# TERMINATION OF PREGNANCY POLICY AND SERVICES: AN APPRAISAL OF THE IMPLEMENTATION AND OPERATION OF THE *CHOICE ON TERMINATION OF PREGNANCY ACT* (92 OF 1996)

by

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# DECLARATION

I declare that this thesis submitted for the degree of Philosophiae Doctor at the University of the Free State is my own, independent work and has not previously been submitted by me at another university/faculty. I furthermore cede copyright of the thesis in favour of the University of the Free State.

Michelle Engelbrecht
Bloemfontein
November 2005

**For Adriaan, my husband**

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## LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| ANC | African National Congress |
| ARAG | Abortion Reform Action Group |
| CEDAW | Convention on the Elimination of All Forms of Discrimination against Women |
| CHC | Community health centre |
| CLA | Christian Lawyers Association |
| CTOPA | *Choice on Termination of Pregnancy Act* |
| DFL | Doctors For Life |
| HPCSA | Health Professions Council of South Africa |
| ICPD | International Conference on Population and Development |
| Ipas | International Projects Advisory Service |
| IPPF | International Planned Parenthood Federation |
| MCC | Medicines Control Council |
| MDG | Millennium Development Goals |
| MEC | Member of the Executive Committee |
| MRC | Medical Research Council |
| MVA | Manual vacuum aspiration |
| NACP | National Abortion Care Programme |
| NGO | Non-government organisation |
| PAC | Post-abortion care |
| PDP | Population Development Programme |
| PHC | Primary health care |
| PPASA | Planned Parenthood Association of South Africa |
| RDP | Reconstruction and Development Programme |
| RHRU | Reproductive Health Research Unit |
| RRA | Reproductive Rights Alliance |
| SANC | South African Nursing Council |
| SPSS | Statistical Package for Social Sciences |
| STIs | Sexually transmitted infections |
| TOP | Termination of pregnancy |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| USA | United States of America |
| USAID | United States Agency for International Development |
| WHO | World Health Organisation |
| WHO-AFRO | WHO Regional Office for Africa |

# TABLE OF CONTENTS


| | |
|---|---|
| Acknowledgements | i |
| List of acronyms and abbreviations | ii |
| Table of contents | iii |
| List of tables | vii |
| List of figures | viii |
| List of maps | viii |

**PART 1: CHAPTER 1**
**RESEARCH PROBLEM AND METHODOLOGY**

| | | |
|---|---|---|
| 1. | Introduction | 1 |
| 2. | Contextualisation and rationale | 2 |
| 3. | Aim and objectives | 6 |
| 4. | Research strategy and methodology | 7 |
| 4.1 | Design of the study | 7 |
| 4.2 | Analysis of existing documents and secondary statistics (unobtrusive research) | 8 |
| 4.3 | The Free State study | 9 |
| 4.3.1 | Sampling methods | 10 |
| 4.3.2 | Research techniques and instruments | 12 |
| 4.3.3 | Recruitment and training of data gatherers | 15 |
| 4.3.4 | Data gathering and quality control | 16 |
| 4.3.5 | Data analysis | 18 |
| 4.3.6 | Feedback workshops | 18 |
| 4.3.7 | Authorisation and ethical concerns | 19 |
| 4.3.8 | Limitations of the Free State case study | 20 |
| 4.4 | Triangulation of primary and secondary data | 21 |
| 5. | Defining the concepts | 21 |
| 6. | Arrangement of the material | 23 |

**PART 2: CHAPTER 2**
**ABORTION LEGISLATION WITHIN A HUMAN RIGHTS FRAMEWORK**

| | | |
|---|---|---|
| 1. | Introduction | 26 |
| 2. | Reproductive health and human rights | 27 |
| 2.1 | The right to reproductive health care | 29 |
| 2.2 | The right to reproductive self-determination | 30 |
| 3. | International developments in reproductive rights | 31 |
| 3.1 | Developments prior to the 1994 ICPD | 31 |
| 3.2 | The ICPD and Beijing Conference | 33 |
| 3.3 | Follow-up reviews and beyond | 35 |
| 4. | Overview of abortion legislation worldwide | 36 |
| 5. | International abortion legislation: the USA and Britain | 39 |
| 5.1 | Abortion Law in the USA | 39 |
| 5.1.1 | The Global Gag Rule | 42 |
| 5.2 | Abortion law in Britain | 43 |
| 6. | Abortion legislation in African countries | 45 |
| 6.1 | History of abortion legislation in Africa | 45 |
| 6.2 | Developments in reproductive rights in Africa | 46 |
| 6.3 | Developments in abortion legislation in Africa | 48 |
| 6.4 | Abortion legislation in countries neighbouring South Africa | 49 |
| 7. | Summary | 52 |

## PART 2: CHAPTER 3
## SOUTH AFRICAN ABORTION LAW: THE PERIOD PRIOR TO THE IMPLEMENTATION OF THE 1996 *CHOICE ON TERMINATION OF PREGNANCY ACT*


| | | |
|---|---|---|
| 1. | Introduction | 55 |
| 2. | The provision of reproductive health care prior to 1975 | 56 |
| 2.1 | Family planning under the National Party government | 56 |
| 2.2 | The status of black South African women and its impact on family planning | 57 |
| 2.3 | Abortion law prior to 1975 | 59 |
| 2.3.1 | The establishment of a select committee to investigate abortion law | 60 |
| 3. | The Abortion and Sterilisation Act of 1975 | 62 |
| 3.1 | Provisions of the 1975 Act | 62 |
| 3.2 | Shortcomings of the 1975 Act | 64 |
| 4. | Events leading to the *Choice on Termination of Pregnancy Act* of 1996 | 67 |
| 4.1 | A changing political environment | 67 |
| 4.2 | Establishment of an *ad hoc* parliamentary select committee to investigate the 1975 Act | 69 |
| 4.3 | Recommendations from the *ad hoc* parliamentary select committee | 73 |
| 4.4 | The *Choice on Termination of Pregnancy Bill* | 74 |
| 5. | Views of other interest groups towards abortion and the *Choice on Termination of Pregnancy Bill* | 75 |
| 6. | Advantages and disadvantages of legalising abortion | 77 |
| 7. | Summary | 78 |


## PART 2: CHAPTER 4
## THE *CHOICE ON TERMINATION OF PREGNANCY ACT* (1996): IMPLEMENTATION AND TRENDS, ACHIEVEMENTS AND CHALLENGES


| | | |
|---|---|---|
| 1. | Introduction | 80 |
| 2. | The Choice on Termination of Pregnancy Act of 1996 | 82 |
| 2.1 | Provisions of the 1996 CTOPA | 82 |
| 2.2 | Key elements of the CTOPA | 84 |
| 2.2.1 | Counselling | 84 |
| 2.2.2 | Minors | 85 |
| 2.2.3 | Designation of TOP service sites | 86 |
| 2.2.4 | Notification and keeping of records | 87 |
| 2.2.5 | Midwifery training | 87 |
| 2.2.6 | Health workers and conscientious objection | 89 |
| 2.2.7 | Offences and penalties | 90 |
| 2.3 | Amendments to the CTOPA | 91 |
| 3. | Implementation and operation of the CTOPA | 91 |
| 3.1 | The first year - 1997 | 91 |
| 3.2 | The second year - 1998 | 93 |
| 3.3 | The third year - 1999 | 94 |
| 3.4 | The fourth year - 2000 | 95 |
| 3.5 | The fifth year - 2001 | 96 |
| 3.6 | The sixth year - 2002 | 97 |
| 3.7 | The seventh year - 2003 | 98 |
| 4. | Overview of trends, achievements and failures in TOP – 1997 to 2003 | 99 |
| 4.1 | Achievements of the CTOPA | 101 |
| 4.1.1 | Cooperation with private facilities | 101 |
| 4.1.2 | Failure of legal challenges | 101 |
| 4.1.3 | Development of a National Strategic Plan for TOP | 102 |
| 4.1.4 | Values clarification workshops | 103 |
| 4.2 | Impediments to and challenges associated with the provision of TOP services | 104 |
| 4.2.1 | Key findings from the Oversight Hearings | 105 |
| 4.2.2 | Views and conduct regarding abortion | 107 |

4.2.3 Designation and location of TOP facilities 108
4.3 Key recommendations from the Oversight Hearings 110
5. Summary 111

**PART 3: CHAPTER 5**
**THE EMPIRICAL STUDY: VIEWS AND EXPERIENCES OF HEALTH WORKERS AND STAKEHOLDERS**

1. Introduction 115
2. Health workers in a position to refer clients to TOP facilities 116
2.1 The respondents 116
2.2 The referral system 118
2.3 Knowledge of the CTOPA 123
2.4 Attitudes towards TOP 126
2.5 Challenges associated with the expansion of TOP services (2003) 129
3. TOP service providers 131
3.1 The respondents 131
3.2 Attitudes toward TOP 133
3.3 Emotional experiences, conduct of and support for TOP service providers 136
3.4 Abortion values clarification workshops 138
3.5 Resources for TOP service delivery 139
3.6 Evaluation of TOP services 141
3.6.1 Counselling 143
3.6.2 Procedures 144
3.7 Evaluation of the physical structure and infrastructure of TOP facilities 146
3.8 Challenges and strengths of providing TOP services 148
4. TOP stakeholders (2003) 149
4.1 The respondents 149
4.2 Achievements of the CTOPA as it applies to women in general 149
4.3 Main impediments to accessing TOP 150
4.4 Recommendations to improve access to TOP 151
4.5 Main challenges regarding access to TOP 151
5. Summary 152

**PART 3: CHAPTER 6**
**THE EMPIRICAL STUDY: TOP CLIENTS**

1. Introduction 155
2. The respondents 156
3. Family planning (2003) 159
3.1 Contraceptive use 160
3.2 Accessibility of family planning services 161
3.3 User-friendliness of family planning services 162
3.4 Services offered at family planning facilities 163
4. Pregnancy and termination history 164
5. TOP facilities 166
5.1 Accessibility of TOP facilities 166
5.2 User-friendliness of the TOP facilities 169
5.3 Services provided at the TOP facilities 172
5.3.1 Pre-counselling 172
5.3.2 Post-counselling 174
5.3.3 Examination and procedure 175
5.3.4 Information provided to TOP clients 177
6. Emotional experiences of and support for TOP clients 177
6.1 Emotional experiences before, during and after the TOP 177
6.2 Discussions with family and friends concerning the pregnancy (2003) 180
6.3 Discussions with family and friends concerning the TOP 181
6.3.1 Support from parents (2003) 181

6.3.2 Support from partners/“father of the baby” 182
6.3.3 Support from family 183
6.3.4 Support from friends 184
7. Knowledge of pregnancy, TOP and the CTOPA 185
8. Attitudes towards TOP (2003) 188
9. Impediments to accessing TOP and recommendations 190
10. Summary 193

**PART 4: CHAPTER 7**
**A SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS**

1. Introduction 197
2. The impact of international reproductive rights on South Africa 198
3. The impact of international and regional abortion legislation on South Africa 200
4. Abortion legislation in South Africa: achievements, challenges and recommendations 201
4.1 Health workers 202
4.2 TOP service providers 206
4.3 TOP stakeholders 210
4.4 TOP clients 210
5. Summary 217
6. Conclusion 218

List of references 221
Synopsis 233
Key terms 236
Appendix A 237
Appendix B 316
Appendix C 318

# LIST OF TABLES


Table 1: Facilities providing TOP services in the Free State (2003) 10
Table 2: Target populations and sample sizes 10
Table 3: Research techniques and instruments 12
Table 4: Persons responsible for data gathering 16
Table 5 Countries that liberalised and restricted abortion law (1985 - 1997) 37
Table 6: Estimates of unsafe abortion (2000) 48
Table 7: Grounds for legal abortion in selected African countries 49
Table 8: Legal abortions and operations to remove residues 65
Table 9: Legal abortions conducted between 1991 and 1993 according to population group 65
Table 10: The annual number of abortions performed under the 1975 Act, 1988-1993 67
Table 11: Summary of submissions made to the *ad hoc* select parliamentary committee 71
Table 12: TOP statistics per province, for maternal and gestational age (1997-2003) 100
Table 13: Main methodological features of the 1998- and 2003-surveys 116
Table 14: Towns where sampled health workers were employed (1998, 2003) 117

Table 15: Occupational category (1998, 2003) 118
Table 16: Number of years in the health profession (1998, 2003) 118
Table 17: Facilities in the Free State said to be providing TOP services (2003) 119
Table 18: Circumstances under which health workers would refer a patient to a TOP facility (2003) 120
Table 19: Information about TOP provided to clients (2003) 121
Table 20: Problems experienced with the referral of TOP clients (2003) 122
Table 21: Knowledge of the CTOPA (1998) 124
Table 22: Knowledge of the CTOPA (2003) 125
Table 23: Attitudes of referral staff towards TOP (1998) 126
Table 24: Attitudes towards TOP (2003) 127
Table 25: Opinions of health workers regarding the number of facilities providing TOP services (2003) 129
Table 26: Expected problems with staff and possible solutions (2003) 130
Table 27: Expected problems with facilities and possible solutions (2003) 130
Table 28: Categories of respondents (1998, 2003) 131
Table 29: Length of time in health profession (1998, 2003) 132
Table 30: Opinion of abortion on request during the first twelve weeks of pregnancy (2003) 134
Table 31: Attitudes towards TOP (1998, 2003) 134
Table 32: Factors influencing the work morale of TOP service providers (2003) 135
Table 33: Harassment of TOP service providers (1998, 2003) 136
Table 34: Staff, infrastructure and equipment at TOP facilities (1998, 2003) 139
Table 35: Evaluation of the quality of TOP services (1998, 2003) 141
Table 36: Evaluation of the physical structure and infrastructure of the TOP facilities (1998, 2003) 147
Table 37: Main methodological features of the 1998- and 2003-surveys 156
Table 38: Cities/towns/villages nearest to place of residence (1998, 2003) 157
Table 39: Age of TOP clients (1998, 2003) 158
Table 40: Marital status (1998, 2003) 158
Table 41: Highest level of education attained (2003) 159
Table 42: Time taken to reach the family planning facility (2003) 161
Table 43: Average waiting time at family planning clinics (2003) 162
Table 44: Treatment received at family planning facilities (2003) 162
Table 45: Degree of satisfaction with services offered (2003) 163
Table 46: Reasons for having a TOP (2003) 165
Table 47: Source of referral to a TOP facility (2003) 166
Table 48: Number of days on a waiting list for TOP (2003) 167

Table 49: Number of times the respondent returned to TOP facility (2003) 167
Table 50: Means of transportation to the TOP facility (2003) 168
Table 51: Degree of satisfaction with treatment received at TOP facilities (1998, 2003) 169
Table 52: Degree of satisfaction with services offered (1998, 2003) 172
Table 53: Time spent on pre-counselling (2003) 173
Table 54: Time spent on examination during the first visit (2003) 175
Table 55: Disposal of the products of conception (2003) 176
Table 56: Emotions and experiences before TOP (1998, 2003) 178
Table 57: Emotions and experiences during TOP (1998, 2003) 178
Table 58: Emotions and experiences after TOP (1998, 2003) 179
Table 59: Who the respondent first consulted about pregnancy (2003) 180
Table 60: Reasons for not discussing TOP with the "father of the baby" (2003) 183
Table 61: Reasons why the intention to terminate was not discussed with friends (1998) 184
Table 62: Reasons for not discussing this TOP with a friend (2003) 184
Table 63: Knowledge of the CTOPA (1998) 186
Table 64: Knowledge of the CTOPA (2003) 186
Table 65: First source of information that TOP is legal (2003) 187
Table 66: Clinical procedure for TOP (2003) 188
Table 67: Explanations why TOP will not be considered in future (2003) 189
Table 68: Why backstreet abortion would be avoided 189
Table 69: Recommendations to facilitate the process for women considering TOP (1998) 190
Table 70: Recommendations aimed at simplifying the process for minors/women (2003) 191
Table 71: Recommendations to improve services (2003) 192
Table 72: Contextualising the main findings from the survey amongst health workers 205
Table 73: Contextualising the main findings from the audit amongst TOP service providers 209
Table 74: Contextualising the main findings from the survey amongst TOP clients 215
Table 75: Classification of the world's abortion laws 317
Table 76: Interpretation of conscientious objection based on the 1996 *Constitution* 319

## LIST OF FIGURES

Figure 1: Provincial breakdown of TOPs conducted during the first year of operation (1997) 92
Figure 2: Provincial breakdown of TOPs conducted during the second year of operation (1998) 94
Figure 3: Provincial breakdown of TOPs conducted during the third year of operation (1999) 95
Figure 4: Provincial breakdown of TOPs conducted during the fourth year of operation (2000) 96
Figure 5: Provincial breakdown of TOPs conducted during the fifth year of operation (2001) 97
Figure 6: Provincial breakdown of TOPs conducted during the sixth year of operation (2002) 98
Figure 7: Provincial breakdown of TOPs conducted during the seventh year of operation (2003) 98
Figure 8: Number of TOPs conducted over the past seven years 99

## LIST OF MAPS

Map 1: South Africa and the nine provinces 9
Map 2: Towns in the Free State with facilities providing TOP services 131

# PART 1: CHAPTER 1

# RESEARCH PROBLEM AND METHODOLOGY

## 1. INTRODUCTION

It is an undeniable fact that abortion, both safe and unsafe, has always occurred and will continue to occur in every culture and society (Brookman-Amissah 2004). Inevitably, women will continue to experience unwanted pregnancies for different reasons, including lack of birth control services, contraceptive failure and sexual assault. Annually, approximately 210 million pregnancies occur worldwide, of which an estimated four in ten are unplanned. Small families have increasingly become the norm as modernisation, urbanisation and women's levels of education and participation in the workforce have grown. Most couples not only wish to control the size of their families but also the timing and spacing of births (Allan Guttmacher Institute 1999a). This has increased the demand for contraception and in its absence, or if contraceptive methods should fail, the demand for abortion. American, European and many Asian women prefer to have only two children, Latin American women prefer two or three children, while women in sub-Saharan Africa still desire large families of five to six children. It is, however, evident that as in developing countries, the desired family size of sub-Saharan African women is also beginning to decline. Despite this, desired family size represents women's goals rather than reality and significant proportions of women worldwide still have more children than they intended to have (Allan Guttmacher Institute 1998).

The right to decide when to have a child is at the very core of reproductive rights. International treaties and laws have traditionally protected independent decision-making in reproductive health matters. The right to physical integrity, which also entails the inherent dignity of the person and the right to liberty and security of the person, protects individuals from unwanted invasions of their body. This principle is recognised in numerous international treaties which acknowledge a woman's right to decide freely and responsibly as to the number and spacing of her children (Centre for Reproductive Law and Policy 2000). In essence, women should have access to safe and effective means of controlling their family size, which includes contraception and abortion services.

International human rights documents and law advocate the right of women to "*the highest attainable standard of physical and mental health*" (*International Covenant on Economic, Social and Cultural Rights* 1966: paragraph 12). The World Health Organization (WHO) defines health as "*a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity*" (WHO 1948). More specifically, reproductive health is defined as "*…a state of complete physical, mental and social well-being and not merely the absence of disease or*

*infirmity, in all matters related to the reproductive system and to its functions and processes"* (*Programme of Action of the ICPD* 1994: paragraph 7.2). Hence, women wishing to access abortion services in countries that criminalise abortion or do not allow for safe access to abortion services are faced with a threat to their physical, mental and social well-being (Centre for Reproductive Law and Policy 2000).

Over the past few years, increased recognition of reproductive rights and the role that unsafe abortion plays in maternal mortality has encouraged many governments to review and liberalise legislation regulating access to induced abortion (Gerhardt 1997).

Abortion, as a reproductive right, is introduced in the chapter with a focus on developments in South Africa that led to the adoption of one of the most liberal abortion laws in the world. However, given previous abortion legislation in the country, as well as the fact that liberalisation of law alone is not sufficient to ensure access to abortion services, the necessity for the research is explicated. The latter part of the chapter describes the methodology followed and key concepts used. The chapter concludes with an overview of the layout of the thesis.

## 2. CONTEXTUALISATION AND RATIONALE

According to WHO estimates, approximately 20 million illegal abortions are performed annually, the vast majority of which occur in South and South East Asia, sub-Saharan Africa, Latin America and the Caribbean (Allan Guttmacher Institute1998) About 35 of every 1 000 women of child bearing age have an abortion each year (Allan Guttmacher Institute 1999b). Introducing additional restrictions on abortion legislation will not reduce the overall number of abortions in these countries, nor the almost 600 000 maternal deaths each year, of which approximately 80 000 are a direct result of unsafe abortions (Allan Guttmacher Institute1998). A possible solution to address high unsafe abortion figures is to legalise abortion. For example, when abortion was legalised in Romania in 1990, the abortion-related mortality rate fell to one-third of its peak level of 142 deaths for every 100 000 live births. However, legalising abortion does not by itself guarantee safe abortion procedures (Allan Guttmacher Institute 1999a).

There has been a global trend toward the liberalisation of abortion laws observed before 1985, and 1973 may be taken as an arbitrary starting point for the liberalisation of abortion laws in many countries. At that stage, early legal abortions were permitted in China, India, Soviet Union, United States of America (USA) and Japan. Abortion policies were liberalised in 1973 and 1974, *inter alia,* in Austria, Denmark and Sweden. By 1975, France had also legalised abortion and the then West Germany permitted abortion on socio-economic grounds. Approximately 25% of the worlds' population still reside in countries where abortion is generally not allowed; however, induced abortions may be permitted when the women's life is in danger (Rahman *et al*. 1998).

The majority of African countries have restrictive abortion laws[1] which contribute to the more than five million unsafe abortions which are conducted annually – 1 900 000 in East Africa, 600 000 in Central Africa, 600 000 in North Africa, 200 000 in Southern Africa and 1 600 000 in West Africa. Worldwide, approximately 78 000 women die annually as a result of unsafe abortion; 44% of these women live in Africa. The average unsafe abortion ratio in Africa is 110 deaths per 100 000 live births, which is more than twice that of any other region in the world. The WHO estimates the maternal mortality ratios (i.e. per 100 000 live births) for Africa as follows: East Africa 1 060; West Africa 950; Northern Africa 340 and Southern Africa 260. Thirteen percent of all maternal deaths in Africa are due to unsafe abortion (Braam & Hessini 2003).

African countries inherited their generally restrictive abortion laws from the European colonial powers which have long since liberalised their own laws. Despite the fact that in many instances colonial law was unsuitable for the African countries, at independence these colonial laws were maintained by the new governments due to a lack of time and resources to undertake full-scale legal reform (Braam & Hessini 2003). In the overwhelming majority of African countries abortion remains both unsafe and illegal. Generally, wealthier and more educated women have easier access to safe abortion services than poorer, more marginalised women. In addition, the laws governing access to abortions in many African countries not only penalise women accessing the abortion, but also the person providing the abortion service (Sai 2004). During the past decade, some African countries have made modifications to their abortion legislation, in particular Benin Republic, Burkina Faso, Chad, Guinea, Mali and South Africa (Braam & Hessini 2003).

More specifically, radical change in abortion legislation occurred in 1996 in South Africa when the *Choice on Termination of Pregnancy Act* (CTOPA) (92 0f 1996) was passed on 31 October 1996 and took effect on 1 February 1997, ensuring that South Africa has one of the most liberal abortion laws in the world (Althaus 2000). The aim of the legislation is to ensure safe, hygienic and accessible termination of pregnancy (TOP) for all women in South Africa (De Pinho & Hoffman 1998) and is based on the 1996 *Constitution of the Republic of South Africa* (108 of 1996), henceforth referred to as the *Constitution* (1996). Regarding the latter, women should not be discriminated against on the basis of gender, race, religion or culture, and they have the right to make their own reproductive health decisions concerning the timing, spacing and number of children that they wish to have. Furthermore, the state is responsible for safe, effective, affordable and acceptable reproductive health care, which holistically incorporates TOP.

[1] Only three out of 54 African countries, namely Cape Verde, South Africa and Tunisia, allow abortion on request during the first twelve weeks of pregnancy; 28 countries allow abortion to save the life of the pregnant woman and the remaining countries impose various restrictions on the availability of abortions (Braam & Hessini 2004; Sai 2004).

In South Africa, abortion on request is available during the **first twelve weeks of pregnancy**. During this period, the woman does not need to provide any reason(s) for wanting the abortion. Abortion from **weeks 13 to 20** of the pregnancy is permitted when the doctor, in consultation with the pregnant woman, agrees that if the pregnancy is not terminated, her physical or mental health would be at risk; if there is a substantial risk that the foetus may suffer from a severe physical or mental abnormality; if the pregnancy is a result of rape or incest; or if the pregnancy continues, the social or economic circumstances of the woman would be significantly affected. Abortion is also available after the **20$^{th}$ week** of pregnancy and up to term if the doctor, in consultation with another medical practitioner or midwife, agrees that the continued pregnancy would: endanger the life of the woman; result in sever malformation of the foetus; or pose a risk of injury to the foetus (*Choice on Termination of Pregnancy Act*, 92 of 1996).

Albeit the product of extensive investigation, consultation and debate, the CTOPA has generated considerable controversy and the South African health system is faced with an enormous challenge to provide safe, effective, affordable and acceptable TOP services throughout the country. The CTOPA replaced the restrictive provisions in the *Abortion and Sterilisation Act* (1975) and promotes reproductive rights and choices. While the CTOPA reflects the intention of the legislature to make TOP accessible to all South African women, it cannot by itself ensure or guarantee equitable access. The CTOPA assumes that health care providers will give effect to the legislative intention, but giving practical meaning to such intention - especially at a provincial level - can be problematic. Although it is not the intention of the study to examine the ethics and morality of abortion, it must be recognised that health care providers who are opposed to abortion and regard the CTOPA as unacceptably permissive have the potential to seriously frustrate the implementation and operation of the Act.

Amongst others, the main impediments and challenges associated with the provision of TOP services may be summarised as the poor organisation of the health system as evident in negative attitudes of health care providers, resulting from a lack of information about the CTOPA and strong religious and moral convictions. This means that few designated facilities are providing TOP services and operational TOP facilities are thus overloaded with patients and staff find it difficult to cope. The problem is compounded by the fact that there is a lack of trained midwives to provide TOP services. Midwives providing TOP services feel unsupported and stigmatised by colleagues not involved in TOP. Furthermore, community members lack information about the CTOPA and facilities providing these services. Many women who wish to access a TOP facility are afraid to ask to be referred to such a facility due to the negative attitudes of some health care providers.

Impediments to the operation of the CTOPA could be classified as client and provider/service factors. Examples of client factors relate to:

- Partners, friends and the community who are hostile to women who access abortion.
- Transport, distance, poverty and accommodation that place an abortion facility beyond the reach of women.
- A lack of knowledge about abortion services.

Provider/service factors include the following:

- Lack of facilities.
- Unavailability of staff.
- Unskilled or incompetent staff.
- Poor staff morale.
- Hostility of staff toward women accessing abortion services.
- Hostility of staff toward colleagues involved in abortion services.
- Poor or inadequate physical health facilities.
- Lack of knowledge about the CTOPA.

Albertyn (1999) notes that despite the progressive ideology of the CTOPA, many South Africans remain somewhat conservative on the issue of abortion. Constitutional rights and progressive abortion legislation are not sufficient to ensure that the reproductive rights of women are realised. Women need to be educated about their rights to reproductive health care and health workers need to be educated about their duties and the limitations to conscientious objection. Regardless of these concerns, the CTOPA and the supportive clauses in the *Constitution* (1996) provide an appropriate model to follow when considering abortion laws within a reproductive rights framework.

Notwithstanding the impediments to the operation of the CTOPA, there has been a dramatic increase in the number of TOPs conducted since 1997[2], when 26 401 terminations were performed compared with 2003 when 70 391 terminations were provided. Seven years after the introduction of TOP services, 348 038 abortions had been performed at public health facilities. Furthermore, Guttmacher *et al*. (1998) report that there has been a substantial decrease in the number of women presenting for treatment of severe complications resulting from incomplete abortions. At the end of 1997, the first official report on maternal deaths in South Africa cited nine deaths resulting from septic abortions compared with the 400 deaths cited in 1994 by the Medical Research Council (MRC).

[2] See Chapter 4 (Table 12) for detail regarding the number of abortions performed since the implementation of the CTOPA.

Evidently, the operation of the CTOPA will benefit from research designed to investigate the functioning of the Act, especially with regard to developments in the reproductive rights field. Ultimately, this will serve to guide efforts to improve the lives and social milieus of women accessing TOP services as well as TOP service providers. Such research should take into consideration abortion legislation both internationally and in Africa. Barriers and success prevalent in other countries serve to inform the operation of the CTOPA and guide the development of recommendations to overcome impediments encountered by service providers and clients at South African health care facilities.

## 3. AIM AND OBJECTIVES

In light of the above, the aim of the research was to describe and analyse the implementation and operation of the CTOPA in order to develop a set of guidelines based on best practices and lessons learnt so as to facilitate the improvement of TOP services in the Free State, in particular, and to suggest recommendations for South Africa. In order to achieve the aim, the study was divided into two distinct phases and the following objectives were pursued:

**Phase 1: Compilation of a detailed literature review to:**

1. Investigate international developments in human, reproductive and sexual rights against which abortion policies could be analysed.
2. Draw lessons from international abortion legislation and developments in countries such as the USA and Britain, which have had a marked influence on abortion legislation in South Africa, one of the countries colonised by Britain. In addition, USA policies have had a substantial influence on donor agencies and non-governmental organisations (NGOs) providing reproductive health care, hence the necessity of examining policies and legislation relating to abortion in the USA.
3. Describe developments in abortion legislation in neighbouring African countries (i.e. Swaziland, Lesotho, Namibia, Botswana, Zimbabwe and Mozambique) which may have offered abortion services to South African women or from where women may come to use abortion services in South Africa .
4. Document the history of abortion legislation in South Africa and the introduction of the 1996 CTOPA.
5. Examine the CTOPA and the implications thereof for health care providers and the health care system.
6. Scrutinise studies and articles on impediments to the implementation and operation of the CTOPA in South Africa.
7. Analyse secondary statistics reflecting progress made in TOP service delivery in South Africa.

**Phase 2: A case study of Free State experiences of the implementation and operation of the CTOPA over a period of six years:**

8. Identify cultural, educational and socio-economic impediments faced by women in accessing TOP services.
9. Investigate impediments experienced by TOP service providers in rendering TOP services.
10. Describe the knowledge and attitudes of health workers in general towards TOP.
11. Develop recommendations to overcome impediments to TOP service delivery particularly in the Free State and more broadly for South Africa.

## 4. RESEARCH STRATEGY AND METHODOLOGY

### 4.1 Design of the study

The research design opted for was predominantly exploratory and descriptive in nature as the researcher sought to provide a background against which developments in abortion legislation in South Africa could be assessed. An exploratory research design is most appropriate when the topic under study is relatively new (Neuman 2000); in this instance, as developments in abortion legislation in South Africa were being undertaken for the first time since the implementation of the 1975 *Abortion and Sterilisation Act*. In addition, it was necessary to describe developments in abortion legislation both internationally and in South Africa, hence the study design was also descriptive, which according to Babbie & Mouton (2001) is one of the most important purposes of social scientific studies.

Both non-empirical and empirical approaches were followed. With regard to the former, an unobtrusive methodology was followed which entailed a review and analysis of existing documents and secondary statistics. Huysamen (1994) notes that unobtrusive research may be used together with other measurement methods to obtain complementary data. In the study, international, regional and local literature, policies, documents and reports on reproductive and sexual rights as well as TOP were searched for in existing databases and on the web. These documents were reviewed and analysed in order to sketch a broader picture of the development of reproductive and sexual rights, as well as abortion legislation and developments in the USA, Britain, Swaziland, Lesotho, Namibia, Botswana, Zimbabwe, Mozambique and South Africa. Secondary statistics relating to the incidence of TOP in South Africa were obtained from the National Department of Health and analysed to provide a picture of abortion provision throughout the country.

The empirical research entailed a longitudinal trend study to describe the implementation and operation of the CTOPA in the Free State. Longitudinal studies involve gathering data over an

extended period of time (Babbie & Mouton 2001; Huysamen 1994; Sullivan 2001). In the study, different respondents participated in two surveys conducted over an extended period of time among TOP clients, an audit among all TOP service providers and a survey among health workers referring clients to TOP facilities in the Free State. A descriptive survey investigates the topic under study with intense accuracy and then describes what the researcher has observed and heard. The assumption is that whatever the researcher has observed and heard is normal, and under the same conditions may be observed again in future (Leedy 1993). Different respondents were interviewed five years apart. The first interviews were conducted shortly after the implementation of the CTOPA and the second series of interviews were conducted approximately five years after the Act was implemented. The strategy aimed to achieve a far richer database of information than if data was only gathered at one point in time, and adds more value than cross-sectional research, which entails a once off gathering of data (Babbie & Mouton 2001; Sullivan 2001). A limitation of the longitudinal trend study is that it is difficult to ascribe differences confidently to trends over time, as different groups of respondents are involved at different points in time (Huysamen 1994).

### 4.2 Analysis of existing documents and secondary statistics (unobtrusive research)

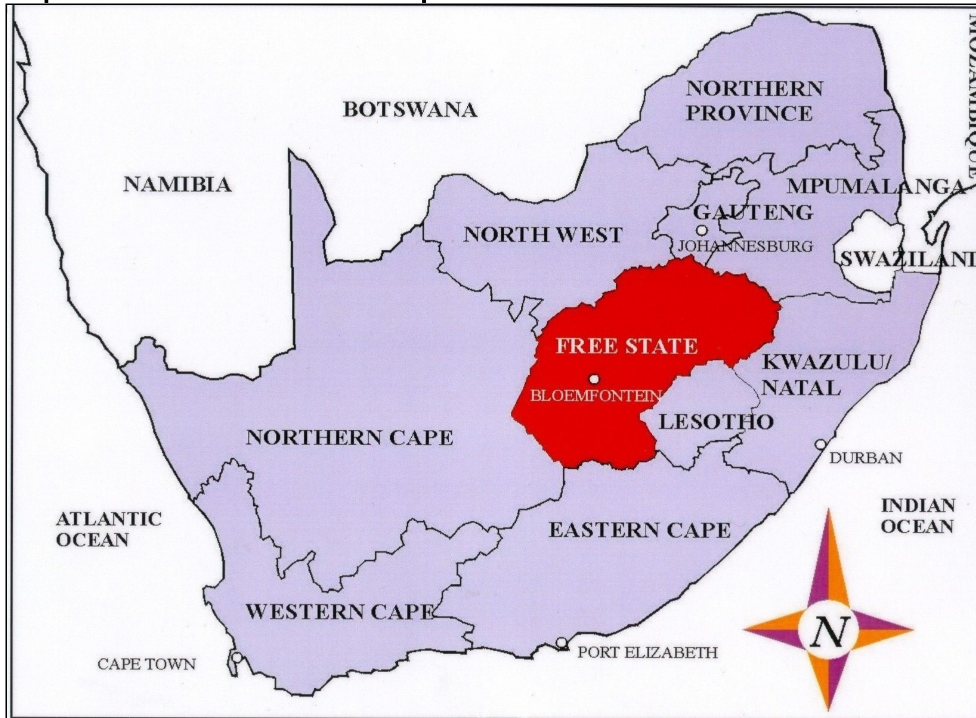
The development of human rights worldwide provides a framework against which to measure the reformation of abortion legislation. Hence an important focus of the literature study was to trace the development of human rights conventions and documentation. In order to achieve this objective, a website search using the search engines Google and Yahoo was undertaken. The United Nations (UN) website was found to be a valuable source of information regarding the development of reproductive rights. Close scrutiny of legislation, articles in popular and scientific journals, as well as newspapers and the web, provided the information necessary to document abortion legislation in the USA, Britain, African countries and, more specifically, South Africa. The literature search was guided through the use of the following databases: the Arts and Humanities Citation Index, PsycLIT, Social Sciences Citation Index, Sociofile, African Studies, South African Studies, ERIC, MEDLINE and EBSCO Host.

The literature review assisted in the formulation of the research problem, familiarisation with current discussions on the topic under study, compilation of research instruments and analysis of empirical data. According to Babbie & Mouton (2001), a thorough literature review enables the researcher to place his/her study within the context of the general body of scientific knowledge on the topic studied.

### 4.3 The Free State study

Although the Free State is the third largest of the nine provinces in South Africa, it has the second lowest population density. The province is home to approximately 2.7 million people on about 129 480km$^2$ of land. The Free State is situated in the heart of South Africa. The main languages spoken in the province are SeSotho and Afrikaans (South African Government website 2004).

**Map1: South Africa and the nine provinces**




Bloemfontein is the capital of the Free State and has well-established institutional, educational and administrative infrastructure, and houses the Supreme Court of Appeal. The province is known as the "granary of South Africa" and field crops produce almost two-thirds of the gross agricultural income of the province. Furthermore, the Free State contributes approximately 16.5% of South Africa's total mineral output. The mining industry is the biggest employer in the Free State. A more than 400km-long gold reef, the Goldfields, stretches across Gauteng and the Free State, with the largest gold mining complex being the Free State Consolidated Goldfields (South African Government website 2004). Despite this, the unemployment rate in the Free State is the fifth highest in the country, at 43%, and slightly higher than the national average of 41.6% (Statistics South Africa 2003). Furthermore, 68% of the Free State population live in poverty (HSRC 2004).

During the 1998-survey, three facilities (located within three of the five districts in the province) were rendering TOP services. By 2003, an additional facility (i.e. Moroka Hospital) was operational.

**Table 1: Facilities providing TOP services in the Free State (2003)**

| District | City/Town | Facility |
|---|---|---|
| Motheo | Bloemfontein<br>Thaba Nchu | National hospital<br>Moroka Hospital |
| Thabo Mofutsanyana | Phuthaditjhaba | Elizabeth Ross Hospital |
| Lejweleputswa | Welkom | Kopano Clinic |

### 4.3.1 Sampling methods

The same broad categories of respondents participated in both the 1998- and 2003-surveys, and included:

- Women who had undergone a TOP since the CTOPA had come into effect.
- Health care professionals, including facility managers, registered midwives, professional nurses, medical practitioners and social workers who provided TOP services.
- Health workers in general who were in a position to refer women to TOP facilities.
- TOP policy makers and decision makers.

**Table 2: Target populations and sample sizes**

| Category of respondents | 1998 Sample<br>N | 2003 Sample<br>N |
|---|---|---|
| TOP clients | 75 | 120 |
| TOP service providers | 16 | 16 |
| Health workers doing referrals | 63 | 100 |
| TOP policy makers and decision makers | 2 | 4 |

- **Women who had undergone a TOP since the CTOPA had come into effect**

During the 1998-survey amongst women who had undergone a TOP, 75 women (25 from each of the three TOP facilities) voluntarily participated in the study. The women were purposively selected and had to have undergone the TOP procedure in order for the "full experience" (i.e. from initial contact, through pre-counselling and the clinical procedure, up until post-counselling, if it was desired) to be investigated. Similarly, during the 2003-survey women who had undergone a TOP were again purposively selected. In this instance, an additional criterion was added, namely age. Of the 120 women selected, 60 were younger than 18 years of age and the remaining 60 were between 18 and 49 years of age. Thirty women were purposively selected at each of the four facilities providing TOP services, with the 50% split based on age maintained at each facility (i.e. 15 girls younger than 18 years of age and 15 women 18 years and older).

Due to the sensitive nature of the topic under study, it was deemed most appropriate to follow a non-probability sampling approach and more specifically purposive sampling. With non-probability sampling, the researcher cannot guarantee that each element of the population will be represented in the sample (Leedy 1993). Purposive sampling allows the researcher to select respondents based on prior knowledge about who will provide the best information for the study (Babbie & Mouton 2001; Sullivan 2001) and is considered to be the most important non-

probability sampling technique (Huysamen 1994). In addition, it is appropriate to use purposive sampling to select members of a difficult-to-reach, specialised population (Neuman 2000). In the study, the respondents were women who had just undergone a TOP at a public facility in the province. It would have been almost impossible and unethical to randomly select women from a list of those who had undergone a TOP to participate in the study due to the confidential nature of TOP.

- **TOP service providers**

During both audits (1998 and 2003) all TOP service providers (i.e. TOP facility managers, registered midwives, professional nurses, medical practitioners and social workers) participated in the study.

- **Health workers doing referrals**

During the 1998-survey, the three TOP facility managers were requested to compile a list of medical practitioners and clinics that had referred patients for a TOP. One hundred health workers were purposively selected to participate in the study, of which 63 responded. Experience indicated the necessity to adapt the sampling strategy, and during the 2003-survey a more rigorous approach was followed. As Huysamen (1994) notes, in survey research it is often difficult to obtain a list of all the elements in the study population. Hence, a process of multistage cluster sampling was a feasible approach to follow in identifying and gaining access to professional nurses who were in a position to refer women to TOP facilities. Multistage cluster sampling is a probability sampling technique in which the final units to be included in the sample are identified by first sampling among larger units (i.e. clusters) in which the smaller sampling units are found (Babbie & Mouton 2001; Huysamen 1994; Neuman 2000; Sullivan 2001). The following process was followed to select 80 professional nurses:

1. All towns in the Free State were listed alphabetically.
2. Each town was then assigned a number, starting with "1".
3. A table of random numbers was used to select 20 towns.
4. Four back-up towns were selected.
5. Each fixed clinic and community health centre (CHC) in each town was listed alphabetically.
6. Each fixed clinic and CHC in each town was assigned a number.
7. A table of random numbers was used to select one fixed clinic or CHC from each town.
8. Four back-up clinics were selected, one from each of the four back-up towns.
9. Four professional nurses were conveniently selected from each facility. When too few professional nurses were available, the back-up facilities were used.
10. Where possible, a medical practitioner providing services in the public sector was interviewed in each of the selected towns. However, due to numerous refusals from medical practitioners

to participate in the study, towns surrounding those selected were also used to select respondents.

- **TOP policy makers and decision makers**

Two key representatives from the Free State Department of Health participated in interviews during the data gathering conducted in 1998. During the 2003-data gathering exercise, key national and provincial managers, as well as representatives from the Planned Parenthood Association of South Africa (PPASA) and the Reproductive Rights Alliance (RRA), were approached to participate in the study (n=4).

### 4.3.2 Research techniques and instruments

As the research followed both an explorative and descriptive approach in identifying and outlining impediments towards accessing TOP services, both quantitative and qualitative research instruments were employed.

**Table 3: Research techniques and instruments**

| Category of respondents | Data gathering technique and tools (1998) | Data gathering technique and tools (2003) |
|---|---|---|
| TOP clients | Structured interview (structured questionnaire) | Structured interview (structured questionnaire) |
| TOP service providers | Self-administered questionnaires | Structured interview (structured questionnaire) |
| Health workers doing referrals | Self-administered questionnaires | Structured interviews either face-to-face or via telephone (structured questionnaire) |
| TOP policy makers and decision makers | Semi-structured interview (semi-structured interview schedule) | Semi-structured interview (semi-structured interview schedule) |

Structured questionnaires, comprising of both open-ended and closed-ended questions, were used to gather data from all respondents during the 1998- and 2003-studies (see Appendix A), with the exception of the TOP policy makers and decision makers with whom a semi-structure interview schedule was used. The specific research instruments contained target group and issue-specific question items (Neuman 2000).

Relevant literature and policy documentation were employed in the development of research instruments, while input from appropriate officials from the Free State Department of Health was obtained to further enrich all data gathering tools. The research instruments used during the 1998-data gathering were adapted for use in the 2003-study. Prior to the data gathering exercises in 1998 and 2003, all research instruments were pilot tested at suitable sites in the Northern Cape (Kimberly Hospital) and the Free State (Department of Health and MUCPP CHC) to ensure relevancy and measurement validity and reliability. In addition, this exercise also served to ensure

that the respondents understand the questions and that the questions were eliciting the type of information that needed (Huysamen 1994; Leedy 1993).

- **Women who had undergone a TOP since the CTOPA had come into effect**

During both surveys (1998 and 2003) the TOP clients were interviewed using structured questionnaires comprising of open-ended and closed-ended questions. The use of open-ended questions allowed the respondents to answer freely in their own words, while the closed-ended questions limited the respondents in that they had to choose from a list of possible answers (Babbie & Mouton 2001; Huysamen 1994; Sullivan 2001). In order to obtain quality data, every attempt was made to ensure that key guidelines for asking questions were followed in the compilation of the questionnaire. Questions and statements were clearly stated; double-barrelled questions were avoided; only questions relevant to the respondents were posed; the questions were kept short; the use of negative statements was avoided; and biased items and terminology were steered clear of (Babbie & Mouton 2001; Neuman 2000).

The main themes covered in these questionnaires were:

- Pregnancy and termination history.
- Health-seeking behaviour.
- Accessibility of TOP services.
- User-friendliness of TOP services.
- Services provided at TOP facilities.
- Support of family and friends.
- Knowledge of TOP and the CTOPA.
- Attitudes towards TOP.
- Main problems experienced and recommendations.

The main advantages of using an interviewer to gather information rather than asking the respondent to complete a questionnaire include: higher response rates; a decrease in “I don’t know” responses; interviewers can clarify confusing questions; and observations are possible. On the negative side, the mere presence of an interviewer may skew the information obtained, especially if the respondent feels inclined to answer in a way that will please the interviewer (Babbie & Mouton 2001; Neuman 2000). All attempts were made during the research, especially during the training of the data gatherers, to ensure that the interviewers remained neutral and did not pose a threat to the respondents (e.g. only persons sympathetic towards TOP were selected to act as data gatherers). In addition, the respondents were given the choice of where they would feel most comfortable being interviewed.

The use of a standardised structured questionnaire, with specific instructions for the data gatherers, ensured that all respondents were presented with the same questions in the same order. According to Sullivan (2001), this heightens the reliability of the research instrument.

- **TOP service providers**

The data gathering technique differed during the two data gathering exercises. In 1998, self-administered questionnaires were used to gather data from the TOP service providers. Due to problems associated with self-administered questionnaires (amongst others incomplete questionnaires and difficulty in acquiring the questionnaires back from the respondents) - during 2003, interviews based on structured questionnaires were used to obtain the necessary data from the TOP service providers. The main themes covered were:

- Quality of TOP services.
- Attitudes towards TOP.
- Availability of support services for TOP service providers.
- Management of TOP services.
- Counselling (pre and post).
- TOP procedures.
- General problems experienced and recommendations.

- **Health workers doing referrals**

As with the TOP service providers, the use of self-administered questionnaires was abandoned during the second data gathering exercise, and professional nurses and medical practitioners in a position to refer women to TOP facilities were interviewed using a structured questionnaire. The main themes included:

- Referral system.
- Knowledge of the CTOPA.
- Attitudes towards TOP.
- Problems and recommendations.

In instances where it was difficult to obtain direct access to medical practitioners due to time constraints, telephonic interviews were conducted. Sullivan (2001) notes that telephone interviews are successful when fairly simply information is required and the questions posed are not complicated. The questionnaire used to obtain information from the health workers doing referrals was concise and to the point, and no difficulties were experienced in administering the questionnaire telephonically.

- **TOP policy makers and decision makers**

Semi-structured interview schedules were developed for use during interviews with TOP policy makers and decision makers. Babbie & Mouton (2001) refer to an interview as an interaction between an interviewer and a respondent which is guided by a general plan of inquiry and not a specific set of questions that should be asked. During the 1998-study, the general aim of these interviews was to obtain more in-depth information regarding the implementation of the CTOPA in the Free State. The information was then used to compile questionnaires for use with TOP service providers and clients. During the 2003, these interviews sought to obtain information on:

- Achievements of the CTOPA.
- Impediments to the CTOPA.
- Main challenges in the operation of the CTOPA.
- Recommendations to overcome impediments to the CTOPA.

The information obtained during the interviews conducted in the 2004-study focused on South Africa as a whole and not specifically on the Free State province. In 1998, the interviews were conducted face-to-face with respondents. All of the interviews in 2003 (except the one conducted face-to-face with the representative from the Free State Department of Health) were conducted telephonically.

### 4.3.3 Recruitment and training of data gatherers

During both the 1998- and 2003-studies, data gatherers were recruited and trained to conduct the necessary interviews. The careful selection of interviewers and good training is essential for a high quality interview (Neuman 2000). Babbie & Mouton (2001) state that the role of the interviewer/data gatherer is indispensable. Errors that occur during data gathering can render the entire research process unsuccessful. Hence the importance of selecting the most suitable persons to collect the type of data that is needed for the study to succeed. Guidelines suggested by these methodologists for selecting suitable data gatherers included the ability to communicate in the home language of the respondents and matching of ethnic group, sex and age categories. These guidelines were followed in the study. Additional criteria were also considered when selecting the data gatherers.

More specifically, during the 1998-study, three female interviews (one each from Bloemfontein, Welkom and Phuthaditjhaba) were selected based on the following criteria: African women between the ages of 25 and 35 years; a nursing or para-medical background; sensitive and non-judgemental attitudes; fluent in SeSotho and English; and in possession of a valid drivers' license. The task of the three data gatherers was to conduct interviews with women who had undergone a TOP. In order to successfully accomplish the task, the data gatherers were trained over a two-day

period on: interviewing techniques; the structured questionnaire that was to be used during the interviews; how to cope with sensitive issues in the questionnaires; and facts about abortion. The training was undertaken by the researcher, in collaboration with a senior researcher from the Department of Sociology at the University of the Free State and officials from the Free State Department of Health. Huysamen (1994) states that interviewers should be properly trained and thoroughly familiar with the questionnaire(s) that they are to administer so that they do not deviate from the wording on the questionnaire.

During the 2003-study, a total of twelve data gatherers and three quality controllers/editors were recruited drawing from an existing pool of data gathering personnel used by the Centre for Health Systems Research & Development, University of the Free State. Criteria used to select the data gatherers included: age (younger women were recruited to interview young TOP clients, while older women were recruited to interview the older TOP clients); sensitivity towards TOP; and population characteristics. The data gatherers were responsible for gathering information from women who had undergone a TOP and professional nurses referring women to facilities providing TOP services. All data gatherers and quality controllers/editors were trained over a three-day period. Training focused on: background to the research; information about TOP, including the CTOPA and procedures; interviewing skills; detailed discussions on how to complete the questionnaires; how to access respondents, especially ethical considerations; and logistical arrangements. The training was undertaken by the researcher in collaboration with a senior researcher from the Department of Law at the University of the Free State and officials from the Free State Department of Health.

### 4.3.4 Data gathering and quality control

During both the 1998- and 2003-studies, data gatherers as well as the researcher were responsible for collecting information.

**Table 4: Persons responsible for data gathering**

| Category of respondents | Persons responsible for collecting the data (1998) | Persons responsible for collecting the data (2003) |
|---|---|---|
| TOP clients | Data gatherers (interviews) | Data gatherers (interviews) |
| TOP service providers | Researcher for distributing and collecting self-administered questionnaires) | Researcher and a quality controller (interviews) |
| Medical practitioners doing referrals | Researcher for distributing and collecting self-administered questionnaires) | Researcher and a quality controller (interviews) |
| Professional nurses doing referrals | Researcher for distributing and collecting self-administered questionnaires) | Data gatherers (interviews) |
| TOP policy makers and decision makers | Researcher and senior researcher from the Department of Law (interviews) | Researcher and senior researcher from the Department of Law (interviews) |

Mechanisms were implemented to verify the completeness and correctness of the data gathered by data gatherers. Classroom and practice training on the research instruments enabled data gatherers to conduct first level quality control, a process that entailed the revisiting of gathered information before proceeding to the following site or respondent. Furthermore, quality controllers/editors scrutinised all questionnaires for completeness. Statistical analysis of the gathered information further exposed minor inconsistencies.

- **Women who had undergone a TOP since the CTOPA had come into effect**

The researcher worked closely with the counsellors at the TOP facilities in order to select TOP clients to participate in the interviews. The counsellors informed all TOP clients about the research that was being undertaken, and these clients were given the opportunity to decide whether or not they would like to participate in the study. TOP clients who agreed to participate completed a consent form, which was provided to the data gatherers. The data gatherers made contact with the TOP clients and arranged to meet at a time and place convenient for the TOP client. During the first data gathering exercise (1998), interviews were almost always conducted outside of the TOP facility; however, during 2003, clients often preferred to be interviewed at the facility. TOP clients were modestly compensated for their time, expenses and the effort taken to share sensitive information.

- **TOP service providers**

During both studies, all the TOP service providers (n=16) participated. During 1998, the questionnaires for TOP service providers were delivered to the TOP facilities. The TOP facility managers were responsible for distributing the questionnaires to all health workers providing TOP services. Upon completion, each TOP service provider placed their questionnaires in sealed envelopes and returned the envelopes to the facility managers. The researcher collected these envelopes from the facilities and checked the questionnaires for completeness. Questionnaires with missing information were returned to the appropriate respondents for checking. A different approach was followed in 2003, when the researcher and a quality controller/editor visited all TOP facilities and conducted face-to-face interviews with service providers.

- **Health workers doing referrals**

During 1998, questionnaires were hand-delivered to professional nurses and medical practitioners in a position to refer women to TOP facilities. A plea was made for these health care providers to complete the questionnaires and a date arranged when the researcher could return to collect the questionnaires. Prior to collecting the completed questionnaires, the researcher telephoned the respondents to remind them of the study and to confirm the collection date. Again, a different approach was followed in 2003, when data gatherers conducted interviews with professional nurses in a position to refer women to TOP facilities, and the researcher and quality

controller/editor conducted either face-to-face or telephonic interviews with relevant medical practitioners.

- **TOP policy makers and decision makers**

During 1998, two key officials responsible for the implementation of the CTOPA in the Free State were interviewed by the researcher and a senior researcher from the Department of Law at the University of the Free State. The interviews were tape-recorded in order to ensure that no valuable information was lost during the discussion. Similarly during 2003, a representative from the Free State Department of Health responsible for TOP in the province; a representative from the National Department of Health involved with TOP; a representative from PPASA; and a representative from the RRA were interviewed by the same persons responsible for the interviews in 1998.

### 4.3.5 Data analysis

All data from the TOP clients, TOP service providers and health workers in a position to refer women to TOP facilities were coded and captured in the Statistical Package for the Social Sciences (SPSS). Qualitative data emanating form open-ended questions were quantified through a process of coding, which Sullivan (2001) describes as the classification of observations into a limited number of categories. Data analysis is the method of finding patterns within individual variables and in relationships between variables. In the study, univariate[3] (frequencies and percentages) and bivariate (cross-tabulations) statistical analysis was undertaken. Univariate analysis involves the examination of only one variable at a time, while bivariate analysis or sub-group comparisons involves two variables and adds the element of comparison (Babbie & Mouton 2001; Neuman 2000; Sullivan 2001). Chi square, a frequently used test of significance in the social sciences (Babbie & Mouton 2001), was used to determine whether there were significant differences in the responses of the minor and adult respondents in the 2003 sample at the 0.05 level.

All qualitative information (i.e. interviews with key health officials and managers) was used to supplement existing quantitative information.

### 4.3.6 Feedback workshops

Once all findings from the 1998-study were compiled, a feedback workshop was held with provincial health authorities concerned with TOP services (policy makers, managers and providers) and other relevant interest groups (PPASA and Marie Stopes). The workshop was

[3] In cases where relatively few respondents provided answers only n values and not percentages are presented, in order to provide the reader with an indication of the frequency of responses.

directed at the development of guidelines to overcome problems associated with and impediments to the delivery of TOP services in the province. In this regard, a participatory approach was followed, where participants were involved in all aspects of the workshop, including the identification and/or finalisation of the aim, objectives, outputs and envisaged outcomes of the workshop. The TOP facility managers along with the researcher were responsible for the finalisation and documentation of guidelines to address impediments to the operation of the CTOPA in the Free State.

Following the 2003-data gathering exercise and compilation of the findings, a series of feedback workshops were held with policy makers, managers and service providers at the TOP facilities in the Free State. In addition a provincial workshop was also held with TOP policy makers, decision makers, managers and other interested stakeholders such as PPASA and Marie Stopes. The main goal of the workshop was to further focus on the development of a set of guidelines for facilitating the improvement of TOP services in the province.

#### 4.3.7 Authorisation and ethical concerns

Authorisation to undertake the research was obtained from the relevant authorities, including the head of health in the Free State and provincial and local authority managers. Voluntary participation was emphasised to all categories of respondents. Potential respondents were informed about the purpose and process of the research, as well as approximate duration of the interviews.

Survey research is subject to voluntary participation and should be conducted in such a way that no harm befalls respondents (Babbie & Mouton 2001). The standard ethical considerations of anonymity and confidentiality were maintained throughout the research endeavour. TOP clients and health workers in positions to refer women to TOP facilities were informed that all information would be pooled and hence their identities could not be retrieved. TOP service provides were made aware of the fact that problems identified by them might be linked to the facility were they worked.

In particular, a survey related to a topic as sensitive as TOP brought to the fore a number of specific ethical considerations. As noted by Sullivan (2001), research may endanger respondent privacy. Accessing clients who had undergone a TOP was especially problematic. The very act of approaching TOP clients to obtain their permission to participate in the study potentially may have caused distress. These women were unavoidably reminded of a traumatic experience, and those who consented to being interviewed inevitably relived the experience. In as far as they may have kept their experience with a TOP facility hidden from their partners, families, friends and communities; they may have been particularly concerned that their experience could in some way

be revealed through the research. The actions of the data gatherers, therefore, sought to minimise any harmful impact on these women. In obtaining their consent to participate in the study, they were approached by the persons responsible for their counselling. The interviews with TOP clients were conducted in a highly confidential manner and in a setting and an atmosphere that encouraged truthful reflection. Respondents were also assured that they would remain anonymous, as no information could be linked to them. However, it must be kept in mind that personal interviews can never be totally anonymous (Huysamen 1994) as the data gatherer located the respondents by means of their names and addresses. The interviews were conducted by culturally-appropriate, well-trained and sympathetic interviewers.

While perhaps less confounding, the ethical considerations relating to the surveying of the health professionals were equally important. In particular, amongst both professionals directly involved with TOP services and those expected to facilitate referral to such services, it was expected that the generation of valid and reliable data would only be possible if the confidentiality of the data-gathering process was emphasised.

### 4.3.8 Limitations of the Free State case study

The reality of the situation is that, almost inevitably, difficulties were experienced in accessing women who had undergone TOP for the purposes of interviewing. Due to the sensitive nature of the research topic, it was not possible to draw a representative sample from all women who had undergone TOP since the CTOPA took effect. Instead, it was necessary to draw a purposive sample of TOP clients. Hence it was clear that accessing TOP users for survey purposes required a certain degree of flexibility.

Problems experienced in gaining access to women who had consented to participate in the research included:

- Many of these women did not have telephones at home, and as a result it was not possible to call and arrange for an interview. Where women did have home telephones, they did not always provide the correct telephone number.
- Data gatherers had to search for the homes of women who had agreed to participate in the study, as often incorrect addresses were provided.
- Some women had offered false names and could not be traced.

These problems resulted in an extended period of data gathering; however, it was deemed worthwhile to obtain a large enough sample that would provide useful data for the province.

The medical practitioners involved in the referral of women to TOP facilities also proved to be a difficult audience, as they were in many cases extremely reluctant to participate in the study. The main reasons for their reluctance were due to busy time schedules and, in some cases, hostility towards TOP and no desire to participate in such a study.

### 4.4 Triangulation of primary and secondary data

Leedy (1993: 145) defines triangulation as "*a compatibility procedure designed to reconcile the two methodologies by eclectically using elements from each of the major methodologies as these contribute to the solution of the major problem*". Simply put, Neuman (2000: 124) notes that triangulation means "*it is better to look at something from several angles than to look at it in only one way*". Information obtained during the review of legislation, policy documents, books, journal articles, newspaper articles and secondary statistics was used to highlight and explain differences and similarities in data gained during the empirical research conducted in the Free State. In addition, the process focused the development of recommendations for addressing impediments to the operation of the CTOPA in South Africa as a whole.

## 5. DEFINING THE CONCEPTS

The following key terms are used throughout the thesis for which brief definitions are provided.

**Abortion:** Termination of a pregnancy before the foetus is capable of life outside of the womb (Braam & Hessini 2003).

**Beijing Conference (Fourth World Conference on Women):** A conference held in 1995 in Beijing to address the human rights of women. A total of 187 UN member states adopted the *Declaration* and *Platform of Action*, which recognises women's right to control all matters related to their sexuality, including their sexual and reproductive health. In addition, it appeals to governments to acknowledge and deal with the public health crisis of unsafe abortion and to consider revising laws that punish women who obtain an illegal abortion (*Beijing Platform for Action* 1995).

**Beijing +5:** The conference was held five years after 1995 Beijing Conference to assess the impact of the *Declaration* and *Platform of Action* (Braam & Hessini 2003).

**The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW):** The Convention was adopted in 1979 by the UN General Assembly and is often described as the international bill of rights for women. This is the only human rights treaty that affirms the reproductive rights of women (CEDAW 1979).

**Family planning:** This involves the conscious effort of couples to regulate the number and spacing of births through artificial and natural methods of contraception. Family planning entails a variety of services to avoid pregnancy and abortion, but also includes attempts to induce pregnancy (Braam & Hessini 2003).

**Global Gag Rule:** The rule, also known as the 'Mexico City Policy", is a USA government policy which prevents foreign NGOs from receiving funding or technical assistance for family planning from the United States Agency for International Development (USAID) if they offer counselling on abortion, provide safe legal abortion services except in very narrow circumstances, or participate in the political debate on abortion (even if these NGOs conduct abortion-related activities with their own funds) (Smith *et al*. 2002).

**International Conference on Population and Development (ICPD):** This UN Conference was held in 1994 in Cairo during which 179 countries acknowledged that advancing gender equality, eliminating violence against women and ensuring women's ability to control their own fertility are the cornerstones of population and development policies (*Programme of Action of the ICPD* 1994).

**ICPD+5:** A five year review of progress made since the 1994 Conference in Cairo (Braam & Hessini 2003).

**Manual vacuum aspiration (MVA):** An abortion procedure that uses a flexible plastic cannula which is connected to a manual aspiration syringe with a locking valve to perform a uterine evacuation. This is a simple yet effective technique that allows a qualified health worker to perform the procedure in a treatment room. Hence it is not necessary to admit the patient to a hospital (Braam & Hessini 2003). In South Africa, the procedure is used to perform a TOP for women who are less than twelve weeks pregnant.

**Maternal mortality ratio:** The number of maternal deaths per 100 000 live births reflecting a woman's chance of dying each time she is pregnant (Braam & Hessini 2003).

**Reproductive health:** "*… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and their right to access appropriate health-care services that will enable*

*women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant*" (*Programme of Action of the ICPD* 1994: paragraph 7.2).

**Reproductive rights:** "*These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents*" (*Beijing Platform for Action* 1995: paragraph 95).

**Unsafe/back-street abortion:** A procedure for terminating unwanted pregnancy that is performed by someone lacking the necessary skills or in an environment lacking minimum medical standards or both (WHO 1997a).

**WHO:** The UN specialised agency for health matters was established on 7 April 1948 and seeks to ensure that all people attain the highest possible level of health (Braam & Hessini 2003), which is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 1948).

## 6. ARRANGEMENT OF THE MATERIAL

The thesis comprises of four main sections, namely the research problem and methodology; the literature review; the Free State empirical study; and the triangulation of information and data obtained during the literature review and empirical studies. More specifically, the following chapters comprise this thesis:

**Part 1:**

- **Chapter 1** introduces the study and provides the rationale and context thereof. In addition, the methodology utilised in gathering information and data are discussed, as well as the limitations of the research. Key terms referred to throughout the thesis are defined.

**Part 2:**

- **Chapter 2** contextualises abortion within a human rights framework and reviews the laws and policies that regulate abortion in the world with an emphasis on countries that have had a direct influence on abortion policies and service provision in South Africa. Attention is given to development in abortion legislation internationally (i.e. the USA and Britain) and regionally

(i.e. countries neighbouring on South Africa – Swaziland, Lesotho, Namibia, Botswana, Zimbabwe and Mozambique).

- **Chapter 3** presents a brief overview of the situation and shortcomings regarding reproductive health, and more specifically TOP, under the National Party government in South Africa. The focus is on the 1975 *Abortion and Sterilisation Act*, the first legislation in South Africa pertaining to abortion. The 1975 Act restricted the circumstances under which an abortion could be conducted and the number of back-street abortions. The situation prevailed until the African National Congress (ANC) came into power in 1994.

- **Chapter 4** considers in detail the CTOPA of 1996 within a reproductive rights context; the provisions thereof; key concepts and functions; important events during the first seven years of operation; and barriers and impediments faced in successfully implementing and operating the CTOPA.

**Part 3:**

- **Chapter 5** summarises the main findings from the 1998- and 2003- surveys among health workers, two audits among TOP service providers and interviews with key stakeholders. Findings from the surveys among health workers are categorised under three main headings, namely, the referral system, attitudes towards TOP and knowledge of the CTOPA. The main findings of the TOP service provider audits are categorised as follows: attitudes towards TOP; emotional experiences and conduct of TOP service providers; abortion values clarification workshops; available resources for TOP service delivery; evaluation of TOP services including pre- and post-counselling and the procedures; evaluation of the physical structure of TOP facilities; and challenges experienced. Responses from the key stakeholders are classified according to achievements of the CTOPA, impediments to access to TOP, recommendation to improve access to TOP and challenges for the future.

- **Chapter 6** discusses the main findings from the 1998- and 2003-surveys among TOP clients in the Free State. The main themes covered in the chapter are: family planning; pregnancy and termination history; accessibility and user-friendliness of TOP services; support of family and friends; knowledge of TOP and the CTOPA; attitudes toward TOP; and main problems experienced and recommendations.

**Part 4:**

- **Chapter 7** is a discussion of the main findings from both the literature review and the empirical study undertaken in Free State. The focus is on recommendations to overcome impediments to the operation of the CTOPA in South Africa.

# PART 2: CHAPTER 2
# ABORTION LEGISLATION WITHIN A HUMAN RIGHTS FRAMEWORK

## 1. INTRODUCTION

Despite decades of international debate, maternal mortality remains unacceptably high in many of the world's poorest countries. The difference in levels of maternal mortality between the developing and industrialised world is greater than for any other health indicator (Tinker *et al*. in Hord & Wolf 2004). In developed countries, women generally have access to safe pregnancies, birth and motherhood due to the availability of high quality obstetric and maternal health-related care. However, inadequate access to such care in developing countries poses a threat to the lives of many women. An important contributor to pregnancy-related deaths in the developing world is unsafe abortion (Hord & Wolf 2004). The WHO (1997a) defines an unsafe abortion as a procedure for the termination of an unwanted pregnancy that is performed by someone who lacks the necessary skills or which takes place in an environment that lacks minimum medical standards, or both. Hord & Wolf (2004) note that this clinical definition of unsafe abortion obscures the reality of the situation, which is one of utter desperation faced by many women confronted with unwanted pregnancies and having no other option but to resort to crude methods and unskilled practitioners.

Approximately 95% of all unsafe abortion procedures occur in the developing world (WHO 1997b). Africa is faced with 4.2 million unsafe abortions annually, which translates to an unsafe abortion rate of 2 per 1 000 women, or one unsafe abortion for every seven live births. In comparison, developing countries experience roughly one unsafe abortion per 25 live births (Ahman & Shah 2002). It is estimated that death due to unsafe abortion accounts for a global average of 13% of all pregnancy-related mortality (WHO 1997b). In 2000, an estimated 30 000 deaths resulted from unsafe abortion practices throughout Africa, equalling 40% of all unsafe abortion-related deaths. Of all the regions, Africa has by far the highest unsafe abortion mortality rate (100 for every 100 000 live births) due to the use of high risk unsafe abortion methods and poor access to health services (WHO 2004).

In recent decades, most countries have come to realise the importance of reproductive health, in particular for women. Achieving reproductive rights awards great benefits for economic and social life. Given the choice, most men and women prefer to have smaller families, which lowers the morbidity and mortality burden, lessens the devastation of hunger and improves the education and opportunities of people. This has led many countries to ratify various treaties and programmes regarding population and development (UNFPA 1999). The 1990s are heralded as an outstanding decade for bringing issues of reproductive health and health rights to the centre of

global and national dialogue on human rights and development (UNFPA 2004). The 1994 ICPD, the 1995 Beijing Conference and the 1999 ICPD+5 led to the development of specific consensus documents focusing on various aspects of women's health. Each consensus document progressively elaborates on women's rights, and more particularly, reproductive health and safe abortion.

This chapter sets out to place abortion within a human and reproductive rights framework, and reviews a variety of laws and policies that regulate abortion around the world. Emphasis is placed on countries that have had both direct and indirect influences on abortion policies and service provision in South Africa. In this regard, South Africa has much to gain from the experiences of the USA. Although abortion is legal in the USA, numerous restrictions have been put in place that limit women's actual access to such services. Similarly, British abortion law, especially Common Law, governed access to abortion in South Africa in the period prior to the 1975 *Abortion and Sterilisation Act*. Although Britain introduced a liberal abortion law in 1967, this was not the case in South Africa until 1996. Similarly, several other African countries have yet to reform the colonial laws governing access to abortion. More specifically, most of the 54 African countries still have restrictive abortion laws. In this chapter attention is paid to the position of abortion legislation in countries neighbouring South Africa, as the extremely liberal CTOPA of 1996 allows for access to abortion on request (i.e. without restriction as to reason) during the first twelve weeks of pregnancy, thus offering African women with the means to travel to South Africa the opportunity to access a safe and legal abortion.

## 2. REPRODUCTIVE HEALTH AND HUMAN RIGHTS

According to the United Nations Population Fund (UNFPA) (1999), reproductive rights, whether for women or men, lay the foundation for prosperity and a better quality life for all people. More specifically, "*… reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents"* (Beijing Platform for Action 1995: paragraph 95).

