



PROTECTING THE BEST INTERESTS OF WOMEN IN TERMINATION OF PREGNANCY PROCEDURES

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❖ ABSTRACT

Pro-choice and Pro-life schools of thought relating to Termination of Pregnancy procedures are all caught up in a trap of infidel circularity, humanism and reductionism. Clearly they have both outlived their usefulness and need urgently be superseded by the new school of thought that protects the best interests of women in the Termination of Pregnancy procedures. This report refers to the new one as the *Pro-Personal Dignity* school of thought.

This report may not masquerade as the omniscient, all encompassing instrument for the pros and cons involved in abortion arguments. Neither does it fail to present the single consistent argument flowing from the current debates on terminations of pregnancies in the context of South Africa as a developing nation battling to find her way to earn the accolades afforded by developed hard currency nations. The principal misconception evidenced in this research involves the perception that procedures undertaken in professional medical settings, by professional health practitioners registered with the Health Professions Council of South Africa (HPCSA), offer hundred percent

safety. Clearly the adoption of the pro-choice rule of thumb, which has globally grown positively *de rigueur*, has increased the demand for the procedures making the protection of best interests of women in abortion activities crucial in current policy, management and development advancements.

DECLARATION

I declare that this report is my own, unaided work. It is submitted in partial fulfillment of the requirements of the degree of Master of Management (in the field of Public and Development Management) in the University of the

Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University.

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With inspiration from my mother, Paulinah Morufe Phatlana Leope, who had the courage not to abort me and believed she would live long enough to see me born, at the time when it made notable medical and pecuniary sense to consider, as it were, the *asylum* offered by abortion.

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DEDICATION

For Yahweh, with thanks

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❖ DEFINITION OF TERMS

1. Abortion - Abortion refers to the ending of a pregnancy before the fetus (baby) is born. In accordance with the Choice on Termination of Pregnancy Act there is certainly no viability before twelve weeks. The WHO defines an abortion as the ending of pregnancy within twenty weeks. Notice that the weeks in this case refer to gestation period primarily because there is a strong link between the gestation period in a pregnancy and the chances of more serious complications of abortion.

2. ED - Emergency Department
 3. EMS -Emergency Medical Service
 4. Miscarriage - "miscarriage is a term which can be used for abortion and is commonly used because many women are distressed by the term abortion" (Odendal et al. 1993:191)
 5. MVA - Manual Vacuum Aspiration
 6. OPD - Out Patient Department
 7. O&G - Obstetrics and Gynecology
 8. Patient - person receiving health services at the hospital. In this study the word patient refers, in terms of this specific research, to those women who have already had the abortion procedure performed in their bodies.
 9. The panel- Strictly for the purpose of this research the phrase 'panel' refers to the ethics committee that was, in my opinion, intensely prejudiced against this research.
- TOP - Termination of Pregnancy; it carries exactly the same meaning as abortion of the unborn baby, only it sounds professionally or deceptively (*depending on whether or not a person is pro-choice or pro-life*) modest.

1. CHAPTER 1

Introduction

Human life is a precious gift. Both pro-life and pro-choice postulations of the good life essentially seek to yield some form of desirable quality of human life. There is no difficulty acknowledging that, termination of pregnancy is, irrespective of the grounds for the procedure, a daunting exigent reality that many South African women have had to face. The *Pro-Personal Dignity* postulations presented are informed by the enlightened conception of the best interests of women as members of society who are afforded reproductive rights.

1.2. Background

The Nelson Rolihlahla Mandela Presidency produced in 1996, the Choice on Termination of Pregnancy Bill, which was enacted by the South African Parliament. According to the Choice on Termination of Pregnancy Act, as amended in 2004, it is perfectly legal for a pregnancy to be terminated purely upon request (no medical reasons needed) within the first twelve weeks of the gestation period; from the thirteenth week up to and including the twentieth week of the gestation period if a medical practitioner is of the view that:

- i. The continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
- ii. There exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
- iii. The pregnancy resulted from rape or incest; or
- iv. The continued pregnancy would significantly affect the social or economic circumstances of the woman.

The Act also provides for termination of pregnancy after twenty weeks of gestation period if after consultation with either another medical practitioner or properly trained

registered midwife, the medical practitioner is of the opinion that the continued pregnancy would result in a severe malformation of the fetus; or endanger the woman's life; or would pose a risk of injury to the fetus. Also in accordance with the Choice on termination of pregnancy Act, the midwife nurses who have taken the prescribed training can perform the procedure up to the gestation age of twelve weeks. Only doctors are allowed to perform the procedures from the thirteenth week upwards. (RSA, 2004)

Prior to these revolutionary changes from the Presidency Office, and arguably from the World Health Organisation influences as informed by the so-called unholy trinity (i.e. the World Bank, the World Trade organization and the International Monetary Fund); the legislation that sought to protect both the woman's reproductive rights and the rights of the unborn child was in place. Under the legislation abortion based purely on choice was illegal and the argument embraced by the emulated developed countries is that this lead to high numbers of back alley abortions which endangered the lives of women. Anti-abortion law is not in line with the concept and context of safe abortion worldwide. (Berer, M. 2005).

This view is emphasized by Ladipo in his argument that "in societies with restrictive abortion laws, clandestine abortion by unskilled personnel results in needless and very high mortality and morbidity, tremendous strain on limited health resources and inexcusable human suffering." (Ladipo, O. 2004:21). Human suffering in this context does not refer to the unborn baby that is aborted because the unborn baby in terms of the understanding from the pro-choice school of thought is only a fetus, not a human being. Ladipo's argument is sufficient evidence of how in the past many deliberations on termination of pregnancy have blamed the illegality of abortions of fetus lives for the consequent deaths of multitudes of non-discerning women. Presently though it is becoming increasing evident, especially in the South African context, that legality itself can be deceptive given, in distinct Aristotelian terms, the necessary but never sufficient clarity to warrant the need to question the enthroned beauty of the *pro-choice* legislation, particularly when considering the reality that pro-choice is not necessarily pro-health. In this sense, the definition of what really enhances the best interests of women has been snowed under by ideology, egotistical humanism, and denial of factual horror.

Theoretically the Choice on Termination of Pregnancy Act provides for counseling which is non-mandatory and non-directive both before and after the termination of any pregnancy. In this sense, any woman who wants to abort her unborn baby has the choice to opt for accepting the counseling or rejecting it, and such counseling should not seek to direct the woman towards deciding not to abort the unborn baby.

The tragedy is that given the volumes of requests for the procedure since its legislation, it is practically impossible with the current work force to give quality pre- and post-abortion counseling to the patients. (Sigh, 2006:184).

The best interests of women cannot be protected without access to efficient services. This is after all the very essence of development. Todaro teaches that mankind generally has an inherent desire for rich resources, efficient medical systems, access to essential mechanisms, the capacity to transact without overwhelming difficulties, and sustainable economic development. (1994, 67). Access to credible psychological services to women who demand abortion services is in their best interest. Common sense

suggests it is reasonable to expect that if a medical procedure can yield certain undesirable consequences then the woman should be allowed excellence of informed choice by being consciously informed of the potential harms she may expose herself to. By contrast, the current abortion practice hardly involves any counseling, let alone informative counseling. In a sense the understanding that the greatest enemy of man is ignorance is not well appreciated. (Munroe, M. 1990)

Another crucial part of the background to TOP services relates to perpetual brain drain problems. South African medical schools, viz Wits Medical School, Stellenboch medical school, Nelson R Mandela School of Medicine, UCT medical school, Medunsa, UPE Medical School, Free State University Medical School and Pretoria University or TUT Medical school bring forth hundreds of medical school graduates annually. Many of them however, seek greener pastures elsewhere on the planet where the provision of decent salaries is not a luxury. The foreign countries offer them attractive conditions and generally seem to be very aware of the tangible meaning of the concept of rare

skills. By contrast in South Africa the state has been seemingly more interested in how best they can make the lives of health professionals more difficult. Case in point: imagine working for ten years in private practice as a General Practitioner and prescribing without any fatal mistakes. Suddenly the state passes an Act, in the name of excellence that claims that you may not prescribe drugs without a certificate for prescribing that requires some lousy training that you do not need in the first place given the continuous learning you have been embracing for ages and still welcome. This is only one example in a handful of questionable legislative reforms that have represented major interruptions to delivery of health care. The number of private pharmacist businesses that have had to close due to laws on price regulation that have been terribly planned have also contributed to both the loss of health professionals and the loss of the morale among health care industry work force.

The implications of such consequent brain drain on delivery of services relating to the reproductive rights are profound. Now midwife nurses are expected to do what Medical officers, Senior Medical Officers, Chief Medical

Officers, Obstetricians and Gynecologists could do with the much-needed excellence.

