SPECIAL REPORT

Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act

By Sally Guttmacher, Farzana Kapadia, Jim Te Water Naude and Helen de Pinho

On December 11, 1996, South Africa enacted the Choice on Termination of Pregnancy Act, which gives women of any age or marital status access to abortion services upon request during the first 12 weeks of pregnancy, and in certain cases, extends access to the first 20 weeks of pregnancy. This act replaced a 1975 law that severely curtailed access to abortion services by requiring a physician's, and in some cases a magistrate's, approval for abortion procedures. The law's passage was a crucial advance for women, as it represented the recognition of reproductive rights by South Africa's first democratically elected parliament.

This article examines the policies that have regulated accessibility of abortion and assesses their impact on reproductive health. We also describe the newly enacted legislation, and examine some of the difficulties that will need to be overcome to ensure that women derive full benefit from the law.

The Apartheid Era

Family Planning and Abortion

During apartheid, the Afrikaner-dominated National Party government advanced separate population policies for white, black and colored (those of mixed black, Malay and white background) South Africans, fueled by fear of unsustainable population growth. This fear took on racist overtones manifested in propaganda suggesting that the black population was growing too quickly while the growth rate of the white population was stagnating, and that the black and colored populations were becoming a burden upon the country's resources. The views of the government were epitomized when the Minister of Bantu Administration and Development, M.C. Botha, asked the white citizens of South Africa to sacrifice by having "...enough children to ensure [South Africa's] continued existence as a Christian and Western country on the continent of Africa."[1]

While most religious groups in South Africa opposed legalization of abortion, the Dutch Reformed Church, the official church of South Africa, not only opposed the new law but propagated the belief that the white population must grow to maintain its supremacy.[2] In addition, government tax incentives were used to encourage white women to procreate. By contrast, contraception was promoted for black and colored women as a measure to stymie the growth of the black population. Thus, family planning became associated with the racist policies of the apartheid government.

Furthermore, by limiting black and colored women's ability to get schooling or hold jobs, apartheid policies granted greater employment and educational opportunities to white women. However, many white women who took advantage of the opportunity to seek employment at a managerial or professional level found the notion of a smaller nuclear family more desirable for their lifestyle, leading to greater demand for contraceptive services and, when an unwanted pregnancy occurred, for abortion services.[3]

Since pregnancies could not be terminated upon request, white women had several options when an unwanted pregnancy occurred. Many procured abortions from their private practitioners, who would perform a dilation and curettage in the office. Prior to 1975, this could be justified by common law, which permitted the termination of a pregnancy if the pregnancy posed a threat to a woman's mental well-being. Physicians who performed abortions beyond this criterion took personal and professional risks, since many were prosecuted or fined. In addition, financially secure upper- and middle-class white women could fly to England to terminate an unwanted pregnancy if they could not procure adequate services privately in South Africa.

In contrast, the relatively low-paying and insecure jobs available to black and colored women limited their ability to seek termination of an unwanted pregnancy. Besides the difficulty of financing a safe abortion, finding a trained doctor willing to perform an abortion was more difficult for women of color.[4]

Under these constraints, clandestine abortions often became the only option. Poor women who could not afford a doctor's fee often sought the aid of less-skilled midwives, lay practitioners or nonregistered doctors who had not completed their medical training. Many of these practitioners offered their services without adequate technical knowledge or access to proper facilities and clean instruments.[5] Women who did not want a "backstreet" abortion, or could not afford one, would often try to terminate their own pregnancies, endangering their lives by attempting abortions using dangerous methods such as knitting needles or detergent.

The 1975 Abortion and Sterilization Act

Seeking protection from the technically illegal abortions they were providing, the medical establishment pressured for expansion of the circumstances for legal abortions, as did women's organizations such as the Abortion Reform Action group (ARAG).* Together, they created momen-

* The Abortion Reform Action Group was the primary grassroots lobby fighting for changes in South African abortion legislation for more than 20 years. Formed largely by middle- and upper-class white women, the group began lobbying in the early 1970s to protest against the conservative abortion policies of the government. Although progressive in its concern for improving women's health, the organization seemed to echo the sentiments of the National Party government by advocating two-child families as the only reasonable measure to facilitate sustainable development of South African land and resources. (Source: reference 1.)