The right to reproductive health is not new; it is an essential component of long established and internationally recognised human rights. The concept of protecting individual dignity and rights was codified with the adoption of the United Nations' *Universal Declaration of Human Rights* in 1948. The declaration laid the foundation for the development of treaties and covenants which

outline standards and obligations for human rights to which signatory countries must adhere. This led to the establishment of international committees and courts that are tasked to monitor compliance with human rights (Sai 2004). The right to reproductive health is captured in the following basic human rights:

- **The rights to life, survival and sexuality**. In order to achieve these rights, governments are required to remove barriers to basic services needed for reproductive and sexual health (e.g. essential obstetric care) (Cook *et al*. 2003). Restrictive abortion laws encourage unsafe abortion and, therefore, governments promoting such laws may be guilty of failing to recognise the right to liberty and security of the person. In addition, governments that deny women access to abortion services may be ignoring the right to be free from inhuman and degrading treatment. As such, it is considered that the South African CTOPA removes barriers to abortion by offering every woman in South Africa the opportunity to have a safe and legal abortion. Designated facilities throughout the country have trained doctors, midwives and registered nurses to perform and assist with abortion procedures. However, this is not to say that access to abortion in South Africa is without impediments (discussed in detail in Chapter 4).
- **The rights to reproductive self-determination and free choice of maternity**. Included under this framework are: the right to decide freely on the number and spacing of one's children and the right to private and family life; the right to marry and to have a family; and, the right to maternity protection (Cook *et al*. 2003). Traditional Black South African women are at a disadvantage as they are controlled to various degrees by customary law, which prohibits them from making their own decisions. This impacts on their reproductive choices, amongst others, the decision to use contraceptives.
- **The rights to health and the benefits of scientific progress**. An important aspect of these rights is the right to the highest attainable standard of health. The right to health depends on the availability, accessibility and quality of health services. Governments need to ensure that health care facilities, goods and services, as well as essential drugs, are readily available and that sufficient quantities are on hand. Accessibility comprises four overlapping dimensions: non-discrimination (i.e. accessible to all); physical accessibility; economic accessibility; and information accessibility. In addition, health care facilities should be acceptable, which implies that these services are ethically and culturally appropriate. Quality of services suggests that the services provided at health care facilities should be scientifically and medically appropriate and of good quality. Hence there should be skilled personnel, approved drugs that have not expired and appropriate equipment available at health care facilities (CESRC 2000: article 12). In line with this, Section 3 of the CTOPA outlines various requirements, including access to personnel, equipment and drugs, that must be available before a facility (both public and private) may render abortion services in South Africa.

- **The rights to non-discrimination and due respect for difference**. Persons have the right not to be discriminated against on the basis of race, colour, sex, language, religion, political beliefs, origin, property, birth or any other status (*International Covenant on Civil and Political Rights*, 2(1) 1976). The *Constitution* (1996) promotes reproductive rights by ensuring that internationally recognised human rights are also maintained in South Africa. More specifically, the *Constitution* (1996) implicitly makes provision for the right not to be discriminated against on any grounds, including religion, conscience and belief (Section 9(3)). Even more significantly, everyone has the right to freedom of conscience, belief, religion, thought and opinion (Section 15(1)).
- **The rights to information, education and decision-making**. According to Article 19(2) and (3) of the *International Covenant on Civil and Political Rights* (1976), "*Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice*". In addition, Article 13 recognises that everyone has the right to education. Article 18, acknowledges the right to freedom of thought, conscience and religion. Similarly, the South African *Constitution* (1996) recognises that everyone has the right to education (Section 29(1)) and access to information (Section 32(1)). Additionally, the CTOPA requires health care workers to provide women requesting a TOP with information concerning the legal requirements for TOP and the location of facilities providing the service.

The intention of human rights is to empower those who are powerless and, as is to be expected, much resistance has been encountered from those who have enjoyed privileges and power. This is also true in the reproductive health field where the paternalistic control of reproductive health decisions has continued to prevail. Human rights are useful tools to shape and mould reproductive and sexual freedom, as well as for monitoring the work of international rights treaties (Cook *et al*. 2003). Seen broadly, reproductive rights entail two principles: the right to reproductive health care and the right to reproductive self-determination.

### 2.1 The right to reproductive health care

Reproductive health is an essential facet of women's well-being. Lack of access to safe, quality health services may result in complications such as maternal mortality and morbidity, unwanted pregnancies and sexually transmitted infections (STIs). Therefore, reproductive rights imply that governments should ensure the availability of comprehensive reproductive health care services, which include: measures to promote safe motherhood; treatment of HIV/AIDS-related illnesses and STIs; abortion; infertility treatments; and, contraceptives, including emergency contraceptives. The right to reproductive health care is encompassed in international human rights instruments which protect life and health, including: the U*niversal Declaration of Human*

*Rights* and the *International Covenant on Civil and Political Rights* (Centre for Reproductive Law and Policy 2000)

Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (1966) recognises the right of everyone to the highest achievable standard of physical and mental health. The WHO (1948) defines health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Similarly, the *Programme of Action of the ICPD* (1994: paragraph 7.2) defines reproductive health as complete well-being in all matters relating to the reproductive system and its function and processes. The right to health does not guarantee perfect health; however, it compels governments to ensure that health care is available. According to the *International Covenant on Economic, Social and Cultural Rights* (1966: article 12), governments should create "*conditions which would assure to all medical services and medical attention in the event of sickness*".

International human rights agreements and instruments recognise the right of individuals to health, and more specifically, the right to reproductive health care. Countries party to such instruments are obliged to ensure that health care is available. Understandably, the quality of such care differs from country to country depending on, amongst others, socio-economic and cultural factors. The South African *Constitution* (1996) "*gives conspicuous expression to the idea of a fundamental right to health care for all. It translates to the health care sector the values of social justice, equality under the law, and respect for human rights*" (Van Rensburg & Pelser 2004:116). Therefore, the foundation is laid for a liberal and egalitarian health care sector in South Africa, which guarantees everyone the right of access to basic health care services. More specifically, in terms of reproductive health, the *Constitution* (1996) guarantees everyone the right to:

- Bodily and psychological integrity, including the right to make decisions concerning reproduction (Section 12(2)), which, in conjunction with the CTOPA, allows women to choose to have an abortion. This links with the right to reproductive self-determination, which is discussed in the following paragraph (2.2 The right to reproductive-self-determination).
- Security in and control over their body (Section 12(2)).
- Have access to health care services, including reproductive health care (Section 27(1)(a)).
- Have access to emergency medical treatment (Section 28(1)(c)).

## 2.2 The right to reproductive self-determination

The right to reproductive self-determination refers to the right to plan one's family and the right to freedom from violence and coercion that may influence a woman's sexual or reproductive life. The CEDAW (1979: paragraph 12) affirms and gives legal force to the right to plan one's family in

terms of the number and spacing of children. This implies that governments will make available, to men and women, various contraceptive methods as well as information about sexual and reproductive health (Centre for Reproductive Law and Policy 2000). According to the *Programme of Action of the ICPD* (1994: paragraph 7.3), women have the right to make reproductive choices "*free of discrimination, coercion and violence*". The CEDAW (1979: paragraph12) notes that governments party to the convention should "*take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning*".

Moodley (1995) notes that for women in developing countries the notion of choice and right to control over one's body is meaningless if women do not have any resources or power, let alone an awareness of their rights. For example, women are generally more socially vulnerable than men as they lack education, social status, resources and decision-making power. This is especially true when it comes to deciding whether, when, and under what circumstances they will have sexual relations, and if or how often they want to have children. Cultural and economic reasons often prevent women from accessing certain services. Due to their biological and social vulnerability, women need to be able to make choices concerning their sexual and reproductive lives. It is in this area that human rights instruments can play an important role. In order for improvements to occur in women's health, not only is better science and health care needed, but also state action to address injustices to women.

## 3. INTERNATIONAL DEVELOPMENTS IN REPRODUCTIVE RIGHTS

International human rights instruments are useful tools to determine the responsibility of government and to define the relationship between the government and the individual. This is especially important when considering reproductive health, as reproductive health not only comprises of individual exposure to disease, but also behaviours and relations between individuals and society as a whole. Customs, traditions and taboos have a significant influence on sexual and reproductive behaviours. Therefore, it is not surprising that less powerful individuals and social groups, who have limited ability to make decisions, will suffer the most. The following discussion regarding international developments in reproductive rights mainly follows the chronological framework utilised by the Centre for Reproductive Law and Policy (2000).

### 3.1 Developments prior to the 1994 ICPD

According to Pillai & Wang (1999) and the Centre for Reproductive Law and Policy (2000), the first formal declaration of reproductive rights occurred in 1968 at the UN International Conference on Human Rights in Teheran, Iran. It was recognised that *"parents have a basic human right to determine freely and responsibly the number and spacing of their children and a right to adequate*

*education and information to do so*" (*Proclamation of Teheran* 1968: paragraph 16). This right of parents to plan their families was reaffirmed several times over the following two decades.

On 18 December 1979, the UN adopted the CEDAW, also known as *The Treaty for the Rights of Women*. The need for a Women's Convention arose in 1975 during the First World Conference on Women in Mexico. The treaty was the first critical step in recognising human rights for women. The CEDAW has been used to incorporate women's rights into national constitutions, including the South African *Constitution* (1996). As of March 2004, 175 countries had ratified the CEDAW. The USA is one of the few countries that have not yet ratified the CEDAW (Milani *et al*. 2004). The Centre for Reproductive Law and Policy (2000) notes that the CEDAW provides the strongest legal support for reproductive health rights for women. Article 16.1(e) of the CEDAW states "*on a basis of equality of men and women … the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights*".

The provision recognising the rights of women and men to decide on the number and spacing of their children was slightly amended at the International Conference on Population in Mexico City to read "*all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so*" (International Population Conference 1983: recommendation 30). This right was again reiterated in *Agenda 21*, from the *Rio Declaration on Environment and Development* and the *Statement of principles for the Sustainable Management of Forests*, and was adopted by 178 governments at the Conference on Environment and Development held in Rio de Janeiro in 1992 (United Nations 2004). In addition, it was also reported that "*Governments should take active steps to implement programmes to establish and strengthen preventive and curative health facilities, which include women-centred, women-managed, safe and effective reproductive health care and affordable, accessible services, as appropriate, for the responsible planning of family size, in keeping with freedom, dignity and personally held values, taking into account ethical and cultural considerations*" (United Nations Environment Programme 1992).

Ngwena (2004a) notes that the 1993 World Conference on Human Rights, held in Vienna, was an important milestone in the recognition of reproductive rights. "*In the context of the World Conference on Women and the CEDAW as well as the Proclamation of Teheran of 1968, the World Conference on Human Rights reaffirms, on the basis of equality between women and men, a woman's right to accessible and adequate health care and the widest range of family planning services, as well as equal access to education at all levels*" (*Vienna Declaration and Programme of Action* 1993: paragraph 41). The goals for the Vienna Conference included an end to gender-based discrimination and violence, and sexual harassment and exploitation.

### 3.2 The ICPD and Beijing Conference

The 1990s proved to be an outstanding decade for bringing, amongst others, issues of reproductive health and rights to the centre of global and national debates on human rights and developments (UNFPA 2004). The 1994 ICPD was well attended by government representatives, policy makers and activists from all over the world. Landmark agreements were achieved on population and development. The *Programme of Action of the ICPD* is the end product of negotiations involving more than 180 states and was conceived as a 20 year programme. In essence, the *Programme of Action of the ICPD* is an endorsement from the international community that reproductive rights are human rights. Haslegrave (2004) reports that the simplistic concept "family planning" used at the Vienna Conference, was replaced with the broader term "reproductive health" during the ICPD.

According to the *Programme of Action of the ICDP* (1994: paragraph 7.2), reproductive health may be defined as: *…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and their right to access appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant*".

The above definition of reproductive health is dependent on the recognition of national laws, international human rights documents and consensus documents which acknowledge the rights of individuals and couples to decide "*freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health*" and to make these decisions "*free of discrimination, coercion and violence*" (*Programme of Action of the ICPD* 1994: paragraph 7.3). The ICPD set the goal of ensuring universal voluntary access to reproductive health care and information by 2015 (UNFPA 2004).

Furthermore, it should be kept in mind that the ICPD placed reproductive health care firmly within the realm of primary health care (PHC) provision. Prior to this agreement, there had been much debate as to whether reproductive health care should form part of PHC provision, or whether separate family planning services should be adopted. Unfortunately, the ICPD did not go further and explicate the process of integrating reproductive health into PHC service delivery

(Haslegrave 2004). According to UNFPA (1999), successful health programmes, including reproductive health care programmes, need to be under one roof, or vertically integrated, offering a wide range of services. A key objective of integrated health care is ensuring that women are aware of their options and have access to these options.

Paragraph 8.25 of the ICPD introduced abortion for the first time as a public health issue and not merely a moral or cultural problem; however, it did not call for the liberalisation of restrictive abortion laws. It explicitly states that "[*i*]n *no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organisations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion … Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling… In circumstances where abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortions. Post-abortion counselling, education and family panning services should be offered promptly which will also help to avoid repeat abortions"* (*Programme of Action of the ICPD* 1994: paragraph 8.25).

The 1995 Beijing Conference consolidated the ground gained during the 1994 Cairo Conference by producing the *Beijing Declaration* and *Beijing Platform for Action* which reaffirmed the principles adopted in Cairo (Centre for Reproductive Law and Policy 2000; Ngwena 2004a). The *Beijing Declaration* acknowledges that there have been advances in the status of women, but that inequalities and obstacles remain (Chasek *et al.* 1995). Paragraph 106(K) of the *Beijing Platform for Action* (1995) suggests that countries should consider reviewing punitive abortion laws, "[*I]n light of paragraph 8.28 of the Programme of Action of the ICPD, consider reviewing laws containing punitive measures against women who have undergone illegal abortions"*.

Both the 1994 ICPD and the 1995 Beijing Conference had a substantial influence on population policies and programmes in developing countries. Firstly, the traditional demographic approach to family planning which determined the success of such programmes by numerical targets (e.g. an increase in contraceptive use and the resulting decrease in fertility rates) was largely discarded. This approach was replaced by a people-centred approach which concentrates on diminishing the root causes of high fertility. Causes of high fertility rates have been found to include low status of women and poor access to good quality family planning services (Onyango 1997). Such reform also occurred in South Africa when the newly elected democratic government in 1994 committed itself to address population issues and did so, amongst others, by using guidelines from the ICPD (Pelser 2004). Secondly, the actions of women's groups at the Cairo Conference compelled

governments to acknowledge that women have a focal role to play in the population debate. This has meant that governments that are serious about population issues are compelled to improve the status of women in their countries (Onyango 1997).

According to the ICPD, a holistic approach to family planning needs to be followed. Such a programme should include: contraceptive distribution, treatment of reproductive tract infections and STIs, provision of sex education and reproductive health care for adolescents, infertility treatments, and assistance for victims of sexual violence. Furthermore, unsafe abortion was declared to be a major public health concern, both at the Cairo and Beijing Conferences. However, the Vatican, which still has a strong influence in many sub-Saharan countries, has rebuffed the recommendations to improve sex education and reproductive health that emerged at the Beijing Conference. High levels of conservatism in many sub-Saharan African countries have made it almost impossible to provide sex education and reproductive health-care to their youth (Onyango 1997). Although antagonism toward reproductive rights still abounds from conservative and religious sectors, especially with reference to the right to sexual health, reproductive rights are part of the broader concept of the right to health due to their inclusion in the *ICPD Programme of Action* (Haslegrave 2004).

The Cairo and Beijing Conferences have left party states with the task of ensuring that reproductive and sexual rights do not remain abstract concepts. Governments should ensure that they are committed to protecting and promoting reproductive rights through effective implementation (Ngwena 2004a). In addition, if reproductive rights are to become a reality, all people working within the health and social services (i.e. doctors, nurses, social workers, lawyers, politicians, etc.) should be committed to change in favour of women (Moodley 1995).

### 3.3 Follow-up reviews and beyond

The five year follow-up reviews of the Cairo and Beijing Conferences during 1999 and 2000 have sought to ensure that reproductive and sexual rights are kept alive by assessing whether party states are keeping to their commitments (Ngwena 2004a). During the five year review of the ICPD in 1999 there was a reaffirmation of the principles agreed to in 1994. The resulting *ICPD+5 Key Actions Document (*1999: paragraph 63(iii)) noted that, "*in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible*". Legalising abortion does not by itself guarantee safety or accessibility. Facilities providing abortion services may be few in number and health care providers may not have received training to conduct abortions. Hence the importance of training and equipping health workers in abortion procedures.

It should be noted that items relating to abortion came under severe attack during the Cairo+5 and Beijing+5 reviews (1999-2000), mainly from the Vatican and some Islamic and developing countries. Despite these attacks, the 1994-1995 consensus was upheld and even slightly expanded (Correa 2003). The 2003 UNFPA survey found that since the Cairo Conference in 1994, 131 countries have changed their national policies or laws, or made institutional changes to recognise reproductive rights. For example, the South African *Constitution* (1996) includes reproductive rights as fundamental human rights (UNFPA 2004).

Equality between men and women was also addressed at the World Summit on Social Development held in March 1995 and in September 2000 when heads of state and government met in New York to negotiate a *Millennium Declaration* (UNFPA 2001). An important outcome of the ICPD, namely universal access to quality reproductive health care by 2015, was not one of the *Millennium Development Goals* (MDG)[4]. This has led to concerns that reproductive health care may not receive the attention it deserves. However, as noted in the ICPD, if reproductive health is not universally accessible, the reduction of poverty, child and maternal mortality, and the spread of HIV/AIDS cannot be adequately addressed. In 2002, the UN Secretary-General, stated that "*the Millennium Development Goals, particularly the eradication of extreme poverty and hunger cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women's rights, and greater investment in education and health, including reproductive health and family plannin*g" (UNFPA 2004: 13).

In May 2004, the 57th World Health Assembly adopted the WHO's first strategy on reproductive health. The aim was to hasten progress toward achieving the reproductive health goals of the ICPD and its five year follow-up, as well as the MDGs. The strategy identified five priority areas in reproductive and sexual health, of which one was eliminating unsafe abortion (UNFPA 2004). An important objective of the ICPD, namely to achieve universal access to reproductive health care, was again agreed upon by world leaders at the World Summit held in September 2005. The leaders resolved to integrate the goal of access to reproductive health into strategies to attain the MDGs to end poverty, reduce maternal death, promote gender equality and combat HIV/AIDS (United Nations 2005)

## 4. OVERVIEW OF ABORTION LEGISLATION WORLDWIDE

Against the background of international developments in reproductive rights, governments worldwide have responded to the growing international consensus and pressure for policies focusing on the well-being of women, including reproductive health (Sai 2004). Cook & Dickens (2003: 5) note that "[*A*]*bortion laws have evolved through courts and human rights tribunals*

[4] Briefly, the MDGs are: i) eradicate extreme poverty and hunger; ii) achieve universal primary education; iii) promote gender equality and empower women; iv) reduce child mortality; v) improve maternal health; vi) combat HIV/AIDS, malaria and other diseases; vii) ensure environmental sustainability; and viii) develop a global partnership for development (UNFPA 2004).

*around the world interpreting human rights to recognize, and sometimes deny, women's rights of access to abortion services and information".* While induced abortion was almost universally illegal during the first half of the 20th century, the majority of countries have agreed that the criminalisation of abortion is dysfunctional (Cook *et al*. 1999). More particularly, there has been a global trend toward the liberalisation of abortion laws observed before 1985, and 1973 may be taken as an arbitrary starting point for the liberalisation of abortion in many countries (Ferreira 1985). Numerous countries have followed a human rights approach, mainly due to growing awareness resulting from the Cairo and Beijing Conferences, regarding reproductive self-determination (Cook *et al.* 1999). The most significant revisions that were made between 1985 and 1997 are represented in Table 5.

**Table 5: Countries that liberalised and restricted abortion law (1985 - 1997)**

| Region | Country | |
|---|---|---|
| **Liberalised abortion law** | | |
| The Americas/Caribbean | Canada* | Guyana |
| Central Asia/Middle East/North Africa | Algeria | |
| East & South Asia/Pacific | Cambodia*<br>Malaysia | Mongolia*<br>Pakistan |
| Europe | Albania*<br>Belgium*<br>Bulgaria*<br>Czechoslovakia*[1]<br>Germany* | Greece*<br>Hungary*<br>Romania*<br>Spain |
| Sub-Saharan Africa | Botswana<br>Burkina Faso | Ghana<br>South Africa* |
| East African Islands | Seychelles | |
| **Restricted abortion law** | | |
| Europe | Poland | |
| The Americas/Caribbean | El Salvador | |

Sources: Centre for Reproductive Law and Policy (1999); Rahman *et al*. (1998);
* Abortion available without restriction during first trimester.
1 Since 1993, the Czech Republic and the Slovak Republic.

At present, more than 61% of the world's population reside in countries that permit induced abortion either for a wide range of reasons or without restriction as to reason[5]. In contrast, 26% of all people live in countries where abortion is generally not allowed (Centre for Reproductive Rights 2004). Determining the legality of abortion is complex as abortion laws are generally addressed in multiple statutes, codes and regulations, which apply simultaneously. In countries where abortion is readily available, various types of laws, including judicial opinions, social security laws and health codes, regulate it as a medical procedure. In counties with laws criminalising abortion, it is generally addressed in the penal code. Nevertheless, most governments permit abortion under certain circumstances, and therefore there may be exceptions to the penal code (Rahman *et al*. 1998).

[5] Abortion is available on request, however most countries impose a limit on the period which women can readily access the procedure (Centre for Reproductive Rights 2004)

The Centre for Reproductive Rights (2004) categorised the world's abortion laws according to five categories. However, factors such as public opinion, the views of government officials and providers, and individual circumstances may result in the law being interpreted more broadly or restrictively.

- 26.1% of the world's population reside in the 71 countries that prohibit abortion altogether or only allow abortion to save the woman's life. Countries in this category have the most restrictive abortion laws; an abortion may only be performed when the pregnancy threatens the woman's life. In other countries, laws that make no explicit exception are often interpreted to allow abortion under life-threatening circumstances on the grounds of necessity. Countries that fall in this category (and will be explored in more depth later in the chapter) include Lesotho and Swaziland.
- 9.9% of the world's population reside in the 35 countries that allow abortion to preserve physical health and also to save the life of the woman. In some countries, these laws require that the threatened injury to health be either serious or permanent. Although countries in this category have laws that do not explicitly permit abortion to protect mental health, many are phrased generally enough referring merely to "*health*" or "*therapeutic*" indications to permit abortion on mental grounds. Mozambique and Zimbabwe are two countries in this category, which will be discussed in more detail later in the chapter.
- 2.7% of the world's population reside in the 20 countries that allow abortion to preserve mental health, as well as to save the woman's life and physical health. The interpretation of mental health varies from country to country and may include psychological distress suffered by a woman who has been raped or severe strain caused by social or economic conditions. Botswana and Namibia are two of the countries which are discussed in this chapter, which serve as examples of countries in this category.
- 20.7% of the world's population reside in 14 countries that allow abortion on socio-economic grounds as well as to save the woman's life and to preserve physical and mental health. Socio-economic grounds take into consideration the economic resources, age, marital status and number of children that the woman has. Such laws are generally interpreted liberally.
- 40.5% of the world's population reside in the 54 countries that permit abortion without restriction as to reason. However, most countries with such laws impose a limit on the time period during which women can easily access the abortion procedure (for example, in South Africa abortion is available on request during the first twelve weeks; thereafter certain restrictions apply.

In addition to the above-described categories, a number of countries also allow abortion if the pregnancy was a result of rape or incest, or if there is a high risk of foetal impairment. Countries that recognise these grounds for abortion may fall within the categories described above. In addition, certain restrictions such as requiring a woman to obtain spousal or parental consent

may impede access to abortion. A table classifying the world's abortion laws according to these categories is provided in Appendix B.

## 5. INTERNATIONAL ABORTION LEGISLATION: THE USA AND BRITAIN

While the first half of this chapter investigated international developments in reproductive rights and generally looked at the status of abortion legislation worldwide, the second half focuses more specifically on abortion legislation in the USA, Britain and certain African countries. Developments in abortion legislation in the USA and Britain are discussed as it strongly impacts on Africa, and more specifically South Africa. The USA has very specific policies that negatively affect NGOs that rely on USA funding to provide reproductive health services. The experience of Britain is especially interesting as the country colonised a number of African countries, including South Africa, and left behind a legacy of outdated Common Law which governed abortion legislation. Therefore, the importance of reviewing the legality of abortion legislation in countries neighbouring South Africa is evident, as these countries have the advantage of directly learning from the experiences of South Africa. In addition, women in countries neighbouring South Africa, who have the means to travel, are also afforded the opportunity of obtaining a legal and safe abortion.

### 5.1 Abortion Law in the USA

Prior to 1800, there was no specific legislation relating to abortion in any of the American States. British Common Law, as interpreted by the American Courts, was used to govern the legal status of abortion and it was believed that aborting a "*quickened*"[6] foetus was a crime. The first anti-abortion statutes were passed in the decades prior to the Civil War and focused on the safety of the woman. After the civil war ended, states began to adopt a stricter approach to abortion and the focus shifted to criminal penalties for women having an abortion as well as for the providers of abortion services. This criminal status of abortion was firmly entrenched in all American states by 1900 (Warren 1989).

The lawsuit of *Roe v. Wade* marked the turning point in abortion law in America. Prior to *Roe v. Wade* in 1973, the legality of abortion essentially rested with the legislature of the states. After the Supreme Court decision in 1973, abortion became an issue of federal constitutional law by holding that abortion was a constitutional right (Abortion Law Homepage 1996). The Roe case arose due to Texas law prohibiting legal abortion. At that time several other states had similar laws to the one in Texas. These laws led to many women resorting to illegal abortions; Jane Roe, a 21-year-old pregnant woman, represented women wanting abortions but who could not legally

[6] "Quickening" was defined as the stage when the pregnant woman first felt the baby move, which usually occurred at four to five months.

obtain one because of restrictive laws. Henry Wade was the Texas Attorney General who defended the law that made abortions illegal. The Supreme Court ruled that Americans have the right to privacy, including the woman's right to decide whether to have children or not. Furthermore, the woman and her doctor had the right to decide, without state interference, at least during the first trimester of pregnancy, whether or not she should have an abortion (National Abortion Federation 2004).

The reaction to *Roe v. Wade* was mixed. Supporters of abortion felt that they had won the battle, while those opposed to legal abortion immediately began to work towards preventing federal or state funding of abortion procedures and also attempted to undermine or limit the effect of the Court's ruling. Anti-abortion violence escalated; services at abortion clinics were disrupted; women trying to enter abortion clinics were harassed; access to abortion clinics was blocked; property was vandalised; bombings occurred; and physical attacks and even murder took place (Mkhondo 1998; National Abortion Federation 2004).

While the outcome of *Roe v. Wade* in 1973 was to allow women the freedom to choose during the first trimester - without state interference - to have an abortion, it was not considered how marginalised and low-income women who are dependent on public health care would access the service (Ngwena 2004b). Since this landmark court ruling, the USA Supreme Court has begun to allow numerous restrictions on abortion, which are briefly mentioned below (National Abortion Federation 2004).

- 1976: Congress adopted the first Hyde Amendment, which barred the use of federal Medicaid[7] funds for abortions for low-income women.
- 1977: Revised Hyde Amendment permitting states to deny Medicaid funding of abortion except for rape, incest, or severe and long-lasting damage to the woman's physical health.
- 1984: Mexico City Policy (Global Gag Rule) restricted NGOs in developing countries that received USAID funding from engaging in abortion activities (Crane & Dusenberry 2004).
- 1991: *Rust v. Sullivan* upheld the constitutionality of the Global Gag
- 1992: *Planned Parenthood of South Eastern Pennsylvania v. Casey* reaffirmed the "core" holdings of Roe that women have a right to abortion before foetal viability, but allowed states to restrict access so long as these restrictions did not impose an "undue burden" on women.
- 1994: *Freedom of Access to Clinic Entrances Act* passed by Congress in response to the murder of Dr. David Gunn and forbade the use of "*force, threat of force or physical obstruction*" to prevent someone from providing or receiving reproductive health services.
- 2003: A federal ban on abortion procedures was passed by Congress and signed into law.

[7] Medicaid is a programme that pays for medical assistance for certain individuals and families with low incomes and resources. The programme became law in 1965 and is jointly funded by the federal and state governments to assist states in providing medical long term assistance to people who meet certain eligibility criteria (Centres for Medicare & Medicaid Services 2004).

African countries can learn from the experiences of the USA abortion law reform where judicial reform of abortion law was disembodied from a holistic approach to reproductive health care. Ngwena (2004b: 332) notes that African countries "*cannot afford the luxury of making abortion a private matter and allowing the state to relinquish all responsibility, save the duty not to interfere with the woman's choice*". Legal reform of abortion law will only have a lasting impact on the lives and welfare of women if it is available in the public domain and part of mainstream health care delivery to which all women have access. This is indeed the intention of the South African CTOPA, which promotes reproductive rights and extends freedom of choice by offering every woman the right to choose whether to have an early, safe and legal abortion (within the public sector), which is in accordance with their beliefs.

In addition to learning from the experiences of the USA regarding abortion law reform, the barriers to accessing abortion services in that country are not entirely unique; similar impediments are experienced in South Africa (see Chapter 4). Briefly, some important barriers were noted as:

- Restrictions on funding for abortion services which came into place soon after the *Roe v. Wade* case in 1973. The US Congress has passed various versions of the Hyde Amendment (first adopted in 1976) which prohibits federal Medicaid funding of abortion procedures. The federal government now pays for almost none of the abortions performed in America (Gerber Fried 2000). In South Africa, abortion services in the public sector are available free of charge; therefore, cost of the actual procedure should not be an issue. However, as there are limited facilities offering the service, many women have to travel far distances to access these facilities, which implies that travelling costs may become an impediment to accessing abortion service in the country.
- There has been a decline in the number of abortion service providers in the USA since 1980. Older physicians who provided abortion services retired and few medical students have been trained in abortion techniques to take their place. Furthermore, abortion services are geographically unevenly distributed (Finer & Henshaw 2003; Gerber Fried 2000). Similarly, in South Africa many health care workers do not wish to become involved with the provision of abortion services. In addition, abortion services are mainly available at hospitals, rendering this service largely inaccessible to many women living in rural areas (RRA 2000).
- In 39 of the 52 American states laws are in place to ensure that minors obtain parental consent, or that minors inform their parents of their decision to have an abortion. Although such laws include provisions for judicial bypass, it means that the teenager has to go to court and discuss her personal life and pregnancy in front of strangers (Gerber Fried 2000). The South African CTOPA allows girls younger than18 years of age to access abortion without parental consent. During 2000, this provision of the CTOPA was challenged as it was said that the Act infringed on the constitutional right of every child to family or parental care and to be protected from maltreatment, neglect or degradation. The state responded by filing an

exception and an application to strike the claim on the basis that it did not layout a plan of action, was vague and embarrassing (RRA 2001a). The challenge failed, leaving the provisions of the CTOPA regarding minors and consent intact.

The USA government not only seeks to restrict abortion availability in their own country, but also further a field in countries reliant upon NGOs for reproductive health care that includes abortion.

### 5.1.1 The Global Gag Rule

The American government's negativity and opposition towards reproductive rights has taken on various forms, including refusal to acknowledge the 1994 *ICPD Programme of Action*, de-funding of UNFPA, and the promotion of potentially harmful abstinence-based programmes in the reduction of HIV transmission. At the centre of these attempts to defy internationally recognised reproductive rights agreements stands the Global Gag Rule. The Global Gag Rule was first announced at the 1984 World Population Conference in Mexico by the then president Ronald Reagan, and remained in effect until 1993 when Bill Clinton was elected president. In 1999, the Republican–dominated Congress adopted a version of the Global Gag Rule, which was fully reinstated in 2001 when George W. Bush took office (Crane & Dusenberry 2004). According to the Global Gag Rule, NGOs outside of the USA which offer abortion services, including abortion for rape or incest victims; counselling and referral for abortion; lobbying to make abortion legal in their country; or conducting public information campaigns regarding the benefits and/or availability of abortion as a family planning method, do not qualify for US family planning assistance through USAID or the state department. This is the case even if abortion is legal in the country where the NGO is operational (Smith *et al*. 2002).

Reinstatement of the Global Gag Rule in 2001 meant almost immediate withdrawal of funding for NGOs that refused to accept the conditions of the Rule and included, amongst others, the International Planned Parenthood Federation (IPPF)[8] and Marie Stopes International[9], which between them run family planning clinics in 180 countries. These NGOs report not being able to deliver the best services possible to women in poor countries if they cannot engage in abortion-related activities (*Economist* 2003). Despite this, Crane & Dusenberry (2004) and Maguire (2003) note that the Global Gag Rule has not achieved an overall reduction in abortion rates. Maguire (2003) reports that the Rule has resulted in increased unwanted pregnancies, unsafe abortions,

[8] The IPPF promotes access to quality, sexual and reproductive health information and services. IPPF assists in empowering individuals to make decisions concerning fertility by working through a network of 46 member associations in North America, Latin America and the Caribbean (IPPF 2005).
[9] Marie Stopes International provides sexual and reproduce health and information and services to 4.2 million people worldwide across Africa, Asia, Australia, Europe, Latin America and the Middle East (Marie Stopes International 2005)

deaths and injuries of women and girls. The Global Gag rule in many instances enforces a moral agenda on developing countries, which is in conflict with local laws.

According to Sai (2004), policies of the Bush administration undermine international consensus building processes such as the ICPD and the USA's withdrawal from previously agreed upon international policies and agreements lessen the effects of these processes and provide African and other governments with the opportunity to not to respect them. It is tragic that developing countries with high fertility rates and extreme poverty are denied access to reproductive services (such as contraceptives and post-abortion care) by a policy that is clearly a threat to women's health and a violation of international human rights agreements. The message sent out by the American government is that reproductive health is not a priority – how then should countries in Africa dealing with high incidences of unsafe abortion and a growing HIV/AIDS epidemic respond?

### 5.2 Abortion law in Britain

The influence of British abortion legislation on her former African colonies (i.e. Zambia, Seychelles, Botswana, Ghana, Zimbabwe, Sudan, Uganda, Malawi, Kenya, Sierra Leone, Nigeria, Gambia, South Africa and Mauritius) (Braam & Hessini 2003) was profound and continues today as there has been limited abortion law reform in many of these African countries. While abortion legislation in Britain was liberalised by 1967, it continues to be a far slower process in Africa. These restrictive abortion laws in Africa are a major cause of unsafe abortions.

Prior to 1803, British Common Law allowed abortion before the "*quickening*" (20-24 weeks) when it was believed that the soul entered the body. Although abortions performed after the "quickening" were an offence, there were no fixed penalties. After 1803, a radical change in abortion laws took place and abortion became a criminal offence from the time of conception. Statutory amendments in 1828 and 1837 culminated in Parliament passing the *Offences Against the Person Act* in 1861 (bpas 2005). Section 58 of this Act became the foundation of abortion prohibition in many jurisdictions of the Common Law world, including South Africa where, prior to passing the 1975 *Abortion and Sterilisation Act*, British Common Law served as an unsatisfactory guide for the circumstances permitting abortion. More specifically, Section 58 of the 1861 Act stated that: "*every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whatsoever, with intent to procure the miscarriage of any woman whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable … to be kept in penal servitude for life…* ".

Abortion became a criminal offence punishable by three years to life imprisonment, even if the abortion had been performed for medical reasons. It was only in 1929 that further legal changes to abortion law took place. Two laws were passed in 1929 and 1967 respectively, which were exceptions to the 1861 Act (bpas 2005). The *Infant Life Preservation Act* of 1929 amended the law, stating that it was not a felony if the abortion was conducted for the sole purpose of preserving the mother's life. It was illegal to kill a child "*capable of being born alive*" and the foetus was presumed viable at 28 weeks. It was, however, felt that abortion legislation was still unsatisfactory and in 1936 the Abortion Law Reform Association was established. By 1966 public opinion concerning abortion was that it should be legalised to eradicate the social and medical ills associated with illegal abortions (bpas 2005; Veil Pregnancy Crisis Centre 2005).

Current abortion law in Britain (the 1967 *Abortion Act*) came into effect on 27 April 1968. Abortion is allowed if a registered medical practitioner conducts the abortion in a National Health Service Hospital or in a Department of Health approved location, such as the British Pregnancy Advisory Services Clinics. Two doctors need to certify that (*Abortion Act* 1967):

- The continuance of the pregnancy would involve risk, greater than if it were terminated, of injury to the physical or mental health of the woman or any existing children of her family.
- The termination is necessary to prevent grave permanent injury to the physical or mental health of the woman.
- The continuance of the pregnancy would involve risk to the life of the woman, greater than if the pregnancy were terminated.
- There is substantial risk that if the child were born it would suffer from physical or mental abnormalities as to be seriously handicapped.

Unlike the South African CTOPA, the 1967 *Abortion Act* does not allow for abortion without restriction as to reason. However, whereas the USA government has succeeded in passing legislation, especially concerning funding that limits access to abortion, this has not been the case in Britain. Although the 1967 *Abortion Act* has been subjected to more than 20 attempts to ensure that legal abortion is more difficult to obtain, these have not all succeeded (Douglas 1991). In 1990, the 1967 Act was amended through Section 37 of the *Human Fertilisation and Embryology Act*, and meant that the first reason given "*the continuance of the pregnancy would involve risk, greater than if it were terminated, of injury to the physical or mental health of the woman or any existing children of her family*" had a time limit of 24 weeks imposed (Diamond 2004).

## 6. ABORTION LEGISLATION IN AFRICAN COUNTRIES

### 6.1 History of abortion legislation in Africa

Prior to colonialism, the availability of abortion in Africa was governed by customary law and it was colonisation that introduced a general law on abortion to the continent (Ngwena 2004a). The colonial models may be divided into two broad categories, namely models based on criminal law (France, Belgium and Portugal) and those based on Common Law (Britain and South Africa) (Braam & Hessini 2003).

African countries under French rule adopted abortion laws based on the French Napoleonic Code of 1810 and its successive formulation in French criminal law. While the prohibition of abortion under this model was absolute, it was taken that abortion was legally justifiable if it was done to save the life of the woman. This was, however, not explicitly provided for in French criminal law until 1939 and also was not explicit in pre-independence Anglophone Africa. The French penal codes of 1810 (as amended in 1839) were adopted by the colonies, although some colonies were more orthodox in their interpretation of the law as to whether an abortion should be allowed to save the woman's life (Braam & Hessini 2003).

Countries colonised by Portugal derived their abortion law from Portugal's Criminal Code of 1886 as amended. The Portuguese Criminal Code was strongly influenced by the Napoleonic Code of 1810 and also in part by Spanish Law (Braam & Hessini 2003). In general, abortion was prohibited and no exceptions were provided for. However, it was accepted that an abortion conducted to save a woman's life was a valid defence. Similarly, Belgian colonies adopted the penal code of Belgium, which prohibited abortion absolutely, but tolerated abortions performed to save the life of the woman. The Belgian Code was also based on the Napoleonic Code (Ngwena 2004a).

Abortion law in the British colonies was mainly determined by the *Offences Against the Person Act* of 1861 with the following provisions: it was a crime for a pregnant woman to unlawfully procure a miscarriage; any person who carried out an act with the intent to procure a miscarriage committed a crime; and a person who supplied or procured a substance or instrument, knowing that it would be used to unlawfully obtain a miscarriage, committed a lesser crime. One may surmise that as with the French, Belgian and Portuguese Law, abortions performed to save the life of the women were legal. The matter became clearer with the adoption of the *Infant Life Preservation Act* of 1929, which provided doctors with the discretion to decide when it was necessary to perform an abortion to save the life of the woman. Most African countries under British control adopted similar provisions in their legal systems. A step further was the court decision in *R. v. Bourne*, whereby it was ruled that an abortion was not unlawful according to the

*Offences against the Person Act* if it was done in good faith to preserve the life of the woman or her physical or mental health. Therefore, in one respect Anglophone African countries had a more liberal abortion law at independence than other African countries, as they explicitly acknowledged that an abortion could be performed to save the life of the pregnant woman, as well as leaving the door open for abortions to be performed to preserve the physical and mental health of women. However, as with the laws of other African countries, there were no guidelines for the procedure to be followed when an abortion was legally justifiable (Braam & Hessini 2003, United Nations 2001).

While the colonial powers, except for Portugal, amended their abortion laws in light of the dangers associated with unsafe abortion and in recognition of reproductive rights, many African countries after achieving independence, have been slow to reform their abortion laws[10]. Factors contributing to this slow reform process include: social and economic crises; patriarchal systems; social status of women; cultural and religious beliefs and practices; and a lack of political will. Abortion law reform first occurred in the Anglophone countries[11]. Abortion law reform in Francophone countries[12] was far less comprehensive and did not follow the models of their former colonial rulers. Change has also been slow to occur in countries once controlled by Belgium[13], Portugal[14], Italy[15], Germany[16] and Spain[17] (Braam & Hessini 2003).

## 6.2 Developments in reproductive rights in Africa

African women could benefit greatly from improvements in reproductive-health services mandated by the ICPD. Since 1994 there have been noteworthy developments in abortion care in Africa, ranging from new or expanded post-abortion care (PAC) programmes to significant debates concerning the revision of restrictive abortion laws (Otsea 2004). More specifically, with regard to policy developments:

- In 1997 the WHO Regional Office for Africa (WHO-AFRO) developed the *Reproductive health strategy for the Africa Region 1998-2007*, which was adopted by the African Health Ministers. The intention of the strategy is for AFRO's 46 member states and their partners to develop programme priorities in the reproductive health field.

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[10] Angola, Lesotho, Malawi, Mauritius, Mozambique, Swaziland, Tanzania and Zaire have maintained the same abortion law that was in place on the eve of their independence (Ngwena 2004a).
[11] Zambia, Seychelles, Botswana, Ghana, Zimbabwe, Sudan, Uganda, Malawi, Kenya, Sierra Leone, Nigeria, Gambia and South Africa. Mauritius had a mix of British and French influence, but was governed by Britain at the time of independence.
[12] Tunisia, Algeria, Morocco, Cameroon, Djibouti, Togo, Burkina Faso, Chad, Central African Republic, Egypt, Madagascar, Mali, Mauritania, Senegal, Benin, Burundi and Rwanda.
[13] Democratic Republic of Congo.
[14] Angola, Sao Tome, Principe, Mozambique and Cape Verde.
[15] A portion of Ethiopia, Eritrea, Somalia, Libya, Equatorial Guinea and Liberia.
[16] Namibia and Tanzania.
[17] Equatorial Guinea.

- In March 2003 in Addis Ababa, the landmark conference entitled *Action to reduce maternal mortality in Africa: A regional consultation on unsafe abortion* took place. More than 100 participants from 15 African countries, representing diverse specialities and perspectives including doctors, lawyers, politicians, activists, journalists, religious leaders, youth leaders, etc. came together to openly discuss the toll that unsafe abortion was taking on African women. The focus of the conference was on the actions needed to prevent unsafe abortions from taking place (Brookman-Amissah 2004b). The conference called upon governments to fund programmes addressing unsafe abortion and to review and amend laws in accordance with international agreements (Otsea 2004).
- In July 2003, the Assembly of the African Union approved the *Protocol to the African Charter on Human and People's Rights Relating to the Rights of Women*. The protocol calls for the protection and advancement of reproductive rights for women, including access to abortion for reasons such as sexual assault and incest. All member states were urged to sign and ratify the protocol, which was the first human rights document to formally acknowledge abortion as a reproductive right (African Union in Otsea 2004). A key objective mentioned in this strategy is the reduction of morbidity and mortality resulting from unsafe abortion (WHO Regional Office for Africa in Otsea 2004)

Recent activities undertaken to plan for abortion service delivery in Africa included an international meeting entitled *Expanding access: advancing the role of midlevel providers in menstrual regulation and elective abortion care*, held in South Africa in 2001. Representatives from Kenya, Mozambique, South Africa and Zambia worked together with delegates from six non-African countries to examine the role of midwives in abortion care. A list of key recommendations for involving midlevel providers in abortion care were developed (Ipas in Otsea 2004). In 2002, a first-ever regional conference was held in Senegal and focused on unsafe abortion and PAC in Francophone Africa. Fourteen African countries were represented at the conference and reviewed information regarding the impact of unsafe abortion in their region and strategised to implement PAC programmes. This occasion also saw the launch of the Francophone PAC Initiative which has undertaken PAC programme planning and implementation in seven countries in the region (IntraHealth in Otsea 2004).

Advocacy for access to abortion services has also been widely embarked upon since the ICPD. The African Partnership for Sexual and Reproductive Health and Rights of Women and Girls (Amanitare) initiated a ten year plan (1999-2009) to implement reproductive health and rights strategies in Africa based on recommendations from the ICPD and Beijing Conferences (Amanitare in Otsea 2004). Medical professionals have also taken up the fight to end unsafe abortion. At the biannual meeting of the Confederation of African Medical Associations and Societies in 1997, the focus was exclusively on unsafe abortion and governments were called upon to review and revise existing laws and policies, as well as to train health care providers in

PAC. In addition, the past decade has seen an increase in networks advancing women's reproductive health in Africa. These networks include the IPPF, AFRO, International Projects Advisory Service (Ipas), the Africa Alliance for Women's Health and Rights, and the Regional Prevention of Maternal Mortality Network (Otsea 2004).

### 6.3 Developments in abortion legislation in Africa

There has been a growing response from some African governments to international consensus and pressure to develop or adapt policies geared toward the enhancement of women's well-being and reproductive health. More specifically, some countries have strengthened their commitment to women's rights and bodily integrity. Since 1960, there has been a movement toward abortion law reform. The process commenced in Anglophone Africa and tended to mirror adaptations made by the former colonial powers. For example, in 1972 Zambia adopted one of the most liberal abortion laws in Africa, which was based on the British 1967 *Abortion Act*. The Seychelles later followed suite. Severe restrictions in Botswana, Ghana and Zimbabwe were also relaxed, allowing broader indications for abortion. Additionally, changes occurred in Tunisia (1965), Burkina Faso (1997), and South Africa (1996) (Sai 2004).

Despite the developments in reproductive rights, advocacy for safe abortion and liberalisation of abortion laws internationally, the majority of African countries still have restrictive abortion laws, which contribute to the more than four million unsafe abortions that are conducted annually. Worldwide, approximately 78 000 women die annually as a result of unsafe abortion; 44% of these women are African. The average unsafe abortion ratio in Africa is 110 deaths per 100 000, which is more than twice that of any other region in the world (Ahman & Shah 2002; Braam & Hessini 2003; WHO 1997b).

**Table 6: Estimates of unsafe abortion (2000)[a]**

| | Estimated number of unsafe abortion | Incidence rate (unsafe abortions per 1 000 women age 15-49) | Estimated number of deaths due to unsafe abortion |
|---|---|---|---|
| World | 19 000 000 | 12 | 78 000 |
| More developed regions[b] | 500 000 | 2 | 500 |
| Less developed regions | 18 500 000 | 15 | 77 500 |
| Africa | 4 200 000 | 22 | 34 000 |
| Asia | 10 500 000 | 11 | 38 000 |
| Europe | 500 000 | 3 | 500 |
| Latin America and Caribbean | 3 700 000 | 26 | 5 000 |
| North America | c | c | c |
| Oceania | 30 000 | 15 | 150 |

Source: Ahman & Shah (2002); WHO (1997)
a Figures may not add up to the totals due to rounding.
b Japan, Australia and New Zealand have been excluded from regional estimates, but are included in the total for developed countries.
c For regions where the incidence is negligible no estimates are shown.

Liberalised laws do not necessarily guarantee expanded access for women. Impediments to access such as a shortage of health care providers and refusal of health care providers to perform abortions do not disappear once laws have been liberalised (Sai 2004). This became clear in the Free State study where it was found that six years after the introduction of the CTOPA negative attitudes and hostility towards abortion continued to prevail amongst health care workers. Negative attitudes and hostility impact on service delivery in that there are a limited number of health care workers willing to provide abortion service. Those health care workers who are willing to provide abortion service are stigmatised, while women seeking abortions are also stigmatised and hesitant to request referral to a facility providing such services. In addition, a lack of public awareness about abortion and facilities providing such services also serve to impede access to abortions[18]. Clearly, this is reason for concern, as women in South Africa, despite the introduction of an extremely liberal abortion law in 1996, still encounter impediments in accessing abortion services. This raises the question of the problems encountered by women residing in African countries that have restrictive abortion laws. In this regard, it was deemed appropriate to investigate the stance of abortion legislation in countries neighbouring South Africa in order to determine the possible effects of the CTOPA on other African countries. South Africa and Cape Verde are the only African countries that allow abortion without restriction as to reason.

## 6.4 Abortion legislation in countries neighbouring South Africa

Table 7 briefly summarises the circumstances governing access to abortion in South Africa and her neighbours; however, it should be kept in mind that classifications are influenced by public opinion, views of government officials and providers, as well as individual circumstances.

**Table 7: Grounds for legal abortion in selected African countries**

| | To save the woman's life | To preserve physical health | To preserve mental health | Rape or incest | Foetal impairments | Socio-economic reasons | On request |
|---|---|---|---|---|---|---|---|
| Botswana | √ | √ | √ | √ | | | |
| Lesotho | √ | √ | √ | | | | |
| Mozambique | √ | √ | √ | | | | |
| Namibia | √ | √ | √ | √ | √ | | |
| South Africa | √ | √ | √ | √ | √ | √ | √ |
| Swaziland | √ | √ | √ | | | | |
| Zimbabwe | √ | √ | | √ | √ | | |

Abortion falls under Common Law in both Lesotho and Swaziland, which is based on Roman-Dutch Common Law (also in effect in South Africa prior to the enactment of the 1975 *Abortion and Sterilisation Act*) and prohibits abortion except in case of necessity. The key question is

[18] Impediments to accessing abortion services in the Free State and South Africa as a whole, are discussed in detail in Chapter 4.

under which circumstances can an abortion be considered as a case of necessity? As is to be expected, there is much controversy surrounding the issue. To worsen matters further, neither Lesotho nor Swaziland has case law on the issue of necessity (United Nations 2001). Similarly, in South Africa prior to passing the 1975 *Abortion and Sterilisation Act* in South Africa, British Common Law served as an unsatisfactory guide for the circumstances permitting abortion. Individual interpretations were made as to when an abortion could legally be acquired. Doctors were not legally protected and could be prosecuted and fined if the situation was incorrectly interpreted.

Although the Centre for Reproductive Rights (2004) places Lesotho and Swaziland in the category of countries with the most restrictive abortion laws (i.e. abortion is prohibited altogether, or only allowed to save the life of the woman), information emanating from the United Nations (2001) suggests that the state of abortion law in these countries is not clear. Lesotho and Swaziland could clearly benefit from the experiences of South Africa regarding the development and implementation of the CTOPA, one of the most liberal abortion laws in the world. The Free State study found that women from Lesotho do access abortion services in the province and that women from Lesotho are not denied access to abortion services in the Free State.

Not only Lesotho and Swaziland, but also Mozambique have maintained the same abortion law that was in place on the eve of their independence (Ngwena 2004a). Although the law has remained stagnant in Mozambique (i.e. the equivalent of the Criminal Code of Portugal of 1886, which only permits abortion on the ground of necessity to save the life of the pregnant woman), liberalisation of abortion has been implicitly condoned by the state (Ngwena 2004a) and since the early 1980s abortion on request has been allowed at a number of hospitals throughout the country in an attempt to cope with widespread clandestine abortions and their impact on woman's health (Agadjanian 1998). In essence, Mozambique allows abortion to save the woman's life, and to preserve maternal and foetal health.

In South Africa's other neighbours (i.e. Zimbabwe, Botswana and Namibia) there have been reforms, all to varying degrees. Ngwena (2004a) notes that Zimbabwe is one of the African countries where there has been half-hearted reform of the abortion law. The 1977 Zimbabwean *Termination of Pregnancy Act* was derived from the *Offences Against the Persons Act* and the derivative Common Law. According to the *Termination of Pregnancy Act* of 1977, an abortion may be conducted: if the pregnancy endangers the life of the woman; if the pregnancy represents a serious threat of permanent impairment of her physical health; if there is a severe risk that the child will suffer from a permanent, serious, physical or mental handicap; or if the pregnancy was a result of unlawful intercourse (e.g. rape, incest or intercourse with a mentally handicapped woman/girl) (Centre for Reproductive Law and Policy 1997 & International federation of Women Lawyers; United Nations 2001). The Act is clearly not concerned with abortion as a public health

issue, and much less as an issue of human rights. The restrictive nature of the Act (e.g. the threat to the woman's health must be "serious" and pose "permanent damage") renders health workers afraid to perform abortions even if the legal requirements for abortion are met. Hence the Act has seemingly created the need for unsafe abortions in the country (Ngwena 2004a). A similar situation prevailed in South Africa until the introduction of the CTOPA in 1996/7, whereby abortion became freely available. Prior to the CTOPA, Common Law was reformed in South Africa in 1975 with the passing of the *Abortion and Sterilisation Act*, which proved to be a futile exercise. The 1975 Act, like the 1977 Zimbabwean Act, used rigid language to identify the circumstances under which abortion was allowed and in reality, access to abortion was even more limited under these Acts than had been the case under Common Law.

Namibia inherited South Africa's 1975 *Abortion and Sterilisation Act* at independence in March 1990 (United Nations 2001) and the following requirements need to be met before an abortion is permitted in Namibia: if the continued pregnancy would endanger the life of the woman or if there is a serious risk to her physical health; if the continued pregnancy poses a serious threat to the woman's mental health and could result in permanent damage to her mental health; if there is a serious risk that the child will suffer from a physical or mental defect of such a nature as to be irreparably handicapped or; if the pregnancy is a result of unlawful sexual intercourse (including rape, incest, or intercourse with a mental defective female who does not understand the consequences of intercourse or bear parental responsibility). In addition to the woman's doctor, two other doctors are required to certify the existence of grounds for abortion. The abortion has to be performed by a medical practitioner in a state hospital or an approved medical facility. Any person violating this law is subject to imprisonment for up to five years and/or payment of a fine (*Abortion and Sterilisation Act*, 2 of 1975). Namibia, which for a long period shared the same abortion law with South Africa (i.e. the 1975 *Abortion and Sterilisation Act*), is in a position to benefit from the experiences of South Africa regarding the reform of abortion law and the introduction of a more liberal system.

Botswana is one of the African countries with a more liberal abortion law. The Penal Code of Botswana enacted in 1964 and based on the British *Offences Against Persons Act* of 1861, governed abortion availability until 1991. Following requests from medical professionals during the 1980s, the government re-evaluated the law and drafted a bill which was sent to Parliament during 1990. Despite much opposition to the bill, it was approved by Parliament and signed by the President in October 1991. According to the new law, abortions are permissible under the following provisions: the medical practitioner performing the abortion is satisfied that the pregnancy was a result of rape, defilement or incest; the continued pregnancy involves risk to the life of the woman or injury to her physical or mental health; or there is evidence of substantial risk that the child will suffer from or later develop serious physical or mental abnormalities or diseases so as to be seriously handicapped. The abortion has to be performed during the first 16 weeks of

pregnancy by a registered medical practitioner in a state hospital or registered private hospital or clinic approved for the purpose. In the case of the second and third provisions, two medical practitioners had to approve the abortion in writing (United Nations 2001).

Unlike in South Africa, abortion is not available for social or economic reasons, nor is it available on request in Botswana. Although not as progressive as the South African CTOPA, Botswana has a fairly liberal law governing the provision of abortion. Despite this the United Nations (2001) noted that illegal abortions continue to be a concern in Botswana due to: the lack of clear procedures to be followed in obtaining permission for an abortion; uncooperative doctors; no clear guidelines for determining whether the pregnancy was a result of rape, incest or defilement; no legal guidelines for the treatment of minor's seeking an abortion; too few facilities providing abortion services; shortage of medical practitioners to perform abortions; and difficulties experienced by woman living in rural areas in accessing facilities providing abortion services (United Nations 2001). Note that many of these impediments were also identified in the Free State study (see Chapter 4). Odubeng & Phala (2005) report that despite the fairly liberal law in Botswana, a number of women cross the border into South Africa in order to obtain a legal and safe abortion. The Department of Women's Affairs has requested the law be amended in order to replace the two-physician approval requirement with a one-physician requirement, as well as the improved availability of accessible, safe and adequate facilities (United Nations 2001).

## 7. SUMMARY

Reproductive rights are firmly entrenched in a number of internationally recognised human rights conventions and treatises. Most noteworthy are the *Programme of Action of the ICPD* (1994) and the *Beijing Declaration* (1995) which have tasked member states to ensure that reproductive and sexual rights do not remain abstract concepts, but are effectively implemented (Ngwena 2004a). Five year follow-up reviews of these conferences sought to assess whether member states were keeping to their commitments. The *ICPD+5 Key Actions Document* (paragraph 63(iii)) called for, amongst others, that "*in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible*". It is positive to note that since the ICPD in 1994, 131 countries have changed their national policies or laws to recognise reproductive rights. However, reproductive rights were not afforded the same importance in 2000 when countries came together to identify the MDGs. The UN Secretary General countered this by noting that it would not be possible to achieve the MDGs, especially the eradication of poverty if, amongst others, reproductive health and family planning did not receive the necessary attention. At the World Summit in 2005, world leaders again reaffirmed their commitment to achieving universal access to reproductive health care by 2015.

Many governments have responded to the growing international consensus and pressure for policies focusing on the well-being of women, particularly their reproductive health. There has been a global trend towards the liberalisation of abortion laws in many countries (Ferreira 1985) and at present more than 61% of the world's population reside in countries that permit induced abortion either for a wide range of reasons or without restrictions as to reason, while 26% live in countries where abortions are not generally allowed (Centre for Reproductive Rights 2004).

Of particular relevance is the situation in Africa, and specifically Southern Africa, where many countries have maintained restrictive colonial laws regarding abortion. Most noteworthy is the abortion law reform that occurred in South Africa in 1996 with the passing of the CTOPA, which allows for abortion on request during the first twelve weeks of pregnancy (see Chapter 4 for a detailed discussion of the CTOPA). An important focus of this chapter was to examine abortion law developments in countries that have had an influence on reform in South Africa. In this regard, South Africa and other African countries have had much to learn form the experiences of both the USA and Britain. In particular, while the court case of *Roe v. Wade* liberalised abortion law in the USA, there was no due regard for a holistic approach to reproductive health care. *Roe v. Wade* led to the recognition that abortion is a constitutional right; however, the US congress passed various laws prohibiting federal funding of abortion, thus denying poorer women access to the service. This is a clear indication that liberalising abortion law does not guarantee access to abortion services. Similarly, restrictions have been passed in the USA regarding teenage girls' access to abortion. South Africa has set an example in this regard, whereby the court has upheld the right of minors (i.e. younger than 18 years of age) to access abortion services without the requirement of consent either from parents or guardians.

With the passing of the Global Gag Rule, the USA has had an even greater influence on the provision of reproductive health care in developing countries. The Global Gag Rule prevents NGOs receiving USA funding from engaging in any abortion-related activities, even counselling and the provision of information regarding abortion. This is the case even if the country in which the NGO is operational legally allows abortions to be performed, which is a serious cause for concern, especially in Africa, where unsafe abortion is rife and there is a desperate need for post abortion care.

In addition to the USA, Britain has also had a marked influence on her former colonies regarding their abortion legislation. More specifically, outdated Common Law, as it relates to abortion, was liberalised in Britain by 1967, but is still to a certain degree in place in many African countries. South Africa and Cape Verde are the only two African countries (out of 54) that allow abortion without restriction as to reason. South Africa's neighbours all have more restrictive abortion legislation ranging from: only allowing abortion to save the woman's life (i.e. Lesotho and

Swaziland); in addition to saving the woman's life, also allowing abortion to preserve physical health (i.e. Mozambique and Zimbabwe); and in addition to saving the woman's life and preserving physical health, also allowing abortion to preserve mental health (i.e. Botswana and Namibia).

Despite high numbers of unsafe abortion - an estimated 4.2 million in 2000 (Ahman & Shah 2002) - restrictive abortion legislation prevails in Africa. In 2003, the Assembly of the African Union approved the *Protocol to the African Charter on Human and People's Rights Relating to the Rights of Women*, which calls for the protection and advancement of reproductive rights for women, including access to abortions. In this regard, the experiences of South Africa in terms of the CTOPA could prove valuable to other African countries in their attempt to deal with unsafe abortion and maternal morbidity and mortality. Africa needs to take steps to protect and promote the reproductive health of women and in order to achieve this, governments, NGOs and all relevant stakeholders should commit to ensuring women's health. As noted by Fathalla (in Otsea 2004: 5) "*Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving*". This is particularly evident in that three countries neighbouring on South Africa (i.e. Lesotho, Swaziland and Mozambique) have maintained the colonial laws governing access to abortion. While limited reform has occurred in Zimbabwe, this has not increased access to abortion in the country. Similarly, despite more liberal abortion law reform in Botswana, this has also not increased access to such services. Clearly, the passing of the CTOPA in South Africa, together with commitment on behalf of the ANC government to providing safe and accessible services to all women in the country, should act as an inspiration to her neighbours to reform their abortion laws. Chapter 3 examines in-depth developments in abortion legislation in South Africa, including the influence of British colonial law on the country. This chapter covers the period until the 1994 elections and the move towards liberalising abortion law in the country.

# PART 2: CHAPTER 3
# SOUTH AFRICAN ABORTION LAW: THE PERIOD PRIOR TO THE IMPLEMENTATION OF THE 1996 *CHOICE ON TERMINATION OF PREGNANCY ACT*

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## 1. INTRODUCTION

Prior to the enactment of the 1975 *Abortion and Sterilisation Act*, the first legislation in South Africa pertaining to abortion, British Common Law served as an unsatisfactory guide for circumstances that permit abortion. Individual interpretations were made as to when an abortion could legally be acquired. Doctors were not legally protected and could be prosecuted and fined if the situation was incorrectly interpreted. Amidst confusion, the government's family planning policy clearly encouraged white women to have large families, while black women were urged to make use of long-acting injectable contraceptives. Maternal health services were far from ideal and back-street abortions were widespread. Clearly legislation was needed to guide the availability of abortion services. An all male commission, devoid of female participation, drafted the *Abortion and Sterilisation Bill* which was passed and implemented in 1975. The Act restricted the circumstances under which an abortion could be conducted to such an extent that it was far more difficult to obtain a legal abortion than it had been in the past. Not only were the grounds more restrictive, but cumbersome certification and administration procedures were also introduced. The number of back-street abortions increased and black women, in particular, were in a far more disadvantaged position than their white counterparts. The situation prevailed until the ANC came into power in 1994. The ANC promoted legalisation of abortion even before the 1994 elections and, once voted into government, access to legal abortion formed an integral part of the national health programme.

In this chapter - the first of two - the focus is on sketching a picture of reproductive health care in general with specific attention to abortion in South Africa. The chapter commences with a brief discussion of the situation regarding access to abortion prior to the introduction of the 1975 *Abortion and Sterilisation Act*. It highlights the processes followed, including the establishment of a select committee to investigate abortion law that resulted in the implementation of the 1975 Act. Provisions of the Act, as well as shortcomings thereof (including the increased incidence of backstreet abortions), are noted as factors that contributed toward the need to reform abortion legislation in the country. The chapter also looks at the changing political environment in South Africa, which together with the international focus on reproductive rights and the need to address high rates of unsafe abortions, called for liberalisation of the existing abortion law. The events, commencing with the establishment of an ad hoc parliamentary select committee to investigate the 1975 Act and culminating in the *Choice on Termination of Pregnancy Bill*, are also reviewed.

## 2. THE PROVISION OF REPRODUCTIVE HEALTH CARE PRIOR TO 1975

### 2.1 Family planning under the National Party government

Prior to 1994, South Africa functioned under the political system of apartheid that deeply affected all spheres of life. South Africans were categorised into four racial groups, namely blacks, coloureds, Indians and whites. In addition to this classification was the notion of separate development. The government designated separate residential areas for each race group, and restrictions were introduced on almost every aspect of life, including spatial mobility, employment and education (Kaufman 1998). Health and health care were similarly organised along racial lines and divides.

The Afrikaner–led National Party government - in power from 1948 until 1994 - perpetuated and aggravated racial segregation and discrimination in South Africa (Cooper *et al.* 2004; Pillay 2001; Van Rensburg 2004a). Van Rensburg (2004a) argues that apartheid and racial segregation - as well as the appearance thereof in the health care system - cannot only be ascribed to the actions of the National Party government. From the outset, colonialisation encouraged segregation and inequality among the different racial groups in South Africa. Prior to 1948, there already existed separate health care authorities, hospital wards and clinics for “whites” and “non-whites”, which resulted in inequality in care and access to health services. In 1948, segregation became the official policy of the National Party government and non-white South Africans were denied political, social, economic and health rights.

Prior to 1994, South Africa lacked a comprehensive reproductive health policy. Women’s health mainly comprised of maternal and child health services, which emphasised limiting population growth through the use of contraceptives (Cooper *et al.* 2004). Racist propaganda suggested that while the white population growth rate was stagnant, the black and coloured populations were rapidly increasing, thereby causing an unnecessary burden on the government (Cope 1993; Guttmacher *et al.* 1998, Kaufman 1997; Kunst 1995). Botha, then Minister of Bantu Administration and Development, clearly illustrated the views of government when he asked white South Africans to sacrifice by having “*enough children to ensure* [South Africa’s] *continued existence as a Christian and Western country on the continent of Africa*” (Guttmacher *et al.* 1998; Van der Westhuizen 1995: 62).

During the early 1960s, the government provided substantial funding for both private and public family planning services, and in 1974 the National Family Planning Programme was launched. The programme sought to increase access to contraceptive services in order to lower the population growth rate, especially that of the black population (Department of Welfare and Population Development in Pelser 2004). Black women were strongly encouraged to make use of

long lasting injectable contraceptives, while oral contraceptive pills, a more easily reversible method, were promoted among white women (Kaufman 2000). In 1984, the *Population Development Programme* (PDP) was adopted to drive the family planning programme and encourage socio-economic development. It was hoped that by improving quality of life, the demand for contraceptives would increase and in turn would lower the population growth rate (Pelser 2004).

By 1994, contraceptive services were widely available with more than 65 000 service points throughout South Africa. This was in stark contrast to the availability of other PHC services in the country, which were poorly developed and inaccessible to the majority of the population. In particular, overcrowding, understaffing and a lack of privacy characterised maternal health services (Rees *et al.* in Cooper *et al.* 2004). Vertical family planning programmes also meant that the opportunity was lost to address other health issues and the burden on women's time was multiplied. For example, women had to visit clinics on one day to have their children immunised, and often on another day to obtain their contraceptives. Critical health issues such as STIs were generally not addressed, except in urban areas (Klugman *et al*. 1998). The issue of integrated reproductive health care was raised at the ICPD in 1994, where it was noted that reproductive health care fell within the realm of PHC. The UNFPA (1999) reported that a successful health programme, including reproductive health care, should be integrated under one roof, with a wide range of services available.

## 2.2 The status of black South African women and its impact on family planning

Black South African women, in particular, had limited ability to make reproductive decisions, which was in part due to the apartheid system and aggravated by customary law. Before the ANC-led government came into power in 1994, black women were discriminated against on the basis of race. While apartheid laws impacted negatively on all black South Africans, black women in particular suffered more. South African women generally had little say in politics and government, and apartheid laws did not promote the protection of women's issues and the advancement of reproductive choices (Haroz 1997; Maitse 2001).

The mobility of black South Africans was controlled by pass laws, whereby black persons older than 16 years of age had to have identification papers. Pass distribution was linked to employment, which meant that black men who did contract work in cities were provided with a pass, while their wives and children were not. The *Urban Areas Act* of 1923 also reduced the number of women in the urban workforce by excluding "idle and undesirable" individuals from urban areas. According to the *Group Areas Act* of 1950, blacks were segregated into rural residential areas. Many black South African women remained behind in rural areas and tended to children and crops, while men went to work in the cities. Rural areas lacked adequate resources

such as hospitals and doctors who could have informed women about their reproductive choices. Black women who were able to gain employment in urban areas generally worked as domestic workers for white families. These women were often separated from their families as they resided with their urban employers. Furthermore, blacks received a separate “Bantu Education” that was designed to teach black children skills that would prepare them for menial labour. Families had to pay to educate their children and when money ran out, female children were removed from schools first. Illiteracy among women contributed to their powerlessness and inability to take control of their reproductive lives (Haroz 1997).

Customary or tribal law was legitimised in 1927 by the *Native Administration Act*, and the post-apartheid *Constitution* (1996) permits the right to live by customary law. Marriage, family relations, children, contractual power and property rights are all regulated by customary law. According to the law, women are seen as perpetual minors and wards of their male relations. A father must grant permission before a daughter may marry and her husband must grant permission before she is allowed to work. Due to her minority status, a woman cannot be sued. Under customary law, a woman may not act independent of the direction of a man, and this belief prevents women from making their own reproductive choices (Haroz 1997).

There are three customary laws that are particularly troublesome and may have an impact on women (Haroz 1997):

- Polygamy, which allows males to have more than one wife.
- Women are not allowed to inherit property.
- The system of *Lobola*, which is a “bride price” paid by the husband to the bride’s parents.

Customary law promotes the idea that a woman is the property of a man, which contributes to high levels of violence against women. Women do not have the authority to make decisions, which impacts on their reproductive choices, for example the decision to use contraceptives. It is evident that black women by and large occupy a position associated with severe poverty and oppression. Often black women are the sole breadwinners providing for their families. Should a woman become pregnant, the situation generally implies a loss of employment which is especially distressing considering high unemployment rates. Even if the woman is able to retain her job, another mouth to feed is a drain on the family. Women generally earn far lower salaries than men, making it even more difficult for a single woman to raise children.

Hence, it is argued by Kaufman (1997: 6) that black South African women needed family planning, and so, in fact, disregarded the government’s racial motivation behind the family planning programme: “*Black women assumed management of their fertility because they found themselves in precarious circumstances*”. Black farmlands were depleted and men/husbands left

to perform migrant labour for a minimal wage, thus sending little money back home to their wives/families. Employed black women were easily dismissed once they became pregnant. Therefore, it was not surprising that 15 years after the implementation of the apartheid government's family planning programme in 1974, 44% of African women were using a modern contraceptive method. The total fertility rate dropped from more than six children per woman of reproductive age to approximately 4.6 per woman, the lowest fertility rate in sub-Saharan Africa at that time (Kaufman 2000; Pelser 2004).