Lastly, it is very important to highlight one of the fairly recent improvements, which presents a vital pillar in any objective observation of the background to the termination of pregnancy services in this country. The government has, courtesy of the hard-working and arguably industrious health minister, approved the active usage of medical abortion which may be viewed as a major breakthrough in the protection of the best interests of women who want abortion.

"Medical abortion (sometimes referred to as medication abortion), using a regimen of *mifepristone* and *misoprostol* has been shown to be a safe, effective and acceptable alternative to surgical abortion in many countries." Cooper, D. et al. (2005:37). In real terms the drugs kill the unborn baby and the woman is then free to have induced stillbirth, very much like an unintended miscarriage situation is handled. This method has been approved for use in early termination of pregnancy in South Africa since 2001. Cooper et al continue to argue, " ...policy makers and providers were supportive as they felt medical abortion could relieve the burden on current services." (2005: 35)

1.3. Purpose of the study

The purpose of this study is to highlight the realistic presence and challenge of post-TOP complications in our society. Secondly, the purpose of this study is to provide motivation for pre-TOP counseling to include the true picture of what lies ahead in terms of the possibilities surrounding the patient's own health; and to revisit the notion of the protection of the best interest of women by indicating how best these may be protected where the TOP procedure is concerned; Lest the solution meant to eliminate the suffering of women aggravates the atrocities.

In this study, the proportion of women still opting for *back street* abortions will be investigated by finding out the prevalence of treatment offered to women who have a history of abortion(s) carried out in non-professional medical settings. It was the intention of the study to analyse the maternal mortality and morbidity statistics if there were no unexpected hurdles hard to surmount.

1.4. Research questions

1.4.1. How can any aspect of the current system impact upon the best interests of pregnant women who want to abort their unborn babies be dealt with?

1.4.2. To what extent is the legislated *pro-choice* legislative reform serving the best interests of women?

1.4.3. Which issues of significant concern influence maximized application of the *Batho Pele* principles in the management of TOPs?

CHAPTER TWO

Literature Review

This section explores the varied literature involving postulations for and against termination of pregnancy. In an ideal medical setting, terminations of pregnancies may be classified as threatened abortion, inevitable abortion and incomplete abortion. (Huntington and Piet-Pelon, 1999: 167). Given the radical nature of the legislation in place in South Africa at the moment, there is arguably no need to differentiate between spontaneous and induced TOP. For this and other reasons the literature review will focus

significantly more on post-abortion complications and the imperative need to protect the best interests of women, rather than arguing whether or not the procedure should be legalized, as legalization is a closed chapter at the present moment. The post-abortion complications can have terrifying effects on the quality of lives that women lead in all three significant dimensions, viz: Spiritual, Soulful (mind, will and emotions/feelings) and Physical. For every woman who suffers infertility following professional TOP procedures then in principle the state has lured her to aggravation of her suffering.

In a study on the role of advocacy in implementing the South African pro-choice abortion law, Fonn, Varkey and Ketlhapile make a very interesting point: " In order to translate the abortion law in South Africa into services that ensure equity of access and women's right to control their bodies, interventions are needed to change judgmental views on abortion." In simple English, these authors are suggesting, among other things, that doctors and nurses who advocate or subscribe to the pro-life school of thought need to have their minds renewed and expediently transformed so that they welcome the pro-choice view of abortion as a morally correct and fundamentally liberating aspect of women's right to control their bodies. By

contrast the pro-life school of thought recognizes, as a momentous point, that the body of the unborn baby is also scientifically a human body. (Dobson, J. 2005). Montgomery et al (2003) also share the same sentiment as Fonn, Varkey and Ketlhapile: they reckon that doctors and nurses' reluctance to perform the procedures characterize the grave barricade against implementing the Choice On Termination Of Pregnancy Act. A good example of the extreme opposite of these pro-choice academics is in the form of Parsely's discourse on the *battleground of science*. Parsely, R. maintains that "the world has achieved brilliance without conscience; ours is a world of...embryonic stem cell research and therapeutic cloning...a world of nuclear giants and ethical infants." (2007:99)

In the significant endeavour to advance current academic debates to a more rewarding level, the proposed *Pro-Personal Dignity* school of thought maintains that magnifying the similarities between pro-choice and pro-life schools of thought can empower the health ministry in the endeavour to protect the best interests of the patients. A good example of these similarities is the acknowledged need to strengthen the sexual education efforts in such a way that preventative measures such as contraception are well

appreciated. Fonn, Varkey and Ketlhapile concur, for instance, that various "tools could be used in sexual education in schools and in nurse-midwifery/medical training, to complement current initiatives taking place at policy and programme levels in South Africa..." (2003:103). There is arguably more peace of mind in being educated enough to avoid pregnancy and in reducing the chances of being date-raped. It is about possible ways of protecting the best interests of women without surgical procedures.

2.1. Complications from the pro-life perspective

An average researcher may rely on the premise that in the past the abortion topic has divided both academics and pressure groups into two distinctly different groups, viz the For Reform group and the so-called Anti-Reform group. In essence these groups should simply be reduced to those who are for abortion and those who are against it. This section deals with the complications following Termination of Pregnancy from a pro-life perspective.

It is worth noting that irrespective of the perspective, from which the Post-TOP complications are viewed, they basically develop from similar mechanism and none of the perspectives can deny the traumatizing existence of the complications. Honest interpretation of the *pathophysiology* should thus accept the following three mechanisms:

- a. **Incomplete evacuation of the uterus and uterine atony, which leads to hemorrhagic complications;**
- b. **Infection**
- c. **Instrumental injury**

2.1.1. Miscarriages

The literal meaning of the phrase suggests missing the process of carrying the baby from a period of being an unborn baby to being the baby that is born. This involves in other words, the process of carrying the baby through the trimesters that cover the full gestation period. In many cases it (miscarriage) is not as intended as induced termination of pregnancy. A study that meets the statistical requirements for generalisability in the United States of America has shown that a high incidence of

cervical damage from the TOP procedure has raised the incidence of miscarriage in women who have a history of abortion to approximately forty percent. This academically and scientifically sound exposé of reproductive problems following an aborted first pregnancy does raise questions about the validity of labeling *pro-choice* notions of TOP as a crucial part of reproductive rights. (Hilgers et al. 1981). Abortion of unwanted pregnancies does increase the risk of future augmented possibility of unwanted spontaneous abortions. Clearly, in an ideal setting it is better and makes more sound medical sense to have spontaneous abortions that are not influenced by any interruptions to the functioning of the reproductive system than to generate an overwhelming number of debilitating spontaneous abortions. By contrast, for the *pro-choice* academics, activists and fervent feminists, the scientific existence of spontaneous terminations of ordinary pregnancy is sufficient evidence of the meaninglessness of the fetus and essentially implies that nature also provides proof that there is fundamentally nothing wrong with abortions. Such misreading on spontaneous abortions is contrary to the findings of a study recently done by top obstetrics and gynecology specialists from the University of Pennsylvania. From this study, it was found that patients with prior

first and second trimester loss of unborn babies "are at significantly increased risk for spontaneous pre-term birth and recurrent second trimester loss in their next pregnancy. (Edlow, A. et al. 2007:581)

2.1.2. Infertility

It makes perfect sense given the logical argument above, that the risk of secondary infertility among those women who have a history of at least one induced abortion shall be greater than that among non-aborted women. This is in accordance with the findings of one of various articles in, for example, the British Journal of Obstetrics and Gynecology. The argument is of crucial significance in terms of the best interests of women who want abortion, particularly because an *Ashermann syndrome* can result from over-rigorous curettage of the uterus in patients for example who have septic shock. Infection as a potential

complication of abortion is not limited to illegal abortions. (Burkman, R. et al. 1984:105)

South Africa has also witnessed numerous unrecorded victims of infertility following professional use of the ostensible safe abortions. In some cases infertility has been the main ground for the breakdown of marital relationships. Infertility in a wife has been shown among African men, to also increase the possibility of what is referred to as *isitheku*, which is an African word for multiple wives married to one man. There is, observably, lack of respect for women in the practice.

2.1.3. Ectopic pregnancies

In normal pregnancy the process of fertilization occurs in the fallopian tube. The pregnancy, however, carries on in the uterus, which is a better-equipped structure to carry the growing baby till she/he is ready to depart through the birth canal. The termination of pregnancy procedure does have an impact on the increase in the number of ectopic pregnancies that the patient may be tormented by, following unqualified interference with the reproductive system. This

is a fact that has been shown in one research and one survey after another.

The following two subtopics include summaries of some medical realities about the link between Ectopic pregnancy and induced termination of pregnancy as confirmed by Odendaal et al:

2.1.4. Abortion and acute cervicitis

In most cases Acute Cervicitis has a venereal aetiology and is due to sexually transmitted microorganisms with or without the additional presence of streptococci, staphylococci and enterococci. (Odendaal et al, 1993:305). It is, however, crucial to note that besides possible trauma related to instrumental delivery, foreign bodies, lost tampons or vaginal pessaries; there may be trauma related specifically to a history of either professional or illegal abortion. This is particularly true because abortion by a doctor does not cancel the possibility of traumatizing mistakes.