Sally Guttmacher is associate professor and Farzana Kapadia is assistant research scientist at the Department of Health Studies at the School of Education at New York University; Jim Te Water Naude is registrar and Helen de Pinho is senior researcher at the Department of Community Health, University of Cape Town, South Africa.

tum for abortion reform in South Africa. However, this call for reform coincided with the prevalent fear among parliament ministers of a stagnating white population.

The pronatalist attitude of the government toward the white population was formalized by an all-male, all-white committee appointed in 1973 to draft legislation regulating the availability of abortion services. By 1975, the committee presented, and parliament subsequently passed, the Abortion and Sterilization Act.

In an attempt to appease its more progressive constituents, the South African parliament framed the 1975 Abortion Act in such a manner that it seemed to grant greater freedom to women seeking abortions. However, by narrowly specifying the conditions under which abortions could be obtained, the new law actually made it more difficult to procure abortions. Under the 1975 Abortion and Sterilization Act, abortions could be performed legally only when a pregnancy could seriously threaten a woman's life or her physical or mental health; could cause severe handicap to the child; or was the result of rape (which had to be proved), incest or other unlawful intercourse, such as with a woman with a permanent mental handicap.[6]

Thus, it appeared that women could seek abortions for a greater number of reasons, and that doctors performing abortions would no longer suffer prosecution. However, to qualify for an abortion under these circumstances, women had to receive approval from two independent physicians, neither of whom could perform the actual procedure. In some cases, the approval of either a psychiatrist or a magistrate was also necessary before permission was granted. Approved abortions had to be performed in state hospitals, and records of all legal abortions conducted were stringently kept.

Impact of the 1975 Act

Not surprisingly, as a health policy, the 1975 Abortion and Sterilization Act failed to increase access to safe abortion services (as its parliamentary advocates had claimed it would) and failed to improve the reproductive health of South African women. Data on abortion following passage of the 1975 abortion act are limited, due to the lack of a comprehensive surveillance system to monitor abortions performed outside the medical system. The extent of health problems arising from clandestine abortions was also difficult to estimate, since women were seldom willing to voluntarily discuss their experiences for fear of negative social, personal and legal consequences.

However, women continued seeking terminations of pregnancies despite the possibilities of serious health risks. Admissions to gynecologic wards increased substantially due to women presenting with incomplete and septic abortions.[7] Maternal morbidity and mortality resulting from septic abortions also increased.[8] Moreover, the 1,000 or so legal abortions performed in South Africa annually represented a tiny fraction of all abortions carried out. Estimates of the number of clandestine abortions were dramatically larger, ranging from 120,000 to 250,000 per year between 1975 and 1996.[9]

In an attempt to understand the epidemiology of induced abortions and their impact on maternal morbidity and mortality, researchers from the Medical Research Council of South Africa began, in 1993, to monitor complications of unsafe abortions. According to adjusted estimates from that study, approximately 45,000 women were admitted to hospitals for spontaneous abortions or complications of induced abortions in 1994. Of these, more than 12,000 had moderate-to-severe complications resulting from clandestine abortions, and more than 400 died from septic abortions.[10]

These data probably underestimate the total number of unsafe abortions. Some women who resorted to clandestine abortion may have been unable or unwilling to seek hospitalization, especially if they did not experience any complications. Furthermore, women who died prior to reaching a hospital, or poorer women with little access to health services of any kind, were unlikely to be accounted for.

A closer inspection of the Medical Research Council data shows that women under the age of 20 were three times more likely to present at a hospital with incomplete abortions than were older women. Women from this age-group were also at greater risk of medical injury during clandestine abortions, perhaps because of the common use of objects such as catheters or sticks inserted into the vagina, uterus or cervix to induce an abortion.[11]

Methods and Costs of Termination

In public-sector hospitals, incomplete abortions were managed primarily by uterine evacuation with sharp curettage, performed under general anesthesia in operating rooms. Vacuum aspiration, although a simpler procedure, was practiced at only a few of the larger hospitals.*

Women presenting with incomplete abortions constituted almost 50% of the gynecology and obstetrics caseload of public-sector hospitals in South Africa.[12] The consequences of an incomplete abortion are usually a longer hospital stay and more extensive use of surgery, anesthesia, blood transfusions and medications, as compared with those associated with an uncomplicated first-trimester abortion. The need for immediate medical treatment often results in a major drain on limited obstetric and gynecologic hospital resources.[13] Moreover, although the long-term psychosocial effects of incomplete abortions cannot be measured in monetary terms, they place a heavy burden on the lives of women and their families.