Although the national family planning programme definitely had a role to play in the declining rate of fertility amongst African women, one should not ignore the influence of racial domination in the form of homeland policies[19], labour migration and discrimination, all of which placed an enormous burden on the social and economic development of men, women and their families. Women realised that in order to cope both financially and socially, they had to have less children (Kaufman 2000). This had to be achieved despite resistance from partners or family members; therefore, women chose to access government family planning services (Kaufman 1998).

### 2.3 Abortion law prior to 1975

Prior to 1975, abortion was allowed only on extremely restricted grounds. White women had several options available to them when faced with an unwanted pregnancy. Some private practitioners discretely performed a dilation and curettage in their offices, thus "illegally" terminating the pregnancy. In fact, prior to the introduction of the *Abortion and Sterilisation Act* in 1975, these so called "illegal abortions" could be justified by Common Law, which allowed a pregnancy to be terminated if it posed a threat to a woman's mental well-being. Doctors who conducted abortions that went beyond this criterion were taking serious risks as they could be prosecuted or fined. A further option open to white women was to fly to Britain to terminate an unwanted pregnancy, while black and coloured women were generally in low paying and insecure jobs, and not in a position to seek help from private doctors or to fly overseas for an abortion. Therefore, their ability to obtain an abortion was far more limited (Cope 1993; Guttmacher *et al.* 1998).

The numerous barriers and impediments encountered by women seeking legal abortions often encouraged back-street abortions. Less skilled midwives, lay practitioners or non-registered doctors still undergoing medical training were generally approached for help. Many of these practitioners performed abortions even although they did not have adequate technical knowledge or skills to do so. Furthermore, they often did not have access to adequate facilities or sterile instruments. Women also attempted to self-induce abortions by using extremely dangerous

[19] Along with racial segregation and separate development, came the introduction of ten homelands, of which four became independent states and the remaining six were included in the Republic of South Africa, but had self-governing rights (Kaufman 1998).

methods such as inserting knitting needles or pouring detergents into their uteri (Guttmacher *et al.* 1998).

In 1969, the South African Minister of Health refused a request for a commission of enquiry to consider the legalisation of therapeutic abortions in the following circumstances: to preserve the life and health of the pregnant woman; if there was a chance that the child born would be abnormal; and in the cases of rape, incest, or if the woman was not able to understand the consequences of sexual intercourse. Had the Minister of Health agreed to such an enquiry, the burden that obsolete Common Law placed on the health care sector would have been better understood. In fact, in 1970 alone 1 820 septic abortion cases (29.3% of all admissions) were admitted to the gynaecology ward of the Groote Schuur Hospital in Cape Town (Cope 1993).

Clearly there was a need to define and clarify the law concerning abortion. A British Common Law case, *R v. Bourne*, played an important role in the reformation of abortion law in South Africa. In essence, a young girl had been raped and an obstetrician had performed an abortion on the grounds that she would have become a mental wreck if he had allowed the pregnancy to continue to term. By doing so, the defence of therapeutic abortion under British Common Law was expanded to include the protection of the physical or mental well-being of the woman. Further court cases were influenced by the experience of Bourne, including *S v. King* and *S v. Van Druten*, where it was argued that the defence of therapeutic abortion included less serious clinical conditions other than only saving the life of the woman (Ngwena 1998). More specifically, in the case of *S v. King* the court found the South African position on abortion to be unsophisticated in comparison with other countries, while the Van Druten case called for the enactment of abortion legislation (Sarkin 1998).

During the early 1970s, Common Law as it pertained to abortion was described as a minefield by the courts. The cases of *S v. King* and *S v. Van Druten* together with growing pressure from the medical profession encouraged the National Party government to investigate the issue. As throughout patriarchal history, the abortion issue was controlled by men, especially men in the medico-legal fraternity. These male reformists were not too concerned with the issue of back-street abortions, despite the fact that statistics revealed that 1 463 women had been treated for incomplete abortions between 1958 and 1959 at Groote Schuur Hospital, and 302 abortion related deaths had occurred between 1959 and 1964 in Johannesburg alone (Sarkin 1998).

### 2.3.1 The establishment of a select committee to investigate abortion law

In February 1972, Fisher tabled a private member's motion in Parliament which called for an investigation into abortion in South Africa. A year later the *Abortion and Sterilisation Bill* was tabled and was referred to a select committee which was unable to complete the investigation

(Sarkin 1998). A Commission of Enquiry into the *Abortion and Sterilisation Bill* was appointed in 1974 to investigate and report on the law concerning abortion (Ngwena 1998: 5). The commission comprised exclusively of senior, white, male parliamentarians. According to Estrich & Sullivan (in Sarkin 1998: 148): "*The direct impact of abortion restrictions falls exclusively on a class of people that consists entirely of women. Only women get pregnant, only women have abortions. Only women will endure unwanted pregnancies and adverse health consequences if states restrict abortions. Only women will suffer dangerous, illegal abortions where legal ones are unavailable. And only women will bear children if they cannot obtain abortions. Yet every restrictive abortion law has been passed by a legislature in which men constitute a numerical majority. And every restrictive abortion law, by definition, contains an unwritten clause exempting all men from its structures*".

Munnik (in Sarkin 1998: 149), who was to become Minister of Health in 1975, stated: "*… One need not have women on a committee to investigate abortion in order to determine what is right or wrong … if one wanted to abolish capital punishment today, surely one would not appoint a bunch of murderers to go into the matter and to see whether it should be abolished*". This sexist viewpoint was more clearly expressed by McIntosh, the United Party Member of Parliament for Pinetown, Natal (Cope 1993: 84): "*For the first trimester of a woman's pregnancy she is, medically speaking, hormonally drugged. Her hormone level is so high as to make it difficult for her to come to a rational and sensible solution*".

The all male commission drafted a Bill, which provided that an abortion could only be performed by a medical practitioner:

- If the continued pregnancy would endanger the women's life, or posed a serious threat to her physical health (certified in writing by two medical practitioners).
- If there was a substantial risk that the baby would suffer from a physical or mental abnormality and hence be seriously handicapped (certified in writing by two medical practitioners).
- If unlawful carnal intercourse resulted in the conception of the foetus (certified in writing by two medical practitioners and a magistrate).

Given the composition and nature of the Commission investigating the abortion issue, it is not surprising to note the restrictive nature of the Bill. In reality, the more "permissive" Common Law was replaced by a new legislation that would introduce even greater obstacles to women wishing to obtain a legal abortion. The approach followed clearly indicates a disregard for the reproductive health needs and rights of women who were seemingly being classified as inferior by not furnishing them with the opportunity to speak for themselves.

South African medical practitioners supported the *Abortion and Sterilisation Bill* as it suited their own self-centred purposes and reflected their conservative stance. The reaction of the legal profession was less clear, especially in light of concerns raised regarding the increasing incidence of back-street abortions and the lack of input from women regarding the Bill (Sarkin 1998). A further reaction to the Bill was the establishment of South Africa's first abortion lobby groups. The South African Abortion Law Reform Group and the Abortion Reform Action Group (ARAG) were founded during the early 1970s and amalgamated in 1976. Meetings were held with various Members of Parliament during which ARAG provided a petition signed by 1 500 people in favour of legalising abortion. Similarly, 10 000 signatures were collected by a Durban activist group. The Minister of Health refused to acknowledge the petitions, stating that the Abortion Bill was being investigated.

The recommendations of the Commission resulted in the adoption of the *Abortion and Sterilisation Act*, and were (Ngwena 1998): to extend the parameters of the Common Law defence for therapeutic abortion; and to rule out the provision of abortion on demand or on the grounds of social or economic conditions.

## 3. THE *ABORTION AND STERILISATION ACT* OF 1975

The 1975, the *Abortion and Sterilisation Act* was worded in such a way so as to seem as if women seeking abortions had been granted more freedom. In reality the opposite had occurred, as the new law restricted the circumstances under which an abortion could be conducted to such an extent that it was now far more difficult to obtain a legal abortion. According to Hansson & Russel (1993: 501), the new abortion law fell "*between the two extremes of outlawing abortion under all circumstances and permitting abortion on request subject to gestational limits*".

### 3.1 Provisions of the 1975 Act

On 12 March 1975, the *Abortion and Sterilisation Act* became South Africa's first statutory legislature in an area of medicine essential to women[20] (Strauss 1968). The 1975 *Abortion and Sterilisation Act* (2 of 1975) allowed for legal abortion:

- If the continued pregnancy would endanger the life of the pregnant woman or if it posed a serious risk to her physical health.

[20] This was the first legislation on abortion to be introduced in South Africa, except for four sections of the Native Territories Penal Code, 1886, which applied in the Transkei. According to Section 104 of this Act, the causing of the death "of any living child [*sic*] which has not yet proceeded in a living state from the body of its mother' to be punishable, subject to the important proviso 'that no one shall be guilty of [this] offence … who by means employed in good faith for the preservation of the life of the mother of the child, causes the death of any such child before or after its birth' (Strauss 1968: 457).

- If the continued pregnancy posed a serious threat to the pregnant woman's mental health and could result in permanent damage to her mental health.
- If there was a serious risk that the child would suffer from a physical or mental defect of such a nature as to be irreparably handicapped.
- If the pregnancy was a result of unlawful sexual intercourse (including rape, incest, or intercourse with a mental defective female who does not understand the consequences of intercourse or bear parental responsibility).

Furthermore, explicit certification and administration procedures had to be complied with. A doctor had to apply for permission to conduct an abortion and a medical superintendent had to authorise, in writing, that the abortion could be performed. The requirement for authorisation was that all proposed abortions had to be certified by two medical doctors, excluding the doctor who was to perform the abortion. These doctors had to certify that the woman satisfied the grounds for legal abortion. One of the certifying doctors had to have been practising for at least four years. If the grounds for abortion were based on mental health issues, one of the certifying doctors had to be a state employed psychiatrist. Once the abortion had been conducted, the medical superintendent of the facility where it was conducted had to submit details of the abortion, including the name and address of the patient, to the Department of National Health and Population Development (Ngwena 1998). Women not only endured cumbersome certification procedure, but also an invasion of privacy as their names and addresses had to be submitted to the National Department of Health.

The certification procedures for rape cases were equally burdensome. One of the certifying doctors had to be the district surgeon who had examined the women after she had lodged her complaint with the police. The magistrate was required to issue a certificate stating that:

- A complaint had been lodged with the police, or if a complaint had not been lodged, there was a good and acceptable reason why it had not been done.
- He/she was satisfied that unlawful intercourse had taken place (Ngwena 1998).

In reality, the Act disempowered women and seemingly disregarded international developments in the human and reproductive rights fields. Not only was the apparent disregard for the reproductive rights of women evident, but basic human rights were also lacking. Restrictive abortion legislation encouraged unsafe abortion; thus the government was ignoring the right of women to health, reproductive self determination, non-discrimination, information and education.

Women wishing to obtain a legal abortion had to approach mainly male doctors, police officers, state officials and magistrates for permission to have an abortion. The certification requirements and the excessive bureaucracy surrounding the Act were further deterrents. According to

Hansson & Russel (1993), woman had to cope with little or no assistance from the state. Furthermore, the large majority of rape or incest victims lived in socio-economic conditions that limited their chances of obtaining a legal abortion. These women generally had little, if any, education, were economically impoverished and lived in areas with poor medical resources. As many of these women had little education and very limited access to legal or medical advice on abortion, they were unlikely to be aware of the fact that they could apply for a legal abortion. Even if they were aware of their legal options, they were likely to be economically disadvantaged and/or living far from a medical facility that could provide such a service. Furthermore, Ngwena (1998) states that the requirement that four doctors (two certifying doctors, one doctor to perform the procedure and the medical superintendent to authorise the abortion) be involved in the process of gaining permission for the abortion - in a country where the doctor patient ratio was highly unfavourable and at a time that health services were separated along racial lines - ensured that the Act would have the greatest adverse effect on black women.

### 3.2 Shortcomings of the 1975 Act

The 1975 Act did not increase access to safe and legal abortion despite claims by parliamentary advocates that it would. No improvements in reproductive health care for South African women took place. In reality, coercive family planning practices, poor quality of care and a restrictive abortion law forced many women to opt for back-street abortions. Walker & McKenzie (1995) noted that so called "legal abortions" were not necessarily safe, nor did empathetic staff always perform these abortions. Furthermore, pre- and post-abortion counselling was largely absent. The required psychiatric visits were mainly to evaluate the situation and not to provide support or counselling. There was also evidence of a lack of medical attention in certain instances, where women were required to deliver the foetus on their own - after the procedure they developed septicaemia and had to seek help from private doctors or clinics. It was precisely for this reason that women wanted a legal abortion in the first place, i.e. to avoid complications associated with back-street abortions

The annual number of legal abortions performed under the 1975 Act were negligible - 347 in 1980 increasing to 1 479 in 1993 (see Tables 8 and 9) - when considered against the estimated 250 000 illegal or back-street abortions that were performed each year (Right to choose demanded in South Africa 1992). Back-street abortions were conducted approximately one in every two minutes (Walker 1996). The large number of operations conducted to remove residues of pregnancy and the low number of legal abortions performed annually (see Table 8) clearly illustrate the ineffectiveness of the Act. The number of operations conducted to remove residues of pregnancies increased, with some fluctuations, from 29 979 in 1980 (compared to 347 legal abortions for the same time period) to 36 062 in 1986 (compared to 770 legal abortions for the

same time period). Hence the restrictiveness of the 1975 Act was in reality forcing the government to deal with and pay the costs of back-street abortions.

**Table 8: Legal abortions and operations to remove residues**

| | Legal abortions | Operations to remove residues |
|---|---|---|
| 1980 | 347 | 29 979 |
| 1981 | 381 | 33 194 |
| 1982 | 464 | 35 759 |
| 1983 | 474 | 32 839 |
| 1984 | 566 | 29 596 |
| 1985 | 712 | 32 500 |
| 1986 | 770 | 36 062 |
| 1987 | 810 | 35 882 |

Source: Department of National Health and Population Development Annual Reports in Sarkin-Hughes & Sarkin Hughes (1990: 376).

Furthermore, the 1975 Act not only discriminated against women in general, but perpetuated racial and class discrimination (Hansson & Russel 1993). Statistics for 1985 revealed that while 712 legal abortions were performed in South Africa, 609 mainly white South African women travelled to Britain for an abortion during the same period (Bourne in Sarkin-Hughes & Sarkin-Hughes 1990). Mainly white, urban, middle-class women “qualified” for legal abortions under the 1975 Act. An average of 69% of abortions were performed on white women from urban middle class backgrounds over the period 1991 to 1993 (whites comprised 16% of the general population in South Africa) (see Table 9). While more than 44 000 mostly black and poor women, with limited access to family planning services, opted for illegal abortions each year (South African Institute of Race Relations 1996). Therefore, approximately one in ten legal abortions was performed for black for black women from 1991 to 1993 compared to six in ten for white women.

**Table 9: Legal abortions conducted between 1991 and 1993 according to population group**

| | 1991 | | 1992 | | 1993 | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| White | 720 | 70.3 | 1002 | 69.2 | 987 | 66.7 |
| Coloured | 169 | 16.5 | 243 | 16.8 | 259 | 17.5 |
| Asian | 28 | 2.7 | 38 | 2.6 | 42 | 2.8 |
| Black | 107 | 10.4 | 166 | 11.5 | 191 | 12.9 |
| Total | 1 024 | 100 | 1 449 | 100 | 1 479 | 100 |

Source: Statistical Analysis Division of the Department of Health in Du Preez (1997: 87).

In 1994, a study conducted by the MRC at 55 hospitals throughout South Africa estimated that 44 686 women presented annually with incomplete abortions. Furthermore, 12 000 women had moderate-to-severe complications resulting from illegal abortions, and more than 400 died from septic abortions. These abortions either occurred spontaneously or were illegally induced (Guttmacher *et al.* 1998). In all likelihood this was an underestimation of the total number of women who had abortions. For various reasons, not all of the women who experienced complications presented at a hospital. Some women visited private gynaecologists, or general practitioners or clinics; and others, especially poorer women with little access to health services,

died without ever going to a hospital. Dixon-Mueller (1990) and Gready (1996) report that many women who experience infection, heavy bleeding or severe pain are reluctant to go to a clinic or hospital as they were afraid that the health workers will be angry or report them to the police.

A doctor at Baragwanath hospital explained, "*We treat between 15 and 20 cases of induced abortion a day. And we see only a fraction of the number of abortions that take place … They come to the hospital in a shocking state. Some have lost one eighth of their blood. In their insides are pieces of wood, barbed wire, knitting needles or some virulent solution. If we think [the woman] can take it, we perform a D&C operation. And then we probably find a hole in the uterus. She is probably only 17 years old*" (Gready 1996: 336). Back-street abortions are generally conducted under unhygienic conditions and may result in sickness and even death. Methods used by abortionists include inserting a catheter or other sharp instruments into the uterus, and is usually done without anaesthetic or any painkillers. Another method is to inject a poisonous solution into the womb (e.g. Jeyes fluid) which may result in shock or kidney failure. These methods usually result in bleeding and then the abortion. Women who have back-street abortions, as with women who have miscarriages, need to see a doctor so that leftover tissue can be cleaned from the womb. If the tissue is not removed, serious infections can result which may cause permanent damage to the womb and fallopian tubes and lead to infertility. Further problems that can arise include a punctured womb and uncontrollable bleeding (Gready 1996; Maforah *et al.*1997).

A study conducted among women who had undergone a back-street abortion (Maforah *et al.* 1997) revealed that five of the 25 women interviewed had first sought a legal abortion but were refused the service. These women commented that the abortion law, i.e. the *Abortion and Sterilisation Act,* was too restrictive and placed them under an enormous amount of pressure during a time of extreme trauma. In general, problems were intensified by the unsupportive and judgemental attitudes of health care providers. The women sought help from illegal abortionists including doctors, nurses, traditional healers and lay people. In two cases, the women were blindfolded so that they could not see the abortionist. Illegal abortionists did their utmost to ensure that their identities remained a secret. Fees charged by abortionists varied from R30 to R500 for traditional healers and lay persons, while professionals such as doctors and nurses charged as much as R1 000. In spite of their poor socio-economic circumstances, most women paid for the service.

Table 10 reveals that the most commonly accepted reason for permitting a legal abortion was to ensure the mental health of the mother.

**Table 10: The annual number of abortions performed under the 1975 Act, 1988-1993**

| | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 |
|---|---|---|---|---|---|---|
| Physical health of the mother | 116 | 110 | 99 | 81 | 71 | 62 |
| Mental health of the mother | 652 | 430 | 397 | 694 | 1 032 | 1 081 |
| Foetal abnormalities | 245 | 163 | 188 | 193 | 263 | 255 |
| Rape/incest | 33 | 33 | 64 | 50 | 73 | 74 |
| Illegal sexual intercourse | 7 | 6 | 8 | 6 | 10 | 7 |
| Total | 1 053 | 742 | 756 | 1 024 | 1 449 | 1 479 |

Source: Information from the Statistical Analysis Division of the Department of Health 1995 in Du Preez (1997: 86).

The procedure for treating incomplete abortions in public hospitals was to perform a uterine evacuation with sharp curettage under general anaesthesia. Although vacuum aspiration was a far simpler procedure, it was only done at a few of the larger hospitals. Approximately 50% of the gynaecology and obstetrics caseload comprised of incomplete abortion cases. Such cases usually required immediate medical attention, which caused a major drain on limited obstetric and gynaecologic hospital resources. In 1994, the estimated cost of treating incomplete abortions was R18.7 million. Approximately 10-50% of women who opted for an induced abortion eventually came for some form of medical treatment; therefore the R18.7 million was probably an underestimate of the actual cost of treating complications arising from unsafe abortions. It was also found that the procedures followed for treating incomplete abortions were not cost effective, safe or widely accessible (Guttmacher *et al.*1998).

High numbers of back-street abortions, incomplete abortions and deaths due to septic abortions are clear indications that the 1975 Act failed dismally to control access to abortion. In essence, women who were denied access to a legal abortion opted for back-street abortions and all the associated dangers. The government, in turn, had to deal with the complications associated with back-street abortions, which amounted to millions of Rands each year. Clearly attention needed to be given not only to abortion, but also to reproductive health care in general, as family planning policies appeared to be inadequate, thereby fuelling the demand for abortions.

## 4. EVENTS LEADING TO THE *CHOICE ON TERMINATION OF PREGNANCY ACT* OF 1996

### 4.1 A changing political environment

Despite the obvious problems surrounding the abortion issue, the apartheid government stood firm in its position regarding abortion legislation and refused to amend the 1975 Act. In 1990, the Department of Health requested the public to put together submissions regarding the *Abortion and Sterilisation Act*. The request for submissions was curious, as the Minister of Health, Rina Venter, had repeatedly stated that the Act would not be amended. She justified the request by stating that it was an attempt to test the feelings of the public. According to the Minister, although

there were 48 486 responses to the Department of Health's request for submissions, in reality there had only been 2 187 responses comprising of 1 876 letters and memoranda and 311 petitions. The figure of 48 486 had been arrived at by counting all the names listed on the petitions (Green in Sarkin 1998). Furthermore, it was stated that less than one percent of the submissions (therefore less than 500 people) favoured a change in the abortion law. However, it was a known fact that of the groups that had made submissions, many had memberships of more than 300, for example the South African Society of Obstetricians and Gynaecologists had 350 members, ARAG had 400 members and the Civil Rights League also had 400 members. In total there were already more than 1 000 submissions in favour of changing the law. However, no changes were made to the Act (Sarkin 1998). Moreover, an organisation like Carmont Workers Industrial Union, which had more than 55 000 female members, was counted as one unit. Similarly the Afrikaanse Christelike Vroue Federasie which comprised of approximately 2 000 women was also counted as one unit (Kunst 1995).

While still in exile, the ANC fought against the system dominated by colonialism and apartheid, as well as against the suppression of women. Even prior to their election in 1994, the ANC embarked upon fundamental reform which was initially guided by two pre-election documents, the *Reconstruction and Development Programme* (RDP)[21] (1994) and the *National Health Plan for South Africa (1994)*[22]. Particularly noteworthy is the fact that already in the 1994 RDP, the ANC set out to prioritise women and sexual health. Mothers and children were addressed as "maternal and child health" and the right to control over fertility was asserted as "*Every women must have the right to choose whether or not to have an early termination of pregnancy according to her own individual beliefs*" (ANC 1994: paragraph 2.12.6.4). Thus, Adar & Stevens (2000: 412) note that "*the basic components of sexual and reproductive health were policy in South Africa before they were articulated as international policy at the International Conference on Population and Development (ICPD) in Cairo, 1994 and the Fourth World Conference on Women (FWCW) in Beijing, 1995."* The aspiration of the ANC was to create a constitutional democracy based upon equality under the law, and the protection of fundamental rights, freedoms and social justice. *The Abortion and Sterilisation Act* of 1975 was clearly an impediment to their search for egalitarianism, non-sexism and liberalism (Ngwena 1998). Together with the ANC, organisations such as the Congress of South African Trade Unions and the Azanian People's Organisation

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[21] The 1994 RDP, the ANC's election manifesto, sought to combat poverty, reconstruct the economy and envisaged transformation that would "*encourage and develop delivery systems and practices that are in line with international norms and standards; introduce management practices that promote efficient and compassionate delivery of services, and ensure respect for human rights and accountability to users, clients and the public at large" (*Van Rensburg & Pelser 2004: 113).

[22] The *National Health Plan* is an extension of the 1994 RDP, and outlines the broad parameters for reform of the health care system. One of the important principles set out in this plan was that everyone has the right to achieve optimal health and to be treated with dignity and respect. Furthermore, the government should be held responsible for ensuring the health of the people. Amongst others, attention was given to women's maternal health. The plan "*posed a fundamental shift from past policies and practices in health care, especially on grounds of its pronounced emphasis on primary health care (PHC), a single, equitable and integrated NHS [National Health System], the district health system (DHS), and community involvement in health matters*" (Van Rensburg & Pelser 2004 : 116).

supported women's rights to choose abortion. The ANC was in favour of abortion up till the third month of pregnancy and supported access to legal abortions as a central part of their proposed national health programme.

Since 1994, the ANC government has recognised maternal, child and women's health as being a priority, and the Maternal, Child and Woman's Health Directorate was established as a separate directorate in the National Department of Health (Adar & Stevens 2000). The need to provide comprehensive reproductive health services incorporating abortions was also recognised and reflected in the ANC's national health programme. The family planning programme and PDP of the previous dispensation were revisited and revised by the ANC government in order to bring these policies in line with international views on reproductive rights and family planning. In this regard, the ICPD[23] (as discussed in Chapter 2) was a turning point in international debates on population policies. The focus shifted to improving the quality of life of the individual and addressing social development beyond family planning. Therefore, the emphasis was on the advancement of women through increased access to education, health services, skills development and employment, and that family planning should be offered within the context of reproductive health care. The ICPD inspired the ANC government to commit itself to addressing population issues as a fundamental part of the national development strategy, taking into consideration socio-economic, cultural and political conditions in South Africa (Department of Welfare in Pelser 2004).

### 4.2 Establishment of an *ad hoc* parliamentary select committee to investigate the 1975 Act

In 1994, women from all over South Africa came together to compose a policy document for liberalising abortion legislation in the country. During the same year, the Minister of Health set up an *ad hoc* parliamentary select committee to investigate whether or not the 1975 Act was operating satisfactorily (Gready 1996). It can be argued that the appointment of the select committee was merely a gesture, as shortcomings of the 1975 Act were well known. The actual question put to the Committee should rather have been how to reform the 1975 Act (Ngwena 1998).

The Committee conducted public hearings and received written submissions from organisations and members of the public from 9 May 1995 to 8 June 1995. As with other parliamentary hearings, distressingly little input from black South Africans was received. Only ten black women provided oral evidence, of whom eight were pro-choice. However, it should be kept in mind that numerous written submissions were received from individuals and organisations that either

[23] South Africa is not only signatory to the ICPD Programme of Action and to the Beijing Platform of Action, but has also ratified the CEDAW.

worked with or represented black South Africans. The Committee submitted its final report to parliament on 29 June 1995 (O'Sullivan 1996).

Two main opposing opinions emerged. Firstly, the pro-choice position which was argued mainly by ARAG (an umbrella lobby group of secular and humanitarian interest groups), women's organisations (including the Women's Lobby, the Women's National Coalition, the National Council of Women, the Young Women's Network, the Women's Health Project, Black Sash, etc.), and medical and academic institutions (such as the Centre for Health Policy, the Centre for Applied Legal Studies, the Reproductive Health Unit at Baragwanath Hospital, Lawyers for Human Rights, the Planned Parenthood Association, etc.). Secondly, the pro-life position which was argued mainly by a lobby group for religious organisations representing Christians, Hindus and Muslims. Pro-choice was in favour of a radical change from the 1975 Act: abortion on request during the first 14 weeks of pregnancy and from the $14^{th}$ to the $24^{th}$ weeks grounds for abortion should include social or economic reasons. The pro-life group took a more traditional and conservative stand, not only against liberalising abortion law, but also indicated that the 1975 Act should be made even stricter. It was argued that the unborn child should have a legal personality and constitutional rights. A woman should only be allowed to have an abortion if the continued pregnancy could lead to her death (Agenda 1995; Ngwena 1998).

It is extremely crude to divide the opposing arguments into two groups, especially in light of the fact that the terms pro-choice and pro-life are often disputed. While pro-life is generally associated with those persons opposing abortion, there are persons in the pro-choice group who also consider themselves to be pro-life. In this regard, pro-life is understood to mean the quality of life; however, pro-lifers certainly disagree with the statement. It is their opinion that anyone who is in favour of abortion cannot view themselves as being pro-life. Furthermore, it is argued that by not granting life to the foetus, how can one be in favour of quality of life? The pro-choice group acknowledges that abortion is not a pleasant option; however, they are in favour of abortion as a last resort. Therefore, abortion should form part of a comprehensive reproductive health care service (Agenda 1995). For the sake of simplicity, the submissions made to the *ad hoc* committee are categorised into two groups and summarised in Table 11.

**Table 11: Summary of submissions made to the *ad hoc* select parliamentary committee**

| Pro-choice | | Pro-life |
|---|---|---|
| | ***The 1975 Abortion and Sterilisation Act*** | |
| ▪ Discriminates against black women as white women have greater access to abortion services.<br>▪ Encouraged back-street abortions.<br>▪ Was too bureaucratic (e.g. women had to convince more than one doctor that they qualified for an abortion). | | ▪ The 1975 Act was interpreted too liberally (e.g. women may claim to have been raped in order to obtain an abortion) and should even be repealed. |
| | **Legal and policy-related arguments** | |
| ▪ According to Roman Dutch Law, a person only has a legal personality once he/she is born alive. Therefore, the Nasciturus Rule, which allows the foetus inheritance rights, is necessary, as the foetus is not yet a person.<br>▪ Denying women access to legal abortions does not prevent them from obtaining an illegal abortion.<br>▪ Quoted the base document of the RDP (1994). South Africa is signatory to the 1994 ICPD, which acknowledges the rights of couples to decide freely and responsibly on the number, spacing and timing of their children.<br>▪ References to the *Constitution* (1996) which entailed the right to equality, dignity, freedom, privacy, security of person, freedom of conscience, religion and belief. | | ▪ South African law acknowledges that an unborn child has the right to inheritance and damage, therefore the foetus is a person with rights.<br>▪ Referred to the *Constitution* (1996), and more specifically to the right to life, as abortion discriminates against the foetus on the basis of age, place of residence (i.e. the womb), degree of helplessness, whether or not the foetus is wanted and socio-economic circumstances. |
| | **Moral and emotional issues** | |
| ▪ Life begins at birth or at brain birth (i.e. ± 24 weeks) as opposed to death which occurs at brain death.<br>▪ Abortions are unpleasant for all involved, and prevention is better than cure. However, becoming a society in which abortions are not necessary would take time. In the meantime, the state has to provide an alternative.<br>▪ Abortions are dramatic, but the overwhelming emotion experienced after an abortion is one of relief rather than distress.<br>▪ Abandoned babies, disappearance of extended families that in the past acted as a support system, low levels of maintenance payment, lack of safety and security, high teenage pregnancy rate.<br>▪ The poor quality of life of women living in difficult socio-economic circumstances – increase in street children and juvenile delinquency. | | ▪ Life begins at conception (or even before and therefore abortion is murder).<br>▪ The horror involved in the different abortion procedures was spelled out (e.g. dilation and curettage involves cutting the foetus to pieces, suction tears the foetus apart, dilation and evacuation involves tearing off the arms and legs and crushing the head, RU468 involved killing the foetus with pesticides).<br>▪ Abortion condones and encourages immoral behaviour, promiscuity, the breakdown of family and community values and spreads HIV/AIDS.<br>▪ Abortion has an adverse effect on women - post-abortion distress syndrome, increased infertility, depression and breast cancer.<br>▪ Liberalising abortion is a further extension of apartheid policy to limit the growth of the African and coloured population. |
| | **International experiences** | |
| ▪ Quoted European experience - sometimes an initial increase in abortions, but within a few years the numbers fell, especially when liberalisation was complemented by a comprehensive health service. | | ▪ Quoted the USA experience – increase in abortion after laws were liberalised. |

**Table 11 continued.**

| Pro-choice | | Pro-life |
|---|---|---|
| **Gender-related issues** | | |
| ▪ Women should be allowed to choose whether they want to have an abortion or not.<br>▪ Unequal power relations between men and women – women are not always in a position to bargain with their partners concerning the spacing and number of children that they would like to have. | | ▪ What about men's choice – men are involved in the conception and should therefore also have a choice. |
| **Consequences of liberalising abortion** | | |
| ▪ Liberalising abortion law would lead to a decrease in costs – both in terms of human suffering and money. The costs associated with treating complications from back-street abortions are far higher compared to the cost of a safe, early abortion. | | ▪ Liberalisation of abortions would lead to an increase demand for abortions – which in turn would drain the state's resources. Money should rather be spent on educating children. |
| **Reproductive health care** | | |
| ▪ No contraceptive method is completely reliable.<br>▪ Comprehensive reproductive health care services need to be put in place. | | ▪ Reproductive health care, including contraceptive services, is available across the country. |

Sources: Agenda (1995); Bennett (1999); Guttmacher *et al.* (1998), Medical Sex Journal (1996).

### 4.3 Recommendations from the *ad hoc* parliamentary select committee

It was the task of the Committee to consider the viewpoints stated in Table 11 and to make recommendations. It can be deduced that the pro-choice position was preferred, although the Committee unfortunately did not provide justifications for many of their recommendations. The Committee recommended that the *Abortion and Sterilisation Act* of 1975 be replaced by a new Act, incorporating the subsequent provisions (Gready 1996; Ngwena 1998):

- Abortion on request should be available during the first 14 weeks of pregnancy.
- Specific grounds should exist for abortion between the 14th and 24th week.
- Minors should be able to access an abortion without first having to obtain parental consent.
- Non-mandatory counselling should be a part of abortion services.
- Minors should be counselled.
- It is not necessary for a husband to consent to the abortion.
- Minors should seek consent from parents, guardians or trusted friends, this should, however, not be mandatory.
- Health workers should be trained to conduct abortions.
- Health workers who object to abortion for moral reasons should only have to refer women to another health care provider.
- Abortion statistics should be kept, but names and identities of the women should remain confidential.

These recommendations led to the formulation of the *Choice on Termination of Pregnancy Bill*, which should be seen as an important part of a comprehensive reproductive health care package, where reproductive health is defined as: "*a condition in which the reproductive process is accomplished in a state of complete physical, mental and social well-being and is not merely the absence of disease or disorders of the reproductive process. Reproductive health therefore implies that people have the ability to reproduce, to regulate their fertility and to practise and enjoy sexual relationships*" (Fathalla in O'Sullivan 1996: 80).

This area of reproductive health was largely neglected under the National Party Government, where vertical family planning programmes operated to control population growth. Most South Africans were denied access to a wide range of reproductive services. Therefore, legal abortions should be incorporated into an integrated reproductive health care package that includes: family planning counselling, information, education and services; prenatal care; safe delivery; postnatal care; prevention of and treatment for fertility; treatment of reproductive tract infections and STIs; and general education on reproductive health and responsible parenthood. Moreover, the package should not end with the provision of reproductive health care services, but should include the improvement of socio-economic conditions for South African women (O'Sullivan

1996). O'Sullivan's (1996) reference to improving the socio-economic conditions of women appears to be too idealistic given the high levels of poverty and unemployment faced by the overwhelming majority of South African women. Nevertheless it is an ideal to strive towards, and one that the previous government did not pay any heed to.

### 4.4 The *Choice on Termination of Pregnancy Bill*

According to Gevisser (1997), the *Choice on Termination of Pregnancy Bill* was the most contentious piece of legislation to be put before South Africa's first democratic parliament. The Bill was introduced to the National Assembly in August 1995 and passed by an overwhelming majority - 209 votes supporting the Bill, 87 against and 87 abstentions. The ANC maintained a united front with the unqualified support of the Pan Africanist Congress. All other opposition parties opposed the Bill, although reasons varied. The African Democratic Christian Party and the Freedom Front were unwavering and adopted an extremist approach based on the sanctity of human life and rejected the Bill in its entirety, stating that it was permissive, irreligious and irreverent of human life. The Democratic Party, Inkatha Freedom Party and the National Party took a more open-minded and appeasing approach, giving the Bill qualified support and wanting certain amendments to the provisions which they regarded as being too permissive (Ngwena 1998).

Political parties were concerned with the following provisions of the *Choice on Termination of Pregnancy Bill*:

- Abortion on request during the first 14 weeks.
- Allowing midwives to perform abortions.
- Allowing minors to have an abortion without parental consent.
- Forcing an unwilling medical practitioner to refer a woman to another practitioner willing to perform the abortion.

The Democratic Party and the National Party were in favour of abortion on request until the twelfth week of pregnancy; only medical practitioners to perform abortions; and parents to be consulted when minors request an abortion. The government insisted that midwives also be allowed to perform abortions and that minors did not need to consult their parents. It was, however, agreed to amend the Bill and reduce the upper limit for abortions on request to twelve weeks. Furthermore, the conscientious objection clause was amended so that medical practitioners only had to inform the woman of her legal rights and not necessarily refer her to another practitioner. Much political bargaining and compromise took place before the final Bill was available. The Bill was passed in the Senate (now the National Council of Provinces) with a large majority - 49 votes in favour of the Bill and 21 against it. The government again had the

unqualified support of the Pan Africanist Congress. Dissent came from the National Party, Freedom Front and Inkatha Freedom Party. In November 1996 the Bill received assent (Ngwena 1998).

It is of concern to note that, while the ruling party bargained and compromised with opposition parties, within their own ranks they did not tolerate open dissent. The ANC parliamentary caucus did not allow its members to have a free vote. The reason for this appears to have been a desire to maintain the image of a united front rather than the fear of losing the vote (Gevisser 1997; Ngwena 1998). A free vote would have permitted Members of Parliament to vote according to their conscience, which would have been an important consideration as abortion is a morally controversial subject. Clearly there is a clash between the cultural/religious beliefs of many South Africans and the legalisation of abortion, especially abortion on request.

Christian groups severely criticised the ANC for not allowing a free vote of individual members who did not agree with the Party's position on TOP legislation. More than 60 ANC party members, who apparently were opposed to the Bill, stayed away from the National Assembly on the day of the vote (Nyberg 1997). The ANC instructed its members to vote for the Bill with the threat of disciplinary action if they did not (Lee 1996). All opposition parties other than the small Democratic Party and the Pan Africanist Congress voted against the Bill (Nyberg 1997). The Catholic Church warned members that involvement in TOP would result in excommunication and Islamic groups warned Moslems that if they supported TOP, their names would be forwarded to religious leaders in the Middle East (Lee 1996).

## 5. VIEWS OF OTHER INTEREST GROUPS TOWARDS ABORTION AND THE *CHOICE ON TERMINATION OF PREGNANCY BILL*

According to research published in 1980 and 1990 concerning gynaecologists' attitudes towards the *Abortion and Sterilisation Act* of 1975, it can be deduced that these specialists were against abortion on request but agreed that the grounds for legal abortions under certain conditions should be extended (Dommisse in Le Roux & Botha 1995). The 1980 investigation revealed that 32% of the respondents were in favour of abortion on request during the first twelve weeks of pregnancy, and 82% agreed that current abortion law should be adapted or changed so that provision could be made, amongst others, for girls under 14 years of age. In 1990, 40% of the respondents indicated that they supported abortion on request, while 85% of the respondents wanted the law to be adapted. Furthermore, 95% of the respondents did not agree with abortion on request during the first twelve weeks of pregnancy.

A similar study conducted in 1991 by the Association of Psychiatrists in South Africa revealed that approximately 51% of the respondents did not agree with abortion on request during the first

twelve weeks of pregnancy and 89% indicated that the 1975 Act should be adapted (Nash *et al.* in Le Roux & Botha 1995). It is possible that more psychiatrists than gynaecologists supported abortion on request as those persons less involved with the actual abortion procedure are less negative towards it.

The results of the above two studies were compared by Christianson & Christianson (1996) to the results of their study conducted among 25 geneticists to ascertain their attitudes towards the 1975 Act. It was found that all three specialist groups (gynaecologists, psychiatrists and geneticists) supported an increase in indications for legal terminations of pregnancy rather than the introduction of TOP on request up until a specific gestational age.

Furthermore, a study conducted during 1991-1992 (Walker 1996: 51-53) amongst 27 African primary health care nurses working in Soweto clinics revealed that 70% expressed strong opposition to abortion, which took the form of angry, hostile and judgmental responses to women with unwanted pregnancies. Hostility was directed at the women requesting the abortion and not at the men who had gotten them into the situation: "*Women who are having abortions are killers. You are a killer. You are killing the child*". The nurses were of the opinion that the women had been irresponsible, careless and even promiscuous: "*Some women just come in and cry and tell you their story, but there's no reason to have an abortion. Family planning must be upheld. Women have these problems because of promiscuity. You find a woman has got four children. When you ask the reason you find she jumps from man to man*". The nurses felt that there was no situation that justified women having abortions: "*If anybody applies pressure to me I tell them that a health centre was never meant to do anything like this. I say to them, if you don't want babies then you must use contraception. I say wait until you have delivered this one, then go for family planning*". Furthermore, the nurses indicated that they mistrusted women who told them that contraceptives had failed and that they had subsequently fallen pregnant. "*These women who want abortions are not telling you the truth. They just say they were using contraception to get you on their side*".

A study conducted amongst final year social work students shortly before the introduction of the new Act found that over half of the respondents (54.4%) were in favour of abortion on demand (Van Rooyen 1998). Doctors working in a community hospital in KwaZulu-Natal raised objections to the *Choice on Termination of Pregnancy Bill*. They indicated that abortion on demand was a violation of not only the sanctity of human life but also of their moral and professional responsibility to preserve life. According to these doctors, the Bill is simplistic as it gives doctors, midwives and social workers wide-ranging powers of decision-making. Health care providers are expected to make decisions about the mental, physical and social conditions of their patients without any such specialised training. Furthermore, the fact that doctors would be forced to perform abortions on the advice of paramedical professionals impinges on their professional

independence. There is also no clarity about the nature of risk to the mother or of the degree of abnormality of foetus required for an abortion to be done. It was felt that the Bill allowed for secrecy between parents and children and between husbands and wives, thereby undermining the family as a social institution (Hardy *et al.*1996).

It is evident that vastly differing opinions regarding abortion existed amongst health care providers and social workers prior to the introduction of the 1996 CTOPA. While some health care providers agreed that the grounds provided for under the *Abortion and Sterilisation Act* of 1975 should be extended, others went as far as to say that abortion on demand should be available. These differences of opinion could potentially play a role in the liberalisation of abortion law, in its eventual implementation, and could even impede access to abortion services in the long run.

## 6. ADVANTAGES AND DISADVANTAGES OF LEGALISING ABORTION

Ferreira (1985) summarises the advantages and disadvantages of legalising abortion:

Advantages:

- Reduction in illegal abortion, with a concomitant positive impact on maternal health and a reduction in pressure on medical resources needed to treat complications resulting from illegal abortions.
- Hygienic environments, as trained personnel in clinical settings conduct legal abortions.
- Back-up if contraceptives fail or if contraceptives were not used. The credibility of contraceptive use is promoted and reinforced, and in turn reduces the need for abortions.
- High risk groups such as adolescents are offered a legal way out of a difficult situation when faced with an unwanted or unplanned pregnancy, which has social implications such as schooling does not need to be interrupted, forced marriages can be prevented, etc.
- High risk pregnancies – lack of contraceptive use or failure of the method, pregnancy after 35 years of age, where there are already four children, and pregnancies that are spaced less than two years apart - can be avoided.
- The experience of a legal abortion is likely to be less traumatic than an illegal abortion, which is generally perceived as unsafe.
- Facilities are available to all women, not only the affluent.
- Allow women to avert unwanted births and to achieve the family size that they desire.
- Provides an opportunity for post-abortion contraceptive education and service.

Disadvantages:

- Providers and promoters of abortion services are likely to be the targets of criticism.

- Churches and other religious organisations are likely to provide much opposition to legal abortion.
- Costly service to provide.
- Not all medical professionals will be willing to provide TOP services, and some medical facilities may refuse to allow abortions to be conducted.
- An abortion “mentality” may arise amongst health personnel providing this service.

## 7. SUMMARY

Prior to 1994, South Africa functioned under a political system of apartheid, and racial segregation manifested everywhere, including in the health care system. These racial divides can be traced back to colonialism, which too encouraged segregation and inequality among different race groups. It was, however, only after the 1948 election of the National Party Government that segregation became official policy. During this period, South Africa lacked a comprehensive reproductive health policy. Concerns surrounding the increasing black and coloured population and stagnating white population led to the introduction of the National Family Planning Programme and the adoption of the PDP, the goal of which was to lower the population growth rate of the black and coloured population groups. While family planning services became widely available, other PHC services remained poorly developed and largely inaccessible.

Black South African women were in a particularly precarious position: not only were they discriminated against on the basis of the colour of their skin, but customary law also placed them in an inferior position and, in essence, allowed black women to be viewed as the property of their male counterparts. Black women by and large occupied a position associated with severe poverty and oppression. Social and legal conditions in the country (e.g. extreme poverty, and legislation such as the Urban Areas Act of 1923, the Group Areas Act of 1950 and the homeland policies) forced black women to accept and use the government’s family planning services (despite the racial motivation behind the family planning programme), as one more mouth to feed was in many cases not an option.

Before 1975, abortion law was governed by British Common Law with unclear provisions as to when an abortion could legally be performed. This uncertainty led to the establishment of an all white male committee to investigate the stance of abortion law in South Africa. In 1975, the *Abortion and Sterilisation Act* was passed, which to a large degree disempowered women and disregarded international developments in the human and reproductive rights fields. The 1975 Act did not increase access to safe and legal abortions, despite claims that it would do so. The number of legal abortions performed under the 1975 Act were negligible when considering that an estimated 250 000 illegal or back-street abortions were performed each year. Furthermore, the 1975 Act not only discriminated against women in general, but more specifically, it perpetuated

racial and class discrimination. Hence the only option available to many women was to have a back-street abortion and often suffer the horrific consequences thereof. The high numbers of back-street abortions, incomplete abortions and deaths due to septic abortions were a clear indication that the 1975 Act failed dismally to control access to abortion in the country. In reality, access was only being controlled regarding safe abortion procedures.

Despite the problems surrounding the abortion issue, the apartheid government refused to amend the 1975 Act. In contrast, the ANC, even while in exile, fought against the system dominated by colonialism and apartheid, as well as against the suppression of women. The RDP (1994) and the *National Health Plan for South Africa (1994)* served as initial guidelines for reform in South Africa. Among others, the ANC sought to create a constitutional democracy based upon equality under the law, and the protection of fundamental rights, freedoms and social justice. The 1975 Act was clearly an impediment to this aim.

The need to provide comprehensive reproductive health services that incorporate abortions was recognised by the ANC and reflected in their national health programme. The process leading to abortion law reform was complex, with many role players, such as researchers, activists, community leaders, political representatives and religious leaders contributing toward change. In 1994, women from all over South Africa came together to compose a policy document for liberalising abortion legislation in the country. An *ad hoc* parliamentary select committee was established to investigate whether or not the 1975 Act was operating satisfactorily and ultimately recommended that it be replaced by a new Act, hence the formulation of the *Choice on Termination of Pregnancy Bill*. Attitudes toward the Bill differed vastly. While some health care providers agreed that the grounds provided for under the *Abortion and Sterilisation Act* of 1975 should be extended, others went as far as saying that abortion on demand should be available. These differences of opinion could potentially play a role in the liberalisation of abortion law, in its eventual implementation, and could even impede access to abortion services in the long run.

While the advantages of liberalising abortion law (e.g. reduction in illegal abortion, provision of safe abortions, opportunity to promote contraceptive use, the service is available to all women, etc.) are numerous, one should not loose sight of the disadvantages. Clearly not all health workers will be willing to provide abortion services; health workers conducting abortion may become targets of criticism and violence; abortion is a fairly costly service; and much resistance, especially from churches and other religious organisations, is likely to prevail.

Chapter 4 discusses in detail the implementation and operation of the CTOPA, which seeks to guarantee reproductive rights for all women in South Africa. Attention is paid to the events that span the first seven years following implementation of the CTOPA with a focus on the success and challenges that were experienced.

# PART 2: CHAPTER 4

# THE *CHOICE ON TERMINATION OF PREGNANCY ACT* (1996): IMPLEMENTATION AND TRENDS, ACHIEVEMENTS AND CHALLENGES

## 1. INTRODUCTION

Despite much opposition from, amongst others, political parties and religious groups, the CTOPA was passed on 31 October 1996. It took effect on 1 February 1997 and replaced the restrictive provisions of the 1975 *Abortion and Sterilisation Act* (discussed in Chapter 3) by offering every women the right to choose to have a safe and legal TOP according to their individual beliefs. The CTOPA marked the beginning of a new era in abortion legislation and indeed in reproductive health care in South Africa. The right to reproductive health care is an internationally recognised human right and should be secured through legislation. The *Constitution* (1996) provides a broad framework for the protection and promotion of reproductive rights and health, especially Sections 12(2) (a) and (b), and Section 27(1) (a). According to these provisions, all South Africans have the right to make reproductive decisions, the right to security in and control over their bodies and should have access to reproductive health care services. The *Constitution* (1996) also provides all South Africans with a substantive right to equality, which helps to secure equal access to reproductive health care services.

The introduction of the CTOPA occurred amidst much health and health policy reform in South Africa that aimed to ensure access to health care, including reproductive health care. Van Rensburg & Pelser (2004) note that the *White Paper for the Transformation of the Health System in South Africa* (1997) provided the main thrust for health reform following the democratisation of the country in 1994. The *White Paper* (1997) set out an approach to developing a comprehensive PHC system[24] and built on the 1994 RDP and *National Health Plan for South Africa*. A wide range of policy measures – unifying health services, decentralising health services, making PHC available to all South Africans, effective referral systems, linking primary, secondary and tertiary levels of care[25], involving communities in health matters, ensuring the availability of essential drugs, giving special attention to the most needy (e.g. the poor, women and children), and developing a national health information system - are noted in the *White Paper* (1997) as fundamental issues to transform health care in the country. In addition, the *White Paper*

[24] The WHO (in Van Rensburg 2004b: 413) defines the main aim of PHC as "*essential health care universally accessible to individuals and families in the community in an acceptable and affordable way and with their full participation*". Comprehensive PHC is only possible when vertical programmes are integrated into a health systems approach and requires collaboration with sectors outside of the health sphere.

[25] The primary level of care is the entry level into the public health system and is offered at mobile, satellite and fixed clinics, as well as at CHCs and district hospitals. The secondary level of care provides for those with more complicated health conditions that cannot be treated at district hospitals and patients need to be referred to regional hospitals with an appropriately staffed intensive care unit and 24 hour casualty service. The tertiary level of care is provided by specialists operating in tertiary or academic hospitals (Van Zyl in Van Rensburg 2004b).

acknowledges the RDP's focus on women, as well as human resource development, educational status and ultimate improvement in health (Department of Health 1997a). Further important policies include the *White Paper on Transforming Public Service Delivery* - also known as *Batho Pele* (1997) - and the *Patients' Rights Charter* (1999).The *Batho Pele* document should be read alongside the 1997 *White Paper for the Transformation of the Health System in South Africa* and focuses on improving service delivery, by, amongst others, putting the public's needs first. The *Patients' Rights Charter*, on the other hand, seeks to guarantee the realisation of patients' constitutional rights of access to health care services, thereby ensuring that patients receive quality care (Van Rensburg & Pelser 2004). The right to health is an important human right and depends on the availability, accessibility and quality of health services (CESRC, article 12, 2000). As such, the above mentioned legislation is pivotal for the promotion of reproductive health care in that it seeks to address deficiencies and inequities in the health care system, thereby opening the door to health for all South Africans.

While such legislation laid the ground work for accessible and quality health care, the passing of the CTOPA was more in line with the government's strategy to revisit previous policies relating to family planning and population issues. In part, the ICDP (discussed in Chapter 2) motivated the ANC to address population and reproductive health issues, while taking into consideration the socio-economic, cultural and political conditions in South Africa. A draft *White Paper for a Population Policy* was first published in 1996 and was based on the RDP and *ICPD Programme of Action*. The *White Paper on Population Policy for South Africa* was endorsed by parliament in April 1988. The policy identified various concerns in the field of sexual and reproductive health (including maternal mortality and high teenage birth rates) which needed to be addressed in order to improve the quality of life of South Africans. It was noted that by improving the quality, accessibility, availability and affordability of PHC services, including reproductive health care (e.g. family planning), concerns such as maternal mortality and unwanted pregnancies could be dealt with. Furthermore, by promoting responsible sexual and reproductive behaviour, the incidence of teenage pregnancies, abortion and STIs could be reduced (Department of Welfare & Population Development in Pelser 2004). The policy acknowledges the interrelated nature of poverty, gender equality/empowerment of women, health, environment and development (Pelser 2004).

Adar & Stevens (2000) note that, despite the transformation of the health system in South Africa and the introduction of various new policies (such as the 1996 CTOPA), reform is taking place slowly and policies are not implemented uniformly throughout the country. Therefore, the quality of health services for women remains compromised. More specifically with regard to TOP, too few facilities provide the service; many health workers do not wish to become involved with TOP; and negative attitudes toward abortion flourish, this despite the ideology surrounding the CTOPA. These and numerous related impediments ensure that access to TOP services is not always smooth or easy. Nevertheless, the Department of Health attempts to deal with these impediments

by promoting values clarification workshops; making training available for doctors and midwives; and creating opportunities for stakeholders to share experiences and ideas regarding the successful operation of the CTOPA.

Chapter 4 builds on and is an extension of Chapter 3 and considers in detail the CTOPA of 1996 within a reproductive rights context; the provisions thereof; key concepts and functions; important events during the first seven years of operation; and achievements and challenges faced in successfully implementing and operating the CTOPA.

## 2. THE *CHOICE ON TERMINATION OF PREGNANCY ACT* OF 1996

### 2.1 Provisions of the 1996 CTOPA

The CTOPA was passed on 31 October 1996 in parliament and took effect on 1 February 1997 to allow time to prepare the health system and train health workers to provide TOP services (Mhlanga 2003; Stuurman-Moleleki *et al*. 1997). The CTOPA was not the result of hurried or unconsidered actions on the part of government, but rather a culmination of political ideology based on equality, equity and non-discrimination (De Pinho & Hoffman, 1998) and the outcome is that South Africa now has one of the most liberal abortion laws in the world (Althaus 2000).

The aim of the CTOPA is to ensure safe, hygienic and accessible abortions for all women in South Africa (De Pinho & Hoffman 1998). The CTOPA is based on the 1996 *Constitution* and the objectives thereof can be summarised as follows (*Choice on Termination of Pregnancy Act*, 92 of 1996):

- To recognise that the *Constitution* (1996) protects the rights of persons to make decisions concerning reproduction and to security in and control over their bodies.
- To acknowledge that both women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and that women have the right of access to appropriate health care services to ensure future safe pregnancy and childbirth.
- To recognise that the decision to have children is fundamental to a woman's physical, psychological and social health and that universal access to reproductive health care services includes family planning and contraception, TOP, as well as sexuality education and counselling programmes and services.
- To acknowledge that the state has the responsibility to provide reproductive health care to all citizens and also to provide safe conditions under which the right of choice can be exercised without fear or harm.

- To provide for legal TOP in a context that recognises the value of human dignity, achievement of equality, security of the person, non-racialism and non-sexism, and the achievement of human values and freedoms which underlie a democratic South Africa.
- To provide for TOP not as a discrete contraceptive service or a form of population control, but as part of broader reproductive health services.
- To dispense with the restrictive provisions of the 1975 Act, promote reproductive rights and extend freedom of choice by offering every woman the right to choose whether to have an early, safe and legal TOP according to her individual beliefs.

The objectives of the CTOPA capture the values expressed in the *Programme of Action of the ICPD* (1994) and the *Beijing Platform of Action* (1995). In essence, women should not be discriminated against on the basis of gender, race, religion or culture. Furthermore, women have the right to make their own reproductive health decisions concerning the timing, spacing and number of children (if any) that they wish to have. In this regard, the state is responsible for safe, effective, affordable and acceptable reproductive health care, which holistically incorporates TOP. The CTOPA allows for abortion on request during the **first twelve weeks of pregnancy**. During this period, the woman does not need to provide any reason(s) for wanting the abortion. A medical practitioner or midwife[26] who has undergone the prescribed training may perform the abortion. The woman has the right to: control over her pregnancy; equality; human dignity; bodily and psychological integrity; privacy; and freedom of religion, belief and opinion (Ngwena 1998). The CTOPA places no limit on abortion during the first-trimester and thereby insinuates that the unborn child's claim to life is less important than the rights of the pregnant woman.

Abortion from **week 13 to 20** of the pregnancy is permitted when the doctor, in consultation with the pregnant woman, agrees that one of the following conditions is met (*Choice on Termination of Pregnancy Act*, 92 of 1996):

- If the pregnancy is not terminated, the woman's physical or mental health would be at risk.
- There is a substantial risk that the foetus may suffer from a severe physical or mental abnormality.
- The pregnancy is a result of rape or incest.
- If the pregnancy continues, the social or economic circumstances of the woman would be significantly affected.

These requirements for abortion from weeks 13 to 20 differ significantly from the requirements of the 1975 Act. The CTOPA requires only one doctor for the certification process, whereas four

[26] In the past, only medical practitioners were permitted to perform abortions. However, it was aimed to improve access to abortion services by allowing midwives to render such services.

doctors (one of whom had to sometimes be a specialist, i.e. state employed psychiatrist, district surgeon and medical superintendents) were required under the 1975 Act.

Abortion is also available after the **20th week** of pregnancy and up to term if the doctor, in consultation with another medical practitioner or midwife, agrees that the continued pregnancy would (*Choice on Termination of Pregnancy Act*, 92 of 1996):

- Endanger the life of the woman.
- Result in severe malformation of the foetus.
- Pose a risk of injury to the foetus.

The CTOPA introduced a new era in abortion legislation and is a major step toward the realisation of reproductive rights for women. The 1975 Act was severely restrictive and only allowed for abortion to be conducted if the continued pregnancy would endanger the physical well-being or mental health of the woman; if the child would be physically or mentally handicapped; or if the pregnancy was the result of unlawful intercourse. In contrast, the CTOPA is extremely liberal, allowing for abortion on request before twelve weeks. Furthermore, abortion is also available from form weeks 13 to 20 for reasons similar to those stated under the 1975 Act, but also including socio-economic reasons, rendering a refusal for a legal abortion between weeks 13 to 20 virtually impossible, especially as only one doctor has to certify that the abortion is advisable. The extremely rigid certification procedures associated with the 1975 Act was also done away with by the CTOPA. Furthermore (and on a highly contentious note), minors are now able to obtain an abortion without parental consent. Finally, trained midwives are now permitted to conduct abortions in order to render abortion services more widely available and cost effective due to the limited number of doctors and costs associated with professional medical care.

### 2.2 Key elements of the CTOPA

Some of the main characteristics of the CTOPA, including pre-and post-counselling; minors access to TOP services; designated TOP facilities; notification of TOPs; midwifery training; duties of health workers, including conscientious objection; and offences and penalties need to be explored in more detail.

#### 2.2.1 Counselling

According to the CTOPA, the state should promote non-mandatory and non-directive counselling before and after the abortion. Thus counselling should be offered to the client and not imposed or made a prerequisite for the abortion service. Counselling should protect the autonomy of the client and as far as possible be free from the personal values of the counsellor. Section 4 of the

CTOPA indicates that counselling should include sufficient information to help women make an informed choice regarding TOP. During counselling, women should be informed of: alternatives to TOP[27]; the TOP procedure and associated risks (e.g. fever, chills, abdominal pain or cramping, backache, prolonged or heavy bleeding, foul smelling vaginal discharge, or a delay in the return of menses); and the use of contraceptives to prevent future pregnancies. Furthermore, counselling should always be kept private and confidential, unless the woman chooses to disclose the nature of the counselling to others (Department of Health 1997b).

The decision to terminate a pregnancy is usually made in secret. Adanlawo (1998) found in his study amongst 400 women attending a TOP clinic at King Edward VIII Hospital, KwaZulu-Natal, that 33% of the respondents did not inform family or confidants of their pregnancy or that they wanted to have an abortion. Reasons for the lack of disclosure include a wide variety of emotions ranging from guilt to sadness and relief. Stigmatisation of women wanting to have an abortion by family, friends and even health workers is not uncommon. Stigma is indicative of a break between an individual's virtual and actual social identity and results in a tainted self concept. Individuals who feel stigmatised may have a low self-esteem (Cockerham 2004) and may have a strong need for psychological support.

The need for pre- and post[28]-abortion counselling is evident. The location of counselling services; timing of counselling; type of counsellor; and nature and content of counselling all influence whether or not a TOP client makes use of counselling services, especially post-counselling services. Given the importance of providing information (e.g. alternatives to TOP, risks involved, use of contraceptives, etc.) to TOP clients, every effort and opportunity should be taken to discuss necessary information even if it is not done during formal counselling sessions.

### 2.2.2 Minors

The CTOPA allows for minors[29] to request an abortion without the consent of their legal guardian. The doctor or midwife is obliged to advise the minor to consult with a parent, guardian or family member; however, the minor may choose not to do so. Thus far young women represent a relatively small percentage of TOP clients compared to other age groups. During the first four

[27] According to Adanlawo (1998), less than one percent of women change their minds about having an abortion.

[28] A key element of post-abortion counselling is family planning and the provision of contraceptives. According to the WHO, quality post-abortion counselling can help avoid further unwanted pregnancies and unsafe abortions and in turn lower the number of maternal deaths. In reality, often post-abortion family planning is not offered to patients. A study amongst 29 women who had undergone an abortion in Ghana revealed that 25 of these women were not told that they could become pregnant as soon as they resumed sexual relations. Only one woman was informed where she could obtain contraceptives once she returned home. At two hospitals in Zimbabwe, a programme offering post-abortion family planning achieved a high success rate where contraceptive acceptance rates increased from 46% before the introduction of the programme to 97% after it had commenced (Barnett 1997).

[29] According to Section 28(3) of the *Constitution* (1996) a minor is a person under the age of 18 years.

years after the implementation of the CTOPA, minors represented approximately 12% of recipients of TOP service provision nationally (excluding Gauteng) (RRA 2001b), which is interesting to note as South Africa has a relatively youthful population with 43.2% of the total population under the age of 20 years (Statistics South Africa 2003). Thirty-five percent of women under the age of 20 years (i.e. one in three teenagers) become pregnant. Motherhood has a significant impact on teenage mothers; typically, they are less educated; have fewer employment opportunities; and have less stable marital relationships compared to older mothers. Furthermore, unwanted children from teenage pregnancies are more prone to psychological and medical problems, and in all likelihood will follow in the same poverty cycle as their mothers (RRA 2001b).

Hence, the RRA (2001b) argued for the inclusion of the minor's provision clause in the CTOPA. The concern related to ensuring an environment in which all South Africans, including minors, could make responsible, informed choices about their sexual and reproductive lives. One of the most difficult issues policy makers face is establishing rules for minors' consent to health care. While it seems reasonable that parents should have the right and responsibility to make health care decisions for their children, it may be more important for youths to have access to confidential health care. Minors who are sexually active, have a STI and abuse alcohol or drugs may not make use of health care services if they first have to obtain permission from or consult with their parents. More specifically, one needs to take into account that TOP is less a medical choice and that it is a major life decision. Those in favour of parental involvement argue that a TOP can have a significant long-term impact on a woman's psychological and emotional well-being and that parental support is needed. Removing the need for parental consent or involvement, therefore, suggests a lack of importance associated with the sanctity of the family as a unit. On the other hand, sexually active adolescents may refrain from seeking care if they first have to obtain their parent's consent (Boonstra & Nash 2000).

### 2.2.3 Designation of TOP service sites

Facilities designated by the Minister of Health to provide surgical TOP services are listed in the *Government Gazette*. According to Section 3 of the CTOPA, both public and private facilities must meet the following requirements before they can be approved to provide TOP services:

- Access to medical and nursing personnel.
- Access to an operating theatre.
- Appropriate surgical equipment.
- Drugs for intravenous and intramuscular injection.
- Emergency resuscitation equipment and access to emergency referral centre or facility.
- Access to appropriate transport should the need for emergency transfer be required.
- Facilities and equipment for clinical observation and access to in-patient facilities.

- Appropriate infection control measures.
- Access to safe waste disposal infrastructure.
- Telephonic means of communication.

Private health facilities must apply to the Minister of Health, in writing, to be designated as a TOP facility.

### 2.2.4 Notification and keeping of records

Abortion still needs to be notified, but confidentiality should be maintained by not recording the woman's name or address. TOP facilities are required to complete monthly summary reports containing information on the number of TOPs performed, age group of the clients, and the gestational age. In addition, facilities are obliged by the CTOPA to complete an individual notification form for every TOP that is performed and the information is reported to the Director General of Health via the relevant provincial health informatics sections (Department of Health 1998).

### 2.2.5 Midwifery training

According to Section 2(2) of the CTOPA, a registered midwife who has undergone the prescribed training may perform a TOP of less than twelve weeks of gestation. Permitting trained midwives to provide TOP services was a strategic move to expand services to the most inaccessible parts of the country and entailed designing a training curriculum; having the South African Nursing Council (SANC) approve the curriculum; and eventually training midwives across the country to render relevant TOP services (Hord & Xaba 2002).

In 1994, the Reproductive Health Research Unit (RHRU) was established to assist in the development and improvement of reproductive health services in South Africa. Shortly thereafter, the SANC (with the technical support of the RHRU) developed guidelines for a short course to train nurses in TOP procedures and related reproductive health matters. In October 1997, the National Termination of Pregnancy Advisory Group mandated the RHRU to produce a national core curriculum for the training of registered midwives in abortion care (Kruger 2000). The National Abortion Care Programme (NACP) was initiated in 1998 by the National Directorate for Maternal, Child and Women's Health to increase the number of trained TOP providers. The Programme was co-ordinated by the RHRU at Baragwanath Hospital (Johannesburg) in partnership with the Maternal, Child and Women's Heath Directorate of the Department of Health, provincial health departments and academic institutions, and was designed to lower maternal mortality resulting from unsafe abortions by providing training in abortion techniques, the management of incomplete abortions and treatment of complications resulting from unsafe abortions. Ipas, an international NGO with widespread knowledge in training and abortion care,

collaborated with the NACP in the design of training content and process as well as the evaluation of midwives (Althaus 2000; Dickson-Tetteh & Billings 2002).

The Midwifery Abortion Care Training Programme undertook three important activities: developing an abortion care curriculum and training manual; training registered midwives in abortion care; and evaluating the quality of midwife abortion care services. In July 1998, the RHRU submitted a curriculum for the training of registered midwives in abortion care services to the SANC. Once the curriculum was approved, the RHRU developed a training manual which was reviewed by the SANC; midwifery training centres; medical schools; reproductive health departments at national and provincial levels; midwives; academic institutions; and reproductive health and rights organisations. The manual was finalised in October 1998. According to the curriculum, abortion care services should be incorporated into a comprehensive reproductive health care approach. The curriculum focuses on the training of midwives to (Dickson-Tetteh & Billings 2002):

- Provide comprehensive abortion services to women who are not more than twelve weeks pregnant (the pregnancy thus far has been normal) and to treat incomplete abortion among women with an equivalent uterine size.
- Stabilise and refer women with abortion complications and a uterine size of more than twelve weeks.
- Provide other reproductive health services, such as diagnosis and treatment of STIs and reproductive tract infections, to women receiving abortion services.

The advantages of permitting trained midwives to perform abortions are numerous and listed by Sibuyi (2004):

- Midwives have a sound skills base which can readily be built on to expand availability, accessibility and quality of abortion services.
- Training midwives to perform abortions is also more cost effective and a good investment for the health system.
- Midwives are generally women and women clients typically feel more comfortable discussing their circumstances with other women who are empathetic and understanding.
- Midwives are usually based in the community and are therefore more likely to understand the needs of the community than doctors, who are thinly spread throughout the country and tend to be located more in centralised urban settings.[30]

[30] Padarath *et al*. (2004) report that, nationally, there was a decline in the ratio of doctors per 100 000 public sector dependent population from 21.9 in 2000 to 19.7 in 2003. Furthermore, the distribution of doctors confirms their availability in terms of rural urban divides; for example, in North West (a more rural province) there are 11.7 doctors per 100 000 population, while in the Western Cape (a more urban province) there are 31.9 doctors per 100 000 population. Similar trends occur within provinces regarding rural urban divides.

### 2.2.6 Health workers and conscientious objection

Health workers are compelled to inform a woman who requests a TOP of the following (Department of Health 1997b):

- She is entitled to terminate a pregnancy on request during the first twelve weeks.
- Under certain circumstances, her pregnancy may be terminated between the 13th and the 20th weeks.
- Only her consent is required for the procedure during the first twelve weeks of pregnancy.
- A minor is advised to consult her parents, guardian, family members or friends before the pregnancy is terminated, but that the termination will not be refused if she chooses not to consult someone.
- Counselling is available.
- The locality of a facility that renders TOP services.

The possible consequences of a health worker refusing to provide a woman requesting a TOP with the required information are fourfold. Firstly, the woman may access a TOP service via another health worker and subsequently not take any steps against the health worker who refused to assist her. Secondly, the woman may report the health worker to the relevant health services. Thirdly, the woman may report the health worker to an appropriate professional body, e.g. the Nursing Council or Health Professions Council of South Africa (HPCSA). Finally, should the woman continue with the pregnancy (which she otherwise may have terminated), she may take action against the health worker for damages. Such a claim may be based on the consequences resulting from the health worker's refusal to inform her about her rights regarding TOP, and may include costs associated with pregnancy, childbirth and child rearing.

While the CTOPA actively protects the right of women to access abortion, Stevens (2000) note that by only requiring health workers to inform women of their right to access abortion, a void was left regarding the ethics of health workers' rights versus clients rights, and seems to suggest that health workers' rights take precedence of the rights of clients. With regard to the rights of health workers and the rights of TOP clients, the CTOPA and the *Constitution* (1996) should be read jointly for clearer guidelines. According to Section 27(1)(a) of the *Constitution* (1996), everyone has a right of access to health care services, including reproductive health care. Therefore, the state is obliged to make resources available for the realisation of the right of access to health care services (McQuoid-Mason 1997). Furthermore, the *Constitution* (1996) implicitly makes provision for the right to conscientious objection to abortion by health workers. According to the *Constitution* (1996), no one may be unfairly discriminated against on any grounds, including religion, conscience and belief (Section 9(3)). Even more significantly, everyone has the right to freedom of conscience, belief, religion, thought and opinion (Section 15(1)). However, the right to conscientious objection should be exercised in such a way that it does not prevent the freedom of

others to participate in abortion or to access abortion services (see Appendix B for a more detailed interpretation of conscientious objection based on the 1996 *Constitution*).

