Chapter 2

Literature review

2.1 INTRODUCTION

A literature review is a process involving reading, understanding and forming conclusions about a theory and the published research on a particular topic (Brink 1996:76). It is done to acquire knowledge for use in practice or to provide a basis for conducting a study (Burns & Grove 2003:55). The review provides information and background for understanding what has already been learned on a topic and illuminates the importance of the new study (Polit & Hungler 1997:91). It also provides the identification of feasible research purposes and problems (Burns & Grove 2003:117). The purpose of a literature review in a qualitative study is to place the findings in the context of what is already known about the topic (Streubert Speziale & Carpenter 2003:21).

In phenomenological studies, the review of literature can follow the data analysis (Streubert Speziale & Carpenter 2003:70) to achieve a pure description of the phenomenon under investigation. The fewer ideas or preconceived notions that researchers have about the topic, the less likely their biases are to influence the research. Once data analysis is complete, researchers review the literature to place the findings in context.

However, in the present study the researcher undertook the literature review first in order to sensitise herself to the phenomenon under study, to develop an inventory of vocabulary and to gain insight into the meaning of the topic (Streubert Speziale & Carpenter 2003:70). Doing this led to the awareness of the phenomenon under study, namely, the experiences of registered nurses involved in termination of pregnancy, and to enhance bracketing.

The result of the literature review is presented under the following headings:

- The phenomenon of abortion
- Termination of pregnancy
- The political and legal aspects of abortion nationally and internaitonally

- Moral and ethical considerations regarding abortion
- Nurses' dilemmas regarding abortion

2.2 THE PHENOMENON OF ABORTION

2.2.1 Definition of abortion

The termination of pregnancy is commonly known as abortion. Abortion may be defined as the intentional ending of pregnancy through the evacuation of the uterus before the foetus has a reasonable chance of survival (Marshal, Gould & Roberts 1994:567). Searle (2000:344) states that abortion means interference with the pregnant uterus in order to expel the foetus with the aim of killing it or causing its death.

Different groups define abortion in different ways:

- Abortion means foeticide for legal purposes: the intentional destruction of the foetus in the womb, or any untimely delivery brought about with intent to cause the death of the foetus (Jali & Phil 2001:25).
- Abortion is defined as the natural or induced expulsion of the foetus from the womb (*Concise Oxford Dictionary* 1983:3). Jali and Phil (2001:25) define abortion as expulsion or removal of the products of conception from the uterus.
- According to pro-life groups, human life begins from the moment of conception, so abortion is the murder of a defenceless human being ((Jali & Phil 2001:25).
- Abortion occurs as a result of intentional interference to deliberately terminate pregnancy.
- In South Africa, abortion is defined as the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman (Termination of Pregnancy Act 92 of 1996).

2.2.2 History of abortion worldwide

Women throughout recorded history have been terminating unwanted pregnancies. Abortion raises controversial and serious ethical questions worldwide. It was restricted or forbidden by most religions in the world, but legislative action in the twentieth century has been permitting termination of unwanted pregnancy for medical, social or private reasons (*Microsoft Encarta Encyclopaedia Plus* 2004).

Abortions at the woman's request were first performed in post-revolutionary Russia in 1920, followed by Japan, then several East European nations after World War II. In the late 1960s abortion regulations became more liberal worldwide.

Abortion is illegal in many Roman Catholic and Islamic countries, although it may be carried out in cases where the mother's life is immediately at risk. It is legal in France and Italy but illegal throughout England, Ireland, Wales and Scotland. A woman seeking abortion in the United Kingdom has to secure the agreement of two doctors rather than just one, the only medical procedure in these countries where this is required (*Microsoft Encarta Encyclopaedia Plus* 2004).

The World Health Organization (WHO) estimates that of the 58 500 maternal deaths that occur worldwide each year, 99% are in the developing world. A number of nations have either legalised or liberalised abortion, in order for women to have these procedures done in the most hygienic environment (*Microsoft Encarta Encyclopaedia Plus* 2004).

Abortion was a secretive and private subject but now is being debated in public in most countries, with religious groups and pro-life activists opposed to the liberalisation of abortion (Marissa & Ventura 1999:44).

2.2.3 History of abortion in South Africa

During the twentieth century, abortion in South Africa was done for medical reasons: danger to the life of the woman or to her health or a serious handicap of the unborn child. The decision was the discretion of the doctors and was to be carried out at an approved clinic (Microsoft Encarta Encyclopaedia Plus 2004).

