about healthcare services for pregnancy and abortion in Norway. Providing information marks professional neutrality and distance from clients. When a client is given information, she is left as the subject of choice, which determines the end-of-care practice they engage in. Access to adequate information has been considered necessary to realize equality and women's autonomy as the extension of self-determination and bodily integrity (Freedman & Isaacs 1993; Porter 1994). For this reason, knowledge and information signify the degree of individual autonomy (Paxson 2002).

My conversations with the interlocutors suggest that autonomy and equality should also be characterized by the absence of interference from other people in making a decision. This understanding, I reckon, is more

than just a moral acclamation. The notion of women's autonomy also portrays a particular imagination of an ideal, 'modern' Norwegian woman within the setting of an egalitarian society. The notion of women's autonomy came together with the idea of gender equality that has long liven up public discussions about what would best characterize Norwegian society. This equation was something I often heard in the field.

Kari, a health worker at Dronningens, once described: 'We [Norwegians] are like single men, single persons, the chieftain[12] is important here [in Norway]. However, in other countries, the big family is a chieftain. You [a person] represent a family. However, I am used to representing myself. That is the difference' (Interview November 2021). One fine morning, counselor Marianne described this similarly by noting that 'my rights as a woman in Norway are equal. I can do whatever I want. I can choose for myself. Nevertheless, some women I meet, they cannot merely choose. Society chooses for them. The man chooses for them. Religion chooses for them. So, they are not used to thinking that way: they can make a choice themselves' (Interview January 2022). Those descriptions imply how a decision should ideally be made. There lies an understanding that women who are in the situation to choose abortion should enjoy their autonomy without interference from others. It should be the woman as a single person who makes the decision.

The seemingly huge contrast between individual choice and a choice with interference from others was also raised by counselors and health workers I met when discussing the challenges of dealing with clients from different ethnic and cultural backgrounds. Social control and complicated relationships with sexual partners and family members were viewed as obstructions to deploying control over reproductive decisions and engaging in sexual and reproductive healthcare services. When discussing this issue, my interlocutors explained the structural barriers that appear to be a crucial issue that hinders women from different ethnic and cultural backgrounds from accessing sexual and reproductive healthcare services in Norway. To illustrate this, Kari once said:

> They [women from different ethnic and cultural backgrounds] are maybe afraid. They do not have the knowledge. It is maybe the first time they heard about it [the knowledge regarding sexual and reproductive health, i.e., family planning, rights and law regarding one's body]. They are not used to trusting the government. They do not trust you in the way that Norwegian women do because Norwegians have the knowledge already. (Interview with health worker Kari, November 2021).

Kari's description illustrates a Westward looking over the notion of individual autonomy, which, in turn, typifies a difference between 'We' (The West or Norwegians in this regard) and 'Other(s)'. More often, a rational, individual choice was contrasted with one's embeddedness in community and/or family, denoting a condition in which personhood does not merely relate to the individual and with this "goes a different attitude to the body and its boundaries" (Twigg 2000, 397). Ties to culture were considered an obstacle for women to exert control over reproductive decisions. Ties to culture were assigned to the Other(s) instead of the so-called knowledgeable and modern subject (if not a Western subject).

In addition to the detachment from familial and cultural bonds, an informed decision should be isolated from emotional impulse but involve rational calculation toward the future:

12 The term 'chieftain' was the exact term that Kari expressed during our interview session. I am not sure if 'chieftain' is the correct term for her description. But then, she equated 'chieftain' with 'single men' and 'single person.' From this equation, I suppose the term 'chieftain' she used was to refer to individual autonomy and the central position of individual authority in her description of Norwegian society that contrasts with other (non-Western) societies.

> We talked to women who told us about their situation right now and there was a woman who told me that she had an abortion four years ago. In that situation, she did not talk to anyone [about her consideration]. She made the decision really quickly and did not feel that she owned the decision. (Interview with counselor Mathilde, November 2021).
>
> The choice that is based on knowledge. They know that their life is not just here and now but also in a year, and so on. So, they know it is not just based on 'right now'. When we bring the women in, if they were just six weeks pregnant for example, remind them that they have six more weeks to choose[13]. [You] do not have to choose today or tomorrow. (Interview with health worker Kari, November 2021).

