SMITH 3

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

CASE NO: _____

In the matter between:

THE VOICE OF THE UNBORN BABY NPC Applicant

and

MINISTER OF HOME AFFAIRS First respondent

MINISTER OF HEALTH Second respondent

AFFIDAVIT

I ASS.

I the undersigned,

LOUISE OLIVIER

state under oath as follows:

1 I am an adult clinical and counselling psychologist, practicing at 741 Rubenstein Drive, Moreleta Park, Pretoria.

2 The facts contained herein are within my personal knowledge unless otherwise apparent from the context, and such facts are true and correct.

3 My qualifications include master's degree in clinical psychology, and a doctoral degree in Philosophy (Psychology). I have 40 years' experience as clinical psychologist, and have treated bereaved parents following stillbirth, miscarriage, and termination of pregnancy. I also have an interest in traditional African approaches to mental health, and have been given an honorary position as Traditional Healer after having done extensive research among the Kgaga of Make (Traditional Healers of the Setswana) in the district of Tzaneen and written a research report on the use of hypnosis as therapeutic technique among the Traditional Healers in treating patients suffering from trauma and other problems.

4 Accordingly, I state that I am qualified to provide the Court with an expert opinion on the psychological consequences on expecting parents in the case of pregnancy loss.

5 I confirm that I am the author of the expert opinion to which this affidavit is attached, dated 14 April 2016, and I confirm the content thereof.

6 In my expert opinion, I refer to various sources. I list these sources in full in the bibliography at the end of my expert opinion. For the Court's convenience, I attach copies of these sources to this affidavit (here I only refer to the author, in alphabetical order):

6.1 ACOG – Committee on Ethics – Attached hereto marked '**LO1**'.

6.2 Anderson – Attached hereto marked '**LO2**'.

6.3 Broen et al – Attached hereto marked '**LO3**'.

6.4 Daurgirdaitè et al – Attached hereto marked '**LO4**'.

6.5 Dlukulu – Attached hereto marked '**LO5**'.

6.6 Giannandrea et al – Attached hereto marked '**LO6**'.

IDS.

6.7 Gray & Caron – Attached hereto marked '**LO7**'.

6.8 Hagamu – Attached hereto marked '**LO8**'.

6.9 Lenow – Attached hereto marked '**LO9**'.

6.10 Martin et al – Attached hereto marked '**LO10**'.

6.11 Major et al – Attached hereto marked '**LO11**'.

6.12 Mbiti – Attached hereto marked '**LO12**'.

6.13 Radzilinai – Attached hereto marked '**LO13**'.

6.14 Robinson – Attached hereto marked '**LO14**'.

6.15 Setsiba – Attached hereto marked '**LO15**'.

6.16 Van den Akker – Attached hereto marked '**LO16**'.

6.17 Walsh et al – Attached hereto marked '**LO17**'.

JMSS

DEPONENT

Thus signed and sworn at SINOVILLE on this 27 day of FEBRUARY 2017 by the deponent who has declared that she has read this affidavit, understands the contents thereof and has no objection to the taking of the prescribed oath, and regards same as binding on her conscience.

COMMISSIONER OF OATHS

Ex officio: CAPT. IDAS SOUTI (REP. OF SA SINOVILLE)

Full names: REGINALD SOUTI.

Address: 257 KONAVLEI ST. SINOVILLE.

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CONFIDENTIAL

POSSIBLE NEGATIVE AND POSITIVE PSYCHOLOGICAL AND PSYCHIATRIC CONSEQUENCES ON PARENTS OF A FOETUS (IN THE CASE WHERE THE FOETUS IS YOUNGER THAN 26 WEEKS) IF THE PARENTS ARE NOT GIVEN THE CHOICE TO HAVE THE FOETUS BURIED

DATE OF THE REPORT: 14 APRIL 2016

POSSIBLE NEGATIVE AND POSITIVE PSYCHOLOGICAL AND PSYCHIATRIC CONSEQUENCES ON PARENTS OF A FOETUS (IN THE CASE WHERE THE FOETUS IS YOUNGER THAN 26 WEEKS) IF THE PARENTS ARE NOT GIVEN THE CHOICE TO HAVE THE FOETUS BURIED