2.1.5. Septic abortions and the concept of best practices

Whilst waiting for some of the procedural hurdles to be overcome just for the approval of this research among other reasons because it represents a major threat to the prejudiced pro-choice researchers I got to know of a woman who had traumatic experiences from an incomplete *safe abortion*. She was treated in one of the hospitals used in this study. Unfortunately she had believed that abortions by midwife nurses and medical doctors are safe. She sadly passed away following horrendous septic shock problems, disseminated intravascular coagulation and death due to embolism. It goes without saying that the professionals who treated this patient knew about immediate management and resuscitation, and generally knew about the principles of management involved in cases such as this one. This purely theoretical head knowledge that makes some doctors to fill like they are the superior human species than for instance clinical psychologist, would include the following good tests with good intentions:

- a) Full blood count to diagnose anaemia and/or *thrombocytopenia*, which might indicate the beginning of disseminated intravascular coagulation (DIC).
- b) Urine microscopy and culture to exclude *pyelonephritis*.
- c) Serum electrolytes, urea, and creatinine to assess renal function.
- d) Blood culture to identify organisms.
- e) Clotting profile to exclude DIC.
- f) Arterial blood gases as baseline to detect development of adult respiratory distress syndrome.
- g) Chest X-ray; with brilliant knowledge that air under the diaphragm indicates a perforation and a laparotomy must be performed (of course the patient should not be told of such horrendous possibilities beforehand, no wonder some authorities who are in the abortion industry will fight passionately to stop upright researchers from TOP related research). The physician is also expected to look out for adult respiratory distress syndrome.
- h) Abdominal and Pelvic X-ray to look for gas in the pelvis possibly due to *Clostridium Welchii* infection, which may indicate a laparotomy. Intravenous antibiotics should be started as soon as blood for the

blood culture has been taken. Of course we certainly cannot rule out the full awareness that under the normal circumstances there is triple therapy that is highly recommended which involves: *ampicilin*, *aminoglycoside* (*Gentamycin*), and *metronidazole*. Ideally *Tetanus toxoid* should be given in situations where tetanus is a problem particularly in the northern areas of the Republic of South Africa.

(Odendaal et al, 1993:200)

The academics further maintain that the following principles of management may be adhered to:

- a. Appropriate resuscitation of the patient, which may involve restoration of circulating volume in order to ensure adequate organ perfusion and where needed correction of acidosis.
- b. Appropriate administration of antibiotics.
- c. It may come in handy to remove the focus of infection; even if the implication is that a hysterectomy is indispensable.

In general, one of the reasons why safe abortions are labeled safe is because skilled personnel perform them. (Ladipo, 2004). The patients who seek termination of

pregnancy services thus come to the state-accredited abortion clinic with several assumptions. One of these assumptions is that only the best practices, which are well known, shall be applied for the few minutes' procedure and freedom to continue with a normal life is guaranteed afterwards. It would be liberating to educate the public about complications such as septic shock and in line with true conception of the best interests of women, they certainly deserve to be informed that complications like septic shock are not limited to illegal back alley procedures.

In her internationally acclaimed study on the best practices in surgical abortion, Keder, L. acknowledges the preference that many American Obstetrics and Gynecology practitioners bestow to surgical abortion in the first trimester. She maintains that the majority of these procedures are done in outpatient department settings with the patient under reliable local anaesthesia. (Keder, L. 2003: 418). In the effort to reduce the chances of pain and more debilitating complications such as septic shock, she confirms that patients are subjected to intravenous administration of sedation and analgesia, and antibiotic prophylaxis is warranted. She continues, " Routine post-

operative care at 2 or 3 weeks following the procedure, is timed to identify complications and to reinforce pregnancy and sexually transmitted disease prevention." (2003: 418). This is an unparalleled practice for protecting the best interests of women.

2.2. Complications from the *pro-choice* perspective

The Post-termination of pregnancy complication such as septic abortion or septicemia and infertility are separated from the pro-choice acknowledged complications because according to the pro-choice school of thought such complications are mostly the consequences of anti-abortion policies and practices. The confirmation that nearly "fifty percent of all elective abortions," in civilized pro-choice countries are repeat elective abortions, suggest a need for a more preventative approach. (Prager, S. et al, 2007:575). The reality though, is that in principle proponents of pro-choice legislation would like every abortionist and every abortion patient to believe that every professional medical

abortion in state-accredited abortion clinics and private practices of specialist nurses, doctors, gynecologists and obstetricians are safe.

Such trained clinicians advertise their flourishing abortion companies with prominent phrases such as "safe abortions". By contrast, the pro-life school of thought maintains there is no such a thing as a safe abortion. (Dobson, 2005). This applies to both the baby and the mother carrying the baby.

Pro-choice *religionism*, if you like, also maintains that more women have died from complications from back-alley abortions than those who have died following professional procedures from able clinicians. (Ladipo, 2004). Considering how the right to confidentiality is utilized to cripple research into post-TOP complications following professional procedures, common sense suggests that it will always remain right that laws against abortion kill women.

2.2.1 Is the fetus a *Person*?

When the haploid human sperm fuses with the haploid human ovum, the diploid human being manifests in the form of an embryo, which travels to the uterus for implantation. This is the beginning of human life. Those advocating pro-choice propaganda, however, seem to be committed to passionate endeavours to modify this reality in favour of rationality that has grown politically, financially, and positively *de rigueur*. One such modification involves the illusory argument that "the beginning of life does not imply the beginning of moral and legal personhood." (Mathieu, D. 1991:16). This author makes reference to research articles whose biased arguments cannot be proven wanting. Mathieu's consistent pro-choice argument throughout the paper is that the fetus is not a person and should not be defined as a human being. Clearly in this sense, there is no such a thing as potential, where the fetus is concerned, except where such potential refers to the mother's horror from the trauma caused by unwanted pregnancy. This school of thought thus disagrees that some of the most terrifying tragedies in life are to watch a tree die in a seed, a man die in a boy, a forest aborted in a seed, and poems die in a poet. (Munroe, M 1990). For centuries and millennia, fertility has often been disposed of as living human fetuses where

disposed of. The implications of such disposal of human lives are profound.

After intense analysis of the pro-choice school of thought, one conclusion has to be made without a shadow of doubt: the rule of thumb in pro-choice funded or supported research is that even where post-abortion complications linked to professional medical procedures are reluctantly acknowledged, such acknowledgement should be done on condition the complications are reduced to as minimal percentages as is possible, so that the abortion industry can continue to flourish in the name of the civilization defining reproductive rights for pregnant women. On the government health ministry website for example, the statistics on the procedures performed reflect data that was last updated in the year 2001. (see <http://www.doh.gov.za/facts/stats-notes>)

By contrast, the pro-life proponents are seemingly not motivated by lucrative returns but by the value of potential. The following pro-life examples may offend sensitive readers. Do go through them with the respect needed and cautiously interact with the bottom line imparted.

- (1) Suppose Beethoven was aborted; the theft of his music would have manifested.
- (2) Suppose Nelson Mandela was aborted; then South Africa and the world would have been denied access to a brilliant leader with passionate love for children.
- (3) Suppose you were aborted; assuming that as a fetus you were not really a *person* that would not be wrong, would it?

I have observed that those who are for abortion have not been aborted. (Abraham Lincoln.)

It follows from these tremendous contrasting notions that the premise of post-top complications from the pro-choice perspective rest heavily on the understanding that the fetus is not a person.

2.2.2. High-Risk Pregnancies

Both pro-life and pro-choice schools of thought acknowledge the possibility of high-risk pregnancies. The differences

of opinion only relates to the role of abortions in the vast phenomena of high-risk pregnancies.

High-risk pregnancy involves, among others, factors such as maternal nutrition and fetal development; risks of alcohol consumption and substance abuse; environmental toxicants; and medication problems. High-risk pregnancy may lead to abortion. Abortion can lead to high-risk pregnancy. Management of health factors that play a role in each case can enhance excellence in curbing prenatal harm.

A patient history, which involves too many ceasarian section births, can represent considerable level of high risk in pregnancy. The following are some of the medical aspects of high-risk pregnancies:

2.2.2.1 Maternal Nutrition and Fetal Development

Input does influence output. "Substantial evidence supports the widely held belief that maternal nutrition influences fetal growth." (Queenan, J.T. 1994:1). Deficits of vitamins and minerals have been shown to be the prime suspect as a cause of neural tube defects. (1994:4). For the few who live in abundance excessive intake of vitamins and minerals

does raise concerns about the probability of harmful effects.

Queenan goes on to elaborate through the use of examples that include for instance that:

- a. Vitamin A (retinal) can be teratogenic.
- b. Carotene, which is found in carrots, is a safer form of Vitamin A.

