

**ABORTION: A SOCIAL WORK STUDY**

by

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- ◆ The Lord God Almighty, who created, called, protected and provided me with the strength and courage begin and to complete my journey.
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### **DEDICATED TO MY FAMILY:**

**MY PARENTS: JOHANNES AND MARIA**

**MY CHILDREN: TUMISANG, KEFILWE AND GORATILEONA**

**MY SISTERS: TSHOLOFELO AND SARA**

**MY BROTHERS: LOUIS AND JIMMY**

**MY BROTHER-IN-LAW: KABELO**

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## SUMMARY

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The aim of the study was to explore and describe the psychological aspects of abortion in the women. Both quantitative and qualitative research approaches were used. The exploratory and descriptive research designs were used, because little information was available on the topic. The specific research questions were: intervention with women who opt for termination of pregnancy.

The quantitative phase was a data collection method that involved a phase of data collection. The quantitative research was conducted on a person-to-person basis. The purpose was to draw a sample, and a sample of thirty (30) women from GaRankuwa Hospital, Termination of Pregnancy (TOP) clinic.

For the qualitative phase of the study, interviews were conducted with selected and reviewed. The data were analysed and interpreted. The data were analysed for themes of pregnancy, decision-making, and the experience of the women and their families. The data were analysed for themes of pregnancy, decision-making, and the experience of the women and their families.

The medical aspects of termination of pregnancy were reviewed. The emphasis of the methods of termination of pregnancy was on the physical, psychological, abortion-related factors, and complications, as well as the prevention of complications.

The psychological aspects of termination of pregnancy were reviewed. The emphasis of the factors leading to the decision to abort was on the psychological, emotional reactions, an experience of the women and their families and decision as well as counselling.

Then followed the legal aspects of termination of pregnancy. The emphasis of the constitutional abortion policy and the legal framework of the study.

## SUMMARY

### ABORTION: A SOCIAL WORK STUDY

**Candidate** : Johannah Sekudu  
**Department** : Social Work: University of Pretoria  
**Promoter** : Dr. C.L. Carbonatto  
**Degree** : DPhil (Social Work)

The aim of this study was to explore and describe the psychosocial aspects of abortion on the woman. Both qualitative and quantitative research approaches were used. The exploratory and descriptive research designs were used, because little information was available on the topic under study, specifically social work intervention with women who opt for termination of pregnancy.

A questionnaire was used as a data collection method for the quantitative phase of the study. The questionnaires were administered by the researcher on a person-to-person basis. The purposive sampling method was used to draw a sample, and a sample of eighty (80) women was drawn at Kalafong Hospital, Termination of Pregnancy (TOP) Clinic.

For the qualitative phase of the study thirty five (35) abortion files were selected and reviewed. These files were selected from the files of women who requested termination of pregnancy at the Women's Choice Clinic in Pretoria. The simple random sampling method was used to draw the sample.

The medical aspects of termination of pregnancy were discussed, with the emphasis on the methods of termination of pregnancy at different periods of gestation; abortion-related risks and complications and the management of complications, as well as the prevention of complications.

The psychosocial aspects of termination of pregnancy were then discussed, with the emphasis on factors leading to unwanted and unplanned pregnancies; emotional reactions to an unplanned and unwanted pregnancy; adolescents and abortion as well as counselling.

Then followed the legal aspects of termination of pregnancy, with emphasis on the international abortion policies and an in-depth discussion of the South

African abortion policy, namely Choice on Termination of Pregnancy Act 92 of 1996.

The findings from the quantitative phase were then presented graphically and discussed. It was confirmed from the study that termination of pregnancy is accompanied by a variety of implications. The major reason for women to opt for termination of pregnancy is financial problems. Women from all religious backgrounds request termination of pregnancy.

It was revealed that termination of pregnancy during the first trimester lessens the occurrence of complications, whereas, termination of pregnancy during the second trimester puts the women at risk of complications.

The provision of the Choice on Termination of Pregnancy Act (92 of 1996), on the non-mandatory counselling services leads to non-provision of counselling at the state abortion facilities. This results in women who opt for abortion at state abortion facilities not receiving a comprehensive service, which could have devastating consequences on their lives.

The social worker as the provider of psychosocial service needs to be a part of the medical team that renders the abortion service, on a full-time basis, so that all the aspects related to termination of pregnancy could be attended to at a one-stop service facility.

The bio-psychosocial model was found to be the appropriate one to use when rendering the abortion services, for the women to be provided with a comprehensive service, as all the psychosocial aspects of their situation will be taken into consideration.

Lastly, the guidelines for social work intervention at the TOP Clinic are provided, based on the findings from the study.

## OPSOMMING

### ABORSIE: 'n MAATSKAPLIKEWERKSTUDIE

**Kandidaat** : Johannah Sekudu  
**Departement** : Maatskaplike Werk: Universiteit van Pretoria  
**Promotor** : Dr. C.L. Carbonatto  
**Graad** : DPhil (Maatskaplike Werk)

Die doel van hierdie studie was om die psigososiale aspekte van aborsie vir die vrou te verken en te beskryf. Beide kwalitatiewe en kwantitatiewe navorsingsbenaderings is benut vir die studie. Die verkennende en beskrywende navorsingsontwerpe is gebruik, omdat baie min kennis oor hierdie onderwerp beskikbaar is, spesifiek maatskaplike intervensie ten opsigte van vroue wat kies om 'n aborsie te ondergaan.

'n Vraelys is gebruik as die datainsamelingsmetode vir die kwantitatiewe fase van die studie. Die navorser het die vraelys deur die respondente op 'n persoon-tot-persoon basis laat voltooi. Die doelgerigte steekproeftrekkingsmetode is gebruik om die steekproef van tagtig (80) vroue by Kalafong Hospitaal se Aborsie Kliniek te trek.

Vir die kwalitatiewe fase van die studie is vyf –en- dertig (35) aborsie gevalle geselekteer en pasiënteleërs hersien by die Women's Choice Clinic te Pretoria. Die eenvoudige ewekansige steekproefnemingsmetode is benut om die steekproef te trek.

Die mediese aspekte van aborsie is bespreek, met klem op die metode van aborsie tydens verskillende trimesters van die swangerskap; die risiko wat verband hou met aborsie en hoe dit behandel is, sowel as die voorkoming van risiko.

Die psigososiale implikasies wat gepaard gaan met aborsie is bespreek, met klem op die faktore wat met 'n onbeplande en onwelkome swangerskap verband hou; die emosionele reaksies op 'n onbeplande swangerskap; adolessente en aborsie sowel as begeleiding.

Daarna is die wetlike aspekte van aborsie bespreek, met klem op die internasionale beleide en indiepte bespreking van die Suid-Afrikaanse

aborsiebeleid, naamlik, die Wet op Keuse oor die Beëindiging van Swangerskap (92/1996).

Die bevindinge van die kwantitatiewe fase is grafies voorgestel en daarna bespreek. Dit is bevestig dat die beëindiging van swangerskap met psigososiale implikasies gepaard gaan. Die hoof motivering vir die vroue om die beëindiging van swangerskap te kies, is finansiële probleme. Vroue van al die gelowe versoek beëindiging van swangerskap.

Die studie het aan die lig gebring dat aborsie gedurende die eerste trimester van die swangerskap nie met komplikasies gepaard gaan nie, terwyl dit gedurende die tweede trimester van die swangerskap baie komplikasies inhou.

Aangesien begeleiding van vroue wat aborsie ondergaan nie deur die Wet op Keuse oor die Beëindiging van Swangerskap (92/1996) afgedwing word nie, ontvang hierdie vroue dus nie so 'n diens nie. Dit veroorsaak dat die vroue wat 'n aborsie by veral staatsfasiliteite ondergaan nie 'n omvattende diens ontvang.

Die maatskaplike werker as die verskaffer van die psigososiale diens moet op 'n voltydse basis inskakel by die mediese span wat die aborsiediens lewer. Sodoende sal al die aspekte wat verband hou met aborsie by 'n een-stop diensfasiliteit aangespreek word.

Die bio-psigososiale model is bevind om die geskikste model te wees wat gebruik kan word wanneer die aborsiedienste gelewer word, sodat omvattende aborsiedienste aan vroue gelewer word.



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KEY CONCEPTS

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ENGLISH

SUMMARY

Abortion

Unplanned pregnancy

Termination of pregnancy

Social functioning

Psychosocial

Health care

Family planning

Multi-disciplinary team

Bio-psychosocial model

Counselling

Social work intervention

PAGE

AFRIKAANS

Aborsie

Onbeplande swangerskap

Beëindiging van swangerskap

Maatskaplike funksionering

Psigososiale

Gesondheidsorg

Gesinsbeplanning

Multi-dissiplinere span

Bio-psigososiale model

Beraad

Maatskaplike werk intervensie

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## CHAPTER 1

### GENERAL INTRODUCTION

#### 1.1 INTRODUCTION

Termination of pregnancy is a very sensitive issue as all people are not in favour thereof. The debate on whether it should be performed is still on, all over the world. It always depends on the ruling party of a particular country at a given time. If the ruling party is in favour of termination of pregnancy, it becomes legalised, despite the opposition of the other parties. This generate dissatisfaction on the other parties and all efforts are made to pressurise the government to reconsider its decision, but in most cases, the results are not positive.

This is confirmed by the Roe versus Wade case, in America, where a woman's decision to end the pregnancy was endorsed by the law and her right to choose, was protected. This case marked the beginning of the abortion controversy in America in the sixties (Craig and O'Brien, 1993:1). They further contended that the ruling of this case symbolised the end of one political era and the coming of a new era, where the abortion decision was removed from the woman to the government.

In South Africa, the Choice on Termination of Pregnancy Act (Act 92 of 1996) was passed after a short debate on the Termination of Pregnancy Bill. The religious movements are not at all satisfied with the passing of this act, as they advocate for the respect of the right to life of the foetus. According to these religious movements, termination of pregnancy is a sin. Despite their objection to termination of pregnancy, it is being practised in South Africa.

Termination of pregnancy is accompanied by psychosocial aspects that need to be attended to at the TOP clinic. As a result of these psychosocial aspects, women who are facing an unplanned and unwanted pregnancy require to be provided with a comprehensive service that is rendered by a multi-disciplinary team. By attending to these psychosocial aspects the women will be equipped to live with their decision and be able to focus on their future.

## 1.2 MOTIVATION FOR THE CHOICE OF THE TOPIC

The Choice on Termination of Pregnancy Act (Act 92 of 1996) does not have the provision for social work intervention, regarding the abortion service. As a result the team that is engaged in this service at the state hospitals/clinics do not include social workers. This was observed at GaRankuwa Hospital, in GaRankuwa, as well as Kalafong Hospital in Atteridgeville (Gauteng Province), where the team mainly consists of the medical staff only, namely, doctors and nurses.

From this observation the researcher realised that these women who undergo termination of pregnancy need social work intervention in the form of pre- and post abortion counselling. Although they choose to have their pregnancies terminated, they are not prepared for the possible implications, therefore, experience emotional trauma after the abortion, thus need social work intervention, to enable them to live with their choice. This motivated the researcher to do research on this topic, so that guidelines could be provided on how to help these women, from the social work perspective. According to the Pretoria News of 08 November 2001; 116000 legal abortions have been performed over the past three years in South Africa. It has also been established that approximately six (6) women undergo termination of pregnancy daily at Kalafong TOP Clinic, which indicates that a considerable number of women do not receive a comprehensive service.

Although termination of an unwanted pregnancy is each woman's choice, it could be accompanied by a variety of psychosocial implications. It is indicated in the literature that some women regret having had an abortion and blame their decision on their circumstances, a lack of information and inappropriate services. For example, a case was mentioned in Michels (1988:15), where a woman called Jennifer realised years after terminating her unwanted pregnancy, that if one person had told her more about abortion, she would not have gone through with it. This clearly shows that due to lack of appropriate services, specifically counselling for these women, they end up making uninformed decisions, which they later regret.

This is more applicable to the South African situation, where the Choice on Termination of Pregnancy Act (92/1996), makes provision for the general counselling services (Section 4), but in practice these services are not provided, most probably due to a lack of funds. Women end up undergoing

this traumatic procedure without any pre-abortion counselling or post-abortion counselling, which might have adverse consequences on their lives later on, as they were not given a chance to make an informed decision.

For this reason there is a need to have the psychosocial factors related to terminating an unwanted and unplanned pregnancy explored, so that guidelines for a comprehensive service can be provided, to ensure that these women receive a service that is responsive to their needs.

### **1.3 PROBLEM FORMULATION**

Although the Choice on Termination of Pregnancy Act ( 92 of 1996) makes provision for counselling service in general, this is not done in practice, at the state abortion facilities. The researcher has established, through the discussion with the staff at the TOP clinics, specifically at GaRankuwa and Kalafong Hospitals, that women who opt for termination of pregnancy at these hospitals, do not receive any pre- or post abortion counselling from the social worker, to prepare them or enable them to deal with the psychosocial implications of the procedure. Women undergo the abortion procedure without any psychological preparation, which could have emotional problems later in their lives. Social workers do not form part of the medical team at the two TOP clinics, mentioned above, which consist mainly of the medical staff, namely doctors and nurses. As a result women are not provided with a comprehensive service at these abortion facilities, which could have serious emotional consequences on their lives in future. There is a need to have guidelines for social work intervention formulated, so that the women who undergo termination of pregnancy at the state hospitals are provided with a comprehensive service.

### **1.4 AIM AND OBJECTIVES**

#### **1.4.1 AIM**

The aim of this study is to explore the psychosocial aspects related to termination of pregnancy on the women.

#### **1.4.2 OBJECTIVES**

The objectives of this study are:

- To investigate termination of pregnancy as a phenomenon.
- To describe the psychosocial factors related to termination of pregnancy on the women.
- To describe the legal aspects related to termination of pregnancy.
- To determine the psychosocial aspects related to having an abortion on the women, after the enactment of the Choice on Termination of Pregnancy Act ( 92 of 1996).
- To provide guidelines for social work intervention with female patients who opt for termination of pregnancy prior to the abortion procedure.
- To make recommendations for an improved social work service delivery, with regard to termination of pregnancy.

### 1.5 ASSUMPTIONS FOR THE STUDY

Assumptions formulated for this study as well as the hypothesis are as follows:

- Giving women a chance to make an informed decision with regard to termination of pregnancy, that is, providing them with pre- and post abortion counselling, would make the experience less traumatic.
- Women who opt for termination of pregnancy need to be provided with social work intervention, that is, pre- and post abortion counselling, to enable them to deal with the long-term implications of their choice.
- Although termination of pregnancy is each woman's choice, it does have negative psychosocial implications.
- Women who are not provided with a comprehensive service at the TOP clinics could regret their decisions later in life.
- If the women who opt for termination of pregnancy could be provided with pre-abortion counselling then their social functioning would be improved.

## 1.6 RESEARCH METHODOLOGY

The research methodology used in this study will be described briefly.

### 1.6.1 RESEARCH APPROACH

In this study, a combination of qualitative and quantitative approaches was used according to Creswell's dominant-less-dominant model (De Vos, 1998:360). According to this model the two approaches are used in one study, with one approach used more than the other, according to the demands of the study. The quantitative approach was used dominantly more than the qualitative approach.

A combination of the two approaches was used based on De Vos' (1998:358) argument that the phenomena which are investigated in the social sciences are so enmeshed that a single approach can most certainly not succeed in encompassing human beings in their full complexity. With this argument in mind it becomes evident that the complexity of the phenomena that are studied in social sciences warrants a combination of the two approaches, if one would like to capture all the needed data. Due to the fact that abortion is a very complex and sensitive topic, a combination of the two approaches was seen to be more appropriate.

### 1.6.2 TYPE OF RESEARCH

The type of research that was implemented in this study was applied research, as the aim was to provide improved service delivery. It is argued by Rubin and Babbie (1993:79), that applied research sets out to solve practical problems in social welfare. This is also in agreement with what is said by De Vos, Schurink & Strydom (1998:8), that the goal of applied studies is to develop situations for problems and applications in practice. This clearly indicates that applied research is aimed at arriving at solutions for the existing problems in practice.

Applied research was found to be relevant because the aim of this study was to explore the psychosocial factors related to termination of pregnancy on the women, so that, guidelines for social work intervention could be formulated. This will benefit the social work service delivery and also prevent future complications in women who opt for termination of pregnancy, because they would be provided with a comprehensive service.



### 1.6.3 RESEARCH DESIGN

A research design is defined by Royse (1991:43) as something like a blueprint which outlines the approach to be used to collect data. On the other hand Bless and Higson-Smith (1995:63) argue that a research design is a planning of any scientific research from the first step to the last step.

The above arguments indicate that a research design is a form of planning that has to be done by the researcher before a research project is undertaken. This implies that this planning is going to guide the research process from the beginning to the end.

As this study is both qualitative and quantitative in nature, the exploratory and descriptive designs were used. The exploratory design was used because there exists little knowledge on the topic, which was studied. According to Grinnell and Williams (1990:105), the idea of an exploratory research study is to explore, and nothing more or nothing less. They further contend that the exploratory design is used when little is known in the research area and the aim is to build foundation of ideas and tentative theories. It is argued on the other hand by Rubin and Babbie (2001:123), that the purpose of exploratory design is to examine a new interest, when the subject of study is relatively new and unstudied. This design was found to be suitable for this study, because of the recent legalisation of termination of pregnancy in South Africa. As a result of this reason, there is little information regarding social work intervention to women who opt for termination of pregnancy.

The descriptive design was used to describe what was observed. The purpose of the descriptive design is to describe situations and events, that is, to observe and then describe what was observed. (Compare Collins, 1990: 254; Babbie, 1992:91 & Rubin and Babbie, 2001:124.) Rubin & Babbie (2001:124), further indicate that because scientific observation is careful and deliberate, scientific descriptions are typically more accurate than causal descriptions. Thus this design enabled the researcher to observe and to describe what was observed in a scientific manner.

The two designs explained above were found to be relevant for this study because after exploring the experience of terminating an unwanted and

unplanned pregnancy, there is a need to describe the psychosocial implications on the women.

#### 1.6.4 RESEARCH PROCEDURE AND STRATEGY

For the first phase of the study, a questionnaire, was used as a method of data collection. It was administered on a one-to-one basis with the respondents at the Kalafong TOP Clinic. The questionnaire was administered before the women could undergo the procedure. Using the purposive sampling method, a sample of eighty (80) women was drawn. The aim with this phase of the study was to establish the psychosocial aspects of terminating an unwanted and unplanned pregnancy from the women, before the procedure, so that these psychosocial aspects could be described.

For the second phase of the study, that is, after the procedure, the researcher aimed at interviewing the women sometime after the procedure, to establish the actual psychosocial implications and to have some case studies, to illustrate these psychosocial implications on the women. It was unfortunate that this did not materialize as the women who had contracted with the researcher for follow-up, did not keep their promise. Efforts were made to make a follow-up with these women, without any positive results. Letters were sent to them, using the addresses found on their hospital records, without any response.

In trying to get respondents for the interviews after the abortion procedure the researcher approached Neobirth, Pretoria- and Rustenburg agencies, but could not succeed. An advertisement was then placed on the university newspaper, with a hope that some respondents will be found, but still, without positive results. As a result of this situation thirty-five files of women who had their pregnancies terminated at the Women's Choice Clinic in Pretoria were reviewed, that is, using document review as a method of data collection. The simple random sampling technique was used to select the files, from the probability sampling method. This technique of data collection was used, as there was no prospect of ever finding the respondents for the interviews after the abortion procedure.

#### 1.6.5 PILOT STUDY

A pilot study is defined by the New Dictionary of Social Work (1995:45) as the "process whereby the research design for a prospective survey is tested."

According to Strydom (1998:179) the pilot study is the “dress rehearsal” of the main investigation. It could thus be said that the pilot study is the process through which the researcher acquaints himself/herself with the envisaged project, before the actual research could be undertaken. This indicates the purpose of the pilot study as an investigation of the feasibility of the planned study and it includes the following four aspects:

#### **1.6.5.1 LITERATURE STUDY**

Literature study is defined by Bless & Higson-Smith (1995:22), as the process of reading whatever has been published that appears relevant to the research topic. The prospective researcher can only hope to undertake meaningful research if he is fully up to date with existing knowledge on his prospective subject (Compare Collins, 1990: 254 & Strydom 1996: 180.) This process enables the researcher to be up to date with the existing knowledge on the prospective subject of study and also to know to what extent has the topic been studied.

In this instance it was established through the literature study that the abortion debate is never-ending. No information was found regarding the psychosocial implications, specifically on the black woman, as well as social work intervention with the women who opt for termination of pregnancy. The literature from other disciplines such as medicine and psychology had to be used instead, and applied to social work. A continuous literature search was done through the Academic Information Service of the university, as well as the internet.

#### **1.6.5.2 CONSULTATION WITH EXPERTS**

Several experts in this field were consulted to determine the extent of the problem and the need for this study. According to Strydom (1998:181), the purpose of consultation with experts is to bring unknown perspectives to the fore or to confirm or reject the researcher’s own views.

Sister S.S. Sikhonde, who was working at the TOP Clinic at GaRankuwa Hospital was consulted, as well as sisters R. Hanyane and M. Mabitsela of Kalafong Hospital TOP Clinic. It was established from these consultations that social workers are not part of the medical teams that render the abortion service.

Proff. C. Myburgh and M. Poggenpoel, qualitative research specialists at Randse Afrikaanse Universiteit, were consulted. From this consultation it was established that there was a need for social work research in the field of abortion, so that a comprehensive service could be rendered for the women who request termination of pregnancy.

Ms. M. Kruger, who did her masters degree on this topic was consulted, as well as Ms. M. Spies, who was working at the TOP Clinic at Pretoria Academic Hospital. From this consultation it was established that this study would benefit the social work profession, as there is a need for the guidelines for social work intervention.

Ms. S. Humpel, a social worker at Potchefstroom Hospital attached to the TOP Clinic, was also consulted. From this consultation the researcher was able to understand the need for pre-abortion counselling.

### **1.6.5.3 FEASIBILITY OF THE STUDY**

The researcher established a working relationship with the staff at the TOP clinic at Kalafong Hospital and this facilitated the research process. Due to the fact that the clinic is on a daily basis it was not difficult to get the respondents for the first phase of the study.

Regarding the second phase of the study there were problems regarding the respondents but other efforts were made. Review of the documents was used as there were no respondents for the interviews after termination of pregnancy.

Permission to conduct the study at the Kalafong TOP clinic was obtained from the hospital superintendent.

### **1.6.5.4 PRE-TESTING OF THE MEASURING INSTRUMENT**

The questionnaire was administered to six women at the TOP clinic prior to the actual study, and they were not included in the sample. This was done to test if the questionnaire that was constructed would be able to yield the expected information. This exercise was fruitful and the necessary changes were made.

## **1.7 DESCRIPTION OF THE RESEARCH POPULATION, DELIMITATION OF SAMPLE AND SAMPLING METHOD**

The research population consisted of all the women who requested termination of pregnancy at Kalafong Hospital (TOP clinic), between June 1999-January 2000. A research population refers to individuals in the universe who possess specific characteristics (Compare Strydom and De Vos, 1998:190.) The population helps the researcher to set boundaries for the study.

A sample of 80 women was drawn from the population using the purposive sampling technique from the non-probability sampling method. Non-probability sampling refers to the case where the probability of including each element of the population in the sample is unknown (Compare Bless & Higson-Smith, 1995:88.) According to Babbie and Mouton (2001:166), the purposive sampling is based on the judgement of the researcher. This method was found to be suitable as it is based on the judgement of the researcher regarding the characteristics of a representative sample.

For the second phase of the study the simple random sampling method was used. According to Strydom and De Vos (1998:195) with this method each individual case in the population theoretically has an equal chance to be selected for the sample. Thirty-five files of the women who have had termination of pregnancy at the Women's Choice Clinic were selected and reviewed. Only five profiles of the women who terminated pregnancy at this clinic are provided in chapter 6, because the information is almost similar, therefore a repetition of information was avoided.

## **1.8 DEFINITIONS OF CONCEPTS**

The following concepts are defined for the better understanding of the text:

### **1.8.1 Abortion and termination of pregnancy**

Abortion and termination of pregnancy are used interchangeably throughout the text, to be in line with the international literature and the South African context (Act 92/1996).

Abortion is defined by the Collins Shorter English Thesaurus (1993:3) as a “deliberate miscarriage”.

According to the Social Work Dictionary (1991:1) abortion is defined as “termination of pregnancy before the fetus has developed enough to survive outside the woman’s body”.

The Dorland’s Illustrated Medical Dictionary (1994:4) define abortion as “the premature expulsion from the uterus of the products of conception-of the embryo or of the non-viable fetus”.

It becomes evident from the above definitions that abortion is a deliberate action whereby the development process of the products of conception is disturbed or stopped.

### **1.8.2 Counselling**

Counselling is defined in the New Dictionary of Social Work (1995:15) as the ‘interviewing procedures aimed at guiding the client towards insight with a view of promoting his social functioning’.

The Social Work Dictionary (1991:52) defines counselling as “a procedure often used by clinical social workers and other professionals from various disciplines in guiding individuals, families, groups and communities by such activities as giving advice, delineating alternatives, helping to articulate goals and providing needed information”.

In the Dictionary of Counselling (1994:63) counselling is defined as “a helping process in which one person, a helper, facilitates exploration, understanding and actions about developmental opportunities and problem conditions presented by a helpee or client”.

From the above definitions, it can be said that counselling is a procedure used by the helping professionals to guide individuals, families, groups and communities towards insight development, with the aim of improving the social functioning of the client.

Social work intervention is defined in the New Dictionary of Social Work (1995:61) as “the process whereby a social worker, within a professional relationship, uses specific methods and techniques, performs functions and tasks and utilises resources to prevent, alleviate social problems to promote the social functioning of a client system”.

The Social Work Dictionary (1991:222) defines social work practice as “the use of social work knowledge and social work skills to implement society’s mandate to provide social services in ways that are consistent with social work values”.

In the Dictionary of Counselling (1994:198) social work practice is defined as “social work services rendered by the social worker which entails individuals, groups and communities with medical, legal, economic and social problems”.

In view of the above-given definitions, it could be said that social work intervention is the process, whereby a social worker uses his/her skills, knowledge and techniques to render a service to individuals, families, groups, and communities, with the aim of improving the social functioning, as well as preventing social dysfunction.

## **1.9 PROBLEMS AND LIMITATIONS OF THE STUDY**

The problems that were encountered with this study are as follows:

- The researcher experienced problems during the literature study on the psychosocial implications of abortion on the women as there is little social work information and most of the sources are not quite recent.
- Old sources were utilised in the literature review because of the scarcity of the recent sources.
- Most of the sources that were utilised are international, because of the fact that the South African sources could not be found.
- The fact that there is limited literature on abortion, from the social work perspective led to a limited literature review for this magnitude of the study.

- There is little information on social work literature regarding social work intervention with women who request termination of pregnancy, as a result most literature that was consulted was from other disciplines, such as medicine and psychology.
- The study was intended to be inclusive with regard to racial representation but this could not be realised, as all the women who did not belong to the black racial group did not want to be part of the study, hence all the respondents were black.
- With regard to the analysis of the quantitative data, it was only possible to have a limited amount of advanced statistical analysis made (mean values and p values), because according to the statistician, Ms. J Pauw, from the Department of Statistics at U.P., who was the statistical consultant for this study, and Ms. E. Mauer, from the department of Research Support, U.P., the data was predominantly descriptive.
- Getting respondents for the qualitative phase of the study was problematic and delayed the progress of the study. All the respondents who contracted with the researcher for the interviews after the procedure decided to provide the incorrect particulars, which made it impossible to have the follow-up as intended. As a result of this situation, document review was used for the qualitative phase of the study, which did not yield the data on the psychosocial implications of abortion on the woman, which was the initial aim of this study. As a result of this situation, the initial topic had to be changed.
- Letters were written and posted to the women, who had indicated that they would need counselling after the procedure, which did not yield any response, and this had an impact on the progress of the study.
- Neobirth as an organisation that deals with post-abortion counselling was approached with the hope of finding respondents for the qualitative phase of the study, but these efforts did not yield the desired results.
- Advertisements were placed in the university newspaper in an effort to find the respondents, as the quantitative data had revealed that the majority of the women who request termination of pregnancy are at



tertiary level of education, with no positive results, and this further delayed the progress of the study.

- As a result of lack of respondents for the follow-up interviews it was impossible to formulate the guidelines for post-abortion social work intervention, but only pre-abortion social work intervention. This affected the initial title that was proposed for this study, as well as the original aim.
- The days that were spent at the Women's Choice Clinic waiting for the respondents, who did not turn up also delayed the progress of the study.
- Reviewing files at the Women's Choice clinic was time consuming and did not yield much information.
- Funding has also played a major role in this study, as enough bursaries could not be secured, which delayed the progress, as the researcher has to wait until the end of each month for her salary before she could execute some of the tasks.

## 1.10 DELINEATION OF THE RESEARCH REPORT

Including this chapter, the thesis consists of the following:

### Chapter 2 : Medical aspects of abortion

The medical aspects of abortion are discussed in detail including: the classification of abortion, the methods of termination of pregnancy during the different periods of gestation, abortion-related risks and complications, management of the complications, prevention of the complications as well as post-abortion family planning.

### Chapter 3 : The psychosocial aspects related to termination of pregnancy.

This chapter deals with the psychosocial aspects related to seeking termination of pregnancy and includes: factors leading to an unwanted pregnancy, emotional reactions to unplanned pregnancy, reactions to abortion, the defence mechanisms used by the women after abortion, the social aspects of abortion, the psychological aspects of abortion, adolescents and abortion, as well as counselling.

#### Chapter 4 : The legal aspects of abortion

This chapter deals with the international and the South African legal aspects of termination of pregnancy. The South African abortion legislation is provided and discussed in more detail as well as how the service is provided.

#### Chapter 5 : The empirical findings from the first phase of the study

This chapter deals with the empirical findings from the first phase of the study, which is predominantly quantitative in nature.

#### Chapter 6 : The empirical findings from the second phase of the study

This chapter deals with the empirical findings from the second phase of the study, which is predominantly quantitative in nature.

#### Chapter 7 : Guidelines for social work intervention

This chapter deals with the guidelines for social work intervention regarding abortion services and it consists of the following: the nature of social work in health care, the role of the social worker in health care, the bio-psycho-social model as well as its utilisation in providing abortion counselling and lastly the guidelines for social work intervention.

#### Chapter 8 : Summary, conclusions and recommendations

This chapter deals with the summary of the whole study, the conclusions drawn from the study and lastly, the recommendations are provided.

The following chapter will deal with the medical aspects of termination of pregnancy.

## 2.2 LIST OF MEDICAL TERMS

The following terms will be defined to make it easier for the reader to understand the chapter.

### Abortion

"the expulsion from the uterus of the products of conception before the foetus is viable." (Duncan's Dictionary for Nurses, 1989:3)

## CHAPTER 2

### MEDICAL ASPECTS OF ABORTION

#### 2.1 INTRODUCTION

Pregnancy, followed by the birth of a child is supposed to be a joyous event, but often this is not the case. This is confirmed by Rodman, Sarvis and Bonar (1987:2) that often the facts do not conform to the ideal situation, where the birth of a child is supposed to be a joyous event. They further indicate that due to a variety of factors that negate what was supposed to be a joyous event, that is, childbirth, a considerable number of women terminate their pregnancies all over the world each year, irrespective of colour, age, race or socio-economic status. This could be attributed to the fact that these pregnancies are unplanned and unwanted. Baird, Grimes and Van Look (1995:1) indicate that between 100 000 and 150 000 unwanted pregnancies, globally, are terminated by induced abortion each day. This clearly indicates that many pregnancies are terminated because they were unplanned and unwanted.

Abortion is an emotive subject, about which widely differing views are held. Despite these different views about abortion, women faced with unwanted pregnancies need to be assisted. The need to have accessible abortion services, with effective methods of termination of pregnancy will always be there.

This chapter deals with the following aspects: definition of medical terms, the classification of abortion, the methods of termination of pregnancy at different periods of gestation, abortion related risks and complications, management of complications, prevention of complications as well as post-abortion family planning.

#### 2.2 LIST OF MEDICAL TERMS

The following terms will be defined to make it easier for the reader to understand the chapter.

- **Abortion**

“the expulsion from the uterus of the products of conception before the foetus is viable.” (Duncan’s Dictionary for Nurses, 1989:3)

- **Amenorrhoea**

"abnormal absence or cessation of the menses" (Duncan's Dictionary for Nurses, 1989:35)

- **Anomalies**

"marked deviation from the normal standard." (Dorland's Illustrated Medical Dictionary, 1981:98)

- **Cannula**

"a hollow tube contained in a trocar that is introduced into a body cavity, after which the trocar is withdrawn and the tube remains in place." (Duncan's Dictionary for Nurses, 1989:123)

- **Catheter**

"a tubular surgical instrument for withdrawing fluids from a cavity of the body." (Dorland's Illustrated Medical Dictionary, 1981:264)

- **Cervix**

"neck: used in anatomical nomenclature to designate the lower front of the part connecting the head and trunk." (Dorland's Illustrated Medical Dictionary, 1981:283)

- **Curettage**

"the removal of growth or other material from the wall of a cavity or other surface with a curet" (Dorland's Illustrated Medical Dictionary, 1981:331)

- **Dilatation**

"a condition of being dilated or stretched beyond the normal dimensions." (Dorland's Illustrated Medical Dictionary, 1981:379)

- **Diuretic**

"an agent that increases the secretion of urine." (Dorland's Illustrated Medical Dictionary, 1981:442)

- **Ectopic**

"out of place." (Stedman's Medical Dictionary, 1990: 501)

- **Embolus**

"a clot or other plug brought by blood from another vessel and forced into a smaller one so as to obstruct circulation." (Dorland's Illustrated Medical Dictionary, 1981:478)

- **Endometrial**

"relating to or composed of endometrium." (Stedman's Medical Dictionary, 1990:529)

- **Gastrointestinal**

"pertaining to or communicating with the stomach and intestines." (Dorland's Illustrated Medical Dictionary, 1981:602)

- **Hypermenorrhea**

"excessively prolonged or profuse menses." (Stedman's Medical Dictionary, 1990:742)

- **Hypertonic**

"having a greater osmotic pressure than a reference solution." (Stedman's Medical Dictionary, 1990:746)

- **Hysterotomy(abdominal)**

"a surgical procedure in which the contents of the uterus are evacuated" (Duncan's Dictionary for Nurses, 1981:348)

- **Hysterectomy**

"the removal of the uterus." (Stedman's Medical Dictionary, 1990:756)

- **Intraamniotic**

"within or into the amniotic fluid" (Duncan's Dictionary for Nurses, 1981:364)

- **Intramuscular**

"within the substance of a muscle." (Dorland's Illustrated Medical Dictionary, 1981:753)

- **Intrauterine**

"being or occurring within the uterus" (Duncan's Dictionary for Nurses, 1981:364)

- **Intravenous**

"within a vein or veins." (Dorland's Illustrated Medical Dictionary, 1981:754)

- **Laminaria**

"the sterile applicator made of kelp which, when placed in the cervical canal, absorbs moisture, swells and gradually dilates the cervix" (Stedman's Medical Dictionary, 1990:838)

- **Laparoscopy**

"endoscopic examination of interior of the abdomen by means of a laparoscope." (Dorland's Illustrated Medical Dictionary, 1981:797)

- **Morbidity**

"the condition of being diseased." (Dorland's Illustrated Medical Dictionary, 1981:943)

- **Mortality**

"the death rate : ratio of total number of deaths to the total number of population." (Dorland's Illustrated Medical Dictionary, 1981: 945)

- **Myometrium**

"the smooth muscle coat of the uterus which forms the main mass of the organ" (Dorland's Illustrated Medical Dictionary, 1981:862)

- **Necrosis**

"death of tissue, usually as individual cells." (Dorland's Illustrated Medical Dictionary, 1981: 985)

- **Osmotic**

"pertaining to or of the nature of osmosis." (Dorland's Illustrated Medical Dictionary, 1981: 1066)

- **Osmotic**  
"pertaining to or of the nature of osmosis." (Dorland's Illustrated Medical Dictionary, 1981: 1066)
- **Polymenorrhea**  
"the occurrence of menstrual cycles of greater than usual frequency"(Stedman's Medical Dictionary, 1990:1235)
- **Prostaglandins**  
"a group of several hormone-like physiologically active substances of similar chemical structure"(Duncan's Dictionary for Nurses, 1981:545)
- **Septic shock**  
"shock produced or due to putrefaction." (Dorland's Illustrated Medical Dictionary, 1981: 1365)
- **Suprapubic**  
"situated or performed above the pubic arch." (Dorland's Illustrated Medical Dictionary, 1981:1472)
- **Uterus**  
"the hollow muscular organ in female animals which is the abode and place of nourishment of the embryo and fetus." (Dorland's Illustrated Medical Dictionary, 1981: 1657)
- **Ultrasound**  
"mechanical radiant energy with a frequency greater than 20 000 cycles per second." Dorland's Illustrated Medical Dictionary, 1981: 1645)

### 2.3 THE INCIDENCE OF ABORTION IN SOUTH AFRICA

The Annual Report of the Department of Health (1997:15-16) indicated that 165 hospitals in South Africa have been designated to perform termination of pregnancy and 24 387 women had already had access to termination of pregnancy services by 30 November 1997. These are the statistics from the state abortion facilities only, which means that after the legalisation of termination of pregnancy in 1996 many women utilised the service. According to the Minister of Health, more than 116 000 legal abortions have been performed in South Africa over the past three years, in provincial state hospitals. (Compare The Pretoria News, 2001:3) This clearly shows that

since the legalisation of termination of pregnancy in South Africa, there is a remarkable number of women who request the service at state hospitals.

## **2.4 CLASSIFICATION OF ABORTION**

According to Plauche', Morrison and O'Sullivan (1992:119) and Pattinson, (1993:191) abortions are divided into two general categories, namely, spontaneous abortions; in which there is expulsion of the products of conception without deliberate interference and induced abortions; in which a deliberate effort to terminate the pregnancy has occurred. These categories will be discussed briefly as follows:

### **2.4.1 Spontaneous abortions**

Plauche' et al. (1992:120) further subdivided spontaneous abortions into the following categories:

#### **2.4.1.1 Threatened abortion**

It is a state in which bleeding of intrauterine origin occurs before the twentieth completed week of gestation, with or without uterine colic, without expulsion of the products of conception and without dilatation of the cervix. (Compare Plauche' et al. 1992:120 and Quilligan & Zuspan 1984:180.) It becomes clear that with threatened abortion the products of conception are not yet expelled from the uterus but there is bleeding only. With the poor prognosis after medical intervention, the therapeutic abortion is done to prevent further complications.

#### **2.4.1.2 Inevitable abortion**

With the inevitable abortion, bleeding of intrauterine origin occurs with continuous and progressive dilation of the cervix (Plauche' et al. 1992:120). On the other hand Quilligan & Zuspan (1984:180) further indicate that this occurs before the twentieth completed week of gestation. The expulsion of the products of conception has not yet happened, but the prospect of saving the pregnancy is not there. Immediate intervention would save the woman's life.



### **2.4.1.3 Incomplete abortion**

According to Plauche' et al. (1992:120) and Quilligan & Zuspan (1984:180) incomplete abortion is an expulsion of some but not all the products of conception. Like the term itself says, the abortion is incomplete, but because it has already started, there is a need to complete the process. This would minimise the complications and ensure the woman's health.

### **2.4.1.4 Complete abortion**

Complete abortion is said to be the expulsion of all the products of conception before the 20<sup>th</sup> completed week of gestation (Compare Plauche' et al.1992: 120 and Quilligan & Zuspan, 1984:180.) In this situation it becomes important to make sure that all the products of conception are expelled, through tissue examination. This could prevent a situation where the necrosis, that is, the dying of tissues, of the remaining products could occur in the woman's uterus, with adverse consequences.

### **2.4.1.5 Missed abortion**

In missed abortion the embryo dies in utero but is retained for 8 weeks or more (Plauche' et al.1992:120). This could have devastating consequences on the woman, who was looking forward to having a child. The woman in this situation would need intense counselling by the social worker, to help her to come to terms with what has happened and also move forward with her life. In cases where the husband or partner is available, he could be drawn into the counselling process, for him not to be left behind with regard to the woman's emotional experience.

### **2.4.1.6 Habitual abortion**

This refers to the occurrence of three or more consecutive spontaneous abortions (Compare Quilligan & Zuspan,1984:180, Plauche' et al.1992:120 & Kruger 1999: 17.) This could have a serious emotional and psychological impact on the woman, because of the repeated nature of this abortion, and counselling is essential, for both the woman and her husband or partner. The impact could be more serious in cases where the pregnancy is planned and the couple were looking forward to having a child. The involvement of the social worker is of great importance in assessing the couple's emotional state and providing the appropriate counselling services.

#### **2.4.1.7 Septic abortion**

According to Plauche' et al. (1992:120) and Pattinson (1993:200) septic abortion refers to an infected abortion in which there is dissemination of micro-organisms and their products into the maternal circulatory system. This could be very dangerous to the woman's life, if intervention is delayed. As a result, there is a need for proper screening of the woman's situation, for proper intervention.

#### **2.4.2 Induced abortion**

Plauche' et al. (1992:120) indicate the categories of induced abortion as follows:

##### **2.4.2.1 Therapeutic abortion**

Therapeutic abortion is the interruption of pregnancy before the twentieth completed week of gestation, for medically approved indications (Compare Quilligan & Zuspan, 1984:180, Plauche' et al.1992:120 and Kruger, 1999: 17.) Therapeutic abortions could be acceptable in a woman with abnormal foetus, but for those who are ready to have children, it could have devastating consequences. In order for them to accept the reality of losing the desired child, there will be a need for counselling. This category of abortion is not specified in the provisions of the new abortion legislation, that is, "The Choice on termination of Pregnancy Act No.92/1996".

##### **2.4.2.2 Non-therapeutic abortion**

This is the interruption of pregnancy without any medical indications. This category is covered in the provisions of section 2(b) of the South African abortion legislation, Choice on Termination of Pregnancy Act (92/1996). The provision of this section and its subsections indicate that from the thirteenth up to the twentieth week of gestation, abortion could be performed if the medical practitioner, after consultation with the pregnant woman, is of the opinion that the continued pregnancy would pose a risk of injury to the woman's physical or mental health; there exist a substantial risk that the foetus would suffer from severe physical or mental abnormality; the pregnancy resulted from rape or incest or the continued pregnancy would significantly affect the social or economic circumstances of the woman. This clearly indicates that any woman presenting one of the above reasons at the abortion clinic will be provided with the service.

The other category of non-therapeutic abortion, as provided by the Choice on Termination of Pregnancy Act (92/1996) section 2(1)(a) refers to abortion that is requested by a woman because of her personal or economic reasons during the first 12 weeks of gestation. This is the category of abortion that this study is based on and it is sometimes referred to as abortion on request or by choice. This provision will be discussed in-depth in chapter 4 of this thesis.

### **2.4.2.3 Criminal or illegal abortion**

Plauche' et al. (1992:120) criminal or illegal abortion refers to the interruption of pregnancy under circumstances not legally acceptable in the country in which the abortion is performed. (Compare Plauche' et al. 1992:120 & Pattinson,1993:198.) Criminal abortion is performed under unsafe circumstances, which could lead to serious complications for the woman. This reason lead to many countries legalising abortion and providing abortion services which are safe for the women.

Methods of termination of pregnancy at different periods of pregnancy and the complications resulting from this procedure, the treatment as well as the prevention of abortion will now be discussed.

## **2.5METHODS OF TERMINATION OF PREGNANCY AT DIFFERENT PERIODS OF GESTATION.**

It is important to look at the methods of termination of pregnancy at the different periods of gestation, because these methods differ according to the period of gestation when the request for termination of pregnancy is made.