1. THE PURPOSE OF THIS REPORT

The purpose of this report is to:

(a) To touch on existing health legislation and policy.
(b) To explore the different cultural perspectives of death, dying and burial of an unborn foetus from a psychological point of view.
(c) To explore the difference between possible choices that would be made from the perspectives of a mother that 1) chooses to have a healthy foetus aborted; 2) chooses to have a foetus aborted for medical reasons related to the foetus (e.g. abnormalities); and 3) chooses to have the foetus aborted for medical reasons related to the health of the mother.
(d) To explore the difference between possible choices that would be made regarding the burial of the foetus from the perspectives of parents/mothers that 1) experience a spontaneous miscarriage of a foetus; 2) experience a miscarriage of a foetus after some intervention (subtle medical or other) and 3) experience a miscarriage/abortion of a foetus after a more aggressive intervention (medical or other).
(e) Explore the possible positive and negative psychological and psychiatric consequences on parents of a foetus (younger than 26 weeks) if the parents are not given the choice to have the foetus buried (but it is viewed as medical waste).

2. HEALTH LEGISLATION AND POLICY

Gray and Jack (2009) refer to the uniqueness of the South African Constitution that recognises the human right status of a woman and that her decision to have children is fundamental to a woman's physical, psychological and social health. The National Health Act 61 of 2003 also states that a

woman does not need the consent from her husband or partner before she can terminate a pregnancy.

At the same time, the South African Law also dictates that foetuses born before 26 weeks of pregnancy should be considered "*medical waste*" and disposed of in medical waste bags and incinerated.

Recent legal actions and policies in the United States of America are aimed to protect the foetus as an entity separate from the woman and they have challenged the rights of pregnant women to make decisions about medical interventions. The Congress Committee on Ethics framing ethics in perinatal medicine points out that some opinions are that the foetus is separable and legally, philosophically and practically independent from the pregnant woman within whom it resides. The Committee however believes that these approaches tend to ignore the moral relevance of relationships, including the physically and emotionally intimate relationship between the woman and her foetus as well as the relationship of the pregnant woman within her broader social and cultural networks.

The Congress Committee on Ethics rejects the "*two-patient*" model of the maternal-foetal dyad because the notion of a patient is someone who is physically separate from others. They thus recognise the interconnectedness of the pregnant woman and the foetus. Jeffrey Lenow, writing a chapter in the book Legal Medicine (Edited by S. S. Saber in 2007) however asks the question if the maternal patient and foetal patient are separate entities, medically and legally and are the rights of the maternal patient the same as or superseding those of the foetal patient? He refers to the Reo versus Wade Benchmark for analysis of foetal rights (1973) where the Roe court suggested that U. S Constitution and its implications are not applicable in the prebirth state and for unborn foetuses.

This question can thus also be asked regarding the rights of the maternal patient to have the choice of burying the foetal patient in the case of a

miscarriage, abortion or the foetus dying in the uterus before the age of 26 weeks.

3. DIFFERENT CULTURAL PERSPECTIVE OF DEATH, DYING AND BURIAL OF UNBORN FOETUS FROM A PSYCHOLOGICAL POINT OF VIEW

In South Africa with its unique diversity of culture, it is important that law makers should take into consideration the perspective of people in different cultures regarding death, dying and burial (also of the unborn foetus). Therefore some discussion of cultural norms is needed:

3.1 THE CONCEPTS OF DEATH, DYING AND BURIAL IN THE AFRICAN CULTURE

In the African culture according to Mbiti (1977) the deceased member of the family becomes an important extension of the living and hence they are called the "*living dead*" or ancestors. The funeral rites in the African culture serves as a public acknowledgement that a death has occurred (Radzilani, 2010). Setsiba (2014) indicates that burial rituals play a therapeutic role to bring back the healthy status to the bereaved members. Therefore in the indigenous African religions grief counselling is conducted in a community setting where a tent is pitched and community members, family members and relatives and neighbours gather for prayers preceding the funeral (Mkhize, 2008).