An ideal decision is made with forethought. It is not 'quickly made', according to Mathilde. Alternatively, in Kari's words, an ideal decision is not based on 'here and now' (current-life situation) but involves cautious anticipation of what may happen in the future. Cautious anticipation involves the capacity to think through every possible scenario: What if the pregnancy is terminated? What are the pros and cons of having a pregnancy terminated? How about continuing a pregnancy instead? How can a woman receive societal support when she chooses to continue the pregnancy and gives birth to a child? As a woman is given information and her choices expand, she is seen to get more control over her reproductive options (Rothman 1994). When people are given knowledge, "they will make certain rational decisions and act accordingly" (Paxson 2002, 312).

The healthcare professionals I met described knowledge and information as salient tools to make informed decisions. From our discussions about what constitutes an ideal choice, we concurrently disclosed what it means to make the non-ideal one. An ideal choice should be based on knowledge and information that are credible and highly rational. This information and knowledge should be obtained from 'above', for instance, from the government and healthcare institutions but not from 'lived experiences of a given problem' (Gaventa & Cornwall 2015, 466). The knowledge 'from above' shapes a particular point of view to define a good choice. In this regard, having an abortion presents an ambivalent position. Some interlocutors affirm the vitality of the right to abortion and for women to determine on their own whether or not to have an abortion. However, women's right to terminate their pregnancy is not absolute.

All healthcare professionals I met strived to facilitate a condition in which having an abortion is a result of rational, calculative thinking. Yet, at the same time, having an abortion can also be an outcome of an uncontrolled and frivolous reproductive decision, for example, having repeated abortions. A statement from Kari provides a representative example of the ambivalence of having an abortion: 'I think the government and everyone are working to decrease the number of abortions. We offer free contraception and advice, and so on. That is the main goal' (Interview November 2021).

Like other interlocutors, Kari argued that women's right to choose an abortion is crucial for realizing women's reproductive rights. Women's opportunity to obtain abortion services should be recognized because it expands women's reproductive options. On the other hand, it intrigued me to hear how Kari contrasted having an abortion with contraception use, as if these two denote quite different reproductive choices. Using contraception implies an ability to control one's body and reproductive decisions. In using birth control, the body was intended to have a particular effect: controlled fertility. The body is being determined and rationally controlled through preventive measures toward unintended pregnancies and abortions.

Although all research participants supported women's self-determined abortion, our conversations indicated that there are still conditions when abortion can be ethically unacceptable. What the law says concerning self-determined abortion may not suit a person's ethical views. Having repeated abortions,

13 The legal limit for self-determined abortion in Norway is up to twelve weeks of gestation.

for instance, indicates an inability to control the body, which is perceived as 'not good' in providing care that empowers women to exert control over their bodies. Having repeated (self-determined) abortions is considered a frivolous action, not an exertion of women's bodily integrity. In contrast, long-term birth control represents calculative thinking toward the body and simultaneously involves anticipation of the future. Long-term contraception thus contrasts with emergency prevention used after the action, that is, after a woman and or partner has unprotected sexual intercourse.

6. COMPROMISING THE RIGHT TO CHOOSE AND WOMEN'S DECISIONAL UNCERTAINTY TOWARDS A PREGNANCY

From discussions with the interlocutors, all stories I heard from them never stopped, only at the pregnant women who present as the subject of choice. We talked about complicated relationships with sexual partners and family members, affecting how and what decisions can be made.

While the social condition surrounding pregnancy is acknowledged, the prime goal of every consultation is to help a woman, as an individual self, make and own a decision that she thinks is most appropriate for her. Nonetheless, arriving at a choice involves hearing out different needs and expectations that more often come from outside the pregnant woman as an individual. Marianne, a counselor at Kirkegata, told me her insight from her 21-year experience as a counselor: 'It is not often the case that it is only the woman who makes a choice, thinking only about herself' (Interview January 2022). Based on Marianne's experiences, men's voice (refers to the sexual partner with whom a woman is pregnant) comes as a critical consideration that either helps a pregnant woman choose or complicates the decision-making process.

'The man is also pregnant in a way, you know,' said Marianne, laughing lightly. Confirmation of one's pregnancy can suddenly turn someone's life upside down. When pregnancy is detected, it can be a new reality for many women and couples. Both the man and the woman may feel confronted by their present reality and readiness to have a child (Kjelsvik et al. 2018), even in the case of a planned pregnancy. Furthermore, even couples with stable relationships would be agitated due to the possible conflicting values regarding the possibility of performing an abortion or not. Various reasons can cause feelings of uncertainty: it could be dependent on, for instance, conflicting life trajectories, pressure toward financial and health conditions, as well as mental unpreparedness for the responsibility of being a parent. It could also be caused by a broken relationship with the child's father. Moreover, having another child might be too overwhelming for some couples because they have had children before.