### **2.5.1 TERMINATION OF PREGNANCY DURING THE FIRST TRIMESTER.**

It is agreed by WHO (1995:48) and Rodman, et al. (1987:49) that the first trimester refers to the first twelve weeks of gestation. This refers to the first twelve weeks after the first day of the menstrual period. The methods of uterine evacuation during this period of pregnancy can either be medical or surgical. Baird, et al(1995:35) the development of prostaglandins and antiprogestogens has created new possibilities for improved technology in the early termination of pregnancy, as compared to the surgical procedure of vacuum aspiration, which has been the method of choice for many years. This is in agreement with what Rodman, et al. (1987:53) indicate that prostaglandins can be successfully used to contract the cervix, leading to the

extraction of the contents of the uterus. These drugs are said to be accompanied by bleeding, uterine pain and gastrointestinal side effects. The advantages however, when compared to the surgical abortion are regarded minimal (Baird, et al.1995: 50-51). This indicates that the use of the said drugs to terminate early pregnancy, with the minimal risks and complications, can successfully be used instead of surgical methods.

On the other hand WHO (1995:49) indicates the methods of uterine evacuation as follows:

### **2.5.1.1 Vacuum aspiration**

Vacuum aspiration is a minor gynaecological procedure, involving minimum trauma. The cannulae used for this procedure are made of flexible plastic, rigid plastic or metal. The vacuum sources for aspiration are manual syringes, electric pumps and foot-operated mechanical pumps. The use of this method seems to be minimising the complications since it is a minor procedure.

### **2.5.1.2 Dilatation and curettage**

This is an endometrial curettage in which soft plastic instruments are inserted into the uterine cavity and hand aspirators are used as suction sources (Zatuchni, Sciarra & Speidel, 1997:112). According to Rodman, et al. (1987:55), this method is preferred to terminate pregnancies between 6 and 12 weeks. With this method the cervix is dilated first and then the lining of the uterus is scraped by the curettage. Rodman, et al. (1987:56) indicate that this method is relatively safe and takes a short period of time to perform.

On the other hand WHO (1995:49) indicates that the use of this method is declining in favour of vacuum aspiration, which is found to be more safer and less traumatic.

It could be concluded that with the development of new technologies, vacuum aspiration is mostly preferred as a method of termination of pregnancy during the first trimester because it is safe and less traumatic, as compared to the use of dilatation and curettage. It is important for the social workers working with these patients to have this knowledge, so that they could provide them with the necessary information. This would help patients to have some expectations and be ready for the procedure.

## **2.5.2 TERMINATION OF PREGNANCY DURING THE SECOND TRIMESTER**

Induction of abortion after 12 weeks of gestation requires fully equipped surgical facilities and a higher level of operative skill, owing to the greater potential for surgical trauma and excessive blood loss (Compare Pattinson, 1993: 199; Baird, et al. 1995:70 and WHO, 1995:52.) This is clearly indicated by one of the provision in the South African abortion legislation, Choice on Termination of Pregnancy Act (92/1996), that termination of pregnancy after 12 weeks of gestation, must be performed by medical practitioners.

This indicates that termination of pregnancy after the viability of the foetus has been reached, is accompanied by complications. This is the reason why it has to be done by highly skilled workers in a well-equipped environment. This requires that abortion services be readily available to all women with unplanned and unwanted pregnancies. This service is also to be in such a way that it is user-friendly, for the women who need it not to hesitate to seek help during the first trimester of the pregnancy. This will eliminate the situation where the women approach the abortion facilities when they are already in the second trimester of their pregnancies. In this way, the complications that accompany the second trimester termination of pregnancy, will be something of the past.

According to Baird, et al. (1995:70), the available methods of termination of pregnancy during this gestation are:

- Medical methods
- Surgical methods
- Combined methods

These methods will subsequently be discussed as follows:

### **2.5.2.1 MEDICAL METHODS**

#### **◆ INVASIVE INTRAUTERINE ADMINISTRATION OF DRUGS**

Invasive intrauterine administration of drugs is accompanied by particular problems and risks, such as faulty injection; the introduction of infection;

massive saline infusion; water intoxication; rupture of membranes and haemorrhage. (Compare Rodman et al. 1987:57 & Baird, et al.1995:75.) Although this is the case, these methods are still used, but with special precautions taken. This indicates the need for the skilled practitioners to minimise the occurrence of complications. This is confirmed by the Choice on Termination of Pregnancy Act (Act 92/1996), that abortion after 12 weeks of gestation, must be performed by medical practitioners.

The invasive methods of termination of pregnancy during the second trimester are discussed below.

#### - **Intra-amniotic administration**

- **Hypertonic saline** as an intra-amniotic method refers to the instillation of hypertonic saline, that is 20% NaCl, into the amniotic sac. According to Baird, et al. (1995:76) this method was first discovered in 1934 and was accompanied by a high rate of maternal deaths. Proper insertion and positioning of the intra-amniotic needle and initial slow instillation of saline over 10 minutes are to be insured, for better results. The needle is inserted in the suprapubic area after an ultrasound scan has been done for accuracy. When used alone, this method takes a relatively long time before the onset of uterine contractions. It is argued by Berger, Brenner and Keith (1981:85), that the success of this method also depends on the active participation of the uterine musculature in the process of self evacuation. On the other hand WHO (1995:52-53) argues that this method should be used with other methods to soften the cervix, such as multiple laminaria tents or prostaglandins suppositories, to ensure better results.

It would seem that these methods should be used with extra care and also used with other methods that soften the cervix, to ensure the success rate and the reduction in the time of the procedure.

- **Prostaglandins** are administered by an intra-amniotic approach to the stimulate myometrium. According to Baird, et al. (1995:77) this method proved to be highly successful and associated with few side effects. This is in agreement with Berger, et al. (1981:104) that this method is more effective than hypertonic saline. It can be deduced that the use of prostaglandins by intra-amniotic administration can produce desired results, that, is induced abortion, in the second trimester of gestation.

- **Hyperosmolar urea** instillation of 80g urea in 5% dextrose is administered by intra-amniotic approach as a method for the induction of abortion during the second trimester. Urea penetrates the cell membranes and acts as an osmotic diuretic, which is relatively harmless. When used alone, urea has a low efficacy and a long induction-abortion interval (Compare Baird, et al.1995:78.) This method should be used together with other methods that soften the cervix, to ensure the desired results and minimise cervical injuries. This clearly indicates that although this method is relatively safe it cannot be used alone, when better results are expected.

#### - **Extra-amniotic administration**

- **Hypertonic Saline**

This solution is administered by a Nelaton or Foley catheter transcervically. According to Baird, et al. (1995:78) this method is not popular as compared to the intra-amniotic administration of the solution. It would seem that this method is not commonly used as it takes a long period to achieve the desired results.

**Rivanol** is a weak base belonging to the acridine dye group with weak antiseptic properties. It is administered by a Nelaton or Foley catheter, passed through the cervix and used together with an intravenous oxytocin drip, to achieve success in 72 hours. This method is accompanied by cervical injuries when used alone. To minimise the injuries to the cervix, it is important to use this method with cervix dilators.

- **Prostaglandins** are administered transcervically by a catheter, with the success rate of 80-90% within 20-24 hours (Baird, et al.1995:80). This is a slow and painful procedure although it is safe and effective.

According to Baird, et al. (1995:81), compared to the intra-amniotic administration, the extra-amniotic route is slightly less effective. This indicates that the popular use of intra-amniotic administration is due to its success rate, as compared to the extra-amniotic administration.

## ◆ NON-INVASIVE ADMINISTRATION OF DRUGS

### - Oral administration

Oral intake of drugs such as progesterone antagonist and mifepristone has been found to result in complete abortion, although the success rate is low. To increase the success rate, prostaglandins are used (Compare Baird, et al.1995:82.) It would seem as if the use of oral administration of drugs to terminate pregnancy has a low success rate if the pregnancy is advanced.

### - Intravenous administration

It is indicated by Baird, et al.(1995:82) that only two drugs are used via this route, namely, oxytocin and prostaglandins. Prostaglandin compound used for this purpose is administered in normal saline, with minimal side effects. In the researcher's opinion not every drug can be administered via this route, due to the side effects, which could occur.

### - Intra-muscular administration

Medical opinion with regard to this method favours a fixed dose of 0.25mg of carboprost, administered every 3 hours. According to Baird, et al.(1995:83), this is accompanied by high incidence of gastrointestinal side effects, therefore suggest that it be used as a supplement of other methods. Sulprostone is also found suitable for intramuscular administration, with less gastrointestinal side effects. It could be concluded that due to the gastrointestinal side effects of the prostaglandins administered intramuscular, they have to be used as supplements to other methods of termination of pregnancy, with low dosage.

### - Vaginal administration of prostaglandins

This is seen as the simple non-invasive and useful method of prostaglandins used in termination of pregnancy in the second trimester of gestation (Compare Baird, et al.1995:83.) This method is also accompanied by side effects such as pain. To minimise the side effects, this method is not used alone as a means of terminating pregnancy during the second trimester of gestation. The researcher is of the opinion that for this method to bring the desired results, it has to be used together with other methods during the second trimester.



It would seem that the non-invasive methods of termination of pregnancy need to be used with great care, as the administration of the different drugs could cause a variety of side effects.

### **2.5.2.2 SURGICAL METHODS**

#### **- Vaginal approach**

Cervical dilatation and surgical evacuation of the uterine contents by suction method (D&E) has shown to be safer than other methods, and instrumental for abortion in the second trimester. Dilatation and evacuation uses the dilated cervix as an advantage for the success of the procedure (Compare Berger, et al.1981: 120; WHO, 1995:52; & Baird, et al. 1995:85.) This procedure requires experienced surgeons, special instruments and preoperative cervical dilatation, to minimise complications. Sufficient cervical dilatation is important to minimise trauma to the cervix, when instruments are inserted. It could be concluded that the use of this technique requires a high level of skill to produce the desired results, with minimal vaginal injuries.

#### **- Abdominal approach/abdominal hysterotomy**

It is indicated by Baird, et al. (1995:85), that this is a very complicated and major operation, which is reserved for selected cases only. They further indicate that the incidence of morbidity and mortality with this method is higher than other methods. It could be concluded from the above discussion that due to the complexity of this method, it cannot be used in a routine manner, but only for the selected cases, where a specialised skill is used.

The surgical method of termination of pregnancy during the second trimester that showed to be successful is the vaginal approach. Due to the fact that it is accompanied by less complications, it is the most used, but its success depends on the skill of the medical practitioner, who will make sure that the cervix is fully dilated, before evacuating the contents of the uterus. The abdominal approach seems to be unsafe, therefore, it is used for special cases only.

### **2.5.2.3 COMBINED METHODS**

A combination of methods can be frequently used to improve the outcome of the procedure. According to Baird, et al. (1995:86) any of the pre-induction cervical ripening and dilating agents or devices can be used with any of the

uterine stimulating procedures or dilatation and evacuation. The agent can be given via the same or different route of administration. The time of therapy may be sequential with an interval of up to three days between the methods.

Termination of pregnancy during the second trimester requires a high level of skill to minimise the complications. The methods and techniques need to be used in combination for the desired results to be achieved with less complications. There is a need to have social workers as part of the medical team involved with termination of pregnancy, for them to educate the patients about all the methods used, why and when they are used. This will equip the patients with the necessary information that will enable them to handle the situation better and also give informed consent. This would alleviate the current situation, where patients just undergo the procedure without any information, leaving them unprepared, which could lead to future emotional problems.

## **2.6 ABORTION-RELATED RISKS AND COMPLICATIONS**

When dealing with abortion issues it is always important to consider that the procedure is not free from risks and complications, irrespective of whether it is done legally or illegally. The techniques available, the medical conditions under which abortions are obtained and the skill of those performing the procedure, are some of the factors that affect the outcome. This is confirmed by WHO (1995:11) that approximately 500 000 women die every year from pregnancy-related causes and a large proportion of these deaths are attributable to complications of abortion. Deaths are considered to be abortion-related when they occur within 42 days of an induced abortion procedure (Compare Rodman, et al. 1987:64 & WHO, 1995:11.)

It can be deduced from the above discussion that induced-abortion procedure is accompanied by risks and complications. The extent of risks and complications depend on a variety of factors, for example, the availability of equipment and skilled service providers. The risks and complications of abortion seem to be affecting most black rural women who usually seek abortion during the second trimester. They are provided with drugs and advised to come back to the hospital when they start bleeding. With this lack of observation by the medical staff most women come too late for medical attention, which could be fatal. For some women, because this is kept secret, they are unable to get the necessary support from their family members, with adverse consequences on their health status.

## 2.6.1 ABORTION-RELATED MORTALITY

It is estimated by WHO (1995:11) that 98% of maternal deaths occur in developing countries mainly because of the women's socio-economic conditions and the limited availability of maternal health services. The criminalisation of abortion in a country can also increase the rate of maternal deaths because most unwanted and unplanned pregnancies will be ended illegally, under unsafe conditions. It is further argued that women in developing countries have a much greater risk of abortion-related death than do women in the well developed countries (Compare Rodman, et al. 1987:65; WHO, 1995:12 & Baird, et al. 1995:97.) This clearly indicates that maternal death following induced abortion is rife in underdeveloped countries, because of lack of needed resources. This leads to women opting for unsafe abortions when faced with unwanted and unplanned pregnancies. The problem is compounded by abortion being illegal in some other countries.

It is further argued by Rodman, et al. (1987:65) that legal abortion performed during the first trimester is safe, as compared to abortions performed later, that is after twelve weeks of gestation. The delays in performing abortion can be due to a variety of factors such as, approval from a Hospital Abortion Committee or parental consent for minors, as abortion laws stipulate in other countries. This increases the risk of abortion-related mortality. In the researcher's opinion, because the abortion legislation in South Africa, that is, Choice on Termination of Pregnancy Act (92/1996), does not require that a woman should wait for approval from the hospital abortion committee, and also parental consent is not required, the delay could be caused by the woman being undecided whether to seek an abortion or not. The delay could also be emanating from the woman's inability to determine the gestation period. This emanates from the situation in South Africa, where a considerable number of black women are not educated and some having to travel long distances before reaching the health facility, with serious financial implications.

This clearly indicates the importance of having women educated on the available abortion services, as well as the advantages of seeking abortion during the first trimester of gestation. It is also important to educate women on their fertility, to avoid situations where they could be ignorant about being pregnant, which could lead to seeking abortion very late. This will minimise the abortion-related mortality rate. It is also important for The

Department of Health to ensure that abortion services are available and accessible, by providing the necessary resources, namely, the multi-professional team at all the designated abortion facilities.

## **2.6.2 ABORTION-RELATED MORBIDITY**

Abortion-related morbidity refers to the non-fatal complications of abortion, which may be difficult to define, due to a variety of factors, such as monthly bleeding accompanied by cramps and fluctuating body temperature in many women (Compare Rodman, et al. 1987:66.) This makes it difficult to determine which complication could be attributed to abortion. These non-fatal complications may be categorised as early, delayed or long-term and late complications (Compare Rodman, et al. (1987:67 & Baird, et al. 1995:98.) These categories of complications will be discussed respectively, as follows:

### **2.6.2.1 EARLY OR IMMEDIATE COMPLICATIONS**

According to Rodman, et al. (1987:67) early complications may be due to the woman's pre-existing medical state or to the skill of the operator or they may be related to the gestation period of the pregnancy. The researcher is of the opinion that abortion can aggravate the woman's pre-existing medical problems, as a result, these medical problems must be taken into consideration prior to the abortion procedure. As it has already been indicated earlier, women are to be encouraged to seek abortion during the early stages of the pregnancy, to minimise these early complications. The following early complications will be discussed:

#### **- Uterine perforation**

Uterine perforation is mostly associated with abortions after 12 weeks of gestation. The extent of this problem is determined by the method used to induce abortion. Dilatation and evacuation during the second trimester abortion is reported to be resulting in more serious uterine perforation (Compare Rodman, et al. 1987:68 & Baird, et al. 1995:99.) It becomes very important for the physician performing abortion during the second trimester, to be experienced and also careful. With particular reference to the use of D&E (dilatation and evacuation), the physician must make it a point that the cervix has dilated enough, to minimise the risk of uterine perforation.

## - Haemorrhage

Prolonged or excessive bleeding is the most common complication seen in abortion care services. This problem is attributed to the retained products of conception as well as trauma or damage from chemical agents and complications of blood coagulation (Compare WHO, 1995:43.) It becomes therefore very important to determine the cause of bleeding before intervention measures could be implemented. If retained products of conception are the reason for bleeding, then the uterus should be evacuated and if it is caused by damage or trauma then the lesion should be sutured. To avoid fatality of bleeding, action to stop it should be taken timeously. This could not be achieved with women who are staying far away from the health care centres, and bleeding could lead to death or prolonged hospitalisation.

## - Unrecognised ectopic pregnancy/failed evacuation

After every abortion the evacuated tissue must be carefully inspected for the presence of foetal tissue or the placental elements before the woman could be released from the abortion facility. Failure to identify an ongoing pregnancy or ectopic pregnancy is potentially lethal (Compare WHO, 1995:47 & Baird, et al. 1995:100.) This clearly indicates the importance of having all the tissue evacuated during an abortion procedure carefully examined. If an ectopic pregnancy cannot be recognised it could rupture and lead to the woman's death. It has been indicated by Bam (2000) and Diseko (2000), during the discussion session on the topic, that this complication is very rare, because abdominal sonar is always used to verify the woman's pregnancy before the procedure could be performed.

This complication can be successfully prevented in women who seek abortion during the first trimester because the whole procedure is done at the hospital. Unlike those who come during the second trimester, where the procedure is started at the hospital and the woman is discharged, to come back when she is bleeding. The uterus could expel the contents whilst she is still at home or on her way to the hospital. If this could happen at home it would be difficult to determine if all the contents of conception has been expelled from the uterus, with devastating results on the woman's health.

possible. As it has already been indicated earlier on, the period of gestation at which abortion is performed, has an effect on the outcomes, including the complications. The researcher is of the opinion that if women could seek abortion before the first 12 weeks of gestation, most complications could be avoided. It is still difficult to determine the immediate complications on women receiving the abortion service at Kalafong Hospital, because there are no follow-up appointments, which according to the researcher need to be included as part of the abortion care services.

### 2.6.2.2 DELAYED COMPLICATIONS

#### - Infection

Infection is seen as one of the most common complications of abortion, particularly when the abortion is incomplete. According to WHO (1995:44-45), the woman who has infection will present with the following:

- Fever
- Foul-smelling vaginal or cervical discharge
- Pain in the abdomen or pelvis
- Prolonged bleeding or spotting
- Tenderness of the uterus or pain with cervical motion.

This implies that women presenting with the above-mentioned symptoms after undergoing abortion, should be screened for infection and be treated immediately.

According to Baird, et al. (1995:101), prophylactic antibiotic at the time of abortion for women without pre-operative screening can prevent this complication. If infection is not treated in time, it could lead to septicaemia or more seriously septic shock, which is life-threatening. It becomes very important to have pre-operative screening for all the women seeking abortion. However, if this cannot be done then prophylactic antibiotics should be given during the abortion procedure. According to Baird, et al. (1995:102) & WHO (1995:45), this has proved to be cost-effective and beneficial to the patients. Patients must always be warned of the signs of infection after the abortion procedure, for them to react immediately at the onset of such signs. This was also confirmed by Bam (2000) and Diseko (2000), and they further said that if women are warned about these signs they are able to seek medical attention before it could be late. They confirmed this based on their experience at the abortion clinics, respectively.

This prevents further complications which could arise from the situation of not treating infection.

### 2.6.2.3 LATE COMPLICATIONS

As it has already been indicated earlier on, induced abortion can have long-term complications on the woman, depending on a number of factors, such as, the period of gestation at the time of abortion; the method of abortion used; as well as the competency of the service provider. Baird, et al. (1995:102) are in agreement with Hodgson (1988:379), that most of the reproductive sequelae have been ascribed to the induced abortion procedure, with no real evidence of a causal relationship. This indicates that the induced abortion cannot exclusively be responsible for some of the complications which the women present with, later in life. According to Baird, et al. (1995:102) women who never had an induced abortion does present with these complications sometimes in life.

The following late complications will be discussed, as they have been found mostly in women who had induced abortions:

#### - **Menstrual disorders**

It is argued by Hodgson (1981:381) that a number of long-lasting menstrual disorders, such as amenorrhea and hyper-polymenorrhea, occur after induced abortion. These disorders are attributed to the traumatic damage of the endometrium. In the researcher's opinion this complication occur mostly in the young women, who seek abortion at an early age, whilst their reproductive organs are still in the developmental process. It could also be added that the method used, together with the expertise of the service provider, play a considerable role in the occurrence of this complication.

#### - **Secondary infertility**

Secondary infertility may occur due to the damage to the uterus and tubes. This is confirmed by the study analysed by Hodgson (1981:382), where induced abortion was found to be the cause of secondary infertility, which is primarily tubal and uterine. This is in contrast to what is said by Baird, et al. (1995:102) that secondary infertility is not increased by induced abortion. It would seem that more research is still needed in this field, to confirm

whether secondary infertility is caused by induced abortion or not, because the literature review could not provide a definite answer.

#### - **Subsequent spontaneous abortions**

An increased incidence of mid-trimester spontaneous abortions has been observed, following induced abortion, caused by dilatation of the cervical tube (Compare Hodgson, 1981:383 & Hern, 1984:283.) Baird, et al. (1995:102-103), further indicate that the method of abortion appears to be playing an important role in this regard. It could be deduced that induced abortion increases the risk of having spontaneous abortions later in life. This could have negative effects on the woman later in life, especially at the time she would be ready to have children.

#### - **Subsequent premature births**

Cervical incompetence caused by induced abortion can lead to subsequent premature births. This was indicated by Dr. Seobi (2001), in one of Radio Pulpit's programme on 20-06-2001, namely, Mahlasedi, that the likelihood that the woman may develop cervical incompetence due to the abortion procedure is great. According to Hodgson (1981:387) induced abortion cannot be the sole reason for the incidence of prematurity, as the latter has multi-causal aetiology, that is, medical, social and economic factors. It could be deduced from the above argument that induced abortion cannot be the sole cause of premature birth. Before it could be concluded that a premature birth resulted from the consequences of induced abortion, there has to be evidence that all the factors mentioned earlier, were not present in the woman. The researcher is of the opinion that women could ultimately develop cervical incompetence after undergoing surgical induced abortion, due to the injuries that could be sustained during the procedure. This situation calls for the service providers to be skilled, so that they can avoid permanent complications for the woman, as this could have serious emotional problems for the woman, by the time she feels ready to have a child.

When looking at the late complications of induced abortion discussed above, it becomes evident that they are not solely caused by induced abortion, because the women who have never had abortion, present with these complications. Although induced abortion could in other cases cause these complications, there are other factors, which are also responsible. It is also



important to note that safe abortions, performed by experts under sterile environment, with appropriate methods, will ensure that these complications are averted.

The researcher is of the opinion that the abortion services in South Africa, after the legalisation of abortion, still need to be improved. It is true that the legalisation of abortion can decrease the incidences of unsafe abortions but this could only be achieved by providing a comprehensive service to the women seeking abortion. At present women who approach the state clinics/hospitals seeking abortion, are not provided with a service immediately, as they have to be screened first. They are given later appointments and for those whose gestation period is above 12 weeks are not helped at Kalafong Hospital but are referred to GaRankuwa Hospital. At GaRankuwa Hospital women are given drugs that will induce abortion at home, and are advised to seek medical attention thereafter. For these women, the procedure is not safe because most are staying far from the hospital, as a result they are unable to reach medical help timeously. Due to the provisions of the Choice on termination of Pregnancy Act (92/1996), where the minor does not need any consent from the parents, many young women seeking second trimester abortion under the above discussed circumstances, could end up losing their lives. They will have no support from the parents and other family members, as they would not be in a position to explain the problem and its cause, for them to receive appropriate help. This could also lead to serious complications, that is, if the young woman could survive.

The other concern is the financial implications for these women, who have to travel long distances to reach the clinic/hospital. The researcher believes that if the services could be more accessible to all the population, specifically for rural women, some of the complications could be avoided.

#### - **Psychological sequelae**

Although abortion is a choice that a woman makes, it is not free from emotional stress. According to Baird, et al. (1995:104), the likelihood of adverse emotional outcomes increases with advancing gestation age and the second trimester abortions are more emotionally stressful. To women who abort desired pregnancies because of foetal indications, such as congenital anomalies, there are long-term emotional effects. The women who seek abortion because of a variety of personal factors, experience it as a relief. It

is argued that adolescents are the ones who experience abortion as a relief (Baird, et al. 1995:104). This could be attributed to the fact that adolescents feel that they still have a lot of things to do, before they could assume the responsibility of child-rearing.

In the opinion of Baird, et al. (1995:104), symptoms of emotional distress observed in women after abortion are a continuation of symptoms present before the abortion. These symptoms are seen to be more a result of the circumstances leading to the abortion, than the result of the procedure itself. It would seem that how the woman will experience abortion depends on a variety of factors. This aspect of abortion will be dealt with in-depth in chapter 3 of this thesis.

#### **2.6.2.4 RISK FACTORS FOR THE ABORTION COMPLICATIONS**

When considering the complications of abortion it becomes very important to also consider a variety of factors that are contributing to these complications. The researcher agrees with what is said by Baird, et al. (1995:106), that several personal and technical factors strongly influence the likelihood of complications from abortion. As it has been indicated earlier on, the age of the woman who seeks abortion, plus the advanced gestation period, increase the risk of serious complications. Some of the factors cannot be controlled by the service providers.

In cases where the service providers can have control of the factors to reduce complications, they really have to take that step. In the opinion of Baird, et al. (1995:106), labour-induction methods have higher complication rates. Therefore the choice of the method of abortion should be done with serious consideration of the risks or complications. The skill of the service provider plays an important role in this regard, as well as the availability of services and facilities. With the advances in technology every effort need to be made to overcome complications from the abortion procedure.

### **2.7 MANAGEMENT OF COMPLICATIONS**

Women who have undergone abortion need to be followed up, to establish any complications that may occur, either immediately or later. If in South Africa, the abortion services could include follow-up, many complications could be treated immediately, with positive results. The skills and attitudes of the service providers also play an important role in the treatment or

management of women who present with complications of abortion. This position is held by WHO (1995:40), that whenever a health care worker at any level of the health care system is consulted by a woman of reproductive age, with the symptoms such as unexpected bleeding, fever or lower abdominal pain; pregnancy-related complications should be suspected, regardless of the woman's menstrual or contraceptive history. Thorough assessment by the service providers is crucial in this instance, because misdiagnosis could lead to inappropriate treatment, which could lead to negative results.

According to WHO (1995:41), the major life-threatening complications resulting from unsafe abortion are haemorrhage, infection, injury to the genital tract and internal organs, as well as retained products of conception. The management of these complications will be discussed briefly as follows:

#### - **Management of haemorrhage**

In an abortion case excessive bleeding can occur because of retained products of conception, trauma from chemical agents or complications of blood coagulation. If retained products of conception are the reason for bleeding, then the uterus should be re-evacuated. In case where the reason is cervical trauma, the lesion should be sutured (Compare WHO, 1995:43.) This clearly indicates that bleeding occurring after the abortion procedure needs to be given a special attention. As excessive bleeding could be fatal, the woman needs to be properly assessed and intravenous fluid replacement coupled with blood transfusion has to be done. It is argued by WHO (1995:44) that selective use of transfusions of blood and blood products is important to reduce the risk of transmitting infectious agents such as hepatitis or HIV. This precaution needs to be taken at all costs and the researcher believes that with the fast spreading infection of HIV, the health department, specifically the blood transfusion services in South Africa, is giving this issue the attention it deserves. This is evident in the way people who donate blood are subjected to intense screening.

#### - **Management of infection**

The treatment of infection in abortion patients is largely determined by the severity thereof. According to WHO (1995:45) these patients can be successfully treated by antibiotic therapy along with evacuation of the uterine contents. Hospitalisation will be required if septicaemia is

diagnosed, followed by specific laboratory assessment. This should be done quickly but with special care, to prevent the occurrence of septic shock, which is life-threatening. This indicates the importance of specialised skills on the part of the service providers, so that they could identify the intensity of infection on assessing the patient. This will be more beneficial for the patient because appropriate treatment will be administered immediately to avoid further complications.

The researcher agrees with WHO (1995:45) that prophylactic use of antibiotics in abortion care should be strongly recommended, when dealing with patients considered to be at high risk, that is, those with a history of pelvic inflammatory diseases and those with multiple sexual partners. This would reduce the occurrence of infections later, after the abortion procedure, and also make the abortion services in the country more desirable.

#### **- Management of injury to the genital tract and internal organs**

Injury to the genital tract and internal organs is a life-threatening complication as well as a cause of serious long-term morbidity among abortion patients (Compare WHO, 1995:45.) In cases where injury is suspected, laparoscopy should be done, to determine the extent and the location of the injury. This will enable the service provider to administer an appropriate intervention procedure. In the researcher's opinion the skills of the service providers in this regard is an important aspect. Without these specialised skills, the patient could end up been mismanaged, which could lead to further complications or even death.

#### **- Management of toxic and chemical reactions**

Toxic and chemical reactions can result from drugs used to induce abortion, with symptoms varying, depending on the particular substance used, as well as the method of application. It is suggested by WHO (1995:46) that women diagnosed with other abortion complications, mentioned earlier, should also be assessed for toxic chemical and drug reaction, because in most cases a combination of methods of abortion are used. The patient should be thoroughly assessed and treated appropriately to prevent further complications. It therefore becomes very important to have patients treated symptomatically, that is, attention will be on the symptoms presented by the patient, followed by thorough assessment.

## - Management of failed evacuation

Even if the induced abortion procedure is done in an appropriate setting, it does happen at times that some of the products of conception could be left in the uterus. This calls for the specialised expertise on service providers, coupled with special care when dealing with these women. As a result of this situation it becomes extremely important to inspect the evacuated tissue

to make sure that all the products have been evacuated. This clearly indicates the importance of having women who have undergone evacuation to be followed-up in a short-term interval, so that any complication could be detected sooner. This would minimise the adverse results on the women's health, following the abortion procedure.

The management of complications depends largely on the expertise of the service providers, as well as the time taken by the patient to reach the health facility. This makes it very important for the abortion services to be more accessible to the whole population and not only for those who stay in urban areas. If the services are not decentralised to reach the whole population, the country will still have a high mortality rate related to abortion, as well as a high rate of unsafe abortions. The other important factor in this regard is the follow-up system for the patients after the abortion procedure. The researcher has observed that there are no follow-up services for patients who seek abortion at state hospitals/clinics, which means that it is not known how many of these women present with complications later. This may result in mismanagement when these women go back to the health facilities with some complications, as it won't be known whether these complications are abortion-related or not. A well co-ordinated and comprehensive abortion service is a need for all the women who utilise this service in South Africa, specifically at the state health facilities.

## 2.8 PREVENTION OF COMPLICATIONS

The prevention of unsafe abortions, coupled with a variety of complications, need to be the priority of every government. It is important to note that the problem of treating the complications of abortion has an impact not only on the women, their families and the medical community, but also affects every sector of society. WHO (1195:115) indicates that in addressing this problem, it becomes important to have the community, provincial, national

and local leaders informed concerning the magnitude, nature and implications of the problem of unwanted pregnancy. Solutions to this problem need to be a multi-disciplinary effort. The social worker as a member of this team, could play an important role in community health education and health promotion. Relevant health programmes could be used in this regard to empower the women.

According to WHO (1995:115), basic elements of a multi-faceted effort to address this problem are:

- Educating the public.
- Providing acceptable and accessible family planning and counselling services to prevent unwanted pregnancy.
- Promoting the expansion of services for emergency treatment of all abortion complications through a decentralised health delivery system.
- Providing high-quality medical services for termination of pregnancies resulting from contraceptive failure, for medical indications, and for other reasons within the provisions of the abortion policies of the particular country.

These elements will be discussed briefly as follows:

#### **- Educating the public**

Informing the community about reproductive health concerns, including safe motherhood, is an essential part of preventative health care (Compare WHO, 1995:116.) This could be accomplished by the involvement of team members and the community leaders. It is important to note that community involvement is an integral part of educating the community. Health education programmes can be effectively used to have the community informed about important reproductive health issues.

Health education is a tool that will prevent situations where women would sit with their reproductive problems, without knowing where to go for help. If they are informed they will know exactly where to go for help and when to seek help, without endangering their health. Situations where women seek abortion very late, when it is no longer possible, will be prevented, and they would not end up opting for unsafe and dangerous procedures. The social worker could assist in the planning and implementation of health education programmes. This could be successfully done when the women are involved in the whole process.

- **The role of family planning in preventing abortion.**

It has been indicated by WHO (1995:116), that contraceptive services have a vitally important role to play in promoting safe motherhood, that is, to prevent further unwanted pregnancy; or to prevent additional high-risk pregnancies. The researcher is in agreement with the above statement because if the contraceptive services are available and accessible, as well as user-friendly they will be utilised optimally and unwanted and unplanned pregnancies would be prevented. In South Africa the contraceptive services are available and free at all state health care facilities, but there is still a high rate of unwanted and unplanned pregnancies. This calls for further research to establish the factors that lead to this state of affairs. The researcher is of the opinion that there is lack of effective education programmes that are responsive to the needs of the women population in the country. Social workers in the health care field, could utilise their skills in primary health care to have health education done effectively to prevent unwanted and unplanned pregnancies, that end up in abortions, sometimes accompanied by complications.

It becomes very important to have the community, specifically women, educated on the available methods of contraception and also allow them to choose the suitable method. This will motivate them to use the contraceptives, thus reducing the risk of unwanted and unplanned pregnancy. Educating the women, coupled with giving them a chance to choose the method that is suitable for them, would give them a sense of responsibility and being in control of their reproductive lives, hence the increase in compliance. It is also important to have the information provided in simple and non-judgemental manner, as this would enhance understanding. With these efforts made, the service providers need to always remember that South Africa has a high percentage of women who are illiterate, as a result there is a need to go to their level of understanding when information is provided. It is also important to have these efforts made by the multi-disciplinary team, and not only health professionals.

- **Expanding access to safe, high-quality emergency abortion care.**

This is seen by WHO (1995:118) as an essential life-saving component of the safe motherhood programme. This is the case because when a woman is faced with an unplanned and unwanted pregnancy, it is possible that she

would consider abortion, irrespective of whether it is legal or not, in a given country. Even if the contraceptive services are available, there are still unwanted pregnancies, therefore there is a need to have safe and high-quality abortion services. There are also spontaneous abortions that need to be attended to, as a result the service have to be safe and of high quality, so that complications could be prevented.

In South Africa the services are available but not accessible to everybody as not all the hospitals are not mandated to perform abortion. In cases of emergency, women reach the service point late, with complications having developed. It would be beneficial if the service is accessible for utilisation in times of need.

- **The role of elective abortion, where the pregnancy resulted from contraceptive failure or where there is a medical reason.**

It is important to note that abortion services that are of high-quality and within the prescribed laws of the country, provide women with a chance to decide on a safe option, when faced with an unwanted pregnancy. This also applies to women whose pregnancies have medical indications for termination, because they will know that they will be provided with a high quality service.

### **2.8.1 POST-ABORTION FAMILY PLANNING**

Induced abortion, whether it occurs in a safe setting with legal requirements or in an unsafe and illegal setting, is an indication of a desire to postpone childbearing. It is for this reason that family planning should always be part of the abortion services. It is argued by WHO (1995:75), that if it is impossible to provide family planning at the abortion clinic, then women are to be provided with proper counselling and be referred to the family planning service delivery point. Effective family planning programmes would reduce the mortality and morbidity that could result from abortion.

The woman's family planning needs should be thoroughly assessed through counselling. The woman needs to be given the chance to express her feelings with regard to pregnancy and when she would like to be pregnant. All the information regarding the available methods of contraception should be provided, so that the woman could make a choice. WHO (1995:66)



argues that adequate counselling that assists women in making fair and informed choices based on information about all available methods, is one of the most basic aspects of quality in family planning, following induced abortion. This counselling should be readily available for all women who have had an abortion, before they are discharged from the clinic/hospital. In cases where the woman is unable to make a decision immediately an interim method should be provided and a follow-up appointment be arranged. This would provide the woman with a chance to think more about her circumstances and make a decision that would best suit her, without any pressure. If the family planning services are user-friendly and rendered with sensitivity, women will use them to the fullest. This would prevent induced abortion being requested due to unwanted and unplanned pregnancies. On the other hand the funds that are allocated for abortion services would be channelled for other necessary services. The social worker could play an important role in educating women on the available contraceptives. The knowledge base and communication skills possessed by the social worker enable him/her to play this role effectively.

The most commonly used methods of contraception are:

- Oral contraceptives
- Intrauterine devices
- Suppositories
- Condom
- Diaphragm
- Injectables
- Implants
- Tubal ligation
- Vasectomy

(Compare Parnell, 1989: 50-84; WHO, 1995:61; Roux, 1995:14 & Huntington, 1999:61-72.)

The table for explaining the management of contraceptive methods used, following abortion formulated by WHO (1995:62-65) is included, to illustrate clearly which method is appropriate as well as the time for use, following abortion.

Table 1

Method	Timing	Advantages	Remarks
Oral contraceptives	Begin use preferably on the	- Highly effective if	- Require continued

	<p>day of the abortion or within a week</p>	<ul style="list-style-type: none"> <li>- used regularly</li> <li>- Can be started immediately even if infection is present</li> <li>- Can be provided by trained non-physicians</li> </ul>	<p>motivation and regular use</p> <ul style="list-style-type: none"> <li>- Re-supply must be available</li> </ul>
Intrauterine devices (IUDs)	<ul style="list-style-type: none"> <li>- Can be inserted immediately after first-trimester spontaneous or induced abortion, if the uterus is not infected.</li> <li>- In the second trimester expulsion rates are lowest if insertion is delayed for six weeks.</li> <li>- If the uterus is infected; insertion should be delayed and an interim method should be used.</li> </ul>	<ul style="list-style-type: none"> <li>- Can be inserted by trained non-physicians</li> <li>- Convenient to use; not related to intercourse</li> <li>- Provides long-term protection</li> <li>- Immediate return to normal fertility following removal.</li> </ul>	<ul style="list-style-type: none"> <li>- Risk of uterine perforation during insertion</li> <li>- May increase risk of PID and subsequent infertility for women at risk of sexually transmitted diseases</li> <li>- Trained provider required to discontinue use</li> <li>- May increase menstrual bleeding</li> </ul>
Implants	<ul style="list-style-type: none"> <li>- Insertion can take place</li> </ul>	<ul style="list-style-type: none"> <li>- Once inserted, convenient to</li> </ul>	<ul style="list-style-type: none"> <li>- May cause irregular</li> </ul>

	<p>immediately after abortion</p> <ul style="list-style-type: none"> <li>- If adequate counselling and informed decision-making cannot be guaranteed, it should be delayed and an interim method used.</li> </ul>	<p>use</p> <ul style="list-style-type: none"> <li>- Can be administered by trained non-physicians</li> <li>- Provides long-term protection</li> <li>- Immediate return to normal fertility following removal</li> </ul>	<p>bleeding or no bleeding; excessive bleeding may occur in rare instances</p> <ul style="list-style-type: none"> <li>- Less effective in heavier women</li> <li>- Trained provider required to discontinue use</li> <li>- Cost-effectiveness depends on long-term use</li> <li>- Must be replaced after 5 years to avoid a decrease in effectiveness and potential increase in risk of ectopic pregnancy.</li> </ul>
<p>Injectables</p>	<ul style="list-style-type: none"> <li>- The first injection can take place immediately after abortion in the first or second trimester</li> <li>- If adequate counselling and informed decision-</li> </ul>	<ul style="list-style-type: none"> <li>- Easily administered by non-physicians</li> <li>2 Convenient for woman; not related to intercourse</li> </ul>	<ul style="list-style-type: none"> <li>- May cause irregular bleeding; excessive bleeding may occur in rare instances</li> <li>- Possible delayed return to fertility</li> <li>- Re-supply must be</li> </ul>

	<p>making cannot be guaranteed, it may be best to delay using</p>		<p>available</p> <ul style="list-style-type: none"> <li>- Convenient access to clinic important as regular return visits are required.</li> </ul>
<p>Female sterilisation</p>	<ul style="list-style-type: none"> <li>- It is imperative that adequate counselling and informed consent precede sterilisation and this is likely in the emergency context</li> <li>- Technically, sterilisation can be performed immediately after first trimester spontaneous or elective abortion, and after treatment of abortion complications except where there is infection or severe blood loss</li> <li>- Sterilisation</li> </ul>	<ul style="list-style-type: none"> <li>- Permanent method</li> </ul>	<ul style="list-style-type: none"> <li>- Permanence of the method increases the importance of adequate counselling and fully informed consent; this is not likely to be possible at the time of emergency</li> </ul>

	<p>after a first-trimester abortion is similar to an interval procedure</p> <ul style="list-style-type: none"> <li>- Sterilisation after a second-trimester abortion is similar to a postpartum procedure</li> </ul>	<p>discontinued when pregnancy desired</p> <ul style="list-style-type: none"> <li>- Easily discontinued when pregnancy desired</li> </ul>	<p>Less effective than other methods</p> <ul style="list-style-type: none"> <li>- Require continued motivation and regular use</li> <li>- Re-supply must</li> </ul>
Male sterilisation	<p>Timing not related to abortion</p>	<p>Permanent method</p>	<p>Permanence of the method increases the importance of adequate counselling and fully informed consent</p>
Barriers not requiring fitting	<p>Begin use as soon as intercourse is resumed</p>	<ul style="list-style-type: none"> <li>- Useful as interim methods if initiation of another chosen method must be postponed</li> <li>- Medical supervision not required</li> <li>- Provide some protection against sexually transmitted diseases</li> <li>- Easily</li> </ul>	<ul style="list-style-type: none"> <li>- Less effective than other methods</li> <li>- Require continued motivation and regular use</li> <li>- Re-supply must be available</li> </ul>

		discontinued when pregnancy is desired.	
Fitted barriers used with spermicides	Fitting and use should be delayed until the cervix and vagina have returned to normal	- Easily discontinued when pregnancy is desired	<ul style="list-style-type: none"> <li>- Less effective than other methods</li> <li>- Require continued motivation and regular use</li> <li>- Re-supply must be available</li> </ul>
Periodic abstinence	Not recommended for immediate post-abortion use. The first ovulation after an abortion will be difficult for the woman to predict and the method is unreliable until after the first post-abortion menses	- No cost	<ul style="list-style-type: none"> <li>- Unreliable immediately after abortion</li> <li>- Alternative methods are recommended until resumption of normal cycle</li> <li>- Women and their partners must be motivated and have a thorough understanding of how to use the method</li> </ul>

Post-abortion family planning is something that has to be seriously considered immediately after the woman has undergone termination of pregnancy. Of importance is to provide the woman with the information regarding contraceptives, so that she could choose the method that will suit her best. This could improve compliance in the utilisation of contraceptives,

hence reducing the occurrence of unwanted and unplanned pregnancies, that could end up in abortions.

## 2.9 SUMMARY

In this chapter the following aspects were discussed:

The methods of abortion at different periods of gestation, where it was found that termination of pregnancy at advanced gestation period is very risky. It could result in serious complications for the woman. The skills and the technology used here also play an important role, in bringing the desired results, with minimal complications. The social worker could play a vital role here in preparing the patients, by providing them with detailed information on the different procedures, depending on their gestation period. This would help ease the anxiety and equip the women, as well as enabling them to have some expectations, with regard to what is about to happen to them.

Abortion-related risks and complications were also discussed, where maternal mortality and morbidity were highlighted at length. It has been found that abortion may be accompanied by a variety of complications, irrespective of whether it is done legally or illegally. The abortion-related complications become more serious with advanced pregnancies. The accessibility of the abortion services could assist in reducing the complications, as women would receive the necessary treatment timeously. Follow-up services are also a need, as part of the abortion services, to reduce the advancement of complications and provide women with the necessary treatment as early as possible.

Management of abortion-related complications is an important part of the abortion services. It is only through follow-up services that these complications could be detected and treated immediately. Assessment plays an important role because the extent of the problem could be determined, so that appropriate treatment could be provided.

