Gaceta Médica de México

Volumen *Volume* 139 Suplemento *Supplement* 1 Julio-Agosto *July-August* 2003

Artículo:

Abortion law in South Africa: Passage of a progressive law and challenges for implementation

Abortion Law in South Africa: Passage of a Progressive Law and Challenges for Implementation

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Resumen

La legislación sudafricana sobre la elección para terminar un embarazo es quizá la más liberal en el mundo. La transición a un gobierno democrático ofreció una ventana de oportunidad única para que la militancia en salud y derechos de las mujeres facilitara su aprobación. No obstante, los cambios políticos tan avasalladores, especialmente en el sector salud, convirtieron esta oportunidad en un logro ambivalente. La ley constituyó una condición necesaria pero insuficiente para el acceso a servicios de aborto seguro para las mujeres en todo el país. En la actualidad, muchas mujeres aún no cuentan con acceso a servicios de aborto ya que dichos servicios no han sido integrados al resto del sector salud, no han sido institucionalizados de manera adecuada y el conocimiento de la legislación entre la población es insuficiente. Es necesario contar con programas de investigación y colaboración con la sociedad civil para incrementar la conciencia y el conocimiento de la legislación entre profesionales de la salud y miembros de la comunidad, así como incluir los servicios de aborto en el primer nivel de atención.

Palabras clave: *Aborto, legislación, Sudáfrica*

Summary

The South African Choice on Termination of Pregnancy Act is perhaps the most liberal abortion law in the world. The move toward democratic government presented a unique window of opportunity for women's health and rights activists to lobby for passage of the act, but sweeping changes in the government and particularly the health sector meant that this opportunity was a mixed blessing; the law was a necessary but not sufficient step in providing access to safe abortion services for all women in the country. Many women still do not have access to abortion services, abortion services have not been integrated with other health services or adequately institutionalized, and awareness of the law is incomplete. Research and advocacy to increase access to abortion services, change attitudes among health workers and in communities, and to include abortion services in health services at the primary-care level are needed.

Key words: *Abortion, legislation, South Africa*

Introduction

In October 1996, the South African Parliament passed the Choice on Termination of Pregnancy (CTOP) Act. The Act came into effect February 1, 1997. The CTOP Act is regarded as one of the world's most progressive abortion laws because of three main provisions: 1) women have the right to abortion on request up to 12 weeks of pregnancy (and up to 20 weeks on mental or physical health, or socio-economic grounds); 2) trained midwives can provide abortions up to 12 weeks of pregnancy, and 3) the Act specifically states that neither spousal nor parental consent (in the case of minors) is required for a woman to have an abortion.

The passage of the CTOP Act was possible because of the unique political situation that developed with the transition to democratic rule in South Africa. The political climate both allowed for the passage of the Act and

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influenced its content. The situation was unique because the transition to democracy and the development of a completely new political system provided a window of opportunity to address the legal status of abortion. The predominant concern in the transition, reflected in the new constitution, was the primacy of equity and human rights in the new legal system. This provided a perfect platform for addressing issues of women's rights and health broadly, and abortion in particular. In addition, sound scientific data on the public health impact of severely restricted access to abortion also played an important role in the passage of the CTOP Act. We describe later how the Act was developed and passed into law, and then review some of the challenges and successes in its implementation. Finally, we reflect on how South Africa's experience might provide lessons for the development of legislation on abortion in other countries. Much of the information we review has been presented elsewhere in more detail, and we encourage interested readers to refer to these sources for additional information.[1-3]

Background

From 1948 through 1994, a minority white male government was in power in South Africa. A system of repressive and racist laws, denying basic rights to the majority black population, called apartheid, was developed and strictly enforced. Black South Africans could not vote and were legally required to live in designated homelands and to carry passes to travel outside these areas. Inter-racial marriage was illegal and political activity of opposition groups was significantly restricted. The African National Congress (ANC), the main opposition party, was banned and its leaders forced into exile, organizing political activity against the government from outside the country.

Separate health care services were set up along racial lines. There were separate health care facilities for whites, blacks, coloreds, and Indians (the racial classifications of the apartheid government). The government pursued a coercive family planning program aimed in part at reducing the black population.[4] Access to abortion was severely restricted. The 1975 Abortion and Sterilization Act allowed abortion in only a few circumstances (serious danger to the physical or mental health of the woman, severe handicap to the child, pregnancy that was a result of rape or incest or other unlawful intercourse, such as with a woman with a mental handicap). To access a legal abortion, a woman had to have approval from two physicians, neither of whom could perform the procedure; in the case of danger to mental health, a psychiatrist was required to be involved as well. The procedural requirements meant that in fact legal abortion was accessible only to white wealthier women.[4]

International sanctions against the apartheid government, increasing international pressure politically and increasing political and military action against the government inside the country led to negotiations for a move to democratic government. In 1990, Nelson Mandela was released from prison, and discussions gained momentum. The first democratic elections were held in 1994, when Nelson Mandela was elected the first president of the new South Africa.

