

# Work in Progress: The Expansion of Access to Abortion Services in South Africa Following Legalization

By Frances A. Althaus

When the Choice on Termination of Pregnancy Act took effect on February 1, 1997, South Africa became the first country in Sub-Saharan Africa in which women had the right to obtain an abortion on request during the first 12 weeks of pregnancy.<sup>1</sup> At that time, 23 countries in the region permitted abortion only to save the woman's life, 10 to preserve her physical health and six to protect her mental health; Zambia was the sole country to allow abortions on socioeconomic grounds. Given these severe restrictions on abortion, as well as the region's low contraceptive prevalence (18% of couples) and high birthrates, many women die each year from causes related to pregnancy and childbirth; some 22,000 die from complications of unsafe abortion.<sup>2</sup>

As other developing countries in Africa and elsewhere struggle with the question of whether to decriminalize abortion, South Africa provides an opportunity to examine the challenges involved in such settings. In some ways, the situation in South Africa appears ideal for such a transition. Unlike governments in many other countries, the South African government led the effort to legalize abortion and committed itself to equal access to services for all women. Moreover, South Africa—though not wealthy—is better off than other countries in the region and has a better developed infrastructure.

Nevertheless, efforts to legalize abortion and to make it equally available throughout the country's nine provinces have presented numerous challenges. During a two-week visit to South Africa in December, interviews with providers, activists and others involved in these efforts shed light on the difficulties involved in implementing the new law and how (and to what extent) they have been overcome.

## Background

Despite ongoing campaigns by numerous South African advocacy groups, the liberalization of abortion became possible only

after the 1994 elections that ended apartheid. The commitment of the new government, under the leadership of the African National Congress (ANC), to public health and to racial and gender equality made it possible to frame the issue in terms of women's health. According to Sanjani Varkey of the Women's Health Project, abortion reform was "sold" to the South African Parliament with data from a 1994 study documenting the toll of illegal abortion. The findings from the study indicated that about one-third of the nearly 45,000 women admitted to public hospitals in 1994 with incomplete abortions had medical complications suggesting an abortion performed under unsafe conditions, and that approximately 425 women died annually in public hospitals from such complications.<sup>3</sup>

The law in effect at that time allowed abortion only when a pregnancy could seriously threaten a woman's life or her physical or mental health; could end in the birth of a severely handicapped child; or resulted from rape (which had to be documented), incest or other unlawful intercourse.<sup>4</sup> Under that law, some middle- or upper-class women were able to obtain an abortion from a private practitioner who would perform the procedure in his office, while others could afford to fly to London to terminate their pregnancy. But clandestine abortions were the only option available to many women with an unwanted pregnancy; estimates of the number of illegal abortions performed each year before 1994 range from 6,000 to 120,000.<sup>5</sup>

The passage of the Choice on Termination of Pregnancy Act on December 11, 1996, was a major victory for the leadership of the ANC, which had made access to legal abortion an integral part of the national health plan it drafted during the 1994 elections. Included in the ANC's Reconstruction and Development Programme was a statement that "every woman must have the right to choose

whether or not to have an early termination of pregnancy according to her own beliefs."<sup>6</sup> The party leadership demonstrated their commitment to this principle by ordering all ANC members of parliament to vote for the Choice on Termination of Pregnancy Act when the bill came before the South African Assembly.<sup>7</sup>

Even after the new law took effect, one final legal hurdle had to be overcome before the right of South African women to safe, legal abortion was assured. In July 1997, three anti-abortion groups challenged the constitutionality of the new law on the grounds that it violated the rights of the fetus; the law remained in effect during the legal proceedings, however, and a year later the Pretoria High Court ruled against the challengers.<sup>8</sup>

South Africa now has one of the most liberal abortion laws in the world. Not only are legal terminations available on request during the first 12 weeks of pregnancy, but no parental or spousal consent is required for minors or married women. From the 13th week through the 20th week, an abortion is permitted if a continuing pregnancy would pose a risk to the woman's mental or physical health, if it would end in the birth of an infant with a severe mental or physical abnormality, if the pregnancy resulted from rape or incest or if carrying it to term would significantly affect the woman's social or economic situation. After the 20th week, terminations are allowed only if the continuing pregnancy would endanger the woman's life or result in a severe fetal malformation or a risk of fetal injury.<sup>9</sup>

Frances A. Althaus is senior editor of *International Family Planning Perspectives*. Much of this report is based on interviews with Sanjani J. Varkey, Women's Health Project, Johannesburg; Kim Dickson-Tetteh, Reproductive Health Research Unit, Chris Hani Baragwanath Hospital, Johannesburg; Helen de Pinho, Department of Community Health, University of Cape Town; and Rachel Jewkes, Centre for Epidemiological Research in South Africa, Medical Research Council, Pretoria.