Prior to the introduction of the Abortion and Sterilisation Act (Act 2 of 1975), there was no properly defined law on abortion. The Abortion and Sterilisation Act stipulated that abortion was to be performed in state-controlled institutions by two medical officers in specific circumstances only:

- pregnancy threatening the woman's health
- pregnancy posing a serious threat to the woman's mental health

- physical or mental defects of the unborn child
- pregnancy due to rape or incest

Performing an abortion except under the above circumstances was illegal (Ehlers 2000:80), causing many women to resort to "back street" abortions by unqualified abortionists. According to the Medical Research Council, in 1994 South Africa reported that at least 425 deaths a year were caused by illegal abortion complications (Albertyn 1998). The same report estimated that at least 45 000 women in South Africa received treatment at hospitals for complications caused by illegal abortions.

The Abortion and Sterilisation Act was replaced by the new Termination of Pregnancy Act (Act 92 of 1996), which came into force on 1 February 1997. The new law promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have a safe and legal termination of pregnancy according to her individual beliefs. The new Act stipulates that all women, irrespective of age, location or socio-economic status, can choose to terminate pregnancy without requiring the permission of their partners or parents (Reproductive Right Alliance 2002:8).

The law is in place to make sure that women can make decisions about their bodies and health without putting their lives and health in danger. Termination of pregnancy is legal if it is carried out at an approved clinic or hospital. Termination is best within the first twelve weeks of pregnancy. The Termination of Pregnancy Act thus permits termination of pregnancy upon request of the woman up to and including 12 weeks of gestation, or under certain defined circumstances after 20 weeks of gestation.

Since the Termination of Pregnancy Act came into force, the number of legal abortions performed has increased. Rantsekeng (1999:17) of the National Directorate for Maternal, Child and Woman's Health, reported that 46 759 abortions had been performed in South Africa from February 1997 to September 1998 at the designated hospitals. The Marie Stopes clinics, which are non-governmental organisations that provide comprehensive family-planning services, conducted 20 000 safe abortions during 1997 and 1998. This statistic has grown tremendously: in 2003 the number of safe abortions in the Gauteng Province alone, as reported by the Gauteng Department of Health Statistics Unit, was 20 348. The observed profile of women seeking abortions suggests that they are doing so for socio-economic reasons and at an early stage of their pregnancy.

When the new Act was promulgated, nurses had to be trained to perform termination of pregnancy. The Act stipulates the right of the woman to terminate pregnancy, but the nurses having to perform the termination may have religious or moral objections, thus many nurses and doctors have refused to be involved in TOP (Poggenpoel, Myburgh & Gmeiner 1998:3).

2.3 TERMINATION OF PREGNANCY

2.3.1 Termination of Pregnancy Act

Termination of pregnancy only takes place with the informed consent of a pregnant woman. In cases of severe mental disability or long-term unconsciousness, the consent of a person other than the pregnant woman is considered (Termination of Pregnancy Act no 92 of 1996).

The new law has the following advantages:

- It ensures the right of a woman to have access to a safe, effective, acceptable method of fertility regulation.
- The women have the right to information.
- Women are counselled before and after the procedure.
- The procedure is performed in a surgically clean environment.
- The woman does not need permission from a partner to terminate her pregnancy.
- Termination of pregnancy offers women greater choice and empowerment.
- The option of medical instead of surgical termination of pregnancy gives women more control, reduces the need for anaesthetic and minimises the risk of infection or trauma to reproductive organs.

(Walker 2000:506)

The law has the following disadvantages:

- The nurses are bound by the Nursing Act (Act 10 of 1997) to nurse women before and after termination, despite conscientious objection to TOP.
- A minor can undergo termination without involving a parent or guardian.

Pregnancy may be terminated for the following reasons:

- Upon the request of a woman during the first twelve weeks of gestation of pregnancy.
- After thirteen weeks if pregnancy poses a health risk to the woman or is due to rape or incest, if the foetus is at risk of suffering physical or mental abnormality or if pregnancy would affect the social or economic circumstances of the woman.
- After the twentieth week if the woman’s life is in danger, if pregnancy would result in malformation of the foetus or if pregnancy poses a risk of injury to the foetus.