Among the VhaVenda ethnic group it is also believed that when a death occurs in a family, the family members have been symbolically crushed by a mud wall and need to be released (Radzilinai, 2010). According to Dlukulu (2010) the slaughtering of the beast seems to still remain a ritual in urban societies and the home coming ceremonies before the burial where the corpse is brought home for the final viewing.

Setsiba (2014) state that mourning rituals currently practiced in South African contemporary townships highlight the needs of the bereaved people living in those environments. The environment demands that mourning should be brief

and intense so that people can go back to their normal lives as soon as possible.

Hagamu (2012) who grew up in a remote area of Tanzania points to the fact that he speaks two local languages, Kinyuanja and Kimatengo and neither of these languages has a word for abortion. He also points out that among the Igbo in Nigeria human life is widely respected and any attempt to kill unborn human life is regarded as an abomination. He stated that he also did some research and the Sotho in Lesotho, the Swazi in Swaziland, the Shona in Zimbabwe, the Chewa in Malawi and the Bagainda in Uganda all have no word for abortion in their language but they do have a work for miscarriage. There is also a special rite to bury the body of a stillborn baby and children were not allowed to attend the ritual. According to Hagamu (2012) abortion is a concept that was imported from the West into African countries and if an African woman does choose an abortion it is followed by extreme guilt.

In a very important study done by Martin et al. (2013) regarding the role of bodies in "*black*" South African bereavement rituals and mourning practices they found that in the African culture the body must be seen. They did research regarding some members of a crew of a South African Navy vessel who died as a result of anti-piracy operations off the east coast of Southern Africa. They also address the unique complexity in the African culture of a body "*lost at sea*" because of the burial at sea while the vessel is still at sea. The researchers found that the body in the burial ritual play especially four important roles: 1) the body must be seen so that mourning rituals can be started; 2) rituals to the body inform and assist the deceased's spirit to move on from the body; 3) it allows the deceased person to assume his or her rightful role in the spirit world and leave the body and 4) if mourning rituals with the body cannot be performed properly the deceased family could be subjected to potential bad luck and difficulties. In a foetus 26 weeks and less the body can also not be viewed during the mourning ritual but the ritual whilst the foetus is lying in the coffin allows the family members to help the spirit to resume his or her rightful role in the spirit world.

It is thus according to the African rituals and belief in mourning of the utmost importance to have a body (or part of a body in the case of a foetus) to bury and to be part of the ritual.

3.2 *ISLAMIC AND WESTERN CULTURES AND OTHER AFRICAN CULTURES*

Anderson (2016) in discussing African religions points to the fact that in religions of Africa, life does not end with death but continues in another realm. He emphasises that the person who dies be given a '*correct*' burial supported by a number of religious ceremonies because if this is not done the dead person may become a wandering ghost unable to live properly after death and therefore a danger to those who remain alive. Most of the Islamic culture and African culture in comparison with the Western dualism does not separate "*physical*" from "*spiritual*" but believe it is the whole person who continues to live in the spirit and receives a new body identical to the earthly body but with enhanced powers to move about as an ancestor. The death of children is regarded as a particular grievous event.

In many religions such as in the Jewish religion there is still a night vigil to comfort and encourage the bereaved. Anderson (2016) also stated that because of the dominance of Christianity and Islam in Africa certain mourning customs have been rejected but the funeral is still a time to declare faith and to take leave of the deceased and to find solace (even if the deceased is a foetus).

4. TO EXPLORE THE DIFFERENCE BETWEEN POSSIBLE CHOICES THAT WOULD BE MADE FROM THE PERSPECTIVE PARENTS IN DIFFERENT LIFE SITUATIONS

It is the clinical experience of the undersigned psychologist that the choices parents would make regard the burial of the foetus or not (should it be allowed by law) depends on different factors. These are the following:

(a) <u>The mother who chooses to have a healthy foetus aborted</u>: The reason for the abortion can be varied such as conceiving during rape, not being able to financially care for the baby once it is born or having a support system;

being too young to be a parent and not really wanting members of the peer group to know about the pregnancy and also having future plans that do not involve a child; the pregnancy being a result of sexual abuse; the pregnancy being the result of a one-night stand, the pregnancy being unintended etc. In these cases there may be different psychodynamics at play which would influence the choice of the mother to have a burial for the foetus or not such as:

- Extreme anger towards the child as a projection of the anger towards the person who fathered the child. In this case there may be a need to have the foetus dead and not buried as a reflection of the anger towards the father;
- Extreme guilt feelings because having an abortion are contrary to the mother's religious beliefs. In this case there may be a need to have a burial of the foetus to atone for the "*sin*" and to send the spirit to the Almighty or there may be a need not to see the foetus at all in order to try and appease the guilt feelings and to repress the guilt feelings.
- Indifference: where the mother convinces herself that it was a good choice and she does not want to be bothered with the foetus again. It is the experience of the undersigned psychologist that the indifference is often just pretence and the actual feelings are hidden deep inside and may later cause pathology in the mother. This mother will most probably not choose to bury the foetus but in very exceptional cases with do so to convince herself of the pretence.
- Repression: That the mother of the foetus convinces herself that it never happened and the memory is repressed in the unconscious mind. This then often causes even posttraumatic amnesia. This mother would not choose to bury the foetus.

(b) A mother who chooses to have the foetus aborted because of medical problems related to the foetus: It is the experience of the undersigned psychologist that this is normally a very difficult choice for the mother and is often accompanied by religious convictions and a belief that the quality of life of the foetus if allowed to live would be very poor. This mother would most probably want to choose a burial of the foetus in order to take leave of her child and to pray for her child's spirit to return to the Almighty. Major et all. (2009) found that women who terminate wanted pregnancy typically do so because of foetal anomalies or risks to their own health. They point out that abortion under these circumstances is a very different physical and psychological event than an abortion of an unplanned or unwanted

pregnancy. They found that the levels of stress of these women were higher than those that delivered a healthy child.

(c) A mother who chooses to have the foetus aborted because of medical problems related to herself: Normally the mother is told that her medical problems may not only cost her own life but also that of the foetus during birth or even before birth. This is also according to the experience of the undersigned psychologist a difficult choice especially as the medical caveat is often that the mother should never fall pregnant again. If the mother chooses abortion she would want to bury the foetus not only to have a bonding experience with the child but also to feel less guilty of having lived and having to have taken the life of the foetus in return.

5. POSSIBLE POSITIVE AND NEGATIVE PSYCHOLOGICAL AND PSYCHIATRIC CONSEQUENSES ON PARENTS OF A FOETUS (YOUNGER THAN 26 WEEKS) IF THE PARENTS ARE NOT GIVEN THE CHOICE TO BURY THE FOETUS

5.1 POSSIBLE POSITIVE CONSEQUENCES

There are several possible **POSITIVE** consequences. These are:

5.1.1 **That the mother and/or father do not have to deal with any aspect of the pregnancy again on a physical level**: This implies that the mother and/or father, immaterial of it having been an abortion, miscarriage or the foetus dying in the womb do not have to deal with what has happened anymore on a physical level but this does not mean that it can be forgotten easily on an emotional level. Some people are able to deal with it well as Major et al. (2016) did some research to evaluate the relationship between induced abortion and mental health and found that abortion encompasses a diversity of experiences and women vary significantly in how they react to this life event. They found four major perspectives that shape the literature on abortion and mental health. These include the perspective that: a) abortion is a uniquely traumatic experience; b) unwanted pregnancy and abortion are potentially stressful life events responses to which are shaped by the women's appraisals and coping resources; c) psychological reactions to abortion are shaped by the socio-cultural context in which abortions occur; and d) unwanted pregnancy and abortion occur in the context of occurring risks that are themselves predictive of poorer mental health irrespective of pregnancy

resolution. They came to the conclusion that the risk of mental health problems among adult women in the USA who have a single, legal, first-time abortion or an unwanted pregnancy for non-therapeutic reasons is no greater than the risk among women who deliver an unwanted pregnancy. They found that the research indicate the risk is higher for mental health problems among young women who have had an abortion in New Zealand. They however did not include women in Africa in the research.