## Challenges of Implementation

Implementation of abortion services presented numerous challenges to South Africa's public health system. Access was a major issue, as many South African women live at a considerable distance from a hospital, especially those in rural areas. To meet the ANC's goal of equitable access for all women, the public sector needed to offer services in the community-based clinics and health centers that provide most health services to populations outside of urban centers.\* Because rural areas in South Africa tend to be resource-poor, such facilities may lack electricity and other amenities.

Another important problem was the lack of health practitioners trained to perform pregnancy terminations. In addition, under the highly restrictive 1975 law, most legal abortions provided by public institutions had been performed in hospitals, regardless of gestation. This system was no longer feasible after legalization. Given that public-sector abortions were to be provided without charge, locating services outside of hospitals would make them much less expensive. Compared to first-trimester procedures performed in clinics, those provided in health centers cost 26% more and those in hospitals 133% more; the cost of second-trimester abortions was 89% higher in a hospital than in a health center.<sup>10</sup>

These considerations led to several conclusions: To move first-trimester abortions to clinics and health centers, the nurse-midwives who provide most reproductive health care in those settings would have to be trained to provide abortions. Further, if abortions were to be provided by health practitioners other than doctors and in resource-poor settings, the training of these practitioners should focus on manual vacuum aspiration, a relatively simple technique of pregnancy termination that does not require sophisticated equipment or electricity to run it.

During the first six months after the law took effect, almost 13,000 legal abortions were performed in South Africa.<sup>11</sup> About half were obtained in urban Gauteng Province,<sup>12</sup> suggesting that women in many areas of the country still lacked access to services. Indeed, at that point, fewer than one in four facilities designated by the Ministry of Health as abortion providers were in fact offering services.<sup>13</sup>

Despite the dramatic change brought about by the new law, the government did not mount a nationwide information campaign to inform people about its provisions. As a result of this lack of public ed-

ucation, only about half (53%) of the South African population knew in 1998 that pregnancies could be terminated legally through the first 12 weeks of gestation.<sup>14</sup>

Moreover, almost half (48%) considered abortion morally wrong, while 41% said it was justified only in the case of rape and just 10% believed it was a woman's right.<sup>15</sup> Attitudes divided sharply along racial lines: Africans were almost three times as likely as whites to see abortion as morally wrong (54% vs. 19%), while whites were three times as likely as Africans to view it as a woman's right (24% vs. 8%). The attitudes of many health care providers reflected those of the general public. In 1996, fewer than 8% of nurses believed that women should be able to obtain an abortion on request.<sup>16</sup>

## Strategies for Change

To lessen provider resistance, values clarification workshops were conducted throughout the country by the Planned Parenthood Association of South Africa, the Reproductive Health Research Unit of Chris Hani Baragwanath Hospital, Johannesburg, and the Reproductive Rights Alliance. The workshops, attended by more than 4,000 health care providers, were designed to educate providers on the new abortion law, to promote a nonjudgmental attitude toward abortion and to encourage them to treat women seeking abortions with dignity and respect.

Providers were asked to participate in various exercises during the workshops. In one, they were presented with several hypothetical cases of women seeking an abortion. Pregnancy presented a serious problem for each woman: For example, one had AIDS, another had been raped and another already had eight children. Still, only one could have an abortion. Each provider had to choose among them and explain why. The workshops appear to have been highly successful; almost 70% of providers who participated in Cape Town said that the values clarification exercises had helped them deal with abortion patients "quite a bit" or "a lot" better.<sup>17</sup>

To increase the number of trained providers, the National Directorate for Maternal, Child and Women's Health initiated the National Abortion Care Programme in 1998. Coordinated by the Reproductive Health Research Unit at Baragwanath Hospital, the program was designed to lower maternal mortality from unsafe abortion by providing training in abortion techniques, management of incomplete abortions and treatment of complications from unsafe abortions.<sup>18</sup>

Training-of-trainer workshops for physicians and for midwives were held in Johannesburg in November 1998, with at least two doctors and two midwives from each province in attendance. The physicians were designated as trainers in manual vacuum aspiration for other doctors and midwives in their provinces; they were also given responsibility for establishing and monitoring services within their provinces. The midwives were trained in manual vacuum aspiration and in postabortion family planning counseling, and were expected to educate other midwives in those skills, working in teams with the physicians designated as provincial trainers.<sup>19</sup>