2.3.2 Training nurses for TOP

Registered nurses can perform termination of pregnancy up to twelve weeks of gestation (if a woman who is more than twelve weeks pregnant requests termination, she is referred to the hospital to be managed by doctors). The nurses must also provide counselling, since any woman requesting termination of pregnancy must be given information about TOP and be counselled before and after the procedure to enhance her emotional well-being (Primary Clinical Care 2001:261).

Despite sound policies, implementation remains problematic due to the low number of nurses trained in TOP and the negative attitudes of healthcare providers to termination of pregnancy.

For registered nurses to be able to implement the policy and guidelines of the Termination of Pregnancy Act, they should undergo training. TOP is performed by a registered midwife who has undergone the prescribed training of 160 hours (Primary Clinical Care 2001:261). The training takes place at a venue arranged by the Deputy Director of Mother-and-Child Health from the Provincial office and is provided by independent consultants together with the provincial trainers. The training includes value clarification, implementation of the Termination of Pregnancy Act, pre- and post-counselling, the termination procedure including different types of termination, and care of a woman post-termination. After theoretical exposure, the midwives are allocated to a TOP unit to perform terminations under supervision of a trained TOP provider. Thereafter a competency assessment is done, followed by certification of the midwife as a certified TOP provider.

The termination of pregnancy policy is particularly problematic for rural hospitals where staff and/or the community do not support it, but there is pressure from the Province to do more terminations (http://www.hst.org.za: accessed on 30 04 2004).

2.3.3 Termination of pregnancy request

A woman can request a TOP at any hospital or clinic in South Africa. If the particular clinic or hospital does not provide TOP services, the client will be referred to a clinic or hospital that provides a TOP service.

Women undergoing termination need adequate information about the details of the procedure and the possible consequences (Walker 2000:508). However, the woman's emotional distress about having a termination will influence her ability to absorb information about the procedure and post-abortion care (Walker 2000:508).

Every woman that requests TOP is given the following information:

- A woman may have to wait some time before the procedure can be done, as there are waiting lists at some clinics/hospitals.
- TOP is free at government hospitals and clinics. It is also available at private clinics and hospitals for a fee.
- Counselling is available for women to discuss their concerns and feelings. Women should feel free to ask about other choices such as adoption and fostering.
- Women have to sign an informed consent form to give permission for the TOP to be performed. A woman does not need to have the consent of a husband, partner or parent to have a termination (Walker 2000:506-508).

Women request TOP for different reasons:

- not being able to provide for the child
- pressure by partner to terminate the pregnancy
- partner having left them
- unemployment
- unstable relationship
- desire to continue schooling

- pregnancy resulting from rape
- partner denying responsibility for the pregnancy
- young girls not wanting their families to know that they are pregnant
- health reasons
- pregnancy being unplanned/unwanted

(Reproductive Right Alliance 2000:1-7)

Bewley (1993:25) highlights that the care of women undergoing termination of pregnancy can be extremely stressful and requires considerable skills on the part of nurses involved in their psychological care.

2.3.4 Termination of pregnancy procedures

A number of hospitals and clinics are providing TOP services in different provinces. If there is difficulty in gaining access to services, the provincial health department can be contacted, or the Reproductive Health Alliance office can provide lists of facilities that are providing services in the relevant province.

Each health institution in South Africa that has been licensed to perform TOPs can provide guidelines on TOP procedures. The guidelines include:

- A termination of pregnancy is a safe, simple procedure, if it is performed by a trained health worker in an approved clinic or hospital. As with any procedure, there is a small risk.
- TOP is much safer if it is done in the first few weeks of pregnancy.
- If it is done in the first twelve weeks of pregnancy, it is a short procedure that can be done while the woman is awake.
- A vaginal pessary may be given to ripen the cervix or a pill may be given instead.
- A tube is inserted into the womb and the contents of the womb are removed through the tube, using a gentle suction that is called evacuation.
- Many women are able to go home an hour or two after the procedure.
- If a woman is more than twelve weeks (three months) pregnant, the TOP is complicated, involving excessive bleeding or retained products. She will have to stay in hospital for a day or two where she will be given medication to bring on labour. Some women may need general anaesthesia.

- Some bleeding after a TOP is normal. Bleeding should get lighter over time and should not last for more than ten days.
- If a woman has severe pain or very heavy bleeding, she should contact her health worker immediately.
- For pain relief the recommended analgesia is Voltaren 75 mg intramuscularly.