The prevention of unsafe abortions, accompanied by a variety of complications should be the focus. Complications of abortion could be eliminated by having abortion services readily available and accessible to all women, that is, those staying in rural areas, as well as those staying in urban areas. These services need to be accessible to avoid a situation where a

woman has to travel a long distance to reach the services. This complicates the situation more, with adverse consequences. Health education is seen as a tool that can assist in alleviating the serious abortion-related complications. This could work hand in hand with accessible family planning programmes, as women would be educated on their health and sexuality. In this way women would have insight and knowledge on the available services, on how to utilise them, as well as when to utilise them. The social worker as a member of the multi-disciplinary team here could be involved in planning, implementation and evaluation of the health education programmes, to ensure their effectiveness. The knowledge-base and skills of the social worker with regard to working with communities would enable him/her to play this role with success.

Post abortion family planning is the other important part of the abortion services. This would ensure that women do not use abortion as a means of family planning. Women need to be educated on the available family planning methods and be given a chance to choose the method they would like to use. Giving women a chance to choose would encourage compliance, hence preventing unwanted and unplanned pregnancies that could end up in abortion.

The following chapter will deal with the psychosocial aspects related to abortion on the woman.



## CHAPTER 3

# THE PSYCHOSOCIAL ASPECTS RELATED TO ABORTION

### 3.1 INTRODUCTION

Abortion is an emotional procedure, irrespective of the fact that the woman chose to undergo it. The intensity of the emotions experienced with abortion depends on a variety of factors. These factors are confirmed by Rodman, et al. (1987:76), by indicating that women seeking abortions are often angry at themselves for getting pregnant, at their sexual partners for getting them pregnant, at a biological situation that makes women pay a heavy price for sexual pleasure without effective contraception, at parents or partners or a society that coerces them into making an abortion decision about which they are ambivalent. This is in agreement with Michels (1988:15-16) and Maluleke (1997:14) that each woman seeking abortion has her own reason. These different reasons are seen by these women to be valid, strong and real enough to overcome any thought of the consequences of abortion.

It becomes clear from the above discussion that there are different factors or reasons that lead to women's decision to seek abortion. As a result the abortion procedure will be experienced differently by different women. With the advent of the new abortion legislation in South Africa, Choice on Termination of Pregnancy Act (92/1996), women have access to abortion services, but due to financial constraints the services are not well equipped, both with human resources and the necessary technology. This state of affairs leaves many women who seek abortion with inadequate services. One of the service that is lacking is the pre- and post counselling to women who seek abortion. In the researcher's opinion this will also have an impact on how women seeking abortion at state hospitals will experience it emotionally, immediately, as well as in the long term.

It is indicated in the Annual Report of the Department of Health (1997:15-16) that 165 hospitals have been designated to perform termination of pregnancy and 24 387 women had access to termination of pregnancy services by 30 November 1997. This clearly indicates that a considerable number of women are utilising the state abortion services, which are not well equipped. This could lead to a variety of psychosocial implications for the women, as they are not receiving a comprehensive service. The researcher does not deny the fact that they have access to safe abortion services, the

concern here is that their emotional being is not attended to, as it has already been indicated in chapter 1 of this thesis.

In this chapter the following aspects will be discussed: emotional reaction to abortion, social implications of abortion, adolescents and abortion as well as counselling as an important aspect of the abortion service.

## **3.2 THE PSYCHOSOCIAL ASPECTS RELATED TO ABORTION ON THE WOMAN**

The psychosocial aspects related to termination of pregnancy will be discussed as follows:

### **3.2.1 FACTORS LEADING TO UNWANTED PREGNANCIES**

Many unwanted pregnancies could be seen to be the result of ignorance on the part of the woman. It has been indicated by Rodman, et al. (1987:76) that there is an astonishing degree of ignorance among people who thought they would not conceive if it was a certain time of the month, if she douched, if the male partner withdrew or did not penetrate, if it was the first time, if she prayed, if she is lactating or if she/he is very young. This ignorance can lead to an unwanted and unplanned pregnancy, which result in the woman seeking abortion.

A high level of ignorance is found in adolescents mostly because the connection between intercourse and pregnancy is not clear to them. This is confirmed by Trad (1993:405), that teenagers are unable to accept that they can become pregnant as a result of sexual activity, because of their cognitive development. In the researcher's opinion this places the adolescents at a risk of becoming pregnant before she could understand what is happening. This challenges all adults to be actively involved in the adolescents' life, in an effort to teach them thoroughly on their sexuality, specifically to teach them the importance of postponing sexual activity to a later age, when they are mature enough to carry the responsibility.

#### **3.2.1.1 IATROGENIC FACTORS**

It is found in some instances that women become pregnant because they did not use any contraceptives because the doctor told them or their partners that they are infertile, without proper assessment tests. Rodman, et al.(1987:77)

further indicates that the woman can become pregnant because the couple was motivated to prove its infertility or the woman was told to give up an effective method of contraception because it might affect her ability to bear children in future. All these factors may lead to an unwanted and unplanned pregnancy, with devastating emotional effects on the woman.

### 3.2.1.2 GUILT AND EMBARRASSMENT

Many young women have their first coital experiences without any contraception because they are reluctant to admit that they are sexually active. This is coupled with feelings of guilt and embarrassment, which prevents many young women from taking responsibility for their sexuality (Compare Rodman, et al. 1987:77.) With these feelings young women engage in sexual activities without any protection which usually leads to unwanted pregnancies.

Unlike women who admit that they are sexually active, women who are overcome by guilt and embarrassment will not feel free to approach the clinic for contraceptives, because they would not like to be associated with being sexually active. The researcher is of the opinion that other women would not seek contraceptives at clinics because of the unfriendly nature of the service there, where women are made to feel guilty for their sexual indulgence by the nursing staff.

### 3.2.1.3 OTHER FACTORS

On the other hand Stotland (1997:676-679) identified the following factors that lead to unwanted and unplanned pregnancies:

- **Ongoing or past psychiatric illness.**

A woman with psychiatric illness has an impaired self-esteem, impulse control, judgement and insight; as a result her ability to use or insist on contraception or to refuse sexual intercourse is disturbed. This situation could lead to the unwanted and unplanned pregnancy which the woman does not have the ability to deal with, except seeking abortion.

- **Poverty**

Women staying far away from health facilities may end up not having money to go for their monthly supply of contraceptives. In countries where contraceptives are not provided free by the government, women who are poor may end up not having money to purchase contraceptives and thus leave it. Both these situations may lead to these women exposed to unprotected sex that could result in unwanted and unplanned pregnancy. For rural women in South Africa the contraceptives are not readily available and accessible, as a result of poverty and high rate of unemployment these women are unable to reach the health facilities for their free supply of contraceptives. Amongst the youth, poverty could lead to them engaging in unprotected sexual intercourse in exchange for money. This could lead to unintended results, that is, pregnancy, with devastating emotional impact.

- **Maturity**

Many young people make uninformed decisions regarding sexual activities because of their immaturity and men take advantage of this situation. The unplanned and unwanted pregnancy may be the result of this situation. This could have devastating emotional impact on the young person.

- **Abandonment**

Many times women hope that sexual activity or pregnancy will cement a relationship. They may be willing to take a risk or be actively interested in conceiving only to be deserted when the pregnancy occurs.

- **Rape and incest**

Rape and incest may lead to unwanted and unplanned pregnancy, leaving the victim psychologically torn apart, and especially that the victim does not receive support that she so desperately needs.

- **Cultural aspects**

The cultural aspects could lead to an unwanted pregnancy. In a cultural background where the men controls the woman's body, he will forbid her to use contraceptives, demand sexual intercourse, which could ultimately lead

to an unwanted pregnancy. Under these circumstances the woman is expected to be submissive and not question anything.

The other aspect could be the fact that amongst the black culture the number of children born in the marriage proves the man's ability to produce. As a result, the man who believes strongly in this myth, would force his wife not to use contraceptives, resulting in unwanted pregnancies, on the part of the woman.

It is also common practice, where the extended family structure is still maintained that the grandparents would look after their grandchildren. With this notion, the woman could just not use the contraceptives, which could lead to unplanned pregnancy. This particular woman would find it difficult to decide on termination of pregnancy, because she would know that her parents would be willing to help her.

The above-discussed factors that have a potential of leading to an unwanted and unplanned pregnancy can have serious effects on the woman. It becomes clear that when a woman is faced with this situation, resulting from whatever reason, it would be difficult for her to come to terms with how to deal with it. This ambivalence on what to do can be complicated by a variety of factors, with devastating emotional implications on the woman.

### **3.2.2 EMOTIONAL REACTIONS**

The women's reactions to an unwanted and unplanned pregnancy, as well as her reactions to abortion will be discussed as follows.

#### **3.2.2.1 REACTION TO PREGNANCY**

It is important to consider what it means for the woman to be pregnant, before looking at how she would respond to abortion. Stotland (1991:121) indicates that women's responses to pregnancy are highly varied and reflect personality and early life experiences. For some women, pregnancy is a highly desirable state containing many gratifications such as a positive identification with motherhood, a heightened sense of womanliness, an enhancement of a relationship and the creation of her own family. While on the other hand, pregnancy for some other women may be experienced as an invasion of the body. It is further indicated by Stotland (1991:122) that particular circumstances whereby a woman becomes pregnant, also shape

her response to the pregnancy. A woman who consciously intended to become pregnant may have difficulty to decide to abort when she learns that she has been exposed to an infectious disease that may produce defects to the foetus. Changes in the woman's circumstances such as a loss of the partner may lead to an easy consideration of abortion.

The above discussion clearly shows that every woman will react to a pregnancy in a unique manner, depending on the circumstances that led to her pregnancy. If the pregnancy is planned, then the woman will react with joy, while on the other hand when it was unplanned it will evoke a variety of emotions. It is possible that the woman could react negatively to an unplanned pregnancy, because she will be faced with a situation of deciding what to do with her circumstances.

### **3.2.2.2 DECISION-MAKING PERIOD**

Making a decision on what to do about an unplanned pregnancy can be a very difficult thing to do, as this happens at the time when it was least expected. This could evoke a variety of feelings in the woman, which could ultimately interfere with her thinking, and this could lead to her requesting termination of pregnancy at a very late stage. In the researcher's opinion, it is during this period that the women are to be provided with counselling, to help them deal with the reality of their situation in a constructive manner. As the woman is having serious inner deliberations because of this unexpected situation, the social worker's intervention could benefit her during this period, which would ensure that her social functioning is not disturbed.

### **3.2.2.3 REACTIONS TO ABORTION**

The woman's reaction to abortion will largely be influenced by the circumstances that led to the decision to have the pregnancy terminated. The major factor that plays a role in the woman's reaction to abortion is whether the pregnancy was planned or not. The other factor is the support she receives from her environment, during the decision-making phase, through the abortion procedure and in the immediate post-abortion period. For many women who seek abortion in South Africa, it is not easy for them to receive any support from their families because they keep this as a secret. This is facilitated or fostered by the provision in the abortion legislation, Choice on Termination of Pregnancy Act (92/1996), that allow minors to give consent

for their abortion. As a result they do not see the reason to inform or consult the family members. This is also fostered by the moral standard of many Christians, who feel that abortion is wrong, as a result become judgemental towards women who seek abortion. As a result of this situation, many women who undergo termination of pregnancy will experience intense emotional reactions, without sharing them; which could lead to serious problems in their lives. The women's reactions to abortion will be discussed according to the different phases, namely, immediately after the procedure and some time after the procedure.

### - Immediate Post-abortion reaction

In the opinion of Michels (1988:29) for many women, the emotion after having an abortion is immediate relief. This is in agreement with what is said by Stotland (1991:124) that women who experience little or no conflict about the decision to undergo abortion feel relieved after the abortion. This relief was illustrated by Michels (1988:29) in the example of a woman who said, "I felt that now I could put things back together again, even though I was said it could not be different." This clearly indicates that this woman was relieved that the pregnancy was terminated and felt in control of her situation.

Some other women experience negative emotional reactions such as sadness, regret or guilt immediately after abortion. Stotland (1991:124) indicates that these feelings resolve fairly quickly and are associated with the ongoing conflict about the decision to abort. Women who had difficulty deciding about the abortion are likely to be depressed after the abortion procedure because they continue to have fantasies about the foetus. The woman's desire to have a baby, which may be concurrent with her certainty that she is not prepared for the child at the time, contributes to depression (Compare Stotland, 1991:125.) This indicates that even though abortion was a woman's choice, it has emotional involvement, which is aggravated by the circumstances prior to the abortion. It is further argued by Rodman, et al. (1987:79) that adolescent girls experience abortion positively. They experience it as a relief because they gain control over their lives to move on without the burden of raising a child, especially as they still have to shape their future.

It is evident from the above discussion that immediately after the woman has successfully had termination of pregnancy, she feels relieved of the problem

that she was having. This relief could be attributed to the fact that at that stage the problem that was faced by the woman has been removed. During this stage the woman does not think anything about the future emotional impact of what has happened. The short-term and long-term reactions will then be discussed.

### - Short-term and long-term reactions

The process of making a difficult decision like that of abortion can have positive effects on a woman's self-esteem and sense of autonomy, that is, it can lead to personal growth. Like the negative emotions experienced in major life events, abortion included, their high level declines with time. Stotland (1991:125) argues that these negative emotions will decline to normal or near-normal levels by the sixth month after the abortion procedure. This is in contrast to what is said by Michels (1988:29) that research has shown that feelings of immediate relief are short-lived and are soon replaced by guilt, sadness and regret. This is illustrated by an example of a woman who was angry at the circumstances that led to her abortion, while she felt relieved immediately after the abortion procedure. This is further illustrated by another woman, Jennifer, in Michels (1987:15) when she years later, realised that if one person had told her not to have the abortion she wouldn't have done it.

This clearly indicates that abortion has long-term emotional effects on the woman. This can be more serious for the women in South Africa, who seek abortion at state hospitals, because they do not receive pre- and post-abortion counselling. The importance of pre- and post-abortion counselling is emphasised by Trad (1993:406) that in general, negative emotional responses to abortion are relatively rare, provided the adolescent receives pre- and post-abortion counselling. In the researcher's opinion women who undergo abortion without any form of counselling are at risk of having long-term negative feelings about the procedure.

It is argued by Butler (1996:397) that it is important for medical professionals to enhance the woman's understanding of the far-reaching implications of a decision for abortion, to help her make a choice for which she feels responsible and find mechanisms for coping with the consequences. This clearly confirms the importance of having women who seek abortion, provided with thorough counselling, to avoid long-term emotional reactions. Sodenberg, Janzon and Sjoberg (1998:173) indicate



that it is common experience among those involved in the care of women seeking induced abortion that for many of them it is a very stressful situation. This indicates that abortion is accompanied by stress, which could lead to serious mental problems, if the woman does not receive the appropriate intervention.

It is further argued by Soderberg, et al. (1998:174) that emotional distress following abortion should not be considered a normal stress reaction, as indicated in their study, where 76.1% of the women interviewed after abortion said that they would never consider an abortion if they became pregnant again. This suggests that abortion have devastating emotional distress on women and should not just be considered a normal reaction. Women's emotional reaction should be looked into in a serious light also bearing in mind that each woman will react in a unique manner, depending on her unique circumstances.

The results of the study conducted by Burnell and Norfleet (1984:75) are in agreement with Stotland (1991:125), that there is a remarkable decline of negative feelings over a period of time, following abortion. This could only be achieved if thorough pre- and post-abortion counselling was done. The social worker at the abortion clinic could play an important role in this regard. It is important to note that each woman's reaction to abortion is unique, depending on the personal circumstances. In order for the woman to function in a healthy state of mind, she needs to deal with her emotional reaction emanating from abortion and allow herself to grieve the death of her child.

As it has already been indicated earlier, different authors discovered different emotional reactions to abortion. Michels (1988:45-149), identified a process which women go through after undergoing the abortion procedure, and this process will be briefly discussed step by step. Michels (1988) did not indicate the time frame during which the reaction occurs after the abortion procedure.

- **Grief**

Grief refers to a process of emotional suffering, usually caused by the loss of someone or something very special to a person. It can be intense and last for years or it can appear momentarily in one's life. To a woman who has undergone abortion, without letting anyone know about it, it becomes

difficult for her to acknowledge grief. She tries to convince herself that what she did was right, but her guilt feelings may catch up with her. Because the woman is trying to justify her action within herself, without sharing it with her significant others, it becomes very difficult for her to grief openly and be helped. This situation will constantly manifest in the woman crying for no apparent reason, especially that she cannot disclose the source of her hurting. This is aggravated by the fact that there is no formal rituals where friends and family can acknowledge her loss and share her grief. In the researcher's opinion this is likely to happen to most women who opt for abortion in South Africa, due to the provision that allow minors to consent for their abortions. Although abortion is legalised in South Africa, it is not morally approved by every person. As a result many parents will never agree to an abortion and this will lead to minors keeping it to themselves. This can lead to a long-term unresolved grief, which can only be dealt with through counselling.

- **Denial**

Denial occurs when a woman who has aborted does not acknowledge her responsibility for it. Denial is used to protect oneself from experiencing abortion as death, which brings with it an anxiety, guilt and anger. Although the woman's circumstances have forced her to go ahead with abortion, she has to acknowledge that abortion goes together with the death of the foetus, therefore it has to be acknowledged. Even though rationalisations are used, deep inside the woman knows that what she did was causing death. Denial aggravates and prolongs the intensity of negative feelings accompanying abortion, as a result women are to be helped to acknowledge what they have done and deal with the emotional reactions emanating from that.

- **Guilt and anger**

Guilt surfaces after the woman recognises that abortion has to do with ending life and that she is responsible for its occurrence. The woman may feel guilty because she based her decision on her own self-centred desires or she valued her life more than the life of her child or that she committed a sin. The intensity of the guilt is mostly determined by the woman's environment, that is, whether the environment is supportive or non-supportive. When the abortion was done secretly, the guilt feelings will be more intense and last for a long period.

Guilt can then be expressed through anger, which could be directed to persons who advised the woman to abort, as well as the circumstances that led to the abortion. Once the woman has broken the denial that she was responsible for the death of a human being, she then feels guilty. The anger is aggravated by the woman's increased knowledge of foetal development and the procedures used to terminate a pregnancy. She may feel anger towards self, because she failed to save her child and this anger can be manifested in self-blame, self-hatred and shame. This inner rage may turn to depression, violence or self-destruction. A woman manifesting this anger must be helped to have it channelled appropriately.

- **Bargain, depression and isolation, fear**

During the bargaining phase the woman who has undergone abortion rationalises her pain. She may throw herself into activities that will keep her busy, she may have another baby shortly after the abortion or she may volunteer to help at the pregnancy crisis centre. During this phase the woman does not deal with her feelings or pain, but tries to reconcile her grief through super-human deeds. After failing to reach this reconciliation it is then that the woman goes back to the emotional upset and feels depressed.

When a woman is depressed she will not care about herself. She may experience a number of changes such as emotional numbness, feelings of worthlessness, dependence on drugs or alcohol, new behaviour relating to her sexuality, preoccupation with the aborted child, isolation and thoughts of suicide. During this phase the woman is unable to function normally. This may lead to fear where the woman might fear that others will find out about her abortion, punishment from God, infertility, subsequent pregnancy loss and loss of dignity. This becomes more serious when nobody was told about the pregnancy and the abortion. When dealing with a woman in this stage she has to be reminded of her worth and her life before the abortion, so that she could realise her self-worth and build her life from there.

- **Forgiveness**

For the woman who has had an abortion, forgiveness means that she stops feeling resentment against the people who influenced her abortion decision, herself included. This happens after the woman has dealt with all the negative feelings she felt and experienced after the abortion. Forgiveness allows the woman to lay down the guilt she has been carrying with her since

she first realised that she killed her baby. It helps her to start over again and take control of her life. The woman also needs to forgive herself because, if she fails to do this, she won't be able to take control of her life. This cannot come automatically, therefore, women who has had abortion need to be helped through counselling, to overcome all the negative feelings accompanying abortion.

Although the woman's reaction to abortion discussed above seem to be occurring through a process, it is important to note that every woman will go through the said process in her own unique way. This means that when dealing with these women the service providers should look at every woman as a unique entity, who reacts uniquely to the given situation. The above reactions provides a broad spectrum, for the better understanding of the women's long-term emotional reactions to termination of pregnancy.

On the other hand Stotland (1997:679) identified the following reactions on women who had induced abortion:

- **Relief**

He argues that relief is the most common emotional reaction following abortion, because women are now able to refocus on their ongoing responsibilities and the future. The researcher agrees with this argument because immediately after abortion the woman feels relieved and ready to go on with her life, without the burden of an unwanted and unplanned pregnancy. This becomes more true with adolescents who go back to school immediately after abortion, being delighted that her schooling will no longer be disrupted, now that she has managed to get rid of the pregnancy.

- **Guilt**

According to Stotland (1997:679), it is not uncommon for women to feel guilty after having abortion. The guilt is said to be related not only to the ending of a potential life, but also to the inopportune conception of that potential life. It could then be argued that although there was immediate relief after abortion, the woman will feel guilty later because of the notion that she terminated life. This could lead to the development of further emotional complications as indicated earlier on, when this issue was addressed under the process that was identified by Michels (1988). The woman in this state would need thorough assessment, followed by

counselling, for her to deal with this feeling and also avoid further emotional complications.

- **Sadness and loss**

It has been found that mild feelings of sadness and loss are experienced by women after abortion. In a way these feelings are confusing to the woman, her significant others, as well as health care providers (Compare Stotland, 1997:679.) Although it was the woman's choice to end the pregnancy, the sense of loss and sadness does occur. The researcher is of the opinion that this is the situation because the woman was forced by external pressures to end the pregnancy, as it has already been indicated, that women decide to seek abortion because of their different circumstances.

- **Maturation**

Many women in Stotland's study (1997:679), reported that their decision to have abortion, though painful, marked a change from passivity to active responsibility, planning and mastery of their destiny. Due to the fact that deciding on abortion is a very sensitive and responsible decision, women need to be assisted to make informed decisions through counselling. By the time the woman makes the decision she should be convinced that she will be able to move on and take responsibility for her decision and future. This will be indicative of the fact that making the decision helped the woman to move to maturation level.

From the literature review it becomes evident that there is no definite conclusion on the reactions of women after abortion. This is confirmed by Adler (1992:1202), that some individual women may experience severe distress or psychopathology, following abortion, but it is not clear whether these are causally linked to the abortion itself. This clearly indicates that there is still a need for further research in this area, where women who undergo abortion are to be followed up for longer periods to determine their actual reactions to the procedure. Adler (1992:1202), further confirms what has already been said with regard to the follow-up services, in his statement that: "we do not know about very long-term effects". This suggests that the follow-ups done were on a short-term basis, which limits the authority to conclude in an inclusive and generalised manner on this issue.

When looking at the emotional reactions presented by women after abortion, it becomes very important to have follow-up services. This will help in monitoring how each woman is coping with her decision of terminating her pregnancy. The researcher is of the opinion that these services need to be introduced in all state hospitals that has been mandated to perform abortions. Presently these women do not receive any pre-abortion counselling and are discharged immediately after the procedure. There is no follow-up for them, so that it could be established whether they have any physical or psychological complications or what their emotional reactions are. If the service in South Africa is going to be rendered in this manner without introducing follow-up services, it will never be known what the emotional reactions and of women are as well as the psychosocial implications on the woman are, following abortion. The researcher sees this as a setback with regard to the development of comprehensive abortion service in the country. It is not enough to provide women with safe abortion without any counselling, that is pre- and post-abortion; as well as without follow-up services. Counselling can prolong a feeling of relief in women who opt for abortion and this would provide them with enough time to reorganise their lives and also take charge thereof.

### **3.2.3 THE PSYCHOLOGICAL ASPECTS OF ABORTION**

Deciding on terminating an unwanted and unplanned pregnancy could have psychological effects on the woman. Although termination of pregnancy was seen as a better option at the time of the decision, it could later have some psychological bearing on the woman. The woman could have some flash-backs of what happened at the TOP Clinic during the procedure. This is confirmed by Butler (1996:396), that after many years one woman had a vivid recollection of the actual procedure, and remembered well what the pro-life nurse told her after the procedure that she had just killed a perfectly formed little boy. The fact that the woman is unable to forget this traumatic experience could be manifested in her constant crying for no apparent reason. This could happen because of her feeling of guilt, resulting in her re-living the experience time and again. In this case study the woman had a loveless marriage after the abortion and never had children of her own. This clearly shows how terminating a pregnancy could affect a woman psychologically, on a long-term basis.

Failing to forget about this incident could affect other aspects in the woman's life, at the psychological level. It is indicated in the study that was presented

by Butler (1996: 396-397), that this woman could not feel loved again or herself love someone. This led to her staying in a loveless marriage that was not fulfilling at all. This indicates that this woman's self-image was affected and therefore she was unable to continue with a normal life after abortion, even if it was her decision to have the pregnancy terminated.

It could also happen that the woman who has undergone termination of pregnancy could experience nightmares or dream about her dead child. This could lead to depression and the woman could be unable to go on with her life. The woman in this situation could only be helped through counselling, if she could be able to see the connection between her depression and the abortion she has undergone in the past.

The other indication that could signal that the woman was psychologically affected by an abortion could be her failure to be involved in intimate relationships with any man. This is confirmed by Butler (1996:396) in a case study of a 24 years old woman who presented to her family physician with difficulties with intimate relationships. It was very difficult for this woman to get involved in an intimate relationship, until she realised that she was having a problem. She was unable to make a link between the abortion she had some years ago, with her inability to have intimate relationships. During the counselling session, it was discovered that her decision to have her pregnancy terminated was based on her failed relationship with her boyfriend. This clearly shows that termination of pregnancy is accompanied by psychological implications on the woman, which could prevent her from having a meaningful life thereafter.

The woman's inability to be involved in intimate relationships could affect her sexual identity. She could end up doubting her being a real woman, who is capable of fulfilling her female roles. This could extend to the woman's femininity being affected, in a sense that her life could come to a stand still. This confirms the psychological impact of termination of pregnancy on the woman.

It is evident from the above discussion that termination of pregnancy is accompanied by psychological implications on the woman, which could result in her inability to move on with her life. Of importance here is to realise that the woman could not be able to link her psychological problems to abortion, which makes counselling crucial, to help the woman to discover the root of her problem.

### 3.2.4 THE DEFENCE MECHANISMS USED BY WOMEN AFTER ABORTION

The decision to have an abortion is the most difficult one, that the woman has to make. As it has been indicated earlier, this depends on a variety of factors. After some inner deliberations and considerations, the woman decides to go on with abortion, because she has no other option. This decision also creates an environment for even greater anguish and pain. To cope with the emotional pain that accompanies abortion, the woman will develop a set of defence mechanisms. Michels (1988: 40), identified the following mechanisms as being used by women who have had abortion:

#### ◆ Rationalisation

With this defence mechanism the woman gives reasons for having an abortion, so that she could cope with her decision. Because rationalisations are very strong, it is difficult to talk a woman out of them. These are defences that a woman uses against the feelings she does not want to deal with. With these rationalisations the woman is able to go on with her life, with minimised emotional stress.

#### ◆ Repression

When using repression, the woman is not aware of any negative feelings that she may have about the abortion. This can be problematic because the woman may repress all her feelings and end up not in touch with reality. It is important for the professionals helping these women to be aware of this defence mechanism so that they could help them deal effectively with what has happened.

#### ◆ Compensation

This occurs when the woman becomes pregnant soon after her abortion, to make up for the lost child. The baby, if carried to term, serve as a substitute for the aborted one, and may be given an excessive amount of attention. If the child has physical or behavioural problems, the mother may suffer excessive anxiety and feel as if she is being punished for her past abortion.



It is important for social workers dealing with women who have had an abortion, to know these defence mechanisms, so that they could be able to effectively help them not to delay their dealing with reality by excessive use of the defence mechanisms. Because the excessive use of the defence mechanisms can block the helping process, it becomes therefore, very important to always be alert of the extent to which they are used. This awareness will enable the social worker to help the woman to be aware of her real feelings and deal with them.

### 3.2.5 SOCIAL ASPECTS OF ABORTION

Raising an unwanted child can lead to a variety of emotions for the mother. In the case of an adolescents, when they become mothers their education is interrupted, their occupational aspirations are stunted and their marriage, if it occurs, become strained (Compare American Psychologist, 1987: 74.) If the adolescent can have a safe abortion, she can be enabled to move on and attain her aspirations. In the researcher's opinion, with legal and safe abortion being available, women are given a chance to plan their future, unlike when they were forced to go for illegal and unsafe abortion, as their future health was not guaranteed.

Safe abortions also help in the financial status of the women in the sense that their jobs can be retained, because they won't have to stay in hospital for a long period of time. The family is also saved some money because it won't have to raise an unplanned child, thus disorganising its budget.

The woman can be able to proceed with her normal relationships after she has been freed of the unplanned burden. The researcher believes that this can only be accomplished if the woman had a supportive environment prior to the pregnancy and abortion. If the woman was not able to disclose her pregnancy and intentions to have abortion, it would be difficult for her to go on with normal relationships, because she will be overwhelmed with variety of negative emotions, which were discussed earlier. The woman can end up being a loner because she is unable to discuss her deep-seated feelings with those around her, or she could resort to aggression, which would isolate her further. In this situation the social worker's intervention would be needed for the woman to acknowledge her feelings and ultimately deal with them.

The other social implication of termination of pregnancy would be that the woman's job performance being affected. Due to the secrecy surrounding

termination of pregnancy, a woman could be overwhelmed by the negative emotions and be unable to share them. As a result this woman's work performance could be affected to an extent that she could ultimately lose her employment, with financial implications on her. If this woman was the sole breadwinner in her family, then the whole family would be affected. Nobody would be in a position to explain this sudden change in the woman's performance, including her. It could be interpreted as her unwillingness to work.

The woman's social functioning could as well be affected by her termination of pregnancy, without her ability to understand why the sudden change. This could have a negative impact on her ability to perform her house-hold chores and making appropriate decisions regarding what is happening in her home. She could end up being unable to give proper guidance to her children, which could disorganise the whole family functioning.

The woman's relationships could also be affected by having her unwanted and unplanned pregnancy terminated. Because she would be unable to communicate her feelings with her significant others, she could find herself overwhelmed by these negative emotions to an extent that she is unable to communicate appropriately with anybody. This could lead to a situation where this poor woman is isolated and nobody understands what has happened to her.

Some of the women presenting psychological problems emphasised that they had developed a psychological vulnerability consisting of a lack of strength and endurance, feelings of guilt and inferiority and resignation and a lack of confidence. (Compare Tornbom and Moller, 1999:25.) This negative self-esteem can be manifested in different ways and could lead to a feeling of powerlessness and a lack of faith in self. This could lead to a situation where the woman could be unable to proceed with her life after abortion.

It could also happen that due to the experience of termination of pregnancy the woman is unable to have heterosexual relationships later in life. This could be the result of the anger that could have built up in the woman because she found herself facing an unplanned and unwanted pregnancy alone, after her involvement with a man. She could go further to express her hatred to all men for the rest of her life.

The woman's self image could also be affected by termination of pregnancy, in the sense that she could be overwhelmed by guilt feelings and end up hating herself. With these negative feelings inside the woman could never feel good about herself and she could ultimately withdraw from the social world and become a loner.

If the woman had termination of pregnancy while she was still studying, this could have an impact on her academic performance. She could ultimately lose concentration on her studies, which could affect her progress. This could also delay her career building and she could end up being a dropout, with negative impact on her self-image.

The other sphere in the woman's life that could be affected is her relationship with God, depending on the nature of the relationship prior to the abortion procedure. For the woman who had a strong conviction to God, this could either strengthen her conviction, if she believes that God will forgive her or isolate her from God. But for the woman whose relationship with God was not clear and strong there will be no change, as she will just go on with her life.

When looking at all the areas of the woman's life that could be negatively affected by terminating an unplanned and unwanted pregnancy, it becomes evident that counselling is a need. It is only through counselling that these women could be assisted to deal with their negative feelings and go on with their lives. Based on the above discussion the researcher strongly believes that the women who opt for termination of pregnancy would benefit greatly if pre-abortion counselling could be provided for them.

### **3.2.6 ADOLESCENTS AND ABORTION**

As adolescence is the voyage from childhood to adulthood, the girl in this stage has many new tasks to master. She has to grow accustomed to her changing body and to the effects of hormonal changes, coupled with the monthly cycle; to recognise her fertility and the consequences of that fact that she has to acknowledge her responsibility. None of these new tasks is easy, especially in the years before her ability to reason abstractly develops. (Compare Stotland, 1991:188.) This implies that before an adolescent's development of abstract reasoning, it is difficult for her to draw a relationship between her actions and the consequences thereof. It is mostly during this period that adolescents become pregnant, followed by a decision

to have an abortion. It is argued by the American Psychologist (1987: 73), that 40% of the 1.1million pregnancies in females under age 20 annually, are terminated by induced abortion and nearly one third of all abortions are performed on females under age 20. This indicates that the adolescents are mostly at risk of becoming pregnant before they are fully developed to face the consequences of their actions. As a result of this most adolescents will opt for abortion, when they realise that they are pregnant.

### 3.2.6.1 ACTIVITIES LEADING TO PREGNANCY DURING ADOLESCENCE

As indicated earlier, it is difficult for the adolescents to make a cause-effect connection between intercourse and pregnancy. Adolescents fail to realise the consequences of their actions because of their cognitive development. It is argued by Trad (1993:405), that the adolescent's cognitive awareness may be such that unless an outcome is certain, the teenager will accept the risk. This implies that teenagers engage in sexual activities because they do not think about the possible consequences. The consequences are just abstract to them. This calls for an early introduction of sexuality education for teenagers, before their desire to be engaged in sexual activities, becomes uncontrollable. The adolescents need to be introduced to a process of choice selection with regard to their actions, that is, they have to be educated on the consequences of each sexual activity, for them to make informed choices. If efforts are not made timeously by all stakeholders, that is, parents; teachers; religious leaders; non-governmental organisations and health workers, most of the resources will be used for abortion services, which would open gaps in other spheres of service delivery. The social worker has a task of educating the adolescents through health education programmes, to prevent teenage pregnancy.

The other contributing factors, are seen by Black and DeBlassie (1985:282-284) as follows:

- **Societal influences**

According to Black and DeBlassie (1985:282) the changes regarding the morality of the society has an influence on how adolescents are behaving. They argue that the emerging values such as love, freedom, interpersonal honesty, open communication, self-actualisation, and short-term commitments are really playing an influential role. Children's

emancipation from parental authority occurs earlier due to outside influences. This can be observed in everyday life, where children are more resistant to parental control.

- **Personal attitude/needs**

Black and De Blassie (1985: 283) indicate that the total life situation of low-income youth, for example, tends to promote attitudes of fatalism and alienation which undermine the rational, planned use of contraceptive devices. Some girls become pregnant deliberately, with the hope of receiving more attention from the boyfriend. Sometime it may occur as a result of a girl's sexual bargaining as she tries to obtain a commitment of affection from her partner. It is unfortunate that in most cases, when the partner of an adolescent girl learns about the pregnancy, he disappears, leaving her without the commitment she was trying to get.

- **Ignorance/ Misunderstanding concerning sexual matters**

The largest number of teenagers who become pregnant each year do so through gross misunderstandings and ignorance of the menstrual cycle and conception. (Compare Black and DeBlassie, 1985: 283.) It is important to note that ignorance could lead a person to do things that he/she could not account for. In this case the adolescent girls find themselves with the unplanned pregnancies even before they could understand their own bodies. This calls for emphasis of primary prevention by providing information as early as possible, to equip them to deal with the changes and make informed decisions.

### **3.2.6.2 ARRIVING AT THE DECISION TO ABORT**

Once the teenager has realised that she is pregnant she is faced with deciding on what to do. If she decides to carry the pregnancy to term, she is then faced with another decision to make, that is, whether to raise the child or give it up for adoption. According to Stotland (1991:191), many adolescents decide to have their pregnancies terminated. This decision is difficult for the girl who has not yet completed her individuation and is thus not accustomed to making autonomous choices. The American Psychologist (1987:73), further indicates that adolescent's decision to terminate pregnancy is externally determined because in most cases parents are involved in helping to make the decision. The researcher supports this notion because in cases

where parents come to realise that their teenage girl, for whom they had great dreams for a successful life, is pregnant, they will definitely take a lead in having the pregnancy terminated. Sometimes this happens because parents are trying to avoid a scandal of having a teenage mother in their home. The decision in this instance, is mainly made by parents, without considering the teenager's input or emotions, in the whole process. The researcher is of the opinion that this situation could have devastating consequences on the teenager later in life, by the time she is capable of comprehending what actually happened to her. In most cases the teenager conforms for the sake of financial support from the parents.

On the other hand Evangelisti (2000:34) is of the opinion that adolescents are more likely to have an abortion if they are sufficiently informed about reproduction to recognise or acknowledge pregnancy within the period in which to have a safe abortion. This shows that information empowers a person to make decisions that he/she could live with.

It has also been indicated in the *American Psychologist* (1987:73) that adolescents are more likely to delay their decision to have the pregnancy terminated. This could be due to a variety of social factors, such as fear of familial consequences, lack of experience in contacting professionals to seek help, lack of money to pay for the service as well as concern about confidentiality. The issue of payment for the service cannot be seen as a factor that could delay the adolescent's decision to request abortion in South Africa, unless the service is requested at the private clinic. Women who request abortion at the state clinics/hospitals are provided with a free service as they are classified as pregnant, and all pregnant women are provided with a free service.

The other factor that influences the teenager's decision is the reason for becoming pregnant (Compare Stotland, 1991:192.) The teenager who become pregnant because of an impulsive and irresponsible behaviour, will find it very difficult or very easy to make a decision, depending on her circumstances. She will find herself experiencing a turmoil of feelings that will disturb her rational thinking towards the reality she is faced with. On the other hand, a teenager who become pregnant because she needed someone to love her, may initially rejoice. Things would change when she realises the responsibilities accompanying raising a child, and the decision to have the pregnancy terminated could be delayed.

It is further said by Franz and Reardon (1992:162), that there are two classes of decision-making problems that are faced by adolescents when they have to decide about their pregnancy. The two classes are intra-psychic and extra-psychic, whereby the intra-psychic problems are poor reality-testing, inability to project self into the future, massive denial, failure of the executive ego function as well as anxiety. The extra-psychic problems include inexperience in decision-making, unfamiliarity with pregnancy as well as peer- and parental pressures, regarding the outcome of the decision. This is in line with the factors that influence the adolescent's decision, which were discussed earlier on. The researcher is of the opinion that the adolescent needs to be assisted to deal with these problems effectively with the aim of reducing unpleasant reactions after the procedure.

From the above discussion it becomes evident that arriving at a decision by a pregnant teenager is not easy. There are a variety of factors that influence the process of decision-making. Social support and the maturity level of the teenager seem to be playing a major role in the decision-making process. The social worker's communication skills could facilitate the decision-making process and the teenager could be provided with unconditional and non-judgemental support.

### **3.2.6.3 THE IMPACT OF ABORTION ON ADOLESCENTS**

The impact of abortion on women has already been discussed in general, but the researcher finds it important to specifically look at the impact on adolescents. This was found to be appropriate because adolescents have unique circumstances as compared to the other population of women in general and the incidence of abortion amongst them is high. According to Trad (1993:400), adolescents, unlike their adult counterparts, are more likely to use abortion as a method of birth control, although this is a small percentage. This confirms the fact that adolescents have their unique problems and ways of addressing them.

Studies of the immediate after effect of abortion on young people have generally concluded that teenagers are not negatively affected as a group, and may even benefit from the procedure. However, there is always a subgroup within the sample which have problems (Compare Franz and Reardon, 1992:161.) This is in agreement with what was indicated by Trad (1993:400), that a small percentage of adolescents who have abortions

experience negative psychological outcomes. Furthermore Myburgh, Poggenpoel and Britz (1998:16) indicate that adolescents experience different dimensions of pain, including physical; psychological; spiritual and social pain. This clearly shows that adolescents do experience negative psychological outcomes after abortion. It is further indicated that adolescents may suffer guilt, anxiety and/or depression and attempt suicide, following abortion. (Compare Trad, 1993:400, Franz and Reardon, 1992:162 & Evangelisti, 2000:35 .) Trad (1993:400) goes further to say that from a psychological standpoint, abortion may be more difficult for teenagers than adult women. This suggests that teenagers need to be given a special consideration when they come for abortion, to minimise the negative consequences and reactions after the procedure. Various factors that contribute to these negative responses such as pre-existing psychiatric disorder; dogmatic religious beliefs; weak family support; ineffective coping skills and late gestational abortion, could be addressed through counselling. This is in agreement with Trad (1993:400) that these negative reactions may be substantially diminished if appropriate counselling is provided. The researcher believes that if the adolescents could be provided with proper pre-abortion counselling, most of the negative reactions would be eliminated.

### **3.3 COUNSELLING**

Proper counselling is necessary and ideal but not always available. It has already been indicated that there is no pre- and post-abortion counselling at the state abortion clinics in South Africa. This makes the abortion services provided by the state incomplete and may have negative consequences on the women who receive these services.

#### **3.3.1 COUNSELLING NEEDS**

Although the decision to have a pregnancy terminated is made by the woman who is faced with an unplanned and unwanted pregnancy, there is a need to provide her with counselling. This becomes important because an unplanned and unwanted pregnancy creates a crisis in the life of the woman.

According to Zakus and Wilday (1987:83), crisis intervention has to be readily available for the women who request termination of pregnancy. This indicates the importance of counselling as part of the abortion services, as women would be helped to face the crisis and also develop coping skills to



outgrow it. Crisis intervention would assist the woman to master the crisis and regain her psychological balance.

Counselling women with an unplanned and unwanted pregnancy should help the woman to ultimately feel that she has had an opportunity to explore her feelings and anxieties and to make an informed choice that will result in no long-term regrets (Compare Baird, et al. 1995:113.) They further argue that the counselling process with women about abortion is centred around three areas, namely, decision-making; information provision and emotional support. On the other hand Zakus and Wilday (1987:83) see the counselling process around an unwanted pregnancy as involving several different stages, which may overlap. They also found decision-making as the first stage, followed by working through the loss of the potential child; dealing with the painful procedure; alleviation of guilt and increasing the responsibility for contraception. The last stage is attending to the post-abortion emotional problems (Compare Zakus and Wilday, 1987: 83.) It becomes evident that counselling is very important prior to the decision-making process, so that the woman could be assisted to explore her feelings, be provided with the relevant information, for her to make an informed decision, that she would be able to live with, for the rest of her life. The above-mentioned aspects on counselling will be discussed briefly as follows:

### **3.3.2 DECISION-MAKING PERIOD**

It is argued by Baird, et al. (1995:113), that most women faced with an unplanned pregnancy, even if they had taken no precautions to prevent it, are surprised or shocked by discovering that they are pregnant. This factor makes counselling a very important aspect at the abortion clinic. Although the woman who approaches the clinic for abortion has already made her decision about her pregnancy, she still needs proper counselling, where all options will be discussed with her. Zakus and Wilday (1987:83), are in agreement with Baird, et al. (1995:113), that counselling should include both educational and therapeutic components, in order to facilitate the decision-making process. Counselling should be directed toward helping the patient perceive the situation realistically, initiate and improve communication with the significant others, express emotions and feelings openly and evaluate positives and negatives of each alternative. It is also argued by Zakus and Wilday (1987:83), that if this is done appropriately the woman would ultimately reach a decision that she could live with, in the future.

In the opinion of Baird, et al. (1995:113), making the decision may be more difficult for teenagers. Stotland (1991:192), agrees with this notion and further suggests that the adolescent should be encouraged to talk about her knowledge of the foetus as well as her fantasies about its development. She should also be encouraged to imagine her feelings about the foetus, as well as after the abortion. The researcher is of the opinion that this particular thinking will help the adolescent to be realistic about the situation and think about it in practical terms. The involvement of the parents would also help the adolescent where she will not be forced to keep her decision as a secret for the rest of her life, with devastating emotional consequences.