Vitamin D is potentially toxic to the fetus; particularly when large doses of the vitamin are given during pregnancy.
(1994:5)

The vast and cosmic elaborations above give a fairly reasonable idea of how broad the aspects relating to complication of termination of pregnancy can be. From procedural complications to nutrition related challenges it is clear that protecting the best interests of women in the implementation of abortion law requires a lot of diligence and more detailed policies. Marion Stevens, one of the pro-choice academics who produced a master's thesis from Wits School of Public and Development Management, has done some work on the passage of the abortion legislation. A single sentence summary of his study could be: the abortion law came from the Presidency Office and not as a mandate from

the electorate. He, however, strongly makes a case for the goodness of the legislation and arguably leaves out the notion of the best interests of women to the medical practitioners, future policy makers and deep thinkers, who will produce more advancements in reproductive rights and responsibilities.

There is an undeniable link between nutritional problems and health problems. For this reason nutritional management during pregnancy is a vital health and wellness factor.

2.2.2.2 Etiology of spontaneous abortions

Spontaneous abortion may be classified as sporadic or recurrent. Recurrent refers to three consecutive abortions before the twenty weeks gestation period. (Pattinson, R.C. 1993:191). By contrast, sporadic abortion applies to all spontaneous abortions not fulfilling the definition of recurrent abortion.

a. *Early spontaneous abortion*

- May involve *chance occurrence*: This includes sporadic chromosomal abnormalities, and environmental factors such as smoking and viral infections that create a hostile environment against normal development of the embryo.
- May also involve *inability of the ovary to cope with the pregnancy*: This includes Corpus luteum defects.
- *Poor placentation*: This involves the uterine septum, in which case the blastocyst on the septum is mainly fibrous tissue; when adequate placentation does not occur then the pregnancy will abort. (1993:192).
- *Autoimmune diseases*: Example: *Systemic Lupus Erythematosus* (SLE) or Other collagen diseases such as Antiphospholipid syndrome- in these diseases there is a wide array of auto-antibodies and circulating immune complexes which result into a higher incidence of spontaneous abortion. (1993:192).
- *Human Lymphocyte Antigen* (HLA): in this condition if both partners are genetically the same and share the same HLA status the female will not be able to recognize the trophoblast tissue as foreign and the normal immune response will not occur. (1993:192).

b. Late spontaneous abortions.

- *Poor placentation and pre-eclampsia* (pregnancy-induced hypertension): this results into inadequate trophoblast invasion of the uterine spiral arterioles, which leads to poor placental function resulting in abortion.
- *Inability of uterus to hold pregnancy.*

Uterine congenital abnormalities such as didelphys, cervical incompetence, and submucous leiomyoma need to be managed well before any discussion of possible post-abortion complications may be entertained. (1993:193).

c. Miscellaneous factors

- *Syphilis:* This is one example of many Sexually Transmissible Infections (STIs). "Pregnant women should be screened serologically for syphilis early in pregnancy." (Ballard, R. et al. 2000:24). This chronic STI is curable; however, where treatment has either been lacking or insufficient, the infection can have

serious effects on the conceived baby,
e.g. affects the long bones.

- *Cytomegalovirus, rubella and toxoplasmosis* also lead to abortions.
- *Chlamydia* and *mycoplasma* infections-also cause abortions
- *Hypothyroidism* and *Diabetes Mellitus* (DM). DM is related to poor insulin control, which leads to the fetus being fully enlarged to the point of death due to abnormal growth. (1993:193).
- *Women with history of Caesarean Section.* There has been cases of miscarriages that occur due to previous Caesarean Section. One example is that of a patient referred to in a study of colonic pseudo-obstruction following elective Caesarean Section. "She subsequently had a spontaneous complete miscarriage at 6 weeks." (Cooley, S et al. 2002:220)

2.2.3. Religion versus Reality

Activists who advocate pro-choice notions blame the evidence of few complications blown to unnecessary proportions on religion and uneducated cultural stereotypical lack of civilization. Pro-life associations such as Doctors For Life hold a different view.

The Doctors for Life organization is of the view that our South African society is a society that is increasingly humanistic in interaction with issues that threaten self-rulership. Thus even where common sense needs to prevail, the will to accommodate pure drivel is perfectly shielded with the reduction of sanity to religion.

On the other hand, insensitive archaic religious misconceptions of reality have in more ways than one enhanced the arguments for pro-choice narratives that have not masqueraded as the meta-narrative powerful enough to obliterate all other narratives.

Any *religionism* that imposes guilt without guidance, pressure without empowerment, and condemnation without caring, and exhibits wanting levels of tangible servanthood certainly is the last thing a frustrated, lonely and confused pregnant lady needs.

In medicine there is continuous evolution of brilliant technologically techniques that enhance the common sense arguments relating to crucial issues of obstetrics and gynecological significance. For example, Magnetic Resonance Imaging (MRI) is a powerful tool in the life of any obstetrician who is interested in acknowledging the serious of *the call* on a medical practitioner to save lives. Menachemi's study on the need for hospitals to adopt information technology for the sake of improved patient safety share a similar view. According to Menachemi, "Hospitals with the most sophisticated and mature IT infrastructures perform significantly better on the largest number of PSIs." (2007:398). In essence it is worth acknowledging that Ultrasound remains the fetal imaging modality of choice since it is widely available, portable, fairly inexpensive and yet offering extensive and fairly accurate information on the developing human being to be born. (Twickler and Zaretsky, 2003: 868). Neither *humanism as a religion* nor traditional religions may undermine the magnitude of enlightenment that tools such as MRI avail to the project of guiding the pregnant mother through the process of nurturing the human life that exists in the uterus.

For every patient who experiences unpredicted **Preterm Birth** (PTB) due to the failure of humanism as a religion or due to any imprudent *religionism* that fails to acknowledge the realistic pregnancy challenges in everyday life then immaturity limits the potency of medical encroachments. Religion has the power to build and the power to destroy. At its best religion improves and essentially enhances human life. If religion means that the issues of risk management in pregnancy are valued less than oppressive interpretation of sacred precepts then the very reproductive rights we seek to shield are irresponsibly diluted. This should objectively be shunned and rejected with the contempt similarly suitable to interpretation of reproductive rights that includes discarding of living human fetuses based purely on choice rather than for instance serious medical difficulties. Such difficulties would include for example the possible implications of Severe Acute Respiration Syndrome (SARS) in pregnancy. This is called the beauty of being realistic rather than irrationally optimistic. True optimism is informed by realistic view of both facts and principles involved.

2.2.4. Legislation versus Reality

There is no liberty without laws. The freedom to drive a vehicle in the country is made stronger by the reality of laws that govern the use of this freedom on our roads. Similarly, South Africa has backed-up women's right to choose whether or not to terminate pregnancy with clear laws. These laws, at least in pro-choice terms, make the medical procedures safe, and certainly safer than high risk back-alley procedures that have killed multitudes of women who were denied reproductive rights. *For a good example of the reality on the ground, see the study referred to in chapter six, from Daponte et al.*

The post-1994 *eureka honeymoon* period is marked by radical legislative shifts and reforms. For example, from the review of the Abortion and Sterilization Act No. 2 of 1975 to the passing of the Choice on TOP Act in November 1996 there is a clear commitment from the state's side to increase the rate of TOPs performed in this country. (Stevens, M. 1998:5). Lately even mere midwife nursing sisters are allowed and encouraged to perform TOPs where the patient so desires. In reality, however, legislating an increasingly faster rate of procedures performed under

professional settings does not automatically imply that the women who entrust themselves to these enthroned precepts are safe. Pro-choice movements still maintain that in essence, there is truly no such a thing as a safe abortion. The biggest tragedy where this reality is concerned is that multitudes of women across the globe really do believe in the preached safety that is supposedly guaranteed within professional medical institutions.

2.2.5. Poor records: A powerful tool

South Africa has more than sufficient pro-choice research dissertations. The bias arguments within them were not even questioned by the research supervisors. The evidenced lack of records relating to post-TOP complications in the hospitals studied in this research helped me understand the reason why I could not find literature on maternal mortality figures relating to post-TOP complications.

The magnitude of horror and death that many women have faced are concealed by the magnitude of poor records on the procedures that go wrong. For example, if a woman undergoes the TOP procedure and later on dies of embolism as has

happened to many in this country, the cause of death is not recorded as TOP. It is recorded as embolism.

The implications thereof are profound. In actual reality therefore, thousands of women in this country choose to terminate the lives of their unborn children clouded with powerful ignorance where the terrifying possibilities are (where health is concerned), which are factually far worse than potential causes of maternal deaths when normal nourishment of the fetus to birth is opted for. What a tragedy that the flourishing culture of poor records perpetuates ignorance with regard to the magnitude of harm accruing to the *messianic* termination procedures.