(Guidelines for TOP for Health Workers 1997:7)

As there are different methods of terminating pregnancy, it is important that women not only understand the types of terminations available, but also the anaesthetic procedures (Dyson & While 1999:481). The different TOP procedures are vacuum aspiration, drug-induced termination and manual vacuum aspiration (MVA).

The choice of method of termination depends on the gestational age of pregnancy, and the facilities available in the community (Primary Clinical Care 2001:264). It is important for primary health care workers to be aware of the method used for TOP so that women can be counselled appropriately.

2.3.4.1 Vacuum aspiration

Vacuum aspiration is the most widely used method of abortion in the first trimester. This method can be used up to the twelfth week of gestation. The procedure takes about five minutes to complete. The potential complications are bleeding due to retained products of conception, infection, uterine perforation and psychological effects (Cronje & Grobler 2003:240).

2.3.4.2 Drug-induced terminations

Drugs that are commonly used are Mifepristone and Misoprostol.

Mifepristone is an anti-progesterone compound used in combination with a vaginal prostaglandin. Mifepristone blocks the activity of progesterone that maintains pregnancy, at the intracellular receptor. It is followed by a low dose of prostaglandin analogue, which activates great uterine contractions and causes termination of early pregnancy (Cronje & Grobler 2003:241; Jacob 1992:210).

Administration

Mifepristone is used for the medical termination of pregnancy up to 63 days from the start of the last period. A single dose of 600 mg is given orally, followed after 48 hours by Gemeprost vaginal pessary to ripen the cervix, then after 2 to 4 hours manual vacuum aspiration is performed.

Caution: Mifepristone should be used with caution in the following situations/cases:

- Clients suffering from asthma or chronic obstructive airway diseases
- Clients with cardiovascular disease or risk factors
- Clients with renal or hepatic failure

(Cronje & Grobler 2003:241; Jacob 1992:211)

Contra-indications for Mifepristone use

Mifepristone cannot be given to clients with the following conditions for fear of complications:

- pregnancy beyond 63 days of gestation
- suspected ectopic pregnancy
- evidence of adrenal dysfunction
- hemorrhagic disorders treated with anti-coagulants
- where the duration of pregnancy is not known

(Jacob 1992:211)

Side effects of Mifepristone

Clients on Mifepristone will be given information on the following side effects:

- nausea
- occasional vomiting
- malaise
- faintness
- headache

- skin rashes

(Jacob 1992:211)

Misoprostol is used for medical termination of pregnancy up to 63 days. It is a vaginal pessary that:

- is a synthetic prostaglandin E_1 analogue that inhabits gastric acid secretion
- promotes ripening of the cervix
- stimulates uterine contractions

(Spratto & Woods 1998:961)

Administration

If the gestational age is twelve weeks or less on the morning of admission to the clinic, 600 micrograms of Misoprostol tablets are inserted per vagina. MVA is performed 2 to 4 hours after insertion of the tablets and after the examination shows that the cervix is ripe. If dilatation of the cervix fails, the patient will be asked to return the following day. The same procedure will be done all over again. If any problems such as retained products or severe bleeding occur, the client will be referred to a tertiary hospital.

Contra-indications of Misoprostol

Misoprostol will not be given to clients who are:

- allergic to prostaglandin
- pregnant
- lactating

Side effects of Misoprostol

The client on Misoprostol will be informed about the following side effects:

- diarrhoea
- abdominal pain
- nausea
- bleeding

- cramps
- dysmenorrhoea

(Spratto & Woods 1998:961)

2.3.4.3 Manual vacuum aspiration (MVA)

Suction curettage is recommended after Mifepristone or Misoprostol use. Manual vacuum aspiration is recommended to ensure that the uterine contents are suctioned. A single valve syringe may be used for TOP at eight weeks gestation or less, but a double valve is recommended for TOP above eight weeks.

MVA can also be used as a primary procedure without the preceding administration of prostaglandin, but then a para-cervical block and adequate systemic analgesia must be given. For pain relief the recommended analgesia is Voltaren 75 mg intramuscularly, 30 minutes prior to the procedure (Guideline for TOP for Health workers 1997:7)

This procedure must be done under medical supervision. The registered nurse must observe the patient for two hours after the procedure. Within 48 hours the patient should start bleeding, which may be heavy and accompanied by cramp-like abdominal pain (Cronje & Grobler 2003:241; Jacob 1992:210).