In some cases, the man with whom a woman is pregnant can feel upset, frightened, and powerless after his partner has confirmed a pregnancy. In such a depressing situation, it is not rare if a man threatens to leave the woman alone if the woman opts to continue the pregnancy. In other cases, the man can feel cornered as another person will decide his life for him (Interview with counselor Mathilde, November 2021).

According to Norwegian abortion law, the pregnant woman's partner does not have a legal basis for deciding whether abortion should be carried out. In principle, the partner cannot take over a decision for this matter, even though the birth of a child or the termination of a pregnancy would significantly impact his life. Nonetheless, the man can choose the degree of involvement with regard to the pregnancy. Meanwhile, pregnancy involves and directly affects the woman's body. Hence, the potential mother is granted legal rights to have the ultimate decision. In this way, women's right to choose is not derived from an absolute and abstract right to own a body (Jagger 1994). The right to choose is derived from women's position in our society as the primary caretaker of children. This fact intrigues me because while reproduction is socially and

historically determined, yet when it comes to choosing whether or not abortion should be performed, the logic shifts: the woman should choose for her own body.

In practice, things do not always work out according to what the abortion law says about the right to choose. Life situations surrounding a pregnancy can be way more complicated than what is solved and stated clearly by the law. In the consulting room, it is not unusual for a counselor to attend to questions like this: 'Is your husband or partner's opinion important to you?' or to pose a similar question to the client, such as, 'What would your mother or father say about that (viable options)?'. It is understandable if a woman feels that her sexual partner or others are the reason behind whatever decisions she will make in the end.

A choice of whether or not to continue a pregnancy is constrained by the absence of limited acceptable alternatives. Reflecting on this matter, I recall being an intern at a women's crisis center in Indonesia a few years back. During my internship, I talked to counselors who gave psychological and legal guidance to pregnant women because of non-consensual intercourse. From our conversations, I realized that having an abortion may not always be the genuine choice for many women. In Indonesia, premarital pregnancy is commonly considered immoral and shameful, not to mention raising a fatherless child. On the other hand, there is hardly official assistance for parents and single mothers. Consequently, a woman must rely on her social networks based on personal relationships if she decides to continue the unwanted pregnancy and give birth to a child. These situations double the burden a woman has when having an undesirable pregnancy. This condition reinforces feelings of powerlessness and, thus, makes the woman who decides to have an abortion perceive themselves as having no choice.

7. WHAT DOES GOOD CARE ENTAIL?

Besides abortion as a socially and emotionally complicated experience for women who seek it (Aastbury-Ward et al. 2012; Kjelsvik et al. 2018), earlier studies have discussed abortion as an ethically and emotionally challenging issue for those who provide the service (Wolkomir & Powers 2007; Nicholson et al. 2010; Lipp 2011). There has been a wide range of studies discussing emotional involvement as a constituent of performing a professional job in healthcare, such as achieving satisfying care outcomes for the recipients, anticipating patients' needs (McQueen 1983), and enabling bodywork of the abortion process to be achieved (Purcell et al. 2017).

My study suggests how emotional engagement between healthcare workers and their clients becomes a necessary practical component in pursuing the intended outcome of a consultation session aimed at helping a pregnant woman arrive at a decision. Rather than seeing the emotional aspect as in binary opposition to the technical aspect, I aim to emphasize the instrumental role of emotional engagement in providing care services for women who feel uncertain in abortion decision-making. Therein, the emotional and the technical aspects are not separate but somewhat intertwined (Brown 2010, 131).

As indicated in the earlier section, all healthcare professionals I spoke to were not direct providers of abortion services. Still, the demand for emotional labor seemed to be inherent in their current work. For two interlocutors, the demand for emotional engagement is the main attribute differentiating the care services they provide from those provided by other public health authorities in Norway. For example, Ida, a manager at Kirkegata, described this:

> We have a much better time. I think if you seek an abortion at the hospital, they do not have much time to guide you in your choice. Because you [the pregnant woman] have already chosen when you are there [at the hospital]. On the other hand, we [Kirkegata] have counselors who are very skilled in having these conversations [around choice] and giving the women, men, and couples good tools to make a choice. (Interview December 2021).