The researcher believes that if women who seek abortion service at the clinic could be provided with proper counselling, where all information is provided, not all would end up going through with the procedure. Those who were uncertain about their decision could end up considering other options, such as adoption, in an attempt to ease their consciences. For those who are still determined to go through with the procedure will be equipped on what to expect and how to deal with their feelings.

According to WHO (1995:74), counselling should be a part of all abortion care and it should be provided by non-judgemental, extremely sensitive and respectful persons. This could be achieved by having the public educated on the abortion services, to alleviate stigmatisation and labelling of the staff who provide the service. If the staff members providing the abortion service are not well accepted by the public, they will end up demoralised and unable to render a proper service. This was indicated on SABC 3 (2000) on Newshour programme, where the nursing staff at Kalafong Hospital indicated that they would rather leave the TOP Clinic and render a service where it will be appreciated. They also indicated that they are labelled by other nursing staff members as murderers, which forced them to decide to abandon the TOP Clinic. Proper counselling will only be done if the service providers are in a supportive environment. The social worker's role in this situation would be to launch awareness campaigns, to educate the public, including the professionals at the hospital, about the abortion services and the service providers. He/she could also provide support for the service providers at the clinic, to assist them to be more sensitive toward the patients.

### 3.3.3 WORKING THROUGH THE LOSS

Abortion is the loss of a potential child, therefore it is followed by mourning. Counselling should be directed toward supporting and strengthening the woman's positive coping skills in making the experience a maturational one. (Compare Zakus and Wilday, 1987.) The researcher believes that the woman would be best equipped to deal with this loss if it was clear to her, during the decision-making process that she was going to lose a potential child. This could only be accomplished through proper counselling. Accurate information and education may help the woman cope with the loss of her potential child.

The other losses that are faced by the woman who had termination of pregnancy are loss of self-image, loss of pregnancy, loss of motherhood and loss of relationship with the aborted child. These losses need to be dealt with, for the woman to be able to move on with her life. Without dealing with these losses the woman's life could be negatively affected.

According to Zakus and Wilday (1987:85), one of the most important factors in coping with this loss is support from the woman's significant others. The researcher agrees with this notion because support plays an important role in assisting a person to deal with a difficult situation. Support will also strengthen the woman to deal better with the loss of the potential child because she would be able to talk about it as well as her feelings, without any fear of being judged. This is supported by Baird, et al. (1995:117) that women who are provided with support usually feel less guilty, less depressed and less isolated. This confirms the fact that we are social beings and we need to belong and be supported, for us to thrive in this world.

### 3.3.4 POST-ABORTION COUNSELLING

While most women experience a huge sense of relief immediately after an unwanted pregnancy has been terminated, some experience emotional difficulties. As a result there is a need for post-abortion counselling. Zakus and Wilday (1987:86) argue that women who have worked through the decision to have an abortion still face ambivalence of medical personnel and of the society, resulting in negative responses. This is true that the attitude of the medical staff providing abortion service, coupled with the attitude of the members of the community towards abortion, may evoke negative reactions in women after the abortion procedure. Baird, et al. (1995:117)

indicate that it is estimated that in the USA 20% of women suffer from severe feelings of loss, grief and regret, after abortion. These feelings may progress to anger or depression and obsession, as it has already been said. For this reason, post-abortion counselling is a very important part of the abortion service. The researcher believes that post-abortion counselling will enable service providers to identify the intensity and the extent of emotional problems in women after abortion. Unlike currently, where the women are only seen when they come for abortion procedure and thereafter nobody cares to know how they cope or feel. Zakus and Wilday (1987:86-87) identified the following categories of women who may present with post-abortion problems and in need of counselling:

- Women who feel coerced into having an abortion by a significant other, such as husband, parents or boyfriend. Some may be forced by medical circumstances such as genetic defects identified in the foetus. In these circumstances women may decide to have an abortion just to comply with the wishes of someone else, that is, the decision is not from within. It may be very difficult for these women to live with this decision because they may feel that they had lost control of their lives.
- Women who place great emphasis on future fertility plans. These women were found to be expressing more neurotic reactions after abortion than women who did not want any children in future. This factor seems to be affecting adolescents more, by virtue of their age, at the time of the abortion.
- Women with pre-existing psychiatric problems. Women in this category may have a high degree of impairment from their psychopathology and a low degree of psychosocial support. As a result, the crisis of an abortion may exacerbate their pre-existing pathology, and this may lead to attempted suicide.
- Women who may be suffering from an unresolved grief reaction, such as a recent divorce, death of a loved one, at the time of the discovery of the unwanted pregnancy. These women are faced with a very difficult situation at the time when they are emotionally drained, as a result they are unable to handle it appropriately. These women may only be helped through counselling to develop the capacity to outgrow this painful experience.

- Women with a history of sexual abuse. Consciously or unconsciously these women may associate gynaecological and abortion procedures with previous aggressive violations. For these women there is a need to have them prepared for the procedure so that they could be able to deal with it. They also need to be helped to deal with the past and not confuse it with the procedure of termination of pregnancy.

It is important to have pre-abortion counselling so that these women who are at risk of experiencing trauma, based on their past experiences, to be identified and helped to deal with the problem at hand, before deciding on abortion or going through the procedure. Without pre-abortion counselling these women will not be identified, and this could have devastating emotional effects on their lives.

It is argued by WHO (1995:74) that it is important that women receiving abortion have an opportunity to discuss their health, feelings and personal situation with knowledgeable, sensitive and non-judgemental counsellors. On the other hand Zakus and Wilday (1995:87) argue that many of the post-abortion emotional difficulties are related to lack of counselling or inadequate counselling. This clearly indicates the important role played by counselling as an integral part of the abortion services.

The researcher is of the opinion that if counselling, that is, pre- and post-abortion, could be introduced at all the state abortion clinics, women would receive a comprehensive service. This will enable them to live at ease with their decisions, irrespective of the reasons that made them come to the abortion decision. The involvement of social workers at the abortion clinic is essential for the women who seek abortion to receive a comprehensive service. This would enable the women to best deal with the psychosocial implications that accompany termination of pregnancy.

### 3.4 SUMMARY

This chapter concentrated on the psychosocial aspects related to abortion on the woman. It is important to note that although abortion on request is the choice of the woman, it is accompanied by the psychosocial aspects. There are a variety of factors that result in unplanned and unwanted pregnancy. When women are faced with this unplanned and unwanted pregnancy they end up opting for abortion. Factors that led to this pregnancy have an

influence on how the decision to abort is reached, as well as the feelings after the abortion.

#### LEGAL ASPECTS OF ABORTION

The emotional reactions of women following abortion differ from one woman to the other. Most women experience relief immediately after abortion. This relief is short-lived in other women and lasts for longer periods in others, depending on various factors prior to the abortion. The literature review is not conclusive on the duration of the feeling of relief, as well as negative feelings after abortion. This result from the fact that women who have had abortion are not properly followed-up. There is a need for proper follow-up services for the women after abortion, to monitor their long-term feelings with regard to the procedure. This will enable the service providers to improve the service to be responsive to the needs of the women.

Adolescents experience abortion in a unique manner due to their cognitive development. They are at risk of developing emotional problems after abortion. As a result they need to be provided with a comprehensive abortion service, that include pre- and post-abortion counselling. This has been found to be giving adolescents a chance to experience abortion positively and be able to go on with life after abortion.

The social implications of abortion may be both negative and positive. On the positive side the woman would be relieved of the unplanned burden that could otherwise jeopardise her schooling, employment or increase her financial responsibilities. While on the negative side, the woman would be unable to resolve her feelings towards abortion, resulting in her isolating herself and being unable to form heterosexual relationships.

Counselling forms the important part of the abortion services, where the women need to be helped to make informed decisions, to work through their losses and to adjust to normal life, after the abortion. Social workers, as part of the team that has to render the abortion service, are equipped with the skills, knowledge and techniques to assist these women to deal effectively with their feelings. Social workers can also help these women to deal effectively with the defence mechanisms, resulting in their ability to take control of their lives.

The following chapter deals with the legal aspects of abortion.

## CHAPTER 4

### LEGAL ASPECTS OF ABORTION

#### 4.1 INTRODUCTION

Prior to 1996, abortion in South Africa was illegal. The decision to have a woman's pregnancy terminated was made by the medical team, primarily doctors on the basis of medical reasons. It was never thought of a woman deciding on whether she would like her pregnancy terminated or not. According to Pattinson (1996:191) the viability of a foetus is six months (26 weeks) after conception. It is important to note that nothing is being said about the viability in the new legislation. During that period, that is, prior to 1996, the abortion legislation with regard to viability in South Africa was seen to be liberal, as compared to WHO, which regarded viability to be attained at 20 weeks of gestation. Even though the viability cut off point was liberal in South Africa, abortion was only performed under restrictive laws.

The legislation of abortion in 1996 brought into being the abortion controversy in South Africa. This is confirmed by Van Rooyen (1998:295), that South African nation is involved in an enormously painful and intense struggle over legal abortion. In fact the legislation of abortion did not resolve the issue, but inflated the controversy. Due to the extreme end of the abortion debate, namely, the pro-life and pro-choice, the debate is never-ending. This was demonstrated by the comments that were made by Valerie Clarke on the programme of "Radio Pulpit" on 20/02/2001 called "Peak Time". She indicated that because God is the one who gives life, no one must take it. This was a clear statement of a pro-life person who is totally against abortion laws in South Africa. On the same programme mentioned above she interviewed a woman who chose not to go through with abortion after it was discovered that the foetus was deformed. Their arguments were based on the Christian principles. This clearly illustrates the point that, despite the liberalization of the abortion laws by the government, the population as a whole is not for the idea.

This is also a situation in other countries, as indicated by Githens and McBride Stetson (1996:1) that, since 1986 there has been evidence that

abortion law remains a hot issue in many countries, such as Ireland, Germany, Canada, Poland and the United States of America. This could be attributed to the fact that the decision has been taken over by the legal system of the countries, which leaves the opposing side of the population dissatisfied. This leads to continuous protest marches and media attacks on the ruling party by the opposing section of the population, which is not in favour of the decision.

On the other hand it could be said that the legislation of abortion has brought relief on women, especially that it gives them control over their bodies. It is also an attempt by the government to eradicate the complications of unsafe back-street abortions, which has devastating results on women.

In this chapter the focus will be on the international abortion policies with special reference to Canada, Netherlands, Israel, Ireland, Britain and USA; the South African abortion policies prior to 1996 and thereafter; the provisions of the Choice on Termination of Pregnancy Act (92/1996); and the comparison of the South African abortion legislation with the other countries.

## **4.2 THE INTERNATIONAL ABORTION POLICIES**

According to the United Nations (1993:2), the abortion policy of a country is the product of its social, political, economic and religious context in which it is embedded. More specifically, the nature of abortion laws and policies depend upon the legal system to which the country adheres, upon the interactions of that legal system with concurrent or prior legal system and upon the ways in which the laws are interpreted and enforced. This indicates that there is a particular context in which the abortion policy is formulated, depending on a number of factors.

The abortion policies of different countries will now be discussed briefly as follows:

### **4.2.1 UNITED STATES OF AMERICA**

When looking at the abortion legislation in the United States of America it becomes very important to first consider the historical developments, so as to have a better understanding of the current legislation



#### 4.2.1.1 HISTORICAL BACKGROUND

When dealing with the abortion policies in the USA it is important to consider how these policies developed up to this stage. It is indicated by Githens and McBride Stetson (1996:76-77) that, by the early twentieth century abortion was indicated in the criminal codes of all fifty states of the United States, and abortion to save the mother's life was the sole exception. The pressure to reform began in 1962, when a woman had to travel to Sweden to obtain an abortion for her deformed foetus. In 1965, the reformers used newspaper accounts of personal tragedies to bring the issue before the public, as a serious health problem. The national policy on abortion came into being in 1973, when the Supreme Court nullified all state abortion laws and affirmed the right of abortion during the first trimester, after the Roe v. Wade case.

This intensified the public debate on the abortion issue. Lewis (2000:2) is in agreement with this argument by indicating that the Supreme Court created a controversy in the American legal community and gave rise to the pro-choice and pro-life movements. This clearly indicates that any decision with regard to the abortion practice will trigger a controversy.

#### 4.2.1.2 LIMITATIONS AND RESTRICTIONS ON ABORTION PRACTICE

Whereas the abortion laws in America were changed to give the women a chance to decide about her life, there are some limitations and restrictions in the practice of abortion. According to the Medical Law (1998:124-128) the limitations and restrictions are as follows:

- Laws requiring parental consent or notification
- Limitations on government funding and the use of government facilities
- Laws requiring spousal or parental consent or notification
- Regulation of the consent process
- Regulation of medical techniques and facilities for use in performing abortion
- Record keeping requirements
- Access to reproductive medicine clinics

These limitations and restrictions will be discussed briefly as follows:

- **Laws requiring parental consent or notification**

The Medical Law (1998:124) indicates that the most common state statutory restriction on abortion in the USA is one that requires a minor wishing to have an abortion to notify and under some statutes, obtain the consent of one or both parents before abortion could be performed. The court has upheld the statutes that allow for the judicial consent when the pregnant minor can show that an abortion is in her best interest, or that she is mature enough to make the decision herself.

This is not the case with the South African abortion law, where the minor is not expected to notify and obtain consent of one or both parents before the abortion could be performed. In South Africa the minor is just advised to inform her parents, guardian, family members or friends of her intentions to have her pregnancy terminated. This does not mean that if the minor does not do as advised the termination of the pregnancy will be denied (Act 92/1996 section 5(3)). In the researcher's opinion the provision of this subsection of the act does not bring any difference with regard to having the parents of the minor involved in her request for a termination of pregnancy. This is confirmed by the provisions of Act (92/1996) section 5(2), where the only consent that is considered before the procedure of termination of pregnancy could be done, is that of the pregnant woman, including the minor. Although it would be difficult for the minor to request her parents to consent for her termination of pregnancy, the researcher is of the opinion that if it was a requirement from the act it could be done. This could assist the minor not to deal with this sensitive decision in isolation, which could have devastating emotional consequences for her later in life.

- **Laws requiring spousal or partner consent or notification.**

It is indicated in the Medical Law (1998:124) that the Supreme Court has refused to counteract any requirement that the pregnant woman's husband or father of the foetus, if not husband, consent to or even be notified of the woman's intention to have an abortion. This was found to be in contravention of the right of the woman to exercise her personal choices and have control over her body. In view of the high rate of women abuse in the world, the researcher found the provision of this law proper, because it

empowers the woman to be in control of her body, in cases where the pregnancy resulted from rape or the woman's subordinate role, regarding reproductive health of family planning in the patriarchal society.

- **Limitations on government funding and use of governmental facilities.**

The Medical Law (1998:125) indicates that the Supreme Court has been willing to accept any limitation that a federal or state agency wishes to impose upon the use of its funds or facilities to perform abortions. This was confirmed when the court upheld state medical plans that refused to cover non-therapeutic abortions as well as a city restriction on the performance of abortions at municipal hospitals in 1977. The abortions are only to be performed at state hospitals, when the aim is to save the woman's life. The provision of this legislation does not assist a poor woman who is faced by an unplanned pregnancy, as she would not be provided with the service at the state hospital, and on the other hand be unable to pay for the service at the private clinic.

Unlike in South Africa, where the state hospitals are designated to perform abortions, the abortion services at the USA seem to be meant for those who can afford to pay, only. Under these laws it could be said that the abortion laws in the USA are not accessible for the poor unless it is an emergency, aimed at saving the woman's life.

- **Regulations of the consent process.**

With regard to the consent process, the court ruled that the woman be provided with information as will be prescribed by the state, before she could consent to the abortion. The information may include the printed material, which describe the foetus and provide information on the medical assistance to women who choose childbirth, access to child support from the father and adoption and other alternatives to abortion. There has to be also a 24 hours waiting period before the abortion could be performed (Medical Law, 1998:125-127). In the researcher's opinion, the provision of these regulations was aimed at discouraging women from going ahead with their decision to have abortion.

- **Regulations of medical techniques and facilities for use in performing abortion.**

According to the Medical Law (1998:127-128) before 1992 the health of the pregnant woman made her interest in having an abortion subject to state regulation only after the first trimester, but now it is the concern of the state. The courts allow the statutory requirement that all the abortions be performed by the physicians rather than by other health professionals. The choice of the technique to be used in performing the abortion rests with the physician but the regulations will be revisited to uphold a certain standard. Although there are no fast rules on which technique to use in performing abortion in the USA, the researcher is of the opinion that there is a need for such regulations to be based on the gestation period, so as to ensure that the women's lives are not endangered.

- **Record keeping requirements.**

The court permits that the records on abortion should not reflect the identity of the woman as well as the reason why she did not inform her husband, but only the identity of the physician who performed the abortion (Medical Law, 1998:128). The provision of this regulation respects the confidentiality and privacy of the woman, which the researcher found to be treating the woman with dignity.

- **Access to Reproductive Medicine Clinics.**

The Congress promulgated the Freedom of Access to Clinic Entrance Act in 1994, after the clinics, which offered abortion services were targets for demonstrations and protests (Medical Law, 1998:128). This was necessary to protect the women who needed the abortion services in the USA. This situation indicates clearly that not every citizen is happy with the legislation of abortion and the women became targets of intimidation and harassment. The abortion legislation in the U.S.A. shows to be aimed at protecting the women and also giving them a choice regarding what to do when faced with an unwanted and unplanned pregnancy.

## 4.2.2 CANADA

The historical background of the Canadian abortion legislation is important to provide a better understanding of how the present legislation developed.

### 4.2.2.1 HISTORICAL BACKGROUND

According to Githens and McBride Stetson (1996:33), Canada changed its abortion laws in 1969, converting abortion from a crime under all circumstances to a crime only under some circumstances. The Canadian parliament enacted a statute that allowed abortions to preserve the life or health of the mother, but only if it is performed in a state hospital after a hospital committee of three doctors has agreed that the abortion would be necessary. This was the first step towards performing restrictive abortion laws, which could be seen positively by the women.

Despite the statute that restricted abortions to be performed at hospitals only, Dr. Morgentaler opened abortion clinics where he performed abortions. He was repeatedly arrested because of the pressure from the Catholic Church and he was tried in 1973, but acquitted. After the appeal from the province he was found guilty and sentenced for eighteen months imprisonment with three years probation to follow. His appeal did not yield the desired results and he had to serve the sentence. (Compare Githens & McBride Stetson, 1996:33-34.) This demonstrated the determination of the state to have the restrictions on the abortion practice, even if it was challenged.

After serving the sentence Dr. Morgentaler continued with his practice and was repeatedly arrested and acquitted until the Minister of Justice announced that the province would no longer enforce the abortion laws. With this victory Dr. Morgentaler took the campaign to other provinces, followed by arrests until 1988, when the Supreme Court declared the existing abortion statutes as unconstitutional. This move was influenced by the adoption of the Canadian Charter of Rights in 1982, which declared that “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principle of fundamental justice”. (Compare Githens & McBride Stetson, 1996:34) and Duhaime, Barrister & Solicitor, 2000:1.) This marked the liberalization of the abortion laws in Canada, with the prospect of having women facing unplanned and unwanted pregnancies having a chance to have abortion.

#### 4.2.2.2 LIMITATIONS AND RESTRICTIONS ON ABORTIONS

The Medical law (1999:97) indicates the following as the limitations and restrictions to the abortion laws in Canada:

- Limitations on governmental funding
- Regulation of medical technique and facilities for use in performing abortion
- Record keeping requirements
- Consent or notification requirements

These limitations and restrictions will be briefly discussed.

- **Limitations on governmental funding.**

The provision of the abortion laws in Canada states that all the abortions must be performed in approved hospitals and any doctor who performs or was likely to perform abortions outside a hospital was to have his/her licence suspended (Medical Law, 1999:98). The researcher is of the opinion that this law was used to control the practice of abortion and have it properly monitored. This could help in having a true indication of the problems that are encountered in abortion practice and lead to proper improvements.

- **Regulation of medical technique and facilities for use in performing abortion.**

It is indicated by the Medical Law (1999:99) that the federal government does regulate drugs manufactured in Canada, including abortifacients. All drugs that are not licensed to be used as abortifacients are not to be prescribed. On the other hand all abortion clinics are regulated and operate with guidelines formulated by the College of Physicians and Surgeons. One of the regulations is that the abortion clinics must offer pre- and post-counselling, and have emergency counseling available at all hours. The researcher found this regulation to be beneficial for the women who opt for abortion at these clinics because they receive a comprehensive service. If the drugs are regulated as well as mandatory counseling is offered, then the women will experience the abortion procedure positively and they will be able to live with their decision.

- **Record keeping requirements.**

According to the Medical law (1999:100) the Canadian courts has not been asked to rule on particular record keeping requirements for abortion facilities. There is no federal or provincial legislation as well, except for the guidelines provided by the College of Physicians and Surgeons. This implies that there are no strict rules on how the records are to be kept, which could lead to the women's identity being revealed. This could also lead to them (the women) being victimized or stigmatized by those people who are totally against abortion.

- **Consent or notification requirements.**

It is indicated in the Medical Law (1999:100-101) that the requirements for consent to abortion are the same as for any therapeutic procedure. Parental consent is required only when the minor is immature and lacks insight of what is about to happen to her. There is no consent required from the woman's husband, as this is seen as an infringement of the woman's rights and freedom. This regulation is in line with the provision of the South African abortion law, namely, Choice on Termination of Pregnancy Act (92/1996), which requires only the pregnant woman's consent before the abortion procedure could be done.

The abortion practice in Canada is done under strict regulations. The researcher is of the opinion that these regulations are important to have, so that the abortion practice could be done in an accountable manner. The government's limited funding for the abortion services is important to make the women take responsibility for their actions and also to avoid a situation where abortion would be used as a means of family planning. It is also important for the government to have control over the drugs that are used, so that no person could end up using these drugs for his/her own selfish reasons. It is very important to have the woman being the only one taken into consideration, as this would help the woman to deal with her decision, unlike when she has been forced to seek abortion.

### 4.2.3 NETHERLANDS

According to the United Nations (1993:166) induced abortion was classified as a capital offence under the Penal Code of the Netherlands of 1886. In 1911 the abortion law was amended to make induced abortion a crime against life and public morality. Abortion was illegal in all circumstances except when performed to save the life of the mother. All efforts which were made, to liberalize the abortion laws during 1970's were unsuccessful. This indicates that the Netherlands government was not keen to liberalize the abortion law for a long period. The abortion controversy seems to have been very strong on the pro-life side, which put pressure on the government not to liberalize the abortion laws. The Bill on the liberalization of abortion laws was passed in 1980 without any events that could have been seen to have influenced that move. (Compare United Nations, 1993:166 & Medical Law, 1995:85.) There are principles stipulated for the practice of termination of pregnancy. The abortion is permitted on request, up to 13 weeks and after this gestation period the woman must attest to a state of distress before abortion could be permitted.

The procedure must be performed only in a licenced clinic or hospital by a doctor. After 13 weeks abortion may only be performed in medical centers complying with special medical and nursing requirements. The doctor must ascertain that the woman's decision was made voluntarily and after the procedure, she must be provided with sufficient aftercare service, which includes education on how to prevent an unwanted pregnancy. Between the day of first consultation and the day of the procedure, there must be a period of at least five days. This waiting period is meant to give the woman a chance to reconsider her decision, but this period may be waived if the woman's life is threatened.

The researcher is of the opinion that the principle of having the doctor ascertaining first that the woman made the decision voluntarily is important. This enables the woman to face and deal with her own decision during the counseling process, which is provided during the waiting period. This principle alleviates a situation where the woman is coerced to terminate the pregnancy by her husband, partner or parents. This principle gives the woman control over her body. The abortion law in the Netherlands seems to be aimed at protecting the woman who opts for termination of pregnancy when faced with an unwanted pregnancy.



#### 4.2.4 ISRAEL

It is indicated in the United Nations (1993:72) that before 1952 abortion was not permissible, except on medical grounds. Before this period a woman who induced her own abortion was liable for imprisonment for seven years, while the person who performed an illegal abortion could be imprisoned for fourteen years. The grounds on which abortion could be performed were extended in 1977. Abortion could be performed if the continuation of the pregnancy could endanger the woman's life. Abortion was also permitted if the pregnancy resulted from rape, incest, and extra-marital sexual intercourse or if the foetus is suspected to have a physical or mental malformation. The law further stipulates that even where official approval of the abortion has been given, such approval cannot compel a gynaecologist to terminate a woman's pregnancy if it is against his conscience or professional judgement. (Compare Medical Law, 2000:119.) This provision is the same as in the South African abortion legislation, Choice on Termination of Pregnancy Act (92/1996), that does not compel the medical practitioner or the registered midwife to perform abortion if it is against his/her conscience or religious belief. The difference is that in South Africa this particular practitioner or midwife is compelled to refer the woman to another setting where the abortion service is available.

The abortion legislation further stipulates that the approval of a three-member committee consisting of a social worker and two physicians, one of whom must be an obstetrician/gynaecologist and one of them being a woman. (Compare United Nations, 1993:72 & Medical Law, 2000:120.) This provision seems to be sensitive to the needs of women who request abortion and also to their psychosocial needs, which are taken into consideration by the social worker who serves on the committee. The researcher is of the opinion that it would best serve the women who request abortion in South Africa, if their psychosocial needs were considered prior to the abortion procedure. There is a need to have social workers involved in the abortion services as team members, especially that there is no provision in the act for the medical committee that has to approve the abortion requests.

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recommendation was stretched to suggest that the community should consider whether abortion should be legalized for social and economic reasons. The abortion law was liberalized after the court ruling in the case of a 14 years old girl, who was raped by soldiers, where she was granted permission to have abortion because her life and health were endangered by the continued pregnancy. This was the turning point in the restrictive abortion legislation in England, with the emphasis being on the woman's health.

In 1951 the abortion issue was revived by the Pope, when he repeated the Catholic Church's traditional objection to birth control, and adding that abortion was never justified, not even to save the life of the woman. (Compare Simms, 1994:33.) This was badly received and was followed by the activities that were geared towards reforming the abortion law, of which the thalidomide tragedy played a significant role. Pregnant women were in danger of giving birth to deformed children after using thalidomide and they were denied abortion. This fuelled the abortion debate, which moved from the health arena to the public arena. These developments confirmed the need to have the abortion legislation liberalized.

Simms (1994:33) further indicates that the publication in the London newspaper, the Daily Mail in 1962, which indicated that 73 percent of the public was in favour of abortion where a child might be born deformed, stirred the abortion debate further. This move confirmed the pressure to have the abortion legislation liberalized in Britain and the first abortion bill was introduced to the House of Lords in 1965. This bill was reintroduced in 1966, after its discussion was disturbed by the general election. The bill was opposed by the right-wing Conservative MPs and Roman Catholic MPs of all parties but won the majority vote. The bill was then passed in October 1967. It is evident that the public pressure to have abortion legislation liberalized played an important role in Great Britain.

#### **4.2.6.2 THE CURRENT ABORTION LAW AND PRACTICE**

According to Mason (1987:4), the Abortion Act of 1967 was passed against the background of mounting public disquiet at the prevalence of illegal abortions together with the concern for the care of large numbers of unwanted children. This is in agreement with what is indicated by Terry (1987:76) that prior to the passing of the Abortion Act of 1967, 100 000

illegal abortions were performed in Britain each year, and this act led to a significant decline in the number of illegal abortions and their physical complications. This act brought about relieve, for the women who were faced by unwanted and unplanned pregnancies, as they were able to obtain safe and legal abortion.

According to Terry (1987:79) and Mason (1987:4), the core provisions of the Act of 1967 are as follows:

- (a) Subject to the provisions of this section, a person shall not be guilty of an offence related to abortion when the pregnancy is terminated by a registered medical practitioner, if two registered medical practitioners are of the opinion, formed in good faith-
  - (i) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy was terminated; or
  - (ii) that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Furthermore, there were three constraints that were introduced in the practice of abortion with this act, namely:

- All abortions had to be notified to the chief medical officer at the Department of health
- Not one, but two doctors had to agree to the abortion and sign the necessary documents
- The abortion had to be carried out in a National Health Service hospital or a private clinic approved by the minister. (Compare Simms, 1994:37.)

It is important to note that the regulations of the act were not welcomed by everybody, which resulted in the continued abortion controversy. It is evident from the provisions of section (1) that abortion was only justified through specific reasons. This implies that every woman who requested abortion would be provided with that service. The decision to have the pregnancy terminated was not made by the pregnant woman, but by the registered medical practitioners. This is unlike in South Africa, where the woman's decision is the only thing considered , before a pregnancy could be

terminated. Of importance again is the fact that nothing is mentioned concerning counseling, as part of the abortion service. The researcher is of the opinion that women would fully benefit from the abortion service if counseling forms part of the service.

### **4.3 THE SOUTH AFRICAN ABORTION LEGISLATION**

After looking at the international abortion legislation it becomes relevant to now look at the South African abortion legislation, beginning with the historical background.

#### **4.3.1 THE HISTORICAL BACKGROUND**

It is indicated by Van Oosten and Ferreira (1988:416) that prior to 1975 the South African abortion law was governed by the Roman-Dutch common law. Abortion was illegal and a criminal offence, except when the life of the woman was endangered by the continuation of the pregnancy. In 1975 the Abortion and Sterilization Act (2/1975) came into operation, after extensive investigations and lengthy debates in parliament. The act was designed to legalize therapeutic abortion that had been long practiced.

The Abortion and Sterilization Act (2/1975) stipulates that, for abortion to qualify as lawful, there has to be specific circumstances. These circumstances as summarized by Clarke & Van Heerden (in Van Rooyen, 1998:276) are:

- Where continued pregnancy was seen to endanger or constitute a threat to the life of the pregnant woman
- If the pregnant woman's mental health would be permanently damaged by the continued pregnancy
- If a serious risk existed that would result in the child in utero suffering from a mental or physical defect that would result in the child being irreparably and seriously handicapped
- If a woman had been raped, provided that the rape had been reported to the police and where, after investigation, a magistrate is convinced that the pregnancy was a result of the rape
- Where the pregnancy is the result of illegitimate carnal intercourse with a woman who, due to a permanent mental handicap or defect, was unable to comprehend the consequential implications of or bear the parental responsibility for the fruit of coitus.

The above stipulations clearly indicate that not every woman could qualify for abortion prior to 1997, as strict considerations were made based on the country's policies.

The Abortion and Sterilization Act (2/1975) also stipulated who should perform the abortion, as well as who should be involved in the decisions and recommendations regarding abortion. This clearly indicates how restrictive the abortion law in South Africa was. Not every woman could decide on having abortion and have the service. The decision was solely made by the medical practitioners, based on the provisions of the Act (2/1975), without taking the woman's decision and circumstances into consideration. The social workers were only involved in doing assessment on the women and providing recommendations to the medical practitioners, but the final decision was made by the medical practitioners. In the researcher's opinion, it is the restrictive abortion laws that contributed to a large extent, to the unlawful and unsafe abortion practice in the country, where many women paid with their lives. This is confirmed by Van Rooyen (1998:296), that in a country where the law is kept within the formal health sector, back-street abortions were bound to flourish, with a negative bearing on the health resources of the country.

It becomes very clear from the Abortion and Sterilization Act (2/1975) that the government was totally against abortion, except when the woman's life was endangered. The woman did not have any say with regard to the decision, as the act clearly stipulated that the decision had to be made by medical practitioners. This disempowered the women and made them the passive recipients of the abortion service that was not responsive to their needs.

#### **4.3.2 THE INCIDENCE OF ABORTION PRIOR TO 1997**

It is important to note that even though the abortion laws were restrictive, prior to the Choice on Termination of Pregnancy Act (92/1996), there were abortions performed on women. According to Van Oosten & Ferreira (1988:418) the total number of the legal abortions on women of any age and for all ethnic groups performed in 1976 were 625, 539 in 1977, 541 in 1978, 423 in 1979, 347 in 1980, 381 in 1981 and 464 in 1982. of the abortions performed during each three consecutive years, 1983-85, an average of 40 percent were performed on unmarried women, 52 percent on married women

and 8 percent on divorced or widowed women. Four-fifths of the abortions performed during each of the same three years were performed on white women, 3 percent on Asian women, 4 percent on black women and 13 percent on coloured women.

It is important to note that the majority of women who had undergone legal abortion during the era of the Abortion and Sterilization Act (2/1975) were white and a very small percentage were the other racial groups combined. The fact that more white women had access to the abortion service, as compared to the other racial groups could be attributed to the uneven distribution of resources in the country during that period, which were based on the principle of inequality. This could also be attributed to the ignorance of the non-white women, specifically the black women, who constitute a large number of illiterate persons in the country.

It is indicated by Van Oosten and Ferreira (1988:419) that an estimate of 200 000 illegal abortions a year in South Africa has been cited. The admissions in gynaecological wards at major hospitals indicated that many of the admissions were for illegal abortions that resulted in medical complications. Ninety percent of the operations in these wards indicated to be as a result of back-street abortions, where the residues of a pregnancy were removed. For the period of three consecutive years, 1983-85, 95 000 operations for the removal of the residues of a pregnancy, were performed. The average percentage of the total number of these operations on women of the four ethnic groups was: twenty-one percent whites; thirteen percent coloureds; six percent Asians and sixty percent blacks. These statistics clearly show that black women opted for back-street abortions more than any other ethnic groups in the country. This could be attributed to the unequal distribution of services that prevailed during that political era, which had a negative impact on the black women.

The above-mentioned statistics indicate that even if there were restrictive abortion laws in the country, many women opted for abortion, when they were faced with unplanned and unwanted pregnancies. According to Van Oosten & Ferreira (1988:420), this state of affairs made medical practitioners realize the necessity to have the abortion law reviewed. The other reasons being the high mortality rate, permanent infertility and a drain on the medical resources, including funds. When looking at the statistics of illegal abortions that were performed in the country, that resulted in

complications, it becomes evident that the funds were spent on the service that could have been prevented.

### **4.3.3 MOVES TOWARDS CHANGE**

It was during 1990 that the Department of National Health and Population Development recognized the need to reconsider legislation regarding abortion. (Compare Van Rooyen, 1998:297.) Interested parties were called to make representation for possible changes to the existing legislation. This indicates that it was no longer possible to uphold the restrictive abortion laws, which resulted in unacceptable numbers of back-street abortions. With the advent of democracy in 1994, a strong culture of rights became evident. The input from the general public into the issues related to the constitution stirred the abortion controversy, because the emphasis was on the freedom of choice. Van Rooyen (1998:297) is of the opinion that after the Termination of Pregnancy Bill (80/1996) was published, much heated discussion and debate ensued. This Bill marked a major move from the restrictive abortion legislation, where the rights of women were recognized for the first time. The Bill was followed by the Choice on Termination of Pregnancy Act (92/1996), which is the law that regulates abortion practice in South Africa.

The preamble of the act states that the Act repeals the restrictive and inaccessible provisions of the previous act; and promotes reproductive rights and extends freedom of choice; by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy, according to her individual beliefs (act 92/1996). This act recognizes the woman's right to choose and provides her with a choice over what she would like to happen with her own body.

### **4.3.4 THE CURRENT ABORTION LEGISLATION**

The dawn of the democratic era in South Africa was accompanied by a recognition of human rights, including women's rights. The rights of women to choose whether they wanted to have abortion was also recognized, followed by the Choice on Termination of Pregnancy Act (92/1996). Van Oosten (1999:62) is of the opinion that the Act (92/1996) affords every woman freedom of choice to have an early, safe and legal termination of an unwanted and unplanned pregnancy, according to her beliefs. The



without the medical practitioner or a registered midwife taking a leading role. After the 13<sup>th</sup> week the medical practitioner has to consult with the pregnant woman, but the exact role that he/she is playing here is not clear. After the 20<sup>th</sup> week of gestation, the medical practitioner consults with another medical practitioner or a registered midwife, and the pregnant woman is not consulted.

It would seem that after the 20<sup>th</sup> week of gestation the decision lies with the medical staff and no longer with the pregnant woman. This is confirmed by Van Oosten (1999:68) when he indicates that “it would appear that the decisive factor in determining whether or not the continued pregnancy would pose a risk of injury to the woman’s physical or mental health...; will be a matter of clinical judgement rather than consultation with the pregnant woman.” This seems to be removing all the decisive power from the woman. The researcher is of the opinion that this provision is aimed at protecting the pregnant woman.

Section 2(2) provides that the termination of a pregnancy may only be carried out by a medical practitioner, except for the termination of a pregnancy during the first twelve weeks, which may also be carried out by a registered midwife, who has completed the prescribed training course. This condition is aimed at protecting the woman against unsafe procedure and it is for the pregnant woman to request abortion at the institutions that are designated to perform abortions, to ensure that they receive an appropriate service.

The researcher has observed that in practice this provision is not completely observed as stipulated. For example, at GaRankuwa hospital, near Pretoria, second trimester abortions are performed by the registered midwife and not the medical practitioner. The reason behind this situation is not known but could be attributed to the shortage of experienced medical staff in the country or to the medical practitioners’ ethical choice not to be involved in termination of pregnancy but rather to preserve life.

- **PLACE WHERE SURGICAL TERMINATION OF PREGNANCY MAY TAKE PLACE**

Section 3 of the Act (92/1996) stipulates the following:

at GaRankuwa hospital where only one registered midwife is responsible for the clinic. Under these circumstances it is impossible to expect a comprehensive abortion service to be rendered.

It is unfortunate that the designated clinics/hospitals are not well equipped with the necessary personnel to see to it that a comprehensive service is provided to the women who come for abortion. The researcher is of the opinion that the abortion service that is provided to the women at the state hospitals/clinics is more mechanical, because of the lack of the mandatory counseling, that is, before and after the procedure. This could lead to a society of women with emotional disturbances in future, especially that the majority of the women receive the abortion service at the state facilities, due to lack of money to pay at the private facilities. This could have devastating results on the society as a whole, because of the important role that is played by women.

If the social worker could be part of the team that render the abortion service at the state hospital/clinics, the women who come for abortion would benefit. The social worker would provide pre- and post-abortion counseling which the researcher see as crucial in the rendering of abortion service.

- **CONSENT**

The provisions of section 5 are as follows:

- (1) The termination of a pregnancy may only take place with the informed consent of the pregnant woman
- (2) No consent other than that of the pregnant woman is required for the termination of a pregnancy
- (3) A medical practitioner or a registered midwife has to advise a minor to consult with her parents, guardian, family member or friends; before the termination of her pregnancy; but the termination of the pregnancy should not be denied because the minor chooses not to consult. This provision raises some questions because under no circumstances does a minor have to consent for her medical treatment, especially surgical procedures, where her parents has to consent. With abortion it is only her consent that is considered. One would wonder what would happen in the case if the procedure for the termination of the pregnancy would require some administration of an anaesthetic. This argument is also raised by

Van Oosten (1999:67) that whether a pregnant girl under the age of eighteen years is legally capable of giving consent to an anaesthetic, should a need arise, during the procedure of termination of pregnancy, is open to debate.

This indicates that not everybody is convinced that a pregnant minor is capable of giving consent to her termination of pregnancy. The reason being that the person under eighteen years is still regarded as a child, according to the Child Care Act (74/1983). To make the situation more complex is that the minor in-question here is facing an unplanned and unexpected pregnancy, which is assumed to be emotionally traumatic, for any woman. The pregnant minor who does not choose to tell anybody about her intentions of having her pregnancy terminated, will live with this burden for the rest of her life. This could lead to the minor experiencing emotional turmoil later in life, specifically as the counseling service is lacking at the state abortion facilities.

The pregnant woman who is severely mentally retarded or in a state of continuous unconsciousness has to have a consent for the termination of her pregnancy given by her natural guardian, spouse, legal guardian or *curator personae*. This consent will only be considered unless two medical practitioners or a medical practitioner and a registered midwife consent thereto. This provision does not clarify the exact role of the medical practitioner and the registered midwife here, whether they are to confirm the woman's mental state or her state of consciousness, or to confirm the woman's period of gestation. The researcher is of the opinion that the consent of the woman's natural guardian, spouse, legal guardian or *curator personae* would be sufficient for the pregnancy to be terminated, without involving the medical practitioner or a registered midwife.

(4) In a situation where two medical practitioners and a midwife are of the opinion that:

- During the period up to and including the 20<sup>th</sup> week of the gestation period of a pregnant woman who is severely mentally disabled or who is in a state of continuous unconsciousness, the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality; or
- After the 20<sup>th</sup> week of the gestation period of a pregnant woman who is severely mentally disabled or who is in a state of continuous

unconsciousness, the continued pregnancy would endanger the woman's life; would result in a severe malformation of the foetus or would pose a risk of injury to the foetus; the two medical practitioners and the registered midwife have the authority to consent for the termination of the pregnancy of the woman described above.

This provision further indicates that this consent may be done after consultation with the natural guardian, spouse, legal guardian or *curator personae* of the said woman. It is not clear whether this consultation is aimed at having the natural guardian, spouse, legal guardian or *curator personae*, as the case may be, also consenting or approving the consent. It would seem that in this provision the two medical practitioners and the registered midwife has the final say with regard to the consent. This is confirmed by the last statement that indicates that the termination of pregnancy shall not be denied if the natural guardian, spouse, legal guardian or *curator personae*, as the case may be, refuses to consent. This provision shifts the decision from the incapacitated woman's guardian, spouse, legal guardian or *curator personae*, to the medical personnel.

#### • INFORMATION CONCERNING TERMINATION OF PREGNANCY

The provision of section (6) states that a woman who in terms of section 2 (1) requests termination of pregnancy from a medical practitioner or a registered midwife, as the case may be, shall be informed of her rights under this act, by the person concerned. As it has already been indicated earlier in this chapter, there is a considerable shortage of personnel at the state clinics/hospitals, which makes it difficult to fully provide the women with the necessary information. The situation is in such a way that the personnel at the TOP Clinic are only able to provide the women with termination of pregnancy, and nothing more. This was observed at Kalafong Hospital, where at some point there was only one registered midwife to run the clinic for the day. Under these circumstances it won't be possible for this registered midwife to provide individual attention to each woman who request termination of pregnancy. This put the women who request termination of pregnancy at such facilities at risk of receiving an incomplete service.

## • REGULATIONS

Section (9) of the Act (92/1996) indicates that the Minister of Health may make regulations relating to any matter which he/she may consider necessary or expedient to prescribe for achieving the objects of this act. For this provision to be implemented to the benefit of the women who request termination of pregnancy, it is important for the minister to see to it that a comprehensive service is rendered. This would be achieved by making regulations that would fill the gaps that have been discussed earlier, for example, having a mandatory pre- and post-abortion counseling for all women who come for termination of pregnancy at the state clinic/hospital; by providing the necessary resources. Regulations that would make this service user-friendly, for the women not to hesitate to seek the service, immediately when they are faced with unplanned and unwanted pregnancies are needed. If this could be achieved, second trimester termination of pregnancy would be eliminated, together with all the complications that accompany it. In establishing such regulations there is a need to have the needs of the women in mind and engage in extensive consultation with all the stakeholders, including the women.

## 4.4 SUMMARY

The abortion controversy all over the world is a never-ending debate because of the extreme ends of the continuum, namely, the pro-life and the pro-choice. In all the countries it is evident that not everybody will be satisfied with the abortion laws in a given country at a given time. Many countries had restrictive abortion laws until a certain section of the population pressurized the government to revise them. This pressure led to the abortion legislation in different countries revised to address the needs of the women to have legal abortion. In many countries the abortion legislation is accompanied by the regulations that stipulate how the procedure should be done. This is seen positively as a means to protect the women who find themselves in need of the abortion service.

Abortion in South Africa, like in other countries, was illegal for quite a considerable period, until the state could no longer bear to witness the high percentage of women losing their lives due to unsafe abortions. Until February 1997, abortion by choice in South Africa was illegal, that is, prior to the Choice on Termination of Pregnancy Act (92/1996). Prior to this era

the decision to terminate a pregnancy was solely in the hands of the medical personnel. With the legalization of abortion not everybody is satisfied, which makes the abortion controversy a never-ending debate, like in other countries all over the world.