While in exile and during the negotiations on the transition to democratic government, the ANC externally and antiapartheid activists internally developed a policy framework for various issues including health. This later became the Reconstruction and Development Programme (RDP), which informed how transition and development would be achieved. These policies were firmly rooted in a human rights framework and equity was of primary importance in the effort to redress the wrongs of the apartheid system. The human rights framework and the focus on equity provided women's health and rights advocates with an important platform from which to advocate for abortion law reform.

The change in government led to across-the-board structural changes aimed at eliminating the apartheid system. Focusing on the health sector, sweeping changes in policy were made, beginning with the elimination of the various race-based health services and the development of a unified public health service. In addition, the ANC supported the primary health care approach for service provision and adopted a district health system model, decentralizing health service provision to newly defined districts in the nine newly defined provinces (formerly four provinces and nine homelands under the apartheid system). The primary health care approach and the move to integrated one-stop services from the previous vertical programs model meant that staff had to be multiskilled, and the demand for these skills outpaced the health service's ability to train providers. In addition, the need for new skills meant many health care providers had to leave their posts to attend trainings sessions, which further strained other staff and management.

Immediately after the first elections, a number of new policies on access to health care were implemented, first free health care for pregnant women and children less than 6 years and then free health care for all. This increased sharply the demands on the health service. A variety of new approaches to patient management were adopted sometimes simultaneously—for example, integrated management of childhood illnesses, re-orientation of tuberculosis (TB) diagnosis, and treatment (adoptions of the directly observed therapy strategy, [DOTS]), and syndromic management of sexually transmitted infections. Many of the new managers were not experienced and struggled to adjust to their new role

and the new model of health care provision. These massive changes in the health service were the backdrop for the change in abortion law and the challenges of implementation.

Changing the Law

Women's rights and health advocates were able to get the liberalization of abortion onto the agenda both as a human rights issue and as a public health issue. A national process of provincial consultations with women culminated in a Women's Health Conference. Some of the key players in the Women's Health Conference Process would go on to be senior members of the new Department of Health (one the first Minister of Health) and this helped ensure that the agenda agreed upon in that process, including liberalization of the abortion law, was included in the ANC's agenda for health.[1]

The actual repeal of the 1975 law and passage of a new law, however, was the result of a longer process. Women's rights had been put on the agenda, but there were mixed feelings about liberalizing the abortion law among the ANC. Women's health and rights groups formed the Reproductive Rights Alliance (RRA) to continue to mobilize for a more liberal law. Hearings were held in 1995 and 1996 on the need for change to the 1975 law and to draft plans for a new law. The RRA and member organizations submitted a large amount of information and helped to ensure that, in particular, poor black women were given the opportunity to testify at the hearings. It was here in the submissions to the parliamentary committee on health that both the rights-based argument as well as the public health and equity arguments for a change in the law were successfully made.

A number of submissions to the Committee included information on a study of morbidity and mortality from unsafe abortion conducted by the Medical Research Council in 1994.[5-8] This was a prospective study of all hospitals in the country with more than 500 beds, as well as a representative sample of hospitals with fewer than 500 beds, which evaluated hospital admissions for incomplete abortion over a 2-week period. The researchers found that based on their data, each year nearly 45,000 women presented at hospitals with incomplete abortion and at least 425 women died due to complications of illegal induced abortion. In addition, a further 12,000 women suffered severe consequences from the experience. The authors note that these are likely underestimates as many women, particularly in rural areas, may not have access to emergency services or might die before they could reach a service.[9] In addition to this data on the magnitude of the problem, data on costs to the health sector for treating women with complications due to unsafe abortion were calculated, and the authors clearly demonstrated that providing access to safe abortion services was much less expensive than dealing with the consequences of widespread illegal abortion.[10] The availability of this data, the fact that the study was conducted by a well-respected, neutral medical research group, and the soundness of the data were extremely important for the eventual passage of the CTOP Act.