2.2.6. Potent Globalization, Poverty and Population Figures

Economic development involves the capacity to transact without difficulties, the improvement of all human lives and the sustainable access to basic services such as health and education. (Todaro, M. 2002). "If you want to be successful, you must set priorities for yourself in relation to your vision." (Munroe, M. 2003:149). In the

light of this principle, the stakeholders that are concerned about development in third world countries can benefit from low population figures.

Common sense suggests it is a good thing to always have healthy equilibrium levels between the supply of resources and the demand for these resources. Indeed the thousands of families in this country that survive on less than one US Dollar per day are starving. Following this argument, the project of NEPAD and the AU can benefit from the TOP revolution that has been shown to be effective in keeping population figures down and enhancing the strategic arsenal against poverty and lack.

This is one passion for flowing with the globalisation bandwagon that embraces the notion that the end justifies the means. In actual reality, though, the end does not always justify the means. Poverty refers more to absence of maximized productivity than it could ever refer to the lack of anything or the irresponsible breeding similar to that of flies.

2.2.7. The Kernel of Post-Abortion Care

Every woman has the right to good, informed and efficient health care. Deceptive caring systems do not serve the best interests of women and should be exposed, eradicated, depleted, and avoided. For this reason, Post-TOP Care should always be evaluated in terms of how well it serves the best interests of women. Both intended and unintended pregnancy loss are increasingly common and so are the psychological burdens such as Post-Traumatic Stress Disorder (PTSD). (Woods and Espaito)

In terms of the diagnostic criteria, PTSD can manifest through recurrent and intrusive recollections of the traumatic event such as the conscious awareness and guilt about the loss of life, difficulties falling asleep or staying asleep, feelings of detachment or estrangement from others, and so on. (DSM IV, 2000). There are numerous other possible post-abortion psychological disorders, which potential abortion patients are virtually never made aware of. These include mood disorders, anxiety disorders, and even psychotic disorders due to General Medical Condition (GMC). Post-TOP caregivers need to draw from Sun Tzu's strategic counsel: "When Calculating the Fundamentals, Examine each one carefully." (Wing, R.L. 1988:23)

Effective care is the best way to avoid complications. Some of the vital aspects of Post-Abortion Care include:

a. Improving the quality of services and contraceptive acceptance in the Post-abortion period.

This can be achieved by:

- (i) *Recruiting* more medical doctors and nurses to work in the public hospitals more especially the rural hospitals because there is a greater shortage of doctors. For the government to be able to achieve this, they need to positively address the basic needs or rather say basic demands for these medical doctors.
- (ii) *Training and monitoring:* physicians, nurses and other counselors need to be trained on the proper management of post-abortion care. The above mentioned team needs advanced Psychology training because some of them often associate abortion with criminal activities whether spontaneous or induced, and this often implies

mismanagement of abortion which may result into septic abortion, septic shock and ultimately death, which at the end of the day highly compromises excellent quality service delivery. Physicians need to always improve or revive their diagnostic skills such as fetal MR technology usage. (Zaretsky and Twickler, 2003). They also need to be highly competent with the proper method of doing Manual Vacuum Aspiration or Dilatation and Curettage, and to prescribe antibiotics after the procedure. One other important thing is health talk, which oftentimes the physicians and nurses forget or do not do due to subtle negligence. Health professionals need to discuss with the patient about post-abortion care and contraceptives. Some of the patients have had to back to the hospital within two months time for another abortion because they were never advised on the issue of contraceptives.

Incidence where care is needed in TOP services do vary widely, but the bottom line is that health care workers need to be more than

equipped to provide effective care for women undergoing or who have undergone the TOP procedure. (WHO, 1995:17)

b. Considerate ethical interaction with patients that involves respecting human dignity

The Constitution, Act 108 of 1996 provides for the right to human dignity. Having rights such as this one on paper does not naturally translate into obedience to the precept. In developing countries the balance of power in doctor-patient relationships is heavily skewed in favour of the doctor. This is aggravated by the patient's level of education as compared to that of a medical doctor. Doctors take an advantage of this situation by either taking a decision without first consulting the patient for consent or enforcing the patient to take a decision without explaining to him/her about the advantages or disadvantages of the said procedure. This is quite dehumanizing and disturbing. The whole issue of *Ubuntu* (also referred to as *botho*) i.e. respect for human dignity is often highly compromised. This can

be corrected by introducing sharper training in medical ethics during undergraduate, postgraduate and continuous learning development programs. The other controlling measure is by educating and empowering patients on their rights to humane treatment in a medical setting such as provided for by the Patient's Rights Charter. The *Batho- Pele* (people first) principles need to be utilized maximally.

There is a need to steer the provision of health services in a direction that offers considerate and complete care. Real complete care will involve maximized awareness of the magnitude of the impact of psychological well being, particularly where the process of being a parent is concerned.

"Feelings of procreativity or generativity
A sense of continuity through the generations;
Fears and expectations about the coming baby;
The impact of this exciting process"
(Cameron, I.T. et al. 2001:169)

Every patient can and should enjoy every right provided for in a sound manner by the legislation passed. The best obstetricians and gynaecologists are those who have the capacity to shield human dignity by employing excellent "interpretation of intrapartum fetal well-being measurements within the context of the entire obstetric situation." (Beckmann, C. et al. 2002:141). It is normal to expect that a medical doctor's top priority is only to protect human life.

c. Informed consent and confidentiality

This is perhaps one of the most sensitive subtopics because it has a lot to do with the persons endowed with power and authority over the patient; more especially if that patient is a woman. In both African and non-African cultures, more often than desirable, a woman does not have decision powers in as far as the issue of her fertility is concerned, the husband has to decide whether she must be induced for abortion or not, confidentiality is not fully respected. Thanks to the patient's rights charter - the woman's confidentiality is protected nowadays. The longer a woman lives with an unwanted pregnancy, in fear of

patriarchal rejection, the more her chances of high risk abortion at higher gestation age.

In general, it is of vital importance to observe the evident need for high standards of training that are more likely to limit high-risk practices by midwives, medical officers, obstetricians and gynaecologists. This also represents a step in the right direction in fighting prejudices against women.

c. How should the Batho Pele principles be employed in TOP services?

There is no such a thing as *batho pele* without putting *people first*. This is after all the heart of the African phrase. The information available from the government website makes reference to among others

2.2.8. How empowering is our policy framework in terms of preventative measures?

African Renaissance is based on the principle of *Ubuntu*. It is based on the notion of valuing people as human beings. True African renaissance appreciates and respects human life. That is one of the many reasons why this country does not subscribe to capital punishment. The policy and legislative potency that rejects capital punishment is rightfully informed by *Ubuntu*. In essence then *Ubuntu* is a principle that sees and respect the notion of potential. This is arguably the reason why some criminals have enjoyed awesome pardon from the state and enjoyed being freed long before their prison terms ended. It appreciates potential to the point where it is very clear that *people*, who form the essence of *Ubuntu*, are neither their mistakes nor their failures. It sees the possible positives and courageously magnifies them to a level that overwhelms the appeal of the negatives. **It is not possible to believe in Ubuntu and be comfortable with the increasing rate of requests for the TOP procedure. The problem is not so much sustainability of the provision of the demanded TOP services as it is the fact that there are individual human beings who make individual decisions to eliminate so many individual human pregnancies.** It is this very understanding that explains why health policies throughout the beautiful continent of Africa, coined by brilliant African minds in different

African countries, do not provide for human abortions based purely on the pro-choice phenomenon.

The Constitution, Act 108 of 1996, as amended, provides for highly significant rights. Among these is the right to life. Presently the country operates on the controversial embrace of the contentious assertion that the right to life does not apply to babies that are still in the womb; hence the approval of *prochoice* legislative jurisdiction. Chapter two of the Constitution, in the midst of all the praises to our constitution, as the so-called best constitution in the world, is loaded with the bill of rights that are plagued by subjective interpretation. The Bill of Rights certainly, therefore, fails to protect the life of any baby who is still in the womb. It is not questionable scientifically that under normal circumstances a baby inside the mother's womb has **life**. Unlike pro-choice activists, pro-life activists maintain that all honest pregnant mothers do know very well that even long before the twelfth gestation week, they certainly do not need midwifery courses or sophisticated sonar machines in order to know that the baby inside is alive. But it is a fact and an exalted precept many celebrate: that in this country **the baby inside the womb does not have the right to the life**. In terms of

humanism we would rather believe and passionately and intelligently protect the status quo that maintains that the baby should be defined as a fetus, a sub-human, an immaterial conglomeration of cells, tissues, organs and systems that should not be afforded the privilege of meeting the definition of a human being. By contrast, In terms of potential, and in terms of *Ubuntu* as highlighted above, it makes perfect sense to argue that for each baby that we abort who carries a significant contribution to the discovery of the cure HIV and AIDS then our society certainly has a gleaming way of shooting itself in the foot. The magnitude of humanist enthroning of human thinking as the ultimate totalitarian over issues of human life and the right to life is increasingly becoming inhuman. For pro-life organizations such as doctors for life, this humanists' extremism floods the policies that run daily activities in South African public and private hospitals.