It is also important to appreciate that, under Common Law, in cases where an emergency arises and there is a serious risk to the pregnant woman and abortion is necessary to avoid the danger, a health worker is legally bound to treat the patient. According to the then South African Medical and Dental Council (now HPCSA), doctors may not refuse to treat a patient in a medical emergency. In cases falling short of an emergency, the health worker is still duty bound to exercise a minimum of care by providing information necessary for the exercise of the right to abortion (McQuoid-Mason 1997). The Democratic Nursing Organisation of South Africa is thus correct in stating that nurses have a right to freedom of conscience. Therefore, they may not be refused employment or be victimised for either choosing to or refusing to assist with abortions. However, nurses must make their feelings known in good time in order for substitute staff to be arranged. According to the Nursing Act (10 of 1997), nurses have a professional and ethical obligation to care for the patient before, during and after the procedure despite conscientious objections to abortion (Poggenpoel *et al.* 1998).

Myers & Woods (1996) suggest that legislation concerning conscientious objection should provide for health workers to refuse to participate in an abortion if there truly is a crisis of conscience, but should also take into consideration the responsibility to provide services and the significance of careful moral decision-making. The intent of a conscientious objection clause should be to protect health workers from performing a service that truly infringes their beliefs. It should not protect health workers who would, for example, refuse to participate in providing abortion services as it is an extra work burden without additional payment. A possible manner in which to deal with staff problems regarding TOP would be to specifically recruit staff to do abortions (Painten in Le Roux & Botha 1995).

### 2.2.7 Offences and penalties

According to Section 10 of the CTOPA, any person who performs an abortion procedure and does not meet the professional qualifications required by the Act is guilty of an offence and may be fined or imprisoned for a maximum period of ten years. Persons who are required to maintain and furnish records pursuant to the CTOPA, but fail to do so, may be fined or imprisoned for up to six months. Furthermore, any person who prevents the lawful termination of a pregnancy or who obstructs access to a TOP facility is guilty of an offence and may be fined or imprisoned for a maximum period of ten years.

### 2.3 Amendments to the CTOPA

In February 2005, the CTOPA was amended by *The Choice on Termination Amendment Act* 2004 to:

- Allow a member of the executive committee (MEC) to designate facilities that could provide TOP services.
- Exempt a facility providing 24 hour maternity services from having to obtain approval for TOP services under certain conditions (i.e. a pregnancy under twelve weeks).
- Provide for the recording of information and the submission of statistics.
- Allow a MEC to make regulations.
- Allow a trained registered nurse (and not only a midwife) to perform a TOP.

The amended CTOPA aims to make TOP services even more accessible by removing cumbersome procedures to designate TOP facilities and allowing trained registered nurses to perform TOPs less than twelve weeks. However, the SANC reported that allowing registered nurses to perform TOPs did not substantially change the situation with regard to the number of nurses that may conduct abortion. The majority of nurses on the SANC register are registered as both nurses and midwives, i.e. 82 213 of the 96 715 registrants. In effect, the amended Act allows an additional 14 2888 registered nurses who are not midwives to perform abortions. However, according to the CTOPA only a person who has undergone the prescribed training may perform an abortion. Therefore, only registered nurses who have undergone the necessary training may perform an abortion, and only for pregnancies of up to twelve weeks (Subedar 2004).

## 3. IMPLEMENTATION AND OPERATION OF THE CTOPA

A brief synopsis of the implementation and operation of the CTOPA over the past seven years is reconstructed in the following sections.

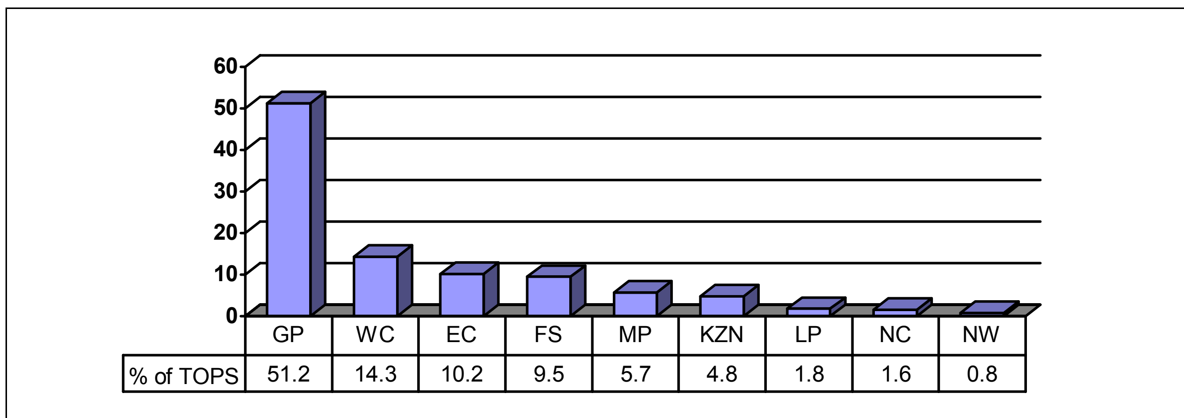
### 3.1 The first year - 1997

A lack of resources and staff resistance prevented many designated facilities from immediately offering TOP services. As many as 50% of health workers nation-wide resisted involvement in TOP services (McCloy 1997). Hospitals urged the Department of Health to speed up the process of training midwives; to find a way to encourage all designated facilities to provide TOPs; and to find ways to cope with shortages of staff. All nine provinces reported difficulties in implementing the CTOPA due to the lack of trained health workers to provide TOP services (Dickson-Tetteh & Billings 2002).

Controversy arose surrounding the administration of Misoprostol, a stomach ulcer drug, to induce abortions. Misoprostol had not been licensed for the purpose of inducing abortions and was widely used by back-street abortionists in the past. The manufacturers of Misoprostol, GD Searle in the United States, refused to register the drug for abortion use due to concerns that the company could be held liable for damage claims. The National Department of Health was of the opinion that GD Searle was concerned with being identified with abortion. The Medicines Control Council (MCC) had to rule on whether Misoprostol could be safely used to induce abortions. Without MCC registration, doctors are open to legal action from their patients if the drug harms them. According to the then Minister of Health, Dr Nkososana Zuma, Misoprostol was part of the TOP protocol (Duffy 1997). Mhlanga (2003) reported that Misoprostil continued to be used for cervical ripening as comparable drugs were unaffordable.

A total of 26 401 TOPs were performed in South Africa during the first year that the CTOPA was operational. Figure 1 provides a breakdown of the percentage of TOPs conducted in each of the nine provinces.

**Figure 1: Provincial breakdown of TOPs conducted during the first year of operation (1997)**




Source: Department of Health 2004
GP=Gauteng, WC=Western Cape, EC=Eastern Cape, FS=Free State, MP=Mpumalanga, KZN=KwaZulu-Natal, LP=Limpopo, NC=Northern Cape and NW=North West.

Fifty-one percent of all TOPs were conducted in Gauteng (n=13 505), followed by 14.3% in the Western Cape (n=3 780), 10.2% in the Eastern Cape (n=2 693), 9.5% in the Free State (n=2 534), 5.7% in Mpumalanga (n=1 509), 4.8% in KwaZulu-Natal (n=1 259), 1.8% in Limpopo (n=487), 1.6% in Northern Cape (n=435), and 0.8% in North West (n=199). Of the cases where maternal age was known (i.e. in 76.3% of the cases), 13.5% of TOPs were conducted for minors and 86.5% for women 18 years and older. With regard to gestational age, 66.2% of TOPs were conducted at less than twelve weeks and 33.8% at twelve weeks or more.

### 3.2 The second year - 1998

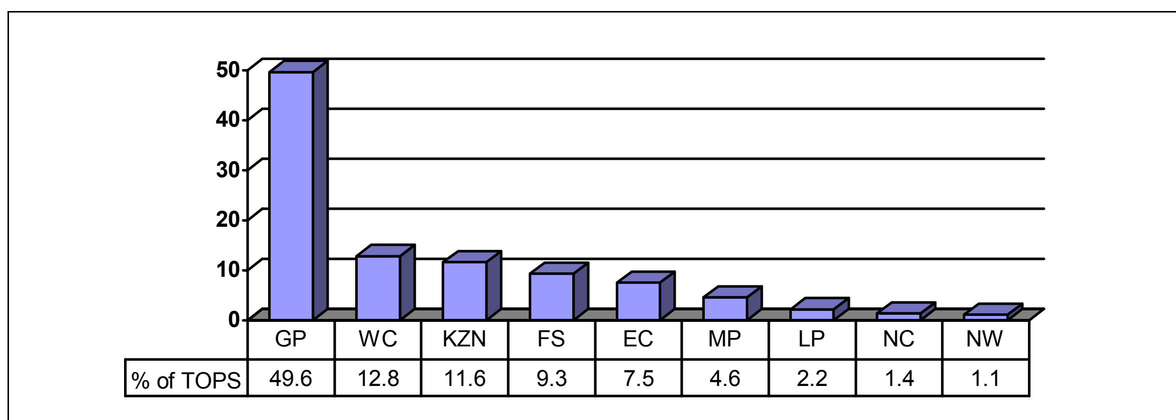
By November 1998, 25 midwives (at least two from each of the nine provinces) were trained on TOP legislation, theoretical aspects of MVA, communication and counselling techniques, post–abortion family planning, and strategising for provincial training. These trainers were tasked to take the process forward by offering training in their respective provinces during 1999-2000. In addition, 22 doctors were trained in the MVA technique. Midwives were tasked to train other midwives on the theoretical aspects of MVA, while the doctors were tasked to provide training on the clinical aspects thereof. The SANC approved the curriculum for training midwives in abortion care. It was envisaged that it would be integrated into the midwifery curriculum and basic medical curriculum within the next three years (RRA 1998a).

Challenges encountered during 1998 included: legal action against the CTOPA by religious groups; staff resistance to providing TOP services; shortages of staff who were willing to provide TOP services; transportation for clients to TOP facilities; training of nurses and doctors on TOP procedures and counselling techniques; the referral of clients to TOP facilities; strengthening of comprehensive reproductive health services; overburdening of certain provincial services; and the lack of community understanding and support for TOP (RRA 1998b). According to Ipas (in RRA 1998c), these challenges could be addressed and access to abortion services improved by:

- Authorising and training a wide range of health workers to provide abortion care.
- Improving the referral chain between PHC facilities and district level facilities.
- Integrating abortion care into existing programmes.
- Supporting programmes that empower PHC workers to provide abortion care.

A total of 39 177 TOPs were performed in South Africa during the second year in which the CTOPA was operational. Figure 2 provides a breakdown of the percentage of TOPs conducted in each of the nine provinces.

**Figure 2: Provincial breakdown of TOPs conducted during the second year of operation (1998)**




Source: Department of Health 2004

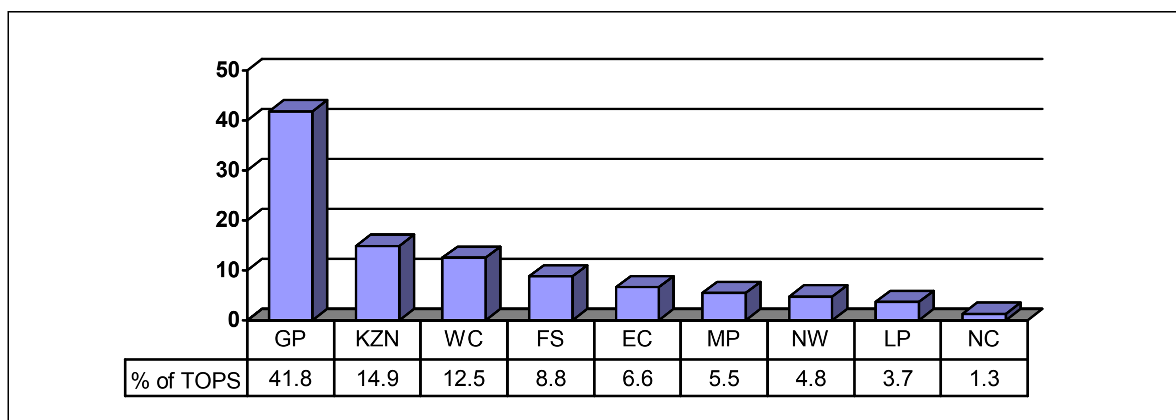
Despite slight decreases percentage wise, Gauteng still conducted the majority of TOPs in the country at 49.6% (n=19 417) followed by Western Cape 12.8% (n=5 008). KwaZulu-Natal moved into third place at 11.6% (n=4 564), followed by Free State 9.3% (n=1 792), Eastern Cape 7.5% (n=2 932), Limpopo 2.2% (n=852), Northern Cape 1.4% (n=530) and finally North West 1.1% (n=446). Of the cases where maternal age was known (in 42.7% of the cases), 14.9% of TOPs were conducted for minors and 85.1% for women 18 years and older. With regard to gestational age, 71.4% of TOPs were conducted at less than twelve weeks and 28.6% were conducted at twelve weeks or more. Note the slight decrease in second-trimester terminations since the previous year.

### 3.3 The third year - 1999

By 1999, 90 midwives completed theoretical training on TOP of whom 45 completed clinical training and 31 were providing abortion services. The 22 doctors who were trained in the MVA technique during 1998 in turn trained a further 124 physicians. However, plans to incorporate the South African Nursing College approved curriculum into the basic nursing curriculum had not yet been approved (Varkey & Fonn 1999).

A total of 46 188 TOPs were performed in South Africa during the CTOPA's third year. Figure 3 provides a breakdown of the percentage of TOPs conducted in each of the nine provinces.

**Figure 3: Provincial breakdown of TOPs conducted during the third year of operation (1999)**




Source: Department of Health 2004

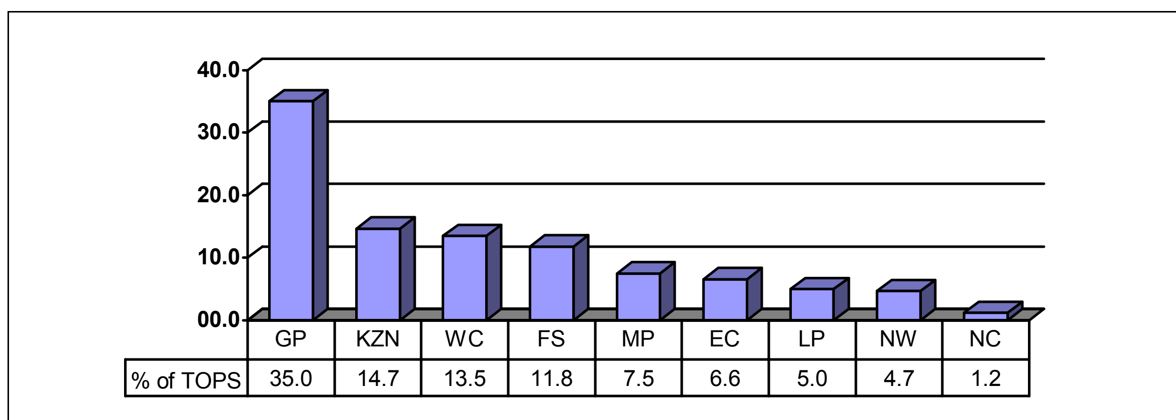
Large urban hospitals in Gauteng continued to provide the majority of TOPs despite the fact that less than one fifth of South Africa's women resided in the province. The situation clearly illustrates an urban bias of access to TOP services (Albertyn 1999). KwaZulu-Natal moved into second position (14.9%; n=6 900) followed by Western Cape (12.5%; n=5 775); Free State (8.8%; n=4 058); Eastern Cape (6.6%; n=3 030) and Mpumalanga (4.8%; n=2 558). There was a significant increase in the number of TOPs conducted in North West (4.8%; n=2 231) which moved from last position to providing more TOPs than either Limpopo (3.7%; n=1 728) or Northern Cape (1.3%; n=610). Of the cases where maternal age was known (58.2% of cases), 10.4% of TOPs were conducted for minors and 89.6% for women 18 years and older. With regard to gestational age, 75.5% of TOPs were conducted at less than twelve weeks and 24.5% were conducted at twelve weeks or more. Note the decrease in second-trimester terminations since 1997.

### 3.4 The fourth year - 2000

The year 2000 saw the second legal challenge to the CTOPA, this time by the Christian Lawyers Association (CLA) regarding the rights of minors to exercise their choice to have a TOP. Furthermore, the Oversight Hearings were conducted by the RRA and Parliamentary Health Portfolio Committee to determine whether the objectives of the CTOPA had been met (see section 5.2).

During 2000, a total of 49 690 TOPs were performed in South Africa during the fourth year that the CTOPA was operational. Figure 4 provides a breakdown of the percentage of TOPs conducted in each of the nine provinces.

**Figure 4: Provincial breakdown of TOPs conducted during the fourth year of operation (2000)**



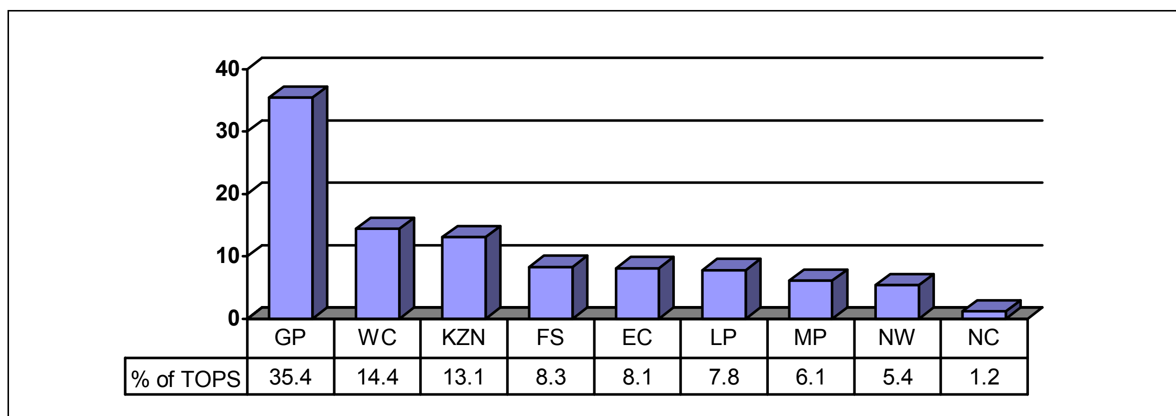

Source: Department of Health 2004

Although still the province that conducted the majority of TOPs in South Africa, the lead that Gauteng had was decreasing from half of all TOPs in 1997 to just more than a third in 2000 (35.0%; n=17 408). KwaZulu-Natal (14.7%; n=7 288), Western Cape (13.5%; n=6 721) and Free State (11.8%; n=5 843) remained above the 10% mark, while minimal TOPs were still being conducted in Mpumalanga (7.5%; n=3 728), Eastern Cape (6.6%; n=3 265), Limpopo (5.0%; n=2 493), North West (4.7%; n=2 329) and Northern Cape (1.2%; n=615). Of the cases where maternal age was known (64.1% of the cases), 12.5% of TOPs were conducted for women younger than 18 years of age and 87.4% for women 18 years and older. With regard to gestational age, 74% of TOPs were conducted at less than twelve weeks and 26% were conducted at twelve weeks or more. Note the increase in second-trimester terminations since 1999.

### 3.5 The fifth year - 2001

A total of 57 451 TOPs were performed in South Africa during the fifth year that the CTOPA was operational. Figure 5 provides a breakdown of the percentage of TOPs conducted in each of the nine provinces.

**Figure 5: Provincial breakdown of TOPs conducted during the fifth year of operation (2001)**




| | GP | WC | KZN | FS | EC | LP | MP | NW | NC |
|---|---|---|---|---|---|---|---|---|---|
| % of TOPS | 35.4 | 14.4 | 13.1 | 8.3 | 8.1 | 7.8 | 6.1 | 5.4 | 1.2 |

Source: Department of Health 2004

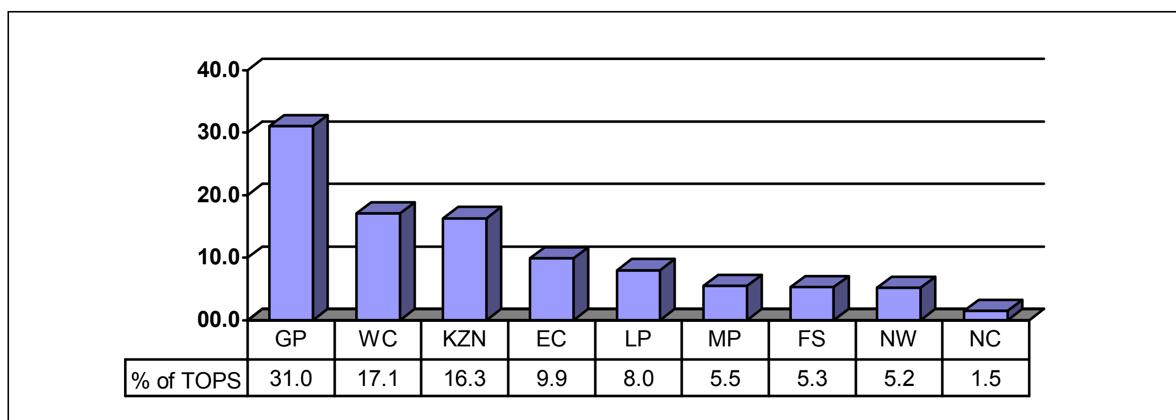
During 2001, Northern Cape provided 1.2% of overall TOP services, North West 5.4%, Mpumalanga 6.1%, Limpopo 7.8%, Eastern Cape 8.1%, Free State 8.3%, KwaZulu-Natal 13.1%, Western Cape 14.4%, and Gauteng 35.4%. Of the cases where maternal age was known (64.6% of the cases), 11.9% of TOPs were conducted for women younger than 18 years of age and 88.1% for women 18 years and older. With regard to gestational age, 76.9% of TOPs were conducted at less than twelve weeks and 23.1% were conducted at twelve weeks or more. Note the slight decrease in second-trimester terminations since 2000.

### 3.6 The sixth year - 2002

The RRA (2002a) reported that: too many second trimester TOPs were performed due to limited access to TOP services which resulted in women being put onto long waiting lists; widespread use of injectable contraceptives led to irregular menses and meant that women did not always notice early signs of pregnancy; and ignorance about the CTOPA still existed. In addition, too few doctors were prepared to perform second trimester TOP procedures.

A total of 58 740 TOPs were performed in South Africa during the CTOPA's sixth operational year. Figure 6 provides a breakdown of the percentage of TOPs conducted in each of the nine provinces.

**Figure 6: Provincial breakdown of TOPs conducted during the sixth year of operation (2002)**




| | GP | WC | KZN | EC | LP | MP | FS | NW | NC |
|---|---|---|---|---|---|---|---|---|---|
| % of TOPS | 31.0 | 17.1 | 16.3 | 9.9 | 8.0 | 5.5 | 5.3 | 5.2 | 1.5 |

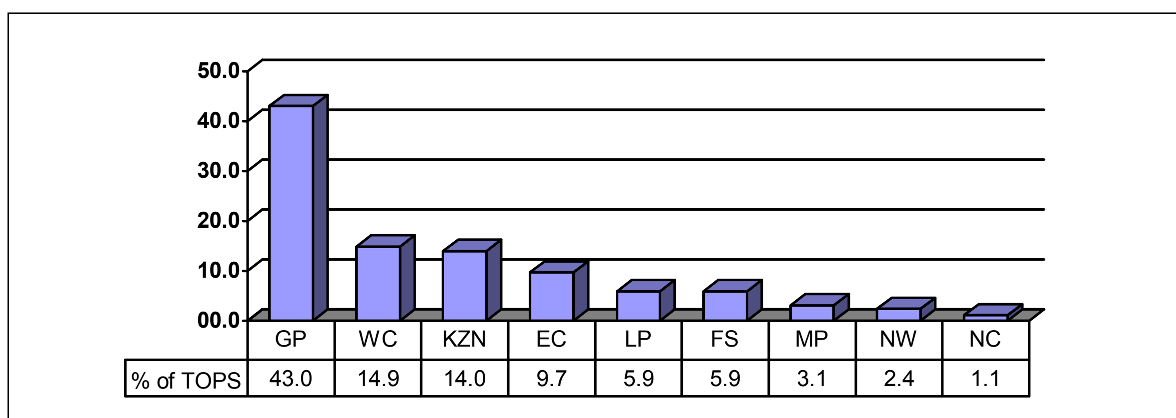
Source: Department of Health 2004

During 2002, Gauteng continued to provide the majority of TOPs (31.0%; n=18 256), followed by the Western Cape (17.1%; n=10 065) and KwaZulu-Natal (16.3%; n=9 592). Free State dropped to seventh position, providing 5.3% (n=3 109) of the TOPs in the country. Northern Cape (1.5%; n=910) continued to provide the smallest percentage of TOPs in the country. Of the cases where maternal age was known (68.6% of the cases) 9.9% of TOPs were conducted for minors. With regard to gestational age, 77.5% of TOPs were conducted at less than twelve weeks.

### 3.7 The seventh year - 2003

A total of 70 391 TOPs were performed in South Africa during the seventh year that the CTOPA was operational. Figure 7 provides a breakdown of the percentage of TOPs conducted in each of the nine provinces.

**Figure 7: Provincial breakdown of TOPs conducted during the seventh year of operation (2003)**




| | GP | WC | KZN | EC | LP | FS | MP | NW | NC |
|---|---|---|---|---|---|---|---|---|---|
| % of TOPS | 43.0 | 14.9 | 14.0 | 9.7 | 5.9 | 5.9 | 3.1 | 2.4 | 1.1 |

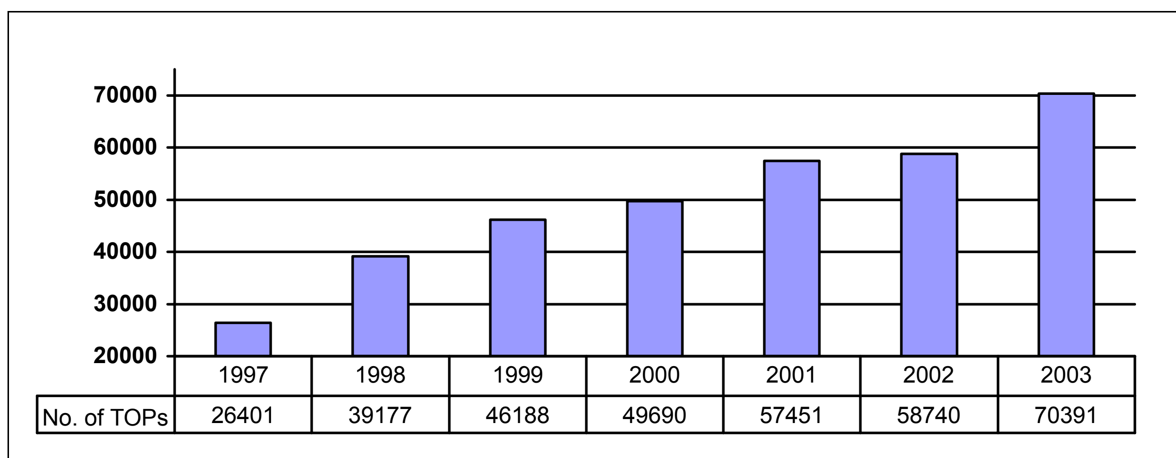
Source: Department of Health 2004

There was a fairly large increase in the percentage of TOPs conducted in Gauteng (43.0%; n=30 250). In fact, almost half of all abortions conducted in South Africa, was done in the province. Western Cape (14.9%; n=10 513) and KwaZulu-Natal (14.0%; n=9 845) remained in the second and third place respectively. Of the cases where maternal age was known (99.8% of the cases), 13% of TOPs were conducted for minors. With regard to gestational age 79.2% of the TOPS were conducted at less than twelve weeks.

## 4. OVERVIEW OF TRENDS, ACHIEVEMENTS AND FAILURES IN TOP – 1997 TO 2003

Despite impediments to the operation of the CTOPA - such as a lack of operational TOP facilities, lack of decentralised services, inadequate knowledge about pregnancy and TOP[31], and negative attitudes on the part of health providers towards TOP - there has been a dramatic increase in the number of TOPs conducted from 1997 (26 401) to 2003 (70 391) (see Figure 8).

**Figure 8: Number of TOPs conducted over the past seven years**




Source: Department of Health 2004

During the first seven years that the CTOPA was operational, there was varied access to services among the provinces (see Table 12). In particular, the overall percentage of service provision in Gauteng decreased with fluctuations from 51.2% during the first year to 43.0% by the fifth year after implementation of the CTOPA, while surrounding provinces showed increased service

[31] While women may know that abortion is legal, it is unlikely that they are familiar with the provisions of CTOPA. Research found that only 44% of women knew that abortion on request was legally available. Less than a quarter knew that consent from partners (22%) or parents (20%) was not necessary (Varkey 2000). In KwaZulu-Natal, 94% of persons living in urban areas had heard of the abortion law, while only 55% in the Northern Cape had heard about the law. Only 24% knew that a woman did not need her parents' or husband's consent to have an abortion (De Lange 2000). As a result of the lack of public education, only 53% of South Africans in 1998 knew that during the first twelve weeks of pregnancy abortion on request was available legally. Of the 183 women wanting to access TOP services in the Cape Metropolitan Region, more than 90% did not know when (i.e. gestational age) abortion was legal (Althaus 2000).

delivery over this period. The intention of the CTOPA is to make TOP services equally accessible to all women. Therefore, access should not be determined by geographic location of services or the socio-economic status of the women. The service is available free of charge at public facilities, and, theoretically, all women (regardless of their socio-economic status) should be able to access TOP services. In reality, geographic location of facilities is a problem in the more rural provinces, such as the North West, Eastern Cape, Limpopo, Northern Cape and KwaZulu-Natal, where women have to travel vast distances to access facilities that provide TOP services.

**Table 12: TOP statistics per province (1997-2003)**[32]

| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
|---|---|---|---|---|---|---|---|
| **Gauteng** | 13 505<br>**51.2%** | 19 417<br>**49.6%** | 19 298<br>**41.8%** | 17 408<br>**35.0%** | 20 321<br>**35.4%** | 18 256<br>**31.0%** | 30 250<br>**43.0%** |
| **Mpumalanga** | 1 509<br>**5.7%** | 1 792<br>**4.6%** | 2 558<br>**5.5%** | 3 728<br>**7.5%** | 3 520<br>**6.1%** | 3 218<br>**5.5%** | 2 206<br>**3.1%** |
| **Free State** | 2 534<br>**9.5%** | 3 636<br>**9.3%** | 4 058<br>**8.8%** | 5 843<br>**11.8%** | 4 758<br>**8.3%** | 3 109<br>**5.3%** | 4 158<br>**5.9%** |
| **KwaZulu-Natal** | 1 259<br>**4.8%** | 4 564<br>**11.6%** | 6 900<br>**14.9%** | 7 288<br>**14.7%** | 7 533<br>**13.1%** | 9 592<br>**16.3%** | 9 845<br>**14.0%** |
| **Northern Cape** | 435<br>**1.6%** | 530<br>**1.4%** | 610<br>**1.3%** | 615<br>**1.2%** | 716<br>**1.2%** | 910<br>**1.5%** | 779<br>**1.1%** |
| **Limpopo** | 487<br>**1.8%** | 852<br>**2.2%** | 1 728<br>**3.7%** | 2 493<br>**5.0%** | 4 512<br>**7.8%** | 4 706<br>**8.0%** | 4 124<br>**5.9%** |
| **Western Cape** | 3 780<br>**14.3%** | 5 008<br>**12.8%** | 5 775<br>**12.5%** | 6 721<br>**13.5%** | 8 300<br>**14.4%** | 10 065<br>**17.1%** | 10 513<br>**14.9%** |
| **Eastern Cape** | 2 693<br>**10.2%** | 2 932<br>**7.5%** | 3 030<br>**6.6%** | 3 265<br>**6.6%** | 4 671<br>**8.1%** | 5 814<br>**9.9%** | 6 819<br>**9.7%** |
| **North West** | 199<br>**0.8%** | 446<br>**1.1%** | 2 231<br>**4.8%** | 2 329<br>**4.7%** | 3 120<br>**5.4%** | 3 070<br>**5.2%** | 1 697<br>**2.4%** |
| **Total** | **26 401**<br>**100%** | **39 177**<br>**100%** | **46 188**<br>**100%** | **49 690**<br>**100%** | **57 451**<br>**100%** | **58 740**<br>**100%** | **70 391**<br>**100%** |

Source: Department of Health 2004

Key findings from research conducted since the implementation of the CTOPA until 2002 indicated that (RRA 2002a):

- Abortion services are most effectively rendered at the lowest appropriate level of care (the clinic) and preferably during the first-trimester.

[32] Neither the National Department of Health nor the Free State Department of Health were able to provide a breakdown of maternal and gestational ages per province.

- Costs can be reduced and the quality of care improved by using the MVA technique and appropriate patient management instead of sharp curettage.
- Misoprostil can be safely used for cervical ripening prior to terminations.
- Ongoing support should be available for midwives from the Department of Health and hospital authorities.
- Communities still lack information concerning TOP.
- Values clarification workshops are valuable in encouraging health workers to be tolerant and supportive of various views on TOP.
- Quality of TOP services can be improved by addressing problems at all levels (i.e. management, service providers and communities).

## 4.1 Achievements of the CTOPA

There have been numerous successes regarding the implementation and operation of the CTOPA, including: public private cooperation, failed legal challenges; successful values clarification workshops; development of a curriculum to training midwives and doctors in TOP procedures; and the establishment of the NACP to coordinate and oversee the training of midwives and doctors in TOP procedures. Additionally, the 2000 oversight hearings brought together government and civil society to share experiences and make recommendations to facilitate the improvement of TOP service delivery, while the National Department of Health in partnership with Ipas and respective stakeholders are working toward developing a National Strategic Plan for the improvement of TOP service delivery in South Africa.

### 4.1.1 Cooperation with private facilities

TOP service provision in the private sector has been important in supplementing access to services (although at a cost to clients) and Marie Stopes Clinics have played a key role in the provision of TOP services in the Eastern Cape, Mpumalanga and KwaZulu-Natal provinces. A steady increase was noticed in the services provided by Marie Stopes, from 7 445 TOPs conducted nationally in 1997, to 16 680 in 2001. Cost is, however, an important factor to take into consideration when investigating whether the private sector improves access to TOP services (RRA 2002a).

### 4.1.2 Failure of legal challenges

Two legal challenges were brought against the CTOPA and both failed. Firstly, in 1998 the CLA, Christians for Truth in South Africa, and United Christian Action attempted to declare the CTOPA void *in toto* under the 1996 *Constitution*. Their argument was that life begins at conception and,

therefore, abortion ends life. According to Section 11 of the *Constitution* (1996) "everyone" has a right to life, and this should also apply to the foetus. As such, the foetus has constitutional rights, and the CTOPA is thus contrary to the 1996 *Constitution* (Mda 1998; Morris & Williams 1998; Ngwena 1998). The defendants in the case - the Minster of Health, the Gauteng Provincial Government, the RRA and the Commission for Gender Equality - argued that the foetus does not have constitutional rights and that Section 11 does not rule out abortion as reflected by the CTOPA. Furthermore, it was argued that the right to choose to have an abortion is supported by various provisions of the *Constitution* (1996). Amongst others, these provisions included the right to: equality; human dignity; bodily and psychological integrity; privacy; freedom of religion, belief and opinion; and health services. Judge J McCreath found in favour of the defendants supporting the fact that the foetus does not have a legal persona under the 1996 *Constitution* and, therefore, that the CTOPA does not breach Section 11 of the 1996 *Constitution* (Ngwena 1998).

Secondly, the CLA brought another legal challenge to the CTOPA regarding the rights of minors to exercise their choice to have a TOP. In June 2000, a summons was issued against the Minister of Health, the Gauteng MEC for Health and the Gauteng Premier. According to the CLA, the CTOPA infringed on the constitutional right of every child to family or parental care, as well as on the right to be protected from maltreatment, neglect or degradation. Section 28(2) of the *Constitution* (1996) states that the best interest of a child should take precedence in every matter concerning the child. The CLA argued that the decision to terminate a pregnancy would have long-term emotional and/or physical and/or spiritual effects on a girl, and that she needs to be protected from such effects by: requiring her to obtain parental consent, or at least requiring her to consult parents/guardians; receiving mandatory pre- and post –abortion counselling; having a period for reflection between the decision to have the abortion and the procedure itself; and not considering a minor to be the same as an adult woman. The State responded by filing an exception and an application to strike the CLA's claim on the basis that it did not lay out a plan of action, and that it was vague and embarrassing (RRA 2001a).

#### 4.1.3 Development of a National Strategic Plan for TOP

The National Department of Health in partnership with Ipas and respective stakeholders are working toward the development of a National Strategic Plan for the improvement of TOP service delivery in South Africa (RRA 2002b). The overall goal of the strategic plan is to provide women with acceptable, accessible, affordable, cost effective, safe and user-friendly TOP services that are located within a comprehensive and integrated reproductive health system. Key strategies identified during the development of the National Strategic Plan are: decentralisation of TOP services; adequate resources; defence of the CTOPA through careful practice and calculated partnerships; support for TOP service providers; user-friendly, quality services; mainstreaming of TOP training for all health workers into existing training programmes; promotion of reproductive

choice; and an adolescent-friendly environment for minors wishing to access TOP services and reproductive health services in general (RRA 2002b). Harrison *et al*. (2000) suggest that the quality of TOP care could be improved through the integration of TOP into broader reproductive health care services, which would also improve access to TOP facilities and women would thereby benefit from a good quality service designed to meet all of their reproductive needs.

#### 4.1.4 Values clarification workshops

The National Directorate for Maternal Child and Women's Health cited the values clarification workshops and the promotion of contraceptive methods as two of the key achievements in the operation of the CTOPA (RRA 1998b). Even prior to the introduction of the CTOPA in February 1997, the PPASA conducted a pilot study to evaluate the impact of values clarification workshops (Marais 1997). The aim of these workshops was to contribute to the implementation and management of TOP. More specifically, the objectives were to:

- Gain an understanding of health workers' concerns regarding TOP.
- Develop a framework for assisting health workers relate their values and belief system to the needs of their client.
- Test the utility of a training module for different levels of health workers.
- Develop recommendations for the integration of values clarification with in-service training of health workers.

Seven workshops, attended by 110 nurses, doctors and other paramedics, were held in the Cape metropolitan area. Of the 110 participants, twelve had had an abortion in the past, of which nine had been performed illegally. A quarter of the participants had previous experience with abortion, as they either knew of someone who had had an abortion, or they had supported someone who had undergone an abortion. At the start of the workshops, almost half of the participants stated that they were not willing to care for abortion patients. Two-thirds of the participants indicated that they were uncomfortable with the concept of abortion or were uncertain about their feelings regarding abortion. At the end of the workshop, there was a significant shift, with more participants indicating that they felt comfortable with the concept of abortion. Almost 70% of the participants found that after the workshop they would be better able to help abortion patients (Marais 1997). In other words, these participants had found the workshops to be valuable, as their views and values toward women opting for an abortion had changed.

Since the introduction of the CTOPA, PPASA (together with the RHRU and the RRA) conducted country-wide values clarification workshops to lessen provider resistance to abortion. More than 4 000 health workers have attended the workshops that endeavour to educate health workers on the new abortion law; promote non-judgemental attitudes toward abortion; and encourage health

workers to treat women seeking abortions with dignity and respect. Health workers participate in a variety of exercises during the workshops; amongst others, several hypothetical cases of women seeking an abortion are presented and participants then have to decide which women should be allowed to have an abortion (Althaus 2000). Abortion values clarification workshops appear to be a useful tool for distributing knowledge about the CTOPA, as well as addressing attitudes toward abortion, which is not only beneficial for health workers providing TOP services, but also for health workers in general.

### 4.2 Impediments to and challenges associated with the provision of TOP services

As noted by Gerhardt (1997), liberalising abortion legislation alone is not sufficient to guarantee access to TOP services. A number of additional requirements should be put into place to ensure access and include:

- The creation of standards, protocols and guidelines to guide abortion service delivery. Such documents should define the abortion techniques that are permitted; who may provide abortion services; and where abortions may be performed.
- The integration of abortion care standards into medical and nursing curricula, national monitoring and evaluation protocols and policy statements.
- The availability of staff who are willing and trained to provide abortion services at hospitals.
- Health workers and the public have an understanding of all administrative regulations included in the abortion law (e.g. the absence of spousal and parental consent).
- The availability of drugs and equipment necessary to provide abortion services.
- The health system must be prepared (e.g. facilities, space, etc.) for the provision of abortion services.
- The allocation of funds for abortion services.
- Security systems in place to ensure that clients and service providers are not harassed by anti-abortion demonstrators.
- Training of staff who are to provide abortion services; clerks who should keep statistics; and administrators dealing with patient referrals, transport, reporting and record keeping.
- Research to assess the effect of abortion reform on women's health, the provision of reproductive health care and on community perspectives.
- Information for the community about the law and where abortion services are available.
- The provision of information about contraception and STIs at schools and health facilities.
- Attention to the provision of family planning services in order to avoid repeat abortions.

The statement by Jewkes, director of the Women's Health Unit at South Africa's MRC that "*Despite progressive legislation, hospitals are still seeing cases where women are being admitted after something like a knitting needle or bleach has been inserted into the cervix to induce a*

*miscarriage*" (in Taitz 2000: 1) clearly supports Gerhardt's notion that liberalising abortion law does not guarantee access to TOP services.

The following discussion indicates that many of Gerhardt's (1997) recommendations for the successful implementation of a new abortion law are not yet in place in South Africa. Specific reference to these deficiencies will be made in the discussion on impediments to and challenges associated with the provision of TOP services. The findings and recommendations of the RRA and the Parliamentary Health Portfolio Committee (i.e. the Oversight Hearings) already identified many impediments and challenges of the CTOPA.

#### 4.2.1 Key findings from the Oversight Hearings

In June 2000, the RRA together with the Parliamentary Health Portfolio Committee conducted Oversight Hearings to determine whether the objectives of the CTOPA had thus far been met. This was an historic occasion, as it brought together government and civil society representatives, including implementers, researchers and organisations, from the entire country to share experiences and make recommendations to facilitate the improvement of TOP service delivery. There was no denying the fact that the CTOPA certainly made available a service that had previously been denied to many women, yet it was evident that far more had to be done in order to make women's rights more real, as expressed in the Act. The RRA (2000a) identified critical challenges that needed attention in order to increase access to TOP services.

- **Lack of decentralisation to PHC levels**. TOP services were still mainly available at hospitals, rendering the service largely inaccessible to many women living in rural areas. A key challenge to addressing the issue is the lack of trained staff.
- **Private sector service provision**. In order to ensure quality and affordable services, there should to be greater control over the private sector TOPs. While private sector services make a contribution, they are not accessible to the majority of South African women. General practitioners can and do have a significant role to play in the provision of TOP services; therefore, they need to receive specific training on the various termination techniques and drugs available.
- **TOPs after twelve weeks**. A concerted effort should be made to decrease the number of second-trimester terminations. The need for second-trimester terminations is directly related to inaccessibility of first-trimester TOPs, which, in turn, may be due to far distances that need to be travelled and a lack of information about TOP. All women should be educated about the early signs of pregnancy. Furthermore, TOPs should be more readily available at PHC clinics.
- **Cytotec/Misoprostol**. The drug, or its generic equivalent, should be registered by the MCC. Furthermore, the national TOP Advisory Committee should appoint a panel of experts to

develop guidelines for the use of the drug. The use of medical abortificients, such as RU 486, should also be researched.

- **Conscientious objection**. While health workers may refuse to perform a TOP, except in a medical emergency, it is still expected of them to refer women to a facility offering TOP services. Guidelines for dealing with health workers who obstruct women's access to TOP services should be compiled. Willingness to conduct a TOP should form part of the job description of persons in resource-deprived settings.
- **Support for health workers.** Each province should have a model in place to provide TOP service providers with support. There should also be support from Members of Parliament who could be encouraged to visit TOP facilities and support provincial departments of health. It is important that institutional management pay attention to and deal with discriminatory practices and attitudes toward TOP service providers. More trained TOP staff would allow for a rotation system to be put in place at TOP facilities. Values clarification workshops are an important mechanism for allowing persons with different perspectives to be exposed to TOP issues and practices.
- **Access to information.** Communities require education about the CTOPA as well as the importance of safe, legal TOP services. Such information should be provided within the context of reproductive health and women's rights.

In short, the challenges faced appear to centre around the type of facility providing TOP; attitudes of health workers; and information available to the public. With regard to the former, there clearly was a need for these services to be more readily available at PHC clinics and CHCs which are far easier to access than district or regional hospitals, or private health workers. The attitudes of health workers, both those providing TOP services and health workers in general, need to receive more attention. In addition, health workers providing TOP services require support from colleagues and supervisors. A system should be put into place to ensure the availability of psychological support for TOP service providers. There is also a need to educate the public in general and women in particular about pregnancy, family planning and the CTOPA. An educated public would be aware of the benefits of contraception, early signs of pregnancy and legal issues surrounding TOP.

As noted both during the Oversight Hearings and from further readings (*cf*. Althaus 2000; Harrison *et al*. 1997; Hord & Xaba 2002; Poggenpoel *et al.*1998; Stevens 2000; Varkey 2000; Varkey *et al.* 2000), significant impediments to the functioning of the CTOPA relate to health workers and facilities. More specifically, the views of health workers and their conduct regarding TOP, as well as the designation and location of TOP facilities proved to be particularly problematic.

#### 4.2.2 Views and conduct regarding abortion

Since the implementation of the CTOPA in February 1997, numerous newspaper articles depicting health workers' dissatisfaction with the Act have been published. The *City Press* (1997) reported the concerns of a medical doctor regarding the process of allowing women to initiate the abortion at home as, in the absence of a trained health worker, severe pain, bleeding and death could occur. Furthermore, doctors had been trained to save and not end lives. The concern was also reported by Johnson (1997) in an article entitled "*Abortion babies should be left to die*" , which commented on the fact that doctors were horrified at a health department directive that babies who survived abortion attempts should be left to die.

Poggenpoel *et al.* (1998: 4) found that there was much dissatisfaction amongst nurses regarding the CTOPA as they had not been consulted about their views on abortion prior to the introduction of the legislation. The majority of nurses indicated that they would refuse to care for patients opting for abortions, which was evident in statements such as "p*ersonally, I will not allow myself to be forced into this situation, I will not do it, okay, and I will tell the matron … I find myself walking out and do something else …* ". Furthermore, many of the nurses stated that they would rather leave the nursing profession than be forced to assist with TOP patients. Similarly, a survey conducted by Doctors For Life[33] (DFL) revealed that 80% of doctors were not willing to perform abortions on demand (DFL International 2004), and of the more than 1 000 nursing staff members at a Pretoria Academic Hospital, only ten were willing to conduct abortions on demand. A comparable situation existed in KwaZulu-Natal where the majority of health workers refused to conduct abortions on demand (Bruyns 1997).

Additional concerns raised by doctors and nurses, as reported by Caelers (1998), related to the "Offences and Penalties" clause of the CTOPA which states that it is illegal for any person to "*prevent the lawful termination of a pregnancy or obstruct access to a facility for the termination of a pregnancy"* (*Choice on Termination of Pregnancy Act*, 92 of 1996). A survey conducted amongst doctors working at 31 medical institutions in the Western Cape that were designated to conduct abortions found that a quarter of the respondents who refused to do abortions would also not refer patients to relevant doctors or facilities. A further 14% of respondents said that they would not see abortion patients, even in cases of a medical emergency. Similar problems were reported in the Free State where doctors at a regional hospital refused on moral grounds to treat women (who had received abortion pills at a nearby TOP facility) with incomplete abortions.

[33] Doctors For Life is a non-governmental, non-profit making organization which was established in 1991 and has a growing number over 1100 members. The members are medical doctors, specialists, dentists, veterinary surgeons, and professors of medicine from various medical faculties across South Africa and abroad, in private practice and in government institutions (DFL International 2004).

Furthermore, they indicated that it was unacceptable that patients were being refused medical care once the abortion procedure has commenced (Versluis 1998).

A survey conducted among PHC nurses working at district hospitals in the Hlabisa District (KwaZulu-Natal) during 1997 (Harrison *et al*. 1997) revealed that only 11% fully supported the CTOPA. These PHC nurses were more supportive of abortion in cases of rape or incest and for saving the woman's life, and were significantly less supportive of abortion on request and abortion being performed for socio-economic reasons. Opposition toward abortion mainly related to religious convictions. Resistance of health workers toward abortion is a powerful impediment to ensuring access to such services, which was confirmed by Varkey (2000) who reported that staff at referral facilities made it difficult for women to gain access to TOP facilities. Some women went from one clinic to another before they found a health worker who would supply them with a referral letter. Not only women seeking a TOP but also health workers providing the service were affected by the judgmental attitudes of some colleagues. Health workers providing TOP services reported feeling unsupported and alienated from their colleagues.

The National Department of Health actively attempts to manage negative attitudes through the abortion values clarification workshops. Despite these attempts, a study conducted in the Northern Cape by Varkey *et al.* (2000) four years after the implementation of the CTOPA revealed that judgemental health worker attitudes were still being reported. This was especially problematic with staff at referral centres and in hospital wards where women were admitted for second-trimester abortions. At referral facilities staff refused to either supply women with pregnancy test results or a referral letter. Women were told that abortion is immoral and sinful, while inaccurate information was given to women regarding abortion and their legal rights. Furthermore, a study by Potgieter (2004) found that TOP service providers were labelled as "serial killers" or "baby killers". These TOP service providers reported that their involvement with TOP had negatively affected their relationships with colleagues and that work overload led to burnout and made it difficult for them to provide quality services. In addition, there was a lack of support from management for TOP.

### 4.2.3 Designation and location of TOP facilities

The Minister of Health designated 248 public health facilities to provide TOP services of which only 73 were doing so by 2000 (Varkey 2000). Hord & Xaba (2002) report that the designation of health care facilities to provide TOP services was an administrative barrier to implementing TOP services. The National Department of Health designated facilities (public and private) to provide TOP services based on applications of provincial and local authorities. The application passed through the legal department and then to the Minister of Health for approval. Initially, provinces were requested to designate facilities as they saw fit. The process of designation could take up to

four months to complete and the reliance on the highest medical authority to finalise the designation process become a bottleneck on several occasions (Hord & Xaba 2002).

Furthermore, some hospital administrators at designated TOP facilities seemingly used a variety of tactics to avoid providing TOP services. These tactics included making operating theatres unavailable and refusing to nominate staff for TOP training (Hord & Xaba 2002). Of the public facilities providing TOP services, 99% were hospitals (Varkey 2000) which, according to Stevens (2000), reinforced the myth that abortion was a technically difficult procedure that should be performed in a hospital. Nearly half (33 of the 73) of the facilities providing TOP services were located in Gauteng and the Western Cape. These two provinces have the lowest levels of poverty, the highest levels of urbanisation, and the best equipped health care facilities in the country (Varkey 2000). Gauteng is home to 18% of South Africa's female population and provided 48% of all abortions, while the North West Province accounted for 8% of the country's women, but only 1% of the abortions (Althaus 2000). KwaZulu-Natal, which has the largest proportion of the country's female population, provided only 10% of reported abortions (Varkey 2000). In 2001, the National Department of Health reported that TOP services were still geographically inaccessible as they were mainly located within urban areas and some women had to travel far distances (approximately 400-500 kilometres) to access the service. Furthermore, there were long waiting times (average of one to seven days) as a result of congestion at functional facilities (Hord & Xaba 2002).

Despite all the efforts to relocate abortion services, the majority were still available within hospital settings. All first-trimester termination, which constituted 75% of public sector abortions, should be conducted at PHC facilities. In reality, many of these terminations were still being performed at hospitals. Under the 1975 Act, abortions were limited to such an extent that they were mainly performed in hospitals, which is, however, not feasible under the CTOPA. Public sector abortions are provided free of charge; therefore, locating such services outside hospitals is far more cost effective (first-trimester abortions conducted in hospitals cost 133% more than those conducted at clinics; second-trimester abortions performed at hospitals cost 89% more than those conducted at clinics) (Althaus 2000).

Equal access to abortion across provinces will only become a reality once services are expanded. As some hospitals and facilities refuse to provide abortions, those facilities that do provide TOPs are overloaded and struggle to cope with the high numbers of clients. Facilities offering abortion services generally have long waiting lists and overburdened staff. Women who have to wait for long periods before being seen at abortion facilities may be turned away when they are eventually seen for being too advanced in their pregnancies, despite the fact that they initially made their appointments long before twelve weeks of gestation.

### 4.3 Key recommendations from the Oversight Hearings

The following recommendations were made during the hearings (RRA 2000):

- Access to TOP services could be increased if, amongst others, first-trimester terminations were more widely available at PHC level.
- A holistic approach to providing information, education and communication about the CTOPA should be followed so that TOP is not dealt with in isolation, but rather forms part of reproductive health care.
- Reproductive rights should be contextualised as part of broader developmental challenges, which will ultimately address issues that prevent women from making their own reproductive choices.
- Service provision would be more effective if supportive management structures could be put into place, thereby creating an environment in which TOP service providers feel more comfortable and supported. Psychological support should also be made available for TOP staff.
- The quality of TOP services, as well as access to these services, is directly related to the roles and attitudes of health workers. Therefore, positive attitudes towards TOP (or at least health workers who are not openly opposed to TOP) would assist in enhancing access to TOP facilities. One way to address negative attitudes would be continued values clarification workshops. Furthermore, measures should be put into place to deal with health workers who obstruct access to TOP services.
- There was a need for more knowledge about TOP as well as the provisions of the CTOPA. Hence an information campaign for both health workers and the community should be undertaken.
- TOP skills should be incorporated into the basic training of all nurses and doctors.
- Midwives should be allowed to prescribe TOP medication so that midwives in rural areas are fully equipped to conduct first-trimester abortions.
- Clear guidelines for the referral and management of TOP patients should be put in place.
- There should be incentives for staff to work in rural and/or other under-served areas, as well as incentives to retain current TOP staff.
- Ensure that all designated facilities provide TOP services so that TOP becomes more readily available at PHC level. In addition, plans should be made to rollout TOP services to additional facilities. Mobile units should be utilised in poorly serviced areas.
- Transport should be made available for TOP patients.
- Establish TOP teams to visit clinics on a regular rotational basis.
- Explore ways to deal with overloaded facilities, e.g. counselling can be provided by other health workers and not only midwives.
- Encourage private practitioners to become involved in TOP service provisioning.

- Doctors for Life recommended that "*structures such as the RRA set up their own clinics to provide TOP services*" (RRA 2000: 2-3). Although not an option, the RRA noted that it was a move toward the positive that the pro-life group was starting to acknowledge the importance of TOP service provision.

## 5. SUMMARY

Against a background of fundamental political change, the election of a new democratic government and a great deal of socio-economic reform (including the introduction of various policies and legislation in the health field), the CTOPA was introduced to ensure that all women in South Africa have access to a safe and legal TOP according to their individual beliefs. This was a strategic move in line with international developments in the reproductive rights arena – such as the ICPD and the Beijing Conference – which sought to ensure that women are not discriminated against on the basis of gender, race, religion or culture; and that women have the right to make their own reproductive health decisions concerning the timing, spacing and number of children that they wish to have. The *Constitution* (1996) provides a broad framework for the protection and promotion of reproductive rights and health, and recognises that all South Africans have the right to make reproductive decisions, the right to security in and control over their bodies, and access to reproductive health care services. The *Constitution* (1996) also provides all South Africans with a substantive right to equality, which helps to secure equal access to reproductive health care services. Hence policies are in place, and it is up to the health system to give practical meaning to these policies. However, as previously noted by Gerhardt (1997), the liberalisation of abortion law alone is insufficient in ensuring equal access to the services.

The CTOPA is one of the most liberal abortion laws worldwide, and indeed the most liberal abortion law in Africa. The CTOPA allows for abortion on request during the first twelve weeks of pregnancy. In fact, the Act makes it almost impossible for a woman to be denied a termination up until the end of the first 20 weeks of pregnancy. Although the CTOPA reflects the intention of the legislature to make TOP accessible to all South African women, it cannot by itself ensure or guarantee equitable access. The Act assumes that health workers will give effect to the legislative intention, but giving impetus to such intention can be problematic. For example, health workers who are opposed to abortion and regard the CTOPA as unacceptably permissive have the potential of seriously frustrating the implementation and operation of the Act. Therefore, not only may other countries benefit from the experiences of South Africa in implementing the CTOPA, but other health care programmes in South Africa also have much to learn from its implementation.

The path of implementation has not been smooth and many challenges and impediments have been encountered. Nevertheless, there are also a number of noteworthy achievements of the CTOPA, including: collaboration with NGOs in the training of health personnel on TOP; permitting

trained midwives to perform TOPs; the use of values clarification workshops to address negative attitudes towards abortion; and the failure of two legal challenges to the CTOPA. Key challenges to the successful operation of the CTOPA include: TOP services are still mainly available at hospitals, rendering the service largely inaccessible to many women living in rural areas; too many second-trimester TOPs are still performed; the issue of conscientious objection and what is expected of health workers; communities still lack education and information about the CTOPA; negative attitudes of health workers toward TOP; and not all designated facilities providing TOP services.

Despite the numerous challenges, a steady increase in the number of abortions performed throughout South Africa is notable (from 26 401 in 1997 to 70 391 in 2003, which is an enormous increase from the 1 479 legal abortions performed in 1993 under the *Abortion and Sterilisation Act* of 1975). Clearly the CTOPA has made abortion accessible for more women in the country. However, questions remain regarding the accessibility of TOP for all women, especially as an estimated 250 000 illegal or back-street abortions were performed each year under the 1975 Act (Right to choose demanded in South Africa 1992). In order to answer the question, it is necessary to again review the objectives of the CTOPA and the degree to which they are being realised.

- While **the 1996 *Constitution* protects the rights of persons to make decisions concerning reproduction and to security in and control over their bodies**, giving practical meaning to the intention is not straightforward. As noted in Chapter 3, the *Constitution* (1996) also permits the right to live by customary or tribal law, and according to the law, women are seen as perpetual minors and wards of their male relations, a situation that has serious limitations for their right to reproductive choice (Haroz 1997).
- **Women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice**. As reported previously, while the CTOPA seeks to ensure that women have access to a safe and legal TOP, health workers who are opposed to abortion have the potential to impede access to TOP by not supplying women with information about the service (*cf*. Caelers 1998; Harrison et al. 1997; Varkey 2000; Versluis 1998). There are widely differing views about the morality of abortion for various reasons, including religious and humanitarian convictions. Hence it would be unconstitutional to require a person to share a particular persuasion on abortion. In addition, it would be equally unconstitutional to compel a person to participate in an activity such as abortion if it is contrary to their religious or moral convictions.
- **The decision to have children is fundamental to a woman's physical, psychological and social health and universal access to reproductive health care services includes family planning and contraception, TOP, as well as sexuality education and counselling programmes and services (i.e. TOP not as a discrete contraceptive service or a form of population control, but as part of broader reproductive health services).**

Prior to 1994, South Africa lacked a comprehensive reproductive health policy, and women's health mainly comprised of maternal and child health services which emphasised limiting population growth. With the election of the ANC in 1994, the focus shifted toward comprehensive reproductive health services that incorporate abortions, and was reflected in the national health programme. Despite the transformation of the health system and the introduction of various new policies, reform is taking place slowly and policies are not implemented uniformly throughout South Africa. The reality of the situation is that there are still far too few facilities in the country providing TOP services. Hence, TOP still to a large extent functions on its own and is not fully integrated at either primary or secondary levels of care.

- **The state has the responsibility to provide reproductive health care to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm**. Varkey *et al*.'s (2000) study in the Northern Cape found that women were being told that abortion was immoral and sinful and that inaccurate information was given to women regarding abortion and their legal rights. In light of such hostility from health workers, it is to be expected that women will remain hesitant to request a TOP.
- **To dispense with the restrictive provisions of the 1975 Act, and to promote reproductive rights and extend freedom of choice by offering every woman the right to choose whether to have an early, safe and legal TOP according to her individual beliefs**. Clearly, the CTOPA has dispensed with the restrictive provisions of the 1975 Act by making abortion available on request during the first twelve weeks. Thereafter, accessibility is to a large degree still unrestricted given the socio-economic grounds permitting TOP to be performed up to week 20. However, as mentioned previously, giving practical intent to the CTOPA is largely dependent on health managers and service providers, each with their own views and beliefs regarding abortion. As is to be expected, health workers with negative attitudes toward abortion have the potential to seriously derail the successful operation of the CTOPA.

Evidence suggests that constitutional rights and progressive abortion legislation are not sufficient to ensure that the reproductive rights of women are realised; nevertheless, it is definitely a major step in that direction. The CTOPA has ensured that all women in South Africa have the choice of whether or not to have a safe and legal TOP, and judging by the steady increase in numbers, this is indeed happening. However, as is to be expected, especially with such a morally controversial subject, human nature has a significant role to play in ensuring that women do indeed access safe and legal TOPs. While the focus has been on the role of health workers in frustrating access to TOP services, it should also be kept in mind that partners/husbands and significant others of the pregnant women too may play a role in preventing of facilitating access to TOP services.

Empirical data was collected at public facilities in the Free State province in order to obtain first-hand evidence of impediments and challenges to the operation of the CTOPA. Chapters 5 and 6 report the findings from the Free State study, which was conducted over a period of six years.

# PART 3: CHAPTER 5
# THE EMPIRICAL STUDY: VIEWS AND EXPERIENCES OF HEALTH WORKERS AND STAKEHOLDERS

## 1. INTRODUCTION

Abortion is a morally dichotomous issue. It would be thoughtless and an affront to human dignity to require every health worker to participate in termination procedures. In recognition of basic human rights, legislation should acknowledge that some health workers do not support TOP for religious, moral or other reasons. The *Constitution* (1996) has certain provisions that implicitly recognise the right of health workers to conscientiously object to TOP (McQuoid Mason 1997; Ngwena 2003). According to the *Constitution* (1996), no one may be unfairly discriminated against on any grounds, including religion, conscience and belief (Section 9(3)). Even more significantly, everyone has the right to freedom of conscience, belief, religion, thought and opinion (Section 15(1)). These provisions do, however, concomitantly recognise the right of women to choose whether to have an early, safe and legal TOP which is in accordance with their beliefs, as captured in the preamble to the CTOPA.

Although the CTOPA reflects the intention of the legislature to make TOP accessible to all South African women, it cannot by itself guarantee equitable access. The CTOPA assumes that health workers will give effect to legislative intent. However, giving practical meaning to such intention, especially at a local level, can be problematic. While health workers may refuse to perform a TOP, the law requires them to inform women of their rights under the CTOPA, as well as the locality of a TOP facility. Ngwena (2003) notes that failure to at least provide women with information about facilities providing the service would effectively thwart the right of access to TOP.

In light of the above, an empirical study was undertaken among health workers in a position to refer women to TOP facilities, as well as TOP service providers in the Free State province in order to describe the attitudes of health workers in general toward TOP and investigate impediments experienced by TOP service providers in rendering services. In addition, key stakeholders were interviewed in 2003 to gauge their opinions regarding impediments to accessing TOP. This chapter comprises three main sections. The first focuses on health workers who were in a position to refer women to TOP facilities, with a particular interest in the following: the referral system; knowledge of and attitudes toward the CTOPA; challenges foreseen with the introduction of TOP services; and recommendations to overcome problems. The second section centres on TOP service providers in terms of: attitudes toward TOP; attendance of abortion values clarification workshops; the availability of resources to render TOP services; an evaluation of TOP services, including counselling and TOP procedures; an evaluation of the physical

structure of TOP facilities; emotional experiences and support for TOP service providers; and challenges and possible solutions to problems. The third section summarises qualitative information obtained from interviews with four key stakeholders regarding: achievements of the CTOPA; main impediments to access; suggestions to improve access; and future challenges regarding access to TOP.

## 2. HEALTH WORKERS IN A POSITION TO REFER CLIENTS TO TOP FACILITIES

### 2.1 The respondents

The methods used to select and gather information from health workers who were in a position to refer women to TOP facilities are presented in Table 13.

**Table 13: Main methodological features of the 1998- and 2003-surveys**

| | Sample size | Sampling technique | Location | Data gathering techniques |
|---|---|---|---|---|
| **1998-survey** | 63 | purposive sampling (non-probability) | 14 Free State towns | Self-administered questionnaires |
| **2003-survey** | 100 | multistage cluster sampling (probability) | 24 Free State towns | Face-to-face and telephone interviews |

During 1998, 100 health workers in the Free State who were in positions to refer women to TOP facilities were conveniently selected from lists provided by TOP facility managers. Only 63 of the 100[34] health workers targeted completed the self-administered questionnaires, which were hand delivered to and collected from them. Due to the lower than expected response rate, a different strategy was followed during 2003, when 100 health workers were interviewed in towns across the Free State. Although 20 towns and one clinic from each of the towns were randomly selected, it was not always possible to find four nurses plus a doctor at each of the selected facilities. In this regard, four back-up clinics were sampled and used to gain access to professional nurses. Numerous challenges were experienced in gaining access to doctors; refusal rates were high which necessitated the selection of doctors from towns surrounding those that were originally sampled. Professional nurses at the clinics were interviewed by data gatherers and telephone interviews were conducted with the doctors. In all instances, potential respondents were given the option whether or not to participate in the study. Participants were assured that all information would be kept confidential. The use of different sampling and data gathering techniques may have introduced a nuance of diversity in the responses; therefore, any comparisons made merely suggest trends and not definite discrepancies in the responses of the 1998- and 2003-respondents.

[34] Methodologists (*cf*. Babbie & Mouton 2001; Neuman 2000) note that a response rate of 50% during self-administered research is adequate for analysis and reporting, while a response rate of 60% can be considered as good.

Table 14: Towns where sampled health workers were employed (1998, 2003)

| Districts and towns in the Free State | | 1998 | | 2003 | |
|---|---|---|---|---|---|
| | | N | % | N | % |
| Motheo | Bloemfontein | 12 | 19.0 | 5 | 5.0 |
| | Botshabelo | 3 | 4.8 | - | - |
| | Excelsior | - | - | 4 | 4.0 |
| | Thaba Nchu | 1 | 1.6 | 3 | 3.0 |
| | Tweespruit | - | - | 1 | 1.0 |
| | Vanstadensrus | - | - | 3 | 3.0 |
| | Wepener | - | - | 6 | 6.0 |
| **Total for Motheo** | | **16** | **25.4** | **22** | **22.0** |
| Lejweleputswa | Boshof | - | - | 1 | 1.0 |
| | Brandfort | - | - | 1 | 1.0 |
| | Bultfontein | 2 | 3.2 | - | - |
| | Dealesville | - | - | 3 | 3.0 |
| | Hennenman | 2 | 3.2 | - | - |
| | Hoopstad | 2 | 3.2 | - | - |
| | Odendalsrus | 2 | 3.2 | - | - |
| | Theunissen | - | - | 4 | 4.0 |
| | Virginia | 3 | 4.8 | 1 | 1.0 |
| | Ventersburg | - | - | 5 | 5.0 |
| | Welkom | 11 | 17.5 | - | - |
| | Wesselsbron | 2 | 3.2 | - | - |
| | Winburg | - | - | 1 | 1.0 |
| **Total for Lejweleputswa** | | **24** | **38.3** | **16** | **16.0** |
| Xhariep | Bethulie | - | - | 4 | 4.0 |
| | Jagersfontein | - | - | 2 | 2.0 |
| | Petrusburg | - | - | 1 | 1.0 |
| | Reddersburg | - | - | 4 | 4.0 |
| | Rouxville | - | - | 4 | 4.0 |
| | Smithfield | - | - | 3 | 3.0 |
| | Zastron | - | - | 4 | 4.0 |
| **Total for Xhariep** | | **-** | **-** | **22** | **22.0** |
| Fezile Dabi | Edenville | - | - | 2 | 2.0 |
| | Kroonstad | - | - | 6 | 6.0 |
| | Steynsrus | - | - | 4 | 4.0 |
| | Viljoenskroon | - | - | 5 | 5.0 |
| **Total for Fezile Dabi** | | **-** | **-** | **17** | **17.0** |
| Thabo Mafutsanyane | Bethlehem | 2 | 3.2 | - | - |
| | Clarens | - | - | 3 | 3.0 |
| | Harrismith | 2 | 3.2 | - | - |
| | Lindley | - | - | 3 | 3.0 |
| | Marquard | - | - | 5 | 5.0 |
| | Phuthaditjhaba | 17 | 27.0 | - | - |
| | Reitz | - | - | 9 | 9.0 |
| | Rosendal | - | - | 3 | 3.0 |
| | Senekal | 2 | 3.2 | - | - |
| **Total for Thabo Mofutsanyana** | | **23** | **36.6** | **23** | **23.0** |
| **Total** | | **63** | **100** | **100** | **100** |

In 1998, no health workers were sampled in two of the five districts of the Free State. In 2003, all districts were fairly uniformly reflected in the sample. In addition, while only 14 towns were included in the 1998-sample, the number increased to 31 towns in the 2003-sample. Therefore, the 2003-sample attempted to better reflect the position in the Free State than was accomplished by the 1998-sample.

A breakdown of the occupational categories of respondents is provided in Table 15.

**Table 15: Occupational category (1998, 2003)**

| | 1998 | | 2003 | |
|---|---|---|---|---|
| | **N** | **%** | **N** | **%** |
| Registered nurse/midwife | - | - | 35 | 35.0 |
| Registered nurse | 27 | 42.9 | 34 | 34.0 |
| Registered midwife | 6 | 9.5 | 8 | 8.0 |
| Staff nurse | 2 | 3.2 | 2 | 2.0 |
| Nursing assistant | - | - | 1 | 1.0 |
| Doctors | 27 | 42.9 | 20[35] | 20.0 |
| Gynaecologist | 1 | 1.6 | - | - |
| **Total** | **63** | **100** | **100** | 100.0 |

The number of years that the respondents had been employed in the health profession is depicted in Table 16.