Although abortion was illegal in South Africa prior to February 1997, it was practiced. A large percentage of women who were receiving the service came from the white population and the blacks did not have access to the service. This led to a large percentage of black women opting for illegal and unsafe abortions. This is attributed to the laws of the country during that period, which were based on unequal distribution of resources to different racial groups.

The dawn of the democratic era in South Africa gave birth to a variety of rights and the women's right to choose is included. This was confirmed by the Choice on Termination of Pregnancy Act (92/1996), which recognizes the woman's right to choose whether to have an unplanned child or to have the pregnancy terminated.

There are a number of loopholes with regard to the Choice on Termination of Pregnancy Act (92/1996), which put the women, as the consumer of the service, at a disadvantage. There is still a need to have the service coordinated and made responsive to the needs of the women. This could be achieved by providing a mandatory pre- and post-abortion counseling, as part of the abortion service, to assist the women to live with the decision, irrespective of the reasons that led to their opting for abortion.

The issue of consent in the Choice on Termination of Pregnancy Act (92/1996), also raises concern, especially with regard to the minor's consent and the informed consent. This is not unique to South African abortion legislation. In other countries, like Israel, the minor is expected to give informed consent before an abortion procedure could be performed. Unlike in South Africa, the law in Israel stipulates that before the abortion procedure is done, the woman has to be provided with all the necessary information pertaining to the abortion procedure. Due to lack of human resources at the state abortion facilities informed consent cannot be a reality. Therefore there is a need to have the state abortion facilities well staffed with appropriate personnel, to provide this information, for informed consent to be realized.

CHAPTER 5

With regard to the minors who request termination of pregnancy it is their sole consent that is required. Although they are advised to talk to someone they trust, this does not happen and could lead to a situation where the society in the near future is concentrated with adult women having emotional problems, because of the unresolved issues in their lives.

Unlike in Israel, where the social worker is serving in the abortion committee, in South Africa, the act does not say anything regarding the role of the social worker at the TOP Clinic. This results in the psychosocial aspects of the women who request termination of pregnancy at the state abortion facilities not taken into consideration. There is a need to have the social workers form part of the team that provides the abortion service at the state clinics/hospitals, so that the women could be provided with a service that is responsive to their needs.

The state abortion clinics/hospitals are not well-resourced, and this deprives women who request termination of pregnancy at these facilities an opportunity of getting the necessary information pertaining to abortion, as stipulated in the Act (92/1996).

There is need for the Minister of Health to establish regulations that would ensure that the abortion service in the country is comprehensive and responsive to the needs of the women.

The following chapter will deal with the quantitative empirical findings.

### 3. RESEARCH FINDINGS

## CHAPTER 5

### EMPIRICAL FINDINGS FROM THE QUANTITATIVE PHASE OF THE STUDY

#### 5.1 INTRODUCTION

In this chapter the research methodology is firstly described briefly, before the quantitative empirical findings are presented according to the subsections of the questionnaire. The aim of this phase of the study is to establish the psychosocial aspects related to termination of pregnancy on the women before the procedure, so that the service could be geared towards meeting their needs. The chapter consists of the brief discussion of the research methodology, the research findings, which are presented according to the subsections in the questionnaire, namely, the biographical data; abortion choice; the psychosocial aspects; abortion service; future plans and the need for social work service at the TOP Clinic.

#### 5.2 RESEARCH METHODOLOGY

The type of research used was applied research, while the research design was exploratory-descriptive. Both qualitative and quantitative research approaches were used in this study. In this chapter only the empirical findings from the quantitative approach will be presented.

The total population consisted of all the women who requested termination of pregnancy at Kalafong Hospital (TOP Clinic) between November 1998 and January 1999. A sample of eighty (80) respondents was drawn from the population using the availability sampling technique from the non-probability sampling method. Questionnaires were completed on a one-to-one basis with each respondent, by the researcher. The questionnaire is attached as Appendix 2 of this thesis.

#### 5.3 RESEARCH FINDINGS

The data that was collected by means of questionnaires will be presented and interpreted. The most important findings are presented graphically.

The findings from figure 1 are as follows:

- 45 respondents (56.2%) were between ages 21-30.
- 23 respondents (28.8%) were between ages 31-40.



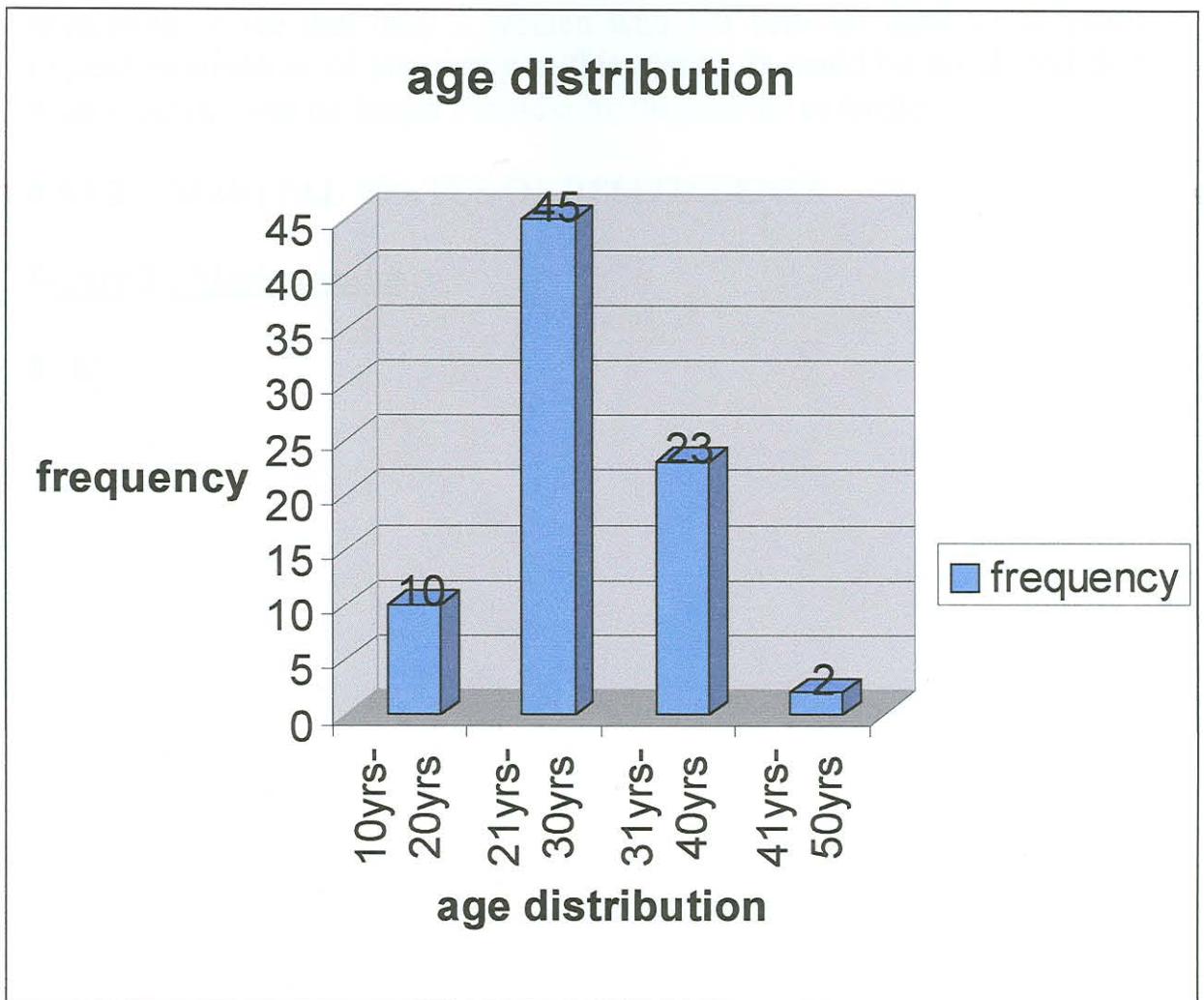
### 5.3.1 BIOGRAPHICAL DATA

This subsection was used to collect personal information from the respondents, for a better understanding of their circumstances.

#### 5.3.1.1 AGE

**Figure 1 : Age distribution**

n=80



The findings from figure 1 are as follows:

- 45 respondents (56.2%) were between ages 21-30
- 23 respondents (28.8%) were between ages 31-40

- 10 respondents (12.5%) were between 10-20
- 2 respondents were between ages 41-50

It is evident from the above information that the majority of women who request termination of pregnancy at Kalafong TOP Clinic fall between age 21-30 years, followed by those falling between ages 31-40 years. There is also a considerable number of women between ages 10-20 years, who request termination of pregnancy at this clinic and this is a cause for concern, because they are still young to be pregnant. This calls for early intervention, where the young women could be provided with information regarding sexuality and how to take responsibility for their bodies. It is also interesting to see that only 2 women who fall between ages 40-50 years request termination of pregnancy at this clinic. It could be concluded that these women were no longer considering themselves as fertile.

### 5.3.1.2 MARITAL STATUS OF RESPONDENTS

**Figure 2 : Marital status**

n=80

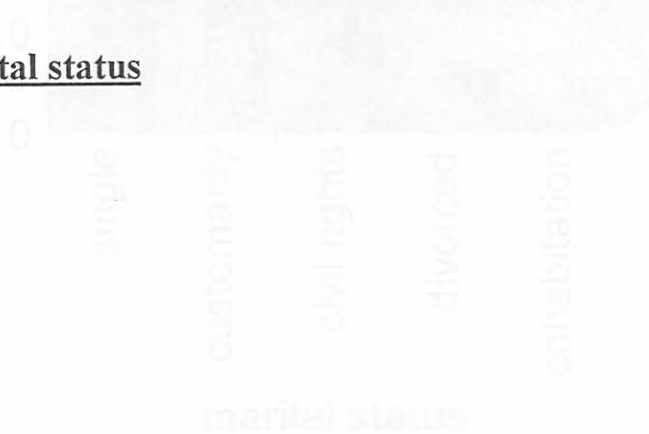


Figure 2 shows that

- 52 respondents (65.8%) were single
- 14 respondents (17.7%) were customarily married
- 8 respondents (10.0%) were married by civil rights
- 4 respondents (5.1%) were divorced
- 1 respondent (1.3%) was staying in cohabitation

Of interest is that most of the women (65.8%) were single, which could aggravate the manner in which they could experience termination of pregnancy, as they have no form of support. This could be made worse by the lack of counselling at the TOP clinic, particularly that this is a most

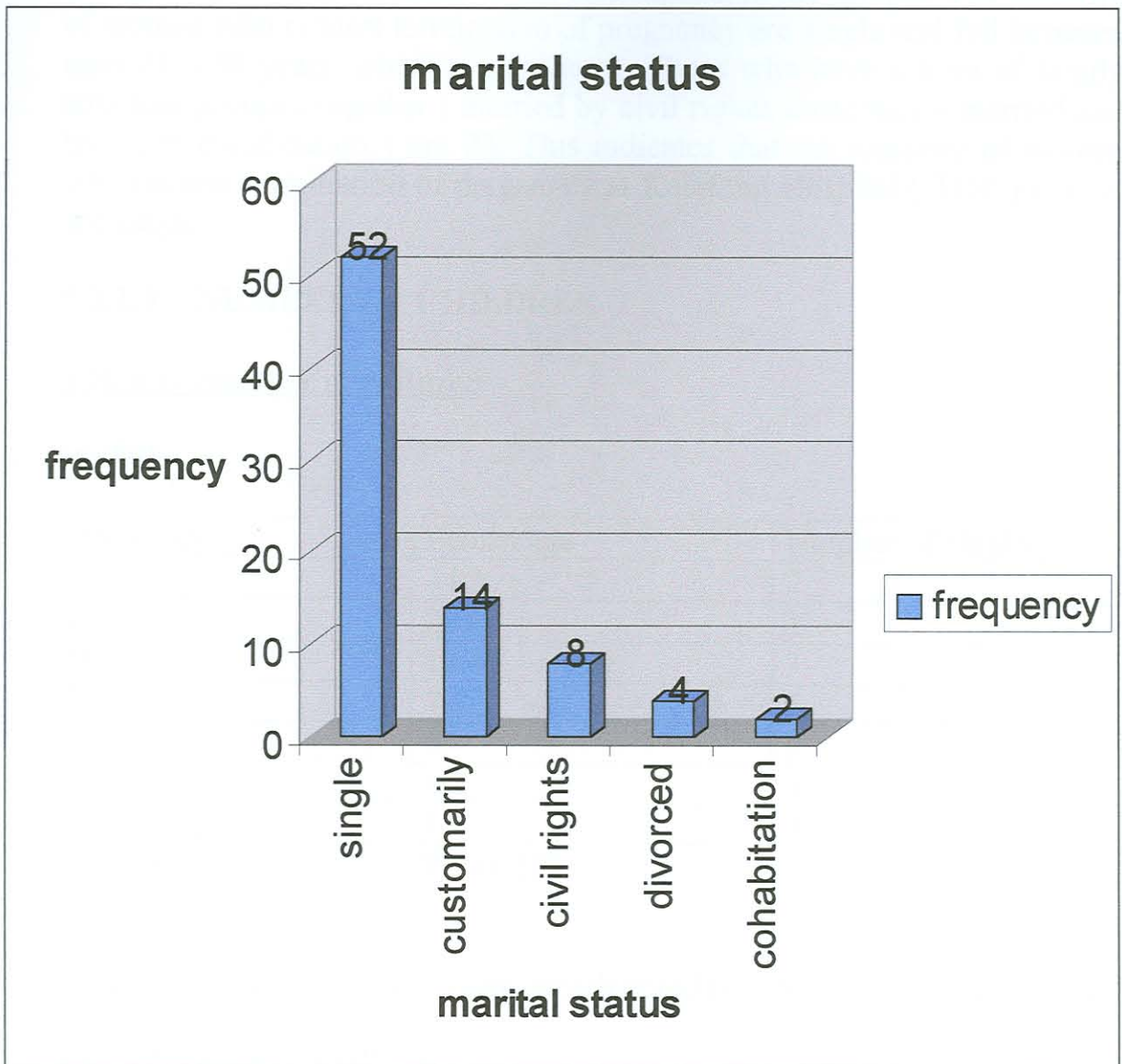


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- 4 respondents ( 5.1% ) were divorced
- 1 respondent ( 1.3% ) was staying in cohabitation

Of interest is that most of the women ( 65.8 % ) were single, which could aggravate the manner in which they could experience termination of pregnancy, as they have no form of support. This could be made worse by the lack of counselling at the TOP clinic, particularly that this is in most

cases kept secret by the women. There seems to be a relationship between the age and the marital status of the respondents in the sample. The majority of women who request termination of pregnancy are single and fall between ages 21 – 30 years; which is significant. Those who have a form of family structure grouped together ( married by civil rights, customarily married and living in cohabitation ) are 23. This indicates that the majority of women who request termination of pregnancy at Kalafong Hospital ( TOP ) Clinic, are single.

### 5.3.1.3 NUMBER OF CHILDREN

**Table 2: Number of children**

(n=80)

Frequency	Percentage	Number of children
23	34.3	2
18	26.9	1
13	19.4	3
5	7.5	5
4	6	0
3	4.5	4
1	1.5	9
Total=67	Total=100	

There are 13 frequencies missing, which could be attributed to those who did not have any child.

Table 2 reflects the following:

- 23 respondents ( 34.3% ) had 2 children
- 18 respondents ( 26.9% ) had only one child
- 13 respondents ( 19.4 ) had 3 children
- 5 respondents ( 7.5% ) had 5 children
- 4 respondents ( 6% ) had no children
- 3 respondents ( 4.5% ) had 4 children
- 1 respondents ( 1.5% ) had 9 children

From Table 2 it is evident that the majority of women who request termination of pregnancy have children, which suggests that they feel that

they are not ready for an additional responsibility of raising another child. The 18 respondents who had only one child could be having it difficult raising this child, and not ready for an additional burden.

### 5.3.1.4 EDUCATIONAL LEVEL OF RESPONDENTS

**Table 3: Educational level**

(n=80)

Frequency	Percentage	Educational level
49	61.3	Grade 8-12
16	20	Tertiary level
6	7.5	Never attended school
5	6.3	Grade 5-7
4	5	Grade 1-4
Total=80	Total=100	

Table 3 shows that:

- 49 respondents ( 61.3% ) were falling between Grade 8-12
- 16 respondents ( 20% ) were at tertiary institutions
- 6 respondents ( 7.5% ) never attended school
- 5 respondents ( 6.3% ) were between Grade 5-7
- 4 respondents ( 5% ) were between Grade 1-4

It is interesting to note that the majority of women in the sample could be regarded as literate. For this majority it could be concluded that they did not want their educational progress disturbed by raising an unplanned child. This indicates that the women who request abortion do not fall within a particular level of education, but they are distributed among the whole spectrum. It could generally be thought that women who are illiterate are ignorant, with regard to family planning matters, but the findings in this study suggest the opposite.

### 5.3.1.5 RELIGIOUS BACKGROUND

**Table 4: Religious background**

(n=80)

Frequency	Percentage	Religion
69	86.3	Christian
9	11.3	African religion
2	2.5	Muslim
Total=80	Total=100	

It is important to note that the majority of the respondents ( 69 ) in the sample, were of the Christian religion. This indicates that, a woman who is faced by an unplanned and unwanted pregnancy, will not be prevented by her religious background to decide on abortion. The women from the Christian religion indicated that they believed that their God will forgive them because he knows and understands their circumstances better than any other person. Even though the Muslim religion is totally against termination of pregnancy, there were two Muslim women who came for termination of pregnancy .

### 5.3.1.6 THE NAME OF THE DENOMINATION

**Figure 3: Church denomination**

(n=80)

It is important to note that women who request termination of pregnancy come from all various denominations. The majority were from the Christian churches which could be attributed to the fact that in the churches there is a lot of fear. The other denominations were a small number from the African religion. It is also considered a significant proportion of the sample. One would think that because of the widespread conviction of

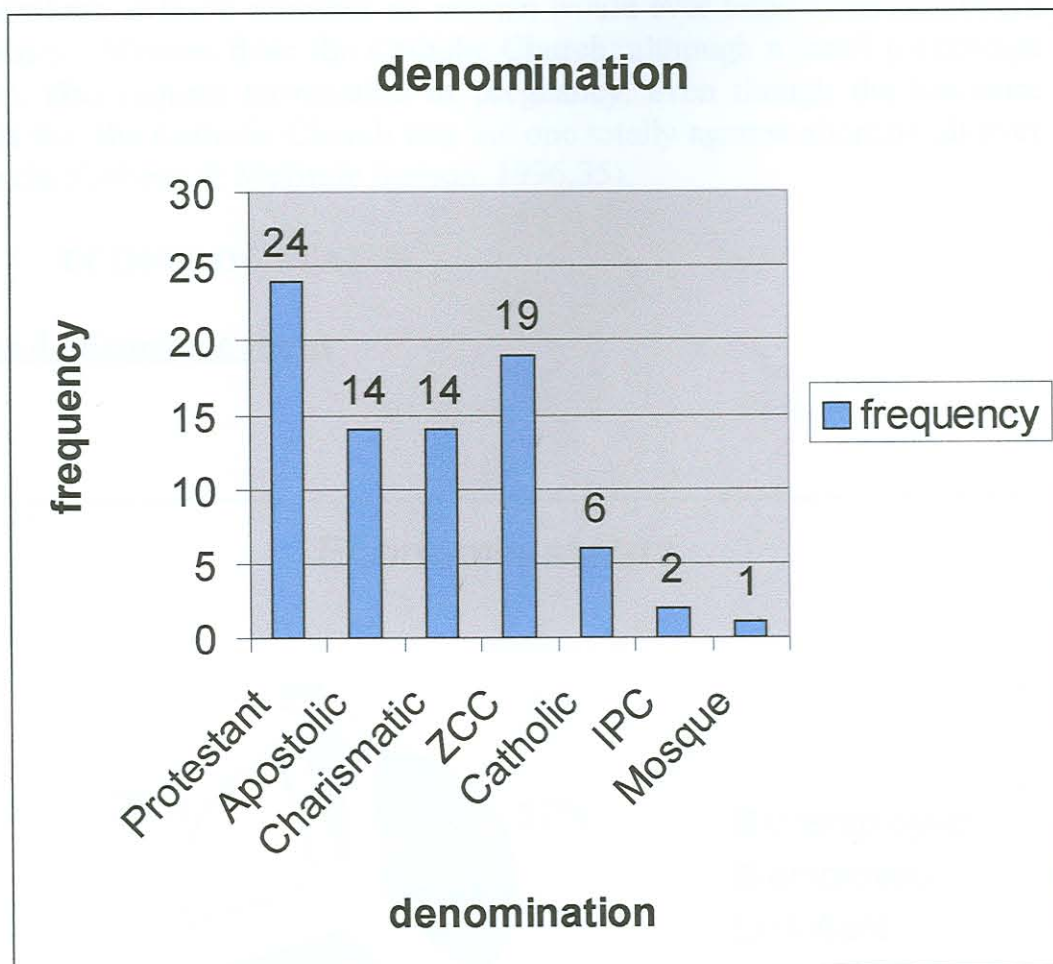


Figure 3 shows the following

- 24 respondents (30%) belonged to the Protestant Churches
- 14 respondents (17.5%) belonged to the Apostolic and Charismatic Churches respectively
- 19 respondents (23.8%) belonged to the ZCC
- 6 respondents (7.5%) belonged to the Catholic Church
- 2 respondents (2.5%) belonged to the IPC
- 1 respondents (1.2%) belonged to the Mosque Church

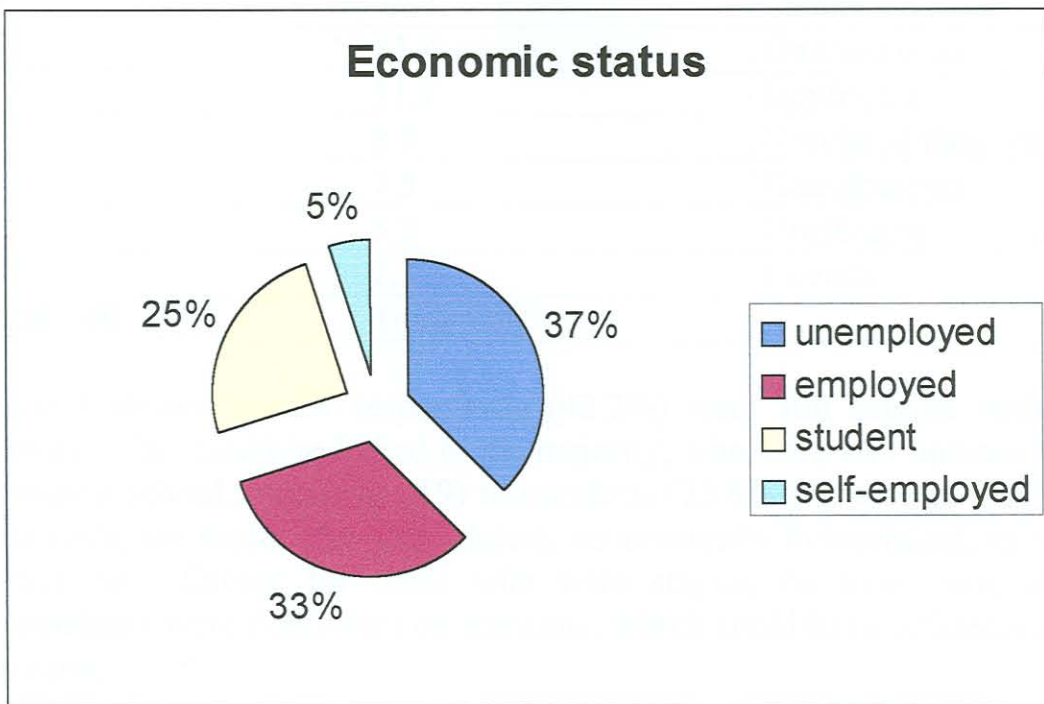
It is interesting to note that women who request termination of pregnancy come from all different denominations. The highest came from the Protestant Churches, which could be attributed to the fact that in those churches there is a level of leniency. The other striking observation is that women from the Charismatic Churches constituted a remarkable percentage of the sample. One would think that because of the confessed conviction of

the members of these churches no woman would ever think of terminating a pregnancy. Women from the Catholic Church, although a small percentage (7.5%), also request termination of pregnancy, even though the literature reveals that the Catholic Church was the one totally against abortion all over the world (Githens & McBride Stetson, 1996:35).

### 5.3.1.7 ECONOMIC STATUS

**Figure 4 : Economic status**

n=80



The findings of figure 4 reveal that:

The majority of the respondents (30), which is 37.5% of the sample were unemployed, which means that they were dependent on someone for financial support. This could have influenced the decision to have the pregnancy terminated. There is a correlation between the age of the respondents and their economic status, which is significant. Most respondents who were economically dependent were those falling between



age 10-30 years (68.7%) with  $p=0.034$ . The older respondents were mostly economically independent, as they were either employed or self-employed.

### 5.3.1.8 PERSONS WITH WHOM RESIDING

**Table 5: Person with whom residing**

$n=80$

Frequency	Percentage	Person staying with
34	42.2	Parents
19	23.8	On their own
9	11.2	Boyfriend
7	8.8	Unrelated families
6	7.5	Grandparents
4	5.2	Uncle/aunt
1	1.3	Friends
Total =80	Total=100	

Table 5 shows that 34 respondents (42.2%) were still staying with their parents. This could be linked to the majority, who were still unmarried and attending school. Nineteen (19) respondents (23.8%), who were staying on their own, are those who were already economically independent, as shown earlier on. Except for those who were staying on their own, all the respondents were dependent on someone, which could have influenced their decision.

### 5.3.1.9 LIVING CONDITIONS OF THE RESPONDENTS

**Table 6: Living conditions**

$n=80$

Frequency	Percentage	Living conditions
45	56.3	House
18	22.5	Zozo
11	13.8	Rented room
5	6.3	Flat

1	1.1	Other unspecified structure
Total = 80	Total =100	

From Table 6 it is evident that the majority of the women were staying in proper accommodation. This could be linked to the majority, who were still staying with their parents as well as those who were already economically independent. The 18 respondents (22.5%) who were staying in zozos and the 11 respondents (13.8%) who were staying in rented rooms, reflect the economic status of the women who request termination of pregnancy, and this could be the major reason behind deciding on termination.

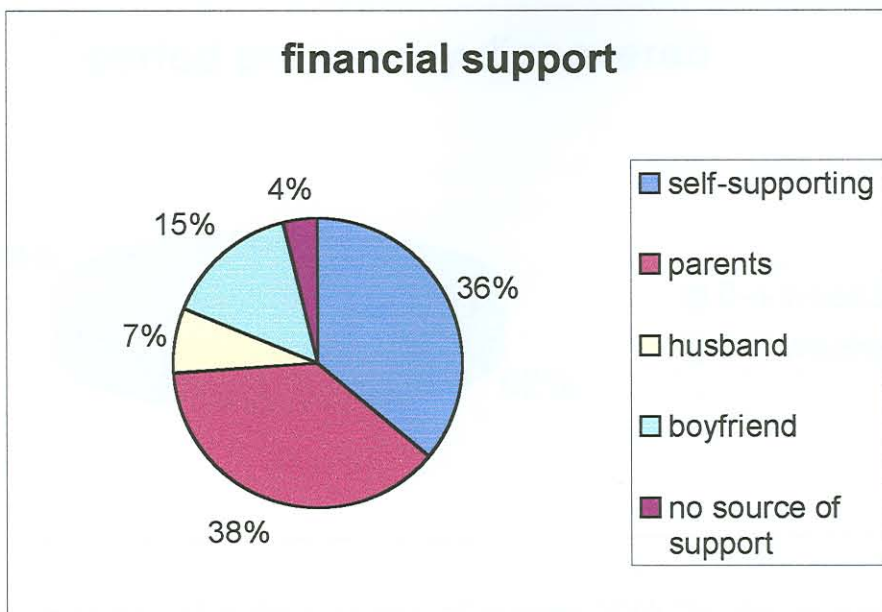
### 5.3.1.10 THE AREAS WHERE THE RESPONDENTS WERE STAYING

The responses to this question revealed that, the TOP Clinic at Kalafong Hospital serves women from different areas, not only those staying around Pretoria. The majority, that is, 22 respondents (27.5%) of the women came from Mamelodi, 16 respondents (20%) from Atteridgeville, 10 (12.5%) from Siyabuswa, while the rest came from different areas, as far as Rustenburg and Hammanskraal. With this clinic serving this vast area, it would be beneficial if the service is comprehensive and responsive to the women's needs.

### 5.3.1.11 SOURCE OF FINANCIAL SUPPORT

#### Figure 5: Source of financial support

n=80



It is evident from Figure 5 that the majority of women in the sample were financially dependent on someone, for survival. This state of affairs can have a negative effect on the person's self-image and also influence how she evaluates the future.

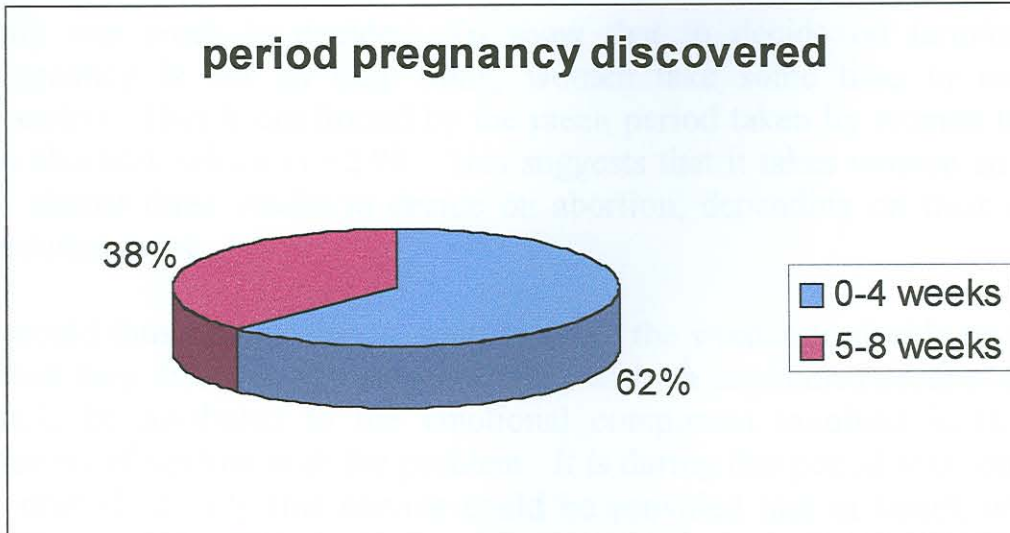
### 5.3.2 ABORTION CHOICE

The aim of this section was to determine how the women came to the decision of terminating the pregnancy as well as to determine the time taken before the decision was reached.

#### 5.3.2.1 PERIOD WHEN THE PREGNANCY WAS DISCOVERED

##### Figure 6: Discovery of pregnancy

n=80



It is interesting to note that the majority of women 50(62%) discovered that they were pregnant between 0-4 weeks, whilst 30 respondents (38%), discovered between 5-8 weeks of gestation. It could be concluded that women who are faced with unwanted and unplanned pregnancies discover quickly that they are pregnant. This could also be motivated by the women’s knowledge that Kalafong Hospital, TOP Clinic deals with the first trimester termination of pregnancy only.

### 5.3.2.2 THE TIME TAKEN TO DECIDE ON ABORTION

**Table 7: Time taken to make a decision**

n=80

Frequency	Percentage	Time taken
26	32.5	4 weeks
17	21.2	2 weeks
16	20	1 week
11	13.8	3 weeks
8	10	5 weeks
2	2.5	6 weeks
Total =80	Total =100	

Table 7 shows that the majority of the women took some time to decide on abortion, which could be attributed to the fact that this is a very sensitive and

traumatic thing to happen in one's life. Only 16 respondents (20%) took only one week to decide. To show that to decide on termination of pregnancy is not an easy thing, women take some time to make that decision. This is confirmed by the mean period taken by women to decide on abortion, which is =2.99. This suggests that it takes women an average of almost three weeks to decide on abortion, depending on their different circumstances.

It could thus be said that it is not easy for the women to decide on abortion when they discover that they are faced with an unplanned pregnancy. This could be attributed to the emotional component involved in the whole process of dealing with the problem. It is during this period that counselling is crucial, if only this service could be provided like in Israel, where the social worker forms part of the team at the TOP Clinic, for a thorough assessment of the women's psychosocial condition. (Compare United Nations, 1993:72 & Medical Law, 2000:120.)

### 5.3.2.3 PERSON WHOSE OPINION INFLUENCED THE DECISION

**Table 8: Person whose opinion influenced**

**n=80**

Frequency	Percentage	Decision influenced by
69	86.2	Self
6	7.5	Partners
4	5	Husband
1	1.3	Parents
Total =80	Total =100	

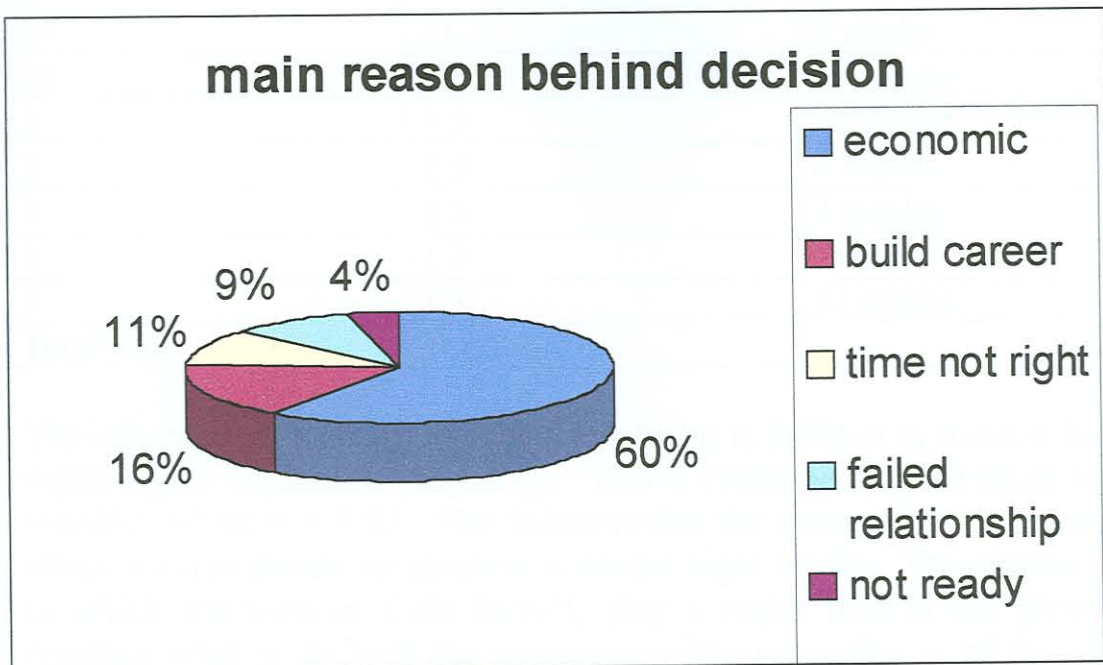
It is interesting to note that the majority of women 69 (86.2%), were not influenced to make the decision on having the pregnancy terminated. This does not suggest that they do not need counselling as they willingly made the decision. They need to be assisted to live with their decision. It is also interesting to note that other women, although in a minority, were influenced to have their pregnancies terminated. Six (6) respondents (7.5%) were influenced by their partners, four (4) respondents (5%) were influenced by their husbands, whilst only 1 respondent (1.3%) was influenced by her

parents. Without proper counselling, these women are in danger of living with this unresolved emotional problem for the rest of their lives, which could disrupt their social functioning. This could result in some emotional complications in future.

### 5.3.2.4 THE MAIN REASON BEHIND THE DECISION

**Figure 7: Main reason behind the decision**

n=80



It is evident from figure 7 that the majority of the women, 48 respondents (60%), were forced by their economic circumstances to decide on termination of pregnancy. None of the women based her decision on her feelings towards the unwanted pregnancy. A small percentage (8.8%), based their decision on failed relationships. This could be the minority whose decision was influenced by their emotions. It could thus be concluded that women decide to have abortions because of the difficult socio-economic circumstances that they experience, which could be aggravated by raising an unplanned child.

### 5.3.2.5 GESTATION PERIOD AT WHICH THE DECISION WAS MADE

**Table 9: Gestation period at which the decision was made**

n=80

Frequency	Percentage	Gestation period
18	22.5	8 weeks
11	13.7	7 weeks
11	13.7	6 weeks
17	21.2	9 weeks
12	15	10 weeks
5	6.3	11 weeks
2	2.5	4 weeks
2	2.5	2 weeks
1	1.3	5 weeks
1	1.3	12 weeks
Total =80	Total =100	

The information from Table 9 confirms that it is difficult to make a decision regarding an unplanned pregnancy. This is confirmed by the mean for this variable, which is = 8.05. This indicates that the average gestation period at which women decide on abortion is almost eight weeks. The circumstances in which the woman finds herself, play a major role in the process of deciding what to do with the pregnancy. The researcher is of the opinion that these circumstances, to a large extent determine the woman's decision. This is the reason why it takes different women different periods to decide on requesting termination of pregnancy.

### 5.3.2.6 ADOPTION CONSIDERED AS AN OPTION

Seventy seven ( 77 ) respondents ( 96.3% ) from the sample did not consider adoption as an option, whilst only 3 respondents ( 3.7% ), considered adoption, but did not go ahead with it. All the women indicated that it would be emotionally difficult for them to part with their babies, if they would carry the pregnancy to term. They also indicated that it would be impossible for them to deal with a pregnancy to term, as this would lead to their working or schooling being disrupted. It could thus be concluded that

abortion was found to be the appropriate solution because the women's lives would not be disturbed in any way.

### 5.3.2.7 SOURCE OF INFORMATION REGARDING THE TOP CLINIC

**Table 10: Source of information regarding the clinic**

n=80

Frequency	Percentage	Source of information
24	30	Friend
21	26.3	General Practitioner
14	17.5	Local clinic
8	10	Media
8	10	Other clinics at hospital
2	2.5	Mother's friend
2	2.5	Husband
1	1.3	Boyfriend
Total=80	Total=100	

This information reveals that a considerable number of women share information regarding available resources. The general practitioners and the local clinics are instrumental in having women referred to the designated abortion facilities. This is in accordance with the provision of the Choice on termination of Pregnancy Act (92/1996), that the medical practitioner who does not perform abortions must refer the woman to the designated clinic.

### 5.3.3 PSYCHOSOCIAL ASPECTS

The aim of this section was to establish the women's reactions to their unplanned pregnancies as well as their partner's reactions. The other aim was to determine the reactions of the women's parents to the unplanned pregnancy, as this would indicate the level of support that the women were enjoying during this difficult period.



### 5.3.3.1 REACTION WHEN PREGNANCY WAS DISCOVERED

On responding to their reaction when they discovered that they were pregnant, the following was revealed:

- 79 respondents ( 98.8% ) were unhappy, whilst 1 ( 1.3% ) was happy
- 73 respondents ( 91.3% ) were shocked, whilst 7 ( 8.8% ) were not
- 71 respondents ( 88.8% ) denied the pregnancy, whilst 11 ( 11.3% ) accepted
- 78 respondents ( 97.5% ) were not excited by the discovery, whilst 2 ( 2.5% ) said that they were excited by the discovery
- 74 respondents ( 92.5% ) were disappointed by the discovery, whilst 6 ( 7.5% ) were not disappointed
- 37 respondents ( 46.3% ) were saddened by the discovery, whilst 43 ( 53.8% ) were not sad
- 55 respondents ( 68.8% ) were embarrassed, whilst 25 ( 31.3% ) were not
- 52 respondents felt guilty, whilst 28 ( 25% ) did not feel guilt

The above information indicates that the majority of women who request termination of pregnancy are overcome by a variety of negative feelings, when they discover that they are pregnant, especially if it is an unplanned pregnancy. These negative feelings seem to be emanating from their unfavourable circumstances, which have been indicated earlier on in this chapter. There are also those women who experience positive emotions, but they decide on termination of pregnancy due to their unfavourable circumstances.

### 5.3.3.2 A PERSON INFORMED ABOUT THE DECISION TO TERMINATE THE PREGNANCY

The following information was revealed by the responses to the question regarding whom the woman has informed about her decision:

- 72 respondents ( 90% ) did not inform husbands, whilst only 8 ( 10% ) did
- 40 respondents ( 50% ) informed their boyfriends/partners, whilst 40 ( 50% ) did not
- 80 respondents ( 100% ) did not inform the grandparents
- 69 respondents ( 86.3% ) did not inform their friends, whilst 11 ( 13.8% ) did
- 63 respondents ( 78.8% ) informed somebody, whilst 17 ( 21.3% ) kept it to themselves

- 10 respondents ( 12.5% ) informed their parents, whilst 70 ( 87.5% ) did not

Only 10 women ( 12.5% ) informed their parents, whilst the majority 70 women ( 87.5% ) did not, which is a cause for concern. As it has already been indicated earlier on, the majority of the women were still students and dependent on their parents for financial support and living arrangements. This could be the reason behind not telling parents about the pregnancy and the intention to terminate it. This shows that there is a remarkable number of women who do not inform anybody about their decision to have the pregnancy terminated. With lack of counselling services at the TOP Clinic, these women are facing unbearable emotional problems in the future. It could be that they are reluctant to tell anybody because of fear of being judged, whilst on the other hand, keeping it to themselves is also detrimental to their health.

### **5.3.3.3 REACTIONS OF THE UNBORN CHILD'S FATHER WHEN HE HEARD ABOUT THE PREGNACY**

The reactions of the unborn child's father as revealed by the respondents were as follows:

- 67 respondents ( 83.8% ) said that fathers were not happy, whilst 13 ( 16.2% ) were happy
- 52 respondents ( 65% ) said that fathers believed the news, whilst 28 ( 35% ) reacted with disbelief
- 29 respondents ( 36.3% ) said that fathers were shocked by the news, whilst 51 ( 63.8% ) were not shocked
- 29 respondents ( 36.3% ) said that fathers were disappointed, whilst 51 ( 63.8% ) were not disappointed
- 11 respondents ( 13.8% ) said that fathers were sad, whilst 69 ( 86.3% ) were not
- 18 respondents ( 22.5% ) said that fathers felt guilty, whilst 62 ( 77.5% ) did not have any guilt feelings
- 12 respondents ( 15% ) said that fathers were excited, whilst 68 ( 85% ) were not

It could be deduced from the above information that fathers to the unborn children react with a variety of feelings, when they learn about the pregnancy. It is only the minority, who reacted with positive feelings.

This could be one of the reasons that facilitates the woman's decision to terminate the pregnancy, as she realizes from these negative reactions that she won't enjoy any support from the father.

#### **5.3.3.4 THE REACTION OF THE PARENTS IF THEY WOULD KNOW ABOUT THE PREGNANCY AND THE DECISION.**

As indicated earlier on, only 10 women ( 12.5% ) informed their parents about the pregnancy and the decision to have it terminated. The majority of the women who did not inform their parents indicated that, their parents would be disappointed if they would have known about the pregnancy, but more so about the decision to have it terminated. This could be attributed to the fact that termination of pregnancy is not yet accepted among the entire South Africans, specifically the older generation. Among the older black people it is totally rejected, because they believe that the ancestors would be angry.

#### **5.3.3.5 HOW THE PREGNANCY AND THE DECISION TO TERMINATE AFFECTED THE WOMAN'S RELATIONSHIPS.**

The responses on how the pregnancy and the decision to terminate affected the women's relationships revealed the following:

Boyfriend – 31 respondents ( 47.7% ) stated that the relationship with boyfriend was not affected, 28 respondents ( 43.1% ) stated that their relationship with the boyfriends was negatively affected, whilst 6 (9.2% ) stated that the relationship with the boyfriend was affected positively. ( 15 respondents did not respond to this question hence the missing frequencies ).