There is sufficient policy in this country for any woman who feels like it to demand abortion services from the state health care institutions. Within the globally *de rigueur* humanism this is a major breakthrough in the empowerment of women. Women have the fêted right to decide

what happens in their body, including what happens to the *fetus* inside the body. As part of globally *de rigueur* civilization women deserve to celebrate the implications of enjoying reproductive rights. Civilization embraced by government health policies includes the economically and politically correct emphasis on getting rid of unborn babies more than availing at least the same energy to preventative measures.

The fact that there are literally hundreds of thousands of requests for the TOP procedure in the public and private health care institutions combined is sufficient evidence that **the message of contraception is not working in terms of tangible effectiveness**. If this study cannot reach any observations and/or conclusive evidence enough to necessitate the full awareness about the need to strengthen the efforts and fiscal provision dedicated to the message of contraception, then it should at least highlight the urgent need for highly mandatory pre-TOP counseling which does not have to threaten the mother's choice to terminate her pregnancy.

The amounts of money that should be forked out for provision of the TOP services that our policies provide for are huge. In terms of the potency of the embraced policy,

for every patient who is not offered the demanded TOP service the state is not sticking to established policy and thus betrays the electorate. Ideally all women who request TOP services within the provisions set out in the Termination of Pregnancy Act must be afforded the services they have the right to without stress. For every woman who lives irresponsibly knowing that the pregnancies (babies) can always be vacuumed out (courtesy of **Manual Vacuum Aspiration** - MVA technological advances) if the state fails to stick to the established promise, then the promised empowerment is mere vanity. In essence then, for every unfulfilled promise in this specific issue then the provisions are harming women among other reasons because many lead sexually adulterated lives relying on the policy that claims to 'empower' women. In this sense, **in pro-life terms, we have moved from a theory that says women are disempowered by laws against abortion that kill women, to one that says women are empowered by laws that kill unborn babies.** As a celebration to our humanist *rulership* the current policy framework is perfectly in line with currently trendy global civilization. The policy framework embraces the *deity* of globalization more than an average citizen may comprehend wholly. The extent to which all that is solid melts, and in borrowing from Marx, all that is

holy is profaned is empowered by intensely subtle and sufficiently cruel craftiness. Recently the rate at which South Africans are empowered to achieve maximized African Renaissance is questionable.

This is a wearisome veracity primarily because everything the policies in this country points to virtually always seeks to be obedient to the precepts that globalization hands down to developing countries and the developed alike. In this sense of helplessness and defeatism actually mean that what the entire tedious west glorifies we take serious effort to glorify. This is the case in redefining and reengineering TOP legislation. It is the case in redefining the marriage institution to include same sex unions. The idea is being so obedient to current trends that the very substance that informs our Africanism is lost in the uneducated passion to please the WB/IMF/WTO, correctly and notoriously labeled the unholy trinity. In this sense we are getting closer and closer to the identical life styles of those known as the so-called successfully developed countries at any price. Pro-life activists are of the notion that we find ourselves inundated by wicked evidence that it does not matter how much we drift away from valuable principles such as *Ubuntu*, as long as we can

obediently meet the aspirations and standards of imposed western civilization.

If the potency of our policies means anything, then our health care institutions, i.e. both public and private institutions, should not be flooded with the profusely copious requests for TOP services at such an overwhelming rate. The state is spending considerably large figures of cash from the fiscal coffers on, for example, spreading the message of condomization. The most appropriate question is, is it working? Judging from the private and public hospital/clinic intake of Sexually Transmissible Infections (STIs), let alone TOP services requests, it is simple logic that the message is not working. Then the next sensible question is: why is the message of *condomization (use of condoms as part of practicing the so-called safe sex)* as a preventative measure against STIs and pregnancies not working?

This following list may not masquerade as the ultimate condom flaw list but only serve to give a good idea of the problems with the use of condoms:

1. Condoms simply do not provide hundred percent protections against both STIs and pregnancies.
2. Not every sexually active person shall faithfully use condoms in every sexual intercourse: Of course if they did the long term result would be magnificent and would certainly reduce the demand for TOP services.
3. Condoms often burst during sexual intercourse and the reasons for the breakage, be it the poor knowledge of how to use them or simple quality issues, really do not change the fact that once it is broken, it is broken and there is very little that a potential STI recipient can do about the possible infection.
4. Condoms are not always within reach for those needing their protection upon yielding to the desperate yearning for sex and sexual feelings often overwhelm common sense.
5. The natural penis and vagina contact involves sensitivity that shall not under the best of technological advancements in condom design and production be replaced. This is particularly the reason why even ladies in some cases demand that the men take off the (*Ijasi lomkhonyana: i.e.*

Zulu for condom) artificial barrier. Thus preaching the use of condoms by both men and women is a message that falls on deaf ears.

CHAPTER THREE

Research hypothesis

A good research hypothesis should in terms of a reasonable definition, represent a logical supposition, a reasonable educated conjecture that provides a tentative explanation for a phenomenon or phenomena under an educated investigation. (Leedy and Ormrod, 2001). This implies then that it cannot just be an empty statement that makes an emotional or uneducated claim.

This study is based on a hypothesis which does not need to be disproved or proved. There is, however, an absolute intention to attain from the study, rejection or support

for the hypothesis. Work on the research hypothesis in this study, is in a sense driven by the research questions.

The following statement is best understandable when viewed from the luminous angle of four key phrases, viz: Post-TOP complications, two state hospitals, best interest of women, and *batho pele*. The Post-TOP complications studied only refer to those discovered in the in-depth interviews with the senior health managers and experts involved in the two hospitals studied. The complications are expected to raise concerns about the needs of women in line with what the best interest of women may be seen as from an observation informed by integrity profound passion to see women leading good quality lives.

The statement is: There are post-TOP complications in two state hospitals, which imply that the choice on TOP legislation is not serving the best interests of women as intended.

CHAPTER FOUR

Research Methodology

4.1. Introduction

If any researcher is to be realistic, in more ways than imagined there is indeed no such a thing as a neutral position of the researcher. From the pro-abortion research dissertations I have read this is so true it is not even funny. Two of those I studied intensively are in the library that is at the Wits Business School campus and one at Wits Medical School library. I am still convinced, however, that it is of crucial importance that the methodology be as free from the unwanted bias as is

possible. The methods and techniques applied in this research certainly bear the attitude of objective and virtually bias-free data collection, lest the whole purpose of the research principles is missed.

Both qualitative and quantitative research methods are employed. The main emphasis is, however, given to the qualitative research methods because of the sample size.

4.2 The acumen of interviews

According to Kvale, S. (1996:144), interview analysis should involve essentially significant levels of credible quality. Such quality includes among others: the extent of spontaneous, rich, specific, and relevant answers from the interviewee; the shorter the interviewer's questions and the longer the respondent's informed answers, the better the quality. Various interview study theorists concur that not only is the ideal interview to a large extent interpreted throughout the interview, but it is also of vital importance that where expositions involve varied

vexed questions such as those included in this study, then the study should be 'self-communicating'; meaning that the dissertation should reflect a carefully narrated story that is contained in itself, such that the story hardly requires a lot of extra descriptions and explanations aimed at driving key points home.

In this Termination of Pregnancy study, the emotional dynamics of an interview study have been successfully taken care of. Such dynamics include for example, *antipositivist enthusiasm phase*. (1996:85). The passion for meaningful qualitative research of people's lives, and not a mere positivist, quantified data gathering was admittedly rekindled to greater heights by the horrendous attitude I faced from an intellectual I shall only refer to as Dr Steven, who was so determined to frustrate the quantitative segment of this research that I had to modify both the methodology section and the research as a whole to accommodate the animosity unleashed in the name of protecting the patients. Confidentiality is so powerful that it fundamentally constituted the main reason why I could not be allowed, at least in the view of the ethics committee having authority on research involving human subjects, to administer any questionnaire to patients

undergoing treatment for post-TOP complications. This study was not initially meant to be heavily reliant on intensive interviews with managers in the chosen field. This Dr Steven insisted I need the Minister's permission to obtain maternal mortality data, which certainly include the data that relates to TOPs completed at Hospital level; and there was certainly no way (at least according to the ethics committee's Dr Steven) I could be allowed to administer questionnaires to willing patients (*of course filling in a questionnaire is never a forced exercise under upright conditions*) who were undergoing treatment for post TOP complications. Every medical doctor in a senior position that I interviewed, except three of them, desperately begged me not to reveal their names to any one in the health ministry for fear of losing their practicing licenses because that is what can happen if you take part in a research that has the potential to reveal the aspects of TOP services that the authorities do not want revealed. These are the realities that limited the excellence of the research methodology; so I had no choice but to work with whatever data for which I did not need the ethics committee permission to collect. Being limited to intensive interviews is not right and in the not so distant future when I am an Obstetrician I shall pursue the same study

with more radical quantitative data demand. If it means seeking constitutional court verdict for that, then I shall oblige accordingly.