**Table 16: Number of years in the health profession (1998, 2003)**

| | 1998 | | 2003 | |
|---|---|---|---|---|
| | **N** | **%** | **N** | **%** |
| Less than one year | 2 | 3.2 | 6 | 6.1 |
| 1-3 years | 5 | 7.9 | 26 | 26.3 |
| 4-6 years | 16 | 25.4 | 16 | 16.2 |
| 7-10 years | 14 | 22.2 | 11 | 11.1 |
| More than 10 years | 26 | 41.3 | 40 | 40.4 |
| **Total** | **63** | **100** | **99** | **100** |

In 1998, approximately two-thirds of the respondents (n=40; 63.3%) had been in the health profession for seven years or more. In 2003, slightly more than half of the respondents (n=51; 51.5%) had been in the health profession for seven years or more.

## 2.2 The referral system

The 1998- and 2003-respondents were asked to indicate in which Free State towns facilities were located that provided TOP services. The responses are recorded in Table 17.

[35] Note that all twenty doctors who participated in 2003 were rendering session hours at clinics while also having private practices. They were requested to answer the questions with the clinic and not their private practices in mind.

**Table 17: Facilities in the Free State said to be providing TOP services (2003)**

| | N | % |
|---|---|---|
| National Hospital | **51** | **38.3** |
| Moroka Hospital | **8** | **6.0** |
| Kopano Clinic | **36** | **27.1** |
| Elizabeth Ross Hospital | **20** | **15.0** |
| Marie Stopes Clinic | **2** | **1.5** |
| Orange Hospital | 1 | 0.8 |
| Pelonomi Hospital | 8 | 6.0 |
| Universitas Hospital | 2 | 1.5 |
| Clinics in QwaQwa | 1 | 0.8 |
| Clinics in Botchabello | 1 | 0.8 |
| Phekolong Hospital | 1 | 0.8 |
| Jagersfontein Hospital | 1 | 0.8 |
| District Hospitals | 1 | 0.8 |
| **Total** | **133** | **100** |

Note: frequencies and percentages in bold depict the correct responses.

The majority of respondents in the 1998-study (n=55; 87.3%) indicated that they were familiar with the facilities that provided TOP services in the province. Ninety four percent of the responses about the location of TOP facilities were correct. The percentage of correct responses decreased slightly in the 2003-survey to 88.0%. Thus, it appears as if a number of health workers were not familiar with the location of the TOP facilities in the province.

During 1998, 12.7% (n=8) of the respondents had not encountered a patient requesting a TOP referral. In 2003, this percentage increased to a third of the health workers not being consulted by either adults (n=35; 35.7%) or minors (n=33; 33.3%) for a referral to a TOP facility. Of the 55 respondents in the 1998-study who had encountered women requesting a TOP, 83.6% (n=46) had referred patients to a TOP facility. The reasons provided by the nine respondents[36] who had not referred a patient to a TOP facility related to personal objections (i.e. religion, morals) (n=7) and the patient being more than 20 weeks pregnant (n=2). During 2003, 62.0% of the health workers (n=62) had referred an adult and 57.0% (n=57) had referred a minor to a TOP facility. However, it should be noted that 33 health workers had not been asked for a referral to a TOP facility. In cases where respondents had not referred adult women to a TOP facility, it was reported that another professional nurse referred the woman (n=1) or it was not necessary to refer the woman as she was more than 20 weeks pregnant (n=1). Health workers who had not referred minors to a TOP facility in 2003 explained:

- *"After a discussion, the patient decided not to terminate the pregnancy"* (n=2).
- *"It is against my beliefs, I ask someone else to refer such patients"* (n=1).
- *"The patient was in an advanced stage of pregnancy and was motivated to change her decision"* (n=1).

[36] In cases where relatively few respondents provided answers, only n-values and not percentages are presented in order to provide the reader with an indication of the frequency of responses.

Slightly more than half of the 1998-respondents (n=34; 54.0%) reported that they would be willing to refer clients to a TOP facility in future; 27.0% (n=17) indicated that it would depend on the circumstances and 19.0% stated that they would not refer a patient to a TOP facility again. The circumstances under which a health worker would refer a patient to a TOP facility were if: the client was mentally retarded, had been raped, incest had occurred, etc. (n=7); it was the client's decision to have the abortion (n=4); the duration of the pregnancy was not further than what was legally allowed (n=3); and the woman could be sent to a well known facility and be treated under supervision (n=1). Respondents would not refer a patient to a TOP facility for: personal reasons (i.e. religion and morals) (n=9); contraceptives were available, hence TOP was not necessary (n=1); and women abused the system by having repeat TOPs (n=1).

In 2003, more health workers would refer an adult (n=68; 68.0%) to a TOP facility than a minor (n=60; 60.0%), which slightly increased since the 1998-survey. Four health workers indicated that they would not refer an adult, while two would not refer a minor. The two health workers who refused to refer a minor to a TOP facility provided the following reasons: "*I belong to Doctors for Life, and do not agree with abortion at all*" (n=1); first consult the minors' parents and then make a decision (n=2); and suggest other alternatives such as adoption (n=1). More respondents in 2003 than in 1998 reported that they would refer clients under specific conditions to a TOP facility. Thirty-eight health workers in the 2003-survey (38.0%) would only refer minors under certain conditions and 28 (28.0%) would only refer adults under certain conditions. These specific circumstances are presented in Table 18.

**Table 18: Circumstances under which health workers would refer a patient to a TOP facility (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| Rape/abuse | 21 | 36.2 | 9 | 20.5 |
| Social problems | 11 | 19.0 | 7 | 15.9 |
| Mother's life is in danger/genetic issues | 3 | 5.2 | 10 | 22.7 |
| Mental state | 5 | 8.6 | 5 | 11.4 |
| Age (if she wants to go back to school) | 7 | 12.1 | - | - |
| Only with parent's permission | 5 | 8.6 | - | - |
| The woman/girl is responsible | 1 | 1.7 | - | - |
| The woman/girl is uneducated | 2 | 3.5 | - | - |
| Parents are not willing to support the girl and her baby | 1 | 1.7 | - | - |
| When they come with their minds already made up | 1 | 1.7 | - | - |
| Cultural traditions | 1 | 1.7 | - | - |
| Not her husband's child | - | - | 2 | 4.6 |
| She does not want the baby | - | - | 3 | 6.8 |
| She already has other children | - | - | 3 | 6.8 |
| No husband | - | - | 2 | 4.6 |
| Contraceptives failed | - | - | 1 | 2.3 |
| Accompanied by her partner | - | - | 1 | 2.3 |
| HIV positive | - | - | 1 | 2.3 |
| **Total** | **58** | **100** | **44** | **100** |

Conditions under which health workers would refer minor and adult patients to a TOP facility included: if the client had been raped (minors n=21; 36.2%; adults n=9; 20.5%); if the client had social problems, e.g. the environment in which she lived was not conducive to raising a child (minors n=11; 19.0%; adults n=7; 15.9%); if the continued pregnancy would put the woman's life in danger or if there were genetic concerns (minors n=3; 5.2% and adults n=10; 22.7%); and if the mental state of the mother was poor (minors n=5; 8.6%; adults n=5; 11.4%). Issues relating more specifically to the referral of minors included her age. More particularly, if the minor wanted to return to school, the health workers would refer her to a TOP clinic (n=7; 12.1%). Five respondents (8.6%) indicated that they would only refer a minor if they had the parents' permission.

Despite a Department of Health's (1997b) directive that health workers inform women requesting a TOP about the locality of such facilities, approximately a third of the health workers did not comply with the policy. Approximately two-thirds of the health workers in 1998 (n=39; 63.9%) and 2003 (minors n=67; 67.0% and adults n=62; 62.0%) informed clients about the location of a TOP facility. Respondents in the 1998-study indicated providing information on: the TOP procedure and aftercare (n=12); the CTOPA (n=7); location of TOP facilities (n=5); negative aspects of TOP, e.g. "*it is against God's will"* (n=5); family planning (n=3); and physical implications of TOP (n=3). The nature of the information provided by the 2003-respondents to women requesting a TOP is provided in Table 19.

**Table 19: Information about TOP provided to clients (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| Procedure – what to expect, tablets to be given, where the abortion will take place, etc. | 40 | 27.4 | 42 | 31.8 |
| To make use of family planning/sterilisation/TOP is not a contraceptive | 12 | 8.2 | 15 | 10.6 |
| Where to go and how to get there | 11 | 7.5 | 11 | 8.3 |
| When it is best to go for TOP (under twelve weeks) | 7 | 4.8 | 11 | 8.3 |
| Counselling – emotional preparation/consent procedures/ psychological problems | 16 | 11.0 | 11 | 8.3 |
| To come back for help (post TOP) if problems are encountered) | 9 | 6.2 | 6 | 4.5 |
| TOP is not a solution | 3 | 2.1 | 12 | 9.1 |
| Risk of HIV/STIs | 5 | 3.4 | 4 | 3.0 |
| Legal implications | 6 | 4.1 | 6 | 4.5 |
| Other options e.g. adoption, keep the baby | 8 | 5.5 | 5 | 3.8 |
| Advantages and disadvantages of TOP | 8 | 5.5 | 7 | 5.3 |
| Who must do the bookings? | 1 | 0.7 | 1 | 0.8 |
| TOP is therapeutic | 1 | 0.7 | 1 | 0.8 |
| TOP complications e.g. possible hysterectomy | 16 | 11.0 | - | - |
| Confidentiality | 1 | 0.7 | - | - |
| Sex education | 1 | 0.7 | - | - |
| Involve counsellors and social workers | 1 | 0.7 | - | - |
| **Total** | **146** | **100** | **132** | **100** |

Information that respondents provided during the 2003-survey to minors and adults included: the procedure, what to expect, how to use the tablets and what the actual termination entailed

(minors n=40; 27.4%; adults n=42; 31.8%); importance of using contraceptives and, more specifically, that TOP was not a contraceptive method (minors n=12; 8.2%; adults n=15; 10.6%); the location of TOP facilities (minors n=11; 7.5%; adults n=11; 8.3%); it was best to have a TOP while less than twelve weeks pregnant (minors n=7; 4.8%; adults n=11; 8.3%); and counselling for emotional issues (adults n=16; 11.0%; adults n=11; 8.3%).

The 1998-respondents experienced the following difficulties when referring patients to TOP facilities:

- Dealing with patients who were more than 20 weeks pregnant (n=6).
- Waiting too long for an appointment at a TOP facility (n=5).
- Transport/distance to TOP facilities (n=4).
- The lack of counsellors was problematic if a patient was undecided about the TOP (n=4).
- Not receiving feedback on patients referred to TOP facilities (n=2).
- Some clients were afraid of their partners/interference from partners (n=2).
- Teenagers who abused the system (n=2).
- Patients who did not want to report a rape (n=1).

Similar problems to those noted in 1998 were still experienced in 2003 with regard to the referral of clients to TOP facilities and is illustrated in Table 20.

**Table 20: Problems experienced with the referral of TOP clients (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| No money for transport to the TOP facility | 7 | 23.3 | 8 | 24.4 |
| Patients come back from TOP facilities with tablets to abort at home and are not told how to dispose with the products of conception | 3 | 10.0 | 2 | 6.1 |
| Patients uncertain about what decisions to make | 3 | 10.0 | 1 | 3.0 |
| No feedback post TOP/no follow-up | 3 | 10.0 | 3 | 9.1 |
| Patients who request a TOP and are more than twelve weeks pregnant | 3 | 10.0 | 5 | 15.2 |
| Lack of sonar equipment to determine gestation age | 2 | 6.7 | 2 | 6.1 |
| No formal referral system/no referral letters | 2 | 6.7 | 4 | 12.1 |
| Parent wants the minor to have a TOP, but the minor refuses | 2 | 6.7 | - | - |
| Poor communication/lack of phones | 1 | 3.3 | 2 | 6.1 |
| Keeping the TOP confidential | - | - | 2 | 6.1 |
| HIV status of patients | - | - | 2 | 6.1 |
| Lack of counselling | 1 | 3.3 | 1 | 3.0 |
| Staff at referred to clinics try to talk patients out of having the TOP | 1 | 3.3 | 1 | 3.0 |
| Patients abscond | 1 | 3.3 | - | - |
| Lack of parental involvement | 1 | 3.3 | - | - |
| **Total** | **30** | **100** | **33** | **100** |

The most commonly mentioned problem with referrals in 2003 was the lack of money for transport to TOP facilities (minors n=7; 23.3%; adults n=8; 24.4%). According to TOP service

providers, commuter transport[37] was available in many towns for patients being referred to another health facility, hence patients should not be paying for transport. Further problems were experienced with women who came requesting a TOP when they were more than twelve weeks pregnant (minors n=3; 10.0%; adults n=5; 15.2%).

***Main findings:***

- *Not all health workers who were in a position to refer clients to TOP facilities were aware of the location of TOP facilities.*
- *During 1998, 12.7% of the respondents had not encountered a patient requesting a TOP referral. This percentage increased to a third of the health workers not consulted by patients for a referral to a TOP facility in 2003.*
- *Not all health workers who were approached for a referral to a TOP facility referred the client to such a facility.*
- *More respondents in 2003 than in 1998 reported that they would refer clients under specific conditions, such as rape, social problems and poor health of the mother.*
- *Three in ten health workers would not provide information about TOP to clients, despite a Department of Health's directive to do so (1997b).*
- *Health workers noted that the main obstacles regarding the referral of clients to TOP facilities were clients who presented too late in their pregnancies (1998) and clients' lack of money to pay for transport to these facilities (2003).*

### 2.3 Knowledge of the CTOPA

During 1998, of a possible 756 correct answers to statements about the CTOPA and TOP, 507 were correct, resulting in an average of 67.1%. There was a slight improvement in the level of knowledge of TOP by 2003 when, of a possible 1 393 correct responses, 1 022 were correct, resulting in an average of 73.4%. Therefore, indications were that respondents were fairly knowledgeable about the CTOPA and its implications, however, certain provisions of the Act remain unclear (see Tables 21 and 22).

[37] Commuter transport is provided free of charge by the Free State Department of Health, while taxi services are private and have to be paid for by passengers.

**Table 21: Knowledge of the CTOPA (1998)**

| | True | | False | | Uncertain/ don't know | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| TOP on request is available during the first twelve weeks of pregnancy | 57 | 90.5 | - | - | 6 | 9.5 |
| A trained midwife is not allowed to conduct a TOP | 23 | 36.5 | 29 | 46.0 | 11 | 17.5 |
| TOPs are allowed from the 13th to the 20th week if the continued pregnancy would significantly affect the social or economic well being of the woman | 33 | 52.4 | 15 | 23.8 | 15 | 23.8 |
| TOPs are allowed after the 20th week if certain conditions are met | 33 | 54.1 | 12 | 19.7 | 16 | 26.2 |
| TOPs conducted at public health facilities cost the client a lot of money | 5 | 7.9 | 53 | 84.1 | 5 | 7.9 |
| According to the CTOPA, it is not necessary to offer post-counselling to a women who has had a TOP | 10 | 16.4 | 42 | 68.9 | 9 | 14.8 |
| The client should consent to pre-counselling | 47 | 78.3 | 9 | 15.0 | 4 | 6.7 |
| The client should consent to post-counselling | 41 | 67.2 | 12 | 19.7 | 8 | 13.1 |
| The counsellor has the right to impose his/her personal values on the client | 1 | 1.6 | 58 | 93.5 | 3 | 4.8 |
| A minor has to obtain the consent of her parents/guardians before a TOP may be conducted | 23 | 37.7 | 34 | 55.7 | 4 | 6.6 |
| Health workers may not exercise their conscientious objection to participate in a TOP | 26 | 43.3 | 29 | 48.3 | 5 | 8.3 |
| If a woman requests a TOP, she must be informed of her rights under the CTOPA | 51 | 82.3 | 4 | 6.5 | 7 | 11.3 |

Matters on which respondents in the 1998-survey were perhaps insufficiently knowledgeable included:

- Trained midwives are allowed to conduct TOPs (n=29; 46.0% correct).
- Health workers may exercise the right of conscientious objection to participate in conducting a TOP (n=29; 48.3% correct).
- TOPs are allowed after the twelfth (n=33; 52.4% correct) week and 20th week (n=33; 54.1% correct) if certain conditions are met.
- Minors do not have to obtain the consent of their parents or guardian before being allowed to have a TOP (n=34; 55.7% correct).

**Table 22: Knowledge of the CTOPA (2003)**

| | True | | False | | Uncertain/ don't know | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| TOP is available on request during the first twelve weeks of pregnancy | 97 | 97.0 | 2 | 2.0 | 1 | 1.0 |
| A trained midwife is not allowed to conduct a TOP | 24 | 24.0 | 60 | 60.0 | 16 | 16.0 |
| TOPs are allowed from the 13th to the 20th week if the continued pregnancy would significantly affect the social or economic well-being of the woman | 75 | 75.0 | 18 | 18.0 | 7 | 7.0 |
| TOPs are allowed after the 20th week if certain conditions are met | 62 | 62.6 | 24 | 24.2 | 13 | 13.1 |
| Some sort of certification is still needed if TOP is to be conducted after the twelfth week | 59 | 60.8 | 20 | 20.6 | 18 | 18.6 |
| TOPs conducted at public health facilities cost the client a lot of money | 9 | 9.1 | 86 | 86.9 | 4 | 4.0 |
| According to the CTOPA, it is not necessary to offer post-counselling to a woman who has had a TOP | 9 | 9.1 | 84 | 84.8 | 6 | 6.0 |
| The client should consent to pre-counselling | 75 | 75.0 | 17 | 17.0 | 8 | 8.0 |
| The client should consent to post-counselling | 71 | 71.0 | 20 | 20.0 | 9 | 9.0 |
| Persons under 18 years of age should first consult their parents/guardians before being allowed a TOP | 30 | 30.0 | 65 | 65.0 | 5 | 5.0 |
| Persons under 18 years should first obtain the consent of their parents/guardians before being allowed a TOP | 25 | 25.3 | 68 | 68.7 | 6 | 6.1 |
| Health workers may not exercise their right to conscientious objection with regard to participating in a TOP procedure | 47 | 47.0 | 45 | 45.0 | 8 | 8.0 |
| Health workers may exercise their right to conscientious objection with regard to participating in a TOP procedure but should refer the woman to another facility | 77 | 77.0 | 19 | 19.0 | 4 | 4.0 |
| If a woman requests TOP, she must be informed of her rights under the CTOPA | 98 | 98.0 | 1 | 1.0 | 1 | 1.0 |

A particular knowledge gap that surfaced during the 2003-survey related to midwives being permitted to conduct a TOP, with 24.0% of the respondents (n=24) stating this not to be the case when in fact it was true that trained midwives are permitted to perform the under twelve week procedure, provided they have undergone the prescribed training. Almost a quarter of the respondents (n=24; 24.2%) indicated that TOP was not allowed after the 20th week even if special conditions were met, which in fact is false. With reference to the certification procedure, 20.6% (n=20) of the health workers stated that there was no need for certification after the twelfth week, when in fact the law requires some form of certification during that period. The issue of parental consent was unclear in the CTOPA and, therefore, it was not surprising that some health workers were uncertain as to how to interpret the law. It was agreed by a low 30.0% of the respondents (n=30) that minors should be asked to consult their parents, although this was not a prerequisite for TOP. Furthermore, a quarter of the respondents (n=25; 25.3%) were incorrect in stating that minors needed to obtain parental consent before being allowed a TOP. Conscientious objection is another grey area in the CTOPA, and needs to be interpreted with sections of the 1996 *Constitution* in mind. Hence 47.0% (n=47) of the health workers incorrectly stated that they may not exercise their right to conscientious objection in participating in a TOP procedure.

***Main finding:***

- *Respondents appeared to be fairly knowledgeable about CTOP and there was a slight improvement in the level of knowledge toward 2003, although some areas still need attention, e.g. the role of the midwife, circumstances under which TOP is allowed, parental consent and conscientious objection.*

## 2.4 Attitudes toward TOP

The 1998-respondents appeared divided in their attitudes toward TOP. It is evident from Table 23 that TOP implicitly entailed a number of highly contentious issues, which caused wide-ranging differences in opinion among members of the health community.

**Table 23: Attitudes of referral staff towards TOP (1998)**

| | Agree | | Uncertain | | Disagree | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| TOP should not be legal | 25 | 41.0 | 8 | 13.1 | 28 | 45.9 |
| I believe TOP is justified under all circumstances | 19 | 31.7 | 9 | 15.0 | 32 | 53.3 |
| A women has the right to make her own decisions concerning her body | 47 | 74.6 | 5 | 8.0 | 11 | 17.4 |
| TOP should be an alternative when contraceptives fail | 21 | 34.4 | 1 | 1.6 | 39 | 64.0 |
| People would support the right of women to have a TOP if they knew more about it | 29 | 46.0 | 15 | 23.8 | 19 | 30.2 |
| My religion does not prevent me from accepting TOP | 25 | 40.3 | 1 | 1.6 | 36 | 58.1 |
| Persons under 18 years of age should first obtain the consent of their parents before being allowed a TOP | 37 | 60.6 | 4 | 6.6 | 20 | 32.8 |
| Social and financial problems are sufficient reasons for requesting a TOP | 29 | 46.0 | 4 | 6.3 | 30 | 47.6 |
| Now that the grounds for TOP have been extended, people will become careless about their contraceptive practices | 38 | 61.3 | 8 | 12.9 | 16 | 25.8 |
| A women should only be allowed to have a TOP if her partner agrees | 12 | 19.7 | 3 | 4.9 | 46 | 75.4 |
| The foetus should have the same rights as the mother | 30 | 47.6 | 12 | 19.0 | 21 | 33.4 |
| Only the woman has the right to decide whether to have a TOP | 34 | 54.9 | 2 | 3.2 | 26 | 41.9 |
| Women do not need to feel ashamed if they decide to have a TOP | 38 | 61.3 | 3 | 4.8 | 21 | 33.9 |

Nearly half of the 1998-respondents (n=28; 45.9%) felt that TOP should be legal. Slightly more than half of the respondents (n=32; 53.3%) indicated that TOP was justified under all circumstances. Furthermore, divisions surfaced in the respondent's opinions concerning social and financial reasons being sufficient cause to allow a TOP, with 46.0% (n=29) in favour of and 47.6% (n=30) against social and financial grounds. Nearly two-thirds of the respondents (n=39; 64.0%) did not agree that TOP was an alternative when contraceptives fail. The issue of TOP being used as a contraceptive method was clearly a concern for many respondents as 61.3% (n=38) felt that, as the grounds for TOP had been extended, people would become careless about their contraceptive practices.

The right of the woman to make her own decisions concerning her reproductive health was apparent in statements such as "A woman has the right to make decisions concerning her body",

where 74.6% of the respondents (n=46) agreed with the statement. Moreover, it was felt that a woman did not need her partner's consent to have an abortion (n=46; 75.4%). Most respondents did, however, feel that minors should have the consent of their parents before being allowed to have an abortion (n=37; 60.6%).

During 2003, it was evident that there was still a considerable degree of hostility and also negative attitudes towards TOP (see Table 24). This is similar to the findings Varkey *et al.* (2000) from a study in the Northern Cape amongst health workers and community members, where the main challenges appeared to emanate from staff at referral centres and in wards where women were admitted for second-trimester abortions. Staff at referral facilities told patients that abortion was immoral and sinful.

**Table 24: Attitudes towards TOP (2003)**

| | Agree | | Uncertain | | Disagree | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| TOP should be legal | 72 | 72.0 | 4 | 4.0 | 24 | 24.0 |
| TOP is justified under all circumstances | 20 | 20.0 | 6 | 6.0 | 74 | 74.0 |
| A woman has the right to make her own decisions concerning her body | 89 | 89.0 | 4 | 4.0 | 7 | 7.0 |
| TOP should be an alternative when contraceptives fail | 33 | 33.0 | 4 | 4.0 | 63 | 63.0 |
| People would support the right of women to have a TOP if they knew more about it | 63 | 63.0 | 12 | 12.0 | 25 | 25.0 |
| My religion prevents me from accepting TOP | 57 | 57.0 | 1 | 1.0 | 42 | 42.0 |
| A 14-year-old requesting TOP should be subject to a different set of rules compared to a 17-year-old requesting TOP | 21 | 21.0 | 1 | 1.0 | 78 | 78.0 |
| There should be stricter rules governing minors' access to TOP | 53 | 53.0 | 4 | 4.0 | 43 | 43.0 |
| Persons under 18 years of age should first consult their parents before being allowed TOP | 54 | 54.0 | 2 | 2.0 | 44 | 44.0 |
| Persons under 18 should first obtain the consent of their parents before being allowed TOP | 49 | 49.0 | 2 | 2.0 | 49 | 49.0 |
| Social and financial problems are sufficient reasons for adults requesting a TOP | 45 | 45.0 | 6 | 6.0 | 49 | 49.0 |
| Social and financial problems are sufficient reasons for minors requesting a TOP | 37 | 37.0 | 7 | 7.0 | 56 | 56.0 |
| Since the grounds for TOP have been extended, people have become careless with contraceptives | 69 | 69.0 | 5 | 5.0 | 26 | 26.0 |
| A woman should only be allowed to have a TOP if her partner agrees | 19 | 19.0 | 1 | 1.0 | 80 | 80.0 |
| Women should feel ashamed if they have a TOP | 16 | 16.0 | 7 | 7.0 | 77 | 77.0 |

In the 2003-study, negative attitudes were still evident in light of the relatively high percentage of agreement with the following statements: TOP should not be legal (n=24; 24.0%); religion prevents me from accepting TOP (n=57; 57.0%); social and financial problems are not sufficient reasons for minors (n=56; 56.0%) and adults (n=49; 49.0%) to request a TOP; and, since the grounds for TOP have been extended, people have become careless with contraceptive use (n=69; 69.0%). Respondents were of the opinion that TOP should not be legal due to religious and moral concerns (n=11), and that family planning was freely available (n=8). Those in favour

of TOP stated that: it helped to prevent backstreet abortions (n=42); it was a woman's right (n=8); and that certain circumstances such as rape and abuse called for TOP to be easily accessible (n=7). With regard to religious concerns, respondents indicated that "a *Christian believes the Bible which says that abortion is wrong*" (n=25) and "*Thou shall not kill*" (n=22). Arguments against social and financial problems being sufficient reasons for a TOP included: women should have thought of the consequences before having sex (adults n=11; minors n=23); women should use contraceptives (adults n=16); social security grants are available (adults n=6; minors n=9); and there are other options such as adoption (adults n=4; minors n=5).

Furthermore, it was clear that health workers were in favour of parental involvement in the decision to have a TOP: 78.0% (n=78) felt there should be a different set of rules for minors compared with adults; 54.0% (n=54) wanted minors to first consult their parents before being allowed a TOP; and 49.0% (n=49) went as far as to say that parental consent should be obtained. Health workers were of the opinion that parents should first be consulted for the reasons that: parents should be more responsible/involved in their daughters' lives (n=20); parents are still responsible for their children who are minors (n=14); and minors are still too young to reason (n=7). It was also noted that minors need parental consent for a TOP because they need support (n=11), even more so in case of complications (n=9).

Despite the continued hostility towards TOP, health workers clearly became more positive toward TOP by 2003. More specifically, in 1998, 45.9% of the respondents (n=28) reported that TOP should be legal, and this increased to 72.0% by 2003 (n=72). Similarly, 74.6% of the 1998-respondents (n=47) indicated that a woman had the right to make her own decisions concerning her body and this increased to 89.0% in 2003 (n=89). In 1998, it was reported by 46.0% of the respondents (n=29) that people would be more supportive of TOP if they knew more about it; this increased to 63.0% in 2003 (n=63). While a third of the 1998-respondents (n=21; 33.9%) noted that a woman should feel ashamed if she had a TOP, this view halved to 16.0% by 2003 (n=16).

In 1998, only nine of the 63 respondents and in 2003, only 13 of the 100 respondents had attended an abortion values clarification workshop[38]. Respondents who attended such workshops considered them to be a valuable experience. Reasons provided by the 1998-respondents included gaining a better understanding of TOP (n=5) and being motivated to look at the needs of others (n=2). The 2003-respondents explained that: they had been informed about the CTOPA (n=13); felt empowered and had more confidence to deal with clients (n=2); had the opportunity to discuss cultural views (n=1); and now felt more positive towards TOP (n=1). Furthermore, eight of

[38] The abortion values clarification workshops allow health care providers to reflect on their feelings and thoughts about TOP. It is an attempt for health care providers to understand the need for TOP services and to separate their needs from the needs of their clients. Through this process, health care providers become familiar with the CTOPA and are encouraged to treat clients with dignity and respect, irrespective of their personal views (RRA 1998b).

the 13 health workers in 2003-study indicated that their views on abortion had changed after attending the workshop. These changes were described as follow: TOP is now seen in a positive light (n= 2), the information was enlightening (n=4), views affirmed perceptions and awareness was raised regarding alternatives (n= 2), and maintained a non-judgemental attitude (n=1).

It is regrettable that only a minority of respondents had been fortunate enough to attend the workshops. In addition, abortion values clarification workshops were no longer held in the province at the time of the research.

***Main findings:***

- *While health workers seemingly became more positive toward TOP by 2003, negative attitudes and hostility towards TOP had not yet been erased. Approximately a quarter of the respondents were of the opinion that TOP should not be legal and more than half stated that their religion prevented them from accepting TOP.*
- *Abortion values clarification workshops were attended by a small proportion of the health workers, which is regrettable as those who attended the workshop found the experience to be valuable.*

### 2.5 Challenges associated with the expansion of TOP services (2003)

Table 25 illustrates the 2003-respondents' opinions of whether or not there are sufficient facilities in the province providing TOP services.

**Table 25: Opinions of health workers regarding the number of facilities providing TOP services (2003)**

| | N |
|---|---|
| There are sufficient TOP facilities in the Free State | 40 |
| There are not sufficient TOP facilities in the Free State | 43 |
| Don't know | 17 |
| **Total** | **100** |

It was the opinion of 43.0% of the respondents (n=43) that there were insufficient facilities in the Free State that provided TOP services. The respondents highlighted potential problems that their facilities would experience if they were to introduce TOP services and suggested ways to overcome them (see Tables 26 and 27).

**Table 26: Expected problems with staff and possible solutions (2003)**

| | N | % |
|---|---|---|
| **Problems** | | |
| Lack of staff (including doctors) | 74 | 64.3 |
| Staff unwilling to do TOPs | 29 | 25.2 |
| Lack of training | 12 | 10.4 |
| **Total** | **115** | **100** |
| **Solutions** | | |
| Appoint willing staff | 49 | 41.5 |
| Employ more staff (including doctors) | 42 | 35.6 |
| Train staff | 22 | 18.6 |
| Counselling for staff | 5 | 4.2 |
| **Total** | **118** | **100** |

Expected staff problems were: a lack of staff (n=74; 64.3%); staff members who are unwilling to perform TOPs (n=29; 25.2%); and lack of training (n=12; 10.4%). Suggested solutions include: the appointment of willing staff (n=49; 41.5%); employing more staff (n=42; 35.6%); training staff (n=22; 18.6%); and providing counselling for staff (n=5; 4.2%).

Table 27 presents problems that could arise with regard to facilities if TOP services were to be extended in the province.

**Table 27: Expected problems with facilities and possible solutions (2003)**

| | N | % |
|---|---|---|
| **Problems** | | |
| Too small | 72 | 77.4 |
| Not a hospital/no theatre | 11 | 11.8 |
| Lack of privacy | 9 | 9.7 |
| Communication problems | 1 | 1.1 |
| **Total** | **93** | **100** |
| **Solutions** | | |
| Extend the building | 68 | 72.3 |
| User-friendly rooms for TOP patients | 9 | 9.6 |
| New building | 6 | 6.4 |
| Integrate into the clinic | 3 | 3.2 |
| Refer | 3 | 3.2 |
| Budget for facilities | 3 | 3.2 |
| Should be done in a hospital/theatre | 2 | 2.1 |
| **Total** | **94** | **100** |

The facilities were said to be too small to provide TOP services (n=72; 77.4%) and the only solution to the problem was to extend the physical structure of the clinics (n=68; 72.3%).

***Main findings:***

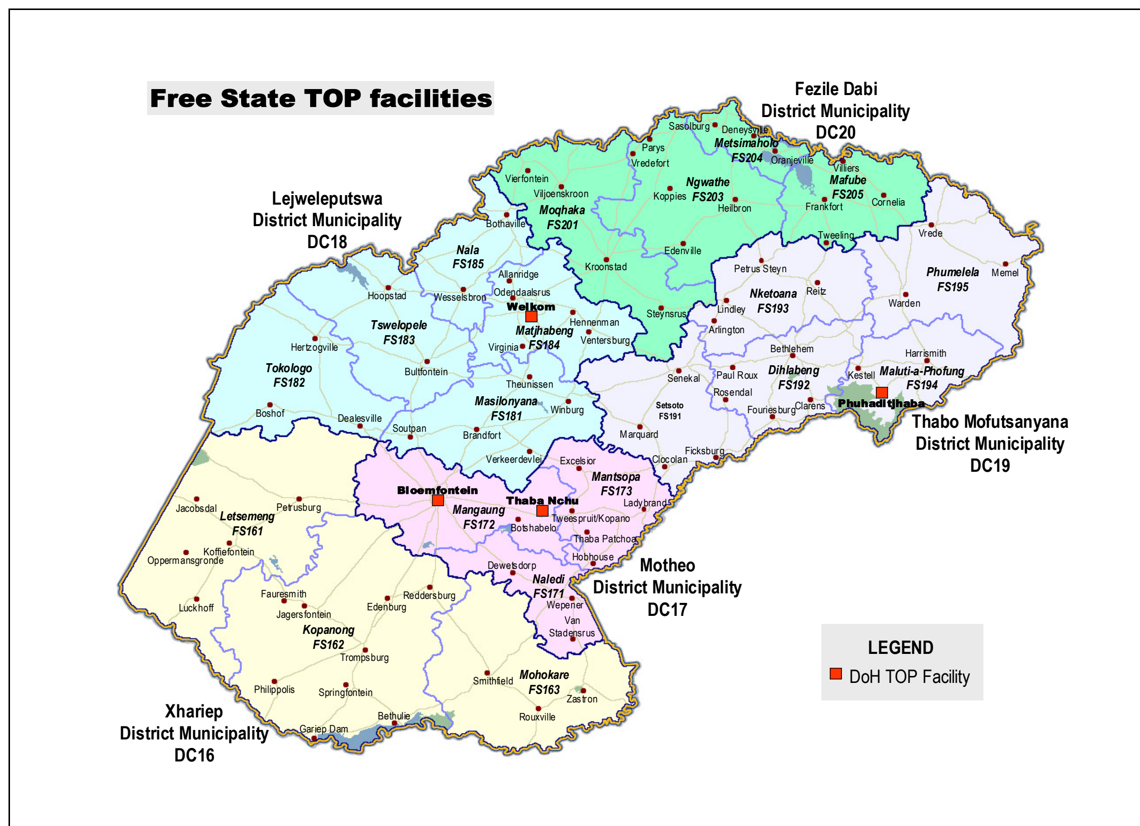
- *There are insufficient facilities in the Free State providing TOP services.*
- *The main anticipated problems if clinics were to introduce TOP services included the lack of willing staff, insufficient space and lack of training.*

# 3. TOP SERVICE PROVIDERS[39]

## 3.1 The respondents

All professional health workers involved in TOP service delivery at National Hospital (Bloemfontein); Elizabeth Ross Hospital (Phuthaditjhaba), Kopano Clinic (Welkom) and Moroka Hospital[40] (Thaba Nchu) participated in both data gathering exercises.

**Map 2: Towns in the Free State with facilities providing TOP services**




The staff categories of respondents are depicted in Table 28.

**Table 28: Categories of respondents (1998, 2003)**

| | 1998 | 2003 |
|---|---|---|
| Medical officers | 4 | 6 |
| TOP facility manager and registered midwife | 3 | 4 |
| Registered midwife | 5 | 3 |
| Registered nurse | 1 | 2 |
| Staff/enrolled nurse | 2 | - |
| Social worker | 1 | 1 |
| **Total** | **16** | **16** |

[39] Note that throughout this section, only n-values (i.e. frequencies) will be reported due to the relatively small number of respondents.
[40] This facility was only included in the 2003 data gathering exercise, as it was not operational in 1998.

It is a concern that the total number of service providers remained relatively constant over both time periods, especially in light of the fact that an additional TOP facility was operational by the time of the 2003-data gathering exercise. While two additional doctors were providing TOP services in 2003, the number of registered midwives/nurses remained unchanged and there were no longer any enrolled/staff nurses at the TOP facilities.

By permitting trained midwives to perform a TOP of less than twelve weeks gestation, the CTOPA aims to increase TOP services to the most inaccessible parts of the country (Hord & Xaba 2002). Despite this goal, in 1998 there were eight trained midwives compared to seven doctors, and in 2003, only seven trained midwives compared to six doctors providing services in the province. Evidently, the goal of the CTOPA to delegate under twelve-week procedures to trained midwives had not yet been achieved in the province. Despite key research findings that abortion services were most effectively rendered at the lowest appropriate level of care, i.e. the clinic (RRA 2002a), TOP services in the Free State were largely available at urban hospitals where doctors were more readily accessible. Similarly, 99.0% of facilities that provide TOP services in South Africa constituted hospitals (Varkey 2000)

Table 29 provides an indication of the level of expertise of TOP service providers by recording the number of complete years that they have been in the health profession.

**Table 29: Length of time in health profession (1998, 2003)**

| | 1998 | 2003 |
|---|---|---|
| ≤ 3 years | 2 | - |
| 4-6 years | 2 | - |
| 7-9 years | 3 | 1 |
| 10 years and longer years | 9 | 15 |

During 1998, nine of the respondents indicated that they worked in the health field for ten years or more. By 2003, all but one of the TOP service providers was in the health profession for 10 years or longer which indicates of a high degree of expertise in the health field.

In 2003, seven of the 16 respondents had worked at their current TOP facility since the introduction of services in 1997. A further seven respondents had been involved in TOP services for more than three years. Only one service provider had been involved with TOP services for less than a year. Therefore, the majority of these health workers had been providing TOP services for a lengthy period of time. Most of the service providers (11 of the 16) had volunteered to become involved in the provision of TOP; four were allocated to a TOP facility; and one service provider reported assisting at the TOP facility, and later became more involved.

***Main findings:***

- *Despite the establishment of a new TOP facility by 2003, the number of TOP service providers remained relatively constant between 1998 and 2003.*
- *The goal of the CTOPA to expand TOP services to inaccessible parts of the country by permitting trained midwives to conduct the under twelve week procedure had clearly not yet been achieved in the Free State, as similar numbers of nurses and doctors were still providing TOP services (and mainly at urban hospitals).*
- *Experienced health workers were providing TOP services as evidenced by their experience in the health profession. In addition, the overwhelming majority of TOP service providers had actively been providing TOP services for at least three years.*
- *Most TOP service providers had volunteered to become involved with the service.*

### 3.2 Attitudes toward TOP

According to the *Programme of Action* of the ICPD (1994 paragraph 7.3), reproductive health is dependent on the recognition of national laws and international human rights which acknowledge the rights of individuals and couples to decide "*freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health*" and to make these decisions "*free of discrimination, coercion and violence*". Given the importance of reproductive rights and health, which are essential components of long established and internationally recognised human rights (Sai 2004), it is encouraging that TOP service providers in 1998 expressed the opinion that TOP was an important human right as:

- "*Every woman has the right to make her own decisions concerning her body*" (n=8).
- "*TOP is necessary under certain conditions, such as rape and social and economic problems*" (n=2).
- "*TOP will lead to a decrease in the numbers of street children and unwanted children*" (n=1).
- "*Women should not be burdened with an unwanted pregnancy*" (n=1).

As noted by Gerhardt (1997), liberalising abortion legislation does not guarantee women access to safe abortion services. Abortion is an emotionally laden subject with numerous conflicting opinions regarding its necessity. In essence, it would be almost impossible for government to compel health workers who are opposed to abortion to perform the service. In this regard, the approach of the Free State Department of Health to utilise the services of health workers who volunteer to work in TOP facilities acts to ensure positive attitudes of TOP service providers toward abortion. Therefore, it is to be expected that TOP service providers would be less hostile towards providing the service than health workers in general. This was indeed the case; while the survey amongst health workers in a position to refer women to TOP facilities found that they had become more positive toward TOP by 2003, these health workers still had negative attitudes and hostile feelings toward the service. In general, the TOP service providers during both data gathering exercises had favourable comments concerning the availability of abortion on request during the first twelve weeks of pregnancy. Table 30 outlines their comments.

**Table 30: Opinion of abortion on request during the first twelve weeks of pregnancy (2003)**

| | N |
|---|---|
| Approve – it is the best thing that could have happened to women | 9 |
| Foetus is still small, fewer complications | 5 |
| Safe procedure/effective medication | 3 |
| It is her right, no matter what her reason | 3 |
| May be good for the women, but health workers need a reason | 2 |
| Avoid backstreet abortions | 2 |
| Helps women in difficulty | 1 |
| Helps avoid family problems | 1 |
| Agree, provided the women are informed | 1 |
| Gestation limit should be reduced from 20 to twelve weeks for all TOPS | 1 |
| Improved access as doctors and nurses are allowed to do it | 1 |

More specifically, respondents during 2003 reported "*it is the best thing that could have happened to women*" (n=9). Furthermore, the foetus was still small and so there were fewer complications (n=5); the procedure was safe (n=3); and it helped to avoid backstreet abortions (n=2). However, it was noted that, while this may be good for women wanting a TOP, it was different for health workers who felt they should know the reason why women wanted to have a TOP (n=2). More detail regarding the attitudes of service providers towards TOP is presented in Table 31.

**Table 31: Attitudes towards TOP (1998, 2003)**

| | Agree | | Uncertain | | Disagree | |
|---|---|---|---|---|---|---|
| | 1998 | 2003 | 1998 | 2003 | 1998 | 2003 |
| TOP should not be legal | 2 | 1 | 2 | 1 | 12 | 14 |
| TOP is justified under all circumstances | 9 | 4 | 3 | - | 4 | 12 |
| A woman has the right to make her own decisions concerning her body | 13 | 15 | 2 | - | 1 | 1 |
| TOP should be an alternative when contraceptives fail | 12 | 6 | - | 2 | 4 | 8 |
| People would support the right of women to have a TOP if they knew more about it | 12 | 12 | 3 | 3 | 1 | 1 |
| My religion prevents me from accepting TOP | 8 | 5 | 4 | 1 | 4 | 10 |
| Persons under 18 years of age should first obtain the consent of their parents before being allowed TOP | 2 | 3 | 5 | 1 | 9 | 12 |
| Social and financial problems are sufficient reasons for adults requesting a TOP | 8 | 8 | 3 | 5 | 5 | 3 |
| Since the grounds for TOP have been extended, people have become careless with contraceptives | 7 | 12 | 2 | 1 | 7 | 3 |
| A woman should only be allowed to have a TOP if her partner agrees | 1 | 1 | 3 | 1 | 12 | 14 |
| Women should feel ashamed if they have a TOP | 1 | 1 | 2 | 1 | 13 | 14 |

By and large, the respondents during both data gathering exercises were largely in favour of legalised TOP. However, despite this positive response, service providers in 2003 were less positive and sometimes seemingly uncertain about several provisions of the CTOPA. For example, during 1998 nine of the respondents were of the opinion that TOP was justified under all circumstances, which decreased to four respondents in 2003. In addition, twelve respondents in 1998 compared to six in 2003 indicated that TOP should be an alternative when contraceptives failed. Far more respondents in 2003 (n=12) than in 1998 (n=7) were of the opinion that people had become careless in their use of contraceptives since the introduction of the CTOPA. The

provision that social and financial problems were sufficient reason for requesting TOP was not clear for both groups. Reasons for uncertainty in 2003 were: *"people with money can also have relationship problems and this too is not an ideal situation in which to have a baby"* (n=1);" *women should prevent falling pregnant if they are not financially independent*" (n=1); and, "*women only use it as an excuse - they do not want to have the baby*" (n=1).

The move toward a more negative outlook on certain aspects of the CTOPA suggests that the longer health workers were involved in providing TOP services, the more cautious they become in their attitudes toward the service. This is a concern as the quality of TOP services, as well as access thereto, is directly related to the roles and attitudes of health workers (RRA 2000). As such, it is important to keep TOP service providers positive toward their work. Furthermore, by 2003 the TOP service providers were also less positive regarding their work morale. In 1998, respondents expressed satisfaction in being able to provide a service (n=7) and that it was safe (n=2). Although the 2003-respondents were happy at work (n=7); enjoyed helping people (n=4); and felt positive about preventing back-street abortions (n=1), numerous issues were also raised that contributed toward their poor work morale as can be seen in Table 32.

**Table 32: Factors influencing the work morale of TOP service providers (2003)**

| | N |
|---|---|
| **Poor work morale** | |
| Anti-TOP attitudes | 15 |
| Lack of staff | 10 |
| Repeat TOPs | 4 |
| Lack of resources/equipment | 3 |
| Lack of space | 2 |
| Lack of training | 2 |
| Lack of support from management | 2 |
| Poor treatment of clients by TOP nurses puts the doctor in a difficult position | 2 |
| Never thanked for our work | 1 |
| Transport problems | 1 |
| **Good work morale** | |
| Use psychiatric experience to overcome problems with work and worries about clients | 1 |
| Gratitude of clients | 1 |
| Enjoy my work, nothing affect my morale | 1 |

Poor work morale was influenced by anti-TOP attitudes (n=15); lack of staff to provide TOP services (n=10); women coming for repeat TOPs (n=4) and a lack of resources and equipment (n=3).

***Main findings:***

- *In line with international human rights, service providers unanimously agreed that TOP was an important human right, particularly as every woman should have the right to make her own decisions concerning her body. In addition, service providers supported the availability of abortion on request during the first twelve weeks of pregnancy.*
- *More respondents in 2003 were of the opinion that people had become careless in their use of contraceptives since the introduction of the CTOPA.*
- *Although still positive, service providers in 2003 were more cautious and conservative in their attitudes toward TOP. Similarly, more issues surrounding poor work morale were raised in 2003.*

### 3.3 Emotional experiences, conduct of and support for TOP service providers

Negative attitudes and hostility not only impact on women who wish to access abortion services, but also on health workers rendering the service. Table 33 provides more detail.

**Table 33: Harassment of TOP service providers (1998, 2003)**

| TOP service providers indicated how often they: | Regularly | | Sometimes | | Seldom | | Never | |
|---|---|---|---|---|---|---|---|---|
| | 1998 | 2003 | 1998 | 2003 | 1998 | 2003 | 1998 | 2003 |
| Felt isolated from colleagues not doing TOP | 3 | 2 | 2 | 1 | 2 | 2 | 2 | 9 |
| Felt guilty about doing TOP | 1 | - | 3 | 6 | 1 | 3 | 6 | 5 |
| Felt resentful of patients requesting TOP | - | - | - | 7 | 4 | 1 | 6 | 6 |
| Had been harassed by colleagues not doing TOP | - | - | - | 2 | - | 2 | - | 10 |
| Thought that TOP should not be within the scope of practice of a registered nurse | 2 | - | 3 | 3 | 1 | 1 | 5 | 10 |
| Refused to assist with a TOP | - | - | - | 1 | 2 | 3 | 9 | 10 |
| Had been pressurised to conduct TOPs that you felt should not be done | - | 1 | - | - | 1 | - | 9 | 13 |
| Had been in disagreement with family members/friends about your involvement in TOP | - | 1 | - | 2 | 1 | - | 9 | 11 |
| Had been in disagreement with community members where you live about your involvement in TOP | - | 1 | - | 2 | 4 | 1 | 7 | 10 |
| Had been ostracised by your church because of your involvement in TOP | - | - | - | 1 | - | - | - | 13 |
| Had been consulted by a minor who emotionally was not ready to consent to a TOP | - | 1 | - | 4 | - | 3 | - | 6 |
| Thought that minors need parental consent to have a TOP | - | - | - | 1 | - | 1 | - | 12 |

Although the majority of TOP service providers had never been harassed by colleagues, four had and they explained that "*they fight with me because of my involvement in TOP*" (n=1) and "*they call me names, and say that we are killers*" (n=1). In 2003, nine respondents compared to two in 1998 indicated never feeling isolated from colleagues. The five respondents who felt isolated stated that: "*people think that I am encouraging TOP*" (n=1); "*people do not approve of what I am doing*" (n=1); "*they look down on me as if I am not a real doctor*" (n=1); and "*they do not invite us* [TOP staff] *to other hospital activities*" (n=1).

Five respondents in 1998 and nine in 2003 reported that they at some stage they felt guilty about doing TOPs. The 2003-respondents provided the following reasons:

- "*I feel guilty for helping people to murder their own baby*" (n=2).
- "*Especially when the client is almost 20 weeks pregnant*" (n=2).
- "*When I allow myself to think about what I am doing, I feel bad*" (n=1).
- "*When people say that I do not care, when I do*" (n=2).
- "*I have mixed feelings about TOP*" (n=1).

More respondents in 2003 (n=8) than in 1998 (n=4) reported that at some point they felt resentful of clients requesting a TOP. Reasons supplied by the 2003-respondents included: "*women do not use contraceptives*" (n=1); "*it depends on my mood*" (n=2); "*people do not accept me, they think that I am doing a dirty job*" (n=2); "*I feel resentful when it is a repeat* [TOP]" (n=2); and "*when the women do not have a justified reason for having a TOP*" (n=1).

Six respondents in 1998 and four in 2003 were of the opinion that TOP should not be within the scope of a registered nurse. Reasons forwarded by the 2003-respondents were: "*cases may be more complicated than you think*" (n=2); "*it is better that a doctor does it*" (n=2); and "*if the midwife does not do it by the book, there could be problems*" (n=2).

Two TOP service providers in 1998 and four in 2003 reported that there were instances where they refused to assist with a TOP. The 2003-respondents indicated refusing under the following circumstances:

- "*When a patient is uncooperative, I refer them*" (n=1).
- "*If she was forced to do a TOP*" (n=1).
- "*Patient who came for the sixth time/too many repeats*" (n=1).
- "*I feel that it is dangerous*" (n=1).
- "*When I did not get support from management*" (n=1).

Four respondents each in 1998 and 2003 had been in disagreement with their family about TOP. Three of the 2003-respondents reported being called a murderer (n=1) and "*most of the time my wife encourages me to change my jo*b" (n=1). The four respondents who indicated that they were in disagreement with the community about TOP were so because: "*they call me a murderer*" (n=1); "*I received visits from pro-lifers who want to counsel patients*" (n=1); and "*it is difficult to make people understand what I do*" (n=1).

Eight TOP service providers in 2003 indicated that they had been consulted by a minor who was not emotionally ready to consent to a TOP and explained how they handled the situation:

- "*I counsel her so that she can make an informed choice"* (n=1).
- "*Send her to fetch her parents/relatives*" (n=1).
- "*Send her to Life Line*" (n=1).
- "*Arrange for a psychologist to see her*" (n=1).
- "*Don't do the TOP if she is not ready*" (n=1).
- "*Give her something to relax*" (n=1).
- "*Ask a doctor to sit in when I talk to her*" (n=1).

In 1998, four of the 11 respondents conducting/assisting with TOPs stated that their work with clients negatively affected their professional relationships with colleagues. Far more respondents in 2003 (seven of the 14 respondents) stated the same: "*they feel that we encourage TOP, we are killers, they call me Harry, after Herod who murdered the babies in the Bible*" (n=3); "*they look at me as if I have done something wrong*" (n=3); "*they are not friendly*" (n=2); "*people's behaviour differ in South Africa from my country where TOP is accepted* (n=1); "*they treat me as if I am doing the dirty job in medicine*" (n=1); "*I work harder in other departments so that I can be accepted*" (n=1); and "*dispensary staff believe TOP doctors cannot prescribe medicine*" (n=1).

A quarter of the 1998-respondents (n=4) reported that psychological support was available at their facilities, while two respondents stated support was available, but not at their facilities. Two respondents were uncertain about the availability of this support. Of the respondents who indicated that support was not available (n=8) or that they were uncertain (n=2), eight indicated that they would like support to be available. In 2003, fewer respondents (n=3) indicated that psychological support was available for TOP service providers. Eight of the 13 respondents who indicated that psychological support was not available said that they would like such support. Despite recommendations by the RRA (2000a) that each province have a support system in place for TOP service providers, this was not yet the case in the Free State by 2003.

***Main findings:***

- *A quarter of the 2003-TOP service providers had been harassed by colleagues due to their involvement with the service.*
- *The number of respondents who indicated that their work with TOP clients has affected their professional relationships with colleagues almost increased by 2003*.
- *Half of the 2003-respondents at some point felt isolated from their colleagues.*
- *The number of respondents who felt guilty about their involvement with TOP and those who felt resentful of TOP clients increased from 1998 to 2003. This, together with increasing poor work morale and less positive attitudes toward TOP, implies that the longer health workers were involved in providing TOP services, the more emotionally drained they became. Despite this growing concern, psychological support was not available for TOP service providers in the province.*

### 3.4 Abortion values clarification workshops

Approximately half of the respondents (nine in 1998 and eight in 2003) had attended abortion values clarification workshops. Almost all of the TOP service providers who had attended the workshops found them to be useful (eight of the nine 1998-respondents and seven of the eight 2003-respondents). This is similar to the findings of Marais (1997) who emphasise the importance of abortion values clarification workshops in promoting an understanding of TOP. The 1998-respondents explained that the workshops had provided them with a better understanding of abortion (n=7) and had helped clarify emotions regarding abortion (n=1). Similarly, the 2003-respondents reported that the workshops were indispensable, as it provided them with the opportunity to clarify their own values and share views with other TOP providers and

psychologists (n=6). Additionally, they had become more confident, changed their attitudes (n=4) and received all the information that was needed to understand the CTOPA (n=2).

Four of the 1998-respondents noted that the workshops encouraged them to become more positive toward abortion as they had a better understanding of the legal aspects of abortion (n=2) and realised that women had the right to make their own decisions (n=2). Seven of the 2003-respondents indicated that their attitudes changed after the workshop: they became more positive towards abortion (n=3); they had certainty that they were doing the right thing (n=2); they were given sufficient information (n=1); and it lowered their stress levels slightly (n=1).

***Main finding:***

- *In light of the hostility and negativity that still surround abortion, coupled with the increased emotional drain of TOP service providers, continued values clarification workshops could play a valuable role in addressing such challenges. The matter was also raised by the RRA (2000a). Despite their benefits, the workshops were no longer held in the province.*

### 3.5 Resources for TOP service delivery

According to Section 3 of the CTOPA, facilities must have access to medical and nursing personnel, operating theatres, appropriate equipment, drugs, emergency transport, in-patient facilities, infection control measures, waste disposal and telephones, before they may provide TOP services (see table 34).

**Table 34: Staff, infrastructure and equipment at TOP facilities (1998, 2003)**

| | 1998 | 2003 |
|---|---|---|
| Willing medical practitioners to perform TOPs | 0/3 | 4/4 |
| Willing nursing personnel for to perform TOPs | 1/3 | 3/4 |
| Trained medical practitioners to perform TOPs | - | 2/4 |
| Trained registered midwives for TOPs | - | 2/4 |
| Counsellors | 1/3 | 1/4 |
| Trained counsellors | - | 1/4 |
| Appropriate surgical equipment | 2/3 | 4/4 |
| Emergency resuscitation equipment and drugs | 2/3 | 4/4 |
| Transport in the case of an emergency | 2/3 | 4/4 |
| Facilities for clinical observation | 3/3 | 4/4 |
| Equipment for clinical observation | 3/3 | 4/4 |
| In-patient facilities | 1/3 | 2/4 |
| Appropriate infection control measures | 2/3 | 4/4 |
| Safe waste disposal infrastructure | 2/3 | 4/4 |
| Telephones | 3/3 | 3/4 |

In 1998, all three clinic managers reported a lack of willing medical practitioners to perform TOPs. There was an improvement in this situation by 2003 (two additional medical practitioners were

providing TOP services, although an additional facility had also been opened), as all facility managers reported having sufficient medical practitioners to provide the service. A similar improvement occurred with regard to willing nursing personnel to perform TOPs. Seemingly, however, despite the availability of willing staff to provide TOP services, staff were not necessarily trained to perform TOPs. Staff shortages mainly related to the lack of enrolled nurses, registered nurses, gynaecologists and social workers. With regard to staff shortages, the 2003-facility managers had the following to say:

- "*Too much work, we can't even cope, somehow we just have to manage*" (n=1).
- "*If necessary we send patients to Life Line for counselling*" (n=1).
- "*Not really coping, we have to be creative to get our work done, sometimes have to turn people away, I feel guilty about that*" (n=1).

Improvements were also evident regarding the availability of surgical equipment; resuscitation equipment and drugs; transport in cases of emergency; in-patient facilities; infection control measures; and waste disposal infrastructure.

During 1998, the facility managers reported the main problems with staff to entail: too few staff members (n=2); a lack of team spirit among personnel (n=1); staff members were sometimes impatient (n=1); and no support existed for service providers (n=1). It was suggested that: more staff be appointed at TOP facilities (n=1); the team spirit could be encouraged through meetings, workshops and in-service training (n=1); support services should be made available for staff (n=1); and more training should be offered (n=1). Similar challenges surfaced in 2003, where it again was reported that there was a lack of staff to provide TOP services (n=3) as well as a lack of training for TOP staff (n=1). It was suggested that the province train volunteer staff for TOP (n=1) and that more staff be allocated to the TOP programme (n=1).

The main problems experienced in 1998 with facilities and equipment were: the lack of equipment and faulty equipment (n=2); facilities were too small (n=1); and renovations at the hospital made it difficult to provide quality TOP services (n=1). It was suggested by all TOP facility managers that the budget for TOP provision should be re-examined so that the necessary steps could be taken to address shortcomings. The lack of space was again mentioned as a problem in 2003 (n=2). It is interesting to note that renovations were still underway at the facility where it had been reported as a problem for the delivery of quality services in 1998. Additional problems reported by TOP facility managers in 2003 were: the lack of finances for more effective pain management (n=1); "*patients come from far, they are given pills for an induction and sometimes bleeding starts while they were travelling*" (n=1); and, far distances between patients' homes and TOP facilities (n=1).

***Main findings:***

- *It appears that there was an overall improvement in the availability of essential resources to provide TOP services. However, despite the availability of willing medical personnel, the lack of training continued to be a problem. Managers continued to indicate that more personnel were needed to provide quality TOP services.*
- *The lack of space at TOP facilities was still problematic during 2003. Of particular concern was that renovations undertaken during 1998 had not yet been completed by 2003 at one of the facilities.*

### 3.6 Evaluation of TOP services

During 2003, it was found that the only document guiding TOP management and service provision in the Free State was Act 92 of 1996 (*Choice on Termination of Pregnancy Act*). There were no protocols assisting TOP service providers in carrying out their daily tasks, hence service providers each interpreted the CTOPA in their own manner. Thus there was an obvious lack of standardised operating procedures at the TOP facilities which may have placed additional strain on already overburdened staff.

Respondents evaluated the quality of TOP services in respect of pre- and post-counselling, examination, procedure, information provided to clients, and aftercare (see Table 35).

**Table 35: Evaluation of the quality of TOP services (1998, 2003)**

| | Good | | Average | | Poor | | Uncertain | |
|---|---|---|---|---|---|---|---|---|
| | 1998 | 2003 | 1998 | 2003 | 1998 | 2003 | 1998 | 2003 |
| Pre-counselling | 12 | 8 | 3 | 5 | 1 | 2 | - | 1 |
| Post-counselling | 12 | 2 | 3 | 5 | 1 | 4 | - | 3 |
| Examination | 14 | 14 | 2 | - | - | - | - | 2 |
| Procedure | 14 | 14 | 2 | 1 | - | - | - | 1 |
| Information on TOP | 12 | 11 | 3 | 2 | 1 | 1 | - | 2 |
| Aftercare | 7 | 10 | 7 | 4 | 2 | 1 | - | - |

Data suggests that the 1998-TOP service providers were more optimistic regarding the quality of services, especially pre- and post-counselling, than during the 2003-survey. More specifically, in 2003 fewer respondents (n=8) were of the opinion that the quality of pre-counselling was good compared to the respondents in 1998 (n=12). In 2003, pre-counselling was reported to be good as patients were counselled individually and not in groups (n=1) and counselling was tailored to meet the needs of the clients (n=2).

Counselling should enable women to make an informed choice regarding TOP by providing information about alternatives to TOP, the TOP procedure and associated risks of TOP, and that contraceptives should be used to prevent future pregnancies (Department of Health 1997b). In practice, it was found that the 2003-counsellors provided information during pre-counselling on: the CTOPA and its legal implications (n=1); the TOP procedure (n=1); possible complications of TOP (n=1); family planning (n=1); and HIV/AIDS and STIs (n=1). Furthermore, it was indicated that sufficient time was spent on counselling (n=1). Poor services were also said to be due to the

lack of staff and time available to counsel patients (n=2). It was noted that one of the clinics referred indecisive clients to Life Line for more in-depth counselling.

The quality of post-counselling services in 2003 was evaluated fairly negatively. Poor services were also said to be due to a lack of staff and time (n=2) and patients not returning for post-counselling (n=3). Two facility managers evaluated post-counselling as good, because patients were encouraged to return for post-counselling (n=1) and that the service was at least available (n=1). Inadequate post-counselling is a cause for concern. The WHO emphasises the importance of quality post-abortion counselling as it could help avoid further unwanted pregnancies and unsafe abortions and, in turn, lower the number of maternal deaths (Barnett 1997).

The majority of respondents during both the 1998 and 2003 surveys indicated that examinations were appropriately undertaken for the following reasons:

- "*The examination is done by a doctor*" (n=5).
- "*A sister or midwife helps the doctor with the examination*" (n=1).
- "*A thorough history is taken during the examination*" (n=1).
- "*An ultrasound/sonar is done if necessary*" (n=1).
- "*The examination procedure in itself is rated as good, but it also depends on whether the patient cooperates or not*" (n=1).
- "*The nurse refers the patient to a doctor if problems are identified during the examination"* (n=1).
- "*Health workers make sure of the gestational age during the examination*" (n=1).
- "*Staff are thorough*" (n=1).

As with the examination, the majority of service providers during both data gathering exercises were of the opinion that the procedure was adequately performed. Reasons forwarded by the 2003-respondents include:

- "*No complications/deaths/infections had yet been experienced*" (n=9).
- "*Under twelve week procedures are done by a doctor*" (n=2).
- "*A doctor with the help of a sister does the over twelve week procedures*" (n=3).
- "*The facilities are well-equipped*" (n=1).
- "*All the staff are qualified to do the procedure*" (n=1).
- "*Staff feel comfortable doing the procedure*" (n=1).

During 1998, twelve of the 16 respondents viewed the quality of TOP-related information provided to the clients as good. Similarly during 2003, 11 of the 16 respondents evaluated the quality of information as good, because it included explanations about the procedure, complications, other

options and family planning (n=4), and provided clients with sufficient information so as to give informed consent to the procedure (n=11). Furthermore, information was provided in the patients' own language and tailored to meet their individual needs (n=3). A social worker was also involved in the provision of information (n=1) and, where necessary, visual aids were used (n=1). One respondent noted that the provision of information was "*poor due to a lack of staff and time and too many patients to see*".

Concerns were raised regarding the quality of aftercare during 1998, especially as there was no follow-up of patients (n=2). The situation improved to some extent toward 2003 when aftercare was evaluated as good by 10 of the 16 respondents. Statements in this regard include: it was available for patients who needed it (n=8); patients were immediately given aftercare, which included pain medication (n=2); nurses were well trained to provide aftercare (n=1); and patients were given a card to take to their nearest family planning clinic (n=1). Again, a lack of staff and time were said to result in poor aftercare services (n=1).

### 3.6.1 Counselling

Given the importance of TOP counselling, it is distressing to note that only six of the ten counsellors in 1998 reported that they had received specific training to counsel TOP patients. The situation improved slightly in 2003 when nine of the eleven respondents indicated that they had received counselling-specific training. The 1998-respondents reported that training for counsellors included: information on pre-counselling such as what options the clients have, legal aspects of the CTOPA, informed consent, possible complications and side effects of drugs (n=4); information on post-counselling and contraceptives (n=3); and values clarification (n=3). Similarly, the 2003-respondents indicated that the training focused on: what information to provide the client with (n=5); legal aspects of TOP/interpretation of the law (n=5); communication and counselling skills (n=4); learning not to be judgemental (n=4); information on reproductive health (n=2), contraceptives (n=1); potential complications during TOP (n=1); obtaining consent (n=1); and the management of TOP patients (n=1).

Five of the six counsellors in 1998 noted that the training was adequate. The counsellor who was dissatisfied with the training reported that it had not been specific enough and that training should be available for all health workers. In 2003, one of the nine respondents who had received training to counsel patients indicated that it did not adequately prepare her for the task as she required more information on how to manage her own stress.

The problems experienced by the 1998-respondents when counselling TOP clients included:

- Cultural problems (ignorance about contraceptives, overpowering male partners) (n=2).

- Inadequate counselling facilities (n=2).
- Counselling style of no follow-up (n=2).
- Clients who are secretive/afraid to talk (n=2).
- Clients wouldn't consider other options (n=1).
- Language problems (n=1).
- How to help clients who are more than 20 weeks pregnant (n=1).

An almost entirely different set of problems were reported by the 2003-TOP counsellors: adults were not interested in what the counsellor had to say (n=6); adults were careless with contraceptives (n=4); and a shortage of staff/lack of time hampered effective counselling (n=2). Problems identified by respondents in 2003 with the counselling of minors were: minors claimed not knowing about family planning (n=11); ignorance (n=3); not listening (n=3); and a lack of time/shortage of staff (n=2).

In 2003, facility managers reported that the main problems with pre-counselling were: a lack of time and staff (n=2); too little space and uncomfortable seating (n=1); language/cultural problems (n=1); and clients' lack of openness about their problems (n=1). Possible solutions to these problems were that the Department of Health should plan and design a more user-friendly venue for TOP services (n=1); the Province should provide more staff (n=3); total privacy for clients should be ensured (n=1); and staff should be able to make clients feel at ease (n=1). The problems surrounding post-counselling related to clients not returning for this service (n=2), as they were not relaxed and in a hurry to leave (n=1). In order to solve these problems, post-counselling should be decentralised to all PHC clinics (n=1) and more counsellors should be appointed (n=1).

### 3.6.2 Procedures

In 1998, seven of the eleven health workers performing/assisting with TOP procedures had not received TOP-specific training. By 2003, all health workers performing/assisting with the TOP procedures had received appropriate training. According to the 2003-respondents, training entailed: all aspects of abortion care including the various procedures (n=11); positioning the client (n=4); physical examinations (n=4); pre- and post-care, including the management of complications (n=3); instruments (n=3); reproductive health and family planning (n=2); history taking (n=2); treatment management (n=1); checking for abnormalities (n=1); and theory (n=1). Thirteen of the 14 respondents reported that the training adequately prepared them to conduct TOPs.

No TOP service provider in 1998 indicated feeling uncomfortable when conducting TOPs. Two respondents did indicate that they felt uncertain of their emotions, while the remaining nine

respondents felt comfortable. Six of the eleven respondents indicated that their emotions differed from client to client. Cases where their emotions were likely to be affected included:

- "*It depends on the clients' attitude, some are arrogant and argumentative*" (n=3).
- "*Situations such as when the client is HIV-positive, or in cases of rape, abuse, young girls under 16 years of age*" (n=2).

Unlike the 1998-respondents, more service providers in 2003 reported feeling uncertain and uncomfortable when conducting/assisting with TOPs (n=4). Furthermore, 13 of the 14 respondents indicated that their emotional feelings differed from client to client, depending upon the nature of the case, especially with: abuse/rape cases (n=4); when the gestational age had been incorrectly calculated and an older foetus was aborted (n=4); the teenager being very upset (n=4); if the client had serious problems (n=3); if the client refused to use family planning (n=1); and if the patient was ungrateful (n=1).

By 2003, service providers doing/assisting with TOP procedures were experiencing numerous problems with clients. Adult patients did not accept the clinics' routine of booking[41] patients and wanted to be attended to immediately (n=3). Furthermore, the attitudes of adult patients with regard to their careless use of contraceptives (n=1) and the belief that it is their right to have a TOP (n=1) was indicated as problematic. Hand in hand with the careless use of contraceptives was the problem of adults who came for repeat TOPs (n=1) and with advanced pregnancies (n=1). The TOP process itself was noted to have the following problems: ineffective pain killers (n=2); lack of staff (n=1); lack of privacy (n=1); poor treatment of patients (n=1); patients not returning to the clinic within 48 hours as prescribed (n=1); frequent complications (n=1); and the fact that the bleeding was sometimes very serious when patients above twelve weeks were sent home for the induction (n=1). Finally, respondents also indicated being concerned about the high number of patients with STIs and HIV/AIDS. Suggested solutions to these problems were: educating TOP clients (n=4); being permitted to prescribe stronger pain killers (n=2); a firm approach to TOP clients (n=1); improved physical structure of facilities (n=1); and not allowing abortions for over twelve weeks (n=1).

Problems peculiar to minors were: the examination was more difficult to undertake (n=2), as was the MVA procedure (n=2); minors were uncooperative and jumped off the bed (n=2); they were not well informed (n=2); and not relaxed (n=1). Possible solutions to these problems included: more time spent on counselling so that minors could be better informed about TOP (n=3); improved physical structure of facilities (n=2); assistance from doctors (n=1); conducting the TOP under general anaesthetic (n=1); not doing abortions above twelve weeks (n=1); providing more

[41] Note, bookings were done at three of the four facilities in 2003.

support (n=1); and, as with the adults, being permitted to prescribe stronger pain medication (n=1) and being provided with more effective pain killers (n=1).

In 2003, facility managers reported that the main problems experienced with the induction procedure (i.e. above twelve weeks) were:

- No feedback on clients/from clients (n=2).
- "*The referral hospital only does cleaning after inductions once a week and the patients are not helped if they do not take the foetus with them*" (n=1).
- Patients who abort at night at home are not readily helped at the second level of care (n=1).
- "*Patients who return to the TOP clinic the day after aborting may already be septic*" (n=1).