## Snags in the System

Despite these efforts, little progress has been made in moving abortion services out of hospitals. According to Kim Dickson-Tetteh of the Reproductive Health Research Unit, only two community centers were providing abortions (both in Gauteng Province) as of December 1999. Moreover, only about 28% of designated providers were in fact performing pregnancy terminations.<sup>20</sup>

Training of midwives to perform manual vacuum aspiration is also proceeding slowly: Just 63 midwives have completed both the theoretical and clinical work required to provide abortion services, and most of them are working in hospitals.<sup>21</sup> It is unlikely that the number of qualified midwives will rise appreciably until abortion care is incorporated into basic midwifery training. Three years after legalization of abortion, plans for integration have yet to be drafted, although an abortion curriculum has been approved by the South African Nursing Council.

As might be expected, given the shortage of providing institutions and trained staff, many women still must make long trips to obtain an abortion. A 1999 study in Eastern Cape Province found that 38% of abortion clients had traveled at least 100 kilometers for services, while an analysis of data from the three state hospitals in the Orange Free State showed that 24% of women had made a journey of at least four hours.<sup>22</sup> These figures reflect inequality in the availability of services across provinces. Gauteng, which is home to 18% of South Africa's female population, provides 48% of all abortions; in contrast, North West

\*In South Africa, clinics provide primary health care services such as treatment for minor ailments, family planning, pregnancy tests, treatment for sexually transmitted diseases and school health services. Health centers offer all of these services plus dental care, delivery by midwives and treatment by visiting specialists.

Province accounts for 8% of the country's women, but only 1% of abortions.<sup>23</sup>

Many women also face informational barriers when seeking abortion services. Of 183 women seeking a pregnancy termination in the Cape Metropolitan Region, more than 90% had no knowledge of the conditions under which abortion was legal.<sup>24</sup> Moreover, in only 8% of cases did the referring providers—mainly private physicians and primary health clinics—give the women all the information mandated by the regional coordinating committee; 32% of women were given none of this information.\* And although most of the women were able to obtain an abortion within 12 weeks of becoming pregnant, the average period between their first contact with the health system and their abortion was more than three weeks.

To some degree, problems of access can be traced to a lack of funding. Although South Africa is the wealthiest country in Sub-Saharan Africa, its resources are spread thin by the struggle to provide sanitation, housing and other basic amenities for its poorest citizens. The government has mandated provision of free abortion services, but at the same time has cut allocations for public health. As Varkey comments, "The government says 'do it,' but provides no funding." She adds that donors have provided money for equipment and training, but not for services. Thus, provincial governments have been forced to move funds from other areas to accommodate abortion services.

To avoid facility overload and staff burnout, Dickson-Tetteh says, some public-sector hospitals have set a weekly quota for pregnancy terminations, after which they turn women away. In response, some provinces have set up mobile teams of doctors and nurses to make sure that all women needing services can obtain them. Private providers like Marie Stopes South Africa have also helped to meet the rising demand for abortion services. According to Varkey, the organization "has been willing to go into provinces that don't want to

deal with abortion." Nevertheless, because private providers charge fees for their services, they do little to increase access to abortion for the most disadvantaged women. Varkey notes that some women's health activists are concerned that such providers are "too business-oriented."

Despite these problems, the South African public health system has achieved a great deal in the three years since abortion was legalized. According to one study in a Pretoria hospital, the rate of complications from incomplete abortions declined from 51% in 1996 to 29% in 1997.<sup>25†</sup> In addition, the proportion of second-trimester abortions has decreased, from one in three pregnancy terminations performed at public health facilities in 1997 to one in four in the first six months of 1999.<sup>26</sup> Some facilities seem to be finding ways to support staff who provide abortions. Mediated discussion groups at one hospital increased acceptance of services among hospital staff, increased the number of staff who volunteered to provide services and decreased the isolation of staff involved in abortion services.<sup>27</sup>

At this point, the results of South Africa's efforts to decrease mortality from unsafe abortion are both encouraging and cautionary. On one hand, the country has instituted model legislation and has begun building, with limited resources, a network of public-sector providers that will offer all women safe abortion services without charge. On the other, the obstacles these efforts have encountered—despite the active support of the government—pose a warning that, even in favorable circumstances, the process of moving from a situation in which abortion is illegal to one in which services are available and accessible to all women is unlikely to be short or smooth.