The estimated cost of treating women for incomplete abortions in South Africa in 1994 was 18.7 million Rand (approximately US $4.4 million). Since only 10–50% of women who have induced abortions present for some form of medical treatment, the estimated cost of treating these women underestimates the actual cost if all women with a complication from a clandestine abortion were to present. Moreover, data from the Medical Research Council indicate that procedures for managing incomplete induced abortions are not cost-effective, and are not safe or widely accessible outside the major hospital centers.[14]

Regional Variation

The incidence of complications related to incomplete or septic abortions varied regionally. For example, in the Western Cape, 14.3% of hospital admissions for incomplete abortions were for severe complications and 3.8% were for moderate complications; in comparison, in Gauteng province, 20.6% were for severe complications and 22.7% were for moderate complications.[15] This disparity is no doubt due to a variety of factors, including differences in the availability of skilled "backstreet" practitioners and variations in women's ability to pay for such services. In addition, because of the lack of adequate health care facilities in rural areas, admissions to urban facilities in Gauteng were bolstered by women from surrounding provinces that have a larger rural population. Some hospitals in nearby provinces also lacked adequate facilities to treat women with complications from induced abortions.

The Transition To Democracy

Struggle for Reform

Access to legal abortion was an integral part of a national health program drafted by African National Congress (ANC) leaders during the 1994 elections. The ANC's

*Training programs are in place to increase the use of this new technique in South Africa.

Reconstruction and Development Programme outlined new national goals stating that "every woman must have the right to choose whether or not to have an early termination of pregnancy according to her own beliefs."[16] After the ANC's electoral victory, the new government began to prepare a new abortion law for consideration by the nation's parliament.

The call to replace the 1975 Abortion and Sterilization Act aroused passionate debates between antiabortion and prochoice advocates. Opponents to change ranged from religious organizations representing the Christian and Muslim churches to professional groups such as Doctors for Life. Prior to the parliamentary vote on the 1996 Termination of Pregnancy Act, almost two dozen antiabortion groups united under the National Alliance for Life and held demonstrations. Groups such as The Women's Health Project, the Reproductive Rights Alliance, Planned Parenthood of South Africa and ARAG supported the prochoice stance of the ANC, and spoke in support of abortion access as a means for creating greater gender equality as well as furthering women's rights.

The debate among prochoice and antiabortion advocates was further complicated by the historically racist use of population control policies under the Nationalist Party government. Even today, black people in South Africa are divided in their views toward abortion. Many blacks oppose abortion for religious reasons or view abortion as yet another vestige of apartheid policy, designed to control the growth of the black and colored population; black public health and women's rights advocates, on the other hand, support easier access to abortion and contraception.[17]

This struggle was most visibly manifested among the rank-and-file members of the ANC—many of whom, despite commitments to gender equality, are devout Christians or Muslims. Prior to the vote in the South African National Assembly, many representatives argued that they should be allowed to vote according to their own consciences. While the ANC leadership was divided on this issue, those who supported the prochoice movement dominated seats in the National Assembly and contended that representatives should vote according to their party platforms. Meanwhile, opposition-party representatives were allowed to vote in accordance with their personal beliefs.

The legislation was passed 209 to 87, with five abstentions and 99 absentees. However, there has been widespread speculation that had the ANC allowed an open vote, the 1996 Act might not have passed by such a wide margin.

The 1996 Act

The Choice on Termination of Pregnancy Act, which came into effect on February 1, 1997, permits abortions to be performed upon the woman's request through the first trimester of pregnancy, without any need for the approval of doctors, psychiatrists or magistrates.[18] Minors are counseled to notify their parent or guardian of their decision but are not required to receive consent for the procedure. Victims of rape or incest are not required to provide any documentation in order to obtain an abortion.