Parents – 37 respondents ( 84.1% ) stated that their relationship with parents was not affected, 4 ( 9.1% ) stated that the relationship was negatively affected, whilst 3 ( 6.8% ) stated that the relationship was positively affected. ( 36 respondents did not respond to this aspect ).

Husband – 10 respondents ( 75% ) relationship not affected, 4 ( 25% ) relationship affected negatively. The 66 missing frequencies marital status of the women.

Friends – 35 respondents ( 89.7% ) relationship with friends not affected, 2 ( 5.1% ) relationship affected positively, whilst 2 ( 5.1% ) relationship affected negatively. ( 41 respondents did not respond to this aspect).

Self – 20 respondents ( 47.6% ) relationship with self affected negatively, 19 ( 45.2% ) relationship unaffected, whilst 3 ( 7.1% ) relationship affected positively. ( 38 respondents did not respond to this aspect).

God – 32 respondents ( 47.1% ) relationship with God affected positively, 19 ( 27.9% ) relationship affected negatively, whilst 17 (25% ) relationship not affected. ( 12 ) respondents did not respond to this aspect).

Family – 7 respondents ( 63.3% ) relationship with family not affected, 2 ( 18.2% ) relationship affected positively, whilst 1 ( 9.1% ) relationship affected negatively. ( 69 respondents did not respond to this aspect).

The above information indicates that termination of pregnancy is accompanied by an emotional component. This can only be addressed through counselling. It is important to note that the majority of women's relationship with God was positively affected. This emanated from the women's religious background, where the forgiveness of sins was emphasized, and the women strongly believed that their God will forgive them because He understood their circumstances.

#### **5.3.3.6 ASPECTS OF THE WOMAN'S LIFE AFFECTED BY THE DECISION.**

The following information indicates the responses to the aspects of the woman's life affected by the decision:

Self-esteem -15 respondents ( 18.8% ) self –esteem was affected, whilst 65 ( 81.3% ) were not affected. It is interesting to see the

majority of women indicating that their self-esteem was not affected, even though they did not receive any counselling. In the researcher's opinion this could be linked to the immediate relieve that women experience after termination of pregnancy, as indicated by Michels ( 1988:29). Due to the lack of follow –up services it is never known how these women feel later, after this phase of the initial relief.

Social Life – 12 respondents ( 15% ): social life was affected, whilst for 68 respondents (85%) their social life was not affected. This could be attributed to the fact that the woman try by all means not to raise any suspicion in her behaviour, hence maintain a normal social life.

Educational progress – In 6 ( 7.5% ) respondents: educational progress was affected, as they were unable to concentrate in class, whilst in 74 respondents (92.5%) the educational progress was not affected, as they did everything in their power not to think about the situation but focus on their school work. This clearly shows the role played by denial as a defence mechanism, that is used by the women when they are faced with unplanned pregnancies, as discussed in detail in chapter 2 of this thesis.

Family life – In 5 respondents ( 6.3% ): family life was affected, whilst in 75 ( 93.8% ) respondents it was not affected. Here the life of pretence is prominent in an effort not to raise any suspicions.

Work – 14 ( 17.5% ) respondents reported their work having been affected, whilst 66 ( 82.5% ) respondents reported that work not having been affected.

Of importance here to note is that women in this situation try by all means to maintain a normal functioning, while they suppress their real emotions. As indicated earlier on, this could lead to developing emotional problems later in life, with no one in the family understanding the root of the problems.

### 5.3.3.7 SHARING THE EXPERIENCE IN FUTURE

**Figure 8: Sharing the experience in future**

n=80

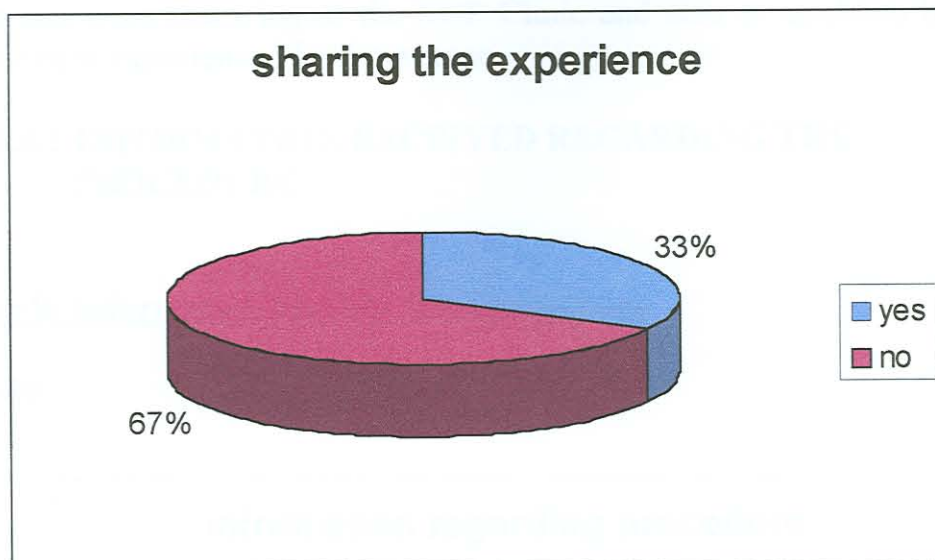


Figure 8 reveals that the majority of women 54 respondents ( 67% ), felt that they will never be able to share this experience with anyone, but would rather keep it to themselves. Only 27 respondents (33%) felt that they will be able to share the experience. The majority of women who felt that they would not be able to share the experience indicated that they will try to forget about it on their own. It is also important to note that there is correlation between the age of the women and the ability to share the experience later in life. The majority of the older women felt that they will not be able to share the experience, as compared to the younger women who felt they could share the experience with someone.

The researcher is of the opinion that if the women who request termination of pregnancy could receive proper counselling prior to the procedure, they would be able to go on with their life, after the procedure. Counselling would enable them to feel free to seek help if they are unable to cope with what has happened, because they would have experienced a non -judgemental encounter with the social worker,

prior to the procedure. Unlike in this situation, where women try to forget what has happened, without any professional help. This could have devastating consequences on them.

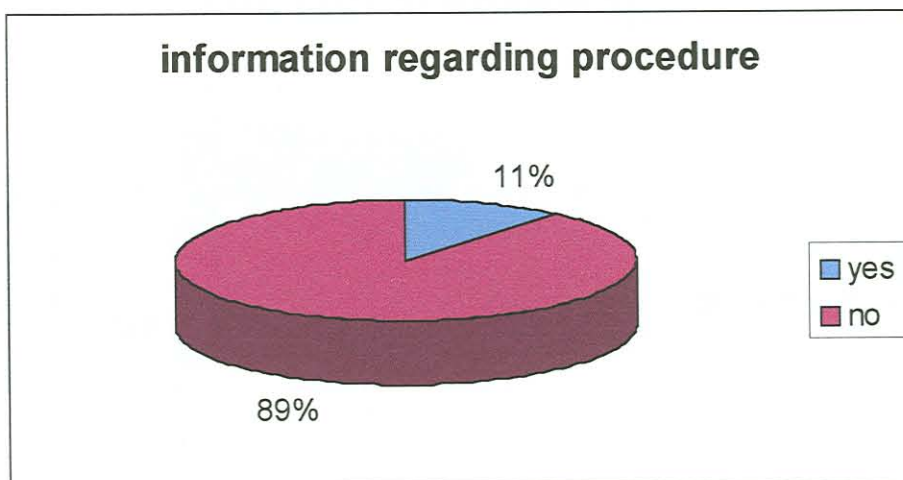
### 5.3.4 ABORTION SERVICES

The aim of this section was to establish the nature of the service that the women were receiving at the TOP Clinic and also to establish how the service is experienced by the women.

#### 5.3.4.1 INFORMATION RECEIVED REGARDING THE PROCEDURE

**Figure 9: Information regarding the procedure**

n=80



The information from Figure 9 indicates that the majority of the women, 71 respondents (89%) did not receive any information regarding the procedure whilst only 9 respondents (11%) did receive information. This clearly indicates the need for counselling as part of the abortion service, to avoid a situation where women have to experience the procedure without any preparation. The researcher is of the opinion that counselling would help the women to go through the procedure with some expectations and psychological readiness.

### 5.3.4.2 THE DIFFERENCE THAT WOULD BE BROUGHT BY INFORMATION

The responses to this question revealed that 8 respondents (72.7%) believed that information would equip them to deal with the situation whilst 2(18.2%) felt that they were fine without information. Seventy (70) missing frequencies could be attributed to the fact that many women do not know the importance of counselling as they were never exposed to it. They just felt that as long as their problem (unwanted and planned pregnancy) could be dealt with, their lives would get back to normal.

### 5.3.4.3 NEED FOR COUNSELLING BEFORE THE PROCEDURE

**Figure 10: Need for counselling before procedure**

n=80

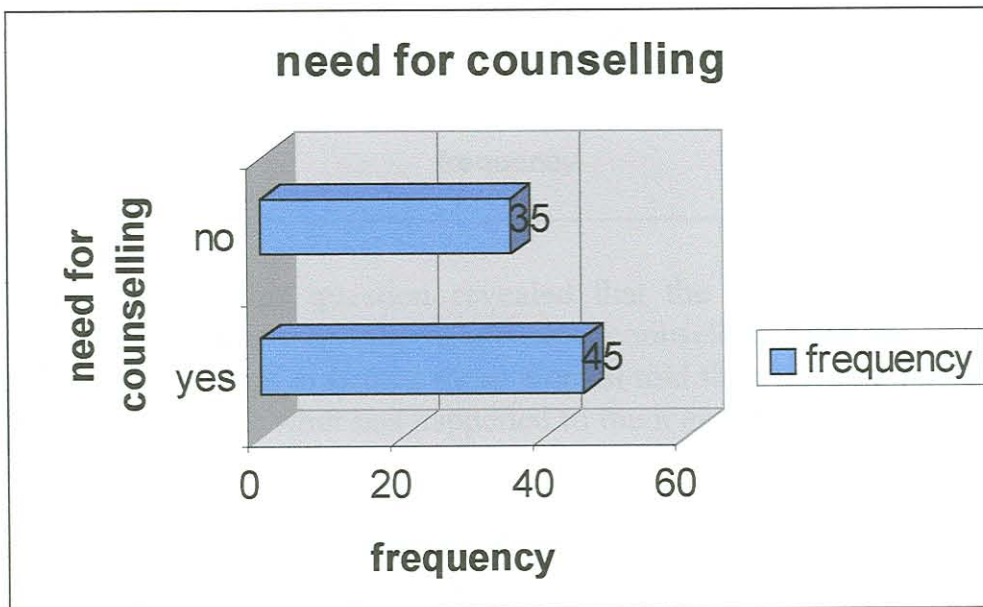


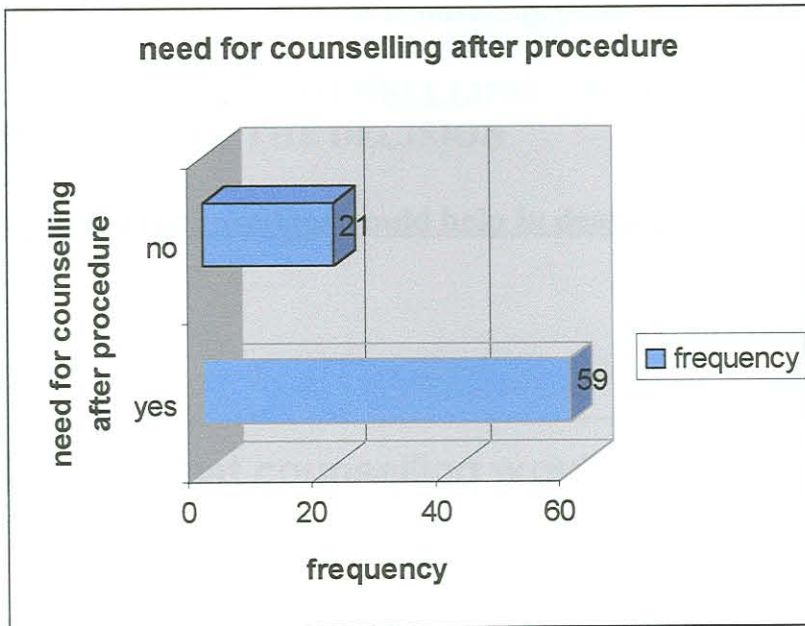
Figure 10 reveals that the majority of women, 45 respondents (56.3%) felt that they needed counselling before they proceed with the procedure. This emphasises the importance of counselling as part of the abortion service. For the minority, that is, 35 respondents (43.7%) who felt that they did not need counselling prior to the procedure, it could be concluded that they did not know what counselling entailed.



### 5.3.4.4 NEED FOR COUNSELLING AFTER THE PROCEDURE

**Figure 11 : Need for counselling after the procedure**

n=80



The responses to this question revealed that the majority of women 59 (63.8%), did not feel that they would need counselling after the procedure. As it has already been indicated these women told themselves that they were going to forget about what has happened to them and they did not want to be reminded.

For those women who indicated that they would need counselling 21 respondents (36.2%), the researcher offered to provide the service. It was then contracted with them that they would contact the researcher after three months has lapsed, so that their emotions could be reassessed and an appropriate service provided. It was discovered after six months by the researcher that the particulars which were given by these women were incorrect, when a follow-up was made because they did not keep their part of the contract. This made their whereabouts to be untraceable and this led to the conclusion that they did not want to be followed up. This was confirmed by the nurses at the clinic that this is a tendency. This was

attributed to the fact that although they felt that they needed counselling they also wanted to forget about this painful experience. The other reason might be that they were not sure if with this counselling their secret would end up known by other people. Although this was made clear and emphasised to them by the researcher, they went on giving incorrect particulars, to make sure that they are untraceable. This indicates that women would like to forget about the abortion experience, in an effort to protect themselves. It would be beneficial if they all received counselling prior to the procedure.

#### 5.3.4.5 BELIEF THAT COUNSELLING WOULD HELP IN DEALING WITH THE DECISION

**Figure 12: Belief that counselling would help in dealing with the decision**

n=80

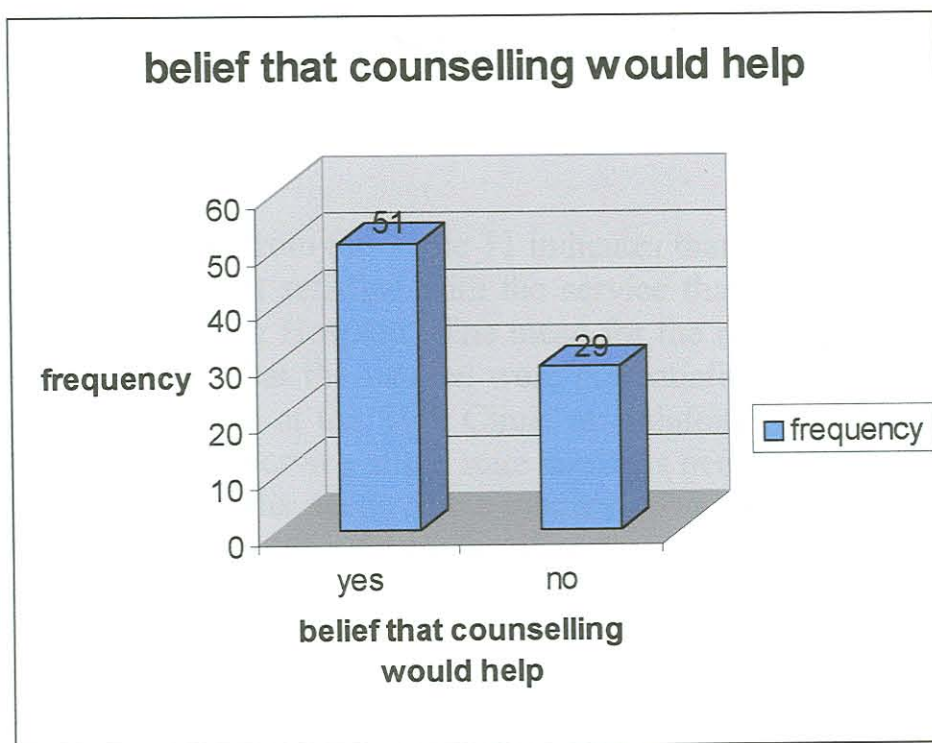


Figure 12 revealed that the majority of women (51) 63.3%, believed that counselling would help them deal better with their decision. In motivating why they believed that counselling would help them, the respondents

emphasised the importance of counselling prior to the procedure. They felt that they would go through the procedure equipped with information and with their emotions explored, which would help them develop insight into their situation.

### 5.3.5 ABORTION SERVICE AT THE CLINIC

The aim of this section was to establish from the women how they rated the service at the clinic.

#### 5.3.5.1 RATING OF SERVICE BEFORE THE PROCEDURE.

**Table 11: Evaluation of the service before the procedure**

n=80

Frequency	Percentage	Ratings
38	47.5	Average
29	36.2	Good
10	12.5	Poor
3	3.8	Excellent
Total=80	Total=100	

The information from the Table 11 indicates that the majority of the women (47.5%), were not satisfied with the service that they received at the TOP Clinic at Kalafong Hospital. The mean for the rating of the service is 2.31, which suggests that the women were not satisfied with the type of service that they received at the TOP Clinic at Kalafong Hospital. This indicates that the abortion service at the state facilities needs to be improved, for it to be responsive to the needs of the women. The quality of the service at the clinic is adversely affected by the shortage of staff as discussed in-depth in chapter 4 of this thesis.

The question regarding the future plans of the respondents was intended to verify that one respondent could give more than one response, as a result 230 responses were given. The responses were as follows:

- 75 responses (31.4%) : decided to be more cautious about contraceptive
- 1 response (0.4%) : would consider another abortion
- 46 responses (19.25%) : will motivate other women to use contraceptive

### 5.3.5.2 RATING OF THE SERVICE DURING THE PROCEDURE.

**Table 12: Evaluation of the service during the procedure**

n=80

Frequency	Percentage	Rating
37	46.2	Average
28	35	Good
12	15	Poor
3	3.8	Excellent
Total=80	Total=100	

Table 12 indicates that the majority of the women (46.2%), were also not satisfied with the service they received during the procedure. It was indicated by the women that the communication style used by the nursing staff was not satisfactory and they would be happy if it could be changed. The mean rating of the service by the women is 2.28, that is, ranging between poor and average. This suggests that the abortion service at Kalafong TOP Clinic does not satisfy the consumers thereof. As indicated earlier on there has to be improvements on the abortion service at the state facilities, for the service to be responsive to the needs of the women who request termination of pregnancy. They further indicated that they were handled with a judgemental attitude which makes them feel more guilty regarding what they have decided to do.

### 5.3.6 FUTURE PLANS

The aim of this subsection was to establish from the respondents how they intend leading their lives after the abortion procedure.

#### 5.3.6.1 FUTURE PLANS AFTER THE PROCEDURE

The question regarding the future plans of the respondents was in such a way that one respondent could give more than one responses, as a result, 239 responses were given. The responses were as follows:

- 75 responses (31.4%) : decided to be more serious about contraceptives
- 1 response (0.41%) : would consider another abortion
- 46 responses (19.25%) : will motivate other women to use contraceptives

- 75 responses (31.4%) : will discourage other women to go for abortion
- 42 responses ( 17.6%) : decided to concentrate on their studies
- 6 responses (2.5%) : decided to abstain from sexual activities until marriage

It is interesting to see that there were 75 responses of the women who will discourage other women from going for an abortion. This indicates that abortion is not a pleasant experience which might be made worse by the lack of a comprehensive service at the clinic.

### 5.3.6.2 PROBLEMS ANTICIPATED AS A RESULT OF ABORTION

Concerning the problems anticipated the respondents gave the following responses:

- None of the respondents anticipated problems with regard to future relationships
- None anticipated problems in dealing with children in future
- Only 1 respondent (1.3%) anticipated problems to have children in future, whilst 79 respondents did not
- 17 respondents (21.3%) anticipated difficulties to live with their decision, whilst 63 (78.3%) would work hard to forget about it
- 61 respondents (76.3%) anticipated no future problems related to abortion, whilst 19 (23.8%) anticipated emotional problems.

The above information clearly indicates the women's determination to forget about this painful experience and go on with their lives and how unrealistic they are about possible implications.

### 5.3.7 NEED FOR A SOCIAL WORKER AT THE TOP CLINIC

The aim of this section was to establish from the women the extent to which they think social work services are needed at the TOP Clinic.

Table 13: Period when social worker is needed about  
n=80

Frequency	Percentage	Period needed
43	75.4	Before the procedure
7	12.3	During the procedure

### 5.3.7.1 THE NEED FOR SOCIAL WORK SERVICE AT THE CLINIC

**Figure 13: Need for a social worker at the TOP Clinic**

n=80

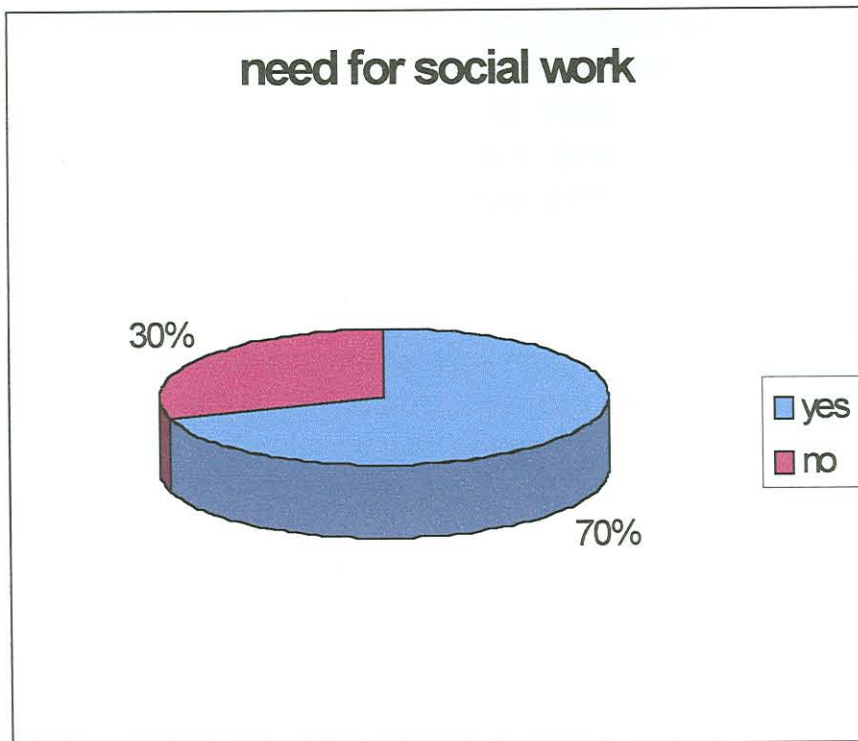


Figure 13 reveals that the majority of the women 56 respondents (70%), felt that the social worker is needed as part of the team that render abortion services. It becomes evident that women did not quite understand the role of the social worker at the clinic. This shows how little people understand the role of the social worker in a health setting because at that setting they expect to be attended to by medical personnel.

### 5.3.7.2 PERIOD WHEN SOCIAL WORKER IS NEEDED MOST.

**Table 13: Period when social worker is needed most**

n=80

Frequency	Percentage	Period needed
43	75.4	Before the procedure
7	12.3	During the procedure

7	12.3	After the procedure
Total=57	Total=100	

Twenty-three respondents did not respond to this question. It may be that they did not understand the role of the social worker at all. It is evident from the above information that women feel that they would benefit greatly if they have social work services in the form of counselling before they go through the procedure. Only a small percentage 12.3%, 7 respondents indicated that they needed the social work services during and after the procedure, respectively. This shows how unrealistic the women are regarding the psychosocial implications of termination of pregnancy.

#### 5.4 SUMMARY

In this study 80 black women who requested termination of pregnancy at Kalafong Hospital (TOP) clinic between June 1999-January 2000 were interviewed before the procedure of termination of pregnancy. This phase of the empirical study was done from a quantitative research approach and the findings are as follows:

- The majority of women who request termination of pregnancy fall in the age category of 21-30 years.
- A considerable number of women who request termination of pregnancy are single.
- The majority of women in the sample had other children, which indicates that they were not ready to raise an additional child.
- A large number of women could be said to be literate because they had an educational level of grade 8-tertiary level.
- The majority of women belonged to the Christian religion although women from other religious requested termination of pregnancy as well.
- Most women who requested abortion were economically dependent on someone as they were students and others were unemployed.
- It has been evident that TOP clinic at Kalafong Hospital serves women from a various areas, with Mamelodi and Atteridgeville being the mostly served areas.
- Most women discovered that they were pregnant before the 8<sup>th</sup> week of gestation.
- It takes women some time to decide on abortion as it is not an easy decision to make.

- A large number of women were not influenced to make the decision to terminate their pregnancies.
- The findings reveals that the main reason for the women to decide on termination of pregnancy is economic circumstances.
- The majority of women did not consider adoption as an alternative because of the emotional attachment to the foetus, if they carry the pregnancy to term which could make it impossible to let go.
- It is evident that the clinic is known and the private practitioners and local clinics are instrumental in referring women to Kalafong Hospital.
- It has been shown by the findings that the women who request termination of pregnancy experience a variety of negative feelings, hence a remarkable number of women do not inform anybody about their decision which could affect them emotionally in future.
- The fathers to these unborn babies also experience a variety of feelings, mainly negative feelings, which have a role to play in the women's decision to have termination of the pregnancy. This was revealed by the respondents.
- As the majority of women were single, students and staying with their parents, the parents would be disappointed if they could know about the pregnancy and the decision to terminate it hence they were not informed.
- The decision to terminate the pregnancy affected various aspects of the women's lives in a variety fashions. The majority of Christians' relationship with God was positively affected, as these women believe that God will forgive them because He understands their circumstances.
- Due to the emotional implications of abortion, women would rather forget about it and not share the experience with someone. This was revealed when the majority of women indicated that they were going to work hard, so that they could forget about what has happened.
- The majority of women did not receive any information prior to the procedure, due to the lack of counselling service at the clinic.
- It has been evident that women need to be provided with counselling prior to the procedure because it is not easy for them to come back for post-abortion counselling, as all their efforts are centred around forgetting about what they have done.
- The majority of women believed that counselling prior to the procedure would help them deal better with their decision.
- A large number of women were not satisfied with the service that they received at the clinic, and felt that the services ranged between poor and average. The quality of the service at the clinic is affected by the shortage of staff.



- It is interesting to note that the majority of women who decided to terminate their pregnancies were determined not to do it again, but take the contraceptives more seriously, to prevent other unplanned pregnancies. This indicates that deciding on termination of pregnancy and going through the procedure is not a pleasant experience.
- Due to the shortage of an appropriate team composition at the clinic, women do not see the role of other team members, such as, the role of the social worker. There is a need to have the necessary team members involved at the TOP clinic, for the women to receive a comprehensive service.
- The need for counselling prior to the procedure, specifically during the decision-making period was indicated by the women, for them to be helped to deal better with their decision.

The following chapter deals with the findings from the qualitative data.

## 2 RESEARCH METHODOLOGY

The type of research that was used in this study is a qualitative research. The purpose of this research was to explore the experiences of women who had terminated their pregnancies at the Women's Choice Clinic, as well as the qualitative data that was collected from the women's files. This chapter illustrates the implications of the findings from the qualitative data. The following chapter deals with the findings from the qualitative data.

The population consisted of all the women who had terminated their pregnancies at the Women's Choice Clinic, at Pretoria, before June 2001. Thirty-five (35) files were selected in the simple random sampling method and reviewed. According to Stydorn and De Vos (1998:193), simple random sampling refers to a situation where each individual case in the population theoretically has an equal chance to be selected for the sample. This sampling method was found to be suitable for this phase of the study, because all the individual cases possessed the characteristics which were representative of the population.

## CHAPTER 6

### EMPIRICAL FINDINGS FROM THE QUALITATIVE PHASE OF THE STUDY

#### 6.1 INTRODUCTION

This phase of the empirical study was to be undertaken with the aim of exploring the psychosocial implications of abortion on the woman, sometime after the procedure, that is, not immediately. The research methodology will be discussed briefly before the empirical findings are described. The research process is then described, to give a background to what has been done in this phase of the study, followed by the profiles of the women who requested termination at the private TOP Clinic, namely, Women's Choice Clinic, as well as the statistical information that was drawn from the women's files. Then follows the case studies that were found from the magazines to illustrate the implications of termination of pregnancy on the woman and lastly the conclusions reached.

#### 6.2 RESEARCH METHODOLOGY

The type of research that was used in this study is applied research. The exploratory-descriptive design was used. As indicated earlier on, both qualitative and quantitative research approaches were used, where Creswell's dominant-less-dominant model was found to be applicable. In this model both qualitative and quantitative approaches are used in one study, with one approach used more dominantly than the other (De Vos, 1998:360). In this chapter only the empirical findings from the qualitative phase of the study will be presented, as the empirical findings from the quantitative phase has already been presented in chapter 5.

The population consisted of all the women who had termination of pregnancy at the Women' Choice Clinic, at Pretoria, before June 2001. Thirty-five (35) files were selected by the simple random sampling method and reviewed. According to Strydom and De Vos (1998:195), simple random sampling refers to a situation where each individual case in the population theoretically has an equal chance to be selected for the sample. This sampling method was found to be suitable for this phase of the study because all the individual cases possessed the characteristics which were representative of the population.

### 6.3 FOLLOW-UP ATTEMPTS FOR THE QUALITATIVE PHASE OF THE STUDY.

The researcher contracted with 21 respondents (36.3%), on the day the questionnaire was administered, from the sample that was drawn for the quantitative empirical study, who indicated that they would need counselling after the procedure, for a follow-up to be made on them. It was agreed that they would contact the researcher telephonically after three months, which did not materialise. The researcher then went to Kalafong TOP Clinic, to search for the women's addresses so that letters should be sent to them to remind them of the contract. This letter was written in a manner that even if it could land in someone's hands at home, besides the woman's hands, it would not be easy for that particular person to figure out what it was all about. This was done in order to protect the woman not to disclose her secret. (The letter is attached in the appendix of this thesis ). After there was no response from the women for six months after the letters were sent out, the researcher went back to the TOP Clinic, where she discussed her frustrations with sister Hanyane and sister Letsoalo, who indicated that the possibility that the addresses were wrong was there. This was the suspected reason why there were no responses from the women. The nurses further indicated that there was no way that the researcher could make follow-up at the clinic because there were no follow-up services for the women after termination of pregnancy.

The fact that the women did not contact the researcher after the procedure, as well as not responding to the letters of request to make contact, confirmed their intention to forget about their abortion experience. This indicated that these women deliberately made their whereabouts untraceable. It is indicated by Reardon (1999:1) that, while many studies have been conducted regarding emotional aftermath of abortion, very little has been firmly established. This state of affairs is the result of complications such as the co-operation of the study population, which is inconsistent and unreliable. This clearly shows how difficult it is to have a conclusive study on the psychosocial implications of abortion on the women, after the procedure. For this study the problem that hindered the exploration of these implications was unreliability on the part of the population.

The researcher then placed an advertisement on the university newspaper, namely, the *Perdeby*, because of the findings from both the qualitative and the quantitative phases, that revealed that, the students from the tertiary

institutions do go for termination of pregnancy. It was hoped that this advert would help them to reach out and talk about their experiences. This was done to invite women who have had termination of pregnancy and were experiencing some problems dealing with it, to come for counselling that was going to be provided without any costs. This advert was given a period of six weeks, but did not yield the expected results. (The advertisement is attached in the appendix of this thesis).

#### **6.4 THE PROCESS AFTER THE DISAPPOINTMENT WITH THE RESPONDENTS**

With the quest to explore the psychosocial implications of termination of pregnancy on the women after the procedure, the researcher reached out to Neobirth agencies in Pretoria and Rustenburg, for her to be given a chance to interview the women who went there for post-abortion counselling. It was unfortunate that her requests were not favourably considered by the management of the said agencies.

Further efforts were made to have interviews with women who have undergone termination of pregnancy, to explore its psychosocial implications on them. The researcher was invited by Dr. C.P. Bam, who is performing termination of pregnancies at the Women's Choice Clinic in Pretoria, which is a private clinic for all women's issues, with the hope that respondents will be found for the qualitative phase of the study. Between 02 July 2001 and 06 July 2001, the researcher was present at the Women's Choice Clinic, on a daily basis, with the aim of using the availability sampling method, to draw the sample from the population of the women who would come to the clinic for post-abortion counselling. As it was indicated by Dr. C.P. Bam that these women do come on a daily basis, the researcher was hopeful that the respondents will be found. But this was not to be and five days were spent at the clinic without any woman coming for post-abortion counselling.

The researcher then requested permission from Dr. Bam to review the records of the women who came for termination of pregnancy at the clinic and permission was granted. This was aimed at helping the researcher to establish the profile of the women who came for termination at that clinic. Review of the records was seen as the appropriate method of data collection at that given time because there were no respondents at the clinic, for the interviews to be conducted, and there were no prospects of seeing them in a

post-abortion counselling session. According to Bless and Higson-Smith (1995:125), record method of data collection is a non-reactive research method, through which the information about the respondents is gathered without direct interaction. Anonymity and confidentiality were maintained when dealing with these records, as no identifying particulars were used.

Utilising the simple random sampling method, where every file had a chance of being selected (Strydom and De Vos, 1998:195), thirty-five files of the women who had already undergone termination of pregnancy before July 2001, were selected. It was discovered that women had to have a short form completed before the procedure, where they have to indicate whether they are satisfied with their choice; informed about other options; informed about the methods of contraception after saying which one failed them; informed about the procedure and the possible complications; and advised to approach the clinic as soon as any sign of the complication is observed.

## **6.5 RESEARCH FINDINGS**

The data that was collected from the files that were reviewed will now be presented, even if it does not give an in-depth information regarding the women who requested abortion at the Women's Choice Clinic.

### **6.5.1 INTRODUCTION TO THE RESPONDENTS**

The findings from the thirty-five reviewed records are as follows:

The findings from the reviewed records are as follows:

- The age of the women in the sample ranged between 17 years and 41 years.
- From the sample 17 women did not have any child and their age ranged between 17yrs-28yrs.
- 8 women had one child and their age ranged between 23yrs-35yrs
- 6 had two children and age ranged between 31yrs-41yrs
- 2 had three children and their age was 33yrs and 34yrs, respectively
- 1 had four children and her age was 38yrs.

It could thus be concluded that the majority who did not have any child felt that they were not yet ready to carry the responsibility of raising a child. When considering their age it could be said that they were of school going age and those who were older, were at the beginning of the career ladder, and did not want to let the pregnancy disturb their progress. For those with

children, it could be said that they felt that they could not cope with an additional mouth to feed. It was interesting to note that nothing in the files indicated how the relationship with the partners were, as this would also have shed light on the women's situation. The reasons for deciding on termination of pregnancy were also not indicated in the files.

All women in the sample indicated that they were satisfied with their choice. It is also interesting to see that all the women in the sample indicated that they would not want to discuss the matter after the procedure. This is seen by the researcher as the reason behind the situation where no woman was coming for post-abortion follow-up. It could be concluded that the women were looking forward to the relief of doing away with the burden of an unwanted and unplanned pregnancy, as indicated by Michels (1986:29), that relief is the first emotion after having an abortion. This indicates the efforts made by women to forget about abortion, so that they could go on with life thereafter.

All the women indicated that they were not interested in other options but would like to go on with the termination of the pregnancy. They also indicated their seriousness with regard to utilising the contraceptives, especially the injectables, as recommended at the clinic, for them to avoid another unplanned and unwanted pregnancy. None of the women blamed herself for the unplanned pregnancy, but were looking forward to doing away with the problem and start afresh. This shows that undergoing an abortion is accompanied by psychosocial implications, which the women need to be helped to deal with. The social worker can play a vital role here if the women could just realise the importance of post-abortion counselling.

#### **6.5.2 PROFILE OF WOMEN WHO REQUEST TERMINATION OF PREGNANCY AT A PRIVATE CLINIC**

Based on the data that was gathered from the files that were reviewed, the following profiles of the women who request abortion at a private clinic is presented. The reason for providing these profiles is to give the background of the women who came to have termination of pregnancy at the Women's Choice Clinic in Pretoria. This cannot be generalised because of the size of the sample. From the thirty-five files that were reviewed, only five were eventually chosen for the profiles, because of the saturation of the information. These five files represent the most common types of persons in

the sample. As a result only five cases were used to avoid a repetition of the information.

#### **6.5.2.1 RESPONDENT 1**

The first file that was reviewed was that of a 17 years old black woman, from Soshanguve and still a pupil at the local secondary school. She had no child and was still dependent on her parents for support, that is, emotionally and financially. None of the family members were aware of her pregnancy and her choice to terminate it. The cost for the procedure at the private clinic were incurred by the boyfriend, who was employed. The boyfriend had been supportive all the way and also accompanied her to the clinic on the day of the procedure. She never used any form of contraception but decided to use the injection immediately after the procedure. She came to request termination of pregnancy during the first trimester of her pregnancy.

#### **6.5.2.2 RESPONDENT 2**

A white woman from Pietersburg, 19 years of age and a university student who was staying at the university residence. She had no child and was still dependent on her parents. Her boyfriend was the one responsible for the financial support at the private clinic. Her parents knew nothing about her pregnancy and her decision to have it terminated. Due to his job commitment, her boyfriend could not accompany her to the clinic on the day of the procedure. She came for the procedure during the first trimester of her pregnancy. She never used any contraceptives but decided to use the injection immediately after the procedure.

#### **6.5.2.3 RESPONDENT 3**

A black woman aged 38 from Kwa-Mhlanga. A married woman with four children and a working husband. Never used contraceptives but decided to use the injection immediately after the procedure. She came during the first trimester of her pregnancy. The husband was not informed about the pregnancy and the decision to have it terminated because he was against her using contraceptives, and would not approve of her decision. As she was also employed, she paid for the procedure and this was her secret.

#### 6.5.2.4 RESPONDENT 4

A white woman from Verwoerdburg. She was 41 years old, married with two children and employed. She was on oral contraceptives but decided to change to injections immediately after the procedure, because the pill was unreliable. Her husband was fully behind her and accompanied her to the clinic on the day of the procedure.

#### 6.5.2.5 RESPONDENT 5

A black woman from Hammanskraal. She was 41 years old, single with two children to raise and the sole breadwinner for her extended family. Her boyfriend deserted her immediately when he learnt about the pregnancy. She was not using contraceptives but decided to use the injection immediately after the procedure.

#### 6.5.2.6 DISCUSSION

The above information provides a clearer picture of the women who ultimately request termination of pregnancy at a private clinic. Due to the financial implications, not every woman can afford to request termination of pregnancy at a private clinic. For the women who are still dependent on their parents for financial support, when they are faced with unplanned and unwanted pregnancies, their hope to get it terminated lies with their boyfriends, as shown in the information provided above. For the married women, who find themselves under the tyranny of their oppressive husbands, where they are denied the opportunity to control their bodies, they devise means to secure money to pay for the abortion service, without the knowledge of their husbands. It is emotionally touching to think that these women go through this traumatic experience without any form of support. The researcher was of the opinion that this type of women would avail themselves for post-abortion counselling, for them to be able to go on with their lives.

For the women who request termination of pregnancy at a young age, the concern is that they are still immature to comprehend what is happening regarding their bodies, as indicated in chapter 3 of this thesis. As a result of this immaturity, together with the secrecy and trying not to disappoint the parents, the woman could experience an emotional turmoil later in life, which could disturb the career that she was trying to build. It is important to



note that almost all the women whose files were reviewed were enjoying the necessary support from their partners.

It is evident that the women who request termination of pregnancy do so because of some circumstances, that are perceived to be not conducive for raising a child. In deciding to have the pregnancy terminated, the women are trying to take control of their lives again. Even though termination of pregnancy is the woman's decision, it is accompanied by psychosocial implications, because the decision is made under some circumstances, that may be overwhelming for the woman. This is the reason why the researcher is convinced that counselling is crucial to ensure that these women are able to continue with their lives after the procedure. It would be more beneficial if the women would be provided with pre-abortion counselling, to help them go through the procedure with lessened emotional burden, because it has been shown that after the procedure, the women would rather forget about their experience, hence post-abortion counselling is not possible.

#### **6.5.2.7 CONCLUSION**

The women who request termination of pregnancy at the private clinic are those who have the means of paying the costs. If they are not financially well off, their partners are prepared to incur the costs, which could be seen as a relief on the woman who is overwhelmed by facing an unplanned and unwanted pregnancy. Women from the different cultural and racial groups are sometimes faced by unwanted and unplanned pregnancies. All women who are of child-bearing age are faced with the problem of unplanned and unwanted pregnancy, which makes the service at the termination of pregnancy facility to be crucial in ensuring that the women are able to move on with their lives after the procedure. If the service is not responsive to the needs of the women, the generation of women in the near future, could be characterised by emotional instability.

#### **6.6 CASE STUDIES TO ILLUSTRATE THE PSYCHOSOCIAL IMPLICATIONS OF ABORTION ON THE WOMAN**

The psychosocial implications of abortion on the woman will be illustrated by using two case studies, which appeared in two local magazines, namely, Drum ( April, 1998) and True Love (January, 2001).

### 6.6.1 CASE STUDY 1

Nonki's story appeared in Drum, by Tladi (1998: 14-15)

She was a 21 years old woman, unmarried, a mother of a 2 years old daughter and the sole breadwinner for the family (extended family). She had broken up with her boyfriend of eight years and felt that she won't be able to cope with an additional mouth to feed. At the local Abortion Clinic she was told that the waiting list was already long and she would have to wait for three months before the procedure could be performed. Considering her gestation period at the time, she felt that she could not wait, and then consulted her family doctor, who referred her to a hospital in Pretoria. It is not indicated whether this was a state hospital or a private one. By the time she booked in at the hospital she was already four and half months pregnant, meaning that she was already in the second trimester of her pregnancy.

She indicated that when entering the ward she was overwhelmed as she looked at all the other women in the ward, who seemed so alone and depressed; and the ward was very dull with nothing to cheer them up. As the medication was administered four hourly to induce labour, the women were constantly reminded by the nursing personnel that it was their own fault that they were in that situation, which made things more unbearable for them. The procedure was then successfully done and after observation, which revealed that she was healthy, she was discharged. This felt like a mechanical procedure in the sense that no one cared about how she felt and whether she was ready to face life constructively.

She did not regret having had an abortion, although she didn't like recalling what she went through. The fact that she was unable to forget what happened is shown by her statement when she said "I sometimes dream that all the little babies are packed in white envelopes with their mothers' names and addresses on them." She is still asking herself where her baby was taken to. This means that without counselling she will live with this question for the rest of her life.

#### 6.6.1.1 DISCUSSION

Nonki's story clearly shows that even if the woman tries hard to forget about the abortion procedure that she had, it is not easy, especially for those who did not receive any counselling. This story further shows that termination of

pregnancy is accompanied by psychosocial implications and the women need to be helped to deal with these implications. This could only be achieved through counselling and the women could ultimately have life after the abortion procedure. Counselling could also be helpful for the women who do not receive any support from their families because of the secrecy that termination of pregnancy is handled with.

As it has been shown earlier in Nonki's story, the women are made to feel guilty about their decision, instead of being provided with counselling to help them deal with their decision better. It has been established from the literature that women experience guilt feelings for their decision to terminate the unplanned and unwanted pregnancy. When these guilt feelings are aggravated by the hospital environment, these women will find it very difficult to live with their decision. It is also not said in the story whether any counselling was provided but the researcher is strongly of the opinion that pre-abortion counselling would benefit the women on a long-term basis.

## 6.6.2 CASE STUDY 2

The other story is that of a 16 years old woman, Joyce, which appeared in True Love magazine, by Gidish (2001:70-72), Joyce indicated that she was unable to look at herself in the mirror, because of what she has done. She fell pregnant because her boyfriend did not want to use a condom and also threatened to leave her if she would not sleep with him. The boyfriend left her immediately after learning that she was pregnant. She did not tell her parents but shared her ordeal with her friend, who ultimately linked her with someone who performs abortions. The illegal abortion was successful, without any physical complications, but affected her emotionally. Her school work deteriorated, she became moody and depressed. She indicated that she felt guilty about everything and hated living with the lie.