4.3. Research design and setting

There are eight themes that the structure of the interviews involved:

- 1) The good aspects of TOP services in the new dispensation and the need to serve the best interest of women.
- 2) Experiences with the known Post-TOP complications.
- 3) TOP and the message of contraception.
- 4) TOP and economic development, given that South Africa is a developing nation whose triumphs over the realities of two economies are still to be realized.
- 5) Legislation procedure: has there been sufficient consultation or any claim of consultation is simply a disgraceful myth? Was the legislation long overdue in line with African Renaissance?
- 6) TOP and the propensity of women to still opt for *backstreet* abortions- are there possible reasons for such unwanted propensity.

7) TOP multiple requests: what are the reasons? Is there a link between age and the multiple requests?

8) TOP and Batho Pele

The setting for the one hospital is semi-urban and the other hospital is situated in a dusty rural area with lots of goats' milk and farm fresh cow milk. The two state hospitals are approximately ninety kilometers apart.

The research was limited to eight senior managers, four from each institution; who were willing and intellectually able to participate in the intensive interview study. This is only one story about the consequential harm from the ethics committee instructions, which imposed major implications for validity and reliability of the findings discussed later, since the quantitative aspects were severely defused. See chapter six for details.

The state institutions that approved of the activities to be carried out at these institutions were assured in writing that:

- a. The data collection is purely for academic reasons.
- b. No data or analysis of the data shall be made available to the media/press.
- c. Under no circumstances shall the name of the hospital be published.
- d. Conscious efforts shall be taken to protect the reputation and autonomy of the hospital; e.g. the name of the hospital shall only be mentioned to the supervisor and the university authorities that are directly involved, such as for example, the research projects team, where truly necessary.
- e. The final findings of the research shall be made available to the institution, together with the recommendations, where such availability is perceived to enhance the best interests of the patients and certainly upon written request from senior hospital board members or the provincial office of the health MEC.

CHAPTER FIVE - Data collection

5.1. Data collection procedure

All the subjects were each presented with the themes at least one day before the actual interview took place. This ensured that the subjects had sufficient time to reconcile with the nature of the study and were needed could use

their right to choose not to be involved in these abortion related interviews.

Simple English was used to make sure that even those subjects who did not enjoy the luxury of having studied first language English could still take part. To make things even much easier, the researcher administered the interviews and collected the data without assistance. Not only was verbal consent sought after, but also important was the need to let the participants know that should any of them, at any point of the study, feel she does not want to continue with the study, she should feel free to stop taking part. Case in point: When I saw one Doctor crying over one aborted baby whereby she remembered how the nurses had to suffocate the baby with refuse bags due to incomplete abortion I realized this freedom to stop was a very crucial part of the information given to these senior practitioners.

The first and second themes

The Doctors were made to feel relaxed and at liberty to relate patiently the good aspects of TOP from their practical experiences with the application of Choice on

Termination of Pregnancy Act 92 of 1996 in their institution. The same freedom was availed for experiences involving bad memories and horrors. Of all the subjects in these intensive interviews, only two had positive stories to tell about how proud they were of the introduction of the Act and the free availability of the services to women. The one was a lady Doctor and the other a male doctor. The lady doctor narrated the story of an adolescent lady she offered the service to, who had reportedly been raped by her step father. The male doctor was very proud to have helped a lady who needed to save her marriage by aborting a child she conceived after sleeping with her boyfriend. This doctor was, however, disappointed that the same lady came for the TOP service three times in less than eighteen months. He said "obviously the boyfriend was having more quality time with the lady than the husband and certainly performing well with his ... will I offend you if I say dick in bed?"

About the bad aspects of the procedure experienced during his practice, one Senior Medical Officer (SMO) said: "if you understood Mr. Leope, how cruel the methods used to abort the babies are, you would realize how much of child abuse and cruel killing this is. I know the government does

not want it to be called killing, but the real truth is that it is killing, cruel killing of innocent lives. Basically the baby inside has a normal life then the mother can make the choice that we must expose the child to terrible pain of, say, a saline abortion; in essence they are poisoned, they are cut, they are scalded and they are torn apart with one goal, to kill the baby before birth. I used to do it but now I have suffered enough traumas to know I had to stop. My mind cannot accommodate the horrendous images I thought I would become used to. I am not religious but my conscience does not allow me to continue performing these procedures any more." All the doctors interviewed had previously lost at least one patient to Post-TOP complications following professional procedures. It is also worth noting that the doctors naturally dwelt more on the complications they have had to attend to because these were quite common. More details on these are in the next chapter that elaborates fairly well on interpretation of the data.

The third theme

The health managers were asked to relate about their impressions regarding the effectiveness of the message of contraception. None of these educated health managers argued that the message of contraception was effective. The one Principal Medical Officer (PMO) said: "it has everything to do with lack of discipline, because people know about the existence of contraceptives, but they are not committed to using them. It is more like some of my friends who are medical doctors like me, well educated on issues relating to health and wellness, but they smoke cigarette, and some take pride in buying imported cigars." In another interview the lady asserted: "Surely there is no motivation to use contraceptives if you know you can always ask the doctors nurses to apply **D & E** or **D & X**." Another clinical manager told a sad story of how one of his patients faithfully used contraceptives for eight years then when she wanted children after eight years of faithfully applying the message of contraception, the reproductive system could not reverse to natural normal conditions necessary for pregnancy to take place.

The fourth theme

In this case the senior managers were interviewed on the link between TOP and economic development given the exciting reality that South Africa is a developing nation struggling to overcome two extreme economies in the midst of unwanted soft currency. The state's six percent growth vision was presented to the health managers as a wonderful goal in a country that is indeed alive with possibility.

Four of the interviewed health managers concurred that there are economic benefits to having the pro-choice friendly legislation. The table below represents an accurate reflection of those who either agreed or disagreed with the notion that there are economic benefits to having TOP services in state hospitals.

	Frequency	Percentage

Valid: Strongly Disagree	2	25
Disagree	2	25
Not Sure	1	12.5
Agree	2	25
Strongly Agree	1	
Total	8	12.5
		100

The fifth theme

These senior managers were asked about consultation practice during the legislation process. Ideally the state should ensure that there are sufficient consultative processes that precede even the most controversial of legislative advancements. Principles of democracy, the system South African politics supposedly operate within; include the consultative nature of policy and jurisdiction changes. Now and then surprises can and have surfaced from the presidency and the abortion legislation is one such Act of law. Two of the clinical managers interviewed concur

that in principle there was no sufficient consultation at all. The recent court case by Doctors for life reveals a lot in this aspect.

Concerning whether or not the legislation was long overdue given the sermonized message of African Renaissance, one biased pro-choice study at the school of Public and Development Management, which claims to have examined the passage of the legislation concludes that there was some kind of consultation.

I will never forget how one clinical manager insisted on not answering any question relating to consultation because of fear of losing his job.

The sixth theme

The propensity for women, in the sexually liberated and highly circularized country to still opt for back street abortions, is disconcerting to many pro-choice gurus. During the penetrative interviews there was a major concern that the existence of back-alley abortions is still evident in the treatment given to women who come to hospitals with

complications. The interviewed subject also indicated that the back-alley abortion patients are not limited to uneducated rural illiterates who may not know about reproductive rights. Four doctors linked this tragic reality to availability of services, the attitudes of nurses who seem to be the first health service providers that the patients wanting TOP procedures come in contact with at the hospitals, and fear of being exposed. Apparently many of the women with back street abortion complications prefer *Inyangas* (*traditional abortionists*) because they can go secretly to them at night.

The seventh theme

The managers where asked about the possibility of multiple request for the procedure and the possible reasons for these multiple requests. They all testified of multiple requests and how the increasing number of patients with the need for multiple requests for abortion services seems to be evidence that the message of contraception is not working.

One of the doctors argued: "There is an urgent need to intensify strategic endeavors to ascertain the success of the message of contraception. At the moment one should be pardoned for believing that abortion services are the preferred contraception for many women who come to our hospital. This should definitely change."

The eight theme

On the question of TOP and *Batho Pele*; all the subjects agreed that these principles should be applied in the offering of abortion services. Unfortunately only three of them were convinced that this needed application of the principles is practiced satisfactorily. One of the clinical managers argued: "Rome was not built in one day. I think the principles have been applied in our hospital. What we should be saying is, can we improve our application of these principles in serving women with their reproductive right to abort their unwanted pregnancies. Secondly, I wish to make it clear that personally I do not support the lack of pre-abortion counseling in our hospital. As I am talking to you now we are afforded only one clinical psychologist

and there is a lot of work on her shoulders. It is certainly not reasonable to expect that she can offer quality pre-abortion counseling service to every lady who comes here seeking abortion services. It is not realistic." When asked who then gives the pre-abortion counseling to the patients the doctor said: "sometimes, underline sometimes, the nurses do that, but it is just a quick two to maybe five minutes in which case it is not possible to talk about complications, the main emphasis is usually on assuring the mother that she will be safe and that there is nothing to worry about."