Giannandrea et al. (2013) did some research on the increased risk for postpartum psychiatric disorders among women with past pregnancy loss. They found that women with a history of pregnancy loss (through miscarriage, abortion or death in the womb) are at increased risk for depression and anxiety, including Posttraumatic Stress Disorder. They found that at least the women were likely to be diagnosed with Major Depression.

Being able to have the choice of burying the foetus may be therapeutic for many women as this gives them the opportunity to: a) take a final leave of the foetus with the support of family and the community; b) get recognition of the fact that they were pregnant and have experienced a loss and c) that the foetus may be recognised as having a spirit and being assisted to the spirit world. For other women choosing not to bury the foetus the funeral and mourning period may not be needed because: a) they do not wish to dwell on what happened and want to move on but this may have a negative impact on their mental health later; b) they may not want their family and community members to know that they were in fact pregnant and c) they may feel so relieved at that moment that the unwanted pregnancy is past that they would not want to dwell on it.

5.1.2 **That women who were pregnant and who had an abortion or miscarriage in the past need not discuss this with a new partner**. Because there was no choice of burial and the foetus was destroyed as medical waste women who were pregnant and had an abortion or miscarriage do not have to share this with a new partner if they do not want to. This ensures the privacy of the women. A choice of burial will however still ensure that the woman who does not want anybody to know will have the option of rejecting a burial.

5.1.3 **That women with unwanted pregnancies are given the opportunity to get rid of the foetus and never see the foetus and to dehumanise it**. Because it is viewed as medical waste the foetus is dehumanised and not viewed by law as a person. This enables many women with unwanted pregnancies to convince themselves that they have not "*killed*" a person but got rid of unwanted medical waste before it could grow into a human being. Unfortunately many of the religions in Africa and South Africa have a different point of view and if the woman is religious it may not be so easy for her to convince herself that she carries no guilt. Having a choice to bury the foetus may in fact assist such women to come to terms with their choice of having an abortion and to help them to be at peace.

5.1.4 **That some women who have had a miscarriage can convince themselves that this was because of medical reasons and thus the appropriate term "*medical waste*":** Often miscarriage of a foetus is viewed as an intervention to ensure that a foetus which is abnormal is not born as a child with serious disabilities. For some women it is then a way of accepting the miscarriage more readily even if they wanted a child. Giving them an option to bury the foetus may thus cause them to rethink the situation and may cause emotional stress.

5.2 POSSIBLE NEGATIVE CONSEQUENCES

There are several possible **NEGATIVE** consequences:

5.2.1 **That parents who had expectations of meeting their offspring do not get an opportunity to take leave of the foetus**: Research regarding the father's experience of ultrasound attendance during their partner's examination was done by Walsh et al (2014). They found that ultrasound attendance contributes to parental feelings of connection to the unborn baby and motivation to change behaviour. The research also found that the experience of the fathers had the following reactions: 1) that they felt reassured that the pregnancy was proceeding normally; that they perceived the reality of the child; that they developed plans and self-expectations to provide for the child; that they believed it would strengthen their relationship with their partner; and that in general the ultrasound experience was often replete with positive emotions. It thus illustrates that the ultrasound experience makes the foetus a reality. It would thus have serious negative consequences to the father and even more so to the mother if they do not have the choice to bury the foetus especially in the case of a miscarriage or abortion due to medical reasons

later. This research corresponds with research done by the Human Sciences Research Council as early as 1987 on the effect of ultrasound experience on parents in South Africa.

5.2.2 **Increase of psychological and social consequences of miscarriage**: Van den Akker (2011) gives the definition of miscarriage as "*foetal death in early pregnancy up to the gestation age of approximately 22 weeks*" and indicates that after 22 weeks it is being considered as stillbirth. She indicates that a 10 week loss is not visible in social and workplace environment but a 25 week loss is very noticeable to all who know the woman. Robinson et al. (2014) defines stillbirth if the foetus dies after 20 weeks of gestation or after reaching 14 ounces in weight.

