A Promising Future?

Abortion Law and Access in Post-Apartheid South Africa

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The Choice on Termination of Pregnancy Act 92 of 1996 (Choice Act) provides the legislative framework that regulates access to abortion in South Africa. It is noted for its liberal stance on abortion and for this reason South Africa 'serves as a global role model of reform in the area of abortion laws'. Despite its celebrated reproductive rights affirming approach, there are several on-ground issues that undermine the aims of the Act and the reproductive rights and health of those seeking abortion care.

In this blog, I position the Choice Act within its historical and contemporary context which provides the necessary backdrop to demonstrate why the Act offers a ground-breaking approach to legislative regulation of abortion care. Thereafter, I explore some of the barriers to access and consider some key state efforts to overcome these issues, thus demonstrating a commitment to ensuring access to abortion care as part of the continuum of sexual and reproductive health care.

A harmful and deadly past: Access to safe abortion determined according to race and class

Prior to the Choice Act, abortion was legalised by the Abortion and Sterilization Act 2 of 1975, but under very narrow circumstances: rape, incest and serious mental or physiological health concerns. Ngwena explains that very few legal abortions took place under this Act (800–1200 per year) because its excessively bureaucratic provisions worked to limit access to abortion services. Indeed, abortion care was determined according to race and class, and most legal abortions were performed for the privileged, 'morally blameless' minority: white, middle-class women living in urban areas. Many poor, black women living in rural communities were unable to navigate the Act's conditions, making illegal abortions their only option. Within this context, reproductive rights were being violated at both ends of the spectrum: the state unduly limited access to reproductive health care and informal abortion providers took advantage of women's exclusion from legal abortion and related vulnerability by offering substandard and dangerous services. While estimates vary, it was clear that many women were harmed or died for the sake of reproductive control.

According to Albertyn, these circumstances fuelled calls for law reform during South Africa's transition into a constitutional democracy. Abortion debates shifted: abortion was no longer framed as a crime and an immoral act, but as a public health and human rights issue. Albertyn explains that women's rights advocates lobbied for the inclusion of the rights to equality and reproductive freedom in the Constitution of the Republic of South Africa (which was still being finalised at the time) and health activists used public health concerns linked to illegal abortions and high mortality rates to justify law reform. These efforts were effective, the Choice Act 'was the first "women's law" to be passed by the new parliament, largely as a result of enabling political conditions, a positive global and national constitutional framework, committed support by key members of the government and ruling party, as a result of the activism from a small but effective alliance of civil society organisations.'

Radical abortion law reform under South Africa's Constitution

Human rights activism proved successful and important rights were included in the final Constitution. Section 12(2)(a) and (b) protects and promotes the right to bodily and psychological integrity which expressly includes the right to make decisions

concerning reproduction. Further, section 27(1)(a) and (2) recognise that everyone has the right to have access to reproductive health care and that the state is under an obligation take reasonable measures, within its available resources, to progressively realise this right. The explicit recognition of the right to access reproductive health care 'is an acknowledgement of the prejudice suffered by women in this area and constitutes an express undertaking to remedy the situation.' Indeed, Albertyn explains that the Constitution provides the framework needed to enact women-centred abortion law in South Africa.

Against this backdrop, the Choice Act can be interpreted as taking a harm-reduction approach which adopts interventions to reduce harms of illegal and unsafe abortions without prohibiting abortion. This approach shifts 'the traditional terms of the debate, and to move public policy on abortion away from crime and toward health. This discursive shift also brings about change in institutional responsibility. The answer to the problem of abortion is found in public health interventions rather than prohibition and punishment'. In line with this view, the Choice Act regulates third parties' conduct in relation to abortion services to ensure that women can exercise their reproductive rights without compromising their health or losing their lives.

The Choice Act supports access to abortion services throughout the course of a pregnancy. Section 2 sets out the circumstances in which and conditions under which pregnancy may be terminated. The Act permits abortion on request during the first 12 weeks of gestation. Registered nurses or midwives with required training can provide care for first trimester abortions. Abortions can be provided after 12 weeks and up to 20 weeks gestation if a medical practitioner determines that there is a risk of injury to physical or mental health to the woman, there is a risk of severe foetal physical or mental abnormality, the pregnancy is a consequence of rape or incest, or when the continued pregnancy would significantly affect the social or economic circumstances of the woman. The Act permits abortions in the third trimester if two medical practitioners find that the pregnancy endangers the woman's life, would result in a severe malformation of the foetus, or would pose a risk of injury to the foetus. While only doctors can initiate abortions after 12 week's gestation, nurses can administer medication and lead patient management for these procedures.

Section 4 specifies that non-mandatory and non-directive counselling should be made available, and section 5 confirms that an abortion may only take place with the informed consent of the pregnant woman and no consent other than that of the pregnant woman is required. In those cases that involve abortion care for minors (people under 18 years of age), a medical practitioner or a registered midwife should advise the minor to consult with her parents, guardian, family members or friends before the abortion, but abortion care cannot be denied if the minor chooses not to consult them.

To ensure implementation of these provisions, section 10(1)(c) of the Choice Act penalises interference with access to abortion services. Any person who is found to have prevented a lawful abortion procedure, or to have obstructed access to an abortion facility, is guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding ten years. There is no criminalisation of women who act outside the scope of the Act when seeking to terminate their pregnancies.