In a similar vein, counselor Marianne remarked: 'When a woman wants to have an abortion, it is not just about something medical, but they need a conversation or somebody to talk about it. Nevertheless, the hospital is a place where everything goes very fast (Interview January 2022). Marianne's argument aligns with the study of Kjelsvik et al. (2019), which has shown that many women who seek an abortion in the gynecological unit at a Norwegian hospital are still ambivalent about their decisions. Unfortunately, no medical personnel specializing in counseling practice are usually available at the hospitals where the preparation and initiation of abortion occur. The need for professional counseling regarding abortion is then delegated to another healthcare institution specializing in consultation for abortion.

As Marianne puts it, deciding whether or not to terminate a pregnancy is not just a matter of 'something medical.' For Marianne, such a decision matters beyond medical treatment imposed on a woman's body. In typical cases, deciding whether to terminate a pregnancy is a challenging process that leads to conflicting and contradicting emotions. This kind of decision would be a life-changing one that is not easy to be made. Given the persistent ambivalent and emotional challenges of considering an abortion, the recognition of needs (Tronto 1993) should be crucial in providing care for women who are uncertain regarding abortion.

Noticing a client's needs is an essential task of a care provider that can be achieved by being attentive to a woman's personal experiences and a range of factors that a pregnant woman must consider before making a decision. A consulting room is not a place for things that 'go very fast.' It leaves room for a woman and counselor to take time, for counselors to attend to clients' specificities, and for them to reflect on things that matter in the decision-making process.

Emotional labor (Hochschild 1983) performed by healthcare professionals paves the way to understanding clients' needs. This understanding enables counselors and health workers to help a woman arrive at a choice that she thinks is best for her. The experience of performing emotional labor was described by Tonje who mentioned 'active listening' as a crucial element of providing care:

> When they [the women] come, they just need to be listened to. So, it is basically listening. We call it 'active listening'. You are not just listening but also asking questions and repeating what they say to make them feel that I am actually listening to what they are saying to me. They need a lot of acknowledgments by saying, 'yes, I have talked to a lot of women who feel this way, who are also in a situation that is difficult'. It will make them feel a little less alone. (Interview with Tonje, a counselor at Kirkegata, February 2022).

The act of listening, acknowledging, and comforting constitute care practices offered to women who feel uncertain about having an abortion or not. In this way, emotional support is the first necessary step in care (Mol 2008, 52). I argue that actively listening and acknowledging what a client has been going through facilitates a client to be an active subject in care. In this regard, it is not only the healthcare professionals who present as active actors in this care provision, but also the clients. This condition encourages and enables the clients to exercise their capability to articulate feelings and express things that are important in shaping their decision-making process.

In helping a woman arrive at a choice, a healthcare professional's ability to be sensible is salient. However, care does not stop only at being empathetic to clients. The sensibility must be followed by attuning and tinkering with the range of factors that a woman must consider in her decision-making process and recognizing that "making a decision is not always clear-cut" (Kimport et al. 2011). Sensibility leaves room for attachment: it leads a healthcare provider to focus on a client's experiences and preferences in a particular situation from the client's perspective. This sensibility is instrumental: it enables a counselor to attune and tinker with the range of factors that shape a client's reproductive options. By attuning and tinkering with the

range of factors, a healthcare professional can help a pregnant woman arrive at a choice that feels right to her.

Being sensible to clients sometimes evokes a certain feeling that should be kept secret. In this way, a claim to neutrality operates to control and suppress the emotional experience that emerges from dealing with clients' lived experiences. As Tonje once remarked:

> I have to do my job in a good way for women and men who contact us. Usually, I do not feel like 'oh, you [clients] should choose this or that'. I am just focused on having gone through anything to have all the information in front of clients and to help them see it clearly themselves. Sometimes I get some feelings but of course, I always work not to show them. Sometimes it is difficult because, of course, you want the woman to make a choice that feels right for her but when I feel like 'I am not sure this is the right one for you' but that is the one she chooses, it might be difficult [for me]. But when it happens, I always go inside myself again and think: 'Okay, is this my need or her need?' But yeah, we cannot just say we are neutral because we are people. (Interview February 2022).

Like Tonje, Jorunn explained: 'We cannot be neutral in the first place. As an individual, I have my own thoughts even though I should keep them during a consultation process (Interview November 2021). As this section aims to show, the healthcare professionals I spoke to did not perform their job detachedly. Neutrality, after all, does not mean not being connected to clients and their lived experiences.