Women between 13 and 20 weeks of gestation can obtain an abortion if a medical practitioner believes that the pregnancy threatens the mental or physical health of the woman or fetus, if the pregnancy resulted from rape or incest, or if it affects the woman's socioeconomic situation. After the 20th week, termination of pregnancy is permissible if a doctor or trained midwife finds that continuation of the pregnancy would threaten the health of the woman or cause severe handicap to the fetus.

The Road Ahead

For the new act to be successful in reducing morbidity and mortality from unsafe procedures in South Africa, abortion services will have to be implemented so that they are available and accessible to all women. This will involve patient outreach, provider education, equalization and expansion of services throughout the country, and continuous monitoring of how these activities are progressing.

- *Outreach.* First, resources will have to be expended to inform all women of their right to have an abortion without fear of legal prosecution. Despite negative publicity that the Choice on Termination of Pregnancy Act received within the first few months of passage,[19] the demand for safe and legal abortion services has increased. However, there have been no comprehensive outreach and educational campaigns to inform women of their newly acquired reproductive rights and to reduce the stigma associated with abortion. Also, while the media have aired stories about doctors and hospitals refusing to perform or even offer abortion services, there has been relatively little publicity or educational material concerning the steps that women need to take to gain access to these services.
- *Provider education*. Second, health care workers must be educated to reduce the tension arising from conflicts in patients' and providers' beliefs and attitudes regarding abortion. Under the new act, health care workers are not mandated to perform abortions, or even to refer women to other providers. Their only obligation is to inform women of their rights under the new law. Thus, lack of cooperation by health care workers claiming conscientious objection due to moral or religious conflicts is emerging as a major obstacle for women seeking abortion services.

As a way of dealing with the antagonism of some health care professionals, the education of providers about their responsibilities under the new law has become a pressing issue. The Planned Parenthood Association of South Africa has been conducting values-clarification workshops in hospitals that provide abortion services. The main goal of these workshops is to facilitate the implementation and management of abortions in an efficacious manner. In addition, the workshops try to gain an understanding of providers' concerns regarding abortion and assist providers in relating their values to their clients' needs. The final aim of the workshops is to develop recommendations for incorporating such training sessions into regular training programs for providers.[20]

Furthermore, many health care workers require technical training in procedures such as manual vacuum aspiration, which is still a relatively new technology in South Africa. Currently, there is considerable variation both in the methods used for first-trimester abortion and in the manner in which some of these methods are applied. Without appropriate training, hospitals will be further delayed before they can begin to offer abortion services, which in turn will place a burden on the few hospitals that provide comprehensive services. Additional funding was recently made available for training programs to increase health care providers' skills and technical knowledge.

- *Accessibility and availability*. Third, the availability of abortion services needs to be expanded by ensuring equality of access to services across provinces. As a result of refusals on the part of some hospitals to offer abortion services, cooperating hospitals are being overloaded, and consequently are finding it difficult to meet the demand for abortions. For instance, hospitals in the Gauteng, Western Cape and Free State provinces provide a substantial proportion of abortions in the country (59%, 13% and 9%, respectively); facilities in KwaZulu/Natal, Northern and Northwest provinces, on the other hand, perform

only 3%, 1% and 1% of abortions. For KwaZulu/Natal, this rate is significantly lower than the anticipated number of abortions, since it is one of the most populous provinces in South Africa.[21]

Thus, women who come to hospitals offering abortion services are often met with long waiting lists and an overburdened staff reluctant to meet their needs. Due to the long wait for services at some hospitals, women are frequently turned away for being too advanced in their pregnancies, despite their having made appointments before 12 weeks of gestation.[22]

Availability of state-funded abortions is limited. Such abortions are not available at many local clinics because of a shortage of trained providers and adequate technology. Currently, state-funded terminations are only available at secondary or tertiary facilities, where the necessary resources are not as scarce. A woman can get an appointment at such a facility only after being referred by a community clinic or local day hospital. If it is economically feasible, a woman can arrange to have an abortion at a private freestanding clinic or with a private doctor, as long as these providers are registered with the state.