Stubborn persistence of unequal access to abortion care

Despite South Africa's world-leading approach to abortion legislation, many women and girls struggle to get access to abortion services. Amnesty International highlights three areas of concern: The failure to regulate conscientious objection; inequalities in access to services for women and girls from poor and marginalised communities; and lack of access to information on sexual and reproductive rights, including how and where to access legal abortion services. These are not new barriers and reflect persistent concerns resulting in an estimated 50% of abortions taking place outside of designated health care facilities.

Conscientious objection

The right to conscientious objection is not specifically mentioned in the Choice Act but it states that the right to refuse to provide abortion services applies only to the abortion procedure. Consequently, those who are not directly involved with an abortion procedure cannot rely on their beliefs to justify their failure to assist a woman and they cannot deny routine medical care and general assistance not related to the procedure. Importantly, all South Africans have a constitutional right to emergency health care which means that a conscientious objector is obliged to care for patients with complications arising from an abortion. Despite this framework, conscientious objection was largely unregulated and research reveals "widespread obstruction to access posed by the (ab)use of the so called right to 'conscientious objection'." This underscores the fact that South Africa has 'wonderful laws but we don't have people to implement those laws'.

Harries et al note that '[i]n order to disentangle what is resistance to abortion provision in general, and what is conscientious objection on religious or moral grounds, clear guidelines need to be provided including what measures need to be undertaken in order to lodge one's right to conscientious objection. This would facilitate long term contingency plans for overall abortion service provision.'

Indeed, in 2019 the National Department of Health developed national clinical guidelines for the provision of abortion care and it provides a much needed clinical regulatory framework that supports the aims of the Choice Act. While clinical guidelines lack authoritative standing comparable to law, these are drafted with the aim to promote human rights under the Choice Act. To this end, it clarifies the boundaries of conscientious objection and frames behaviour that falls outside of this as the criminal offence of 'obstruction to access' under section 10 of the Choice Act. Nebaneh et al note that '[t]he adoption of this wording not only brings the country's regulation in line with the existing international human rights standards in this regard but can also foster the necessary cultural change that needs to occur around abortion.'

Inequalities in access to services

Amnesty International stresses that '[p]rofound inequalities persist between the private and public health systems in terms of infrastructure and resources. Nearly 83% of the population relies on the public health system, yet the private health care sector employs the majority of health care professionals and spends nearly 6 times more per patient.' This can be explained, in part, with reference to the legacy of South Africa's colonial and apartheid past. Women and girls from the poorest and most marginalised communities experience the greatest challenges in accessing public health.

Efforts to address issues around access include free provision of abortion care at public health facilities under section 4 of the National Health Act 61 of 2003. Further, in response to concerns about implementation, the Choice Act was amended in 2008 to increase accessibility to abortion services by allowing registered nurses and midwives to perform first trimester abortions, and local governments and executive councils to approve new facilities and the maintenance standards of abortion facilities. However, concerns remain in relation to a shortage of public health service providers, the impact of unregulated conscientious objection, violence and abuse during abortion services, and failure to ensure all public health facilities are able to provide abortion services.

Increasing the pool of abortion providers is a noted area of concern for the Department of Health, and the national clinical guidelines address this issue in several ways. It includes the introduction of abortion training into the medical and nursing school curricula, training doctors in second-trimester management, and developing a sexual and reproductive health and rights course that covers a continuum of reproductive health services. Further, it aims to strengthen public-private partnerships in areas where the public sector is unable to meet the needs for safe and legal abortions. Nevertheless, troubled abortion care must be situated within its broader context: Overhauling the health system after apartheid together with the demands that emerge from the HIV epidemic reflects an enormous task that counts against the

development of quality health services, and the result is 'poor health outcomes relative to the total health expenditure'. The repeated failure to invest sufficient resources will undermine the transformative power of the new clinical guidelines.

Lack of access to information

Research reveals a concerning lack of knowledge among women and girls about the legal status of abortions and this is understood to be a driver of unsafe abortions. Further, lack of information can lead to unnecessary delays in accessing abortion services and some delays can result in women and girls being denied abortion services because of gestational limits under the Choice Act. Stakeholders note there is a need 'to push for population-wide education of women about their rights under the CTOPA [Choice Act], and how and where to gain access to services'. However, concerns are raised in relation to provider knowledge too. Reports expose limited understanding of how to interpret the Choice Act grounds for legal abortion which results in service providers setting unnecessary barriers to women seeking abortions. This is problematic given that health care professionals are often the primary source of health-related information. The Choice Act obligates health care professionals to inform women and girls of their rights under the Act, but they are not properly equipped to do so. It is also worth noting that the relationship itself might be strained in this context given concerns around abortion stigma and conscientious objection. Much of the training supported in the new national guidelines may help to address these concerns.

The Choice Act provides a powerful legislative framework to realise safe access to abortion care in South Africa, but clearly the law cannot do all the heavy lifting on its own. The new national clinical guidelines complement the Choice Act and provide a promising step in the right direction, but clinical guidelines may prove ineffective in contexts that are not properly resourced and which continue to carry the scars of South Africa apartheid history.

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