Issues of equity and data supporting the disproportionate frequency of complications from illegal abortion among black women were also frequently cited in submissions and testimony to the Committee. In the MRC study, only 1% of women attending with abortion complications were white and 84% were black. In addition, it was also true that wealthier white women had easier access to better-trained illegal providers (for example, a general practitioner would do a dilatation and curettage) or could travel abroad to access a legal abortion. The MRC also collected data on legal abortion and in 1994, 2,180 legal abortions were performed; 61.3% of these were performed on white women (who made up approximately 10% of the population of women of reproductive age). Thus, wealthier white women could access better or safer illegal services, could access legal services abroad, and were more likely to be able to successfully navigate the bureaucracy required for a legal abortion.[5]

In South Africa, there was (and is) a rural-urban disparity in access to physicians. Rural areas are underdeveloped and are home to more poor people and more women. Differential access to providers and services in part explains the regional variation in severity of complications among women admitted for incomplete abortion. In the Western Cape, 14.3% of complications were severe and 3.8% moderate. In Gauteng, 20.6% were severe and 22.7% moderate.[10] Skill of illegal providers and women's ability to pay for services probably account for some of the difference, but a proportion of the higher percentages in Gauteng has been attributed to admission of women from surrounding rural areas where access to health facilities is limited.[4] Health services at the primary health care level are staffed predominantly by nurses. If the new law was to address equity it had to take into account rural women's access to services. Submissions to parliamentarians and advocacy on the equity issue led to the provision in the new law allowing nurses as well as physicians to perform abortions.

Finally, submissions also referred to South Africa's obligations under international agreements. South Africa had ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and was party to the Beijing and Cairo platforms.

The CTOP Act was passed by a vote of 209 to 87, with five abstentions and 99 absentees. This overwhelming

support however, may mask internal disagreement concerning the Act, as the ANC asked members to vote with the party platform. Other parties allowed their members to vote their conscience.[1,4]

Interestingly, health workers did not feature prominently in efforts to liberalize the abortion law. In 1980, a survey found that 82% of obstetricians and gynecologists were in favor of liberalization of the abortion law, and 32% supported abortion on request; however, a 2000 survey of members of the Nursing Association indicated that 64% did not support abortion.[1] This fact, in addition to disagreement within the ANC and tension between women's rights and religious freedom had a significant impact on the content of the final Act. The Act protects women's rights to abortion but also specifies that health workers have a right to choose not to do abortions. Interpretation of this piece of the legislation and the tension between individual morals and rights of women and patients continue to prove a challenge to implementation of the law.

Implementation

Passage of the CTOP Act provided the framework for women to exercise their right to decide whether or not to continue a pregnancy; nonetheless, despite the equity focus in development and passage of the legislation, the promise of the law is impeded by issues of access, lack of institutionalization and integration of abortion into other health services, and lack of awareness of the Act.

Access

The number of legal abortions performed in South Africa has steadily increased since the passage of the CTOP Act. In 1997, more than 26,000 abortions were performed, in 1998 almost 40,000, in 1999 more than 46,000, in 2000 more than 47,000, and in 2001, more than 57,000.[11] These figures are likely underestimates of legal abortions, as anecdotal reports indicate that data from facilities may not be complete. Results of a recent study also indicated that severe morbidity and mortality due to unsafe abortion have declined since passage of the CTOP Act.[12]

Despite the continual increase in abortions performed, there are still significant barriers to access for many women, and unsafe abortions, which are difficult to quantify, still take place. The CTOP Act specifies that for a facility to offer abortion services, it must be so designated by the Minister of Health. At the end of 1998, there were 246 designated public health facilities, but only 73 were providing abortion services (online). In addition, 99% of facilities providing services were hospitals, most in urban areas.[13] Only two facilities providing services were community health centers, and both were located in Gauteng, one of the most developed and urban provinces. Approximately 138 private facilities were also providing abortion services, but these also are more likely to be located in urban areas and cost of the service may be prohibitive for poor women.

Not only are designated facilities likely to be urban hospitals, they additionaly are not evenly distributed throughout the country, and some provinces (notably Gauteng and the Western Cape, the two most developed provinces) are home to the majority of the online facilities. Between February 1997 and June 2000, 44% of abortions were performed in Gauteng, which has 17% of the country's population of women of reproductive age. In contrast, KwaZuluNatal, the province with the highest proportion of women of reproductive age, 21%, registered only 10% of total terminations performed.[11] These statistics indicate that access, particularly for rural and poor women outside of Gauteng and the Western Cape provinces, is still a challenge.

The facilities that are online and that offer abortion services are often overburdened. Waiting times for abortions in the public sector range from 1–4 days, with most provinces falling in the 1–7 day range.[11] However anecdotal information, indicates that women often wait longer and often are passed from facility to facility in search of an available appointment. This may lead to woman having abortions later, in the second trimester, which by law requires physician involvement. There are many fewer facilities that provide second trimester abortion services, and many of these services have recently closed down.

Institutionalization

Institutionalization can be broken down into two main issues, first the inclusion of abortion services in general health services, and second including abortion in formal nursing training curricula.