• *Monitoring implementation.* Finally, implementation of the act will have to be monitored and evaluated, as is the case with many other newly developed programs and policies of this transitional society. A quality evaluation requires allocation of resources and trained research personnel. Although to date no resources have been allocated for such work, a National Abortion Task Force has been set up, and is to meet quarterly to assess the situation in each province. To equalize provision of services throughout all of South Africa's nine provinces, the government will have to evaluate access as it is affected by differences between health care provision in urban and rural areas and by conflicting cultural attitudes toward abortion. On the clinical side, evaluations of the effectiveness of various abortion methods in the South African context will also need to be conducted.

Conclusion

As in many other countries, abortion is a volatile issue in South Africa. Implementation of the 1996 Choice on Termination of Pregnancy Act faces many challenges: the pronatalist views of conservative South Africans; limited access to health care for medically underserved blacks and coloreds; and limited access in hospitals, due to staff resistance and lack of resources. Despite these setbacks, the Pretoria High Court recently upheld women's right to abortion.

Approximately 30,000 abortions were performed in the year since implementation of the new act, while the number of women presenting for treatment of severe complications resulting from incomplete abortions decreased significantly.[23] In late 1997, the first official report of maternal deaths in South Africa cited only nine deaths resulting from septic abortions, compared with the Medical Research Council's reports of more than 400 in 1994.[24]

However, despite these advances, adequate social and financial support for the implementation of this much-needed legislation is still necessary to ensure the reproductive health of South African women.

References

1. Cope J, *A Matter of Choice: Abortion Law Reform in Apartheid South Africa,* Pietermaritzburg, South Africa: Hadeda Books, 1993.

2. Bradford H, *Herbs, Knives and Plastic: 150 Years of Abortion in South Africa: Science, Medicine and Cultural Imperialism*, New York: St. Martin's Press, 1991, pp. 120–145.

3. Bradford H, You call that democratic? struggles over abortion in South Africa in the 1970s, paper presented at the Wits History Workshop, University of Witswatersand, Johannesburg, May 1994.

4. Ibid.

5. Ibid.

6. The Abortion and Sterilization Act No.2 of 1975, Section 3, *Government Gazette*, 478 (1975).

7. Fawcus S et al., Management of incomplete abortions at South African public hospitals, *South African Medical Journal*, 1997, 87(4):438–442.

8. Shweni PM, Margolis J and Monokoane TS, Abortions: the King Edward VIII Hospital experience, *O & G Forum,* July 1992, pp. 25–26

9. Rees H et al., The epidemiology of incomplete abortion in South Africa, *South African Medical Journal,* 1997, 87(4):432–437.

10. Ibid.

11. Ibid.

12. Shweni PM, Margolis J and Monokoane TS, 1992, op. cit. (see reference 8).

13. Fawcus S et al., 1997, op. cit. (see reference 7).

14. Kay BJ et al., An analysis of the cost of incomplete abortion to the public health sector in South Africa, *South African Medical Journal,* 1997, 87(4):442–448.

15. Ibid.

16. African National Congress, *The Reconstruction and Development Programme: A Policy Framework,* Johannesburg, South Africa:Umanyano Publications, 1994.

17. Kay BJ et al., 1997, op. cit. (see reference 14).

18. Choice on Termination of Pregnancy Bill, Section 2, *Gazette*, 45 (1997).

19. Reproductive Rights Alliance, A six month overview of implementation of the Choice on Termination of Pregnancy Act, *Barometer*, 1997, 1(2):1–2.

20. Marais T, Provisional overall results from abortion values clarification workshop pilot study, Health Systems Trust Update, Planned Parenthood Association of South Africa (Western Cape), Issue No. 21, Nov. 1996.

21. Reproductive Rights Alliance, Provincial access to TOP: are all provinces equal? *Barometer*, 1997, 1(1):3.

22. Reproductive Rights Alliance, Overview of new abortion legislation, *Barometer*, 1997, 1(1):1–2.

23. Department of Health, Republic of South Africa, *Epidemiological Comments*, 1998, 24(3):2–9.

24. National Committee on Confidential Enquiries into Maternal Deaths, First interim report on confidential enquiries into maternal deaths in South Africa, Department of Health, April 1998, p. 6.