

Abortion Services in South Africa: Available Yet Not Accessible to All

By Sanjani Jane Varkey

The new political regime elected in South Africa in 1994 ushered in a wave of reform aimed at redressing the imbalances between people of different races, classes and geographical boundaries inherited from the apartheid era. The government's commitment to women's health was indicated in key documents such as the Reconstruction and Development Programme, in which it recognized that "every woman has a right to choose," and the African National Congress' National Health Plan, in which it aimed to deal with the problem of clandestine, unsafe abortion. Within this enabling environment, the efforts of prochoice parliamentarians, women's activists and health advocates led to passage of the Choice on Termination of Pregnancy Act in 1996, which replaced the Abortion and Sterilisation Act of 1975.

Since February 1997, research and monitoring initiatives accompanying the implementation of the Act have documented the increased availability of abortion services. In the first two-and-a-half years after the reform, the total number of reported abortions at public health facilities had reached 92,399.¹ Within the first six months (February to July 1997), the number of legal abortions reported by public health facilities was more than twice the number legally conducted during an eight-year period (1984–1991) prior to the reform.² Yet although the Act has undoubtedly made abortion services more available in South Africa, the question of how accessible these services are remains to be answered.

One way to evaluate accessibility is to assess the implementation of three provisions of the Act that were intended to ensure access for all. These provisions are: training midwives to perform first-trimester abortions so that services can be provided in primary health care facilities; placing no restrictions on access to services besides individual choice; and ensuring that wo-

men—including minors—have the sole right to consent to an abortion. Because of these provisions, the Act is considered a model for other countries, especially those in Sub-Saharan Africa. Yet its implementation has been slow and has been geared toward meeting immediate service requirements: It lacks a long-term, sustainable plan on how to ensure equity and promote women's right to self-determination.

First-trimester procedures, which constitute 75% of reported public-sector abortions, should be performed at the primary health care level. Nevertheless, abortions are still being conducted mainly in hospitals. Of the 248 public health facilities designated by the Minister of Health to provide abortion services, only 73 are doing so, and 99% of these facilities are hospitals. Nearly half (33) of the providing facilities are located in Gauteng and Western Cape.³ Of South Africa's nine provinces, these two have the lowest levels of poverty, the highest levels of urbanization and the best-equipped health facilities. The province with the largest proportion of the country's female population—Kwa Zulu Natal—provides only 10% of reported abortions.⁴ Reasons why designated facilities are not providing abortions have not been documented, but personal communication with managers suggests that unwillingness of staff members to be involved in abortion is the main problem.

The shift from hospitals to primary health care facilities would be expected to be slow initially, given that midwives—who make up the majority of their staff—need to be trained in abortion care. Still, because the national abortion training program started a year after the Act and because abortion has not yet been integrated into the basic curriculum of nurse training institutions, the number of fully qualified midwives has reached only 63. These midwives serve mainly as provincial trainers and are therefore located at

hospital levels. Increasing the number of trained midwives is critical to ensuring the decentralization of first-trimester abortions to lower and more accessible levels of health care. Not surprisingly, therefore, abortions are inaccessible for many women who do not live close to health facilities that provide abortions.⁵

No systematic data exist on the number of facilities providing second-trimester abortion services. This information gap needs to be remedied, as national trends are showing a decline in the number of second-trimester abortions. In the first year of implementation, second-trimester abortions made up 35% of all abortions reported at public health facilities. This proportion declined to 29% in the second year and is down to 25% in the first six months of the third year.⁶ Informal conversations with provincial managers reveal that because staff are unwilling to be involved, facility managers are reluctant to provide second-trimester abortions and in some cases are discontinuing the service. To the extent possible, abortions should take place within the first trimester; however, given the widespread lack of knowledge about basic reproductive biology⁷—such as the timing of the fertile period and the early signs of pregnancy—as well as the distances women must travel to obtain an abortion, it is important to ensure that second-trimester procedures remain accessible.

Although the training of midwives to provide abortions will help decentralize services from hospitals to primary health care facilities, the attitudes of other health workers, including managers, have not received sufficient attention. Studies examining women's experiences when obtaining an abortion reveal that staff at referral centers sometimes put obstacles in the way

Sanjani Jane Varkey is research manager, the Women's Health Project, Department of Community Health, University of Witwatersrand, Johannesburg, South Africa.

of women seeking services. Some women have had to go from one clinic to another to find a sympathetic health worker who would give a referral letter, while others have had to listen to the provider's personal opinion about abortion. One woman recounted her experience: "(The sister) was just telling me 'It's killing, it's murder, your life won't be the same'...she even tried to call in a pastor...I said, 'I am sure what I am doing here. I don't need a pastor.' I was in a way angry... She was just wasting my time, just telling me not to do it."⁸

Such judgmental attitudes affect those who provide abortion services as well as those who use them. Health workers involved in these services report feeling unsupported by and alienated from their colleagues.⁹ As one provider commented, "Their attitude affects me. At times I tell myself that they are ignorant, why should I be offended. However, they break you, at times."¹⁰ Willing providers thus have to bear the brunt of understaffed services and an unsupportive environment. This situation underlines the need to destigmatize abortion by making it a basic part of training curricula—a strategy that will ensure a larger cadre of technically capable and responsive personnel.

At the community level, little has been done by health services to inform people of the Act. In one study, only 9% of respondents reported that their health facility had told them about the new Act, while 45% cited radio and television as their main source of information.¹¹ In another survey conducted among women requesting an abortion, radio and television were the most important sources of information for 65% of the respondents.¹² Women are more likely to know that abortion is legal than to be aware of other provisions of the Act. In both the 1998 South African Demographic and Health Survey¹³ and the Gender Opinion survey,¹⁴ 53% of respondents knew that women could obtain a legal abortion during the first 12 weeks of pregnancy. A community- and facility-based survey in three study sites of one province found that 45% of the respondents had heard that legal abortions are now available under the new law, but

that only 23% were aware that neither parental nor spousal consent is required.¹⁵

Attitudes on abortion in the general community and among health workers do not support women's right to choose: Studies indicate a preference for abortions to be permitted only under certain circumstances, such as rape, physical or mental harm to the woman or fetus, or medical reasons such as being HIV positive.¹⁶ Furthermore, there is a general reluctance to allow minors to have an abortion without parental consent.¹⁷ This prevailing atmosphere could help to explain the decline in the percentage of reported abortions among minors; from 16% of all abortions in the first year of implementation, this proportion decreased to 14% in the second year and to 11% in the first six months of the third year.¹⁸

Nongovernment organizations are responsible for the only efforts to build supportive social structures for women having an abortion. These groups have organized and conducted workshops to explain the content of and reasons for the new Act, and the rights set forth in the Act. Initiatives to inform and build support for women having abortions are required, as women cite the reaction of their partner as an important factor affecting their postabortion adjustment.¹⁹ Although women want to receive support from their partners, many women are unable to talk to them for fear of a negative reaction. Those who do choose to have such a discussion often face some form of abuse.²⁰

In conclusion, the information gathered from various research and monitoring efforts indicates that although the Act has increased availability, the right to abortion remains elusive for certain groups, especially women from peripheral areas and younger women.²¹ Within the South African transformation agenda of achieving an equitable society, abortion serves as a litmus test indicating the extent of work left to be done. Unless a concerted effort is made to maintain the rights guaranteed by the Act, the right to self-termination and the right to equal access will not become a reality for all South African women.

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