2.4 THE POLITICAL AND LEGAL ASPECTS OF ABORTION NATIONALLY AND INTERNATIONALLY

2.4.1 A national perspective

Abortion has become one of the most debated and emotional issues facing South Africa. Also, the extent to which the significant policy changes with respect to abortion have been translated into services on the ground level, leaves a lot to be desired in many instances. Globalisation has increasingly been accompanied by a shift towards minimal state involvement and has impacted on social delivery in South Africa. The resultant erosion of social welfare services, such as health services, necessitates a political commitment towards investing into the public health sector as a critical area of intervention (Barometer 1999:3).

2.4.1.1 Pro-life organisations

There are organisations that oppose the Termination of Pregnancy Act. In South Africa the pro-life nurses, doctors and others say that preserving and protective life is what they stand for, not taking the life of another human being (Thom 1998:5).

In South Africa anti-abortion groups representing some doctors and nurses (Doctors for Life, Nurses for Life) have repeated their intention to refuse to take part in any abortions or to refer women to abortion clinics (Thom 1998:5). Some nurses were said to be insisting on imposing their own beliefs on their clients seeking to terminate pregnancies. For example, in Bloemfontein a nurse was said to be praying for women seeking abortion before sending them to an abortion agency (Thom 1998:5).

2.4.1.2 Religious groups

Three Christian groups: The Christian Lawyers Association of Southern Africa; Christians for Truth in South Africa; and United Christians Action challenged the Act in South Africa in court in 1998. Their argument was based on the fact that the life of the human being starts at conception, so abortion terminates the life of a human being (Prabhakaran 1998:15). This challenge to South Africa's legislation was brought against the Minister of Health, the Gauteng Premier and the members of the executive council responsible for health in Gauteng. The Commission for Gender Equality and the Reproductive Right Alliance, representing more than 30 pro-choice organisations, joined the case of the defendants. The counter's argument relied in part on section 12 of the South African Constitution, which guarantees everyone the right to make decisions concerning reproduction. In an important decision reaffirming freedom of reproductive choice, the Pretoria High Court dismissed the application (South African Health Review 1998:19).

According to Ehlers (2000:80), though many nurses and midwives opposed the passing of this legislation and refused to undergo training to perform termination of pregnancies, there were no nationally united voices from the nurses reported in the media.

2.4.2 An international perspective

Countries in different regions such as Brazil and the United Kingdom are assessing their laws, policies and practices to achieve the goals of reproductive health, including TOP. Some countries considered legal and policy reforms for this purpose while others made changes. The Brazilian Ministry of Health initiated the Programme for Integral Assistance to Women's Health, which includes: access to contraception, treatment of sexually transmitted infection (STIs), assistance for pregnancy and childbirth and for breast and cervical cancer (*Microsoft Encarta Encyclopaedia Plus* 2004).

The fourth World Conference on Women in Beijing reaffirms the Cairo program's definition of reproductive health but advances the wider interest on sexual health. The human rights of women include the right to have control over sexuality, including sexual and reproductive health, consent and shared responsibility for sexual behaviour and its consequences. In healthcare law there is generally no age of consent, but only a condition of consent: the woman must be capable of sufficient comprehension to give adequately informed consent. This applies to such sensitive services as contraception care and abortion (*Microsoft Encarta Encyclopaedia Plus* 2004).

By specific laws governing reproductive health services or general laws concerning human rights, sometimes embodied in countries' constitutional laws, many legal systems protect health care providers from legal obligations to perform procedures, such as abortion, to which they have conscientious objections (www.who/rhr/00 accessed on 18.04.2004).

In England the Abortion Act of 1967 provides that abortion is lawful where to continue with a pregnancy would involve greater risk to the life of the woman or injury to her health than if the pregnancy were terminated. The act also allows for abortion where there is substantial risk to the unborn child. The abortion is to be carried out in an approved clinic (*Microsoft Encarta Encyclopaedia Plus* 2004). In the United Kingdom the responsibility to decide on the issue of abortion largely rests with the medical profession rather than with the woman. In contrast, philosophical arguments in this context suggest a spectrum of views ranging from a woman's right to choose to the right to life of the foetus.

Some governments openly advocate abortion. The Japanese government instituted a policy using both contraception and abortion to limit family size. In China in the year 2000, 1.3 billion married women with one child were forced to terminate a second or later pregnancy, due to overpopulation (*Microsoft Encarta Encyclopaedia Plus* 2004).