In addition to attuning and tinkering with the factors that must be considered, enabling a client to feel secure and heard is not the least important aspect of this care provision. It is crucial for healthcare professionals to perform caring attitudes (Harbers et al. 2002) that involve emotional labor, that is, by accommodating clients' specificities and consoling them during difficult decisions. In this care context, for a pregnant woman to finally arrive at a decision is one thing, but in the process, care matters when there is consolation for the pregnant woman.

Emotional work performed by healthcare professionals has made a consultation session more than just figuring out things that can be done, but also moments of enacting a client as a subject of choice. In this care practice, women who come to the clinic are theoretically addressed as clients with the right to make free decisions. At first glance, the notion of 'women's right to choose' seems to imply authenticity, as if the will and the ability to make a choice are intrinsic to the individual. However, in this care context, women as subjects of choice are not predetermined but enacted through practices of care. Emotional work performed by healthcare professionals contains the capacity to create closeness and affect a client's openness, which in turn helps a consultation process achieve its desired outcomes.

In the consulting room, the condition that enables a woman to exert control over her reproductive decisions is built up through interactive processes between a woman and a healthcare provider who guides the woman in making a decision. The relational knowledge (Driessen 2018) acquired from clinical encounters with clients helps healthcare professionals find a way to tinker with the factors that must be weighed in the decision-making process.

In this context, relational knowledge is the lived experiences that a woman shares with a counselor. Clients' lived experiences are not treated as mere facts that serve as a means to make a choice. The lived experiences provide a source of knowledge that opens up a way of how a decision should be made. In developing relational knowledge, a counselor and health professionals talk to the clients to understand what value most to them. Sometimes the questions being asked are not questions that point directly to abortion. A counselor and health professionals may ask the woman: 'How do you see the fetus that you carry?'; 'What does it mean for you to take an abortion or go on with the pregnancy instead?'; 'Is your partner's opinion

important to you in making a decision?'; 'Does other people's opinion matter to you in making a decision? If it matters, why is it important to you?'. The statement from counselor Marianne can be an example of this:

> I was trained to talk to people: I do not know anything about you [clients]. I do not know anything about your life or values. I need you to tell me. Then I can avoid stepping on them. I think the women I met in the counseling session educated me. I asked them questions so they could teach me. So, I can understand how they feel and think about things. So, I can stop myself from saying wrong things and make them feel unsafe. (Interview January 2022).

Significant in this account is learning how to choose becomes an essential part of the care process. The notion of women's right to choose, cannot be seen as something that is exclusive and absolute. In this context, women as subjects of choice with the ability to choose for themselves is the result of the interactive processes with the healthcare professionals. This situation is made possible through emotional engagement between the care provider and pregnant women who are in doubt during pregnancy.

Adherent to that case above, I recall the work of Jeannette Pols on patients' appreciation during their long-term treatment in mental healthcare in the Netherlands. I have been intrigued by Pols' co-production concept to explain the way health workers produce a situation in which patients–who cannot speak clearly in words–can enact appreciation of their likes and dislikes. However, the way health workers produce such situations is not the consequence of health workers' activities alone but the result of long-term interactions with patients. From the concept of co-production, patients as subjects are being co-produced: "neither is the subject characterized by an isolated, autonomous position and a free will" (Pols 2005, 212). In this case, patients are enacting themselves and are enacted by health workers to be active subjects in care.

My study suggests that healthcare workers and clients were engaged and related to each other within the interactive processes. This engagement is built through inferring important points from the discussion during the consultation, giving a client a cup of coffee to induce feelings of being taken care of, and giving persistent acknowledgements that life is not always easy. Within such a comfortable environment, an open dialogue then can be achieved: healthcare professionals may know what value most to their clients in the decision-making process. Likewise, clients may feel comfortable sharing their thoughts and innermost feelings until they understand what matters most to them.

It is not important for a counselor to know what decisions a woman makes. What is more important is how a decision is made. The most concerning matter is for counselors to help clients reflect and understand the important factors that should be considered in weighing the viable options. In this practice of care, how a woman is facilitated to decide for themselves matters more than arriving at a decision.

In practice, making an individual choice can be worked upon through relational practices between the counselor and the woman as a subject of choice. In this regard, I offer an alternative way not to take clients' ability to choose for granted. From healthcare professionals' experiences, I suggest that women's ability to decide on their own does not solely emerge on its own but instead, involves time and emotional engagement worked upon, involving time and emotional engagement between healthcare professionals and clients.