Possible solutions to these problems were that each clinic should have a midwife who is trained to attend to TOP clients (n=1) and a 24 hour service (n=2).

***Main findings:***

- *The lack of clear policy guidelines for TOP service providers adds to the emotional strain that they experience and renders them open to criticism.*
- *As with the increase in negative attitudes over time, TOP service providers in 2003 were also more inclined than in 1998 to evaluate TOP services negatively.*
- *Clients did not return for post-counselling.*
- *The provision of quality post-counselling remained an area that required attention, particularly in light of the importance thereof in preventing further unwanted pregnancies.*
- *The lack of training for counsellors compounded the problem of too little staff to provide counselling services.*
- *More service providers in 2003 reported feeling uncertain and uncomfortable when performing/assisting with a TOP which was in line with the increasing concerns of TOP service providers with the tasks they were involved in.*
- *Service providers in 2003 experienced numerous problems with clients.*
- *The careless attitudes of adult patients, as well as their misuse of the system, were reason for concern.*
- *The main problems reported by the facility managers regarding pre-counselling were: lack of time, staff and space; communication/language barriers; and the reluctance of clients to open up during counselling.*
- *Problems experienced with the induction procedure were the lack of feedback on clients and reluctance of health facilities (other than the four TOP facilities) to accommodate TOP clients.*
- *Other management problems were the lack of staff, training for staff, and space at TOP facilities.*

### 3.7 Evaluation of the physical structure and infrastructure of TOP facilities

The physical structure of the TOP facilities, including the reception area, waiting room, consultation rooms, counselling rooms, recovery area, toilets, staff rest room, office space and subsequent degrees of auditory and visual privacy, were evaluated by the service providers (see Table 36). It should be kept in mind that during 2003, one of the TOP facilities was temporarily

based in a building located at the back of the hospital, and that the service would be moved to a more appropriate venue once the renovations to the hospital were completed.

**Table 36: Evaluation of the physical structure and infrastructure of the TOP facilities (1998, 2003)**

| | Non-existent | | Adequate | | Average | | Inadequate | | Uncertain | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1998 | 2003 | 1998 | 2003 | 1998 | 2003 | 1998 | 2003 | 1998 | 2003 |
| Reception area | 4 | 13 | 4 | 1 | 4 | 1 | 4 | 1 | - | - |
| Waiting area | - | - | - | 5 | - | 7 | - | 4 | - | - |
| Consultation rooms | 1 | - | - | 3 | 3 | 5 | 8 | 8 | - | - |
| Counselling rooms | 2 | - | - | 5 | 1 | 3 | 13 | 7 | - | 1 |
| Recovery area | - | - | - | 3 | - | 6 | - | 5 | - | 2 |
| Toilets | 1 | - | 6 | 11 | 5 | 3 | 3 | 2 | 1 | - |
| Staff rest room | - | 7 | - | 3 | - | 5 | - | 1 | - | - |
| Office space | - | 4 | - | 5 | - | 2 | - | 4 | - | - |

During 1998, there was much dissatisfaction with the physical aspects of the TOP facilities, especially with regard to the consultation rooms which were either inadequate (n=8) or non-existent (n=1). In most cases, counselling rooms were inadequate (n=13). Concerns with the physical structure and infrastructure were evidently not resolved by 2003. Opinions differed concerning the adequacy of the waiting areas at the TOP facilities. Adequate waiting areas were large enough with sufficient seating (n=5). With regard to average responses: the waiting areas were said to lack privacy (n=3) and nurses asked friends to wait outside if more seats were needed for patients (n=1). The waiting areas were indicated to be inadequate as: there was no privacy for clients (n=2); they were cold in the winter (n=1); and the TOP clinic was located at the back of the facility, hence clients had to walk through the entire facility to reach the TOP clinic (n=1).

According to the facility managers, in 2003 each of the four facilities only had one consulting room. Again respondents' opinions differed regarding the adequacy of the consultation rooms. Those who evaluated them as adequate reported: patients are consulted and examined in the same area (n=1); they are well equipped (n=1); and are private (n=1). With regard to inadequate responses, it was noted that: one consultation room was insufficient (n=4); there was a lack of privacy (n=3); and patients were examined and counselled in the same area (n=2).

In 2003, facility managers reported that three facilities each had two rooms where counselling could be offered. At one facility, one room was also used for consultations and examinations, while the second room was the office of the social worker who served the entire hospital and not only the TOP facility. Counselling rooms were said to be adequate as: there were a sufficient number of rooms (n=3); there was enough privacy (n=2); and the rooms were well planned (n=1). Inadequacy was explained in terms of too few rooms (n=5) and the subsequent lack of privacy (n=3).

With reference to the number of beds in the recovery areas at the TOP facilities during 2003, there were ten, eight, three and two respectively. Two of the TOP facilities did not have staff rest rooms or tearooms. No office space existed at one facility.

> ***Main findings:***
> - *During 1998, there was much dissatisfaction with the physical aspects of the TOP facilities, and these concerns were evidently not resolved by 2003.*
> - *The reception and waiting areas did not promote confidentiality and privacy for clients.*
> - *Patients at two of the facilities were consulted, examined and counselled in the same room.*
> - *There were far too few beds in the recovery areas at two of the facilities*

### 3.8 Challenges and strengths of providing TOP services

The main problem mentioned by eight of the 14 service providers in 2003 was the lack of management support from the Free State Department of Health. It was indicated that appropriate representatives from the Department should visit TOP facilities in order to have a better understanding of the situation and of the ongoing struggle to provide efficient, effective and quality TOP services. It was noted that there is a "*constant fight with administration for everything that we nee*d" (n=4). Further internal problems included: the lack of staff (n=5); inadequate physical structure of buildings (n=4) coupled with the lack of privacy (n=1); shortage of gloves (n=1); the lack of a 24 hour facility (n=1); and the inadequate information-keeping system, i.e. statistics (n=1). It was noted that health workers not involved with TOP services were still very negative toward TOP (n=1). TOP service providers were under stress (n=1) and, on occasion, shouted at the clients (n=1). Finally, patients were said to be uncooperative and returned for repeat TOPs (n=2).

Despite problems, TOP services are in place and functioning. Key factors contributing to the smooth functioning of TOP facilities were reported by the 1998-respondents to be: involvement of skilled/dedicated staff members (n=3); sufficient trained staff (n=3); co-operation of staff members at the TOP facility (n=2); treatment available at all times (n=1); and stress and time management (n=1). Similarly, successes in 2003 were ascribed to: dedicated and experienced/well-trained staff (n=9); teamwork/staff supportive of each other (n=6); the determination to make the clinic work (n=2); never a shortage of equipment (n=2); never refusing to help a patient (n=2); quality service (n=2); committed and cooperative nurses (n=2); respect for women's rights (n=2); and professionalism (n=1).

> ***Main findings:***
> - *A serious problem related to the lack of management support from the Free State Department of Health. It was indicated that appropriate representatives from the Department should visit TOP facilities in order to have a better understanding of the situation and of the ongoing struggle to provide quality TOP services.*
> - *The dedication of experienced and well-trained staff, as well as teamwork, were the main factors contributing to the smooth functioning of TOP services.*

## 4. TOP stakeholders (2003)[42]

### 4.1 The respondents

Four stakeholders, namely a representative from Maternal Child & Women's Health Cluster at the National Department of Health, the TOP Programme Coordinator in the Free State, and one representative each from PPASA and the RRA were either interviewed telephonically or in person regarding four specific matters. Persons from this study population were purposely targeted to gather information about shortcomings/impediments and achievements/successes in implementing national TOP legislation. The stakeholders were asked to respond to the following questions.

1. In your opinion, and in general terms, what have been the achievements of the CTOPA as it applies to women in general?
2. What would you identify as the main impediments to access to TOP?
3. What recommendations can you suggest to improve access to TOP?
4. What are the main challenges for the future regarding access to TOP?

The responses of the stakeholders to these questions are summarised below.

### 4.2 Achievements of the CTOPA as it applies to women in general

Three stakeholders reported that there had been a significant decline in the number of women dying as a result of complications of an abortion, as reflected in the downward trend from 5.7% in 1998 to 3.9% in 2000. Hence, there was less morbidity and mortality as most abortions took place in safe health facilities. Therefore, the risks of dying or having medical complications were much lower i.e. there was a decrease in back street abortions (n=3).

A further achievement noted by one of the respondents was that, although access to services continued to be uneven in provinces (Gauteng initially rendered 50% of national abortions, but had been reduced to 40% over a 5-year period), a number of provinces experienced an increase in the delivery of TOP services. The gains made in South Africa were reported to have taken place within an international context of increasing privatisation of women's health services. The impact of globalisation and the Bush Gag Rule prevents countries in the developing world from accessing much needed funding to provide post-abortion care and/or advocacy to reform existing laws, and results in women dying unnecessarily. The stakeholders noted further achievements as:

[42] Note that as there were only four respondents, only n values (i.e. frequencies) will be reported in this section.

- "*Women can enforce their right to choice in their sexual and reproductive life*" (n=3).
- "*An increase in the number of health workers trained to provide TOP services*" (n=2).
- "*Over the period (Feb 1997 to date) there has been a growing research information base in South Africa on aspects such as: developing an understanding of the implementation of the CTOPA; exploring approaches to improve and increase access; reflecting on the ways in which to improve effectiveness and efficiency; and, attitudes towards abortion at a community and broader societal level*" (n=1).

One stakeholder reported that, since the CTOPA was passed, it had successfully faced two legal challenges: "*in 1997 a case was brought by the Christian Lawyers Association to have the CTOPA declared unconstitutional as it violated the right to life. In this instance the law was successfully defended and precluded further challenges to the law as a whole. The second challenge was brought in 2000 by the same group attacking minor's consent to termination of pregnancy. These challenges serve as a sharp reminder to South Africans to guard the gains made and to work towards entrenching sexual and reproductive rights*" (n=1).

***Main findings***:

- *The CTOPA resulted in a decrease in backstreet abortions and maternal morbidity and mortality.*
- *Although Gauteng continues to provide the largest percentage of abortions, there has been an increase in the number of TOPs performed in other provinces.*
- *There has been an increase in the number of trained TOP service providers.*
- *There is a growing database of research on various aspects of abortion in South Africa.*

### 4.3 Main impediments to accessing TOP

Three of the four stakeholders noted that many health workers were still opposed to TOP and refused to refer clients to TOP facilities. One respondent reported referring a woman to a doctor at a PHC clinic for an abortion where the woman was told: "*I am a pro-lifer, and my religion prevents me from helping you obtain an abortion*". A more serious cause for concern is the allegation that some nurses say that women are more advanced in their pregnancy (i.e. more than twelve or 20 weeks) in order to prevent them from accessing TOP services.

One stakeholder indicated that the lack of information and education on sexual and reproductive health was a further impediment to young women seeking a termination, as they tend to delay obtaining an abortion until later stages in their pregnancy. A number of factors contributed to the problem, namely: denial or lack of recognition of pregnancy signs; finding a provider who will respect their rights to privacy and confidentiality; and difficulty in obtaining financial resources to procure an abortion. Furthermore, a stakeholder reported that unfriendly, inaccessible reproductive health services, as well as the lack of decentralised TOP services were problematic. It also appeared as if access to contraceptives was declining in the public health sector.

***Main findings**:*
- *Some health workers continue to have negative attitudes towards TOP.*
- *There is a lack of information and education on sexual and reproductive health.*
- *Some reproductive health services are unfriendly and inaccessible.*
- *There is a lack of decentralised TOP services.*
- *Reportedly there has been a decline in access to contraceptives in the public health sector.*

### 4.4 Recommendations to improve access to TOP

The respondents provided a number of recommendations to improve access to TOP services:

- "*Screen professional staff involved in TOP, paying especially close attention to their religious viewpoints. No one should be forced to become involved in providing TOP services"* (n=1).
- "*Information about the CTOPA should be disseminated further, not only to health workers, but also to the community at large*" (n=1).
- "*More awareness must be raised among health providers regarding the CTOPA and why the Act was instituted* "(n=1).
- "*An education drive is necessary to inform young women of the early signs of pregnancy*" (n=1).
- "*By providing TOP services at the lowest level of care, i.e. PHC level and preferably in the first-trimester, greater access could be achieved*" (n=1).
- "*Contraceptive counselling must be strengthened through outreach programmes to schools and communities to curb the rising incidence of teen pregnancy and HIV infection. The integration of reproductive health services (including HIV) cannot be over-emphasised*" (n=1).

***Main findings:***
- *Staff should volunteer to become involved in TOP.*
- *More information about TOP should be disseminated at the community level.*
- *Young women should be educated on the early signs of pregnancy and contraceptive use.*

### 4.5 Main challenges regarding access to TOP

It was noted by one stakeholder that youth-friendly services were needed that were sensitive to the realities that many young women face: "*they are generally in relationships with older men and hence are likely to succumb to their partners' desires; unequal gender/power relations has contributed to unprotected sexual practices as it is difficult for young girls and women in general to persuade their partners to use condoms; young women are often coerced into sexual relationships and have been openly violated by either an older member of the family or a boyfriend*". Furthermore it was noted that women have been socialised by familial arrangements and cultural and religious beliefs to put their own desires and wishes below those of their male counterparts. Despite South Africa's progressive legislation, many women (especially in rural

areas) have little or no control over their own reproductive lives which are dictated by a male-dominated society. There should be an emphasis on the education of girls and women to improve their status in society and increase their chances of realising their full potential.

One respondent noted other health system challenges that need to be addressed to include: "*improving the respective levels of TOP management; dealing with staff who deliberately obstruct access to TOP services; ensuring that support for the caregivers is in place; addressing the fact that designated services are not rendering the service as a result of conscientious objection; developing policy guidelines that address all obstructions; and, building a political understanding for reproductive health*". In addition, two respondents indicated that the pool of trained providers needed to be increased and innovative ways be sought to retain staff.

Additionally, more attention should be paid to preventive measures for unwanted pregnancy and to the strengthening of services, including ensuring more sensitive and responsive health workers (n=1). It was emphasized that TOP is not a contraceptive method, but should be viewed as a method of last resort.

***Main findings**:*
- *Sexual and reproductive rights should be entrenched in the South African society.*
- *Girls and women should be educated to improve their status in society and be supported to increase their chances of reaching their full potential.*
- *Impediments hampering access to quality TOP services should be addressed.*
- *Communities should be educated that TOP is not a contraceptive method.*

## 5. SUMMARY

Although the CTOPA sets out to make TOP accessible to all South African women, evidence strongly suggests that equitable access has not yet been achieved in the Free State. Only four urban facilities, three of which were hospitals, provided TOP services throughout the province, despite key research findings that abortion services were most effectively rendered at the lowest appropriate level of care, i.e. at PHC clinics (RRA 2002a). The provision of the CTOPA to delegate under twelve week procedures to trained midwives in order to extend services to rural areas has not yet been realised, as almost equal numbers of doctors and midwives provided TOP services in the province. In addition, a lack of willing health workers to provide TOP services, no clear policy guidelines, inadequate support from the Free State Department of Health, and negative attitudes towards TOP further served to ensure that access to TOP was not always smooth or easy for clients.

Not all health workers were familiar with the location of TOP facilities, which raised concern about their ability to refer patients to relevant TOP facilities. It is also worrying that despite official guidelines requesting health workers to at least inform patients of the location of TOP facilities,

not all health workers did so. While health workers seemingly became more positive toward TOP by 2003, negative attitudes and hostility toward the service have not yet been eradicated. Approximately a quarter of the respondents were of the opinion that TOP should not be legal and more than half stated that their religion prevented them from accepting TOP. Furthermore, roughly half the respondents were not supportive of social and financial reasons being sufficient cause for a TOP. Very few respondents attended the abortion values clarification workshop; those who attended the workshops were extremely positive about the content and outcome thereof.

As is to be expected, TOP service providers (who mostly volunteered to be involved with the service) were more optimistic concerning TOP than health workers in general. In line with international human rights, TOP service providers unanimously agreed that abortion was an important human right, particularly as every woman should have the right to make her own decisions concerning her body. In addition, TOP service providers supported the availability of abortion on request during the first twelve weeks of pregnancy. Although still positive toward TOP, service providers were more cautious and conservative in their attitudes toward TOP in 2003. Service providers supported the legalisation of TOP, but did not agree that TOP should be justified under all circumstances. Similarly, more issues surrounding poor work morale were raised in 2003.

Evidence of general hostility and negative attitudes toward abortion were again raised as a quarter of the 2003-service providers indicated having been harassed by colleagues due to their involvement with TOP service provision. This reality was reiterated during interviews with key stakeholders. By 2003, the number of respondents who indicated that their work with TOP clients affected their professional relationships with colleagues increased. This, together with increasing poor work morale and less positive attitudes towards TOP, implies that the longer health workers were involved in providing TOP services, the more emotionally drained they became. Despite this growing concern, psychological support services were not available and abortion values clarification workshops were no longer held in the province.

Indications are that the lack of clear policy guidelines for TOP service providers add to the uncertainties that they experience. As with the increase in negative attitudes over time, TOP service providers in 2003 were also more inclined to evaluate TOP services negatively (especially its pre- and post-counselling components). The provision of quality post-counselling remained an area that required attention, particularly in light of the importance thereof in preventing further unwanted pregnancies. The lack of training for counsellors compounded the problem of too little staff to provide counselling services.

A serious problem related to the lack of management support from the Free State Department of Health. Since TOP services were introduced in the province, health workers were largely been left to provide services without the continued support of management or clear policy guidelines. As noted by Gerhardt (1997), liberalising abortion law does not guarantee access to abortion. Additional requirements need to be met to ensure that women have access to the service, amongst others: protocols and guidelines to guide service delivery; integration of abortion care into nursing and medical curricula; availability of willing and trained staff; understanding of abortion legislation; a well prepared health system; information campaigns for the public about abortion; and attention to the provision of family planning services in order to avoid repeat abortions. Thus, the province faces a number of crucial challenges that need to be met before abortion services become equitably accessible to all Free State women.

Similarly, at a national level, it was noted that, in order for access to TOP services to increase and improve, more TOP service providers need to be trained. In addition, staff should volunteer to become involved in providing TOPs. Services should also be decentralised so that more women have easy access thereto. Additionally, sexual and reproductive rights need to become entrenched in our society, and this, together with education, should serve to improve the status of women and increase their chances of reaching their full potential. Following on these recommendations, Chapter 6 reports on the main findings of interviews conducted with TOP clients during 1998 and 2003, and summarises the cultural, educational and socio-economic impediments that they faced in accessing TOP services in the public health care system.

# PART 3: CHAPTER 6

# THE EMPIRICAL STUDY: TOP CLIENTS

## 1. INTRODUCTION

The right to decide when to have a child is at the core of reproductive rights. Only the pregnant women can decide whether or not to carry the pregnancy to term. With the introduction of the CTOPA, a new era in abortion legislation commenced and was a move toward the realisation of reproductive rights for women. The CTOPA promotes reproductive rights and extends freedom of choice by offering every woman the right to choose whether to have an early, safe and legal TOP in accordance with her beliefs. The objectives of the CTOPA capture the values expressed in the *Programme of Action* of the ICPD (1994) and the *Beijing Platform of Action* (1995). In essence, women should not be discriminated against on the basis of gender, race, religion or culture. Furthermore, they have the right to make their own reproductive health decisions concerning the timing, spacing and number of children that they wish to have. Therefore, the government is responsible for providing safe, effective, affordable and acceptable reproductive health care, which, in South Africa, incorporates TOP.

Constitutional rights and progressive abortion legislation are not sufficient to ensure that the reproductive rights of women are realised. Women need to be educated about their rights to reproductive health care (Albertyn 1999). Numerous factors, including poor organisation of the health care system, negative attitudes on the part of health workers, and a lack of knowledge about TOP services, all imply that women in many areas of the country, especially rural areas, still access unsafe abortions.

A review and analyses of existing documentation and discussions with key stakeholders highlighted concerns that, although TOP was legal in South Africa, women faced numerous impediments in accessing the service. More specifically, Potgieter (2004) notes that the lack of trained health workers to provide TOP services eliminates freedom of choice for the majority of South African women. With this concern in mind, it was deemed necessary to conduct interviews with women who had undergone a TOP in order to identify the cultural, educational and socio-economic impediments that they faced in accessing TOP services in order to inform the health system and contribute toward the improvement of TOP service delivery in the province, as well as in South Africa.

The main themes covered in this section include an overview of: family planning services in terms of accessibility and user-friendliness; pregnancy and termination history; TOP facilities with a focus on accessibility, user-friendliness and services provided; emotional experiences of and

support for TOP clients; knowledge of contraceptives, pregnancy, TOP and the CTOPA; attitudes towards TOP; problems experienced with TOP services; and recommendations to facilitate access to the service. More detailed information was obtained on certain themes (e.g. respondents in 2003 were asked for more detailed explanations for the lack of privacy during counselling, examinations and procedures, as well as for detailed recommendations on how to overcome impediments) and new themes (e.g. family planning in terms of contraceptive use, accessibility and user-friendliness; methods used to dispose with the products of conception; discussions with family and friends regarding the pregnancy; the support minors received from their parents; and attitudes towards TOP) were introduced during the 2003-survey. In addition, where there were significant and important differences in the responses of minors and adults in the 2003-survey, the two groups are discussed separately.

## 2. THE RESPONDENTS

Table 37 briefly describes the methods used to sample and gather information from TOP clients during the 1998- and 2003-surveys.

**Table 37: Main methodological features of the 1998- and 2003-surveys**

| | Sample size | Sampling technique | Location | Data gathering techniques |
|---|---|---|---|---|
| **1998-survey** | 75 | purposive sampling (non-probability) | 13 Free State towns | Face-to-face interviews |
| **2003-survey** | 120 | purposive sampling (non-probability) | 22 Free State towns | Face-to-face interviews |

The 1998-TOP client sample comprised of 75 women (i.e. 25 women from each of the facilities) who had utilised TOP services at one of the three public facilities in the Free State (Pelonomi Hospital, Kopano Clinic and Elizabeth Ross Hospital). An attempt was made to select women proportionately from various age groups in order to be representative of the entire population of women utilising services at these three facilities. During the 2003-survey, 60 minors (i.e. girls under the age of 18 years) and 60 adults (women between 19 and 39 years) who had undergone a TOP in the Free State during December 2003 – March 2004 were interviewed by trained data gatherers. In other words, data was gathered from 15 minors and 15 adults each from National Hospital, Kopano Clinic, Elizabeth Ross Hospital and Moroka Hospital. During both the 1998- and 2003-surveys, the names of clients who agreed to participate in the study were obtained from counsellors and/or registered midwives at the TOP facilities. TOP clients during both the 1998- and 2003-surveys were interviewed by trained data gatherers at a time and setting of their choice.

All discussions relating to differences in responses from the two surveys are cautiously presented; the reader should keep in mind that the comparisons merely suggest trends and not definite discrepancies in the responses of the 1998- and 2003-respondents.

The cities/towns/villages closest to where the respondents resided are listed per district in Table 38.

**Table 38: Cities/towns/villages nearest to place of residence (1998, 2003)**

| Districts and towns in the Free State | 1998 | | 2003 | |
|---|---|---|---|---|
| | N | % | N | % |
| **Motheo** | | | | |
| Bloemfontein | 16 | 21.3 | 23 | 19.2 |
| Botshabelo | 6 | 8.0 | 19 | 15.8 |
| Excelsior | - | - | 1 | 0.8 |
| Ladybrand | - | - | 3 | 2.5 |
| Thaba Nchu | 2 | 2.7 | 10 | 8.3 |
| Tweespruit | 1 | 1.3 | - | - |
| Wepener | - | - | 1 | 0.8 |
| **Total for Motheo** | **25** | **33.3** | **57** | **47.5** |
| **Lejweleputswa** | | | | |
| Allanridge | - | - | 1 | 0.8 |
| Hennenman | 1 | 1.3 | - | - |
| Hoopstad | - | - | 1 | 0.8 |
| Odendalsrus | 2 | 2.7 | 2 | 1.7 |
| Theunissen | 1 | 1.3 | 1 | 0.8 |
| Virginia | 2 | 2.7 | 4 | 3.3 |
| Welkom | 18 | 24.0 | 16 | 13.3 |
| Wesselsbron | - | - | 1 | 0.8 |
| **Total for Lejweleputswa** | **24** | **32.0** | **26** | **21.5** |
| **Xhariep** | | | | |
| Zastron | - | - | 1 | 0.8 |
| **Total for Xhariep** | **-** | **-** | **1** | **0.8** |
| **Fezile Dabi** | | | | |
| Kroonstad | 1 | 1.3 | 4 | 3.3 |
| **Total for Fezile Dabi** | **1** | **1.3** | **4** | **3.3** |
| **Thabo Mofutsanyana** | | | | |
| Bethlehem | 1 | 1.3 | 2 | 1.7 |
| Ficksburg | - | - | 1 | 0.8 |
| Harrismith | 1 | 1.3 | 2 | 1.7 |
| Phuthaditjhaba | 23 | 30.7 | 24 | 20.0 |
| Reitz | - | - | 1 | 0.8 |
| **Total for Thabo Mofutsanyana** | **25** | **33.3** | **30** | **25.0** |
| Other provinces (Mafikeng) | - | - | 1 | 0.8 |
| Outside South Africa (Maseru, Lesotho) | - | - | 1 | 0.8 |
| **Total** | **75** | **100** | **120** | **100** |

The 1998-respondents mainly resided in the cities/towns/villages where the TOP facilities were situated, namely Phuthaditjhaba (n=23; 30.7%), Welkom (n=18; 24.0%) and Bloemfontein (n=16; 21.3%). This represents a limitation of the research, as these women are likely to have had different experiences from those who lived a distance away from the TOP facilities (i.e. in terms of transport and accommodation arrangements). The 2003-respondents were slightly wider

dispersed and came from 21 South African towns (i.e. 20 towns in the Free State and one in North West) and one town in Lesotho.

The age breakdown for respondents from both surveys is provided in Table 39.

**Table 39: Age of TOP clients (1998, 2003)**

| | 1998 | | 2003 | |
|---|---|---|---|---|
| <18 years | 10 | 13.4 | 60 | 50.0 |
| 18-25 years | 32 | 42.7 | 35 | 29.2 |
| 26-40 years | 32 | 42.7 | 25 | 20.8 |
| 40+ years | 1 | 1.3 | - | - |
| **Total** | **75** | **100** | **120** | **100** |

In 1998, only 13.4% of the sample was younger than 18 years, while in 2003 the respondents were selected in such a manner to ensure that half of the sample was younger than 18 years. SeSotho was the home language of the majority of the 2003-respondents (minors n=43; 71.7%; adults n=45; 75.0%), followed by Xhosa (minors n=11; 18.3%; adults n=8; 13.3%); seTswana (minors n=2; 3.3%; adults n=6; 10.0%); isiZulu (minors n=2; 3.3%) and Afrikaans (minors n=2; 3.3%; adults n=1; 1.7%). The marital status of the respondents is provided in Table 40.

**Table 40: Marital status (1998, 2003)**

| | 1998 | | 2003 | |
|---|---|---|---|---|
| | **N** | **%** | **N** | **%** |
| Single | 52 | 69.3 | 110 | 91.7 |
| Married | 16 | 21.3 | 8 | 6.7 |
| Divorced | 2 | 2.7 | 1 | 0.8 |
| Widowed | 2 | 2.7 | 1 | 0.8 |
| Living together | 2 | 2.7 | - | - |
| **Total** | **75** | **100** | **120** | **100** |

During both surveys, the greater proportion of respondents was single. The majority of 1998-respondnets (n=52; 69.3%) had some form of high school (Grades 6-12) education, while 20.0% (n=15) only attended primary school (Grades 1-5) and 10.7% (n=8) received tertiary education. Almost half of the respondents were still at school or receiving some form of tertiary education (n=33; 44.0%). Of the remaining 42 women who were not learners/students, 24 (57.1%) were unemployed and 18 (42.8%) were employed. Of the 18 working respondents, 13 (72.2%) were employed in *blue collar* jobs such as hawking, sewing, domestic work and tree chopping, and five were employed as *white collar* workers (e.g., a clerk, a cashier, a typist and a sales lady). Of the 24 unemployed respondents, 23 (95.8%) were seeking work and one was a housewife (4.2%). The highest level of education attained by the 2003-respondents is provided in Table 41.

**Table 41: Highest level of education attained (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| Std 3/Grade 5 | 1 | 1.7 | - | - |
| Std 4/Grade 6 | - | - | 1 | 1.7 |
| Std 5/Grade 7 | 3 | 5.0 | 5 | 8.3 |
| Std 6/Grade 8 | 8 | 13.3 | - | - |
| Std 7/Grade 9 | 8 | 13.3 | 2 | 3.3 |
| Std 8/Grade 10 | 15 | 25.0 | 6 | 10.0 |
| Std 9/Grade 11 | 10 | 16.7 | 15 | 25.0 |
| Std 10/Grade 12 | 15 | 25.0 | 31 | 51.7 |
| **Total** | **60** | **100** | **60** | **100** |

In 2003, two-thirds of the minors (n=40; 66.7%) completed Grade 10 and a quarter passed Grade 12 (n=15; 25.0%). Similarly, the majority of adults (n=52; 86.7%) also completed Grade 10, with half (n=31; 51.7%) having successfully completed high school. All the minors (n=45; 75.0%) who had not yet completed Grade 12 were still attending school. Twelve adults (20.0%) also indicated that they were still attending school. Thirteen of the adults who no longer attended school (27.1%) were employed as factory workers (n=4)[43], shop assistants (n=3), domestic workers (n=2), assistant nurse (n=1), teacher (n=1), sewage worker (n=1) and clerk (n=1). Incomes were generally poor, with only one employed adult bringing home more than R2 500 per month. Two adults brought home less than R500 per month; six between R500 and R1 000; three between R1 001 and R1 500; and one between R1 500 and R2 000 per month.

***Main findings:***

- *While the 1998-respondents mainly resided in towns where the TOP facilities were located, the 2003-respondents were slightly more widely dispersed.*
- *In 1998, only 13.4% of the sample was younger than 18 years, while in 2003 half of the respondents were younger than 18 years.*
- *During both surveys, the greater proportion of respondents was single.*
- *During 1998, almost half of the respondents were still learners and during 2003, 75.0% of the minors were still attending school. Hence a large proportion of both samples comprised of women/girls who still attended school.*
- *Of the respondents who completed their schooling, the majority received some form of high school education.*
- *Of the women no longer attending school, the majority were unemployed.*
- *A general profile of women accessing TOP services may be described as young women who either are still studying or are not employed and hence do not have the financial means to care for a child.*

## 3. FAMILY PLANNING (2003)

Questions regarding the use of contraceptives, accessibility and user-friendliness of family planning services, as well as an evaluation of family planning services, were incorporated in the 2003-questionnaire due to the important link between effective and efficient family planning services and a decrease in abortion prevalence.

[43] In cases where relatively few respondents provided answers, only n-values and not percentages are presented in order to provide the reader with an indication of the frequency of responses.

### 3.1 Contraceptive use

At the time of the 2003-survey, two-thirds of the respondents (n=81; 67.5%) were using contraceptives. Note that some methods were used in combination, for example the condom and the injection: injection (n=67; 79.9%), pill (n=9; 10.9%), condom (n=13; 15.5%), and traditional contraceptives (i.e. a small belt tied around the waist) (n=1; 2.5%)

Contraceptive methods were changed by 18 of the respondents (43.9%) as: it had side effects such as dizziness and headaches (n=8); they wanted to use the injection as the pill made their period irregular (n=4); the method they used failed (n=2); the injection made them fat (n=2); the clinic sister changed it out of her own (n=1); women forgot to take the pill (n=1); the woman wanted to use the injection so that she could still produce milk for the baby (n=1); and, the woman changed to the pill after using the loop for five years (n=1).

Fewer minors (n=3; 7.5%) than adults (n=10; 24.4%) were using a contraceptive at the time they became pregnant with their youngest child ($p<0.05$). The high percentage of respondents who became pregnant due to not using a contraceptive (when they obviously were not planning a baby) is a cause for concern (minors n=37; 92.5%; adults n=31; 75.6%). Of the respondents utilising a contraceptive method, only four experienced problems in accessing family planning services. Problems mentioned related to being sent to another clinic for the injection (n=2); living far away from the clinic (n=1); and being forced by the nurse to use depo provera, which gave the woman headaches and reportedly made her fat (n=1). Nearly half of the minors (47.5%; n=19) reported only starting to use contraceptives after the TOP (at the TOP facility), hence they could not comment on the accessibility of family planning clinics.

Nineteen respondents (15.9%) knew about emergency contraceptives of whom six had used emergency contraceptives in the past. Accessing emergency contraceptives was said to be problematic (n=6); although the respondents had heard about emergency contraceptives, they had not yet had the opportunity to see them (n=3); and they had to be obtained from a doctor (n=1).

***Main findings:***

- *Two-thirds of the respondents were using contraceptives, of whom the majority were using the injection.*
- *Respondents mainly changed their contraceptive methods due to the side effects thereof.*
- *Very few respondents (less than 20.0%) knew about emergency contraceptives and not even half of them had used an emergency contraceptive in the past. Accessing emergency contraceptives was noted as problematic.*

### 3.2 Accessibility of family planning services

This section of the questionnaire was only completed by 2003-respondents who utilised family planning services on more than one occasion. Therefore, TOP clients who received contraceptives for the first time immediately following the TOP were excluded. No significant differences in the experiences of minors and adults were noted at family planning facilities; hence these two groups are not discussed separately.

Respondents generally walked (n=35) to family planning facilities, although some went by car in addition to walking (n=4) and others travelled by taxi (n=12). The time taken to reach family planning facilities varied and is illustrated in Table 42.

**Table 42: Time taken to reach the family planning facility (2003)**

| | N | % |
|---|---|---|
| 5-10 min | 6 | 12.0 |
| 11-15 min | 10 | 19.6 |
| 16-20 min | 7 | 13.7 |
| 21-25 min | 2 | 3.9 |
| 26-30 min | 13 | 25.5 |
| 31-35 min | 1 | 1.9 |
| 41-45 min | 3 | 5.9 |
| 56-60 min | 5 | 9.8 |
| >60 min | 4 | 7.8 |
| **Total** | **51** | **100** |

In most cases, it took 30 minutes or less for the respondents to reach the family planning service (n=38). However, four respondents reported that it took them more than an hour to reach the family planning clinic.

Eighteen of the respondents utilising family planning services paid for transportation to these facilities. The costs ranged between R6 and R70 and three respondents indicated not being able to afford the costs. The problem was dealt with by walking to the clinic. Bearing in mind that many of the respondents were unemployed and that the average household income was very low, one can only suspect that money for transport is truly a problem. An additional transport problem related to too few taxis providing transport to the clinics.

The average waiting times at family planning facilities are captured in Table 43.

**Table 43: Average waiting time at family planning facilities (2003)**

| | N | % |
|---|---|---|
| <10min | 9 | 17.6 |
| 10-19 min | 9 | 17.6 |
| 20-29 min | 5 | 9.8 |
| 30-39 min | 5 | 9.8 |
| 40-49 min | 3 | 5.9 |
| 60-69 min | 5 | 9.8 |
| 90-99 min | 3 | 5.9 |
| 120+ min | 12 | 23.5 |
| **Total** | **51** | **100** |

Slightly more than half of these respondents (n=28; 54.9%) waited for 30 minutes or more at the family planning facilities, while almost 40% (n=20; 39.2%) waited for an hour or longer.

***Main findings:***

- *In most cases, it took less than half an hour to reach family planning facilities.*
- *Lengthy waiting periods were noted at the family planning facilities.*

### 3.3 User-friendliness of family planning services

No significant differences were noted in the experiences of minors and adults regarding the user-friendliness of family planning facilities and data from the two groups are not discussed separately (see Table 44).

**Table 44: Treatment received at family planning facilities (2003)**

| | Well | | Uncertain | | Poorly | | Did not see | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| Reception staff | 45 | 86.5 | 1 | 1.9 | 1 | 1.9 | 5 | 9.6 |
| Nurses | 40 | 76.9 | 5 | 9.6 | 6 | 11.5 | 1 | 1.9 |
| Doctors | 3 | 5.8 | - | - | - | - | 49 | 94.2 |
| Other patients | 42 | 80.3 | 9 | 17.3 | - | - | 1 | 1.9 |
| Security guards | 13 | 25.0 | - | - | - | - | 39 | 75.0 |
| Cleaners | 21 | 4.4 | 4 | 7.7 | 4 | 7.7 | 23 | 44.2 |

In general, the respondents indicated being treated well at the family planning facilities by reception staff (n=45; 86.5%) and nurses (n=40; 76.9%). Only three respondents saw a doctor who reportedly treated them well. There was no indication of problems arising with other patients, or security guards, but four respondents did report being poorly treated by the cleaners who were unfriendly. The majority of the respondents (n=42; 80.0%) were satisfied with the times that family planning services were open. Problems with the opening hours were explained as follows:

- "*Only open during school hours*" (n=3).
- "*I work full-day and the clinic is closed in the afternoons*" (n=3).
- "*It should open earlier, we wait too long*" (n=2).
- "*They cut the queue at four and learners who come late can't be helped*" (n=1).

- “*Family planning clients are not ill, we should be helped first*” (n=1).

It was the opinion of the majority of minors (15 of the 17) that family planning clinics provided youth-friendly services. Reasons included: minors were afforded the opportunity to make their own decisions (n=12); teenagers were given advice and information (n=7); youth were receiving a service (n=5); they were treated well and not discriminated against (n=4);and nurses respected the privacy of minors (n=1). The two respondents who did not agree that youth-friendly services were provided at family planning clinics felt that youth were being discriminated against (n=1) and that they preferred more privacy, i.e. separate from adult patients (n=1). Suggestions for a more youth-friendly service were noted as: equal treatment for all clients regardless of age (n=13); increased privacy for the youth (n=1); and different times for the youth to visit family planning services (n=1).

***Main findings:***
- *Overall treatment received at the family planning facilities from reception staff and nurses was reported to be good.*
- *Almost all minors were of the opinion that the family planning facilities were providing a youth-friendly service.*

### 3.4 Services offered at family planning facilities

No significant differences were found in the experiences of minors and adults at family planning facilities and data from the two groups are not discussed separately (Table 45).

**Table 45: Degree of satisfaction with services offered (2003)**

| | Satisfied | | Uncertain | | Dissatisfied | | Service not available | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| Information about contraceptives | 46 | 88.5 | 1 | 1.9 | 3 | 5.8 | 2 | 3.8 |
| Examination | 45 | 86.5 | - | - | 4 | 7.7 | 3 | 5.8 |
| Provision of contraceptives | 44 | 86.3 | - | - | 7 | 13.7 | - | - |

Overall, respondents were satisfied with the services that they received at the family planning facilities. More specifically, 88.5% (n=46) were satisfied with the information they obtained about contraceptive methods. Dissatisfied respondents provided the following reasons: “*I went for condoms, but they gave me no information about other contraceptive methods*” (n=1); “*they did not explain the different types of contraceptives*” (n=1); and “*they had no time to give me information*” (n=1). With regard to the examination, the majority of respondents 88.5% (n=45) were satisfied with the service. Reasons for dissatisfaction (n=4) were: “*they made mistakes with my pregnancy test*” (n=1); “*I was treated and examined in a group*” (n=1); “*they don’t listen to us*” (n =1); and, “*they don’t say anything*” (n=1). Finally, the majority of respondents (n=44; 86.3%) were also satisfied with the provision of contraceptives Dissatisfied responses (n=7) included:

"*when I came late from school, they would not help me at the clinic*" (n=1); "*sometimes they do not have contraceptives*" (n=2); and, "*I would like them to give me information about the contraceptive they give me"* (n=1).

***Main finding:***

- *Overall, respondents were satisfied with the services – information about contraceptives, examination and provision of contraceptives – offered at family planning facilities.*

## 4. PREGNANCY AND TERMINATION HISTORY

Background information concerning previous pregnancies was obtained from both the 1998- and 2003-respondents. Nearly half of the 1998-respondents (n=34; 45.3%) indicated that the pregnancy that was terminated was their first pregnancy. The majority of women who had been pregnant previously indicated that they neither had a spontaneous nor an induced abortion before (n=33; 82.5%). Of the seven women who have had an abortion before, all had had a spontaneous abortion/miscarriage. With reference to the 2003-respondents, one minor and 36 adults (30.8%) had been pregnant before. One adult respondent had previously undergone an induced abortion at a TOP facility, reportedly as she was unemployed and could not support another child.

More that three-quarters of the 1998- (n=59; 78.7%) and 2003-respondents (n=99; 82.5%) discovered that they were pregnant during the first-trimester. Approximately two-thirds of the TOPs conducted on the 2003-respondents were performed while they were in the first-trimester of their pregnancies (n=81; 67.5%). Reasons for having a TOP after twelve weeks included:

- "*Did not know that I was pregnant*" (n=11).
- "*I was afraid/depressed/shocked/ confused*" (n=11).
- "*Waited for a booking date*" (n=7).
- "*Undecided whether or not to abort*" (n=3).
- "*I did not know where to go*" (n=3).
- "*Staying far away from the TOP facility*" (n=2).
- "*Did not know about TOP until a doctor at the clinic told me*" (n=1).
- "*It was delayed because I was out of town*" (n=1).
- "*My boyfriend refused* "(n=1).
- "*I have* f*inancial problems"* (n=1).

The reasons forwarded by the 1998-respondents for having an abortion included financial problems (n=39; 34.5%), personal problems/external motivations (n=28; 24.8%) and family-related issues (e.g. already having a large family) (n=22; 19.5%). More in-depth probing took place during the 2003-survey to identify the reasons women opted for a TOP (see Table 46).

**Table 46: Reasons for having a TOP (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| I wanted to complete my studies | 40 | 46.5 | 19 | 22.4 |
| Financial problems – could not afford a child/unemployed | 16 | 18.6 | 28 | 32.9 |
| Not ready to raise a child | 17 | 19.8 | 12 | 14.1 |
| I was raped, had to have TOP | 1 | 1.2 | 2 | 2.4 |
| My parents forced me to have TOP | 3 | 3.5 | - | - |
| My boyfriend was supportive of me having a baby | 3 | 3.5 | - | - |
| Afraid to keep the baby | 2 | 2.3 | - | - |
| People will not accept me | 2 | 2.3 | - | - |
| I do not know the father well | 1 | 1.2 | 1 | 1.2 |
| My boyfriend killed himself after impregnating another girl | 1 | 1.2 | - | - |
| Already have children and do not want another child | - | - | 8 | 9.4 |
| Not married | - | - | 5 | 5.9 |
| My boyfriend is married | - | - | 3 | 3.5 |
| I was very sick/had previous spontaneous abortions | - | - | 2 | 2.4 |
| No parents to support me | - | - | 2 | 2.4 |
| I am HIV positive and on TB drugs, I fear the child may be infected | - | - | 2 | 2.4 |
| Cannot get maternity leave | - | - | 1 | 1.2 |
| **Total** | **86** | **100** | **85** | **100** |

Similar to the answers of the 1998-respondents, the adults in the 2003-survey mainly provided financial reasons (n=28; 32.9%) for having a TOP, while the desire to complete their education was the main reason forwarded by almost half of the minors (n=40; 46.5%). The view that they were not ready to raise a child was common to both minors (n=17; 19.8%) and adults (n=12; 14.1%). One minor and two adults reported that they had been raped and, therefore, needed to terminate the pregnancy. A limited number of minors indicated that: they were too young to have a baby (n=4; 4.7%); their parents forced them to have a TOP (n=3; 3.5%); and their boyfriends supported them in the decision to have TOP (n=3; 3.5%). Adults mentioned that: they already have children and did not want any more (n=8; 9.4%); they were not married (n=5; 5.9%); and their boyfriends were already married (n=3; 3.5%) as reasons for seeking TOP.

***Main findings::***

- *More than three-quarters of the respondents in 1998 and 2003 knew in the first trimester that they were pregnant.*
- *Approximately two-thirds of the TOPs conducted on 2003-respondents were done in the first- trimester.*
- *Financial problems were reported by almost a third of the 1998-respondents and by 2003-adult respondents as the main reason for having a TOP. Almost half of the minors opted for a TOP in order to complete their education.*

## 5. TOP FACILITIES

### 5.1 Accessibility of TOP facilities

Table 47 provides an indication of source of referral to a TOP facility.

**Table 47: Source of referral to a TOP facility (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| A health worker | 30 | 50.0 | 46 | 76.7 |
| Family | 15 | 25.0 | 4 | 6.7 |
| Friend | 10 | 16.7 | - | - |
| Went there out of my own | 5 | 8.3 | 10 | 16.7 |
| **Total** | **60** | **100** | **60** | **100** |

In 1998, 62.7% of the women (n=47) were referred by a health worker to the TOP facility, 22.7% (n=17) went to the facility on their own initiative and 14.7% (n=11) were advised by family/friends to visit the TOP facility. In 2003, three-quarters of the adult respondents (n=46; 76.7%) were referred to a TOP facility by a health worker, compared to only half of the minors (n=30; 50.0%) ($p<0.05$). More minors (n=15; 25.0%) than adults (n=4; 6.7%) were referred by family members ($p<0.05$). The five minors (8.3%) and ten adults (16.7%) who went to the TOP facility out of their own reported hearing about the facility from their teachers (minors n=2), neighbours (minors n=1), community (minors n=2; adults n=6), boyfriends (adults n=2), nurses (adults n=1) and the radio (adults n=1).

Despite negative attitudes and the finding that just less than half of the 1998-health workers and approximately a third of the 2003-health workers would not unconditionally refer clients to TOP facilities, no women in 1998 and only one in 2003 experienced such problems. The 2003-respondent stated that the "*health worker was unhelpful and changed times without consulting me*". Only two respondents in 2003 asked more than one health worker to refer them to a TOP facility. The complaint that arose from one of these respondents was that the health worker wanted R700 before he/she was willing to help her. With reference to women who had been referred by a health worker to a TOP facility, only three of the respondents in 1998 and four in 2003 had transport arranged for them to the TOP facilities, despite the availability of patient transport in the Free State.

In 1998, 13 respondents (17.3%) visited more than one TOP facility before receiving assistance, while none of the 2003-respondents experienced such problems. Slightly less than half of the 1998-respondents (n=32; 42.7%) were put onto a waiting list, while a slight increase was noted during the 2003-survey (61.7%; n=74) (see Table 48).

**Table 48: Number of days on a waiting list for TOP (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| < 5 days | 6 | 19.4 | 11 | 26.8 |
| 5-9 days | 10 | 32.3 | 4 | 9.8 |
| 10-14 days | 4 | 12.9 | 9 | 22.0 |
| 15-19 days | 6 | 19.4 | 3 | 7.3 |
| 20-24 days | 1 | 3.2 | 2 | 4.9 |
| 25-29 days | 1 | 3.2 | 4 | 9.8 |
| 30+ days | 3 | 9.7 | 8 | 19.5 |
| **Total** | **31** | **100** | **41** | **100** |

Far more adults (n=26; 63.4%) than minors (n=15; 48.4%) were put onto a waiting list ($p<0.05$). The finding that so many respondents had to wait for ten days or more is especially worrisome. Service providers at one of the TOP facilities noted that clients who were under seven weeks pregnant were asked to return at seven or eight weeks as the procedure could only be conducted then. Again, it is a matter for concern that patients had to keep returning to the TOP facilities before the procedure was finally completed (see Table 49).

**Table 49: Number of times the respondent returned to TOP facility (2003)**

| | N | % |
|---|---|---|
| No return visits, helped the first time | 8 | 6.6 |
| 1 | 70 | 58.3 |
| 2 | 35 | 29.2 |
| 3 | 5 | 4.2 |
| 4 | 1 | 0.8 |
| 5 | 1 | 0.8 |
| **Total** | **120** | **100** |

In 2003, half of the minors (n=31; 51.7%) and almost two-thirds of the adults (n=39; 65.0%) returned once for a visit and approximately 30% of all respondents (n=35; 29.2%) returned twice. However, seven of the 2003-respondents (5.8%) were asked to return more than twice to the TOP facilities as:

- "*The pills did not work, so I had to go back*" (n=2).
- "*The first time the doctor was not there, the second time he couldn't examine me, because I was not cooperating, the third time I was given pills that did not work, the fourth time I was given more pills, and the fifth time I was cleaned out*" (n=1).
- "*The first time, I was not supposed to come, the second and third times the queue was too long and they cut it, the fourth time I was helped*" (n=1).
- "*I was on the waiting list"* (n=1).

Cost considerations were noted as transport to the TOP facilities and, where necessary, overnight accommodation as well. The means by which respondents travelled to the TOP facilities is depicted in Table 50.

**Table 50: Means of transportation to the TOP facility[44] (2003)**

| | 1998 | | 2003 | |
|---|---|---|---|---|
| | N | % | N | % |
| Car | 3 | 4.0 | 11 | 9.2 |
| Bus | 4 | 5.3 | 1 | 0.8 |
| Taxi | 63 | 84.0 | 98 | 81.7 |
| Walk | 5 | 6.7 | 6 | 5.0 |
| Ambulance | - | - | 4 | 3.3 |
| **Total** | **75** | **100** | **120** | **100** |

In both the 1998- (n=63; 84.0%) and 2003-surveys (n= 98; 81.7%) the majority of respondents travelled by taxi to the TOP facilities. Almost all of the 1998-respondents (n=67; 95.7%), excluding those who walked (n=5), paid for transport to and from the TOP facility. The fees varied from as little as R2 to as much as R44. Sixty percent of the respondents paid R12 or less, and the majority of respondents (n=54; 80.6%) were able to afford these costs. Of the 13 respondents (19.4%) who could not afford transport costs, twelve dealt with the problem by: borrowing from relatives (n=4), a neighbour (n=4), an employer (n=1); friends (n=1) or receiving the money from their boyfriend (n=2). Similarly, in 2003 transportation costs were paid by the majority of respondents (n=100; 83.4%) and expenses varied from less than R10 to as much as R109. The overwhelming majority of respondents (n=87; 87.0%) paid less than R30 for transport. Although more minors (n=13; 27.1%) than adults (n=6; 11.8%) were unable to afford these transport costs, the finding was not statistically significant. Respondents made the following arrangements to pay for transportation costs:

- "*My parents paid my transport costs*" (n=10).
- "*Another family member paid my transport costs*" (n=4).
- "*Borrowed from my neighbour*" (n=1).
- "*I only had enough to pay for a single trip, so I walked back*" (n=1).

Three-quarters of the 1998-respondents (n=57; 76.0%) travelled for an hour or less to the TOP facility from their homes. The remaining 18 respondents (24.0%) travelled for as long as four hours to reach the facility. Similarly, in 2003 slightly more than half of the respondents (n=69; 57.5%) travelled for 30 minutes or less. Only 11 respondents (n=9.1%) travelled for more than an hour to reach the TOP facilities. It must, however, be kept in mind that 76.0% of the respondents in 1998 and 60.0% in 2003 lived in the cities/towns where the TOP facilities were located. If more interviewed women were living in cities/towns/villages situated further away from the facilities, travelling time was likely to have increased. This was found in a study conducted in the Eastern Cape during 1999, which revealed that 38% of clients travelled at least 100 kilometres to access a TOP facility (Althaus 2000).

[44] According to TOP service providers, commuter transport is available in certain areas for TOP clients. Hence the question: Why do clients not make use of this free transport when accessing TOP services?

No respondents in 1998 and only five in 2003 (4.2%) required accommodation while visiting the TOP facilities. Four of these respondents stayed with family and one stayed with friends, and no cost was incurred.

***Main findings:***

- *In 2003, far more adults than minors were referred to a TOP facility by a health worker.*
- *Despite negative attitudes and reluctance of some health workers to refer women to TOP facilities, only one respondent reported experiencing such problems.*
- *Less than half of the 1998-respondents were put onto a waiting list, while in 2003 there a slight increase was noted. It is especially worrisome that clients had to wait for ten days or more to undergo a TOP.*
- *It is a concern that some patients had to keep returning to TOP facilities before the procedure was finally completed; in 2003, approximately 30% of all respondents returned at least twice to a facility.*
- *The majority of respondents during both the 1998- and 2003-surveys travelled by taxi to the TOP facilities. Most respondents were able to afford taxi costs, while others had to borrow money from family, friends or their boyfriends.*
- *Less than a quarter of the 1998-respondents and far less from the 2003 group travelled for more than an hour to reach a TOP facility. This may be ascribed to the sample, as 76.0% of the respondents in 1998 and 60.0% in 2003 lived in the cities/towns where the TOP facilities were located.*

## 5.2 User-friendliness of the TOP facilities

Respondents were asked to indicate whether they were satisfied with the treatment received from staff and other patients at the TOP facilities. The responses are captured in Table 51.

**Table 51: Degree of satisfaction with treatment received at TOP facilities (1998, 2003)**

| | Satisfied | | Uncertain | | Dissatisfied | | Did not see | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| **1998** | | | | | | | | |
| Reception staff | 50 | 66.7 | 6 | 8.0 | 14 | 18.7 | 5 | 6.7 |
| Nurses | 66 | 88.0 | 6 | 8.0 | 3 | 4.0 | - | - |
| Doctors | 61 | 81.3 | - | - | - | - | 14 | 18.7 |
| Counsellors | 56 | 76.4 | - | - | 3 | 4.1 | 14 | 19.2 |
| Other patients | 52 | 69.3 | - | - | 19 | 25.3 | 4 | 5.3 |
| Security guards | 19 | 25.3 | - | - | 5 | 6.7 | 51 | 68.0 |
| Cleaners | 30 | 40.0 | 2 | 2.6 | 6 | 8.0 | 37 | 49.3 |
| **2003** | | | | | | | | |
| Reception staff | 86 | 71.7 | 4 | 3.3 | 12 | 10.0 | 18 | 15.0 |
| Nurses | 92 | 76.7 | 3 | 2.5 | 25 | 20.8 | - | - |
| Doctors | 65 | 54.2 | 14 | 11.7 | 4 | 3.3 | 37 | 30.8 |
| Counsellors | 69 | 57.5 | 4 | 3.3 | 5 | 4.2 | 42 | 35.0 |
| Other patients | 101 | 84.2 | 11 | 9.2 | 1 | 0.8 | 7 | 5.8 |
| Security guards | 53 | 44.2 | 1 | 0.8 | 1 | 0.8 | 65 | 54.2 |
| Cleaners | 57 | 47.5 | 14 | 11.7 | - | - | 49 | 40.8 |

Considering the positive attitudes of TOP service providers in both the 1998- and 2003-surveys toward legalised TOP, it is to be expected that they would treat their clients well. As such, it is not surprising that respondents were mostly satisfied with the treatment received from TOP staff and other patients, except in the case of the 2003-adult respondents' experience of the treatment

received from nurses. This is in line with the finding that the longer that health workers are involved with TOP service delivery the more cautious they become in their attitudes towards TOP; seemingly their work morale becomes less positive over time. This is a cause for concern since the quality of TOP services, as well as access to the service, is directly related to the roles and attitudes of health workers (RRA 2000).

Overall, respondents in the 1998-study were satisfied with the treatment that they received from reception staff (66.7%), although 18.7% indicated feeling dissatisfied as nurses at reception were unfriendly (n=5) and there was no privacy (n=1). With regard to the 2003-respondents, it is interesting to note that 28.3% of the adults (n=17) compared to only 1.7% (n=1) of the minors did not see reception staff at the TOP facilities. This, in part, explains why 86.7% of the minors (n=52) and only 56.7% of the adults (n=34) were satisfied with the treatment received from reception staff ($p<0.05$). Dissatisfaction with reception staff (minors n=5; 8.3%; adults n=7; 11.7%) was minimal and largely due to a lack of privacy (adults n=7), poor communication skills and rude staff (minors n=4), and having to wait too long before being attended to (n=1).

The 1998-respondents were mostly satisfied with the treatment they received from nurses at the TOP facility. The four dissatisfied respondents noted that the nurses were: rude and shouted (i.e. nurses in the hospital and not TOP nurses) (n=2); unhelpful (n=2); scolded patients in front of relatives (n=1); and made patients feel scared and guilty (n=1). Thirty percent of the adult respondents in the 2003-study (n=18) were dissatisfied with treatment received from the nurses compared to only 11.7% of the minors (n=7) ($p<0.05$). The main complaints received from the 2003-respondents were:

- Negative attitude, unfriendly, harsh words "d*on't you know you are sinning*" (minors n=6; adults n=15).
- "*Criticised the behaviour that led to my having a TOP*" (minors n=1).
- "*Not qualified for the job*" (adults n=1).
- "*Could not address me in my own language*" (adults n=1).
- "*Just in a hurry to finish her work*" (adults n=1).

Doctors were generally viewed favourably by the 1998-respondents (n=61; 81.3%), although 14 (n=18.7%) of the women have not seen a doctor at the TOP facility. Similarly, in 2003 there were few complaints with only four respondents (3.5%) indicating that they were dissatisfied with the treatment received from doctors. However, it should be borne in mind that 37 respondents (30.8%) did not see a doctor. Reasons provided for their dissatisfaction with the doctors included: "*they were impatient with me*" (n=2); "*they inserted a painful instrument without any explanation*" (n=1); and "*they did not talk to me*" (n=1).

Similarly, few complaints regarding the counsellors were voiced during both the 1998- (n=3; 4.1%) and 2003-studies (n=5; 4.2%). Reasons for dissatisfaction provided by the 2003-respondents were:

- "*They were unfriendly and harsh with me*" (n=1).
- "*I wanted privacy*" (n=1).
- "*She intimidated me*" (n=1).
- "*I wanted to be alone with the counsellor*" (n=1).
- "*Many interruptions while being counselled*" (n=1).

Overall, fewer respondents in 2003 (n=13.4%) found the hours that the TOP facilities were open to be unsuitable. The 2003-respondents were asked a series of questions related to the visual and auditory privacy at the TOP facilities. Six in ten respondents (n=54; 61.4%) were of the opinion that there was sufficient privacy in the counselling rooms[45]. Explanations for the lack of privacy (n=34; 38.6%) related to receiving counselling either in a group or while other people were sitting in the same room where the counselling took place (n=33).

The majority of respondents, except for five (4.2%), indicated that there was sufficient auditory and visual privacy in the consultation rooms. The lack of privacy was ascribed to: being addressed in a group (n=4); other people could hear what was said (n=3); and only a screen separated the patients from each other (n=2).

Respondents were slightly more satisfied with the degree of visual privacy in the examinations rooms (n=117; 97.5%) than with the degree of auditory privacy (n=112; 93%). The fact that there was slightly more visual privacy may be attributable to patients being consulted, examined and counselled in the same room, while only a screen separated them from others in the room. Two respondents explained that the nurses had very loud voices and that other patients could hear what was being said.

All but two of the 2003-respondents were of the opinion that the procedure room[46] offered sufficient auditory and visual privacy. Far more minors were dissatisfied with the degree of auditory (n=27; 67.5%) and visual (n=28; 62.8%) privacy in the recovery room than adults ($p<0.05$), who were more dissatisfied with auditory (n=9; 18.0%) and visual privacy (n=10; 20.0%). The lack of privacy was explained as follows: "*we were all lying in the same room*" (minors n=28, adults n=7); "*nurses shout so that everyone can hear*" (adults n=1); and "*nurses discuss you with other patients, call you a killer*" (adults n=1).

[45] Note that 32 of the 2003-respondents indicated not receiving counselling.
[46] Note that 12 minors and five adults indicated that this was not applicable as the procedure was only done at home.

***Main findings:***

- *The 1998- and 2003-respondents were mostly satisfied with the treatment received from TOP staff and other patients.*
- *There was an increase in the level of dissatisfaction between 1998 and 2003 regarding the treatment received from nurses. This correlates with findings from the TOP service provider study, where it was found that health workers became more cautious in their attitudes toward TOP over time, which also impacted on their work morale.*
- *Overall, few respondents (even fewer minors than adults) found the hours that the TOP facilities were open to be unsuitable.*
- *There was inadequate auditory and visual privacy in the counselling rooms.*
- *Auditory and visual privacy were adequate in the examination and procedure rooms.*
- *More minors than adults were dissatisfied with the lack of privacy in the recovery area.*

## 5.3 Services provided at the TOP facilities

Respondents commented on their degree of satisfaction with the services (i.e. pre- and post-counselling, examination, procedure, information received on TOP, and information on and provision of contraceptives) that they received at TOP facilities (see Table 52).

**Table 52: Degree of satisfaction with services offered (1998, 2003)**

| | Satisfied | | Uncertain | | Dissatisfied | | Service not needed | | Service not available | |
|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % |
| **1998** | | | | | | | | | | |
| Pre-counselling | 54 | 72.0 | 3 | 4.0 | 1 | 1.3 | 1 | 1.3 | 16 | 21.3 |
| Post-counselling | 32 | 42.7 | 1 | 1.3 | - | - | 6 | 8.0 | 36 | 48.0 |
| Examination | 69 | 92.0 | 6 | 8.0 | - | - | - | - | - | - |
| TOP procedure | 68 | 90.7 | 4 | 5.3 | 3 | 4.0 | - | - | - | - |
| Information on TOP | 69 | 92.0 | 2 | 2.7 | 4 | 5.3 | - | - | - | - |
| Information on and provision of contraceptives | 67 | 89.3 | 4 | 5.3 | 2 | 2.7 | - | - | 2 | 2.7 |
| **2003** | | | | | | | | | | |
| Pre-counselling | 77 | 64.2 | 4 | 3.3 | 11 | 9.2 | 3 | 2.5 | 25 | 20.8 |
| Post-counselling | 31 | 25.8 | 6 | 5.0 | 24 | 20.0 | 4 | 3.3 | 55 | 45.8 |
| Examination | 114 | 95.0 | - | - | 6 | 5.0 | - | - | - | - |
| Procedure | 108 | 90.0 | 8 | 6.7 | 4 | 3.3 | - | - | - | - |
| Information on TOP | 113 | 94.2 | 1 | 0.8 | 5 | 4.2 | - | - | 1 | 0.8 |
| Information on and provision of contraceptives | 102 | 85.0 | 5 | 4.2 | 2 | 1.7 | 4 | 3.3 | 7 | 5.8 |

### 5.3.1 Pre-counselling

The 1998-respondents expressed overall satisfaction with pre-counselling services (n=54; 72.0%), and this decreased slightly by 2003 (n=77; 64.2%). A similar trend was noted in the study among TOP service providers, where three-quarters of the 1998-respondents indicated that the pre-counselling service was good, but decreased to half reporting the same in 2003. More specifically, significant differences ($p<0.05$) were noted in the responses of minors and adults during 2003 regarding pre-and post-counselling services. It is worrying that slightly more than a quarter of the minors (n=16; 26.7%) and 15.0% of the adults (n=9) indicated that the service was

not be available at the TOP facilities. Of those who did have access to pre-counselling (36 of 44 minors and 41 of 51 adults), the majority of minors (n=36; 81.8%) and adults (n=41; 80.4%) were satisfied with the service. Dissatisfaction with pre-counselling was attributed to: "*counsellors ask sensitive questions in a group, as counselling was not done individually*" (minors n=2; adults n=3); the counselling environment was perceived to be negative and intimidating (minors n=1; adults n=1); and the counsellor was perceived to be in too much of a hurry (adults n=1).

Seven in ten respondents in both the 1998- (n=57; 76.0%) and 2003-studies (n=84; 70.0%) received counselling prior to the termination and almost all in 1998 (n=54; 94.7%) compared to just more than half in 2003 (n=47; 55.8%) had received individual counselling. The lack of privacy during counselling in 2003 was attributed to: receiving counselling in a group (n=25); sensitive questions being asked in the presence of others (n=6); the presence of the parents of minors (n=2); and the nurse having had too many clients to see (n=2) (see Table 53 for an indication of the time spent on pre-counselling).

**Table 53: Time spent on pre-counselling (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| < 10 min | 8 | 20.5 | 2 | 4.4 |
| 10-19 min | 4 | 10.3 | 11 | 24.4 |
| 20-29 min | 16 | 41.0 | 6 | 13.3 |
| 30-39 min | 10 | 25.6 | 22 | 48.8 |
| 40-49 min | 1 | 2.6 | 1 | 2.2 |
| 60+ min | - | - | 3 | 6.7 |
| **Total** | **39** | **100** | **45** | **100** |

While only 4.4% of the adults (n=2) reported that counsellors spent less than 10 minutes on pre-counselling, it is of concern that 20.5% of the minors (n=8) noted the same. Furthermore, seven in ten minors (n=28; 71.8%) compared with four in ten adults (n=19; 42.2%) received less than 30 minutes of pre-counselling.

If one considers that it appears as if less time was spent on pre-counselling for minors, it is not surprising that, while all the adults (n=45; 100%) felt that pre-counselling had sufficiently prepared them for the TOP, fewer minors (although still a very high percentage, n=35; 89.7%) held the same opinion ($p<0.05$). Two minors and two adults also received counselling from someone other than the counsellor at the TOP facility: loveLife (minors n=1); a next-door neighbour who is a nurse (adults n=1); and a doctor (adults n=1).

Just more than half of the 1998-respondents (n=32; 56.1%) indicated that the counsellor had explained options other than the termination to them compared to slightly more than two- thirds of the 2003-respondents (n=59; 70.0%). Section 4 of the CTOPA indicates that counselling should comprise sufficient information to help women make an informed choice regarding TOP, including

alternatives to TOP. The vast majority of the 2003-respondents (n=80; 96.3%) understood what the counsellor explained to them. However, eight respondents had specific needs during counselling and wanted: to ask more questions (n=1); the counsellor to advise against TOP (n=1); more information about AIDS medication for future pregnancies (n=1); to know whether women from other countries could also access the service (n=1); more information on contraceptives (n=1) and the TOP procedure (n=1); and to know whether they could become pregnant again (n=1).

### 5.3.2 Post-counselling

It is a concern that nearly half of the 1998-respondents (n=36; 48.0%) stated that post-counselling was not available. The situation had not changed much by 2003 (n=55; 45.8%), despite the provisions in the CTOPA that the state should promote non-mandatory and non-directive counselling before and after the abortion. In 2003, TOP service providers also rated the quality of post-counselling services fairly negatively due to a lack of staff and time. This may explain why, in 2003, half of the minors (n=31; 51.7%) and 40.0% of the adults (n=24) reported that post-counselling was not available[47]. Of the respondents who did access post-counselling services (4 of the 29 minors and 20 of the 36 adults), more than half of the adults (n=20; 55.6%) and far fewer minors (n=3; 13.8%) were dissatisfied with the service, as they had to go for counselling at another facility (minors n=3) and were only given pills to take home (minors n=3).

The large number of respondents in both the 1998- and 2003-studies who did not receive post-counselling suggests that the issue needs serious attention. More particularly, in 1998 more than half of the respondents had not received counselling after the termination procedure (n=42; 56.0%). In 2003, 58.3% of the minors (n=35) and 81.7% of the adults (n=49) did not receive post-counselling ($p<0.05$). Of the respondents who did receive the service (minors n=25; 41.7%; adults n=11; 18.3%), almost all the minors (n=23) and half of the adults (n=5) received individual counselling, while the remaining respondents were counselled in a group setting.

All 25 minors who received post-counselling in 2003 also indicated that the counsellor had informed them about contraceptives. Ten of the 11 adult respondents reported the same. Since the termination, two-thirds of the minors (n=40; 66.7%) and almost three-quarters of the adults (n=44; 73.3%) were using contraceptives. Reasons why minors (n=20; 33.3%) were not using contraceptives included: they have not yet accessed family planning services (n=10); they would not have sexual intercourse again (n=3); their mothers forbade them to use contraceptives until they reached 18 years of age (n=3); they were not ready (n=3); they knew nothing about contraceptives (n=2); and it was thought that contraceptives made women gain weight (n=1).

[47] Note, “not available” means that the service was not offered at TOP facilities, even if the respondents requested it.

The majority of the 2003-respondents (n=106; 88.3%) were of the opinion that the information they disclosed to TOP staff was treated confidentially. Respondents who noted the contrary stated that: "*they call out our names in front of other people*" (n=2); "*they have a bad attitude and shout at us*" (n=5); and "*they discuss us amongst themselves"* (n=3).

### 5.3.3 Examination and procedure

As with the TOP service providers, the overwhelming majority of clients in both the 1998- and 2003-surveys were satisfied with the examination (1998 n=69; 92.0%; 2003 n=114; 95%) and the procedure (1998 n=68; 90.7%; 2003 n=108; 90.0%). The minimal degree of dissatisfaction that was noted with the examination by the 2003-respondents was explained as follows: "*they were rough*" (n=1); "*they left me, said I was stiffening my body*" (n=1); "*no privacy*" (n=1); "*the sister was rude*" (n=1); "*I had to undress in the corridor and lie on a bed, I waited, I was the seventh patient to be carried in*" (n=1); and "*they did not explain anything to me*" (n=1). Dissatisfaction with the TOP procedure was due to pain (1998 n=2); and ineffective tablets (1998 n=1), and the health workers performing the procedure without any explanations (2003 n=2).

Only four of the 1998-respondents (5.3%) reported that the physical examination had been conducted in the presence of other people (n=2) or other health workers (n=2). Similarly, all but three of the 2003-respondents were examined alone. Nine of the 2003-respondents (7.5%) reported that other persons could hear what was being said as: only a screen/curtain separated them from the other patients (n=4); the nurse spoke loudly (n=3); and another patient was in the next bed (n=2). The time spent on the examination varied and is provided in Table 54.

**Table 54: Time spent on examination during the first visit (2003)**

| | N | % |
|---|---|---|
| < 5 min | 18 | 15.1 |
| 5-9 min | 60 | 50.4 |
| 10-14 min | 25 | 21.0 |
| 15-19 min | 9 | 7.6 |
| 20-24 min | 5 | 4.2 |
| 25+ min | 2 | 1.7 |
| **Total** | **119** | **100** |

With regard to the first examination of patients, almost a third of the respondents (n=78; 65.5%) indicated it to have lasted less than ten minutes. Only one respondent in 2003 indicated that a health worker asked her to bring someone along when the procedure was conducted, as she lived far away from the TOP facility and may have been in need of assistance upon leaving.