One reason for more facilities not being online is that managers or hospital superintendents do not prioritize abortion services and in some cases do not support provision of abortion services and either refuse to offer the services, or divert resources and trained staff to other services so that abortion cannot be effectively provided. This is part of the larger issue of interpretation of health workers' rights not to perform abortions. Many abortion providers are harassed by their colleagues and denied access to resources needed to provide services. In addition, some nurses and physicians have interpreted their right to opt out of abortion services as allowing them to refuse basic care to abortion patients.[11]

Issues of institutionalization must be seen in the context of the radical changes in the health service described previously. There are relatively few nurses trained to provide abortions; thus it is difficult to integrate them into health services that are themselves struggling to keep up with the need for multi-skilled providers. In addition, because of lack of support for abortion services among many nurses and managers they are not likely to prioritize training in abortion care. This situation is likely to persist, as abortion training, unlike many other reproductive health care skills, is not included in general nursing curricula. A catch-22 develops, where the lack of many trained providers means that abortion cannot be integrated with other health services and remains marginalized (also due to stigma), and this marginalization (and stigma) means that few new providers are trained who could support abortion as part of an integrated health service. Not including abortion as part of integrated health services is also a barrier to access.

In retrospect, lack of involvement of nurses and health service managers in the process of legislative change may have added to these problems of institutionalization, and wider consultation and buy-in might have avoided this blockage.

Awareness

Survey data indicate that many women are not aware of their rights under the CTOP Act. Research in the Northern Cape province indicates that approximately 55% of women and men were aware of the Act. Research from other provinces showed higher figures (KwaZuluNatal, 94%), but this knowledge is also tempered by lack of community support for abortion and severe stigma around the procedure. In the same study in KwaZuluNatal, only 18% of respondents supported abortion on request; in the Northern Cape this figure was 8%.[3] Reports from women also indicate that they fear being chastized or treated badly by nurses, and this also is a barrier to access to services.[3]

Submissions to the Health Committee on the CTOP Act called for a comprehensive public information campaign on the Act.[8] Unfortunately, this has not taken place to date, but the National Department of Health is now planning such a campaign. Small-scale, community-based interventions that address the reasons for unwanted pregnancy and recourse to abortion have shown substantial effect in changing community attitudes, and similar interventions have shown promise in changing attitudes among health workers.[2,11,14-16] Additional research and evaluation of possible scale-up of such interventions is needed. In addition, as part of the National Abortion Care Programme, which trains nurses and physicians in using manual vacuum aspiration (MVA) for termination of pregnancy, values clarification workshops have been held with providers. These workshops also aim to address health worker attitudes toward abortion services and women who choose to have abortions. These workshops have shown some success in improving acceptance of abortion services and improving support of women's right to choose abortion but again there is a need to expand these types of interventions and evaluate their longer-term effects.[17]

Concluding Remarks

Passage of the CTOP Act in South Africa was a huge victory for women's health and rights activists. The Act was the product of the unique political environment around the end of apartheid and the change to democratic government. The new political discourse placed a heavy emphasis on equity and human rights, which provided a very useful framework within which to address liberalizing the abortion law. The window of opportunity that these political changes created, nevertheless, was a mixed blessing. The sweeping changes occurring across all sectors, but specifically in the health sector, meant that implementing changes in the law was extremely difficult. Health care providers and managers were overwhelmed with change in the structure of the health service, as well as the changes in health policy and the approach to health care provision. Ambivalence or outright hostility toward abortion among political leaders and health care providers nearly guaranteed that abortion services would suffer marginalization in this process. Continued advocacy both within the formal health service and from women's health and rights advocates and non-governmental organizations (NGOs) has increased service provision and has increased the number of women with access to safe services.

Passage of the law was a victory for women's health and rights activists and shows the value of the consultative process adopted. In addition, availability of scientifically sound evidence for significant morbidity and mortality as a result of restricted access to abortion was also crucial. In the South African context, availability of data that highlighted inequitable suffering from illegal abortion was also extremely important.

However, passage of the law has been a necessary but not sufficient step in affording women access to safe abortion services. Access to services, institutionalization and integration of abortion services, and awareness of the law still present significant challenges; continued advocacy and public education, in addition to more research on how to efficiently and successfully address these issues, are needed.

What lessons can be learned to potentially avoid the implementation pitfalls experienced in South Africa? Legislating or advocating for inclusion of training in abortion services in medical and nursing school curricula in parallel to passage of the Act could have made a significant difference. In addition, it is likely that including health care providers as key actors in the advocacy process might have led to development of more champions for the service, which could have sped up the process of institutionalizing and integrating abortion services into primary health care services. Finally, women need more information on reproductive health generally and on their rights to reproductive health services. Public education campaigns are vital to spur demand for the services and to provide women with the information they need to be able to access available services.

Change of the law has greatly improved access to safe abortion services, and severe morbidity and mortality from unsafe abortion have been significantly reduced; nonetheless, there is still much to be done to improve access. The law was a necessary but not sufficient step to give women full control over their reproductive health. The challenge for government and NGOs is to develop the resources and infrastructure for all women to be able to exercise this right.

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