### 6.6.2.1 DISCUSSION

Of importance to note here is that this girl did not receive any counselling and support from her family, except from her friend alone, as this was her secret.

The story of Joyce, further illustrates the emotional trauma that the woman experiences when faced with an unplanned pregnancy. For this woman the worst thing is that she was forced to sleep with this irresponsible and selfish

boyfriend against her will, only to be abandoned when he found out about the pregnancy. This clearly demonstrates the circumstances that force women to opt for termination of pregnancy.

Joyce did not want to disappoint her parents, thus she went for abortion without involving them. This could have a devastating effects on her life on the long-term, as we have already seen how on the short-term, her life had been affected.

The importance of pre-abortion counselling is shown by the story of a 21years old woman, in the same article as Joyce' story. This lady was from Springs in the East Rand, and she had an abortion at a private abortion clinic. She was provided with pre-abortion counselling which helped her to deal with her decision. This is indicated in her statement that reads: "I feel quite OK about it all and have no regrets whatsoever." This shows the important role played by counselling prior to the abortion procedure, which prepares the woman emotionally and also enhances her coping capabilities after the procedure.

#### **6.6.2.2 CONCLUSION**

It is evident from Joyce's story that termination of pregnancy is not an experience that brings joy to the women. As a result of this fact it becomes very important to acknowledge this fact and strive towards providing a comprehensive service, so that the women could be equipped to deal and live with their decision. This has been seen with the women in the sample, who were determined to keep their undergoing abortion a secret, without considering the emotional impact on them. Although pre-abortion counselling is essential, in this case, the girl would benefit from post-abortion counselling, as she could not receive counselling prior to the procedure.

### **6.7 FINAL CONCLUSIONS REGARDING QUALITATIVE DATA**

The unavailability of respondents for the interviews with the researcher shows that termination of pregnancy is accompanied by psychosocial implications. Even if women are aware of these psychosocial implications, like the 21 respondents in the sample, they try hard to deal with them on their own without any professional help. The major motivation in this

situation is the women's efforts to forget about this traumatic experience, without being reminded.

The results from this phase of the study show that the majority of the women who seek abortion are young and have no other children. The major reason for the decision is that they do not want their career paths to be disturbed by the unplanned pregnancy. For those who have other children are unable to cope with an additional responsibility of raising an unplanned child.

When the woman goes for abortion she has already taken a decision, this is the reason why all the women in the sample indicated that they were not interested in any other option. The shock of dealing with an unplanned pregnancy motivates the women to be more serious about their utilisation of the contraceptives. After dealing with the problem, that is, an unplanned pregnancy, through abortion, women become relieved. Because this relief is short-lived, it is important to see to it that the women are provided with counselling prior to the procedure.

Women who are provided with counselling prior to the abortion procedure are able to cope with their decision, unlike those who are not provided with any counselling.

## 6.8 SUMMARY

In this chapter the research methodology was discussed, followed by the attempts that were made by the researcher to have respondents for the interviews. The process that followed after the disappointment from the respondents was then discussed, followed by the profiles of the women who requested termination of pregnancy from the Women's Choice Clinic, that were drawn from the data found in the files. Then the data regarding the women that were found in their files was then presented, followed by the case studies, to illustrate the psychosocial implications of termination of pregnancy, as experienced by different women.

The following chapter deals with the guidelines for social work intervention.

## CHAPTER 7

### THE GUIDELINES FOR SOCIAL WORK INTERVENTION REGARDING THE ABORTION SERVICE

#### 7.1 INTRODUCTION

Abortion is a sensitive procedure, which is accompanied by the psychosocial implications. This has been established from the literature and the empirical findings. As a result of this state of affairs, there is a need for a comprehensive abortion service, which would ensure that the women are able to go on with life after abortion. The social worker, with the professional knowledge and skills, is equipped to be part of the multi-disciplinary team that renders a service at the abortion clinic. The fact that the women need to be provided with counselling, as part of the abortion service has been shown in the empirical findings. The researcher is of the opinion that pre-abortion counselling is most essential, as women would not like to be reminded of what happened, after the procedure; and this has been confirmed by the empirical findings of this study.

Although the indication for the need to be provided with counselling has been during the decision-making period, it is not always practical to see the women during this time. The only practical period to see these women is when they have reached the abortion clinic for assistance. The social worker can provide a meaningful service during this period, that is, prior to the procedure.

The following aspects are discussed in this chapter: the definition of key concepts, the nature of social work in health care, the role of the social worker in health care, the social worker as a team member, the bio-psychosocial model, the utilisation of the bio-psychosocial model in abortion counselling as well as the guidelines for social work intervention at the TOP Clinic.

#### 7.2 DEFINITION OF KEY CONCEPTS

The following concepts are defined to facilitate understanding of the chapter.

### 7.2.1 Social Work in Health Care

Social work in health care is defined by Barker (1991:141) as follows :  
“Social work in health care is the social work practice that occurs in hospital and other health settings to facilitate good health, prevent illness and aid physically ill patients and their families to resolve the social and psychological problems related to illness.”

On the other hand Skidmore, Thackeray and Farley (1994:146) define social work in health care as the application of social work knowledge, skills, attitudes and values in health care, where the social worker addresses himself/herself to illness brought about by or related to social and environmental stresses that result in failures in social functioning and social relationships.

Social work in health care could thus be said to be social work that is practised within a health care setting, where the social worker aims at improving the patients' social functioning, that was affected by illness or related to illness.

### 7.2.2 Bio-psychosocial

The term bio-psychosocial is defined by Barker (1991:23) as “a term applied to phenomena that consist of biological, psychological and social elements.”

According to Kaplan, Sadock and Grebb (1994:1), the bio-psychosocial model of disease stresses an integrated systems approach to human behaviour and disease.

Engel (1980:535) sees the bio-psychosocial model as a scientific model constructed to take into account the missing dimensions of the biomedical model.

From the above definitions it becomes clear that the bio-psychosocial model recognises the interaction between the medical, social and psychological dimensions of disease and illness. This means that without taking all these dimensions into consideration, it won't be possible to come to an appropriate diagnosis. Without this appropriate diagnosis then the patient could not be provided with the service that is responsive to his/her needs.

### 7.3 THE NATURE OF SOCIAL WORK IN HEALTH CARE

It becomes important to look at the nature of social work in health care, before looking at the roles played by the social worker in a health care setting. In rendering social work intervention, social workers operate within the scope of the multi-disciplinary team, where all the members of the team are concerned with having the patient provided with a comprehensive service. The major function of the social worker in this context is to improve the patient's social functioning while at the hospital and also after discharge. This has to apply to the patients who receive the abortion service as well. This makes it important for the women who request termination of pregnancy to be treated by the multi-disciplinary team, so that all the aspects of their lives could be attended to. This will ensure that their social functioning is enhanced, after the procedure.

Social work in health care is the application of social work knowledge, attitudes and values to health care and it is practised in collaboration with medicine and other related professions. According to Skidmore, Thackeray and Farley (1994:146), social work intervenes with medicine and other related professions in the study, diagnosis and treatment of illness at the point where social, psychological and environmental forces impinge on role effectiveness. The social workers in health care use problem-solving methods in assisting individuals, families, groups and communities in solving health-related problems.

#### 7.3.1 THE ROLE OF SOCIAL WORK IN HEALTH CARE

There are specific roles that the social worker plays within the health care setting. Skidmore, et al. (1994:151) identify a variety of specific roles that are played by the social worker within the health care setting and these roles will be dealt with briefly as follows:

- **Assessment of the patient's psychological and environmental strength and weaknesses**

The social worker is equipped with the skills to make a thorough assessment of the patient's psychological and environmental strengths which are needed for the team to fully understand the patient. This understanding is needed for the patient to be provided with an appropriate treatment. It is only through understanding the patient's strengths and weaknesses that the team



could be able to plan the treatment programme accordingly. This assessment is applicable for the women who request termination of pregnancy, because it is important to understand them fully, before they undergo the procedure. Knowing the women's strengths and weaknesses will enable the team to assist them (women) to proceed with life after the procedure.

- **Collaboration with the multi-disciplinary team in the delivery of services to assure the maximum utilisation of the skills and knowledge of each team member**

Due to the difference in knowledge and skills of the team members, there is a need for collaboration, so that the patients are provided with a comprehensive service. This is the reason that makes the role of the social worker at the TOP Clinic important. Without the involvement of the social worker the women are denied the specialised knowledge and skills, that would otherwise facilitate their coping after the procedure.

- **Assist the family to co-operate with treatment and to support the patient's utilisation of medical services**

There are times where the patient's family is not keen to co-operate with the team regarding its member's treatment. This could lead to a situation where this poor patient could end up not motivated to proceed with the treatment process, which could have devastating results. The social worker in this situation could help in facilitating this co-operation, so that the patient could ultimately benefit from the treatment as well as the support from his/her family. With regard to the women who request termination of pregnancy, the social worker could motivate the family members not to be judgemental towards her (woman), but to understand her situation and provide her with the necessary support. This would help the woman to move on with life after the procedure. If the family do not know, the social worker could try to motivate her to tell them, for them to provide her with the needed support.

- **Serve as a broker of community services, thus providing linkages of patient needs with appropriate resources**

As a broker of community services the social worker has to make sure that the community is provided with the resources that are responsive to their needs. The community could be equipped with the knowledge regarding

these resources by the social worker, through the utilisation of the communication skills that are part of the social work training. For the TOP Clinic the social worker has to make it his/her task that the service is responsive to the needs of the women. This makes it very important to have social workers as part of the team at the TOP Clinic.

▪ **Participate in the policy-making process**

For the service to be responsive to the needs of the patients, there is a need to have appropriate policies formulated and implemented to that effect. Having this in mind, the researcher is of the opinion that even though at this stage the abortion legislation does not include the social workers as service providers at the TOP Clinic, the social workers need to challenge this. The social workers have to challenge the legislation so that it could be responsive to the needs of the women, as all the aspects related to their decisions would be attended to, by their involvement as part of the team that renders the abortion service.

▪ **Engage in research to assure a broadening of the knowledge base for successful practice.**

Research informs social work practice, as a result the social workers need to be involved in research, in order for social work practice to be responsive to the needs of the patients and not what the practitioners think are the needs. It is from research results that the researcher has established that the women who request termination of pregnancy need counselling before they go through with the procedure.

Cowles (2000:30-31) on the other hand identified the specific functions of the social worker in health care as follows:

- Assessment of the need for social work services.
- Pre-admission planning and discharge planning.
- Direct services and treatment to individuals, families and groups.
- Case-finding and outreach.
- Information and referral.
- Client advocacy within and outside the organisation, including attention to fiscal constraints.
- Protection of clients' rights and entitlement, including the right to redress.
- Short and long term planning.

- Promotion and maintenance of health and mental health.
- Prevention, remedial and rehabilitative measures.
- Provision for continuity of care, including guarantee of access and effective utilisation.

It is evident from the above functions that the social worker has to be involved as broadly as possible in the patients' situations. This has to start with the prevention, which must be followed by assessment for social work intervention. This notion is supported by Mabe (1996:54) that social workers should be knowledgeable regarding the legislation, so that they could assist women who are faced with unplanned and unwanted pregnancy within the legal parameters. This could only be attained by having the social worker as a member of the team that renders the abortion service. These functions are also relevant for dealing with women who opt for termination of pregnancy. It is very important for the social worker to be involved in the outreach programmes where unwanted and unplanned pregnancies could be prevented. In cases where the unwanted and unplanned pregnancy has already occurred, the social worker's involvement must include the promotion and maintenance of health and mental health by providing appropriate counselling.

Although at this stage the role of the social worker at the TOP Clinic is not yet recognised, the researcher is of the opinion that the social worker has a vital role to play. Fulfilling the functions of assessment of the need for social work service and case-finding and outreach, as advocated by Cowles (2000:30), the social workers will be moving away from the traditional tendency of relying on referrals from physicians and nurses, which allow the selection of the kinds of clients problems that the social worker should address. This calls for the social workers to make the team members aware of the need for their involvement at the TOP Clinic.

The role of assessment of the patients' circumstances is in agreement with what is indicated by Skidmore, et al. (1994:151), that the social worker has to make a thorough assessment of the patients' psychological and environmental strengths and weaknesses. This will enable the team to understand the patient better, hence provide the needed service with sensitivity. Without this understanding, the women who request termination of pregnancy will be provided with the service that only satisfies their physical needs only, which is, getting rid of the pregnancy, without considering all the other aspects that are involved in the situation.

According to Germain (1984: 78), the roles and tasks of the social worker in helping the patients cope with the stress of illness, injury or disability are as follows:

Table 14

Roles	Tasks
Mobiliser	Providing incentives and rewards for patients to cope. Deal with ambivalence, resistance and dependency of patient
Teacher/coach	Provide instruction in coping skills individually and in groups
Collaborator	Provide instruction in coping skills individually and in groups and influence the environment to do the same.
Enabler	Providing emotional support and influence the organisation to be responsive to emotional needs
Organiser	Organising and working with natural support systems
Facilitator	Providing information, time and space for effective coping; opportunities for choice; decision-making and action
Innovator	Creating new programmes and services to meet needs
Advocate	Influencing organisational and outer environments to change when needed.

Roles of the social worker in health care are seen by Auslander (1997:28-31) as follows:

- To claim the territory of case management. In this role the social worker employ his/her skills to see to it that the patient is correctly linked with the needed resources. The patient and his/her family are helped to define their needs, understand the constraints and options that affect meeting those needs and engage them in problem-solving.
- Address the impact of the illness on the patient and his/her family, and prepare them to deal with the reality, that is, addressing the psychosocial needs of the patient and the family.
- Emphasis on primary care and preventative services. In this role the social worker has to make sure that the programmes that are aimed at prevention of diseases are developed and implemented.
- Offer counselling to new patients, chronically ill and their caretakers, elderly patients, terminally ill and those suffering from emotional problems.

The above roles and tasks can also be used at the TOP Clinic, for the patients to receive a comprehensive service which is responsive to the needs of the consumer.

Cowles (2000:73) indicates the following as the roles of the social worker in health care:

- An advocate who fights for or defends clients' rights.
- A broker who knows all the relevant resources and links the clients with the most appropriate ones.
- A case manager who assesses a client's needs, link that client with needed resources and co-ordinates and oversees resource delivery.
- A consultant who provides expert opinion to others, when asked.
- A counsellor who engages in personalised interpersonal interaction with a client, which involves the client's feelings, attitudes, perceptions or behaviour
- A liaison who acts as a go-between, between two or more people or organisations.
- A mediator who facilitates conflict resolution between parties.
- A researcher who develops new knowledge.
- A planner who prepares a design for a course of action.
- A teacher who transmits knowledge to others.

The above roles are in agreement with the roles that were identified by Germain (1984:78) as discussed earlier on. All these roles clearly indicate the importance of social work service in health care, including the TOP Clinic.

### **7.3.2 THE SOCIAL WORKER AS A TEAM MEMBER**

It is important to note that the social worker performs his/her roles and tasks as a member of the interdisciplinary team, which has to be characterised by a high level of collaboration. Cowles (2000:133) argues that the social workers' claim to a place on the interdisciplinary team must be based on expertise. Without this expertise the role of the social worker will be confused with that of other role players. This is the reason why the social worker must have a clear knowledge base of his/her profession, as well as the skills that distinguish it from the other professions. This knowledge and skills must be clearly communicated to the other team members, to avoid role blurring amongst the team members.

According to Davidson and Clarke (1990:273) collaboration and co-operation has to be the major characteristics of the multi-disciplinary health team, for it to meet the needs of the patients. In this team approach many different perspectives are brought to bear on how care is provided and on what emphasis and value are placed on the contribution of the social worker.

Collaboration is defined by Germain (1984:199), as a co-operative process of exchange involving communication, planning and action on the part of two or more disciplines, with the purpose of achieving specific goals and tasks related to health care, that cannot be achieved by one discipline alone. In this process there has to be a clear role identity which will enable each team member to competently perform his/her role. Even though there could be overlapping of roles amongst the team members, collaboration can facilitate the team's efforts of providing a comprehensive service.

Inherent in the concern for providing good health care through collaborative rather than co-operative interdisciplinary teams is the necessity for social work to function as an autonomous profession. (Compare Schlesinger, 1985:225 and Erickson and Erickson 1994:8.) With the maintenance of this autonomy role blurring could be avoided. This also applies to the TOP Clinic, where all the team members are to work together, for the benefit of the patients. No team member must see himself/herself as more important than the others.

In this setting social workers need to develop collaborative skills in order to be recognised, as well as render a meaningful service. Davidson and Clarke (1990:273) are of the opinion that these collaborative skills include the strategies of interpretation, negotiation, marketing and education. With these skills the social worker enables other team members to understand the patient's psychosocial problems and their stressful impact on recovery and adaptation.

It is clear from the roles discussed above, that there is no way that the social worker in a hospital could work in isolation, but as a member of the interdisciplinary team, for the patients to receive an appropriate service, that is responsive to their needs. This shows the importance of having the social worker involved at the TOP Clinic, where the patients will be provided with a comprehensive service by all the team members, without neglecting some aspects in their lives. Without the involvement of the social worker at the TOP Clinic, there is no other team member who could play social work

roles, and this will forever leave the women who request termination of pregnancy without their psychosocial needs attended to.

Carbonatto and Du Preez (1990:319) indicate the skills that the social worker in a health care setting should have as follows:

- Acquiring sufficient knowledge of various diseases, the symptoms, the causes, the treatment and the implications for the patient and his family.
- Acquiring thorough knowledge of the specific diseases related to each area appointed in, in a hospital or medical setting, (for example gynaecology) including the symptoms, the causes, the treatment and implications of the disease, treatment or disability for the patient and his family.
- Being able to work in a hospital or medical setting.
- Being able to work with the sick and sometimes mutilated people on a daily basis.
- Understanding and intervening in the psychosocial implications of hospitalisation, illness, trauma, treatment and disability.
- Understanding the emotional implications of hospitalisation, illness, trauma, treatment and disability for the patient and his family and offering the necessary support and atmosphere for emotional catharsis.
- Being able to work with the terminally ill or dying patient and his family and to provide the necessary bereavement counselling.
- Being able to remain objective, with the necessary empathy in these highly emotional circumstances.
- Being able to work with the long-term chronically ill, disabled or geriatric patients, requiring patience, perseverance and knowledge of the applicable community resources.
- Having efficient therapeutic skills.
- Having adequate skills in crisis intervention.
- Having skills in short-term counselling.
- Providing continuous supportive counselling throughout the hospitalisation and treatment period.
- Having effective communication skills.
- Being able to motivate, develop insight and prepare patients for treatment, hereby ensuring their co-operation in the total plan of treatment.
- Having adequate skills in implementing the social work methods and techniques.
- Being able to do a thorough psychosocial assessment in a short period of time.

- Being able to share the knowledge of the emotional or psychosocial effects of illness, hospitalisation, treatment and disability with other disciplines, patients and their families.
- Functioning in an inter-disciplinary team or the ability to collaborate.
- Having assertive skills, especially of necessity in the inter-disciplinary team
- Maintaining a professional image.
- Developing adequate skills in constantly educating other professionals, students and patients, regarding the roles and tasks of the medical social worker.
- Constantly educating other disciplines, regarding the psychosocial effects of hospitalisation, illness, treatment and disability on the patient and his family.
- Acquiring sufficient knowledge of community resources and knowing when it is appropriate to refer a patient.
- Innovating, facilitating, organising and co-ordinating services.
- Educating patients and their families, as well as the community regarding the prevention of certain diseases and thereby enhancing their health and social functioning.

It is important for the social worker to have the above-mentioned skills for him/her to render a meaningful service for the patients in a health care setting. Without these skills the social worker will not be in a position to function within the team.

#### **7.4 THE BIO-PSYCHOSOCIAL MODEL**

The bio-psychosocial model is seen by Engel (1980:535), as a scientific model constructed to take into account the missing dimensions of the biomedical model, which represents the application to medicine of the classical factor-analytic approach that characterised Western medicine for many centuries. The biomedical model disregards the interaction between the medical, psychological and the social aspects in illness or human behaviour. Engel (1980: 535) goes further to say that the bio-psychosocial model is based on the systems approach. Kaplan, Sadock and Grebb (1994:1) indicate that Engel, the psychiatrist, is the prominent proponent of the bio-psychosocial model. With this model a relevant model that looks at the patient as a whole was introduced. This new way of looking at the patient is vital because the patient is treated as a whole, with all the aspects that are relevant to his/her situation taken into consideration. Kaplan, et al.



(1994:1) argue that Engel's model does not assert that the medical illness is a direct result of a person's psychological or socio-cultural makeup but, rather, encourages a comprehensive understanding of disease and treatment.

According to Kaplan, et al. (1994:1), this model stresses an integrated systems approach to human behaviour and disease, because of the continuous interaction between the individual's body, mind and social context. It becomes evident that the bio-psychosocial model came into being after the realisation that in order for the person's illness to be understood there is a need to look at the three dimensions in his/her life, namely, biological, psychological and social. This understanding enables the health team to provide a treatment programme that is responsive to the needs of the patient.

Brannon and Feist (1992:11) argue that a systems approach emphasises the mutual dependence of each system within the whole and suggests that a change in one system will produce changes in the other systems. The systems approach is not a necessary component of the bio-psychosocial model but it helps one to understand the interaction among the biological, psychological and social components of disease and wellness. This understanding is very important for the health practitioners not to deal with human beings in a fragmented manner. Every human being, who seeks medical attention must be seen as having the three components, which are in constant and continuous interaction. It must be remembered that it is this interaction that determines the state of health of a person.

It is argued by Green and Shellenberger (1991:19) that, the bio-psychosocial approach to health and wellness views health and wellness as the result of the interaction of biological, psychological and social factors. This implies that, no wellness can be attained without utilising this approach, including the abortion service. Green and Shellenberger (1991:19) further indicate that the biological factors include genetics, environmental factors and behaviour that affect biological functions, whilst psychological factors include personality, feelings, stress management, life goals, perceptions of health and sickness behaviours, whilst social factors include social values, customs and social support. Of importance here is to note that the interaction of these factors impact on the person's wellbeing. If only one aspect is attended to and the others are neglected, wellness cannot be attained.

Karoly (1985:434) argues that, the bio-psychosocial orientation involves an interdisciplinary systems orientation to health care. This orientation enables the service providers to consider the biological, psychological and environmental information about a patient, to make appropriate diagnosis and develop the treatment programme that encompass all the three areas. Looking at the abortion service, when all the aspects of the woman's life, specifically, her decision to terminate a pregnancy, are not attended to, this woman will experience this procedure with intense pent-up feelings.

The three dimension of health and illness will be discussed briefly.

#### **7.4.1 THE BIOLOGICAL DIMENSION**

As indicated earlier on, the bio-psychosocial model is based on the systems approach, which stresses an integrated systems approach to human behaviour and disease. The biological system emphasises the anatomical, structural and molecular substrate of disease and its effects on the patient's biological functioning. (Compare Kaplan, et al. 1994:1.) According to Bernard and Krupal (1994:13), the biological aspects include the genetic predisposition, physiological reactivity, pathogens and immune responses. This aspect of the person is where the medical practitioner always begins when consulted by a patient (Engel, 1980:538). This happens within a doctor-patient relationship and the medical practitioner will collect the data that will enable him/her to reach a diagnosis.

With regard to the woman who requests termination of pregnancy, the unwanted and unplanned pregnancy is the biological aspect the caused her to approach the facility. The service provider gets to know the woman because of this biological condition, but in understanding the other dimensions that are related to the condition must be taken into consideration. Without this understanding the woman will be provided with an incomplete service, where the other aspects of her conditions are not attended to, which could create problems for her later in life. This is the reason why the researcher is of the opinion that the bio-psychosocial model is the relevant model to be used at the TOP Clinic.

#### **7.4.2 THE PSYCHOLOGICAL DIMENSION**

According to Kaplan, et al. (1994:1), the psychological dimension emphasises the effects of psycho-dynamic factors, motivation and

personality on the experience of illness and the reaction to it. This dimension forms an important component of the bio-psychosocial model in the sense that it helps the medical practitioner to understand the patient's perceptions of his/her condition and the extent to which he/she is motivated towards getting help. The factors of the psychological dimension that are relevant here are seen by Kerns and Curley (1985:150), as the psychological functioning of the individual, the nature and severity of deficits in psychological functioning associated with the biological state and the individual's residual abilities to evaluate, adapt and cope with the psychological, biological and social changes, as well as the resulting deficits as a function of the biological condition.

When using the biomedical model these aspects are neglected, with a negative impact on the patient. Kerns and Curley (1985:150), further argue that the individual's cognitive, affective and behavioural functioning greatly influences the extent and meaning of perceived psychological and social losses, as well as the coping with or adapting to these losses. This clearly shows that an individual's condition cannot be successfully treated through the biomedical model, that is, disregarding the interaction among the biological, psychological and the social dimensions of his/her condition.

Engel (1980:538) argues that in collecting data regarding the biological aspects of the patient, it is crucial to also explore the psychological being, because the course of the illness and the care of the patient may be importantly influenced by processes at the psychological level. It is important to know that a person is only labelled as sick when he/she experiences something or exhibits some behaviour or appearance that is interpreted as indicating illness. How this person will react to this experience depends largely on the person's perception of what is happening.

Rationalisation and denial are the defence mechanisms that are mostly used by patients and this affects their reactions towards what is happening. This is the reason why some patients seek help when their conditions have advanced, sometimes to a level where intervention could no longer be effective. This also applies to the women who are faced with unplanned and unwanted pregnancies. They start by denying the reality and hope that it is not true, while in the meantime the pregnancy is advancing. This leads to women seeking termination of pregnancy during the second trimester, when the procedure could be risky, as indicated in chapter 2 of this thesis. Understanding these inner deliberations within the woman will help the

service providers to be sensitive towards the women who seek termination of pregnancy. The adoption of the bio-psycho-social model at the TOP Clinic will make it possible for the women's feelings and perceptions regarding their biological state to be attended to. In this way the women's coping capacity will be improved.

#### **7.4.3 THE SOCIAL DIMENSION**

Kaplan, et al. (1994:1) argue that the social dimension emphasises the cultural, environmental and familial influences on the expression and the experience of illness. On the other hand Sue, Sue and Sue (1994:27) indicate that it would be a serious oversight to neglect the powerful impact on the mental health of family upbringing and influence. It is important to note that this social aspect of the person's life does not only have an impact on the mental health but also on health in general. This shows the important role played by the social system in as far as an individual's health and mental health is concerned.

Engel (1980:543) is of the opinion that in using the bio-psycho-social model the medical practitioner is able to identify and evaluate the stabilising and destabilising potential of events and relationships in the patient's social environment, not neglecting how the destabilising effects of the patient's illness on others may feed back as a further destabilising influence on the patient. This argument emphasises the importance of the patient's social environment on his/her health and illness.

It is clear that the bio-psycho-social model is the relevant model when treating patients, to ensure that all the aspects pertaining to the patient's condition are considered. This model enables the medical service providers to understand the patients, which leads to designing an appropriate treatment plan, that is responsive to the needs of the patients.

#### **7.4.4 UTILISATION OF THE BIO-PSYCHOSOCIAL MODEL IN ABORTION COUNSELLING**

It is important to look at the woman who seeks abortion in totality, and not only as a person with a medical problem only. What is happening presently at the state abortion clinics is undermining the psychosocial aspects of the woman who seeks abortion. The woman is only helped medically, without considering the other aspects in her life, that could be affected or be the

reasons behind her decision to terminate the pregnancy. It would seem that when the problem, that is, the unplanned pregnancy, is dealt with, everybody sees the goal as being accomplished. It has been established from the literature and the empirical findings that abortion is accompanied by psychosocial implications. With this in mind, it becomes very crucial to have the state abortion clinics providing a comprehensive service, by looking at all the aspects that accompany termination of pregnancy.

The bio-psychosocial model has been found to be addressing all the aspects in the patient's life, hence enabling the provision of a comprehensive service. Without providing this comprehensive service, women who terminate pregnancy and are unable to share the experience with someone, might find themselves experiencing emotional problems later in life. This could lead to a situation where the majority of the women in the society are emotionally unstable, which could affect the society as a whole. As it has been seen, since the advent of the legalised abortion in the country, there is a considerable number of women who utilise the service at the state hospitals/clinics (Department of Health, 1997:15).

According to Shannon (1989:32), the social workers as the primary providers of psychosocial care can close the gap between physical health and mental health. This applies to the abortion service, where at present, social workers are not yet seen as important role players. The bio-psychosocial model emphasises the interplay between disease process and psychological and social functioning. (Compare Shannon, 1989:35.) In this regard women who seek abortion will be seen in the light of having a medical problem, which is accompanied by psychosocial implications. This would make it inadequate to address the medical problem alone, without looking at the psychosocial aspects.

The application of the bio-psychosocial model will be discussed briefly, to illustrate its importance in the abortion service.

#### **7.4.4.1 PREMISES UNDERLYING SOCIAL WORK ROLES IN THIS MODEL.**

The social worker as a member of the multi-disciplinary team at the abortion clinic has specific roles to play, to ensure that the women receive a comprehensive service. The importance of the pre-abortion counselling in this regard cannot be overemphasised. The following are the specific

premises that underlie social work's speciality practice in the health care field, as seen by Shannon (1989:35); which are also relevant to the abortion service:

- Social, cultural and economic conditions have a significant and measurable effect on health status, illness prevention and recovery. For the women who seek abortion the social, cultural and economic conditions play a significant role. The major reason that was indicated by women for the decision to terminate the pregnancy in this study was the economic condition, mostly because the majority of the women were still dependent on their parents. In providing pre-abortion counselling to these women the social worker would look into how this situation affects the woman psychologically, especially that the women did not tell their parents about the pregnancy, because they suspected that it would cause some problems, hence jeopardise their schooling or career path.

The other important aspect here is the cultural one, where amongst the black people, the extended family always tries to encompass all its offspring. For the woman who decides to terminate the pregnancy in this cultural background, she would feel guilty about the decision but also have the desire to proceed with either her schooling or career, without having to be disturbed by the unplanned pregnancy. The social worker will be able to help the woman to deal with these feelings prior to the procedure, which would facilitate the coping process, after the procedure.

With regard to the social aspects, isolation after the abortion could be prevented through pre-abortion counselling. This isolation is directly linked to depression which follows abortion, when the woman realises that her abortion is an unchangeable act (Michels, 1988:92). This could be dealt with through counselling prior to the procedure, where the woman could be helped to acknowledge her feelings, regarding her decision and deal with them. With this pre-abortion counselling the woman will be prepared for what is to come and also proceed with her life after the procedure.

- Illness related behaviours, whether perceived or actual, frequently disrupt personal or family equilibrium and coping abilities. It has been established in this study that when a woman is faced with an unplanned and an unwanted pregnancy, she becomes overwhelmed with a variety of feelings, which affect her behaviour. As a result of this situation the woman's relationships are affected, as well as her work performance. In

cases where this woman did not tell anybody about her predicament, she is not going to receive any support, which will isolate her further. This is the reason why the researcher is of the opinion that pre-abortion counselling is crucial. These variety of feelings that the woman experiences could be dealt with, for her (woman) to go through the procedure with new coping abilities. This would prevent long-term negative effects of abortion on the woman's life and enable her to maintain a personal equilibrium.

- Medical treatment alone is often incomplete and occasionally impossible to render, without accompanying social support and counselling services. It is evident from the literature and empirical findings indicated earlier on, that abortion is accompanied by a variety of psychosocial implications. Providing a woman who seeks abortion with the medical treatment alone does not help her deal with her circumstances in totality. As a result the psychosocial implications that were not attended to, could lead to intense disturbance in the woman's life in future. Due to the provision in the Choice on Termination of Pregnancy Act (No.92/1996), where the woman, the minor included, could give consent for her termination of pregnancy, without informing anybody about it, the woman who are just provided with the medical treatment could end up with a disturbed self-esteem. Because of this secrecy this poor woman would be unable to be provided with the appropriate support. But if this woman could be provided with pre-abortion counselling as part of the abortion service, she would be equipped with coping skills and be able to face life positively after abortion.

As the social worker is not going to act as a judge in this woman's situation, he/she will be in a position to help her look at her situation constructively, hence empowering her to go on with life after abortion. This is emphasised in the developmental approach in social work practice, as proposed by the South African government (White Paper for Social Welfare, 1996). For the woman who was provided with pre-abortion counselling it would be relatively easy for her to go back for post-abortion counselling, if she finds it difficult to go on with her life after the procedure.

- Problems of fragmentation, access and appropriate utilisation of health services are sufficiently endemic to the health care system as to require concerted community planning as well as institutional innovations. With regard to abortion services that are provided at the government facilities

presently, there is fragmentation, where the medical personnel is seen as the only service providers. With this fragmentation the women who seek abortion are not provided with a comprehensive service, because not all the aspects of their situations, are taken into consideration. This could lead to long-term negative effects on the woman's life. It would be beneficial if the social worker could be part of the multi-disciplinary team that renders the abortion service. In this situation the social worker would attend to the psychosocial aspects of the women's situation, as it has been indicated by Shannon (1989:32), that social workers are primary providers of psychosocial care in a health care setting. This would do away with the fragmentation of the service and ensure the provision of the comprehensive one, which is responsive to the needs of the women.

Multi-professional health team collaboration on selected individual and community health problems can be an effective approach to solving complex social-medical problems. In the case of abortion service the multi-professional team collaboration is a necessity, to ensure the provision of a comprehensive service. The women who seek abortion at the state abortion clinics need to be provided with a comprehensive service, where not only the medical personnel would be the sole service providers, but also other members of the team. As it has been revealed that the women who seek abortion need counselling, specifically before the procedure, there is a need to have social workers as part of the team that provide abortion service. This collaboration will ensure that all the aspects of the women's lives are attended to, making her to a better adjusted person after the procedure.

MacLean-Brine (1994:199), on the other hand, identified primary issues that need to be focused on by the social worker at the termination of pregnancy clinic during the pre-abortion counselling session, and these issues are:

- Previous experience with abortion, that is, own pregnancy/pregnancies or that of others
- Inner conflict arising from personal moral, ethical or religious beliefs about abortion
- Clear understanding of the therapeutic abortion procedure, that is, fears, misconceptions, physical response and recuperation
- Emotional adjustment to having to terminate a pregnancy and coping with the ramifications of the decision
- Possible risks and complications of the procedure and potential for affecting her childbearing ability in the future



- Pregnancy denial and requests for mid-trimester therapeutic abortions
- Future relationship with father of the aborted child and future partners in regard to the abortion experience
- Request for pregnancy termination following successful conception after reversal of sterilisation.

It is very important for the above-mentioned issues to be addressed prior to the abortion procedure in an effort to help the women to see their situation in the right perspective. This will also enable the women to effectively deal with what lies ahead. In this way all the aspects pertaining to the woman's situation will be addressed, thus ensuring the woman's well-being. The social worker at the termination of pregnancy clinic has to aim at equipping the women with all the necessary information pertaining to the procedure and also help them project into the future, that is, the life after the procedure. It is also important for the social worker to help the women deal with their emotions pertaining to their decision, and not just think that they can forget about it, without any professional help. The danger with this effort of forgetting by themselves is that the women could end up stuck with over-utilisation of defence mechanisms, which may be counter-productive.

The roles that the social worker has to play at the TOP Clinic, are seen by MacLean-Brine (1994:201-206) as follows:

- The social worker has to identify the psychosocial issues inhibiting the woman's ability to adjust and to cope with the various issues related to her obstetrical and gynaecological health care, and this includes adjusting to the unplanned and unwanted pregnancy. The social worker uses his/her skills to engage the woman in addressing the identified areas of concern, with a view to enhance her psychosocial functioning, hence promoting a healthier adjustment to changes inherent in the problem she is facing, namely an unplanned pregnancy. Assessment plays an important role in this regard because it will enable the social worker to establish the women's level of psychosocial functioning. This will lead to the provision of appropriate supportive counselling to enhance adjustment to the situation and improve psychosocial functioning.
- The other role that the social worker has to play when dealing with an unplanned pregnancy is to examine each of the patient's options with her, encourage her to examine those options and assist her to appreciate the inappropriateness of certain options, based on her unique circumstances.

The social worker has to help the woman to make a competent decision and provide support regardless of the decision made. This means that the social worker has to be non-judgemental towards the woman, after she has made her decision to terminate the pregnancy. The woman needs to be supported so that she could come to terms with her decision and also deal with the ramifications of her choice. This will equip the woman with coping mechanisms and also prepare her to deal with what is lying ahead, after the procedure. As it has already been shown in this study, the decision-making process is very crucial and the woman needs to be helped to move through this stage constructively.

It is important to note that the woman who choose termination of pregnancy when faced by an unplanned and unwanted pregnancy does not do so automatically or casually, as it has already been established from this study. It takes the woman a period of inner deliberations, coupled with a variety of emotions. Even though the decision is made by the woman herself, the social worker must be alert and sensitive to the emotional pain the woman could be experiencing because of her choice.

At the time of making the decision to terminate the pregnancy it may be difficult for the woman to understand that her grief reaction and her sense of loss, can mirror that of a miscarriage, even though she has voluntarily given up the pregnancy. The fact that intellectual reasoning does not remove emotional pain must be addressed through counselling. The social worker has to assist the woman to understand that no decision is made in an emotional void and that she will experience some inner emotional response to her decision, no matter how sure she is of the appropriateness of her decision.

In providing counselling during this period the social worker must be aware of the uniqueness of each woman. Again during this period the woman who is faced with an unplanned pregnancy is unable to anticipate grief reaction in response to termination of pregnancy. It becomes therefore very important for the social worker to assist the woman to project into the future, because at this stage the woman is overwhelmed with getting rid of the problem without thinking about the period thereafter.

With the utilisation of the bio-psychosocial model when rendering the abortion service, the researcher is convinced that the women will benefit from the service that the state is providing. The women who seek abortion

are going through a difficult time and would benefit from a comprehensive abortion service, which is provided by all the appropriate team members, because all the aspects pertaining to their circumstances would be attended to. It has been established from the findings that there is shortage of the nursing personnel at abortion clinics, which puts a considerable amount of stress on them. Under these circumstances it cannot be expected of them to provide counselling for these women. This emphasises the importance of having social workers as part of the abortion service team at all state clinics/hospitals to provide counselling, which is so needed. As it has already been indicated, social work professional knowledge base and skills, equip the social workers to provide this most needed service. To ensure that the women who are faced with unplanned pregnancy are not doomed for the rest of their lives, it is important that they are provided with a comprehensive abortion service.

## **7.5 GUIDELINES FOR SOCIAL WORK INTERVENTION AT THE TOP CLINIC**

The social worker who provides counselling for the women at the TOP Clinic, within the bio-psychosocial model needs to observe all the social work values and principles. The most important principle in the researcher's opinion in this context, is adopting a non-judgemental attitude. The guidelines for the pre-abortion counselling are based on the empirical findings.

### **7.5.1 PRE-ABORTION COUNSELLING**

When a woman approaches the TOP Clinic with an unplanned and unwanted pregnancy, all the aspects that are related to her condition need to be taken into consideration. The social worker has to realise that this woman is going through a turmoil of emotions. As a result of this, there has to be a thorough assessment of these emotions and also assist the woman in dealing with them. This can only be achieved when the social worker is consciously utilising all the social work principles, where this woman will be seen as an individual, not judged and also allowed to exercise her self-determination.

#### **- The woman's feelings**

It has to be in the social worker's mind that it is during this period that the women indicated their need for social work intervention. It could be that

during this period the woman is not sure of what to do with her circumstances, therefore exploring her feelings could help her to see her situation in the right perspective. It is evident that during this period the woman is overwhelmed with a variety of feelings, because of the decision she has made to have the pregnancy terminated. Exploration of these feelings will assist the woman to identify them and deal with them. If the woman could go through the procedure without her feelings been attended to, she could find herself with emotional problems after the procedure.

#### - **Woman's reaction to the pregnancy**

It is also important to explore the woman's initial reaction when she discovered that she was pregnant. These reactions will help the woman to identify her real feelings regarding the pregnancy and enable her to cope with the situation. From the findings it is clear that the women experienced a variety of reactions to the unplanned and unwanted pregnancy. This calls for the social worker's sensitivity towards the women when dealing with these reactions.

#### - **Woman's reasons for the decision**

The reasons for the decision to terminate the pregnancy need to be explored during this period. These reasons need to be discussed in-depth, to help the woman to really see her situation in the right perspective. This has to be done because the woman during this period would be overwhelmed by negative feelings which has an impact on her judgement. The woman needs to be helped to project into the future to see if she could not regret the reason/s she based her decision on. From this study the major reason was the economic circumstances, which can be changed over time, depending on what efforts are made and the resources that are available. These are the facts that need to be discussed and clarified with the woman, for her to be able to make an informed decision and move on with her life, without being judgemental on herself.

#### - **Other options**

All the options at the woman's disposal need to be discussed in-depth for the woman to feel at ease with the one she ultimately decides to implement. Even if the woman has come to the TOP Clinic, she could consider other options, if she is provided with an opportunity to explore them. It has to be

taken into consideration that when a woman is faced by an unplanned and unwanted pregnancy her whole focus is on the problem and the quickest way of solving it. As a result of this situation the woman's thought processes are merely centred around getting rid of the problem, without projecting into the future, on how this solution could affect her. By discussing other options with the woman there should not be aimed at convincing her to change her decision, but to assist her to make an informed decision that she could live with in future.

#### - **Woman's feelings regarding her decision**

The woman's feelings regarding her decision needs to be explored during this period. Although the woman has made the decision to have a termination of pregnancy, it should not be taken for granted that her feelings are positive towards this, as it has been confirmed in this study. These feelings need to be explored and dealt with before the procedure to enable the woman to go through the procedure with clear feelings. It is important to note that due to this unplanned situation the woman could end up over-utilising the defence mechanisms, that could prevent her from dealing with the real situation. This is the reason why it becomes very important to address these feelings prior to the procedure.

#### - **Information provision**

Providing information forms an important aspect of the pre-abortion counselling. Due to the fact that it is not always practical for the medical personnel to provide this information, the social worker has to fulfil this role. Because one of the social work tasks, within the health care sphere, is educating the patients and their families regarding the diagnosis and treatment procedure. The woman has to be informed about the methods of termination of pregnancy at different periods of gestation, the risks and complications involved, as well as what to do when sign or symptoms are observed. With this information the woman will be equipped to deal better with the process and also have some psychological preparation, as she would be able to have some expectations. This could reduce anxiety in the woman to a manageable level.

### - **Woman's religious background**

The social worker has to consider the woman's religious background during the pre-abortion counselling session. Although women from all the religious backgrounds do request termination of pregnancy, the individual woman's convictions need to be dealt with. For the woman with a strong religious conviction, deciding on termination of pregnancy might be an extremely painful thing to do. She could find herself battling with her real situation as opposed to her religious background. The thing that makes this situation very difficult is that this poor woman won't be able to discuss this with anybody, especially the church members, because of avoiding their judgement. This could lead to this woman not being able to go on with life after the procedure. This is the reason why she has to be provided with proper counselling before the procedure, to allow her to deal with all the inner emotions evoked by her situation as opposed to her religious background and the ethical-moral issues involved.

### - **The woman's cultural background**

It is also important to look at the woman's cultural background during the pre-abortion counselling, because this influences how she sees herself and interprets what is happening to her. As a result, this aspect has to be considered when the pre-abortion counselling is provided. For example, within the African culture, it is difficult or unheard of, of a woman to decide on terminating a pregnancy, especially for the rural people. This is the reality because the extended family is always ready to look after all its offspring, regardless of the financial implications. A woman with this background will strongly feel guilty about her decision, to an extent that she is unable to face life after the procedure. As a result she needs this aspect to be fully explored and dealt with before the procedure.

### - **Woman's perception of self.**

How the woman perceives herself in the situation is very important because it influences the way she will handle the current situation as well as the future. As a result this aspect needs to be fully explored during the pre-abortion counselling session. The woman needs to be assisted to look at herself and her circumstances in the right perspective. Due to the variety of emotions that accompany an unplanned and unwanted pregnancy, leading to

the decision to terminate it, the woman's perception of self is very crucial to attend to and help her deal with it.