The following table reflects the main arguments for or against the TOP procedure as gathered during the in-depth interviews carried out. When the *batho pele* principles are applied with the aim of overcoming Post-TOP complications; the patient's health comes before loyalty to any of the two sides:

<i>THE MOTIVATIONS FOR TOP</i>	<i>THE MOTIVATIONS AGAINST THE PROCEDURE</i>
1. Fewer women shall die from complications	1. The women can, in most cases, make the choice to live and let live
2. The unborn baby is not a human being, it is merely a fetus/ morula/ a conglomerations of growing cells.	2. The unborn baby is a human being.
3. The fetus has no right to life.	3. The fetus has the right to life like all human beings.
4. The mother is the only patient in any pregnancy.	4. Both the mother and the child are patients in any pregnancy.
5. The fetus is part of the mother's body.	5. The fetus is an individual person growing in the mother's body.
6. The fetus is like a cancerous tumour that the mother can choose to remove	6. Comparing the fetus to cancer cells is dehumanizing.
7. Laws against abortion kill women. Pro-choice laws help	7. Most women who die from street abortions die from the

more women to live with freedom from unwanted pregnancies.	mission to kill irrespective of the existence of any threat to the mother's body/life. Pro-choice laws are laws for killing babies. Pro-choice laws do not help women to lead better quality lives.
8. Morals and truth are relative. There is no such a thing as truth.	8. There is such a thing as truth. Only humanism that seeks to exalt man as god asserts that all morals and truth remain relative.
9. Abortion can ease financial burdens and limit social problems.	9. Providing killing as the solution for financial and other social difficulties is dehumanizing.
10. Abortion is merely termination of pregnancy. It should never be defined as killing.	10. Abortion is killing. The baby is killed.
11. Research funded seeks to prove the advantages of	11. Research funded seeks to prove the advantages of

prochoice legislation in everyday life.	letting the child grow till the trimester period reaches the time for birth
12 Human life has equal value from birth; not when aborting the unborn child	12. Human life has equal value from conception

CHAPTER SIX – Data interpretation and limitations of the study

Interpretation

It is clear from this study that there is a significant impact from prejudices against women who want to abort their babies. These need to be attended to by systematic application of the policies in place. Among other things this means the time for hospitals to know how many nurses and doctors in each hospital are willing and able to offer abortions which may be safer than back-alley procedures is long overdue.

Only well-trained nurses and doctors can offer some kind of safety. Thus patient access to TOP services in line with *batho pele*, makes it necessary to embrace the notion that since these professionals may not be forced to perform the procedures, let it be clear whether or not there is availability of staff in every institution, who are not prejudiced against the mothers who want their babies aborted. Clear records need to be kept and vacancy lists should be reflective of the health ministry's desire to attend to the possible lack of access caused by unwillingness to perform the procedure.

The second major aspect which has to be discussed fairly well in this section relates to the existence of the

complication in the two hospitals where the study was carried out. All the subjects who took part in this study mentioned complications they clearly remember, which had to be treated following professional, supposedly safe abortions. The following is a brief discussion of some of the common complications referred to:

The interviews revealed that none of the Termination of Pregnancy procedures offer hundred percent safety. The key argument from the two doctors who are pro-life is that despite the reality that the procedures fail to give hundred percent safety, the good news is the ability of the professional procedures to remain better than the back street abortion hazards. The preferred professional procedures include saline abortion, *prostaglandine* abortion, Manual Vacuum Aspiration (MVA), Suction Curettage, Dilation and Evacuation (D & E), Dilation and Extraction (D & X), *Mifepristone RU486* abortion pill, morning after pill, and in some cases hysterectomy.

The tragic procedural risk the doctors reported are overwhelmingly horrible to imagine, I wonder what the actual patients' lives are like in the process and afterwards. One of the doctors claimed that whilst meant to

dismember and suck the baby, the suction aspiration method can be harmful to the reproductive system. The doctor who said he used to perform the procedures is convinced that the use of a surgical knife to cut the baby and have the remains scraped through the cervix can also be traumatizing to the doctor performing the procedure. The other doctor was not comfortable with the way the saline literally implies poisoning the baby to death and inducing artificial labor to get the body out.

The lady doctor 's testimony narrated below is one evidence of psychological trauma that the mother can suffer. She said after one abortion was carried out, the patient who came for the procedure was traumatized when the baby had come out still alive and she sadly witnessed the last desperate efforts they had to take to suffocate the baby to definite death before dumping him into the plastic bag. This doctor also spoke about nightmares some of her colleagues have talked about following safe abortions.

The doctors all gave examples of real life infection complications they have treated which included pelvic inflammatory disease (PID) that is said to often complicate into sterility even though prompt treatment is availed. The

complication of perforation of the uterus is also said to be common in professional settings. All the doctors interviewed have also dealt with failure to extract all products of the conception. In some cases these remaining products from a professional abortion have lead to emergencies requiring hysterectomy, which involves removal of the womb. The implications thereof are profound. This means every lady who came for this abortion left the hospital not only without the unwanted baby, but also without any possibility of giving birth in the future. This cannot be defined as the best interest of the woman.

Anesthetic complications are also common in the two hospitals where this study was carried out. The complications involve convulsions, heart arrests, and in some cases even death. The testimony from the doctors that this has been the fate of some patient implies that the choice on TOP in their specific cases certainly cannot represent easing the suffering of women. The doctors also concurred that embolism is one of the common complications they have failed to save patients lives from. The bottom line is that there are complications very real that affect the lives of women who opt for the safety offered by choice on TOP Act when they are faced with unwanted pregnancies.

Recently I was talking to one of the doctors who were interviewed for the purpose of this research. She referred me to recent journal articles that confirm the reality of complications following professional safe abortions. One of these is an enlightening article by pro-choice doctors at Johannesburg Hospital, Daponte et al, who did a study on complications of abortions carried out on women whose patient history involves more than one caesarian section. Since a patient history of too many caesarian sections can constitute high risk in a pregnancy, the notion pursued is that a safe abortion can be used to avoid the risk. In this study, which by the way was carried out by pro-choice doctors, the findings are nothing of a positive picture about termination of pregnancy as easing the suffering of women. Firstly only twelve out of the twenty-one abortions were completed, the rest were incomplete abortions. (Daponte et al, 2007:597). The implications of the incomplete procedures are not pleasing at all, especially because some of the patients had to be rescued through the irreversible hysterectomy procedures, which basically meant the women remain barren for the rest of their lives.

Following the performance of aspirations by these doctors, the article states that "major complications" including among others "placental retention, failed medical termination, uterine rupture, and hysterectomy" were all sadly recorded. Considering that these procedures were all done in the Johannesburg hospital, which is a local academic hospital, highly respected for Wits Medical school expertise from internationally well-known professors of among other medical fields, Obstetrics and Gynecology. In this study, only "57.14 %" (2007:597) of the procedures were completed with minor complications treated over a period of two to three weeks. Given that private and public clinics perform hundred of thousands of abortions annually in this nation, and many of these are performed without the luxuries enjoyed by academic hospitals, this spells out a lot of challenges before any claim of easing the suffering of women can be made.

Limitations of the study

The prevalent limitation to this study is the direct consequence of the limit of the data to in-depth interviews. The instructions from the ethics committee that deals with research on human subjects had to be obeyed: The

ethics committee restricted my research to mainly in-depth interviews data and rejected the administration of any questionnaire to mothers who had opted to abort their unborn babies.

The maternal mortality and morbidity data from the department of health also involved two major challenges:

1. The fact that deaths from abortions are hardly recorded as abortion deaths.
2. The fact that every mother has the right to confidentiality and there are major ethical implications from this one rule; such as for example that this constituted the main reason why quantitative data planned for this study could not be availed.

The other limiting factor is the fact that the managers and senior health practitioners who took part in this study were willing participants. This is limiting in terms of the nature of the sample. These limitations imply among other things that the findings of this study, may not be generalized, for example, to the whole country.

CHAPTER SEVEN - Conclusion

There is overwhelming evidence of post-abortion complications in the two hospitals used in the study. These complications do not reflect the best interest of women. In more ways than one the application of the pro-choice

legislation requires more manpower, more planning, more equipment and other crucial resources such as excellent surgical theaters, more willing and well-trained staff, and more fiscal provision. It also follows that the sooner mandatory pre- and post-abortion counseling is available the better the chances of excelling in applying principles such as *batho pele* principles in ensuring the best interest of women where the offering of TOP services is concerned.

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