Missed miscarriage (where the foetus is not expelled by the woman) and a complete miscarriage refer to the complete expulsion or delivery of a nonviable foetus. Van den Akker lists the following psychological effects of miscarriage on the woman identified in the literature:

- Morbidity following the miscarriage;
- The parents have to cope with their loss in isolation because the societal ramifications of pregnancy loss are harsh because of loss of recognition.
- Major Depressive episodes;
- Posttraumatic Stress Disorder;
- Obsessive-Compulsive Disorder;
- Panic Disorder;
- Strain on the relationship with the partner.

She identifies the following psychological effects listed in the literature on the partner of the woman who had the miscarriage (and co-parent):

- Morbid levels of anxiety;
- Depression and grief;
- Greater despair in men who had witnessed the ultrasound scan;
- Trying to ignore the situation and worry.

Van den Akker also found that the literature stated that women need to understand their loss and to be given a chance to mourn their lost pregnancy – there is no better way in doing this than to be able to bury the foetus. Van den Akker warns that healthcare professionals should develop a deeper insight into the psychological and social effects of miscarriage and accept it as a real and significant loss and should recognise and support women who have had this experience. Giving prospective parents the choice of burying the foetus would be an important step in the intervention and support of such parents to prevent development of more serious psychological and social problems.

Robinson (2014) found that the literature they studied regarding pregnancy loss indicated the following psychological effects:

- Feelings of loss and grief;
- Feelings of guilt or self-blame;
- Depressive symptoms;
- Anxiety;
- Concern about future pregnancies;
- Lack of social support;
- Increased of rate of marriage dissolution especially in the case of a stillbirth;
- Delayed grief due to repression in the case of a stillbirth and
- Masked grief resulting in somatic symptoms.

She also found that management should include follow up, giving a name to the potential baby, holding a memorial service or burial for the foetus; preserving mementos such as the mother's hospital identification band or buying something to signify the existence of that pregnancy and therapy. It is the opinion of the undersigned psychologist that part of this should also be allowing the parents to choose if they want to bury the foetus.

5.2.3 **Increase of Posttraumatic Stress and Posttraumatic Stress Disorder after termination of pregnancy**: Daugirdaité et al. (2015) found that Posttraumatic Stress or Posttraumatic Stress Disorder can evolve after miscarriage or abortion, and Posttraumatic Stress Disorder is infrequently reported three months after miscarriage although an increase over time has

also been reported. They also found that unplanned pregnancies are significantly related to Posttraumatic Stress Disorder in cases of abortions. Broen et al. (2004) found that women with induced abortions had more feelings of relief and guilt while women with miscarriage experience a shock-like event when the pregnancy is terminated. In order to decrease the negative impact on the mental health of the person management after the induced abortion or miscarriage is of importance. One of the important management techniques would be to give the woman the choice to bury the foetus or not.

6. SUMMARY

From the clinical experience of the undersigned psychologist as well as the literature it is clear that an abortion, miscarriage or still birth of a foetus/baby can be extremely traumatic for not only the mother but also the father of the deceased foetus/baby. The management of the mother and father after such an event is important for their mental health. One of the important management strategies would be to give the parents the choice if they want to bury the foetus or have the hospital discard it as medical waste.

It is clear that part of the social impact and psychological impact on the father and mother of the foetus is the religious beliefs and cultural beliefs of the mother and father. Many of the research done in the United States and Europe do not take into consideration the unique cultures in Africa and in South Africa specific. Most of the cultures in Africa recognise the belief of the spirit of each human being (even the unborn) and the importance of rituals to take leave of such a spirit in time of death and if it is not done appropriately that it has consequences for the community and the individual.

The constitution of South Africa recognises the right of each member of the society to be true to themselves and their culture and religious beliefs. It is the opinion of the undersigned psychologist that it is part of the rights of parents to according to their beliefs be able to achieve closure by burying even an unborn, deceased foetus no matter what age should they wish to do so.

It is also the opinion of the undersigned psychologist that burying an unborn foetus (if they choose to do so) may also allow the parent of such a foetus the relief to know that he or she has honoured and acknowledge the existence (no matter how short) of such a "person" and to honour the memory of such a "person" should they wish to do so.

DR. LOUISE OLIVIER

CLINICAL-AND COUNSELLING PSYCHOLOGIST

2016-04-14