In almost all of the cases in 1998 (n=74; 98.7%), the termination procedure was conducted in private. In one case two ambulance men assisted. With regard to the 2003-respondents who

terminated at the TOP facilities (n=31), all reported that the procedure was conducted in privacy. There was confusion with regard to whether the 2003-respondents had terminated their pregnancies at home or at the clinic. Three-quarters of the respondents (n=89; 74.2%) claimed to have terminated at home, while 50 of the 89 respondents (56.2%) were under twelve weeks pregnant. Possible explanations for this unusually high number of home abortions (where the tablets were inserted at home, but clients had to return to the clinic for the MVA procedure) include: clients inserted the tablets the night before the scheduled MVA, started to bleed at home and then did not return to the TOP facility for the MVA[48]; some of the women started the process at home and then returned for the MVA the next morning (hence the procedure was actually conducted at a TOP facility); and incorrect gestation dates were provided to the interviewers.

Of the respondents who indicated that the termination took place at home, four in ten (n=37; 41.0%) reported that there had been no one to assist them with the procedure. Other respondents (n=52; 59.0%) were helped by their mothers (n=19), boyfriends/husbands (n=8), cousins (n=4), sisters (n=12), grandmothers (n=3), aunts (n=5), employer (n=1) and friend (n=1). Of the respondents who did not have someone at home to help them with TOP, approximately half (n=19; 51.3%) wished to keep the termination a secret. Women who abort at home need to return to a health facility to ensure that all products of conception have been aborted (see Table 55).

**Table 55: Disposal of the products of conception (2003)**

| | Minors | |
|---|---|---|
| | N | % |
| Flushed away in the toilet | 7 | 7.9 |
| Took back to the hospital/clinic | 54 | 60.7 |
| Buried the products of conception | 4 | 4.5 |
| Only blood, no solid products - washed it/flushed it away | 17 | 19.1 |
| I don’t know because my aunt got rid of it | 1 | 1.1 |
| Burned at home | 3 | 3.4 |
| Wrapped it in paper and threw it away in the dustbin | 3 | 3.4 |
| **Total** | **89** | **100** |

In more than half of the cases in 2003 (n=54; 60.7%), respondents disposed of the products of conception by returning to a hospital or clinic. Seventeen respondents (19.1%) noted that there was only blood and no solid products to dispose of (suggesting that they might have been under twelve weeks pregnant). Although not all respondents returned with the products to a health facility (n=18, excluding those who reported only bleeding), they did report returning to a health facility for an examination. In total, seven respondents (7.7%) reported not returning for an examination as “*my mother used her own way to clean me*” (n=2) and “*I felt I did not need it*” (n=5).

[48] Note: patients at only one of the facilities were not sent home to insert the tablets before the MVA procedure.

### 5.3.4 Information provided to TOP clients

Only four of the 1998- and five of the 2003-respondents were dissatisfied with the information given to them about TOP as they did not understand the language (1998 n=2); the nurse made them feel guilty (1998 n=2); they were not given an explanation of what the procedure entailed (2003 n=4); and the nurse shouted at them (2003 n=1). It is worrying to note that seven of the 2003-respondents reported that contraceptive services are not available at TOP facilities.

***Main findings:***

- *There was a slight decrease in the level of satisfaction regarding pre-counselling services from 1998 to 2003, as observed from the responses of both TOP clients and TOP service providers.*
- *Seven in ten respondents in 1998 and 2003 received counselling prior to the termination. Of those who received pre-counselling, almost all in 1998 compared to just more than half in 2003 had received counselling in private. In the 2003-study, the lack of privacy was mainly attributed to receiving counselling in a group.*
- *Just more than half of the 1998-respondents compared to more than two-thirds of the 2003-respondents indicated that the counsellor had explained options other than the termination to them.*
- *Despite provisions in the CTOPA that non-mandatory and non-directive counselling be available before and after the TOP, this was clearly not the case as almost half of the respondents from both studies stated that post-counselling was not available.*
- *In 1998 more than half of the respondents had not received counselling after the TOP and in 2003 slightly more than half of the minors and more than three-quarters of the adults did not receive post-counselling. Of the respondents who did receive post-counselling in 2003 almost all the minors and half of the adults received counselling alone with the counsellor.*
- *More than half of the adult respondents who accessed post-counselling services in 2003 were dissatisfied with the service.*
- *By far, the majority of 2003-respondents who received post-counselling had also been informed about contraceptives and, since the TOP, two-thirds of the minors and almost three-quarters of the adults were using contraceptives.*
- *As with the TOP service providers, the overwhelming majority of clients in both the 1998- and 2003-studies were satisfied with the examination and the procedure.*
- *Three-quarters of the respondents claimed to have terminated at the home while half of them were under twelve weeks pregnant, despite the fact that all under twelve week procedures should be done at a TOP facility.*
- *Of the respondents who indicated that the termination had been conducted at home, four in ten reported that there had been no one at home to assist them with the procedure.*
- *In 40.0% of cases respondents did not dispose of the products of conception by returning to a hospital or clinic.*

## 6. EMOTIONAL EXPERIENCES OF AND SUPPORT FOR TOP CLIENTS

### 6.1 Emotional experiences before, during and after the TOP

The emotions and experiences of respondents before, during and after the termination were gauged by allowing the women to talk freely (See Tables 56-58).

**Table 56: Emotions and experiences before TOP (1998, 2003)**

| | N | % |
|---|---|---|
| **1998** | | |
| Depressive symptoms (sad, disappointed, ashamed, upset, scared, guilty) | 54 | 58.7 |
| Worried | 18 | 19.4 |
| Wanted TOP (satisfied, happy, good) | 8 | 8.7 |
| Did not know I was pregnant | 4 | 4.3 |
| Angry | 3 | 3.3 |
| Unable to concentrate/poor memory | 3 | 3.3 |
| Painful | 2 | 2.2 |
| **Total** | **92** | **100** |
| **2003** | | |
| Depressive symptoms (scared/confused/guilty/alone/bad) | 92 | 57.5 |
| Just wanted it over with/get rid of it | 25 | 15.6 |
| Headaches, vomiting, abdominal pain | 20 | 12.5 |
| Doubts/didn't know what to do | 11 | 6.9 |
| Tired/sleepy | 5 | 3.1 |
| Felt nothing | 2 | 1.3 |
| Did not want to see people | 2 | 1.3 |
| That the termination would never be done | 2 | 1.3 |
| Angry because I did not want to have a TOP | 1 | 0.6 |
| **Total** | **160** | **100** |

Prior to the termination, slightly more than half of the 1998-responses indicated a fair amount of depression (n=54; 58.7%), with respondents reporting feeling sad, scared, confused and ashamed. Some (n=18; 19.4%) were worried. Similarly, in 2003 slightly more than half of the responses indicated feeling depressed (n=92; 57.5%), i.e. scared, confused, guilty and alone. In addition, there were a number of responses indicating that the women wanted the procedure over with as soon as possible (n=25; 15.6%).

**Table 57: Emotions and experiences during TOP (1998, 2003)**

| | N | % |
|---|---|---|
| **1998** | | |
| Painful | 34 | 39.8 |
| Positive feelings (happy, good, satisfied, hopeful, relaxed, relieved) | 33 | 37.5 |
| Negative feelings (bad, guilty, depressed, heart broken) | 10 | 11.4 |
| Worried/scared | 8 | 9.1 |
| Embarrassed | 1 | 1.1 |
| Unconscious | 1 | 1.1 |
| **Total** | **87** | **100** |
| **2003** | | |
| Pain | 74 | 54.4 |
| Scared | 31 | 22.8 |
| Ashamed | 7 | 5.1 |
| Wondering whether it would be a success | 6 | 4.4 |
| Felt nothing | 7 | 5.2 |
| Weak | 5 | 3.7 |
| Not much pain | 3 | 2.2 |
| Relieved/happy | 2 | 1.5 |
| Felt hate for my boyfriend | 1 | 0.7 |
| **Total** | **136** | **100** |

During the termination, almost 40% of the 1998-respondents indicated that they experienced physical pain (n=34; 39.8%). Despite the pain, they felt positive once the procedure was under

way (n=33; 37.5%). Even more responses in 2003 (n=74; 54.4%) indicated that the respondents experienced pain during the TOP procedure. In addition, 22.8% (n=31) of the responses revealed that the women were also scared.

**Table 58: Emotions and experiences after TOP (1998, 2003)**

| | N | % |
|---|---|---|
| **1998** | | |
| Positive feelings (healthy, happy, well, relieved, satisfied, back to normal) | 61 | 62.9 |
| Guilty/ashamed/bad/shocked/everybody knows/cannot forget | 24 | 24.7 |
| Regret (sorry, sense of loss, feeling empty) | 7 | 7.2 |
| Some pain | 4 | 4.1 |
| Worried | 1 | 1.1 |
| **Total** | **97** | **100** |
| **2003** | | |
| Felt good/relieved | 81 | 50.0 |
| Disturbed/haunted by what I had done/guilty | 31 | 19.1 |
| In pain and tired | 26 | 16.0 |
| Pain subsided | 12 | 7.4 |
| Could now go back to school | 5 | 3.1 |
| Nothing | 2 | 1.2 |
| No appetite | 2 | 1.2 |
| Longed for parents' support | 1 | 0.6 |
| Angry that I had been forced to have a TOP | 1 | 0.6 |
| Mixed feelings | 1 | 0.6 |
| **Total** | **162** | **100** |

Once the procedure had been completed, slightly less than two-thirds of the responses in 1998 (n=57; 62.9%) indicated that the women felt satisfied and happy that everything would soon return to normal. Despite this, almost a quarter of the responses pointed to women feeling guilty, ashamed (n=24; 24.7%) and remorseful for what they had done (n=7; 7.2%). There were slightly fewer positive responses in 2003 (n=81; 50.0%), with 19.1% (n=31) illustrating that women felt disturbed and guilty by what they had done, and 16.0% (n=26) revealing that women were in pain after the procedure.

According to Urquhart & Templeton (in Walker 2000), a grief reaction to the loss of a pregnancy, including a terminated pregnancy, is common. Although feelings such as guilt, loss, sadness, regret, grief, reduced self-esteem and self-reproach occur frequently, these feelings tend to be short lived. Ports (in Walker 2000) notes that a pregnancy that is terminated early on has no long-term psychological side effects and usually results in profound relief.

***Main findings:***

- *Prior to the termination, TOP clients were experiencing depressive emotions such sadness, fear, confusion and guilt.*
- *Physical pain was the most common response provided during both studies in relation to the feelings that were experienced during the TOP procedure.*
- *After the procedure had been conducted, both groups of women indicated feeling a sense of relief, although a substantial number of responses related to feelings of guilt.*

### 6.2 Discussions with family and friends concerning the pregnancy (2003)

More in-depth information was obtained during the 2003-survey regarding discussions about the pregnancy (see Table 59).

**Table 59: Who the respondent first consulted about the pregnancy (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| Mother | 14 | 23.3 | 4 | 6.7 |
| Friend | 11 | 18.3 | 3 | 5.0 |
| Partner "father of the baby" | 8 | 13.3 | 29 | 48.3 |
| Aunt | 6 | 10.0 | 1 | 1.7 |
| Grandmother | 5 | 8.3 | - | - |
| A female relative who I live with | 5 | 8.3 | - | - |
| Nobody | 4 | 6.7 | 5 | 8.3 |
| Cousin | 3 | 5.0 | 2 | 3.3 |
| Sister | 2 | 3.3 | 12 | 20.0 |
| Father | 1 | 1.7 | 1 | 1.7 |
| Health worker | 1 | 1.7 | 2 | 3.3 |
| Co-worker | - | | 1 | 1.7 |
| **Total** | **60** | **100** | **60** | **100** |

The 2003-survey found that minors mainly consulted their mothers (n=14; 23.3%) and friends (n=11; 18.3%) when they first discovered that they were pregnant, while adults mainly consulted their boyfriends/husbands, i.e. the father of the baby (n=29; 48.3%) and sisters (n=12; 20.0%).

In total, 31 of the 60 minors (51.7%) discussed the pregnancy with a parent because: they wanted advice (n=5); their mothers were suspicious and wanted to know what was going on (n=6); and the minor's mother had accompanied her to the clinic and heard that she was pregnant (n=1). Minors who had not discussed the pregnancy with their parents said that: they were too scared to discuss it with them (n=10); their parents were too strict (n=9); they did not live with their parents (n=5); they did not want to disappoint their mothers or lose their trust (n=3); and were afraid that their parents would not allow them to have a TOP (n=1).

Far more adults (n=42; 70.0%) than minors (n=32; 53.3%) discussed the pregnancy with their partners. In other cases, partners were not consulted because: they did not live with the respondents (minors n=2; adults n=2); respondents were afraid that he would not allow them to have a TOP (minors n=4; adults n=3); the relationship was over (minors n=6; adults n=1); and he was not interested (minors n=1; adults n=1). Further reasons provided by minors for not consulting the "father of the baby" were: not wanting to involve him (n=8); parents forbidding her to tell him (n=2); he would not be able to help (n=2); she had been raped (n=1); and he would not believe her (n=1). Additionally, adults reported not consulting the "father of the baby" as they did not know who he was (n=1); avoiding family involvement in the decision to terminate (n=1); he was married (n=1); and wanting to keep it a secret (n=1).

More minors (n=19; 31.7%) than adults (n=8; 13.3%) discussed the pregnancy with friends/peers. Reasons provided why respondents did not discuss the pregnancy with friends/peers included wanting to keep the pregnancy a secret and being afraid of gossip (minors n=19; adults n=30), and because they did not have friends to discuss it with (minors n=7; adults n=7). Minors also remarked that they did not trust their friends (n=13), they felt ashamed of wanting to have a TOP (n=2), and that their mothers had forbidden them to talk about the pregnancy (n=1). Adults noted that it was a personal matter between them and their partners (n=11), friends would not be able to help (n=7), and that they felt ashamed as they had been raped (n=1).

## 6.3 Discussions with family and friends concerning the TOP

The questions related to discussions about the TOP with parents, the “father of the baby”, family and friends were asked to determine whether respondents had support before, during and after the TOP. The decision to terminate a pregnancy is usually made in secret. Adanlawo (1998) found in a study among 400 women attending a TOP clinic at King Edward VIII Hospital (KwaZulu-Natal) that 33% of the respondents did not inform family or confidants of their pregnancy, or that they wanted to have an abortion. Reasons for the lack of disclosure include a wide variety of emotions ranging from guilt to sadness and relief.

### 6.3.1 Support from parents (2003)

In the 2003-study, six in ten minors discussed having a TOP with their parents (n=37; 61.7%). The outcome of these discussions was mainly positive, as represented by the following responses: “*my mother supported me*” (n=16); “*agreed because of the situation at home*: (n=2), and “*we discussed the advantages and disadvantages of a TOP”* (n=3%). Some parents were hesitant and angry at first, but later agreed to the termination (n=3%). On the negative side, nine respondents indicated that their mothers told them to do what they wanted or kept quiet and said nothing (n=2). Two respondents reported that their parents forced them to have a TOP. The respondents who did not discuss the TOP with their parents (n=23; 38.3%) were scared to face their parents (n=10), as they would not understand (n=6) and did not want to disappoint their mothers (n=4). These minors were concerned that their parents would want to decide for them (n=3), or would not allow them to terminate (n=2). Two minors reported that their parents had passed away.

Three of the 23 minors who did not discuss the intended TOP with their parents indicated that their parents found out that they wanted to have a termination and their responses amounted to: anger (n=1), sadness (n=1), and support (n=1). The remaining 20 minors whose parents did not know about the procedure reported that they could live with the secret.

### 6.3.2 Support from partners/"father of the baby"

Almost two-thirds of the 1998-respondents had a male partner at the time of the study (n=47; 62.7%). Of these respondents, 29 (61.7%) discussed their desire to have a termination with their partner. In most instances, partners acted in a supportive manner (n=15), with six in fact having suggested the procedure. Five respondents reported that their partners were at first reluctant, but later agreed to the TOP. Two respondents stated that their partners were against the TOP and one denied that the baby was his. The 18 respondents (38.3%) who did not discuss the matter with their partners where generally afraid of his reaction or were experiencing relationship/marital problems (n=12). One respondent stated that she had not discussed the termination with her partner, as she did not want to hurt him.

During 2003, approximately a third of the minors (n=22; 36.7%) and slightly more than half of the adults (n=34; 56.7%) had discussed wanting to have a TOP with the "father of the baby" ($p<0.05$). In this regard, the percentages of 1998-respondents and 2003-adult respondents were similar, although far less minors had done the same. As with the 1998-respondents, in most instances the 2003-respondents also indicated that the "father of the baby" was supportive of their decision to have a TOP. More particularly, the minors indicated receiving support (or at least approval) from the "fathers of the babies" as is evidenced by the following statements:

- "*We made the decision together*" (n=7).
- "*He understood*" (n=6).
- "*He wanted us to keep the baby, but later accepted my reasons"* (n=4).
- "*He agreed to the TOP"* (n=4).
- "*He did not say anything*" (n=1).

Adults also mainly received support from the "fathers of the babies":

- "*He agreed to the TOP*" (n=27).
- "*He accompanied me to the hospital and supported me*" (n=3).
- "*He was relieved/he is married*" (n=2).

The respondents who did not discuss the intended TOP with the "father of the baby" (minors n=38; 63.3%; adults n=26; 43.3%) were afraid that he would refuse (minors n=11; 27.5%; adults n=6; 20.7%) and knew that he would be unsupportive (minors n=8; 20.0%; adults n=7; 24.1%). More adults reported not having seen the "father of the baby" since having had intercourse with him (n=7; 24.1%), while minors simply stated not wanting to discuss the matter with him (n=8; 20.0%).

**Table 60: Reasons for not discussing TOP with the "father of the baby" (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| I was afraid that he would refuse | 11 | 27.5 | 6 | 20.7 |
| He is unsupportive/I don't want him to know | 8 | 20.0 | 7 | 24.1 |
| Not seen him since we had intercourse | 4 | 10.0 | 7 | 24.1 |
| I was raped | 1 | 2.5 | 2 | 6.9 |
| He won't believe me/deny being the father | 1 | 2.5 | 2 | 6.9 |
| I did not want to discuss it with him | 8 | 20.0 | - | - |
| Our relationship was over | 5 | 12.5 | - | - |
| He hates children | 1 | 2.5 | - | - |
| My mother forbade me to tell him | 1 | 2.5 | - | - |
| He is a married man | - | - | 3 | 10.3 |
| He also impregnated another girl | - | - | 2 | 6.9 |
| **Total** | **40** | **100** | **29** | **100** |

Of the 2003-respondents who had not discussed the intended termination with the "father of the baby", one minor and one adult reported that he did find out before the termination. Their responses were: "*he found out from a friend and said that I could do as I like*" (minors n=1) and "*we discussed it*" (adults n=1). One minor indicated that the "father of the baby" had found out about the TOP after it had been performed and that he had been very angry. Of the remaining 36 minors and 22 adults who reported that the "father of the baby" had not found out, 32 minors and 21 adults stated that they could live with the secret. The minors could live with the secret: by just not telling him (n=15); breaking off the relationship (n=6); ensuring that he never found out (n=5); and by having the support of someone whom she trusts (n=5). One minor was afraid that the "father of the baby" would find out. The adults also stated that they would just not tell the "father of the baby" (n=7), because they had no other option (n=5); they had the support of someone they trusted (n=2); and they ensured that only certain people know about the termination (n=3).

### 6.3.3 Support from family

It appears as if many of the respondents attempted to cope with the termination on their own. This is evident as just more than a third of the 1998-respondents (n=29; 38.7%) indicated that they discussed the intended termination with a family member. The reasons why 46 respondents (61.3%) did not discussed the matter with a family member included: "*I was afraid of their response*" (n=20); "*I wanted it to be a secret/I didn't want to tell them*" (n=14); "*I don't live with them*" (n=5); "*they are all younger than me*" (n=4); "*I am only living with my partner/husband*" (n=2); and "*I was embarrassed*" (n=1). While family members encouraged some of the respondents to terminate (n=8) and were supportive of the decision (n=5), others were shocked (n=3), angry (n=3) and sad (n=2). Some did not agree at all with the decision (n=2), although some later came to accepted it (n=6). Many of the respondents were relieved and happy with these reactions (n=12), while others felt depressed, ashamed (n=10) and embarrassed (n=3).

In 2003, slightly less than half of the respondents (n=57; 47.5%), which is somewhat higher than in 1998, discussed wanting to have a TOP with a family member. The majority of these women

reported that person to have been supportive (n=45; 78.9%). Twelve respondents (21.0%) indicated that the family member was shocked about the intended TOP. Respondents (n=63; 52.5%) who did not discuss the intended TOP with a family member felt that:

- "*I don't want them to know*" (n=18).
- "*They gossip too much and cannot keep a secret*" (n=14).
- "*They would have tried to convince me to have the baby*" (n=9).
- "*My siblings would have told my parents*" (n=4).
- "*I was afraid*" (n=4).
- "*My mother told me to keep it quiet*" (n=2).
- "*They do not live nearby*" (n=2).

### 6.3.4 Support from friends

The reasons for not discussing the intended TOP with friends are given in Tables 61 and 62.

**Table 61: Reasons why the intention to terminate was not discussed with friends (1998)**

| | N | % |
|---|---|---|
| Friends are not trustworthy | 39 | 54.9 |
| I want it to be a secret | 19 | 26.8 |
| Don't have close friends | 6 | 8.5 |
| My friends will react negatively | 4 | 5.6 |
| Too embarrassed | 2 | 2.8 |
| Found out late that I was pregnant | 1 | 1.4 |
| **Total** | **71** | **100** |

Again, very few of the 1998-respondents (n=13; 17.3%) discussed the intention to terminate with their friends. The main reasons why 62 respondents (82.7%) did not discuss the matter with their friends were that they thought that they could not trust them (n=39; 54.9%) and they wished to keep it a secret (n=19; 26.8%). The respondents who did discuss the intention with their friends reported that they: "*encouraged me/supported me*" (n=6); "*felt sorry for me*" (n=2); "*not happy at first, but later agreed*" (n=2); "*were very shocked*" (n=1); "*concerned about my feelings"* (n=1); and "*my friends were against my decision*" (n=1).

**Table 62: Reasons for not discussing the TOP with a friend (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| Will not keep it a secret/gossip | 16 | 41.0 | 21 | 39.6 |
| No friend to discuss personal matters with | 6 | 15.4 | 9 | 17.0 |
| Do not want to tell them | 6 | 15.4 | 12 | 22.6 |
| Don't trust them | 9 | 23.1 | - | - |
| If they spread the news, I will be ashamed | 1 | 2.6 | - | - |
| My mother asked me not to discuss it | 1 | 2.6 | - | - |
| They won't be able to help me | - | - | 1 | 1.9 |
| It is a private matter | - | - | 10 | 18.9 |
| **Total** | **39** | **100** | **53** | **100** |

As with the 1998-respondents, in 2003 far more adults (n=54; 91.5%) than minors (n=43; 71.7%) did not discuss the TOP with friends ($p<0.05$), mainly because "*they would not keep it a secret*" (minor n=16; 41%; adults n=21; 39.6%); "*I do not have a friend to discuss such personal matters with*" (minors n=6; 15.4; adults n=9; 17.0%); and "*I did not want to tell them*" (minors n=6; 15.4%; adults n=12; 22.6%). Minors also indicated not trusting their friends (n=9; 23.1) and adults (n=10; 18.9%) stated that it was a private matter. The minors who discussed the TOP with a friend (n=17; 28.3%) reported receiving support (n=13) and being referred to a TOP facility (n=3). Some minors stated that their friends were against TOP (n=2) and were shocked by the intention (n=2). Adults also reported receiving support from friends (n=4), although one indicated that her friend was against TOP.

A study conducted by Walker (2000) among 88 TOP patients revealed that 86% of respondents had confided in friends and 40% in family members about the procedure. This was a more positive response than that found in the Free State study where 17.3% had confided in friends and 38.7% had spoken to family members. Similarly, Webb (in Walker 2000) reported that women are often unable to tell family members or significant others about the termination.

***Main findings:***

- *Half of the minors discussed their pregnancies with their parents.*
- *Far more adults (n=42; 70.0%) than minors (n=32; 53.3%) discussed the pregnancy with the "father of their baby".*
- *In the 2003-study, six in ten minors discussed having a TOP with their parents and the outcome of these discussions was mainly positive.*
- *In the 1998-survey, six in ten respondents discussed their desire to have a termination with their partner, while approximately half of the adults in the 2003-study compared to only a third of the minors had done the same. In most instances the "father of the baby" was supportive of the decision to terminate the pregnancy.*
- *In 2003, just less than half of the respondents (which is slightly higher than during the 1998-survey) discussed wanting to have a TOP with a family member.*
- *As with the 1998-respondents, in 2003 far more adults than minors did not discuss the TOP with friends as they wanted to keep it a secret.*
- *In total, of the 2003-respondents 17.3% had confided in friends and 38.7% had spoken to family members about the TOP.*

## 7. KNOWLEDGE OF PREGNANCY, TOP AND THE CTOPA

All the respondents appeared to know that pregnancy could be prevented by using a contraceptive method. The question that arises is: why is there a need to have TOP if the minor or adult knows how to prevent a pregnancy? Respondent's knowledge about TOP and the CTOPA is illustrated in Tables 63 and 64.

**Table 63: Knowledge of the CTOPA (1998)**

| | True | | False | | Uncertain | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| TOP is only available during the first twelve weeks of pregnancy and not thereafter | 22 | 29.3 | **34** | **45.3** | 19 | 25.3 |
| Your partner must give consent for a termination to be conducted | 11 | 14.7 | **49** | **65.3** | 15 | 20.0 |
| Minors do not have to obtain the consent of their parents to have a TOP | **31** | **41.3** | 20 | 26.7 | 24 | 32.0 |
| TOP from the thirteenth week of pregnancy is allowed if certain requirements are met | **26** | **34.7** | 28 | 37.3 | 21 | 28.0 |
| TOP after the twentieth week is available if the continued pregnancy would endanger the life of the woman | **37** | **49.3** | 9 | 12.0 | 29 | 38.7 |

Note: figures in bold represent the frequency and percentage of correct answers.

With regard to the respondents' knowledge of the CTOPA, the average of correct responses for all five questions posed in 1998 was 47.2%, thereby indicating that the respondents were not well informed about the Act. This observation was also evident in the relatively high proportion of "uncertain" responses (to a certain extent the uncertain responses should be treated as "incorrect" answers, thus depicting a lack of knowledge). The women were better informed about issues such as their partner not having to give permission for the TOP (n=49; 65.3%) and that TOP was available after the twentieth week if the continued pregnancy would endanger the life of the woman (n=37; 49.3%). Clearly these women were slightly better informed of their rights than those in the studies conducted by De Lange (2000) and Varkey *et al.* (2000), who found that less than a quarter of women knew that they did not need their husbands' consent to have an abortion.

The lack of public awareness on TOP was also evident in 1998, when it was found that 53% of South Africans did not know that abortion on request was available during the first twelve weeks of pregnancy. Furthermore, of the women wanting to access a TOP service in the Cape Metropolitan Region, more than 90% did not know when TOP was legal (Althaus, 2000).

**Table 64: Knowledge of the CTOPA (2003)**

| | Minors | | | Adults | | |
|---|---|---|---|---|---|---|
| | True | False | Uncertain | True | False | Uncertain |
| TOP is only available during the first 12 weeks of pregnancy and not thereafter | 30<br>50.0% | **13**<br>**21.7%** | 17<br>28.3% | 43<br>71.7% | **10**<br>**16.7%** | 7<br>11.7% |
| Minors have to obtain the consent of their parents to have a TOP | 27<br>45.0% | **30**<br>**50.0%** | 3<br>5.0% | 29<br>48.3% | **20**<br>**33.3%** | 11<br>18.3% |
| TOP from the 13th week of pregnancy is allowed if certain requirements are met | **18**<br>**30.0%** | 5<br>8.3% | 37<br>61.7% | **39**<br>**65.0%** | 9<br>15.0% | 12<br>20.0% |
| TOP after the 20th week is available if the continued pregnancy would endanger the life of the woman | **15**<br>**25.0%** | 2<br>3.3% | 43<br>71.7% | **35**<br>**58.3%** | 13<br>21.7% | 12<br>20.0% |
| TOP is available free of charge at government facilities | **58**<br>**96.7%** | - | 2<br>3.3% | **56**<br>**93.3%** | 1<br>1.7% | 3<br>5.0% |

Note: figures in bold represent the frequency and percentage of correct answers.

Four of the five questions posed in the 1998-study were again asked in the 2003-survey with the addition of one new question. Significant differences were recorded in the answers of minors and adults to four of these questions. The average of correct answers for minors was 44.7% and for adults 51.3%. Clearly there was not an improvement in the level of knowledge of TOP clients regarding the CTOPA since 1998. More specifically, only 21.7% of the minors (n=13) and even fewer adults (n=10; 16.7%) knew that TOP was also available after the first twelve weeks of pregnancy. The question that arises is, if 20 minors and 18 adults had a TOP above twelve weeks, why did not all of these respondents answer the question correctly? Only half of the minors (n=30; 50.0%) knew that parental consent was not a prerequisite for having a TOP, which was slightly better than De Lange's (2000) and Varkey et al.'s (2000) findings that less than a quarter of women knew of this. Twice as many adults (n=35; 58.3%) knew that TOP after the 20$^{th}$ week was available if the continued pregnancy would endanger the life of the woman. Only one adult noted that TOP was not available free of charge at government facilities. Although it appears as if, overall, the adults (53.3% correct responses) were more knowledgeable about the CTOPA and its implications than minors (44.7% correct responses), the level of knowledge for both groups remained poor.

The lack of knowledge concerning the details of the CTOPA was also noted by Varkey (2000) who reported that, while women may know that abortion is legal, it is unlikely that they will be familiar with the provisions of the Act. Women had first heard about TOP from different sources (as evidenced in Table 65).

**Table 65: First source of information that TOP is legal (2003)**

| | N | % |
|---|---|---|
| Newspaper/magazine/radio | 62 | 53.0 |
| Health worker at a clinic | 12 | 10.3 |
| Teacher/school | 10 | 8.5 |
| Doctor | 10 | 8.5 |
| Family | 7 | 6.0 |
| Friends | 7 | 6.0 |
| People in the community | 3 | 2.6 |
| At work | 3 | 2.6 |
| HIV activist/loveLife | 2 | 1.7 |
| Neighbour | 1 | 0.9 |
| **Total** | **117** | **100** |

The majority of 1998-respondents had first heard about the CTOPA from the media (n=58; 77.0%), while other sources of information included family/friends (n=6; 8.0%), doctors (n=5; 6.7%), clinic/hospital (n=4; 5.3%) and school (n=2; 2.7%). Similarly, in 2003 the media was still an important source of information regarding TOP (n=62; 53.0%). Clinic health workers (n=12; 10.3%), teachers (n=10; 8.5%) and doctors (n=10; 8.5) were also sources of information regarding TOP.

In 1998, seven in ten respondents (n=53; 70.7%) did not know what the clinical procedure for TOP entailed. Clearly there was an improvement in the situation by 2003, when the clinical procedure was explained to almost 80% of the adults (n=47; 79.7%) compared to 60.0% of the minors (n=36) ($p<0.05$). Table 66 provides a summary of the information provided to clients regarding the clinical procedure for TOP.

**Table 66: Clinical procedure for TOP (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | **N** | **%** | **N** | **%** |
| Being given pills to insert and drink | 34 | 52.3 | 26 | 36.1 |
| Returning to the hospital for cleaning | 27 | 41.5 | 23 | 31.9 |
| Using a vacuum (MVA) | 1 | 1.5 | 5 | 6.9 |
| Vaginal exam to determine pregnancy duration | 1 | 1.5 | 1 | 1.4 |
| Not eating the day before the procedure | 2 | 3.1 | - | - |
| The procedure being done by trained people | - | - | 1 | 1.4 |
| Can do a TOP of under 20 weeks pregnant | - | - | 1 | 1.4 |
| The baby will be aborted by bleeding | - | - | 9 | 12.5 |
| Same signs as labour/very painful | - | - | 6 | 8.3 |
| **Total** | **65** | **100** | **72** | **100** |

Some of the explanations of the TOP procedure entailed: "*I was told what pills to insert and drink*" (minors n=34; 52.3%; adults n=26; 36.1%), and that "*it is important to return to a hospital for cleaning*" (minors n=27; 41.5%; adults n=23; 31.9%).

***Main findings:***

- *There has not been an improvement in the level of knowledge of TOP clients regarding the CTOPA since 1998.*
- *The media is the most important source of information regarding TOP.*
- *The clinical procedure for TOP was explained to more respondents in 2003 than in 1998.*

## 8. ATTITUDES TOWARDS TOP (2003)

The 2003-respondents were asked whether or not they would consider having a TOP again, and only three reported that it was a future option. The remaining 117 respondents provided a variety of reasons why they would not consider another TOP (see Table 67).

**Table 67: Explanations why TOP will not be considered in future (2003)**

| | N | % |
|---|---|---|
| Use contraceptives | 56 | 36.6 |
| It is too painful | 30 | 19.6 |
| It is not the right thing to do/God is watching | 21 | 13.7 |
| It was a bad experience | 16 | 10.5 |
| Afraid that I could die | 10 | 6.5 |
| Afraid that I will not be able to have children | 4 | 2.6 |
| Abstain from sex | 3 | 2.0 |
| The treatment by staff was too bad | 3 | 2.0 |
| I am more responsible now | 3 | 2.0 |
| It is not easy | 2 | 1.3 |
| I was forced this time, I won't let them force me again | 2 | 1.3 |
| It is a criminal offence | 1 | 0.7 |
| The outcome may not be successful again | 1 | 0.7 |
| Not a simple process/too many people to consult | 1 | 0.7 |
| **Total** | **153** | **100** |

A third of the responses why clients (n=56; 36.6%) would not consider having another TOP related to rather using contraceptives in order to avoid another unwanted pregnancy. Further reasons included: "*it is too painful"* (n=30; 19.6%); "*it is not the right thing to do, God is watching*" (n=21; 13.7%); and, "*it was a bad experience*" (n=16; 10.5%). Five minors (8.3%) indicated that young girls would still prefer backstreet abortions as they did not want their parents to find out (n=1) and due to the negative attitude of TOP staff (n=2). Two adults said that women would prefer a backstreet abortion due to the lack of privacy at TOP facilities. Reasons why backstreet abortions would be avoided are provided in Table 68.

**Table 68: Why backstreet abortion would be avoided (2003)**

| | N | % |
|---|---|---|
| At hospitals you are treated by professionals | 53 | 32.9 |
| It could be very dangerous/destroy your womb | 52 | 32.3 |
| People not qualified/no proper medical assistance | 23 | 14.3 |
| You could die | 15 | 9.3 |
| TOP is legal, not necessary for a backstreet abortion | 13 | 8.1 |
| It is a bad thing to do | 3 | 1.9 |
| You could get arrested for dumping products of conception anywhere | 1 | 0.6 |
| You children at home could be traumatised by seeing it | 1 | 0.6 |
| **Total** | **161** | **100** |

The main reasons why backstreet abortions would be avoided were: "*at hospitals you are treated by professionals*" (n=53; 32.9%) and "*it is dangerous and could destroy your womb*" (n=52; 32.3%).

***Main findings:***

- *Only three of the 2003-respondents said that they would consider having a termination again in the future.*
- *A third of the 2003-repondents indicated that they would use contraceptives in order to avoid further unwanted pregnancies.*

## 9. IMPEDIMENTS TO ACCESSING TOP AND RECOMMENDATIONS

Seven of the 1998-respondents experienced problems when arranging the TOP including: stress (n=1); concern that a family member would find out (n=2); transport problems (n=2); problems with the date of the TOP (n=1); being put onto a waiting list (n=1); and high blood pressure (n=1). Problems experienced at the TOP facility amounted to: the treatment not working (n=4); the negative attitudes of nurses (n=4); being sent from one facility to a hospital to have the waste products removed (n=1); and developing an infection (n=1). Recommendations to overcome the problems are outlined in Table 69.

**Table 69: Recommendations to facilitate the process for women considering TOP (1998)**

| | N | % |
|---|---|---|
| The entire TOP procedure should be done at clinics/hospitals and not alone at home | 18 | 30.0 |
| Information on the CTOPA and location of TOP facilities | 13 | 21.7 |
| More accessible services | 8 | 13.3 |
| More trained/professional staff | 6 | 10.0 |
| There should be strict requirements for TOP so that it is not used as a contraceptive | 5 | 8.3 |
| Privacy at TOP facilities | 4 | 6.7 |
| Women and especially teenagers should be taught about contraceptives | 3 | 5.0 |
| Patients should be given medication for pain relief | 2 | 3.3 |
| Minors should have consent from parents | 1 | 1.7 |

The most frequently mentioned recommendations by the 1998-respondents were that the entire TOP procedure should be conducted in a health care environment (n=18; 30.0%). This would mean that women would no longer have to start inductions at home; instead they would be under the constant supervision of health staff. Therefore, the risk of complications and perhaps even the psychological trauma of disposing with the products of conception could be reduced. A further recommendation was that more information was needed on the CTOPA and on the location of the TOP facilities (n=13; 21.7%).

During 2003, respondents were probed for more detail concerning problems experienced in accessing a TOP, as well as for recommendations to overcome impediments (see Tables 70 and 71). In 2003, almost two-thirds of the minors (n=39; 65.0%) and half of the adults (n=29; 48.3%) reported experiencing no problems at the TOP facilities. Those who experienced problems noted the following:

- "*The sister was unfriendly and had a bad attitude*" (minors n=5; adults n=7).
- "*Long waiting lists*" (minors n=4; adults n=4).
- "*Too little privacy*" (minors n=1; adults n=7).
- "*Being sent home to abort*" (minors n=2).
- "*Patients above twelve weeks have to return to see the doctor*" (minors n=2).
- "*There are too few staff and too long waiting times*" (minors n=2).

- “*I was sent from the TOP facility to the hospital while in severe pain*“ (minors n=2).
- “*Pain during the procedure*“ (adults n=3).

**Table 70: Recommendations aimed at simplifying the process for minors/women (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| Provide education on TOP | 13 | 24.1 | 12 | 21.8 |
| Provide education on family planning | 13 | 24.1 | 5 | 9.1 |
| Ensure positive attitude of staff | 8 | 14.8 | 4 | 7.3 |
| Aim for entire procedure to be conducted in a hospital | 8 | 14.8 | 8 | 14.5 |
| Ensure privacy | 1 | 1.9 | 4 | 7.3 |
| Give pills at first visit/long waiting period stressful | - | - | 7 | 12.7 |
| Implement TOP in all local clinics | - | - | 4 | 7.3 |
| Provide more staff | - | - | 3 | 5.5 |
| Go early to the TOP clinic so that you can be helped | - | - | 2 | 3.6 |
| Make use of the TOP clinics and not a private doctor | - | - | 2 | 3.6 |
| Educate on other options | - | - | 1 | 1.8 |
| Give information in own language | - | - | 1 | 1.8 |
| Do TOP in the doctor’s surgery | - | - | 1 | 1.8 |
| Provide an ambulance to take weak patients home | - | - | 1 | 1.8 |
| Share your decision to terminate with someone | 6 | 11.1 | - | - |
| Improve relationships between teenager and parents | 2 | 3.7 | - | - |
| Seek help as soon as possible | 2 | 3.7 | - | - |
| Be patient and follow instructions | 1 | 1.9 | - | - |
| **Total** | **54** | **100** | **55** | **100** |

The most frequently mentioned recommendations during the 2003-survey aimed at simplifying access to TOP facilities, namely: increased education on TOP (minors n=13; 24.1%; adults n=12; 21.8%); education on family planning methods (minors n=13; 24.1%; adults n=5; 9.1%); improved staff attitudes (minors n=8; 14.8%; adults n= 4; 7.3%); and the entire TOP procedure should be conducted in the hospital/clinic (minors n=8; 14.8%; adults n=8; 14.5%). Furthermore, adult clients mentioned that women should be given the pills at their first visit and told how to use them, as this would shorten the lengthy waiting period for the procedure to be completed (n=7; 12.7%). Others felt that TOP should be implemented at all health care facilities (n=4; 7.3%). Minors noted that it was important to share the decision to terminate with someone as they could provide support and assistance (n=6; 11.1%).

Respondents were asked to suggest recommendations to improve the various aspects of TOP services, including pre- and post-counselling, the examination, MVA and inductions (see Table 71).

**Table 71: Recommendations to improve services (2003)**

| | Minors | | Adults | |
|---|---|---|---|---|
| | N | % | N | % |
| **Pre-counselling** | | | | |
| Provide more privacy – addressed individually | 9 | 29.0 | 5 | 12.5 |
| Encourage more openness | 2 | 6.4 | 1 | 2.5 |
| Spend more time with patients | 3 | 9.7 | 6 | 15.0 |
| Provide more trained staff | 1 | 3.2 | 11 | 27.5 |
| Make counselling available for all clients | 5 | 16.1 | 12 | 30.0 |
| Give demonstrations/videos | 2 | 6.4 | 1 | 2.5 |
| Show more compassion | 2 | 6.4 | - | - |
| Consider other options | 5 | 16.1 | - | - |
| Discuss the advantages and disadvantages of TOP | 1 | 3.2 | - | - |
| Encourage clients not to repeat a TOP | 1 | 3.2 | - | - |
| Pre-counselling available at clinic where TOP requested | - | - | 1 | 2.5 |
| Educate the community | - | - | 3 | 7.5 |
| **Total** | **31** | **100** | **40** | **100** |
| **Post-counselling** | | | | |
| Make post-counselling available for all clients | 12 | 46.2 | 35 | 60.3 |
| Do follow-up visits | 4 | 15.4 | 4 | 6.9 |
| Provide more qualified counsellors | 3 | 11.5 | 12 | 20.7 |
| Teach people what is right | 1 | 3.8 | 3 | 5.1 |
| Encourage friendly staff | 1 | 3.8 | - | - |
| Advise patients to use contraceptives | 3 | 11.5 | - | - |
| Encourage youth to abstain from sex | 2 | 7.7 | - | - |
| Provide more privacy | - | - | 3 | 5.1 |
| Post-counselling done by the doctor doing referrals | - | - | 1 | 1.7 |
| **Total** | **26** | **100** | **58** | **100** |

Minors were concerned with the need for more privacy, and specifically individual counselling (n=9; 29.0%), and that pre-counselling should be available to all clients (n=5; 16.1%). Adults' recommendations for improved pre-counselling focused also on counselling being provided to all clients (n=12; 30.0%), and the availability of more trained staff (n=11; 27.5%). Both minors (n=12; 46.2%) and adults (n=35; 60.3%) recommended that post-counselling be available to all TOP clients. Furthermore, minors recommended improved post-counselling through follow-up visits (n=4; 15.4%), and adults identified the need for more qualified counsellors (n=12; 20.7%).

Minors recommended that the examination process could be improved by: "*spending more time on the examination so as to be gentle*: (n=10); "*using a sonar to determine the duration of pregnancy*" (n=1); "*ensuring more privacy*" (n=1); and "*more friendly staff*" (n=1). Adults also recommended more privacy (n=12); more staff (n=4); a doctor to undertake the examination (n=1); keeping the patient informed (n=1); and not having patients see the instruments (n=1).

Reportedly, the MVA procedure could be greatly improved by lessening the pain (minors n=14; adults n=18). Minors also recommended rather using pills than the vacuum (n=2), friendly staff to explain what is happening (n=1), and being more gentle when doing the procedure (n=1). Adults recommended that more doctors should be available (n=3). As with the MVA, respondents recommended stronger pain medication for the induction procedure (minors n=1; adults n=11). It

was strongly recommended that inductions be done in the hospital and not at home (minors n=20; adults n=14). Minors also recommended more privacy (n=3) and shortening of the process (n=1).

***Main findings:***

- *The majority of respondents in both the 1998- and 2003-surveys did not experience any problems at the TOP facilities.*
- *The main recommendation from the 1998-respondents to improve user-friendliness of TOP services was that the entire procedure should be conducted in a health facility.*
- *Problems that were experienced by 2003-respondents included: unfriendly nurses, long waiting lists, too little privacy, being sent home to abort, return visits, and pain.*
- *Recommendations to improve services were: more education on TOP and family planning, encouraging staff to have more positive attitudes, and the entire TOP procedure to be conducted in the hospital.*
- *Recommendations to improve counselling were: privacy, individual counselling, and ensuring that counselling is available for all patients.*
- *Recommendations to improve the examination amounted to more time being spent on the procedure and ensuring privacy for the patients.*
- *The main recommendations to improve the MVA procedure was that stronger pain medication should be provided.*
- *The main recommendation for the induction procedure was that patients should be admitted to hospital for the procedure and not sent home to abort without medical supervision.*

## 10. SUMMARY

In order to determine whether inaccessible family planning services were contributing towards increased and continued use of TOP, the 2003-respondents were asked a series of questions relating to the accessibility and user-friendliness of family planning facilities. It was found that, in most instances, it took less than half an hour to reach family planning facilities, although lengthy waiting periods at the facilities were noted. Overall, treatment received at the family planning facilities was noted to be good, and respondents were satisfied with the services (i.e. information about contraceptives, examination and provision of contraceptives). These findings illustrate that, although lengthy waiting times were problematic at facilities providing family planning, the services were easily accessible and, to a large degree, user-friendly.

Despite hostile attitudes and reluctance of some health workers to refer women to TOP facilities, it was encouraging to observe that only one respondent in the 2003-study and none in the 1998-survey reported problems with referral agents. Less than half of the 1998-respondents were put onto a waiting list at the TOP facilities, while in 2003 a slight increase was noted. It is especially problematic that some clients were put onto a waiting list of ten days or more. Furthermore, it is a concern that patients had to keep returning to TOP facilities before the procedure was completed; in 2003, approximately 30% of all respondents returned twice to a TOP facility. Lengthy waiting lists and repeat visits to facilities impede access to TOP and may result in women who are under twelve weeks pregnant to only access the service in their second trimester.

A further impediment to accessing TOP services relates to the majority of respondents travelling by taxi to the TOP facilities. Most respondents were able to afford taxi costs; however, those who could not had to borrow money from family, friends or their boyfriends. Less than a quarter of 1998-respondents and far less in the 2003-study travelled for more than an hour to reach a TOP facility. This may be ascribed to the sample as, 76.0% of the respondents in the 1998- and 60.0% in the 2003-survey lived in the cities/towns where the TOP facilities were located. If more facilities rendered TOP services, it would not be necessary for women to travel to different cities/towns to access the services. In turn, the problem of overload at the TOP facilities would be addressed.

It is positive to note that TOP facilities were mostly perceived to be user-friendly. More specifically, the 1998- and 2003-TOP clients were generally satisfied with the treatment received from TOP staff and other patients. Seemingly, there was an increase in the dissatisfaction of respondents from the 1998- to the 2003-surveys regarding treatment received from nurses. The level of dissatisfaction correlates with findings from the TOP provider study, where it was found that health workers became more cautious in their attitudes toward TOP over time. Similarly, their work morale tended to decrease. As such, it is not surprising that the 2003-respondents more frequently reported hostility on the part of TOP service providers.

With regard to the services provided at TOP facilities, more problems were reported with counselling than with the examination and TOP procedures. More specifically, a slight decrease is evident in the level of satisfaction regarding pre-counselling services from 1998 to 2003. During both studies, seven in ten respondents received counselling prior to the termination of whom almost all in 1998 compared to only just more than half in 2003 had received counselling in private. The lack of privacy during counselling experienced by 2003-respondents was mainly attributed to receiving counselling in a group. Despite provisions in the CTOPA that non-mandatory and non-directive counselling be available before and after the TOP, this was clearly not the case. Almost half of the respondents during both surveys stated that post-counselling was not available. More than half of the 1998-respondents had not received counselling after the TOP; in 2003, slightly more than half of the minors and more than three-quarters of the adults did not receive post-counselling. More than half of the adult respondents who accessed post-counselling services in 2003 were dissatisfied with the service. By far, the majority of 2003-respondents who received post-counselling were also informed about contraceptives. Since the TOP, two-thirds of the minors and almost three-quarters of the adults were using contraceptives. As with the TOP service providers, the overwhelming majority of clients in both the 1998- and 2003-surveys were satisfied with the examination and TOP procedures.

Confusion prevailed about what the actual TOP procedure entailed despite the fact that the clinical procedure was explained to more respondents in the 2003- than 1998-study. Three-quarters of the 2003-respondents claimed to have terminated at the home (while half of them

were under twelve weeks pregnant), while all first-trimester procedures should be performed at the facilities. A possible explanation for this is that, after inserting the tablets, the patients started to bleed at home and did not return to a TOP facility for the MVA procedure. Of the respondents who indicated that the termination had been conducted at home, four in ten reported that there was no one to assist them with the procedure. It is a concern that in 40.0% of the cases the respondents did not dispose of the products of conception by returning to a hospital or clinic. Complications, such as sepsis, could arise if the client retained some of the products.

There was no improvement in the level of knowledge of TOP clients between the 1998- and 2003-surveys regarding the CTOPA. Clearly a need existed for information campaigns on sexual and reproductive health, with focus on TOP.

The majority of respondents in the 1998-study did not experience any problems at the TOP facilities. The main recommendation from the 1998-respondents to improve user-friendliness of TOP facilities relates to the entire procedure being conducted in a health facility. Furthermore, almost two-thirds of the minors and half of the adults in the 2003-survey experienced no problems at TOP facilities. Problems that were experienced in 2003 included: unfriendly nurses, long waiting lists, too little privacy, being sent home to abort, return visits, and pain during the procedure. Recommendations to improve services were: more education on TOP and family planning, encouraging staff to have more positive attitudes, and the entire TOP procedure to be conducted in the hospital. Counselling could be improved by ensuring more privacy, individual counselling and available of the service for all clients.

The study clearly demonstrates that, although the CTOPA has opened the door to women to access TOP services, the implementation of the Act is confronted by numerous challenges. Only four facilities in the province provided TOP services, which meant that women wishing to access the service may have to travel far distances and incur transportation costs. Furthermore, evidence indicates that women have to visit a TOP facility more than once to access the service. In addition, many women have been put onto a waiting list at TOP facilities, and in many cases they have waited more than 10 days to receive the service. Increasing negative attitudes of TOP nurses is a further deterrent to accessing the service, as many 2003-adult respondents indicated that nurses used harsh words when speaking to them. An additional problem experienced at the TOP facilities relates to the lack of pre- and post-counselling services, as well as the absence of a 24 hour service (which entails clients being sent home to abort). Clients clearly lack knowledge about the implications of TOP and need to receive education on sexual and reproductive health issues.

Given the numerous impediments reported in both Chapters 5 and 6, Chapter 7 sets out to discuss the findings of the empirical study in relation to the literature reviewed, ultimately to

suggest recommendations to overcome impediments in accessing TOP services in the Free State and South Africa as a whole. Included in the discussion are the views of Free State TOP managers, facility staff and other stakeholders who attended feedback workshops on the findings of the 1998- and 2003-studies.

# PART 4: CHAPTER 7

# A SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

*"In every part of the world, in every era of history, women from all walks of life have obtained abortions to end unintended pregnancies. Despite the history and universality of women's need for safe abortion care, access to abortion is neither socially nor legally sanctioned in many parts of the world. As a result, almost half of the women seeking abortions each year - 19 million - must resort to untrained providers working in unsanitary conditions. Almost a quarter of these unsafe abortions occur in Africa"* (Otsea 2004: 5).

## 1. INTRODUCTION

Approximately 210 million pregnancies occur annually worldwide, of which four in ten are unplanned (Allan Guttmacher Institute 1999b). Small families have increasingly become the norm and most couples not only wish to control the size of their families, but also the timing and spacing of births. This has increased the demand for contraception and, in its absence or if contraceptive methods should fail, the demand for abortion. The right to decide when to have a child is at the core of reproductive rights. In essence, it means that women should have access to safe and effective means of controlling their family size, including contraception and abortion services. Over the past few years, increased recognition of reproductive rights and the role that unsafe abortion plays in maternal mortality has encouraged many governments to review and liberalise legislation that regulate access to induced abortion. Despite this, the WHO estimates that approximately 20 million illegal abortions are performed annually with the vast majority undertaken in South and South East Asia, sub-Saharan Africa, Latin America and the Caribbean (Allan Guttmacher Institute1998). While the majority of African countries still have restrictive abortion laws, which contribute to the more than five million unsafe abortions conducted annually, radical change in abortion legislation occurred in 1996 in South Africa when the CTOPA was passed, ensuring that the country has one of the most liberal abortion laws in the world. The aim of the legislation is to ensure safe, hygienic and accessible TOP for all women in the country. The CTOPA has generated considerable controversy and the South African health system is faced with an enormous challenge of providing safe, effective, affordable and acceptable TOP services throughout the country. Evidently, constitutional rights and progressive abortion legislation are not sufficient to ensure that the reproductive rights of women are realised.

In light of this challenge, the aim of the research was to record and analyse the implementation and operation of the CTOPA with the purpose of developing a set of guidelines/recommendations based on best practices and lessons learnt. In pursuing the aim, relevant legislation and articles from various sources (including popular and scientific journals, newspapers and the web) were reviewed. Empirical data were collected over a six year period (1998 to 2003) from health workers in general, TOP service providers, TOP clients and key stakeholders. This chapter

reflects on the main findings of both the literature review and the empirical study. The objectives of the research (see Chapter 1) directed the structure of the discussion and were categorised into the following main areas: the impact of international developments in the human and reproductive rights field on South African abortion law; the impact of international and regional abortion legislation; abortion legislation in South Africa - trends, achievements and challenges; and recommendations to address challenges associated with the implementation and functioning of the CTOPA.

## 2. THE IMPACT OF INTERNATIONAL REPRODUCTIVE RIGHTS ON SOUTH AFRICA

The first formal declaration of reproductive rights occurred in 1968 at the UN International Conference on Human Rights in Teheran, Iran, where the right of parents to decide on the number and spacing of their children was acknowledge. This right of parents to plan their families was reaffirmed several times over the following decades. The CEDAW was adopted in 1979 and the treaty marked the first critical step in recognising human rights for women, particularly given its specific reference to the rights of men and women to decide on the number and spacing of their children. The struggle for reproductive rights reached an all time high in 1994 at the ICPD in Cairo, where, for the first time, abortion was seen as a public health issue and not merely a moral or cultural problem. However, the ICDP did not call for the liberalisation of restrictive abortion laws. The 1995 Beijing Conference reaffirmed the principles adopted in Cairo and took the process a step further by suggesting that countries review punitive abortion laws. The five year follow-up reviews of the ICDP and Beijing Conferences took the reference to abortion further, and it was noted in the *ICPD+5 Key Actions Document* that in countries where abortion is not against the law, measures should be taken to ensure that abortion is safe and accessible.

During the 1990s, when reproductive rights were receiving substantial attention internationally, South Africa was in a process of political transformation as the first democratic government was elected in 1994. Even prior to the democratisation of the country, the focus of the ANC was to bring about fundamental socio-economic reform. Plans for reform were documented in the RDP and *National Health Plan for South Africa*. Already in the RDP, the ANC set out to prioritise women and sexual health, and the right to TOP was acknowledged. In part, the ICDP motivated the ANC to address population and reproductive health issues, while taking into consideration the socio-economic, cultural and political conditions in South Africa. This culminated in the *White Paper on Population Policy for South Africa,* which was based on the *ICPD Programme of Action* and the RDP, and was drafted in 1996 and endorsed by government in 1998. The policy identified various concerns in the field of sexual and reproductive health, including maternal mortality and high teenage birth rates. It was noted that by improving the quality, accessibility, availability and

affordability of PHC services, including reproductive health care, concerns such as maternal mortality and unwanted pregnancies could be addressed.

More specifically, the ANC aspired to create a constitutional democracy based upon equality under the law and the protection of fundamental rights, freedoms and social justice, as elaborated upon in the 1996 *Constitution*. Particularly noteworthy is the fact that reference to woman's rights in the *Constitution* was influenced by the CEDAW. Furthermore, in terms of reproductive health, the *Constitution* (1996) guarantees everyone the right to bodily and psychological integrity, including the right to make decisions concerning reproduction, which, in conjunction with the CTOPA, allows women to choose to have an abortion. This links with the right to reproductive self-determination; security in and control over their bodies; access to health care services (including reproductive health care); and access to emergency medical treatment.

Clearly international developments in reproductive rights, together with increasing numbers of unsafe abortions and the need to address women's issues, motivated the ANC prior to and after the election to address the issue of abortion in South Africa. Against a background of health reform, the CTOPA was introduced and serves as a vital piece of legislation striving to achieve reproductive rights for women. The CTOPA, in line with international consensus, offers every woman the right to choose to have a safe and legal TOP according to their individual beliefs. The objectives of the CTOPA noticeably summarise the intentions of international agreements such as the ICPD, the Beijing Conference and their follow-up reviews: both women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, while the state has the responsibility to provide reproductive health care to all and to provide for legal TOP in a context that recognises the value of human dignity, achievement of equality, security of the person, non-racialism and non-sexism, as well as the achievement of human values and freedoms.

Through various legislation and policy developments, such as the *White paper for the Transformation of the Health System in South Africa* (1997), *Batho Pele* (1997) and the *Patients' Rights Charter* (1999), the South African government has addressed deficiencies and inequities in the health care system, thereby opening the door to health care for all citizens. Furthermore, attention has been paid specifically to the health of women in the CTOPA (1996) and *White Paper on Population Policy for South Africa* (1998). Through these policy documents and legislation, the South African government has upheld the recommendations of the ICPD and Beijing Conferences by strengthening its commitment to women's health, addressing unsafe abortion, and offering safe and legal abortion services.

## 3. THE IMPACT OF INTERNATIONAL AND REGIONAL ABORTION LEGISLATION ON SOUTH AFRICA

The experiences of Britain and the USA regarding abortion law liberalisation were investigated. Although both countries have liberal abortion laws, the USA has succeeded in passing legislation that impede access to abortion services, while this has not been the case in Britain. The situation in Britain is particularly noteworthy as the country colonised a number of African countries, including South Africa, and left behind a legacy of outdated Common Law which governed abortion legislation. While South Africa undertook radical abortion law reform in 1996, many African countries have maintained restrictive abortion laws. In this regard, the experiences of South Africa (in terms of the CTOPA) could prove valuable to other African countries in their attempt to deal with unsafe abortion and its resulting effects on maternal morbidity and mortality.

The influence of British abortion legislation on her former African colonies and protectorates (i.e. Botswana, Gambia, Ghana, Kenya, Malawi, Mauritius, Nigeria, Seychelles, Sierra Leone, South Africa, Sudan, Uganda, Zambia and Zimbabwe) was profound and continues today as there has been limited abortion law reform in many of these countries. Current abortion law in Britain (the 1967 *Abortion Act*) came into effect in 1968 and allows an abortion to be performed to save the life of the woman, to preserve the physical and mental health of the woman (as well as any other existing children) and in case of foetal impairment. Unlike the South African CTOPA, the 1967 *Abortion Act* does not allow for abortion on request.

Regarding the experiences of the USA, the court case of *Roe v. Wade* (1973) liberalised abortion law in the country; yet, there was no due regard for a holistic approach to reproductive health care. Although *Roe v. Wade* led to the recognition that abortion is a constitutional right, the US Congress has succeeded in passing various laws prohibiting federal funding for abortion, thus denying poorer women access to the service. South Africa has followed a different route by offering abortion services in the public sector free of charge. However, as there are limited public health facilities offering the service in South Africa, many women have to travel far distances to TOP facilities, which implies that travelling costs may become an impediment to accessing abortion in the country. Additionally, 39 of the 52 American states have passed laws ensuring that minors obtain parental consent, or that minors inform their parents of their decision to have an abortion. South Africa has set an example in this regard, whereby the court has upheld the right of minors to access abortion services without the requirement of consent either from parents or guardians. Evidently developments in the USA regarding restrictions to abortion services have served as important learning experiences for South Africa, which has strived to ensure that not only does the law allow for legal abortions, but also that, as far as possible, additional legislation does not impede access to this service. In this regard, the South African *Constitution* (1996) had an important role to play in acknowledging the rights of women to reproductive health care.

The USA government's negativity and opposition toward reproductive health (and more particularly abortion) has taken on various forms, including refusal to acknowledge the 1994 ICPD. At the centre of these attempts to defy internationally recognised reproductive rights agreements rests the Global Gag Rule which does not allow NGOs outside of the USA, which offer any abortion-related services, to qualify for US family planning assistance through USAID or the state department. The Rule is enforced even if abortion is legal in the country where the NGO is operational. Clearly the Global Gag Rule prevents NGOs from participating in their own country's democracy and encourages governments to act in an authoritarian manner.

Restrictive abortion legislation prevails in Africa despite an estimated 4.2 million unsafe abortions performed annually (Ahman & Shah 2002). In 2003, the Assembly of the African Union approved the *Protocol to the African Charter on Human and People's Rights Relating to the Rights of Women*, which calls for the protection and advancement of reproductive rights for women (including access to abortions). Africa needs to take steps to protect and promote the reproductive health of women. Toward this end, governments, NGOs and all relevant stakeholders should commit to ensuring women's health. However, three countries neighbouring South Africa (i.e. Lesotho, Swaziland and Mozambique) have maintained the colonial laws governing access to abortion. While limited reform has occurred in Zimbabwe and Botswana, it failed to increase access to abortion services. The passing of the CTOPA in South Africa, together with commitment on the part of government to provide safe and accessible TOP services to all women in the country should act as an inspiration to her neighbours to reform their abortion laws.

## 4. ABORTION LEGISLATION IN SOUTH AFRICA: ACHIEVEMENTS, CHALLENGES AND RECOMMENDATIONS

Prior to 1975, abortion law was governed by British Common Law with unclear provisions regarding the conditions under which a termination could legally be performed. The situation prevailed until the passing of the 1975 *Abortion and Sterilisation Act* which, to a large degree, further disempowered women and disregarded international developments in human and reproductive rights. The 1975 Act did not increase access to safe and legal abortions, despite claims that it would do so. The number of legal abortions performed were negligible when it is considered that an estimated 250 000 illegal or back-street abortions were performed annually. Furthermore, the 1975 Act not only discriminated against women in general, but more specifically, it perpetuated racial and class discrimination - approximately one in ten legal abortions were performed for black women from 1991 to 1993 compared to six in ten for white women. As such, the only option available to many women was to resort to back-street abortion, often suffering the horrific consequences thereof. The high numbers of back-street abortions, incomplete abortions

and deaths due to septic abortions were a clear indication that the 1975 Act failed dismally to control access to abortion in the country.

The need to provide comprehensive reproductive health services that incorporate abortions was recognised by the ANC-led government and reflected in the national health programme. Despite much opposition from, amongst others, some political parties and religious groups, the CTOPA was passed in 1996. It replaced the restrictive provisions of the 1975 Act by offering every woman the right to have a safe and legal TOP. The CTOPA marked the beginning of a new era in abortion legislation (and indeed in reproductive health care) in South Africa by allowing abortion on request during the first twelve weeks of pregnancy. In fact, the Act renders it almost impossible for a woman to be denied a termination up until the end of the first 20 weeks of pregnancy. Although the CTOPA reflects the intention of the legislature to make TOP accessible to all South African women, it cannot by itself ensure or guarantee equitable access. Additional requirements, such as the availability of willing health workers, training, drugs, equipment, an understanding of the Act and its legal implications, and community awareness, also need to prevail.

The following discussion entails a triangulation of secondary data emanating for the policy and literature reviews, on the one hand, and the primary data that emanated from the 1998- and 2003-empirical studies conducted in the Free State (i.e. Chapters 4, 5 and 6), on the other. The main points of discussion are summarised in table format. The focus is on describing the achievements and challenges of the CTOPA as noted by health workers in general, TOP service providers and TOP clients, and substantiated by policy and literature references.

### 4.1 Health workers[49]

While an important objective of the CTOPA is that women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice**,** health workers who are opposed to abortion have the potential to impede access to TOP by not supplying women with appropriate information about the service (*cf.* Caelers 1998; Harrison *et al*. 1997; Versluis 1998; Varkey 2000). Views about the morality of abortion differ substantially and for various reasons (e.g. religious and humanitarian convictions). As such, it would be unconstitutional to require a person to share a particular persuasion on abortion, let alone compel a person to participate in the procedure if it is contrary to their religious or moral beliefs. Therefore, the *Constitution* (1996) makes provision for the right to conscientious objection to abortion by health workers, although it should be exercised in such a way that it does not prevent the freedom of others to participate in abortion or to access the service. As stipulated by

[49] The sample of health workers for the 1998- and 2003-studies comprised of 63 and 100 persons respectively (key findings are captured in Table 72).

the CTOPA, the state has the responsibility to provide reproductive health care to all and to provide safe conditions under which the right of choice can be exercised without fear or harm. However, the Northern Cape-study of Varkey *et al*. (2000) found that health workers told women that abortion was immoral and sinful. In light of health worker hostility, it is to be expected that women will remain hesitant to request a TOP.

It is also important to appreciate that doctors may not refuse to treat a patient in a medical emergency and that nurses have a professional and ethical obligation to care for patients. Therefore, the CTOPA does not implicitly force health workers to participate in abortion procedures, but rather requires them to at least inform women about TOP and the location of facilities that render the service. However, evidence indicates that the directive is not always adhered to. The Free State studies noted that a small percentage of the health workers did not know which facilities provided TOP services, which implies that a lack of knowledge hinders access to TOP services. In addition, slightly more than a third of the respondents (during both data gathering exercises) indicated that they did not provide information about TOP to clients who request a referral. Similarly, Caelers (1998) and Varkey (2000) reported that staff at referral facilities were impeding access to TOP services. Additionally, the Free State studies indicate that more respondents in 2003 than in 1998 reported that they would only refer clients under specific conditions (such as rape, social problems and poor health of the mother) to a TOP facility, despite the law allowing for abortion on request during the first twelve weeks. Health workers noted that the main obstacles regarding the referral of women to TOP facilities were clients who presented too late in their pregnancies (1998) and clients' lack of money to pay for transport to these facilities (2003). Although commuter transport is available for patients in the Free State, the service was seemingly not well utilised by TOP clients.

Health workers in the Free State studies appeared to be fairly knowledgeable about CTOPA and there was a slight improvement in the level of knowledge by 2003. Nevertheless, attention still needs to be paid to particular areas, including the role of the midwife, circumstances under which TOP is allowed, parental consent, and conscientious objection. Given that the CTOPA acknowledges the provision of TOP "… *in a context that recognises the value of human dignity, achievement of equality, security of the person, non-racialism and non-sexism*", it is important that positive attitudes toward women and their reproductive health care prevail. Although health workers became more positive toward TOP by 2003, the evidence indicates that negative attitudes and hostility toward the service has not yet been eradicated. In 1998, slightly less than half of the health workers felt that TOP should be legal, while parallel responses increased to almost three-quarters by 2003. This is in comparison to a study by Harrison *et al*. (2000) which found that 11% of the PHC nurses in a particular district of KwaZulu-Natal supported the CTOPA. Varkey *et al*. (2000) also found that judgemental attitudes on the part of health workers were still being reported. Very few respondents in the Free State studies attended the abortion values

clarification workshops; those who had attended the workshops were extremely positive about the content and outcome thereof. The National Directorate for Maternal and Child Health cited the abortion values clarification workshops as being a key achievement of the CTOPA (RRA 1998b).

**Recommendations:**

- The Department of Health should launch education campaigns to inform all health workers about their rights (as specified in the 1996 *Constitution*, the guidelines of the HPCSA and the South African Nursing Council) vis-à-vis the directives of the CTOPA. A useful mechanism to disseminate information would be to make use of values clarification workshops. Hence the focus would not only be on addressing attitudes toward abortion, but also on imparting knowledge about the CTOPA and what is expected of health workers regarding TOP. In addition, the Department of Health should distribute newsletters to all employees regarding the CTOPA and its legal implications.
- Abortion values clarification workshops should be regularly scheduled throughout the province and provision made for all health workers to attend the workshops. It is important that the dates and location of such workshops be scheduled well in advance so that health workers and facility managers can make the necessary arrangements for staff to attend.
- Determine why commuter transport, which is available for patients in the province, is not used for women referred to TOP facilities.