At present women worldwide are still susceptible to unplanned pregnancies although effective contraceptive methods are available. According to WHO, each year more than 70 000 women die of complications of unsafe abortions, 99% of them in developing countries. Most of these women are poor and in countries where abortion is either illegal or severely restricted by law (*Microsoft Encarta Encyclopaedia Plus* 2004).

The availability of legal abortions actually reduces pregnancy maternal morbidity. According to Rosenfeld (1997:33), since the legalisation of abortion in the United Kingdom, no deaths had been recorded from abortion, whereas there were 75 to 80 in the three years prior to legalisation. According to Rodriguez and Strickler (1999:60), in Latin America it is estimated that unsafe abortions are responsible for 24% of maternal deaths. It was further observed that as well as the increasing numbers of maternal deaths, unsafe abortion strains public health resources such as hospital beds, blood supply and antibiotics. Beyond the financial costs, the individual tragedy of maternal death carries with it a variety of severe repercussions on families and society in general.

2.5 MORAL AND ETHICAL CONSIDERATIONS REGARDING ABORTION

Abortion raises many fundamental questions such as issues concerning the right of the foetus; the meaning, quality and definition of life; the rights of the individual versus those of society; and sexual norms and values.

Commitment to certain values guides us in the design-making process and motivates us to act on those decisions from an ethical perspective. Valuing is part of being human, thus the morality of abortion causes an ethical dilemma to society and raises many controversial issues. The issue of religion affects how one translates one's religious beliefs or values. Moral arguments against abortion continue to rest on the theological status of the foetus and its potential right to life, versus the view that a foetus has not attained personhood. This ethical perspective was one of the most significant barriers to women's choice (Reproductive Right Alliance 2002:4). Compared with abortion,

choosing adoption requires that the woman still carry the pregnancy to term and deal with the reality of separation from the newborn, a painful experience even if the woman is highly motivated. Others who decide to keep their pregnancies and have their babies, especially teenagers, may lack the ability and appropriateness of caring for the children.

Abortion is the most controversial issue in the medical ethics. An ethical dilemma occurs not only when a woman has to make a difficult choice in what she regards as the least harmful decision, but also when medical personnel grapple with the moral values of providing care to women, preserving life and avoiding unsafe termination of pregnancy (Reproductive Right Alliance 2002:4).

2.5.1 Nursing ethics

One of the most important features of a profession is that it has a professional code of ethics based on personal morality. Individual moral integrity is regarded as the key to a safe standard practice (Searle 2000:100).

"Ethics can be considered as a system of morals used by people to evaluate their experiences and plan their course of action. For most of the things in life there is a moral dimension, which is the realm of ethics. Nurses must observe the norms of their profession such as conservation of life, loyalty to the patient and colleagues, and adherence to the laws" (Searle 2000:101). Health care professionals find themselves in a dilemma, as the ethical code says to respect the law and to preserve life. The fundamental responsibility of the nurse/midwife is to conserve life, promote health and alleviate suffering (Searle 2000:97).

Searle (2000:97) states that professional ethical codes set the parameters of the responsibilities the nurse owes her patients. Professional ethics are moral dimensions of attitudes and behaviour based on values, judgment, responsibility and accountability, which the practitioner takes into account when weighing up the consequences of her professional actions. The nurse also has a professional and ethical obligation, according to the Nursing Act (Act 10 of 1997) and its related regulations, to nurse the patient before and after the TOP procedure, despite conscientious objection to the termination of pregnancy. The principle of unconditional acceptance should be adhered to - nurses should accept the woman who chooses to have an abortion and view her as a human

being in need. Although the nurses may not necessarily agree with her choice, the woman should be nursed within her own framework of reference and not the nurse's (Poggenpoel et al 1998:6).

A nurse/midwife who abuses the ethical trust placed in her by her profession, employer, patient and fellow professionals betrays a professional trust and brings the profession into disrepute. Ethical standards are frameworks or guidelines for decision-making (Searle 2000:103). The Code of Ethics, which was instituted to guide nurses in decision-making, promotes preservation of life and respect of the law, yet implementation of the Termination of Pregnancy Act, which allows ending of pregnancy before the foetus can have a chance of survival, causes a dilemma for nurses.