## References

1. Rahman A, Katzive L and Henshaw SK, A global review of laws on induced abortion, 1985–1997, *International Family Planning Perspectives*, 1998, 24(2):56–64.
2. Rosen JE and Conly SR, *Africa's Population Challenge: Accelerating Progress in Reproductive Health*, Country Study Series 4, Washington, DC: Population Action International, 1998.
3. Rees H et al., The epidemiology of incomplete abortion in South Africa, *South African Medical Journal*, 1997, 87(4):432–437.
4. The Abortion and Sterilization Act No. 2 of 1975, Section 3, *Government Gazette*, 478 (1975).
5. Rees H et al., 1997, op. cit. (see reference 3).
6. African National Congress, *The Reconstruction and Development Programme: A Policy Framework*, Johannesburg, South Africa: Umanyano Publications, 1994.
7. Reuters World Service, South Africa's ANC orders its MPs to vote for abortion, news release, Oct. 11, 1996.

8. Bennett T, Reproductive health in South Africa, *Public Health Reports*, 1999, 114(1):88–90; and Reproductive Rights Alliance, Victory for women's rights in court battle over choice on termination of pregnancy act, *Barometer*, 1998, 2(2):20.

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

10. de Pinho H and McIntyre D, Cost analysis of abortions performed in the public health sector, Cape Town, South Africa: Department of Community Health and University of Cape Town, 1997, pp. 1–33.

11. Reproductive Rights Alliance, National statistics on termination of pregnancy: February to July 1997, *Barometer*, 1997, 1(2):3.

12. *Ibid.*, p. 3.

13. *Ibid.*, pp. 31–32.

14. *South Africa Demographic and Health Survey 1998, Preliminary Report*, Calverton, MD, USA: Macro International, 1999.

15. Smith MJ, Sdanki G and Kimmie Z, *The Second Kaiser Family Foundation Survey of Health Care in South Africa*, Menlo Park, CA, USA: Henry J. Kaiser Family Foundation, 1999, p. 30.

16. Harrison A et al., Barriers to implementing South Africa's termination of pregnancy act: a case study from rural KwaZulu Natal Province, Hlabisa, South Africa: Medical Research Council, 1996.

17. Dickson-Tetteh K and Rees H, Efforts to reduce abortion-related mortality in South Africa, in: Berer M and Ravindran TK, eds., *Safe Motherhood Initiatives—Critical Issues*, 1999, pp. 190–197.

18. *Ibid.*

19. *Ibid.*; and Reproductive Rights Alliance, National Abortion Care Programme, *Barometer*, 1998, 2(2):6–7.

20. Reproductive Rights Alliance, 1998, op. cit. (see reference 19).

21. Varkey SJ and Fonn S, How far are we? assessing the implementation of abortion services: a review of literature and work-in-progress, Johannesburg, South Africa: Women's Health Project, 1999.

22. Bennun M, Developing socio-economic profiles of women requesting terminations at Cecilia Makiwane Hospital in the Eastern Cape Province, East London, South Africa: East London Hospital, 1999; and Engelbrecht M et al., A project management strategy to overcome impediments to the operation of the Choice on Termination of Pregnancy Act of 1996 in the Free State: findings from the survey, Bloemfontein, South Africa: University of the Orange Free State, 1999.

23. Reproductive Rights Alliance, Provincial overview, *Barometer*, 1998, 2(2):5.

24. de Pinho H and Morrioni C, Assessing access to termination of pregnancy services in the Cape Metropolitan Region, *Barometer*, 1998, 2(2):26.

25. de Jonge ETM, Pattison RC and Mantel GC, Termination of pregnancy (TOP) in South Africa in its first year: is TOP getting on top of the problem of unsafe abortion? *Sexual and Reproductive Health Bulletin*, No. 7, 1999, pp. 14–15.

26. Reproductive Rights Alliance, *Barometer*, 2000, 3(3):1.

27. Leon N and Nicholls L, Report on TOP groups run at G.F. Jooste Hospital, Western Cape, *Barometer*, 1998, 2(2):25–26.

\*Points to be covered included estimated gestational age; information about the abortion procedure; and the phone number, appointment schedule and contact person at the providing institution. The staff at the referring facility were also required to make the woman an appointment for the procedure at the providing facility and an appointment for a follow-up visit.

†The total number of incomplete abortions did not change. Some observers speculate that the increase in uncomplicated incomplete abortions is a result of illegal administration of misoprostol by private physicians, who tell their patients to go to the hospital when they begin bleeding. Misoprostol use is legal only in hospitals (see reference 21).