- **Relationship with partner**

The relationships of the woman who requests termination of pregnancy must be attended to during the pre-abortion counselling session, especially her current relationship with the partner, which resulted in this situation. The social worker has to make it a point that the woman is not biased with regard to her decision, that is, basing her decision solely on the failed or soured relationship with the partner. If this is the situation it could be that the woman made the decision out of anger, which could later subside and leave her with guilt feelings. This could lead to the woman having difficulty living with her decision, after her anger has subsided.

- **Future planning**

Regarding the future planning the social worker has to assist the woman to focus on new relationships, how to prevent another unwanted and unplanned pregnancy, as well as her career planning. Of importance here is to explore the woman's feelings regarding her future heterosexual relationship/s, so as to help her not to be overcome by anger, that could lead to her leading a life characterised by vengeance towards men. This anger could cloud the woman's judgement resulting in her inability to make constructive decisions in future.

- **Family planning**

Another aspect that the worker has to focus on during counselling prior to the procedure is the woman's plans for the future regarding family planning. Family planning has to be discussed in-depth, where the failed method and the other available methods should be included. This will help the woman to see where she went wrong and decide on which method would be most suitable for her, to prevent the occurrence of another unplanned and unwanted pregnancy. Letting the woman choose the method that she thinks would be most suitable in her situation will improve her sense of compliance and also makes her feel in control of her life.

## CHAPTER 8

### - Sharing the experience in future

It has been established from the study that termination of pregnancy is still surrounded by secrecy. As a result the women who request termination of pregnancy need to be made aware of the danger of holding this inside without sharing it with anybody. It is during the pre-abortion counselling that this aspect could be discussed and dealt with.

#### SUMMARY

In this chapter the following aspects were discussed: the nature, functions, tasks and role of social worker in a health care setting, where it was established that the social worker in this field has a major role to play; the bio-psycho-social model as an alternative to the biomedical model; the specific premises that the social worker has to concentrate on within the bio-psycho-social model; the utilisation of the bio-psycho-social model at the TOP Clinic; the specific roles that the social worker has to play at the TOP Clinic within the bio-psycho-social model; as well as the guidelines for social work intervention prior to the procedure.

The following chapter will deal with the summary, conclusions and recommendations for the whole study.

- The focus of this chapter is on the summary, conclusions drawn from the study, as well as the recommendations. The content of each chapter in this thesis will be highlighted by means of a summary, conclusions and recommendations, according to the following theme:
- The medical aspects of abortion
- The psycho-social aspect of abortion
- The legal aspects of abortion
- The empirical findings from the quantitative approach
- The empirical findings from the qualitative approach
- The guidelines for social work intervention regarding pre-abortion counselling



## CHAPTER 8

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### 8.1 INTRODUCTION

Termination of pregnancy is a very sensitive issue, especially that not every person is in favour thereof. In all the countries, the abortion controversy is never-ending, because of the two ends of the continuum, namely, those who are for it and those who are against it. In a given country, the legislation on termination of pregnancy depends on the ruling party's opinion. If the ruling party is for termination of pregnancy, then it will be legalised, despite the opposition from the other parties.

In South Africa, the legalisation of termination of pregnancy in 1996 was not without opposition, and this opposition is still evident even now. The religious movements are totally against termination of pregnancy and are vocal about this through the media.

Termination of pregnancy is accompanied by psychosocial implications. The aim of this study was to explore these implications, so that the guidelines for appropriate social work intervention could be formulated.

The focus of this chapter is on the summary, conclusions drawn from the study, as well as the recommendations. The central focus of each chapter in this thesis will be highlighted by means of a summary, conclusions and recommendations, according to the following themes:

- General introduction
- The medical aspects of abortion
- The psychosocial aspects of abortion
- The legal aspects of abortion
- The empirical findings from the quantitative approach
- The empirical findings from the qualitative approach
- The guidelines for social work intervention regarding pre-abortion counselling

## 8.2 GENERAL INTRODUCTION OF THE STUDY

### 8.2.1 SUMMARY

Chapter one provided a general introduction and orientation to the study. It commences with the motivation for the choice of the topic, the problem formulation, the aim and objectives of the study and the assumptions for the study. Then followed the research methodology which includes, the research approach, the type of research, the research design, research procedure and strategy, as well as the pilot study. Subsequently, the research population and sampling method were described, the key concepts for this study were defined, followed by the problems and limitations. The chapter ended with the delineation of the thesis.

The aim of this study was to explore the psychosocial aspects related to termination of pregnancy on the woman, whilst the objectives were:

- To investigate termination of pregnancy as a phenomenon
- To describe the psychosocial aspects related to termination of pregnancy on the woman
- To describe the legal aspects of abortion
- To determine the psychosocial aspects related to having an abortion on the women, after the enactment of the Choice on Termination of Pregnancy Act (92/1996)
- To provide the guidelines for social work intervention with female patients who opt for termination of pregnancy.
- To make recommendations for an improved social work service delivery, with regard to termination of pregnancy.

The aim and objectives were met by means of this study, except the determining of the psychosocial implications of termination of pregnancy after the procedure, through an empirical study, as the respondents were not available. The objectives will be referred to under the specific themes.

The **assumptions** and a **hypothesis** for the study were formulated were as follows:

- Giving women a chance to make an informed decision with regard to termination of pregnancy, that is, providing them with pre- and post-abortion counselling, would make the experience less traumatic.

- Women who opt for termination of pregnancy need to be provided with social work intervention, that is, pre- and post abortion counselling, to enable them to deal with the long-term implications of their choice.
- Although termination of pregnancy is each woman's choice, it does have negative psychosocial implications.
- Women who are not provided with a comprehensive service at the TOP Clinics could regret their decision later in life.
- If women who request termination of pregnancy could be provided with a comprehensive service then their social functioning could be improved.

How the assumptions and hypothesis were met will be discussed at the end of this chapter.

## 8.2.2 CONCLUSIONS

- Literature from the fields of medicine and psychology were mostly used in this study because there is limited social work literature.
- Women who request termination of pregnancy at the state facilities are provided with a medical service only, without any consideration of their psychosocial needs. The service is solely provided by the medical practitioners and nurses, which means that a multi-disciplinary team approach is not used.
- Termination of pregnancy is accompanied by psychosocial implications, hence the need for a multi-disciplinary team approach at the TOP Clinic.
- It is difficult to get women as respondents after the abortion procedure, to determine the actual implications on them.
- This study makes an important contribution in terms of the provision of the abortion service in South Africa, especially at the state abortion facilities.

### 8.2.3 RECOMMENDATIONS

- Termination of pregnancy is not a medical problem alone, as it is accompanied by emotional, psychological, religious and social implications that have an impact on the woman's life. It is therefore recommended that a holistic approach be adopted when rendering the abortion service.
- A comprehensive abortion service by a multi-disciplinary team at all the state abortion facilities, to enable the women to live with their decisions is highly recommended.
- Social workers have to be part of the multi-disciplinary team at the TOP Clinic, for them to deal with the psychosocial aspects of abortion.
- Follow-up as part of the TOP service needs to be established at all TOP facilities in South Africa, so as to determine all the implications of termination of pregnancy on the women after the procedure. This would lead to the provision of an appropriate service that is responsive to the needs of the women.

## 8.3 THE MEDICAL ASPECTS OF ABORTION

### 8.3.1 SUMMARY

Chapter 2 focussed on the medical aspects of termination of pregnancy and the following aspects were included: definition of the key concepts (medical concepts), classification of abortion, methods of termination of pregnancy at different periods of gestation, abortion-related risks and complications, management of the abortion-related complications, prevention of complications as well as the post-abortion family planning.

This chapter fulfilled the first objective of the study: To investigate termination of pregnancy as a phenomenon. An in-depth description of the medical aspects of termination of pregnancy was provided.

### 8.3.2 CONCLUSIONS

- The method of termination of pregnancy used when the woman requests it, is determined by the period of gestation.
- Termination of pregnancy during the first trimester is a simple procedure and is not accompanied by complications, as compared to termination of pregnancy during the second trimester.
- It would be beneficial if all women who are faced by an unplanned and unwanted pregnancies could request termination of pregnancy during the first trimester.
- Due to the lack of follow-up service for the women who undergo termination of pregnancy, it is not easy to have a full record of what the women go through after the procedure.
- Improved abortion service is needed for a better management of the abortion-related complications.
- The prevention of abortion-related complications needs to be the focus of the abortion service.
- Family planning after the abortion procedure must be presented to women in a way that they are given a chance to choose a method that they feel is suitable for their circumstances, in an effort to improve compliance, hence prevent unplanned pregnancies.

### 8.3.3 RECOMMENDATIONS

- The abortion services need to be accessible for all the women to utilise during the first trimester, to prevent the complications that could occur during the second trimester.
- It is important to have a follow-up service for the women who undergo termination of pregnancy, for the complications to be observed and treated as early as possible.

- Family planning services need to be provided in a manner that they are readily accessible and appealing, for the women not to hesitate to use them, so that the incidence of unplanned pregnancies could be eliminated.

## **8.4 THE PSYCHOSOCIAL ASPECTS RELATED TO ABORTION ON THE WOMAN**

### **8.4.1 SUMMARY**

Chapter 3 dealt with the psychosocial aspects related to termination of pregnancy on the woman and consisted of the following: factors leading to unwanted pregnancies, emotional reactions, including reactions to pregnancy as well as to abortion, the defence mechanisms used by the women after abortion, social aspects of abortion on the woman, the psychological aspects of abortion on the woman, adolescents and abortion, as well as counselling.

This chapter fulfilled the second objective of the study: To describe the psychosocial aspects related to termination of pregnancy on the women. An in-depth description of the psychosocial aspects related to termination of pregnancy are provided after an intensive literature study.

### **8.4.2 CONCLUSIONS**

- Termination of pregnancy is accompanied by a variety of psychosocial aspects on the women, which makes counselling an important aspect of the abortion service.
- There are various factors in the woman's life, that could lead to an unwanted pregnancy.
- An unwanted and unplanned pregnancy evokes a variety of feelings on a woman and her reactions largely depend on her personal circumstances.
- Undergoing abortion is accompanied by a variety of emotions, both on a short- and long -term basis.
- Deciding on terminating an unwanted and unplanned pregnancy could have devastating psychological effects on the woman's life.

- In trying to cope with the emotional burden of undergoing an abortion, women use a variety of defence mechanisms. Over-utilisation of these defence mechanisms could delay the woman's process of recovery.
- Termination of pregnancy has serious social implications on the woman as it is an emotive issue, and the decision to go through with it is made based on a variety of factors.
- Adolescents react in a different way to unplanned pregnancy, as well as to termination of pregnancy. Their level of maturation plays an important role in how they react.
- Counselling is very important as part of the abortion service, for the women to be assisted through the whole process, starting from the period of discovering the pregnancy, decision-making period, going through the procedure and dealing with the loss, after the procedure.
- It is only through counselling that women could be assisted to go on with their lives after termination of pregnancy.

#### 8.4.3 RECOMMENDATIONS

- Counselling needs to be included as an integral part of the abortion service, to make sure that the psychosocial needs of the women who request termination of pregnancy are attended to.
- Sexuality education needs to be provided to young girls as early as possible, to ensure that they are empowered to make informed choices concerning their bodies.
- With sexuality education the young girls will be equipped to prevent teenage pregnancies, as this interferes with their education progress and career building.

## 8.5 THE LEGAL ASPECTS OF ABORTION

### 8.5.1 SUMMARY

Chapter 4 focussed on the legal aspects of abortion. And consisted of the following: the international abortion policies with reference to USA, Canada, Netherlands, Israel, Ireland and Great Britain. Regarding the South African abortion legislation the focus was on the period before the legalisation of abortion as well as thereafter, as well as the provisions of the Choice on Termination of Pregnancy Act (92/1996).

This chapter fulfilled part of the third objective of this study: To describe the legal aspects of termination of pregnancy. This objective was fulfilled by an in-depth discussion of the circumstances prior to the legalisation of abortion as well as the provisions of the act. A comparison of the South African abortion legislation with the international abortion legislation was also provided in this chapter.

### 8.5.2 CONCLUSIONS

Many countries had to legalise abortion due to the pressure that was coming from the people. The women's groups formed part of the protest, as they felt strong that it was time for them to have a choice regarding their bodies.

- Although abortion was legalised there are some restrictions imposed on how it has to be practised in all the countries.
- Up to this stage Great Britain has not yet legalised abortion, mainly because of the influence of the Catholic belief that it is a sin.
- In all the countries the woman's consent is the only one that is required, for the woman to undergo termination of pregnancy. This gives the women responsibility over their bodies.
- The legalisation of abortion in South Africa has reduced the incidence of unsafe abortions, which was having devastating results on the women and sometimes claiming their lives.



- The South African abortion legislation is in line with the international policies, although it has some loopholes, namely, lack of social work intervention and a non-mandatory counselling service. Unlike in Israel, where the social worker forms part of the team that provides the abortion service. The women's psychosocial needs are attended to before they could undergo the procedure.
- Providing women with safe abortions, without any counselling could result in emotional problems later in their lives.
- The issue of the minors being able to consent for their termination of pregnancy, where they are not provided with counselling could result in their future lives being negatively affected. Specifically that they always try to keep this experience to themselves, without receiving any support from their families.

### 8.5.3 RECOMMENDATIONS

- Although the women are given a chance to make a choice regarding their bodies, it is recommended that the involvement of the parents be seriously considered when it comes to the minors.
- It is recommended that a mandatory counselling be part of the abortion service at all the TOP facilities, for the women to be provided with a comprehensive service.
- The social worker must be part of the team that provides the abortion service at all the TOP facilities.
- It is not beneficial for the women to receive an incomplete abortion service at the state TOP facilities, as a result it is recommended that these facilities be provided with the necessary resources, namely, staff and equipment.
- The abortion service provided at state facilities must be responsive to the needs of the women, seeing that the majority of the women receive this service.

## 8.6 THE QUANTITATIVE EMPIRICAL FINDINGS

### 8.6.1 SUMMARY

Chapter 5 focussed on the quantitative empirical findings regarding the psychosocial implications of abortion prior to the procedure, and it consisted of the following: a brief discussion of the research methodology, followed by the presentation and interpretation of the research findings.

This chapter fulfilled objective three of this study: To determine the psychosocial aspects related to having abortion on the woman, after the enactment of the Choice on Termination of Pregnancy Act (92/1996).

### 8.6.2 CONCLUSIONS

- The majority of women who request termination of pregnancy fall in the age category of 21-30yrs.
- A considerable number of women who request termination of pregnancy are single.
- The majority of women in the sample had no other children, which indicates that they were not yet ready to raise children.
- A large number of women could be said to be literate, because they had an educational level of grade 8-tertiary level.
- The majority of women belonged to the Christian religion, although women from other religions requested termination of pregnancy as well.
- Most women who requested abortion were economically dependent on someone, as they were students and others unemployed.
  - It has been evident that TOP clinic at Kalafong Hospital serves women from a variety of areas, with Mamelodi and Atteridgeville being the mostly served areas.

- Most women discovered that they were pregnant before the 8<sup>th</sup> week of gestation.
- It takes women sometime to decide on abortion, as it is not an easy decision to make.
- A large number of women were not influenced to make the decision to terminate their pregnancies.
- The findings reveal that the main reason for the women to decide on termination of pregnancy is economic circumstances.
- The majority of women did not consider adoption as an alternative, because of the emotional attachment to the foetus, if they carry the pregnancy to term, which could make it impossible to let go.
- It is evident that the clinic is known and the private practitioners and local clinics are instrumental in referring women to Kalafong hospital.
- It has been shown by the findings that women who request termination of pregnancy experience a variety of negative feelings, hence a remarkable number of women do not inform anybody about their decision, which could affect them emotionally in future.
- The fathers to these unborn babies also experience a variety of feelings, which have a role to play in the women's decision to have termination of the pregnancy.
- As the majority of women were single, students and staying with their parents, the parents would be disappointed if they could know about the pregnancy and the decision to terminate it, hence they were not informed.
- The decision to terminate the pregnancy affected various aspects of the women's lives in a variety of fashions. The majority of Christians' relationship with God was positively affected, as these women believe that God will forgive them because He understands their circumstances.
- Due to the emotional implications of abortion, women would rather forget about it and not share the experience with someone. This was

revealed when the majority of women indicated that they were going to work hard, so that they could forget about what has happened.

- The majority of women did not receive any information prior to the procedure, due to the lack of counselling service at the clinic.
- It has been evident that women need to be provided with counselling prior to the procedure because it is not easy for them to come back for post-abortion counselling, as all their efforts are centred around forgetting about what they have done.
- The majority of women believed that counselling prior to the procedure would help them deal better with their decision.
- A large number of women were not satisfied with the service that they received at the clinic, and felt that the service ranged between poor and average. The quality of the service at the clinic is affected by the shortage of staff.
- It is interesting to note that the majority of women who decided to terminate their pregnancies were determined not to do it again, but take the contraceptives more seriously, to prevent other unplanned pregnancies. This indicates that deciding on termination of pregnancy and going through the procedure is not a pleasant experience.
- Due to the shortage of an appropriate team composition at the clinic, women do not see the role of other team members, like the role of the social worker. There is a need to have the necessary team members involved at the TOP clinic, for the women to receive a comprehensive service.
- The need for counselling prior to the procedure, specifically during the decision-making period was indicated by the women, for them to be helped to deal better with their decision.

### 8.6.3 RECOMMENDATIONS

- Seeing that the majority of the women who request termination of pregnancy are single, it is recommended that they be provided with counselling, to equip them to deal better with the situation.
- It is recommended that the information on the implications of termination of pregnancy be provided to girls as early as possible, to instil the spirit of preventing unwanted and unplanned pregnancies, that are ended by abortions. That must also be focussed at tertiary institutions, because the majority of the women who request termination of pregnancy are the students at tertiary institutions.
- There has to be an emphasis on the utilisation of contraceptives, but of importance is to make the family planning service to be user-friendly to improve compliance on the women, to prevent unwanted and unplanned pregnancies.
- Regarding the minors, it is recommended that the sexuality education be provided at primary schools on a continuous basis, to prevent unwanted and unplanned pregnancies on these minors.
- It is important to have abortion services to be responsive to the women's needs.
- Counselling prior to the procedure is a need that was expressed by the respondents, as a result it is recommended that it be provided by having social workers as part of the team that renders the abortion service.

## 8.7 THE QUALITATIVE EMPIRICAL FINDINGS

### 8.7.1 SUMMARY

Chapter 6 focussed on the qualitative empirical findings and it consisted of the following: a brief presentation of the research methodology, the process after the disappointment with the follow-up of respondents, profiles of the women who request termination of pregnancy, information from the files that were reviewed and case studies to illustrate the psychosocial implications of termination of pregnancy on the women.

This chapter fulfilled the fourth objective of this study: To determine the psychosocial aspects related to termination of pregnancy on the women, specifically after the enactment of the Choice on termination of Pregnancy Act (92/1996).

### 8.7.2 CONCLUSIONS

- Termination of pregnancy is accompanied by psychosocial implications and women try to deal with these implications on their own.
- Women try their level best to forget about their experience of termination of pregnancy, hence did not come back to the researcher for follow-up.
- Women from all racial groups do request termination of pregnancy at private clinics, depending on their financial background.
- The majority of the women who requested termination of pregnancy at the private clinic were still young and without children.
- Other options were not considered by the women.
- The shock of dealing with an unplanned and unwanted pregnancy motivates the women to be more serious about the utilisation of contraceptives, after the procedure.
- Pre-abortion counselling equip the women to deal with their situation and move on with their lives after the procedure.

### 8.7.3 RECOMMENDATIONS

- Sexuality education is needed for all the girls as early as possible, to prevent unplanned and unwanted pregnancies in young women.
- Counselling as part of the abortion service needs to be introduced, to assist the women to deal constructively with their situations and be able to move on after the procedure.

## 8.8 THE GUIDELINES FOR SOCIAL WORK INTERVENTION REGARDING THE ABORTION SERVICE

### 8.8.1 SUMMARY

Chapter 7 focussed on the guidelines for social work intervention regarding the abortion service, and it consisted of the following: the nature of social work in health care, the role of the social worker in health care, the social worker as a member of the multi-disciplinary team, the bio-psycho-social model, the utilisation of the bio-psycho-social model in abortion counselling and the guidelines for social work intervention at the TOP Clinic.

This chapter fulfilled the fifth objective of this study: To provide guidelines for social work intervention with female patients who opt for termination of pregnancy.

### 8.8.2 CONCLUSIONS

- The social worker in health care has a variety of roles to play, for the benefit of the patients, and these roles are performed within the multi-disciplinary team context.
- As a team member the social worker has to collaborate with the other members, so that the patients could receive a service that is responsive to their needs.
- The adoption of the bio-psycho-social model at the TOP Clinic will ensure that the women are provided with a comprehensive service, that is responsive to their needs.
- The social worker as the provider of the psychosocial service has to be a full time member of the multi-disciplinary team that renders the abortion service, because no other member could render this service.
- When providing pre-abortion counselling there are specific aspects that the social worker has to focus on, namely, the woman's feelings, the woman's reactions to the pregnancy, the woman's reasons for the decision, other available options, the woman's feelings regarding the decision, providing information regarding the procedure, the woman's

religious background, the woman's cultural background, the woman's perception of self, the woman's relationship with the partner, future planning, family planning, as well as the sharing of the experience in future.

### **8.8.3 RECOMMENDATIONS**

- It is recommended that termination of pregnancy be seen not only as a medical problem, but the bio-psychosocial model be used to provide the abortion service.
- The social worker must be a member of the multi-disciplinary team that renders the abortion service, for the women's psychosocial needs to be attended to.
- Pre-abortion counselling is strongly recommended to enable the women to go on with their lives after the procedure.

## **8.9 COMPARISON OF THE FINDINGS FROM THE QUANTITATIVE AND THE QUALITATIVE PHASES OF THE STUDY.**

### **8.9.1 SUMMARY**

Both quantitative and qualitative approaches were used in this study, with the quantitative approach dominant and the qualitative one less dominant.

The findings from both approaches were presented in chapters five and six respectively and the comparisons are now presented.

### **8.9.2 CONCLUSION**

- The majority of the women in the sample for the quantitative phase already had children, whilst from the qualitative phase the majority were not yet parents. For those who were not yet parents it could be said that they were still in the process of shaping their careers, and for those who were already having children, they were not ready for an additional responsibility.



- The major reason for having the unplanned pregnancy terminated was the economic circumstances and most women were dependent on someone for financial support.
- The other striking finding for both phases is that adoption was not considered as an option.
- Women from both phases decided to take contraceptives more seriously, to avoid another unplanned pregnancy. It could thus be said that the women were not proud about what they had done, therefore they decided to prevent its repeated occurrence.
- The quantitative phase was much easier to conduct because the respondents were available.
- The qualitative phase was very disappointing, time consuming and due to the topic studied, respondents were not at all willing to participate.

### 8.9.3 RECOMMENDATIONS

- It would be most beneficial if all the women who request termination of pregnancy are provided with pre-abortion counselling, as it is difficult or impossible to have them for post abortion counselling.
- It is also recommended that the study on the psychosocial implications of termination of pregnancy be undertaken, as this study could not accomplish this aim, as it has already been indicated.
- There is a need to explore the factors behind the high incidence of abortion in a country where the contraceptive devices are provided free by the government.

### 8.9.4 THE ASSUMPTIONS AND HYPOTHESIS FOR THE STUDY

The assumptions and hypothesis for the study will be subsequently discussed as follows:

- Giving women a chance to make an informed decision with regard to termination of pregnancy, that is, providing them with pre- and post-abortion counselling, would make the experience less traumatic. This assumption has been confirmed by the empirical findings, where the women indicated that they believe that being provided with information would help them deal better with the procedure. (Chapter 5)

- Women who opt for termination of pregnancy need to be provided with social work intervention, that is, pre- and post-abortion counselling, to enable them to deal with the long-term implications of their choice. This has been confirmed by the findings where the women indicated that they needed social work intervention during the decision-making period, for them to be equipped to move on with their lives after the procedure. For the post-abortion counselling it was not possible to determine its need amongst the women because the respondents could not be found. This emphasises the researcher's opinion of the importance of pre-abortion counselling.

#### 5.6 CONCLUDING REMARKS

- Although termination of pregnancy is each woman's choice, it does have negative psychosocial implications. The findings from the qualitative data have confirmed that termination of pregnancy is having psychosocial implications on the women even if she decides on her own to have it. This is aggravated by the reasons that force the woman to decide on termination of pregnancy.
- Women who are not provided with a comprehensive service at the TOP Clinic could regret their decision later in life. The literature has confirmed that providing women who request termination of pregnancy with the medical service only, could have devastating effects on their lives. It has also been confirmed by the empirical findings (chapter 6), in the case of a 16 years old woman who was unable to look herself in the mirror, because of what she has done. This indicates that she regretted what she had done, but could not do anything to change it.
- If women who request termination of pregnancy could be provided with a comprehensive service then their social functioning could be improved. This hypothesis has been confirmed in chapter 6, through the case study of the 21 year old woman from the East Rand, who received pre-abortion counselling, and was emotionally well after the procedure, and did not regret her decision but was able to move on with her life. It shows that pre-abortion counselling equipped her to deal with her situation without any disruptions.

Based on the findings from this study the researcher strongly believe that there is still a need to have a study on the real psychosocial implications of abortion on the women, through follow-up interviews with the women after

the procedure. The hypotheses that are formulated for further investigation are:

- If the women who request termination of pregnancy are not provided with a comprehensive abortion service then they will end up experiencing emotional problems later in life.
- If termination of pregnancy could be accepted by everybody, then women would feel free to seek the service, without being afraid of any judgement from the family members and friends.

## 8.10 CONCLUDING REMARKS

Opting for a termination of pregnancy is accompanied by psychosocial aspects, that can destabilise the woman's life. This calls for an adoption of the bio-psychosocial model by the team that renders the abortion service, for the women to be provided with a comprehensive service that is responsive to their needs. It is not beneficial for the women who opt for termination of pregnancy to be provided with an incomplete service, as this could lead to a situation where the future society would be full of women who are psychologically disturbed.

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## **APPENDIX 1**

### **LETTER OF PERMISSION**

P O Box 1320  
MOGWASE  
0314  
03/05/99

University of Pretoria

Pretoria 0002 (Republic of South Africa) Phone No. (012) 4209111  
Fax (012) 4209111 / 4209112 / 4209113

Faculty of Arts

Department of Social Work

The Superintendent  
Kalafong Hospital  
Private Bag X396  
PRETORIA  
0001

Sir/Madam,

**RE : REQUEST TO CONDUCT A RESEARCH PROJECT**

I hereby request permission to conduct a research project at your hospital. I am in the employment of the University of Pretoria as a Clinical Lecturer and busy with my D. Phil (Social Work) studies, at the very same university.

The aim of my study is to explore the psycho-social implications of women who undergo termination of pregnancy. Your hospital has been identified because it is within the researcher's reach and the necessary working relationship has been already established with the nursing staff at the TOP clinic.

The research proposal has already been approved by the Social Work Department research committee of the university and it is attached for your attention. The findings will be published so that the social work service in this field could be improved.

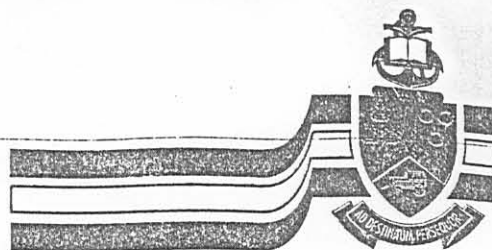
Hoping that my request will be favourably considered.

I thank you in advance.

Yours sincerely,

J. SEKUDU (MISS)

Approved  
Mogwase  
20/5/99



University of Pretoria

Pretoria 0002 Republic of South Africa Tel (012) 4209111  
Fax (012) 437431 / 3422712 / 432185

Faculty of Arts

Department of Social Work

TO WHOM IT MAY CONCERN

ref. Miss J Sekudu  
D.Phil-student ~  
Prof A Lombard  
Tel. (012) 420-2396

1999-05-27

D.PHIL STUDENT: MISS J SEKUDU  
REG. NO.: 92-76483

I hereby confirm that miss J Sekudu is a registered student at this University for the D.Phil.(Social Work) degree.

Your permission to allow her to do her research at Kalafong Hospital would be highly appreciated.

Yours sincerely,

A handwritten signature in cursive script, appearing to read 'Antoinette Lombard'.

**PROF. ANTOINETTE LOMBARD**  
**A/HEAD: DEPARTMENT OF SOCIAL WORK**

Approved  
Mc  
28/5/99

QUESTIONNAIRE

PSYCHOSOCIAL IMPLICATIONS OF ABORTION ON THE WOMEN

Dear respondents

This questionnaire is aimed at determining the psychosocial implications of abortion on women, since it is relatively new after it was legalised in South Africa. It is aimed at the services being provided, after determining what the countries have to offer. You are therefore kindly requested to complete the questionnaire with honesty. The questionnaire has to be completed anonymously and you are requested to confidentiality.

**APPENDIX 2**

**QUESTIONNAIRE**

## QUESTIONNAIRE

### PSYCHOSOCIAL IMPLICATIONS OF ABORTION ON THE WOMEN

Dear respondents

This questionnaire is aimed at determining the psychosocial implications of abortion on women, since it is relatively new after it was legalised in South Africa. It is aimed at the services being improved, after determining what the consumers have to say. You are therefore kindly requested to complete this questionnaire with honesty. The questionnaire is also to be completed anonymously and you are assured of confidentiality.



--

1. BIOGRAPHICAL DETAILS

--	--

V1-2

Mark appropriate block with x

1.1 In which age category do you fall?

10yrs - 20yrs

21yrs - 30yrs

31yrs - 40yrs

41yrs - 50yrs


--

V3

1.2 What is your marital status?

Married by civil rights

Single

Custom marriage

Staying in cohabitation

Divorced

Other (Specify)


--

V4



1.3 Please indicate the age, gender and educational level of your other children or

V5

Not applicable

Child no	Age	Gender		Educational level			
		Male	Female	Preschool	Primary	Secondary	Tertiary
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							

V6

V7

V8

V9

V10

V11

V12

1.4 What is your educational level?

Never attended school

Grade 1 - Grade 4

Grade 5 - Grade 7

Grade 8 - Grade 12

Tertiary level of education (after school training)

Still at school


V13

1.5 What is your religion?

- Christian
- Muslim
- Hindu
- African Church
- Other (specify)


V16

V14

1.6 What church do you belong to?

- Catholic
- Protestant
- Apostolic
- Charismatic churches
- None
- Other (specify)


V15

1.7 Economic status. What is your economic status?

- Scholar/Student
- Employed
- Self-employed
- Unemployed
- Other (specify)


V18

V16

1.8 With whom do you live?

Parents

Grandparents

Uncle/Aunt

Other family

Friends

Boyfriend

On your own

Other (specify)


V17

1.9 What are your living conditions?

House

Flat

Zozo

Room in a house (rented)

Other (specify)


V18

1.10 Where do you live? .....

- Atteridgeville
- Mamelodi
- Kwaggasrand
- Pretoria West
- Ga Rankuwa
- Sunnyside
- Soshanguve
- Mabopane
- Hammanskraal
- Other (specify)


--	--

V19-20

1.11 Who provides you with financial support? .....

- Parents
- Yourself
- Boyfriend
- Husband
- Other (specify)


--

V21

2.3 Abortion Choice

2.1 During which period did you discover that you are pregnant?

On my own

0 week - 4 weeks

5 weeks - 8 weeks

9 weeks - 12 weeks

13 weeks - 16 weeks

17 weeks - 20 weeks

Other (specify)


--

V22

2.2 How long did it take you to decide to have an abortion?

Economic circumstances

..... weeks pregnancy

Unplanned pregnancy

Failure of relationship with father

Want to finish school/learning

Wrong time to do it/child

Other

--

--	--

V23-24

--

V26

Specify

2.3 Of the following people, whose opinion influenced you **most** to decide on abortion?

- On my own
- Friend's
- Parents'
- Partner's
- Husband's
- Other (specify)


--

V25

2.4 What is the **main reason** that made you decide on an abortion?

- Economic circumstances
- Feelings towards pregnancy
- Unplanned pregnancy
- Failure in relationship with father
- Want to finish school/training
- Wrong time to have a child
- Other


--

V26

Specify

.....

.....

2.5 When did you decide on an abortion? (At which period of your gestation?)

Weeks

.....  
.....

..... weeks

V27 -28

2.6.1 Did you consider giving the baby up for adoption?

Yes

No

V29

2.6.2 Motivate your answer to question 2.6

.....  
.....  
.....

2.7 Who told you first about the TOP (Termination of Pregnancy) clinic at Kalafong hospital?

- Media
- Friend
- Husband
- Parents
- Boyfriend
- Other (specify)


V30

3. Psychosocial aspects

3.1 How did you react when you learnt that you are pregnant? Mark the most prominent reactions.

- |                 |                          |                          |     |
|-----------------|--------------------------|--------------------------|-----|
| Happy           | <input type="checkbox"/> | <input type="checkbox"/> | V31 |
| Shocked         | <input type="checkbox"/> | <input type="checkbox"/> | V32 |
| Disbelief       | <input type="checkbox"/> | <input type="checkbox"/> | V33 |
| Excited         | <input type="checkbox"/> | <input type="checkbox"/> | V34 |
| Disappointed    | <input type="checkbox"/> | <input type="checkbox"/> | V35 |
| Sad             | <input type="checkbox"/> | <input type="checkbox"/> | V36 |
| Embarrassed     | <input type="checkbox"/> | <input type="checkbox"/> | V37 |
| Guilty          | <input type="checkbox"/> | <input type="checkbox"/> | V38 |
| Other (specify) | <input type="checkbox"/> | <input type="checkbox"/> | V39 |



3.2 Who else knows about your pregnancy?

Parent/s	<input type="checkbox"/>	<input type="checkbox"/>	V40
Husband	<input type="checkbox"/>	<input type="checkbox"/>	V41
Partner/Boyfriend	<input type="checkbox"/>	<input type="checkbox"/>	V42
Grandparent/s	<input type="checkbox"/>	<input type="checkbox"/>	V43
Friend/s	<input type="checkbox"/>	<input type="checkbox"/>	V44
Nobody	<input type="checkbox"/>	<input type="checkbox"/>	V45
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	V46

3.3 How did the father to the unborn baby react to your pregnancy? Mark the most prominent reaction.

Happy	<input type="checkbox"/>
Disbelief	<input type="checkbox"/>
Shock	<input type="checkbox"/>
Disappointed	<input type="checkbox"/>
Sad	<input type="checkbox"/>
Guilty	<input type="checkbox"/>
Excited	<input type="checkbox"/>
Overjoyed	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>

V47

3.4.1 If parents do not know, how do you expect them to react to your pregnancy?

V48

.....  
.....

3.4.2 If parents know, how did they react to your pregnancy?

Happy

Angry

Disappointed

Excited

Other (specify)


V49

.....

3.5 Has the pregnancy affected your relationship with any of the following persons?

	Positive	Negative	Did not affect relationship	
Boyfriend				<input type="text"/> V50
Parents				<input type="text"/> V51
Husband				<input type="text"/> V52
Friends				<input type="text"/> V53
Yourself				<input type="text"/> V54
God				<input type="text"/> V55
Family				<input type="text"/> V56
Other (Specify)				<input type="text"/> V57
				<input type="text"/> V58

3.6 Has the pregnancy affected any of the following aspects in your life?

Self-esteem

Social life

Educational progress

Family life

Work

Normal functioning on a daily basis

<input type="checkbox"/>	<input type="checkbox"/>	V59
<input type="checkbox"/>	<input type="checkbox"/>	V60
<input type="checkbox"/>	<input type="checkbox"/>	V61
<input type="checkbox"/>	<input type="checkbox"/>	V62
<input type="checkbox"/>	<input type="checkbox"/>	V63
<input type="checkbox"/>	<input type="checkbox"/>	V64

3.7.1 Do you think you will be able to share your experience freely, after the procedure?

Yes (Specify)

No

<input type="checkbox"/>
<input type="checkbox"/>

<input type="checkbox"/>
--------------------------

V65

3.7.2 Motivate your answer to question 3.7

.....

.....

4. Abortion services

4.1 Did you receive information on what the procedure entails?

Yes

No


--

V66

4.2 Who gave you the information?

Nurse

Doctor

Psychologist

Social worker

Other (Specify)



V67

V68

V69

V70

V71

4.3.1 Did the information help you to feel better?

Yes

No


--

V72

4.3.2 Motivate your answer to question 4.3.1

.....

.....

.....

Counselling entails providing information on the procedure possible complications options after the procedure and exploration and support with feelings experienced.

4.4.1 Do you think you needed counselling before the procedure?

Yes

No


--

--

V73

4.4.2 and do you think you will need it after the procedure?

Yes

No


--

V74

4.4.3 Motivate your answers to questions 4.4.1 and 4.4.2:

.....

.....

.....

.....

4.5.1 Do you believe counselling will help you to deal better with this decision you made for an abortion later in your life?

Yes

No


V75

4.5.2 Motivate your answer to question 4.5.

.....

.....

4.6 Rate the services provided at this clinic on the scale provided, in terms of

Before the procedure	During

V76

V77

1 = Poor

2 = Average

3 = Good

4 = Excellent

4.7 Give your own opinion on how the services rendered at this clinic are, and how it could be improved if there is a need for improvement

Service: .....

.....

Improvements: .....

.....

4.8 What are your future plans after this abortion?

- |  |                          |                          |     |
|--|--------------------------|--------------------------|-----|
| Be serious about contraceptives                | <input type="checkbox"/> | <input type="checkbox"/> | V78 |
| Consider another abortion if pregnant again    | <input type="checkbox"/> | <input type="checkbox"/> | V79 |
| Motivate others to use contraceptives          | <input type="checkbox"/> | <input type="checkbox"/> | V80 |
| Encourage others to seek an abortion           | <input type="checkbox"/> | <input type="checkbox"/> | V81 |
| Go on with my schooling/work                   | <input type="checkbox"/> | <input type="checkbox"/> | V82 |
| Abstain from sexual relationships till married | <input type="checkbox"/> | <input type="checkbox"/> | V83 |
| Other (specify)                                | <input type="checkbox"/> | <input type="checkbox"/> | V84 |

4.9 What problems do you predict as a result of this abortion?

- |                                     |                          |                          |     |
|-------------------------------------|--------------------------|--------------------------|-----|
| Problems with relationships         | <input type="checkbox"/> | <input type="checkbox"/> | V85 |
| Problems with dealing with children | <input type="checkbox"/> | <input type="checkbox"/> | V86 |
| Problems to have own children       | <input type="checkbox"/> | <input type="checkbox"/> | V87 |
| Rejection from others               | <input type="checkbox"/> | <input type="checkbox"/> | V88 |
| Difficulty to live with my decision | <input type="checkbox"/> | <input type="checkbox"/> | V89 |
| None                                | <input type="checkbox"/> | <input type="checkbox"/> | V90 |
| Other (Specify)                     | <input type="checkbox"/> | <input type="checkbox"/> | V91 |

4.10.1 Do you think a social worker is needed at the abortion clinic as a service provider?

Yes

No


--

V92

4.10 If your answer to question 4.10 is yes indicate when the social worker is mostly needed.

Before the procedure

During the procedure

After the procedure


--

V93

4.11 Using this scale:      1 = Needed very much  
   2 = Needed less  
   3 = Not needed

rate the value of social work services during

-decision making

-before the procedure

-during the procedure

-after the procedure



V94

V95

V96

V97

Thank you very much.



University of Pretoria  
Department of Social Work  
Pretoria  
0002

Dear

Ms. Khensho & Khathang, I appreciate your previous response.

I am sure you have already passed your work to a staff of your own expertise. As a social worker from the University of Pretoria, I am interested in your work, as indicated during the interview. I am still interested in your work, especially your hospital experience, and especially your research on the topic of the study.

### APPENDIX 3

I am hoping to hear from you soon and that we will be able to discuss your work and experience and help you to deal with your current situation.

I hope to hear from you before the end of June 2014. If you are unable to do so, please contact me on 4202599 from 9:00 to 17:00 on weekdays.

The possible date of the interview is 10 June 2014.

### LETTER TO THE RESPONDENTS

- 11 April 2014
- 12 April 2014
- 13 April 2014
- 14 April 2014
- 15 April 2014
- 16 April 2014
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- 31 December 2014

Please choose a date and time that suits you.

I am looking forward to your response.

Yours sincerely,

J. Sekude

Social work researcher

University of Pretoria  
Department of Social Work  
Pretoria  
0002

.....  
.....  
.....  
.....  
.....  
.....

Dear .....

Re: Research at Kalafong hospital on patients' experience.

Three months have already passed since we last met at Kalafong hospital, where I, the social worker from the University of Pretoria, saw you in an individual interview. As I indicated during the interview, I am still concerned about how you are coping with your hospital experience, and especially with nobody being available to discuss this with you.

I am hoping to hear from you soon and that we could discuss your feelings and experience and help you to deal with your future positively.

I hope to hear from you before the end of June 2000. You can contact me at 012-4202599 from 8:00-16:00 or 0837475642 from 18:00-21:00, to make an appointment.

- The possible dates for appointments are:
- 25 May 2000
  - 30 May 2000
  - 01 June 2000
  - 06 June 2000
  - 13 June 2000
  - 22 June 2000
  - 26 June 2000
  - 27 June 2000

Please choose a date and contact me immediately.

I am looking forward to your response to this letter.

Your's sincerely  
J. Sekudu  
Social work researcher.

21 MAY 2001

**APPENDIX 4**

**ADVERTISEMENT IN THE PERDEBY**

# Perdeby

Year 63 Edition 12

<http://perdeby.up.ac.za>

21 MAY 2001

*Have you terminated your pregnancy?*

Have you had termination of pregnancy recently?  
It must have been a very difficult decision to make.  
You are probably experiencing some emotional  
problems presently as a result of this. Don't despair,  
you are not alone! I am offering a free counselling  
service to persons like you, for my doctoral study on  
this topic. It will be dealt with highly confidentially,  
and you will remain anonymous. Please contact  
Johannah @ 083 747 5642 before 1 June 2001  
for an appointment or details.

**APPENDIX 5**

**DOCUMENTATION OF THE DOCTORAL SEMINAR**

THE UNIVERSITY OF PRETORIA

You are cordially invited to a Doctoral Seminar

The programme of activities of the seminar is attached to this invitation.

DATE: 17 October 2004

TIME: 09:00 - 11:30 am

VENUE: Department of Education, University of Pretoria, 1st Floor, 101

**INVITATION TO  
ATTEND A  
DOCTORAL  
SEMINAR**

REPORT on the progress of the research

The Department of Education

Dr. C. J. ...

1. WELCOME
2. INTRODUCTION
3. ...
4. ...
5. ...

*TO: MR/MS/DR/PROF*

.....  
*You are cordially invited to a Doctoral Seminar,*

*Topic: The psychosocial implications of abortion on the woman: a  
social work study.*

*DATE: 11<sup>th</sup> October 2001*

*TIME: 10h00 - 11:30 am*

*VENUE: University of Pretoria, Human Science Building  
10-02.*

*RSVP: on or before: 1<sup>st</sup> of October 2001.*

*To: Johannah Sekudu (083) 747-5642 or (012) 420-2599*

*Or: Promotor: Dr C L Carbonatto (012) 420-2410*

*PROGRAMME*

- 1. WELCOMING*
- 2. INTRODUCTION*
- 3. PRESENTATION*
- 4. QUESTIONS*
- 5. REFRESHMENTS*

## **PROGRAMME**

- 1. 10h:00 Welcoming: Dr. C.L. Carbonatto**
- 2. 10h:00-11h:00 Presentation: Ms. J. Sekudu**
- 3. 11h:00-11:30 Questions**
- 4. Refreshments**
- 5. 12h:00-13h:00 Oral exam**