The modern nurse is confronted with a greater number and variety of ethical problems than ever before due to the complexity of modern medicine and healthcare technology. Searle (2000:103) observes that society worldwide has accepted that nursing is crucial to its well-being, while nurses/midwives are expected to be worthy of this trust. The ethical codes for professions sets the parameters of the responsibilities the nurse owes her patients. The nurses/midwives who have not made their professional code their way of life, who observe the do's and don'ts because they must and not because they believe in them, are often the ones who advocate the solutions to an ethical dilemma at the cost of the vulnerable individuals, such as the unborn child, the aged, or the incurably ill.

It is important to study these moral and ethical issues around abortion as the ethical viewpoint and religious beliefs of each participant in this study will affect his or her experience and perception of TOP.

2.5.2 Rights of the foetus

Hammond (1999:8) says in his argument against abortion: "Of what worth is human dignity if babies are denied the right to life?" He calls abortion "murder" of a helpless and innocent human being. Smith (1998:6) observes that the legal and intellectual issues are open to interpretation, but on moral grounds terminating life is seen by many to be indefensible. As life is neither given nor created by politicians, he questions whether, morally, they have the right to decide on its viability.

2.5.3 Nurses' rights

According to the Constitution 1996 Section 15(1) as stated in Pera and Van Tonder (2005:84), the nurse's right to choose not to participate in specific procedures such as TOP is protected. The nurse must inform the employer timeously in writing about not being prepared to take part in TOP.

In England the Abortion Act of 1967 provided health care professionals with the right to do what they felt was ethically right for them with regard to participation in the process of abortion (Jones 1999:677). The South African Constitution 1996 Section 15(1) clearly states the rights of health care professionals to act according to their ethical beliefs, in order to prevent their personal and moral compromise, yet it would appear that a variety of interpretations of this right exist (Searle 2000:360).

2.5.4 Clients' rights

TOP clients have the right to:

- a healthy and safe environment
- participation in decision making
- access to health care
- confidentiality and privacy
- informed consent
- continuity of care
- be treated with respect

2.6 NURSES' DILEMMAS REGARDING ABORTION

Abortion remains an emotional and wrenching issue (Marissa & Ventura 1999:44). With the basic rights to have an abortion still intact, nurses who personally oppose the procedure may face a professional dilemma of how to uphold their duty to care for patients while remaining true to their personal convictions. According to Dyson and While (1999:478), nurses who were involved in termination of pregnancy felt stressed and experienced conflicts between termination and their values at times. Resolving this

dilemma, of how to uphold their duty to care for patients while remaining true to their personal convictions, is no small matter for nurses (Marissa & Ventura 1999:44).

More nurses today are opposed to abortion. In the event of numerous available options to prevent pregnancy, most nurses only support abortion in cases of rape, incest or a threat to the mother's life or health. They are opposed to those women who use abortion as a contraceptive method. A nurse from New York said, "It is difficult to care for women who refuse contraceptive methods, or fail to use them correctly, and then have three or more abortions (Marissa & Ventura 1999:45).

The dilemma of the nurse occurs when a woman comes to demand abortion perhaps for social reasons, and at the same time, in the same ward, another woman is grieving and mourning the loss of her baby. Most nurses find themselves being biased in their counselling towards the latter patient. The two situations become extremely difficult and stressful. According to the Reproductive Right Alliance (2002:4), an ethical dilemma occurs to medical personnel when they grapple with the moral values of providing care to women, preserving life and avoiding unsafe termination of pregnancy.

Most nurses have refused to assist in abortions because they are highly affected by the procedure. They remain with the duty of disposing of the foetus and pieces of flesh and emptying of the suction bottle. Since many nurses and doctors refuse to take part in abortion due to the procedure being against their personal ethics, those who are willing to perform abortion are left with an extra workload (Prabhakaran 1998:3).

The majority of the literature regarded it as the duty of the nurse to safeguard the vulnerable against abortion and euthanasia, and to direct all her efforts towards preservation of life.

2.7 CONCLUSION

Although abortion is no longer a secretive issue in many parts of the world, it remains a highly controversial issue, especially among health care providers who are supposed to implement the legislation.

Before abortion was liberalised, studies done on the nurse's experiences of abortion focused on the woman who was undergoing TOP for medical reasons. With the legalising of abortion in many countries, the role of the nurse continues to expand and so too her dilemma on ethical issues. The numbers of women demanding abortion continue to increase and thus also the burden on nurses and doctors. The ethics of abortion continue to confront nurses, doctors and many other interested parties, because the question of life and death is involved.