8. CONCLUSION

Abortion is one of the reproductive issues that has been contentiously debated. As is the case in Norway, the debates surrounding abortion have never been far from disputes around individual rights entitled to pregnant women and the fetus. From the pro-choice viewpoint, choosing abortion is a women's right. From this interconnection of biological and social-constructed reality, women should be provided with the means

to exercise their right to choose. However, this way of seeing becomes problematic when the attribute of personhood is assigned to the fetus. When the fetus is personified, it is assumed to have its own life; thus, pregnancy termination would be ethically unacceptable. Moreover, in Norway, the language of human rights has also been used to justify the right to respect individuals' religious and moral views so that Norwegian medical personnel who have a disinclination to abortion can withdraw themselves from performing an abortion.

Central to this debate is the use of human rights justification to shape positive and negative views of abortion and protect the interests of certain political groups. However, these political debates around abortion rights still have not focused on the decisional uncertainty many pregnant women may experience. Amidst the grand narratives about women's right to choose, my study sought to explore subtle issues that are left unnoticed by the lively contestations on abortion rights: making an individual decision towards pregnancy termination is long and winding.

All healthcare professionals I met affirmed the centrality of women's autonomy and the ideal of individual choice in abortion decision-making. The care services they provide emphasize clients' individualism and ability to insert value judgment in making decisions. In this regard, healthcare professionals perceive the ideal choice for their clients according to their image of the client as an active, rational, and autonomous person, who inherently has control and authority to choose.

First, an ideal choice should result from exerting decisional authority without interference from other people. This decisional authority comes from adequate information and knowledge from the 'above' (refer to p.18). If the knowledge is gained from ties to culture and familial relations, this is deemed an obstruction to rational decisions.

Second, healthcare professionals' description of an ideal decision that is autonomous from external intervention, also marked healthcare professionals' detachment from clients' value judgment and decisions. The logic of choice provides no answer to what the right decision is. The responsibility for deciding on having an abortion should primarily fall on the pregnant woman. This discrete and defined division between healthcare professionals and the women who seek guidance reflects the idea of professionalism as a framework for providing good care and performing a fine job.

However, the imagined ideal choice clashes with the reality of living. Rather than attending counseling sessions as an autonomous decider, some women who feel anxious and frightened do not know how to make the right decision for themselves. They do not even know what would be viable options they can consider in the uncertainty about a pregnancy. The limit of women's right to choose prompts many pregnant women to seek care in the first place.

Healthcare professionals I met are emotionally engaged with their clients in helping them arrive at a decision. When uncertain about their pregnancy, this emotional engagement is built by being attentive to the client's needs, preferences, and experiences. Being attentive involves active and careful listening to what clients say and think. The so-called active and careful listening enables a client to be an active subject in care. These acts may affect a client's openness and comfortability to share their thoughts and innermost feelings until they understand things that are important to them. It is about showing concern and empathy for clients' experiences that would open up a conversation in a counseling session. Therein, the emotional element of care has an instrumental role. By seeing this emotional constituent as instrumental, I propose an alternative way to see women as subjects of choice as something that is not predetermined. Within this care provision, women as subjects of choice and their ability to exercise their rights are enacted through relational processes involving the healthcare professionals.

Within this emotional engagement, providing neutral guidance was challenged. Some healthcare professionals I met expressed the hardships of maintaining distance from their clients: some research

participants may have personal opinions on what their clients thought and spoke. However, as professionals, they were not allowed to insert their own views into clients' decision-making processes. From the twists and turns of providing neutral guidance, some research participants I spoke to realized how challenging it was to be neutral. While describing their work as professional and distant from clients' emotional and value judgment, concurrently, my research participants acknowledged themselves as people who may have their own values and perspectives toward their clients. The 'vulnerability' of maintaining neutrality creates moments of reflection for the research participants on how making an individual decision is not always clear-cut.

The stories I heard from the research participants suggest the importance of not taking professional neutrality for granted. Is being neutral the 'right' way to provide good care? This study reveals how the ideal of individual choice remains intact discursively: the imagined client as a rational and autonomous decider has been the underlying force behind the care provision for women who are uncertain whether to have an abortion. However, in practice, women as subjects of choice are enacted through the relational engagement between women and healthcare professionals.

ACKNOWLEDGEMENT

My heartfelt gratitude to all the counselors and health workers for their willingness to participate in this study. I would like to thank my thesis supervisor from Universitas Gadjah Mada, *Mbak* Elan Lazuardi, PhD., for her valuable comments on my thesis back then. This article would not have been possible without guidance from my thesis supervisor from the University of Agder, Associate Professor Margit Ystanes, who had patiently given fruitful advice throughout the process of writing my thesis.

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