**Table 72: Contextualising the main findings from the survey amongst health workers**

| Key provisions of the CTOPA | Key references from secondary data | Key findings: 1998 Free State study | Key findings: 2003 Free State study |
|---|---|---|---|
| **Referral of patients to TOP facilities** | | | |
| ▪ Health workers must inform women about the condition under which a TOP is allowed and of the location of TOP facilities.<br>▪ Women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice. | ▪ A study in the Western Cape found a quarter of the doctors (31 medical institutions) would not refer patients to TOP facilities (Caelers 1998).<br>▪ Staff at referral facilities made it difficult for women to gain access to TOP facilities (Varkey 2000).<br>▪ Some health workers told women abortion was a sin and provided incorrect information regarding TOP (Varkey *et al*. 2000). | ▪ 94.0% were familiar with the location of TOP facilities.<br>▪ 12.7% have never been asked for a referral to a TOP facility.<br>▪ 36.1% did not provide information about TOP to clients requesting such information. | ▪ 88.0% were familiar with the location of TOP facilities.<br>▪ 33.3% have never been asked for a referral to a TOP facility.<br>▪ 35.5% did not provide information about TOP to clients requesting such information. |
| **Knowledge about the CTOPA** | | | |
| ▪ A registered midwife, who has undergone the prescribed training, may conduct an under twelve week TOP.<br>▪ TOP is allowed from week 13-20: to preserve the woman's physical and mental health; if the foetus may be impaired; if the pregnancy is a result of rape or incest; and on socio-economic grounds.<br>▪ Minors do not need consent from parents or guardians for a TOP. | ▪ The *Constitution* (1996) allows for the right to conscientious objection to abortion by health workers. However, the HPCSA notes that doctors may not refuse to treat patients in a medical emergency.<br>▪ According to the Nursing Act (10 of 1997), nurses have a professional and ethical obligation to care for the patient before, during and after the procedure despite conscientious objections to abortion (Poggenpoel *et al.* 1998). | ▪ 46.0% noted that a trained midwife was allowed to conduct a TOP<br>▪ 52.4% indicated that TOPs are allowed under specific conditions from the 13th to the 20th week.<br>▪ 55.7% knew that minors did not need parental consent for a TOP.<br>▪ 48.3% indicated that health workers may exercise their right to conscientious objection with regard to participating in a TOP procedure.<br>▪ 67.1% correct responses to questions testing knowledge about the CTOPA. | ▪ 60.0% noted that a trained midwife was allowed to conduct a TOP<br>▪ 75.0% indicated that TOPs are allowed under specific conditions from the 13th to the 20th week.<br>▪ 68.7% knew that minors did not need parental consent for a TOP.<br>▪ 45.0% indicated that health workers may exercise their right to conscientious objection with regard to participating in a TOP procedure.<br>▪ 73.4% correct responses to questions testing knowledge about the CTOPA. |
| **Attitudes towards TOP** | | | |
| ▪ The state has the responsibility to provide reproductive health care to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm.<br>▪ Legal TOP should be provided in a context that recognises the value of human dignity, achievement of equality, security of the person, non-racialism and non-sexism, and the achievement of human values and freedoms, which underlie a democratic South Africa. | ▪ In a survey of PHC nurses in KwaZulu-Natal only 11% supported CTOPA (Harrison *et al.* 2000).<br>▪ Judgemental health worker attitudes reported in Northern Cape (Varkey *et al.* (2000).<br>▪ The National Directorate for Maternal Child and Women's Health cited values clarification workshops as a key achievement (RRA 1998b).<br>▪ According to Section 15(1) of the *Constitution* (1996) everyone has the right to freedom of conscience, belief, religion, thought and opinion. | ▪ 45.9% were of the opinion that TOP should be legal.<br>▪ 46.0% women should have the right to make decisions concerning her body.<br>▪ 9 respondents had attended the abortion values clarification workshops. | ▪ 72.0% were of the opinion that TOP should be legal.<br>▪ 89.0% women should have the right to make decisions concerning her body.<br>▪ 13 respondents had attended the abortion values clarification workshops. |

### 4.2 TOP service providers[50]

Despite the establishment of an additional TOP facility by 2003, the number of TOP service providers remained constant between 1998 and 2003. The goal of the CTOPA to expand TOP services to inaccessible parts of the country by permitting trained midwives to conduct the under twelve week procedure had not yet been achieved in the Free State, as similar numbers of nurses and doctors were still providing TOP services. Moreover, TOP services were rendered mainly at urban hospitals. Varkey (2000) also noted that of the public facilities providing TOP services, 99% were hospitals.

In line with international human rights developments, TOP service providers in the Free State unanimously agreed that TOP is an important human right, particularly as every woman should have the right to make her own decisions concerning her body. In addition, they supported the availability of abortion on request during the first twelve weeks of pregnancy. Although still positive toward TOP, service providers in 2003 appeared to be more cautious and conservative in their attitudes toward the service, and issues surrounding poor work morale were also raised. More specifically, nine respondents in 1998 compared to four in 2003 felt that TOP was justified under all circumstances. In 1998, twelve respondents noted that TOP should be an alternative when contraceptives failed, but the number of parallel responses halved by 2003. In line with this argument, more TOP service providers in 2003 indicated that since the implementation of the CTOPA, people have become careless in their use of contraceptives.

The data indicate that by 2003, TOP service providers were feeling more harassed than they had in 1998. While five respondents indicated sometimes feeling guilty about conducting TOPs in 1998, this figure increased to nine in 2003. Similarly, five service providers in 1998 compared to eight in 2003 occasionally felt resentful of clients requesting a TOP. Furthermore, an increase was found regarding the number of TOP service providers who felt that their professional relationships with colleagues had been affected due to their involvement with the service. Varkey (2000) also reported that health workers providing TOP services felt unsupported and isolated from their colleagues.

The Free State studies found that increasing feelings of guilt, resentment and isolation, together with poor work morale and less positive attitudes toward TOP, all imply that the longer health workers are involved in providing the service, the more emotionally drained they become. In addition to this concern, the absence of psychological support for TOP service providers in the province is truly worrisome, even more so in light of the 2000 Oversight Hearings' recommendation that such services be made available. On a positive note, abortion values

[50] All TOP service providers participated in both the 1998- and 2003-studies (key findings are captured in Table 73).

clarification workshops were found to be beneficial, however, the province no longer facilitated these workshops at the time of the research. .

The research noted an overall improvement in the availability of essential resources to provide TOP services. However, although facility managers reported having access to willing medical personnel, staff shortages as well as the lack of training continued to be problematic. This was the case despite the fact that the CTOPA only allows for a facility to be designated to provide abortion services if there are sufficient medical and nursing personnel. Furthermore, the lack of space at TOP facilities was still problematic during 2003. Of particular concern was that renovations undertaken during 1998 had not yet been completed by 2003 at one of the facilities and restructuring had commenced at a second facility.

TOP services in the Free State were based on the CTOPA and no other policy documents or service guidelines are in existence. The lack of clear operating procedures for TOP services added to the emotional strain that service providers experienced. As with the increase in negative attitudes over time, TOP service providers in 2003 were also more inclined than in 1998 to evaluate TOP services negatively. This is a cause for concern as the quality of TOP services, as well as access, is directly related to the roles and attitudes of health workers. With regard to service provision, the quality and availability of post-counselling remained an area that required attention, particularly in light of the importance thereof in preventing further unwanted pregnancies. The lack of training for counsellors compounded the problem of too few staff to provide counselling services. The main problems regarding pre-counselling were lack of time, staff and space; communication/language barriers; and the reluctance of clients to open up during counselling. The careless attitudes of adult patients and their misuse of the system were also raised. Management problems included the lack of staff, training for staff, and space at TOP facilities. In addition, service providers reported a lack of management support from the provincial Department of Health. Despite these challenges, it was positive to note that the dedication of experienced/well trained staff (as well as teamwork) was the main factor contributing to the smooth functioning of TOP facilities.

**Recommendations:**

- Determine why only four facilities in the Free State are providing TOP services, and identify what needs to be done in order for additional facilities to become operational.
- Conduct a situational analysis at TOP facilities to determine whether staff establishments are sufficient, which should include consultations with staff about their workloads.
- Investigate the feasibility of providing incentives (e.g. scarce skills allowances, rural allowances and additional vacation leave) for health workers at TOP facilities, as this may encourage more staff to volunteer for the provision of TOP services.

- The South African Nursing Council needs to consider the incorporation of TOP into the basic training curricula of nurses.
- The Free State Department of Health should continue abortion values clarification workshops and encourage all health workers to attend them. In addition, refresher workshops should be initiated for staff who have already attended similar initiatives.
- The Free State Department of Health should establish psychological support for TOP service providers. Appropriate partnerships (e.g. in collaboration with counselling units at the University of the Free State) should be explored.
- TOP facilities should be upgraded in order to facilitate patient privacy during counselling, examinations and procedures.
- Protocols and policies need to be formulated to guide the functioning of TOP facilities, as well as the management and treatment of TOP clients (e.g. determining the gestation period; assessing clients; clear guidelines on what procedure to follow with MVAs and inductions; disposing with the products of conception; obtaining consent for minors; providing guidelines on the amount of time to be spent on pre-counselling; record keeping; etc.).
- The Free State Department of Health should consider outsourcing post-counselling services (e.g. as is done at one of the facilities where patients make use of Life Line) or decentralise the service to more PHC facilities in the province.
- Counsellors need to be trained in the techniques required to counsel TOP clients.
- The training of health workers in abortion techniques needs to be scaled up and refresher courses for all TOP service providers should be scheduled.
- Health managers should become more involved in the functioning of TOP facilities in order to have a better understanding of the challenges that staff face. This could include regular supervisory visits and meetings, as well as feedback on TOP statistics and reports.

**Table 73: Contextualising the main findings from the audit amongst TOP service providers**

| Key provisions of the CTOPA | Key references from secondary data | Key findings: 1998 Free State study | Key findings: 2003 Free State study |
|---|---|---|---|
| **Views regarding TOP** | | | |
| ▪ The state has the responsibility to provide safe reproductive health care to all, and under conditions which allow the right of choice to be exercised without fear or harm.<br>▪ Legal TOP should be provided in a context that recognises the value of human dignity, equality, security of the person, non-racialism, non-sexism, and achievement of human values. | ▪ According to Section 15(1) of the *Constitution* (1996), everyone has the right to freedom of conscience, belief, religion, thought and opinion.<br>▪ The National Directorate for Maternal Child and Women's Health cited values clarification workshops as a key achievement (RRA 1998b). | ▪ TOP justified under all circumstances (n=9).<br>▪ TOP should be an alternative when contraceptives fail (n=12).<br>▪ Since CTOPA, people have become careless with contraceptives (n=7).<br>▪ 8 of the 9 respondents found the values clarification workshops to be useful. | ▪ TOP justified under all circumstances (n=4).<br>▪ TOP should be an alternative when contraceptives fail (n=6).<br>▪ Since CTOPA, people have become careless with contraceptives (n=12).<br>▪ 7 of the 8 respondents found the values clarification workshops to be useful. |
| **Support for TOP service providers** | | | |
| ▪ It is considered that TOP service providers share in the right to provide for legal TOP in a context that recognises the value of human dignity, security of the person and the achievement of human values and freedoms, which underlie a democratic South Africa. | ▪ TOP service providers felt unsupported and alienated from their colleagues (Varkey 2000).<br>▪ Oversight Hearings (RRA 2000) recommended that psychological support be made available for TOP staff.<br>▪ TOP service providers were labelled as killers; involvement with TOP negatively affected relationships with colleagues; work overload led to burnout; and a lack of support from management (Potgieter 2004). | ▪ 7 felt isolated from colleagues not doing TOP.<br>▪ 5 felt guilty about doing TOP.<br>▪ 4 felt resentful of patients requesting a TOP.<br>▪ 4 indicated their work with TOP had affected their professional relationship with colleagues.<br>▪ 4 said that psychological support was available.<br>▪ 8 would like psychological support to be available. | ▪ 5 felt isolated from colleagues not doing TOP.<br>▪ 9 felt guilty about doing TOP.<br>▪ 8 felt resentful of patients requesting a TOP.<br>▪ 7 indicated their work with TOP had affected their professional relationship with colleagues.<br>▪ 3 said that psychological support was available.<br>▪ 8 would like psychological support to be available. |
| **Resources for TOP service delivery** | | | |
| ▪ Facilities must have access to medical and nursing personnel before they can provide TOP services. | ▪ Some hospital administrators at designated TOP facilities used a variety of tactics to avoid providing TOP services, including the refusal to nominate staff for TOP (Hord & Xaba 2002). | ▪ 2 of the 3 TOP facility managers noted that there was a lack of TOP staff<br>▪ Renovations underway at one of the three facilities | ▪ 3 of the 4 TOP facility managers noted that there was a lack of TOP staff<br>▪ renovations underway at two of the four facilities |
| **Evaluation of TOP services** | | | |
| ▪ Women and men have the right to safe, effective, affordable and acceptable methods of fertility regulation. | ▪ The quality of TOP services, as well as access, is directly related to the roles and attitudes of health workers (RRA 2000). | ▪ 12 said pre-counselling was good.<br>▪ 12 said post-counselling was good.<br>▪ 6 of the 10 counsellors were trained. | ▪ 8 said pre-counselling was good.<br>▪ 2 said post-counselling was good.<br>▪ 9 of the 11 counsellors were trained. |

## 4.3 TOP stakeholders[51]

In general, the achievements of the CTOPA were noted to be the fact that, theoretically, all women in South Africa – be they in the public or private sector – have access to safe TOPs. Even more importantly, all women in South Africa have been awarded the right to make their own reproductive decisions. This has reportedly resulted in a decrease in back-street abortions and a subsequent reduction in maternal morbidity and mortality. In general, more health workers were trained in TOP and the database on TOP-related research in the country is growing.

The main impediments faced by women wishing to access TOP services were noted to include: the negative attitudes of some health workers; a lack of information and education on sexual and reproductive health; unfriendly and inaccessible reproductive health services; lack of decentralised TOP services; and a decline in access to contraceptives in the public health sector. In order to address these problems, it was noted that staff should volunteer to become involved in TOP; information on TOP should be widely disseminated; and young women should be educated on the early signs of pregnancy and contraceptive use.

Four broad challenges were noted for TOP services in the country:

- Entrenching sexual and reproductive rights in society.
- Educating girls and women to improve their status in society and increase their chances of reaching their full potential.
- Addressing the impediments that hamper access to quality TOP services.
- Educating communities that TOP is not a contraceptive method.

## 4.4 TOP clients[52]

The greater part of respondents in the 2003-study used contraceptives following a TOP. Four in ten respondents changed their contraceptive methods due to side effects experienced from the particular methods. Very few respondents (less than 20%) knew about emergency contraceptives, and not even half of these had ever used an emergency contraceptive. Furthermore, accessing emergency contraceptives was reportedly problematic. With regard to access to facilities offering family planning, in most instances it took the respondents less than half an hour to reach a facility, although lengthy waiting periods at the facilities were noted. Nevertheless, respondents were generally satisfied with the treatment that they received at family planning facilities, and minors noted that these services were to a large degree youth-friendly.

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[51]A representative from the Maternal Child & Women's Health Cluster at the National Department of Health, the TOP programme coordinator in the Free State, and one representative each from PPASA and the RRA, were interviewed regarding shortcomings and successes in implementing TOP legislation.

[52] The TOP client samples comprised of 75 women during 1998 and 120 women during 2003 (key findings are captured in Table 74).

The CTOPA aims to ensure safe, hygienic and accessible abortions for all women in South Africa. Notwithstanding this aim, in 2001 the National Department of Health reported that TOP services were still largely inaccessible as these services were mainly located within urban areas and some women had to travel far distances (approximately 400-500kilometres) to access an abortion. As noted, by 2003 TOP services were only offered at four public health facilities across the Free State, leaving large areas underserved or difficult to access. In addition, limited personnel were available at these facilities to provide TOPs. Therefore, to a degree, it may be argued that TOP services remain practically inaccessible to many women in the Free State who, due to extreme poverty (68% of the Free State population live in poverty), may not be able to afford transport to TOP facilities. The Free State studies found that the majority of respondents, travelled by taxi to access TOP facilities. In addition, roughly half of the 1998-respondents and almost two-thirds in 2003 were put onto a waiting list at the TOP facilities. The practice that women have to return to TOP facilities for the procedure is a further factor that may impede access to the service, especially if clients have to travel far distances to each time reach the facility.

It is positive to note that, despite the negative attitudes and reluctance of some health workers to refer women to TOP facilities, only one respondent in 2003 and none in 1998 experienced such problems.

TOP facilities were mostly perceived as user-friendly, and both the 1998- and 2003-clients were generally satisfied with the treatment received from staff and other patients. There was, however, an increase in the dissatisfaction of respondents from 1998 to 2003 regarding the treatment received from nurses. This correlates with findings from the TOP provider study where it was found that health workers become more cautious in their attitudes toward TOP the longer they are involvement with the service. Less positive work morale was also evidenced. Hence it is not surprising that the 2003-respondents more frequently reported hostility on the part of TOP service providers. The lack of privacy in the counselling rooms and examination rooms, as well as in the recovery areas, remains a cause for concern.

With regard to the services provided at TOP facilities, more problems were noted with counselling than with the physical examination and the TOP procedure. More specifically, there was a slight decrease in the level of satisfaction regarding pre-counselling services from 1998 to 2003, as noted in the responses of both TOP clients and service providers. Seven in ten respondents in both studies received counselling prior to the termination and of those who received pre-counselling, the majority were satisfied with its content. Seven in ten respondents in 2003 compared to five in ten in 1998 were informed about options other than TOP during pre-counselling, despite the CTOPA requiring health workers to provide all women requesting a TOP with sufficient information to make an informed choice (i.e. options available other than TOP such as adoption). Almost all the 1998-respondents compared to only slightly more than half in 2003

received counselling in private. The lack of privacy during counselling in 2003 was mainly attributed to receiving counselling in a group.

Despite provisions in the CTOPA that non-mandatory and non-directive counselling be available before and after the TOP, this was clearly not the case in the Free State. Almost half of the respondents in the 1998- and 2003-studies stated that post-counselling was not available. While none of the 1998-respondents were dissatisfied with the service, more than a third of the 2003-respondents were dissatisfied with post-counselling. By far the majority of 2003-respondents who received post-counselling had also been informed about contraceptives. Note that the CTOPA requires all women to be informed about the use of contraceptives to prevent future pregnancies. Furthermore, although the CTOPA directs that all women should be informed about the clinical procedure for TOP, this was clearly not the case in 1998 when less than a third of the women were provided with this information. The situation improved by 2003, when seven in ten adults and six in ten minors indicated receiving information about the clinical procedure for TOP.

As with the TOP service providers, the overwhelming majority of clients in both the 1998- and 2003-surveys were satisfied with the physical examination and the TOP procedure. Three-quarters of the 2003-respondents claimed to have terminated at home, half of whom were under twelve weeks pregnant, despite practice in the Free State that all under twelve week procedures should be performed at a TOP facility. A possible explanation for this is that, after inserting the tablets, the patients started to bleed at home and did not return to a TOP facility for the procedure. Of the respondents who indicated that the termination had been conducted at home, four in ten reported that there had been no one at home to assist them. It is a concern that in 40.0% of the cases the respondents did not dispose of the products of conception by returning to a hospital or clinic. Complications such as sepsis could arise if the client retained some of the products of conception.

There has not been an improvement in the level of knowledge of TOP clients regarding the CTOPA since 1998. Clearly women were not aware of their rights regarding access to TOP. Almost two-thirds of women thought that parental consent was required for a TOP. In addition, approximately a third of the 1998-respondents thought that they needed their husband's consent for a termination. Similarly, De Lange (2000) notes that 24% of women thought that they needed parents' or husbands' consent to have an abortion, and Varkey *et al.* (2000) report that less than a quarter of women knew that they did not need consent from partners (22%) or parents (20%).

The main problem noted by the 1998-respondents regarding TOP services amounted to women being sent home to abort, while in 2003, almost two-thirds of the minors and half of the adults reported experiencing no problems. Problems that were experienced included: unfriendly nurses, long waiting lists, too little privacy, being sent home to abort, return visits, and pain.

Recommendations to improve services were: more education on TOP and family planning; improved attitudes among staff; and that the entire TOP procedure should be conducted at the hospital. Recommendations to improve counselling included: privacy, individual counselling and the availability of counselling to all patients. Recommendations to improve the examination were that staff should spend more time on the examination, be more gentle and steps should be taken to ensure privacy.

**Recommendations:**

- Family planning clients should be fast-tracked at PHC clinics to promote utilisation of the service.
- After-hour family planning services should be provided to learners.
- The feasibility of re-introducing school health services should be investigated to educate learners about family planning.
- Official transport between relevant PHC facilities should be availed for TOP clients.
- Strategies need to be implemented to avoid TOP clients being put on waiting lists.
- Attention ought to be given to the process of obtaining a TOP (i.e. the number of times a patient is expected to return to a TOP facility), especially in light of the vast distances that some clients need to travel to reach the four TOP facilities in the province.
- Mechanisms need to be put in place to ensure adequate privacy for TOP clients, especially in the counselling rooms and recovery areas. Furthermore, suitable (alternative) locations should be utilised when restructuring and renovating existing facilities.
- A strategy should be developed to decentralise TOP counselling to more health care facilities, or to outsource counselling to other services such as Life Line.
- All TOP clients have to be offered a contraceptive method and family planning counselling before leaving a TOP facility.
- TOP service providers should ensure that clients understand the TOP procedure and exactly what to expect.
- Closer collaboration with health care facilities that do not provide TOP services needs to be encouraged in order for clients to receive appropriate assistance and treatment regarding the disposal of the products of conception and follow-up medical procedures.
- Public information campaigns, via radio, newspapers, television, magazines and talks at community functions should be undertaken to inform women of their rights under the CTOPA.
- The Department of Health should develop and distribute information and education materials (i.e. posters and pamphlets) that depict the provisions of the CTOPA and the location of TOP services to all PHC facilities and NGOs providing reproductive health care.
- TOP service providers should ensure positive attitudes when dealing with clients. One way to encourage this would be for TOP service providers to attend abortion values clarification workshops.

- Psychological support for TOP service providers needs to be introduced.
- The possibility of a 24 hour TOP service should be investigated so that patients can be admitted and the entire procedure supervised by appropriately trained health workers.

**Table 74: Contextualising the main findings from the survey amongst TOP clients**

| Key provisions of the CTOPA | Key references from secondary data | Key findings: 1998 Free State study | Key findings: 2003 Free State study |
|---|---|---|---|
| **Accessibility of TOP facilities** | | | |
| ▪ The aim of the Act is to ensure safe, hygienic and accessible abortions for all women in South Africa who request an abortion. | ▪ In 2001, the National Department of Health reported that TOP services were still geographically inaccessible as these services were mainly located within urban areas to which some women had to travel far distances (approximately 400-500 kilometres).<br>▪ Long waiting times (average of 1-7 days) to receive the service have been recorded (Hord & Xaba 2002). | ▪ 62.7% referred by a health worker to a TOP facility.<br>▪ No problems experienced with the health worker during the referral.<br>▪ 42.7% put on a waiting list at the TOP facility.<br>▪ 84.0% travelled by taxi (i.e. at own cost) to the TOP facility. | ▪ 76.7% of the adults and 50.0% of the minors referred by a health worker.<br>▪ 1 respondent experienced problems with a health worker during the referral.<br>▪ 61.7% put onto a waiting list at the TOP facility.<br>▪ 81.7% travelled by taxi (i.e. at own cost) to the TOP facility. |
| **User-friendliness of TOP facilities** | | | |
| ▪ The state is responsible to provide reproductive health care under safe conditions where the right of choice can be exercised without fear. | ▪ Some health workers told women abortion was a sin (Varkey *et al*. 2000). | ▪ General satisfaction with treatment received from staff at TOP facilities. | ▪ 20.0% were dissatisfied with treatment received from nurses. |
| **TOP services** | | | |
| ▪ The state should promote non-mandatory and non-directive counselling before and after the TOP.<br>▪ Counselling should include sufficient information to help women make an informed choice regarding TOP (i.e. women should be informed of alternatives to TOP), the TOP procedure, risks of TOP and the use of contraceptives to prevent future pregnancies.<br>▪ Counselling should always be kept private and confidential, unless the woman chooses to disclose the nature of the counselling to others. | ▪ Less than one percent of women change their minds about having an abortion (Adanlawo 1998).<br>▪ A key element of post-abortion counselling is family planning and the provision of contraceptives. According to the WHO (in Barnett 1997), quality post-abortion counselling can help avoid further unwanted pregnancies and unsafe abortions, and, in turn, lower the number of maternal deaths. | ▪ 9 in 10 satisfied with the examination and procedure.<br>▪ 21.3% pre-counselling not offered.<br>▪ 93.1% of those who had pre-counselling were satisfied.<br>▪ 94.7% received counselling alone with the counsellor.<br>▪ 56.1% noted the counsellor had explained options other than TOP.<br>▪ 48.0% said post-counselling was not offered.<br>▪ Of those who had post-counselling, no one was dissatisfied.<br>▪ 29.3% were told what the clinical procedure for TOP entailed. | ▪ 9 in 10 satisfied with the examination and procedure.<br>▪ 20.8% pre-counselling not offered.<br>▪ 83.7% of those who had pre-counselling were satisfied.<br>▪ 55.8% received counselling alone with the counsellor.<br>▪ 70.0% noted the counsellor had explained options other than TOP.<br>▪ 45.8% said that post-counselling was not offered.<br>▪ 39.3% of those who had post-counselling were dissatisfied.<br>▪ 79.7% of the adults and 60.0% of the minors were told what the clinical procedure for TOP entailed.<br>▪ 97.2% were told about contraceptives.<br>▪ 66.7% minors and 73.3% adults using a contraceptive since the TOP. |

**Table 74 continued.**

| Key provisions of the CTOPA | Key references from secondary data | Key findings: 1998 Free State study | Key findings: 2003 Free State study |
|---|---|---|---|
| **Knowledge of TOP and the CTOPA** | | | |
| ▪ Only the woman's consent (including in the case of minors) is required for a TOP to be performed. | ▪ While women may know that abortion is legal, it is unlikely that they will be familiar with the provisions of the CTOPA (Varkey 2000).<br>▪ 24% of respondents knew women did not need her parents' or husbands' consent to have an abortion (De Lange 2000).<br>▪ Less than a quarter of women knew that they did not need consent from partners (22%) or parents (20%) for a TOP (Varkey *et al*. 2000). | ▪ 47.2% correct responses to a series of knowledge questions<br>▪ 26.7% knew that parental consent is not required for a TOP<br>▪ 65.3% knew that a husband's consent is not required for a TOP<br>▪ 77.0% of clients first heard about TOP from the media. | ▪ 44.7% minors and 53.1% adults correct responses to a series of knowledge questions.<br>▪ 33.3% knew that parental consent is not required for a TOP.<br>▪ 53.0% of clients first heard about TOP from the media. |
| **Problems and recommendations** | | | |
| ▪ Facilities must have access to health workers, equipment, medication, emergency transport, infection control measures, safe waste disposal and communication systems before they can be designated to provide TOP services. | ▪ Doctors concerned that women initiating an abortion at home could experience severe pain, bleeding and death (*City Press* 1997). | ▪ 30.0% said that the entire TOP procedure should be conducted at a medical facility. | ▪ Problems experienced were unfriendly nurses, long waiting lists, too little privacy, being sent home to abort, and pain. |

## 5. SUMMARY

Although the research has highlighted a number of impediments and challenges related to the functioning of the CTOPA, notable achievement and successes should not be ignored. The following section briefly records and summarises the achievements and successes of the CTOPA, as well as the challenges and impediments, as identified during the 1998 and 2003 Free State studies.

**Achievements and successes of the CTOPA:**

- The CTOPA, in line with international consensus, offers every woman the right to choose to have a safe and legal TOP according to their individual beliefs.
- All women in South Africa have been awarded the right to make their own reproductive decisions.
- The passing of the CTOPA in South Africa, together with appropriate commitment from government to provide safe and accessible services to all women in the country, should act as an inspiration to neighbouring countries to reform their abortion laws.
- Staff experienced the abortion values clarification workshops as extremely valuable.
- The dedication of experienced/well trained staff, as well as teamwork, contributes to the smooth functioning of TOP facilities.
- There is a growing database of TOP-related research in the country.
- Since having a TOP, the majority of clients were using contraceptives.

**Provider/service factors that impede the functioning of the CTOPA:**

- Some health workers are still reluctant to provide women with information about TOP or to refer women to facilities that provide the service.
- Negative attitudes and hostility of health workers toward TOP continue to prevail.
- Too few health workers have attended the abortion values clarification workshops.
- A goal of the CTOPA, namely to expand TOP services to inaccessible parts of the country by permitting trained midwives to conduct the under twelve week procedure, has not yet been achieved in the Free State, as similar numbers of nurses and doctors were still providing TOP services and mainly at urban hospitals.
- Some TOP service providers feel harassed, guilty, resentful and isolated from colleagues since their involvement with the service.
- Psychological support services are not available for TOP service providers.
- More personnel are needed to provide quality TOP services.

- The practice that clients often have to return more than once to TOP facilities for the procedure to be conducted; this impedes access, especially if they have to travel far distances to reach the facility.
- Except for the CTOPA, clear guidelines to manage TOP facilities and patients are absent.
- There is insufficient management support from the Free State Department of Health for TOP services.
- Long waiting lists exist at TOP facilities.
- TOP post-counselling was not always available at facilities.
- Women are sent home to abort (i.e. the over twelve week procedure).

**Client factors that impede the functioning of the CTOPA:**

- Since the introduction of the CTOPA, women have seemingly become careless in their use of contraceptives.
- Not all women are aware of their rights regarding access to TOP, including the fact that they do not require consent from husbands and parents for the procedure to be performed.
- Women in general are not well informed about sexual and reproductive health matters.
- Not all women return to a health facility to dispose of the products of conception, and complications such as sepsis could arise if the client retained some of the products.

## 6. CONCLUSION

Although much planning and debate went into drafting and eventually passing the CTOPA, it is observed that the health system at the service delivery level was not well prepared to undertake the challenge of offering every woman the right to choose whether to have an early, safe and legal TOP by making such services available across the country. Evidence suggests that the Department of Health gave insufficient attention to, amongst others: the recruitment and appointment of health workers to provide TOP services; the training of TOP staff; information campaigns about the CTOPA and the implications thereof for health workers and the public at large; the drugs to be used for TOP procedures; facilities and space for TOP services; and the referral of women to relevant service sites. From the start, problems were reported regarding health worker resistance and refusal to become involved with TOP services. The dilemma was further fuelled by the fact that the training curriculum for midwives was only approved in 1998 (more than a year after the implementation of the CTOPA). By the end of 1998, a minimal number of midwives had been trained across the country. In addition, the drug that was to be used to induce abortions had not been registered for this purpose by the time that the CTOPA was implemented. These and numerous similar problems continue to be reported eight years after the promulgation of the CTOPA.

It may be surmised that the impediments and achievements encountered in the Free State are not unique to the province, but may in fact be similar to the experiences of other provinces in the country. It is particularly cumbersome that despite a six year interval and feedback on impediments identified during the 1998-study, the situation in the Free State remained to a large degree unchanged. More specifically, despite the slight improvement in the knowledge of general health workers regarding the CTOPA and more positive attitudes towards TOP, the reluctance to refer women unconditionally to a TOP facility was evident. Even more discouraging is the fact that, as time progressed, TOP service providers ostensibly became more negative in their views of and attitudes toward TOP. Increasing negative views, poor work morale, feelings of guilt and resentment, and isolation from colleagues suggest that the longer health workers engage in providing TOP services, the more emotionally distressed and even burnt-out they become. It is distressing to note that little is being done to alleviate the situation, as counselling and psychological support services remained unavailable for TOP service providers in the province. Therefore, it comes as no surprise that by 2003, TOP service providers were less likely to evaluate their services as being good compared to the previous survey. The impact thereof is evident in the comprehensiveness of TOP services, particularly insofar the counselling of clients is concerned. Although, on the positive side, it should be noted that there was seemingly an improvement in the content of counselling, it could be argued that disgruntled counsellors may have been attempting to discourage women from opting to have the TOP. Furthermore, there were still no facilities providing a 24-hour service, which meant that women who were more than twelve weeks pregnant had to initiate the abortion at home.

The question arises, when will TOP service providers reach a point that they decide to resign from abortion services? In many cases the TOP staff who participated in the 1998-study were still offering TOP services during 2003, which is a clear indication that the Department of Health has not yet engaged in activities to actively recruit new personnel for TOP. In addition, it should be kept in mind that, in most cases, health workers in the province volunteered to become involved with the service. TOP facility managers continued to report a lack of staff to provide quality TOP services. By 2003, more women were put onto waiting lists at the TOP facilities. Statistics show that TOPs in the Free State steadily increased annually from 2 534 conducted in 1997 to 4 158 conducted in 2003. However during this period only one additional facility became operational in the province and the number of staff providing services remained constant, which is indicative of increasing workloads for TOP service providers.

The absence of support from the Free State Department of Health is in line with the sentiment that TOP is now legal and it is up to volunteering staff to see that the service is offered. Amidst difficult conditions and a shortage of human resources, TOP staff are indeed offering the service. Women do have access to safe and legal TOPs in the province, but in many instances need to rely on their own resources to access the service. Furthermore, the quality of the service is

compromised – women are put onto long waiting lists and pre- and post-counselling is not always available. Nevertheless, TOP service providers should be applauded for the difficult task that they perform amidst much hostility and a lack of support from colleagues and management.

Although the enactment of the CTOPA was a victory for women's rights in South Africa, this alone is not sufficient to guarantee access to safe abortion services. The introduction of the CTOPA occurred amongst much political transition and health reform in South Africa, which while encouraging liberalisation of abortion law, also added to the difficulties of implementing the Act. Indeed there was a fundamental shift in health policies in the country with the focus on the district health system, PHC and free public sector health care. It could be surmised that health managers and workers were overwhelmed with changes in the health system and this, together with ambivalence and even outright hostility toward abortion, contributed to the poor preparation for and eventual implementation of the CTOPA. Despite its turbulent history, the focus of the CTOPA should now shift to addressing impediments related to access to TOP services. The main recommendations in this regard include: bringing health managers on board and motivating their involvement in TOP services; formulating clear policies and guidelines for the management and provision of TOP; educating health workers and communities about the CTOPA and its legal implications; continuing with abortion values clarification workshops and making these more widely available; introducing incentives for health workers providing TOP services; investigating manners in which to encourage health workers to volunteer for TOP service delivery; including TOP in the training curriculum of nurses; and making psychological support available for TOP service providers.

Important lessons learnt in the implementation of the CTOPA in South Africa were that there should be: sufficient involvement of health workers in the process of planning and implementing a new programme; education campaigns in the community to promote awareness about the CTOPA (as well as reproductive rights); sensitisation of health workers regarding the legal implications of the CTOPA; a plan for the training of service providers and stakeholders on the new law and the procedures thereof prior to the implementation of the Act; a human resource strategy for the delivery of quality TOP services; and the availability of adequate drugs, equipment and infrastructure. The current challenge for both government and NGOs relates to a re-strategising of abortion services to facilitate women exercising their reproductive right to TOPs. As noted in the *ICPD+5 Key Actions Document* (1999: paragraph 63(iii)), "*in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible*".

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# SYNOPSIS

The right to decide when to have a child is at the very core of reproductive rights and in essence means that women should have access to safe and effective means of controlling their family size, including contraception and abortion services. Despite this, the WHO estimates that approximately 20 million illegal abortions are performed annually. While the majority of African countries still have restrictive abortion laws, radical change in abortion legislation occurred in 1996 in South Africa with the passing of the CTOPA. This has generated considerable controversy and the South African health system was faced with the enormous challenge of providing safe, effective, affordable and acceptable TOP services throughout the country.

Against this background, research was undertaken to record and analyse the implementation and operation of the CTOPA with the purpose of developing a set of recommendations based on best practices and lessons learnt. In order to achieve the aim, the study was divided into two phases with specific objectives - a literature review to investigate international, regional and local developments in reproductive rights and particularly abortion, and a case study of the implementation and operation of CTOPA in the Free State. The literature review was accomplished by consulting relevant legislation, articles in popular and scientific journals as well as newspapers, and the web. The Free State case study entailed the collection of empirical data during a series of interviews in 1998 and 2003 with health workers in general, TOP service providers, TOP clients and key stakeholders.

The literature study revealed that the objectives of the CTOPA clearly summarise the intentions of international agreements such as the ICPD, the Beijing Conference and their follow-up reviews. In addition, South Africa has had the advantage of learning from the experiences of the USA and Britain regarding abortion law reform. South Africa has strived to ensure that not only does the law allow for legal abortions, but also that, as far as possible, additional legislation does not impede access to the service. The CTOPA, together with the commitment of government to provide safe and accessible services, should act as an inspiration to neighbouring countries to reform their abortion laws.

With regard to the Free State case study, the following main findings emerged. Despite the slight improvement in the knowledge of health workers regarding the CTOPA, and more positive attitudes toward TOP, there was a reluctance to refer women unconditionally to TOP facilities. As time progressed, TOP service providers became more negative in their views of and attitudes toward the service. Little was done to alleviate the situation as counselling and psychological support services remained unavailable for TOP service providers. By 2003, TOP service providers were less likely to evaluate their services as being good, and post-counselling remained illusive for many clients. There were still no facilities providing a 24-hour service; as such, women

who were more than twelve weeks pregnant were sent home to initiate the abortion. Furthermore, more women were put onto waiting lists at the TOP facilities when compared to the situation in 1998. Statistics show that TOPs in the Free State have steadily increased, yet only one additional facility became operational in the province while the number of staff providing the service remained constant.

The main recommendations included: motivating health managers to become involved with TOP; formulating policies and guidelines for provision of TOP; educating health workers and communities about the CTOPA; implement strategies to address negative attitudes; introducing incentives for TOP service providers; including TOP in the training curriculum of nurses; and making psychological support available for TOP service providers.

## OPSOMMING

Die reg om te besluit wanneer om ‘n kind te hê vorm die kern van reproduktiewe regte en behels dat elke vrou toegang tot veilige en effektiewe metodes (insluitend voorbehoedings- en aborsiedienste) behoort te geniet om die grootte van hul gesinne te beheer. Desnieteenstaande beraam die WGO dat ongeveer 20 miljoen onwettige aborsies jaarliks uitgevoer word. Alhoewel die meerderheid Afrika lande steeds beperkende aborsie wette toepas het radikale veranderinge Suid-Afrikaanse aborsie wetgewing in 1996 gekenmerk deur die instelling van die CTOPA. Die wetgewing het tot wesenlike twispunte gelei en die Suid-Afrikaanse gesondheidsisteem was met die enorme uitdaging getaak om veilige, effektiewe, bekostigbare en aanvaarbare beëindiging van swangerskap (BVS) dienste in die land beskikbaar te stel.

Teen hierdie agtergrond is navorsing onderneem om die implementering en funksionering van die CTOPA te dokumenteer en te analiseer ten einde ‘n stel aanbevelings op grond van goeie praktyke en lesse geleer daar te stel. In nastrewing van hierdie doel is die studie in twee fases met spesifieke doelwitte opgebreek – ‘n literatuurstudie om internasionale, streeks en plaaslike ontwikkelings in die veld van reproduktiewe regte en aborsiewetgewing te ontleed, en ‘n gevallestudie rakende die implementering en werking van die CTOPA in die Vrystaat. Eersgenoemde is deur middel van gepaste wetgewing, artikels in allerdaagse en wetenskaplike tydskrifte, sowel as koerante en die internet onderneem. Die gevallestudie in die Vrystaat het die insameling van empiriese data deur middel van ‘n reeks onderhoude in 1998 and 2003 met gesondheidswerkers in die algemeen, BVS diensverskaffers, BVS kliënte en hoofrolspelers behels.

Die literatuurstudie het aan die lig gebring dat die doelstellings van die CTOPA ‘n opsomming van die oogmerke van internasionale ooreenkomste soos die ICDP, die Beijing Conference en hul opeenvolgende oorsigte, behels. Verder het Suid-Afrika voordeel geniet deur van die ervarings

van die VSA en Britanje rakende reformasie van aborsiewetgewing te leer. Suid-Afrika het nie net na die wettiging van aborsies gestreef nie, maar ook versker dat, sover moontlik, addisionele wetgewing nie toegang tot die diens belemmer nie. Dit is duidelik dat die CTOPA, tesame met die nodige steun van die regering om veilige en toeganklike BVS dienste te verseker, as inspirasie vir buurlande kan dien in die wysiging van hul aborsiewette.

Hoofbevindinge uit die Vrystaatstudie sluit die volgende tema's in. Alhoewel 'n matige verbetering in die kennis van gesondheidwerkers rakende die CTOPA (asook positiewer houdings teenoor die wet) opgemerk is, blyk dit dat teensinnigheid rakende die onvoorwaardelike verwysing van kliënte na BVS fasiliteite steeds bestaan. Verder dui die studie aan dat, oor tyd, BVS diensverskaffers meer negatief in hul sienings van en houdings teenoor BVS word. Min word gedoen om dié situasie teen te werk aangesien geen sielkundige ondersteuning vir BVS diensverskaffers bestaan nie. Teen 2003 was diensverskaffers minder geneigd om hul dienste as goed te beskou, en na-berading was nie vir meeste BVS kliënte beskikbaar nie. Geen 24-uur BVS diens het bestaan nie en gevolglik moes vroue wat meer as twaalf weke swanger was hul aborsies tuis inisieer. Verder was daar, vergelyke met die 1998 situasie meer vroue op waglyste geplaas. Statistiek dui aan dat BVSe in die Vrystaat geleidelik toeneem; niettemin is slegs een addisionele BVS fasiliteit in die provinsie ge-open terwyl die hoeveelheid personeel vir die diens konstant gebly het.

Die sleutelaanbevelings van die studie sluit in: motivering van gesondheidbestuurders om by BVS dienste betrokke te raak; formulering van beleid en riglyne vir die verskaffing van BVS dienste; die inlig en opleiding van gesondheidwerkers and gemeenskappe oor die CTOPA;
Implimentering van strategieë om negatiewe houdings onder gesondheidswerkers aan te spreek; die inwerkingstelling van aanmoedigingsmeganismes vir BVS diensverskaffers; insluiting van BVS in die opleidingskurrikulum van verpleegsters; en die voorsiening van sielkundige ondersteuning aan BVS diensverskaffers.

## KEY TERMS

Abortion

Back-street/unsafe abortion

Termination of pregnancy

South African abortion legislation

*Abortion and Sterilisation Act* (1975)

*Choice on Termination of Pregnancy Act* (1996)

Conscientious objection

Value clarification workshops.

Reproductive health

Reproductive rights

# APPENDIX A

- 1998 Questionnaire for health workers who were in a position to refer clients to TOP facilities.
- 2003 Questionnaire for health workers who were in a position to refer clients to TOP facilities.
- 1998 Questionnaire for TOP service providers.
- 2003 Questionnaire for TOP service providers.
- 1998 Questionnaire for TOP clients.
- 2003 Questionnaire for TOP clients.

**Delivery of TOP services in the Free State:**
**Health Worker Referral Questionnaire (1998)**

1. Town:______________________________________________________________

2. At which facility are you working?

| | |
|---|---|
| Clinic | 1 |
| Community Health Centre | 2 |
| District Hospital | 3 |
| Regional Hospital | 4 |
| District Medical Officer services | 5 |
| Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | |

## Section A: Background Information

3. Indicate your occupational category:

| | |
|---|---|
| 3.1 General practitioner | 1 |
| 3.2 Gynaecologist | 2 |
| 3.3 Registered midwife | 3 |
| 3.4 Registered nurse | 4 |
| 3.5 Staff nurse | 5 |
| 3.6 Nursing assistant | 6 |
| 3.7 Social worker | 7 |
| 3.8 Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | |

4. How long have you been working as a health care provider/social worker?

| | |
|---|---|
| Less than 1 year | 1 |
| 1 - 3 years | 2 |
| 4- 6 years | 3 |
| 7 - 10 years | 4 |
| More than 10 years | 5 |

5. How long have you been working with TOP referrals?

________________________________________________________________

## Section C: Attitudes towards TOP

6. Please indicate whether or not you agree or disagree with the following statements:

| | Strongly agree | Agree | Uncertain | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| 6.1 TOP should not be legal | 1 | 2 | 3 | 4 | 5 |
| 6.2 I believe TOP is justified under all circumstances | 1 | 2 | 3 | 4 | 5 |
| 6.3 It is our moral and ethical responsibility to preserve human life, irrespective of any circumstances. | 1 | 2 | 3 | 4 | 5 |
| 6.4 A women has the right to make her own decisions concerning her body | 1 | 2 | 3 | 4 | 5 |

| | Strongly agree | Agree | Uncertain | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| 6.5 TOP should be an alternative when contraceptives fail | 1 | 2 | 3 | 4 | 5 |
| 6.6 People would support the right of women to have a TOP if they knew more about it | 1 | 2 | 3 | 4 | 5 |
| 6.7 My religion does not prevent me from accepting TOP | 1 | 2 | 3 | 4 | 5 |
| 6.8 Persons under 18 years of age should first obtain the consent of their parents before being allowed a TOP | 1 | 2 | 3 | 4 | 5 |
| 6.9 Social and financial problems are sufficient reasons for requesting a TOP | 1 | 2 | 3 | 4 | 5 |
| 6.10 Now that the grounds for TOP have been extended, people will become careless about their contraceptive practices | 1 | 2 | 3 | 4 | 5 |
| 6.11 A women should only be allowed to have a TOP if her partner agrees | 1 | 2 | 3 | 4 | 5 |
| 6.12 The foetus should have the same rights as the mother | 1 | 2 | 3 | 4 | 5 |
| 6.13 Only the woman has the right to decide whether to have a TOP | 1 | 2 | 3 | 4 | 5 |
| 6.14 Women do not need to feel ashamed if they decide to have a TOP | 1 | 2 | 3 | 4 | 5 |

7. Some people believe that TOP is an important human right. Others, however, are of a different opinion. What are your views on this? (Please be precise, and stipulate conditions - if any).

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

8. In general, how do you feel about the concept of abortion on request during the first twelve weeks of pregnancy, as it is currently stipulated by law in South Africa?

| Very positive | Positive | Uncertain | Negative | Very negative |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

9. How would you feel if you had to refer a patient to a TOP facility?

| Very comfortable | Comfortable | Uncertain | Uncomfortable | Very uncomfortable |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

10. Have you attended an Abortion Values Clarification Workshop?

| Yes | 1 | Go to Q 11 |
|---|---|---|
| No | 2 | Go to Q 16 |

11. **If yes**, how did you experience the workshop?

| Very useful | 1 |
|---|---|
| Of limited use | 2 |
| A waste of time | 3 |

12. Please explain…

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

13. Did your opinions or attitudes towards abortion change during/after the workshop?

| Yes | 1 | Go to Q 14 |
|---|---|---|
| No | 2 | Go to Q 15 |

14. **If yes**, please explain …

________________________________________

________________________________________

________________________________________

15. Do you think that by attending this workshop, your effectiveness in dealing with TOP users improved, or not?

| Has improved | 1 |
|---|---|
| Has not improved | 2 |

16. Please explain your response to the previous question.

________________________________________

________________________________________

________________________________________

________________________________________

**Section D: Knowledge of the Act.**

17. Are the following statements true or false?

| | True | False | Uncertain |
|---|---|---|---|
| 17.1 TOP on request is available during the first 12 weeks of pregnancy. | 1 | 2 | 3 |
| 17.2 A trained midwife is not allowed to conduct a TOP | 1 | 2 | 3 |
| 17.3 TOPs are allowed from the 13th to the 20th week if the continued pregnancy would significantly affect the social or economic well being of the woman. | 1 | 2 | 3 |
| 17.4 TOPs are allowed after the 20th week if certain conditions are met. | 1 | 2 | 3 |
| 17.5 Some sort of certification is still needed if the TOP is to be conducted after the 12th week. | 1 | 2 | 3 |

| | True | False | Uncertain |
|---|---|---|---|
| 17.6 TOPs conducted at public health facilities cost the client a lot of money. | 1 | 2 | 3 |
| 17.7 According to the TOP Act, it is not necessary to offer post counselling to a women who has had a TOP. | 1 | 2 | 3 |
| 17.8 The client should consent to pre-counselling. | 1 | 2 | 3 |
| 17.9 The client should consent to post-counselling. | 1 | 2 | 3 |
| 17.10 The counsellor has the right to impose his/her personal values on the client. | 1 | 2 | 3 |
| 17.11 A minor has to obtain the consent of her parents/guardians before a TOP may be conducted. | 1 | 2 | 3 |
| 17.12 Health care workers may not exercise their conscientious objection to participate in a TOP. | 1 | 2 | 3 |
| 17.13 If a woman requests a TOP, she must be informed of her rights under the ACT. | 1 | 2 | 3 |

(17.14)

**Section D: Referral of Patients to TOP Facilities**

18. Do you know at which hospitals/clinics TOP services are provided in the Free State?

| Yes | 1 | **Go to Q 19** |
|---|---|---|
| No | 2 | **Go to Q 20** |

19. If yes, please name two such facilities:

________________________________________
________________________________________

20. Have you had patients coming to you and requesting a TOP?

| Yes | 1 | **Go to Q 21** |
|---|---|---|
| No | 2 | **Go to Q 23** |

21. Have you referred any patients to a TOP service?

| Yes | 1 | **Go to Q 23** |
|---|---|---|
| No | 2 | **Go to Q 22** |

22. **If no**, why not?

________________________________________
________________________________________
________________________________________

23. **If yes**, what are the main problems that you experience in referring patients to TOP facilities?

________________________________________
________________________________________
________________________________________
________________________________________

24. Would you in future willingly refer a patient requesting a TOP to a facility that provides this service?

| Yes, unconditionally | 1 | **Go to Q 27** |
|---|---|---|
| Yes, depending on the circumstances | 2 | **Go to Q 25** |
| No | 3 | **Go to Q 26** |

25. If **yes depending on the circumstances**, what circumstances? (**Go to Q 27**)

______________________________________________________________________

26. Why would you not refer such a patient to a TOP facility?

______________________________________________________________________

27. Do you provide patients requesting TOPs with information concerning TOP?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 28** |
| No | 2 | **Go to Q 29** |

28. If yes, what type of information do you provide them with?

______________________________________________________________________

## Section E: Problems and Recommendations

29. What would the main **problems** be, in the following categories, if **your facility** was to introduce TOP services?

29.1 Service? ________________________________________________________

29.2 Clients? ________________________________________________________

29.3 Staff? __________________________________________________________

29.4 Facilities and equipment? __________________________________________

29.5 Other_____________________________________________________________

30. How can these problems be solved?

30.1 Service? ________________________________________________________

30.2 Clients? ________________________________________________________

30.3 Staff? __________________________________________________________

30.4 Facilities and equipment? ______________________________________________
__________________________________________________________________________
__________________________________________________________________________

30.5 Other ________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

31. What would the main **problems** be **for you**, if your facility was to provide TOP services?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

32. How could these problems be solved?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

33. What **factors** could secure the **smooth running** of a TOP facility?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

**Thank you for taking the time to participate in this survey**

## Interview Schedule for Health Care Providers (2003)

Official use

Questionnaire number
Date of interview ____________________
Name of interviewer ____________________
1. Name of Town ____________________
2. Name of Clinic ____________________
3. What type of facility do you work at?

| Clinic | |
|---|---|
| Community health centre | |
| Other | |

## Section A
## Background information and the referral system

4. Indicate your occupational category

| Registered midwife | |
|---|---|
| Registered nurse | |
| Staff nurse | |
| Nursing assistant | |
| Social worker | |
| Other | |

5. For how long have you been working as a health care provider?

| Less than 1 year | |
|---|---|
| 1-3 years | |
| 4-6 years | |
| 7-10 years | |
| More than 10 years | |

6. Which facilities in the Free State provide TOP services?

7. On average, how many adults **consult** you for a possible TOP per month?

8. On average, how many minors **consult** you for a possible TOP per month?

9. Have you ever referred an adult patient to a TOP facility?

| Yes | |
|---|---|
| No | |

10. Have you ever referred a minor to a TOP facility?

| Yes | |
|---|---|
| No | |

11. **Interviewer: If no ask:** Why have you not referred patients to a TOP facility?
11.1 Adults ____________________

11.2 Minors ____________________

| | Official use |
|---|---|
| 12.**Interviewer: If yes, either adults or minors have been referred, ask**:<br>To which TOP facility(ies) do you generally refer patient(s)? | |
| | |
| 13. On average, how many adults do you **refer** per month for a possible TOP? | |
| 14. On average, how many minors do you **refer** per month for a possible TOP? | |
| 15. What problems do you experience with the referral of patients to TOP facilities?<br>15.1 Minors ______ | |
| | |
| | |
| 15.2 Adults ______ | |
| | |
| | |
| 16. Would you in future willingly refer a minor patient requesting a TOP to a facility that provides this service? | |

| | | |
|---|---|---|
| Yes, unconditionally | | |
| Yes, depending on the circumstances | | |
| No | | **Interviewer: If no. skip to Q18** |

| | |
|---|---|
| 17. **Interviewer: If yes, depending on the circumstances ask**: What are these circumstances? | |
| | |
| | |
| | |
| 18. **Interviewer: If no, ask**: Why would you not refer such a patient to a TOP facility? | |
| | |
| | |
| | |
| 19. Would you in future willingly refer an adult patient requesting a TOP to a facility that provides this service? | |

| | | |
|---|---|---|
| Yes, unconditionally | | |
| Yes, depending on the circumstances | | |
| No | | **Interviewer: If no, skip to Q21** |

| | |
|---|---|
| 20. **Interviewer: If yes, depending on the circumstances, ask:** What are these circumstances? | |
| | |
| | |
| | |
| 21. **If no**, why would you not refer such a patient to a TOP facility? | |
| | |
| | |
| | |

| 22. Do you provide minor patients requesting TOPs with information concerning TOP? | Official use |
|---|---|
| | |

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q24**

23. **Interviewer: If yes, ask**: What type of information do you provide them with?

24. Do you provide adult patients requesting TOPs with information concerning TOP?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q26**

25. **Interviewer: If yes, ask:** What information do you provide them with?

**Section A: Part Five**
**Youth-friendly services**

26. Has your facility put any special provisions (procedures or services) in place to facilitate minors' access to TOP services?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q28**

27. **Interviewer: If yes, ask:** What does this entail?

28. **Interviewer: If no, ask:** Why not?

29. Does your facility make any provisions for representing the youth (e.g. a youth on the clinic committee)?

| | |
|---|---|
| Yes | |
| No | |

30. Does this facility have any outreach activities in place specifically for the youth?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q32**

31. **Interviewer: If yes ask:** Please elaborate.

32. Do you personally have any difficulties with minors requesting a TOP?

| | |
|---|---|
| Yes | |
| No | |

33. Please explain

| Section C<br>Knowledge of the Act | | | | | |
|---|---|---|---|---|---|
| 34. Are the following statements true or false? | True | False | Uncertain | Don't know | Official use |
| 34.1 TOP on request is available during the first 12 weeks of pregnancy. | | | | | |
| 34.2 A trained midwife is not allowed to conduct a TOP | | | | | |
| 34.3 TOPs are allowed from the 13th to the 20th week if the continued pregnancy would significantly effect the social or economic well-being of the woman. | | | | | |
| 34.4 TOPs are allowed after the 20th week if certain conditions are met. | | | | | |
| 34.5 Some sort of certification is still needed if the TOP is to be conducted after the 12th week. | | | | | |
| 34.6 TOPs conducted at public health facilities cost the client a lot of money. | | | | | |
| 34.7 According to the TOP Act, it is not necessary to offer post counselling to a woman who has had a TOP | | | | | |
| 34.8 The client should consent to pre-counselling | | | | | |
| 34.9 The client should consent to post-counselling | | | | | |
| 34.10 Persons under 18 years of age should first consult their parents/guardians before being allowed a TOP | | | | | |
| 34.11 Persons under 18 years of age should first obtain the consent of their parents/guardians before being allowed a TOP | | | | | |
| 34.12 TOP service providers should first obtain the consent of both parents before performing a TOP on a minor | | | | | |
| 34.13 TOP service providers should first obtain the consent of at least one parent before performing a TOP on a minor | | | | | |
| 34.14 Health care workers may not exercise their right to conscientious objection with regard to participating in a TOP procedure | | | | | |
| 34.15 Health care workers may exercise their right to conscientious objection with regard to participating in a TOP procedure but should refer the woman to another facility | | | | | |
| 34.16 If a woman requests a TOP, she must be informed of her rights under the Act. | | | | | |

## Section D

### Attitudes towards TOP

| 35. Do you agree or disagree with the following statements | | | | | | |
|---|---|---|---|---|---|---|
| SA=Strongly agree, A=Agree, U=Uncertain, D=Disagree, SD=Strongly disagree | SA | A | U | D | SD | Please explain. |
| 35.1 TOP should be legal | | | | | | |
| 35.2 TOP is justified under all circumstances | | | | | | |
| 35.3 A woman has the right to make her own decisions concerning her body | | | | | | |
| 35.4 TOP should be an alternative when contraceptives fail | | | | | | |
| 35.5 People would support the right of women to have a TOP if they knew more about it | | | | | | |
| 35.6 My religion prevents me from accepting TOP | | | | | | |
| 35.7 TOP is justified for minors | | | | | | |
| 35.8 A 14 year old requesting a TOP should be subject to a different set of rules compared to a 17 year old requesting a TOP | | | | | | |
| 35.9 There should be stricter rules governing minors' access to TOP | | | | | | |
| 35.10 Persons under 18 years of age should first consult their parents before being allowed a TOP | | | | | | |
| 35.11 Persons under 18 years of age should first obtain the consent of their parents before being allowed a TOP | | | | | | |
| 35.12 TOP service providers should first obtain the consent of both parents before performing a TOP in a minor | | | | | | |
| 35.13 TOP service providers should first obtain the consent of at least one parent before performing a TOP in a minor | | | | | | |
| 35.14 Social and financial problems are sufficient reasons for adults requesting a TOP | | | | | | |
| 35.15 Social and financial problems are sufficient reasons for minors requesting a TOP | | | | | | |
| 35.16 Since the grounds for TOP have been extended, people have become careless with contraceptives | | | | | | |
| 35.17 A woman should only be allowed to have a TOP if her partner agrees | | | | | | |
| 35.18 Women should feel ashamed if they have a TOP | | | | | | |

Official use

36. Have you attended an abortion values clarification workshop?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q44**

37. **Interviewer: If yes ask:** When did you attend the workshop (date – year and month) (**Interviewer:** If more than one workshop was attended, obtain the dates of all workshops, the following questions pertain to the respondents overall opinion of the workshops)

38. How did you experience the workshop(s)?

| Indispensable | |
|---|---|
| Very valuable | |
| Of limited use | |
| A waste of time | |

39. Please explain.

40. Did your opinions or attitudes regarding TOP change during/after the workshop(s)?

| Yes | |
|---|---|
| No | |

41. Please explain (in both cases).

42. Do you think that by attending this/these workshop(s), your effectiveness in dealing with TOP clients has improved or not?

| 42.1 Has improved in dealing with minors | |
|---|---|
| 42.2 Has not improved in dealing with minors | |
| 42.3 Has improved in dealing with adults | |
| 42.4 Has not improved in dealing with adults | |

43. Please explain (in both cases).

43.1 Minors

43.2 Adults

**Section E**
**Concluding comments**

44. Are there sufficient facilities in the Free State providing TOP services?

| Yes | |
|---|---|
| No | |

45. Please explain

46. What would the main problems/constraints be, in the following categories, if your facility was to introduce TOP services?
What solutions can you suggest for these problems?

| | **Problems experienced** | **Possible solutions** | Official use |
|---|---|---|---|
| 46.1 Service | | | |
| 46.2 Adult clients | | | |
| 46.3 Minor clients | | | |
| 46.4 Staff | | | |
| 46.5 Facilities | | | |
| 46.6 Equipment | | | |
| 46.7 Other  specify) | | | |
| 46.8 Other specify) | | | |

**Delivery of TOP services in the Free State:**
**Provider Questionnaire (1998)**

**Kindly answer the following sections that apply to you.**
**Section A - all respondents**
**Section B - TOP facility managers**
**Section C - persons providing counselling for TOP clients**
**Section D - all persons doing/assisting with TOP procedures**

## SECTION A (TO BE COMPLETED BY ALL RESPONDENTS)

1. At which facility are you working?

| | |
|---|---|
| Bloemfontein: Pelonomi Hospital | 1 |
| Welkom: Kopano Clinic | 2 |
| QwaQwa: Elizabeth Ross Hospital | 3 |

2. Indicate your occupational category:

| | |
|---|---|
| 2.1 TOP facility manager | 1 |
| 2.2 General practitioner | 2 |
| 2.3 Gynaecologist | 3 |
| 2.4 Registered midwife | 4 |
| 2.5 Registered nurse | 5 |
| 2.6 Staff nurse | 6 |
| 2.7 Nursing assistant | 7 |
| 2.8 Social worker | 8 |
| 2.9 Other: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | |

3. How long have you been working as a health care provider/social worker?

| | |
|---|---|
| Less than 1 year | 1 |
| 1 - 3 years | 2 |
| 4 - 6 years | 3 |
| 7 - 10 years | 4 |
| More than 10 years | 5 |

4. How long have you been working at a TOP facility?

_______________________________________________

5. How would you evaluate the quality of the following aspects of the service rendered at your facility?

| | Very good | Good | Average | Poor | Very poor | Non existent | Uncertain |
|---|---|---|---|---|---|---|---|
| 5.1 Counselling | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5.2 Examination | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5.3 TOP Procedure | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5.4 Health information about TOP to users | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5.5 After care/post TOP care | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

6.1 If counselling is “poor” or “very poor” please explain:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

6.2 If the examination is “poor” or “very poor” please explain:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

6.3 If the TOP procedure is “poor” or “very poor” please explain:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

6.4 If health information about TOPs is “poor” or “very poor” please explain:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

6.5 If after care/post TOP care is “poor” or “very poor” please explain:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

7. Evaluate the following aspects of the <u>physical structure</u> at your facility where TOP services are provided.

| | Good/ sufficient | Average | Poor/ Insufficient | Non existent | Uncertain |
|---|---|---|---|---|---|
| 7.1 Reception area | 1 | 2 | 3 | 4 | 5 |
| 7.2 Number of consulting rooms | 1 | 2 | 3 | 4 | 5 |
| 7.3 Number of rooms available for counselling | 1 | 2 | 3 | 4 | 5 |
| 7.4 Number of toilets | 1 | 2 | 3 | 4 | 5 |
| 7.5 Degree of <u>visual</u> privacy for TOP users | 1 | 2 | 3 | 4 | 5 |
| 7.6 Degree of <u>auditory</u> privacy for TOP users | 1 | 2 | 3 | 4 | 5 |
| 7.7 Staff rest room | 1 | 2 | 3 | 4 | 5 |
| 7.8 Office space for staff | 1 | 2 | 3 | 4 | 5 |

8. Please indicate whether you agree or disagree with the following statements:

| | Strongly agree | Agree | Uncertain | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| 8.1 TOP should not be legal | 1 | 2 | 3 | 4 | 5 |
| 8.2 I believe TOP is justified under all circumstances | 1 | 2 | 3 | 4 | 5 |
| 8.3 It is our moral and ethical responsibility to preserve human life, irrespective of any circumstances. | 1 | 2 | 3 | 4 | 5 |
| 8.4 A women has the right to make her own decisions concerning her body | 1 | 2 | 3 | 4 | 5 |
| 8.5 TOP should be an alternative when contraceptives fail | 1 | 2 | 3 | 4 | 5 |
| 8.6 People would support the right of women to have a TOP if they knew more about it | 1 | 2 | 3 | 4 | 5 |
| 8.7 My religion does not prevent me from accepting TOP | 1 | 2 | 3 | 4 | 5 |
| 8.8 Persons under 18 years of age should first obtain the consent of their parents before being allowed a TOP | 1 | 2 | 3 | 4 | 5 |
| 8.9 Social and financial problems are sufficient reasons for requesting a TOP | 1 | 2 | 3 | 4 | 5 |
| 8.10 Now that the grounds for TOP have been extended, people will become careless about their contraceptive practices | 1 | 2 | 3 | 4 | 5 |
| 8.11 A women should only be allowed to have a TOP if her partner agrees | 1 | 2 | 3 | 4 | 5 |
| 8.12 The foetus should have the same rights as the mother | 1 | 2 | 3 | 4 | 5 |
| 8.13 Only the woman has the right to decide whether to have a TOP | 1 | 2 | 3 | 4 | 5 |
| 8.14 Women do not need to feel ashamed if they decide to have a TOP | 1 | 2 | 3 | 4 | 5 |

9. Some people believe that TOP is an important human right. Others, however, are of a different opinion. What are your views on this? (Please be precise, and stipulate conditions - if any).

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

10. In general, how do you feel about the concept of TOP on request during the first twelve weeks of pregnancy, as it is currently stipulated by law in South Africa?

| Very positive | Positive | Uncertain | Negative | Very negative |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

11. How would you describe your work morale?

| Very good | Good | Uncertain | Poor | Very Poor |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

12. Please motivate your answer to question 11.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

13. Is there any psychological support for staff providing TOP services?

| | | |
|---|---|---|
| Yes, at my facility | 1 | **Go to Q 14** |
| Yes, but not at my facility | 2 | **Go to Q 14** |
| No | 3 | **Go to Q 18** |
| Uncertain | 4 | **Go to Q 18** |

14. **If yes**, what type of support is available?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

15. Do you make use of this support?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 17** |
| No | 2 | **Go to Q 16** |

16. **If no**, why not? (**Go to Q 21**)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

17. Who gives this support? (**Go to Q21**)

______________________________________________________________________
______________________________________________________________________

18. **If no or uncertain**, would you like psychological support to be available?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 19** |
| No | 2 | **Go to Q 21** |

19. **If yes**, what type of support would you like to be available and please explain why?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

20. From whom would you like support to be available?

______________________________________________
______________________________________________
______________________________________________

21. Have you attended an Abortion Values Clarification Workshop?

| Yes | 1 | **Go to Q 22** |
|---|---|---|
| No | 2 | **Go to Q 26** |

22. **If yes**, how did you experience the workshop?

| Very useful | 1 |
|---|---|
| Of limited use | 2 |
| A waste of time | 3 |

23. Please explain ….

______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

24. Did your opinions or attitudes change during/after the workshop?

| Yes | 1 | **Go to Q 25** |
|---|---|---|
| No | 2 | **Go to Q 26** |

25. **If yes**, please explain…

______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

26. Do you think that by attending this workshop, your effectiveness in dealing with TOP users improved or not?

| Has improved | 1 |
|---|---|
| Has not improved | 2 |

27. Please explain your response to the previous question

______________________________________________
______________________________________________
______________________________________________
______________________________________________

28. Are the following statements true or false?

| | True | False | Uncertain |
|---|---|---|---|
| 28.1 TOP on request is available during the first 12 weeks of pregnancy. | 1 | 2 | 3 |
| 28.2 A trained midwife is not allowed to conduct a TOP | 1 | 2 | 3 |
| 28.3 TOPs are allowed from the 13th to the 20th week if the continued pregnancy would significantly affect the social or economic well being of the woman. | 1 | 2 | 3 |
| 28.4 TOPs allowed after the 20th week if certain conditions met. | 1 | 2 | 3 |

| | True | False | Uncertain |
|---|---|---|---|
| 28.5 Some sort of certification is still needed if the TOP is to be conducted after the 12th week. | 1 | 2 | 3 |
| 28.6 TOPs conducted at public health facilities cost the client a lot of money. | 1 | 2 | 3 |
| 28.7 According to the TOP Act, it is not necessary to offer post counselling to a women who has had a TOP. | 1 | 2 | 3 |
| 28.8 The client should consent to pre-counselling. | 1 | 2 | 3 |
| 28.9 The client should consent to post-counselling. | 1 | 2 | 3 |
| 28.10 The counsellor has the right to impose his/her personal values on the client. | 1 | 2 | 3 |
| 28.11 A minor has to obtain the consent of her parents/guardians before a TOP may be conducted. | 1 | 2 | 3 |
| 28.12 Health care workers may not exercise their conscientious objection to participate in a TOP. | 1 | 2 | 3 |
| 28.13 If a woman requests a TOP, she must be informed of her rights under the ACT. | 1 | 2 | 3 |

(28.14)

29 What **do you recommend** for other facilities that need to implement TOP services that will assist in the smooth running of the facilities?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**SECTION B (TO BE ANSWERED BY TOP FACILITY MANAGERS ONLY)**

30. How many of the following members of staff are providing TOP services on a i) **full-time** and ii) **part-time basis** at your facility?

| **Members of staff** | **Number of staff providing services** | |
|---|---|---|
| | **Full-time** | **Part-time** |
| 30.1 General practitioners | | |
| 30.2 Gynaecologists | | |
| 30.3 Registered midwives | | |
| 30.4 Registered nurses | | |
| 30.5 Staff nurses | | |
| 30.6 Nursing assistants | | |
| 30.7 Social workers | | |

31. Who is providing counselling for TOP patients at your facility? (**Not names but occupational categories**)

| **Occupational category** | **Number of staff providing services** | |
|---|---|---|
| | **Full-time** | **Part-time** |
| 31.1 General practitioners | | |
| 31.2 Registered midwives | | |
| 31.3 Registered nurses | | |
| 31.4 Staff nurses | | |
| 31.5 Social workers | | |
| 31.6 Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | | |

32. Is your staff component sufficient for TOP?

| Yes | 1 | **Go to Q 34** |
|---|---|---|
| No | 2 | **Go to Q 33** |
| Uncertain | 3 | **Go to Q 34** |

33. **If no**, how many additional members of staff do you need in the following categories?

| **Members of staff** | **Number of additional staff needed** |
|---|---|
| 33.1 General Practitioners | |
| 33.2 Gynaecologists | |
| 33.3 Registered midwives | |
| 33.4 Registered nurses | |
| 33.5 Staff nurses | |
| 33.6 Nursing assistants | |
| 33.7 Social workers | |
| 33.8 Cleaners | |
| 33.9 Any other? ____ ____________ ________________ | |

34. To what extent do you have access to the following personnel/equipment/services at your facility? Do you have sufficient

| | Yes | No | Uncertain |
|---|---|---|---|
| 34.1 willing medical practitioners for TOP? | 1 | 2 | 3 |
| 34.2 willing nursing personnel for TOP? | 1 | 2 | 3 |
| 34.3 counsellors? | 1 | 2 | 3 |
| 34.4 appropriate surgical equipment? | 1 | 2 | 3 |
| 34.5 drugs for intravenous and muscular injection? | 1 | 2 | 3 |
| 34.6 emergency resuscitation equipment and drugs? | 1 | 2 | 3 |
| 34.7 transport in the case of an emergency transfer? | 1 | 2 | 3 |
| 34.8 facilities for clinical observation? | 1 | 2 | 3 |
| 34.9 equipment for clinical observation? | 1 | 2 | 3 |
| 34.10 inpatient facilities? | 1 | 2 | 3 |
| 34.11 appropriate infection control measures? | 1 | 2 | 3 |
| 34.12 safe waste disposal infrastructure? | 1 | 2 | 3 |
| 34.13 telephones? | 1 | 2 | 3 |

35. Approximately how many patients are seen on an average working day at your TOP facility?

______________________________________________________________

36. On average, how much time is spent on counselling per patient prior to the TOP procedure?

_____________ Minutes/per patient

37. On average, how much time is spent on counselling per patient after the TOP procedure?

____________________Minutes/per patient

38. On average, how much time is spent examining the patient?

____________________Minutes/per patient

39. On average, how much time is spent on doing the TOP procedure?

39.1 MVA _____________ Minutes/per patient

40. What are the main **problems** experienced by **your facility** with regard to the following categories?

40.1 Service? ____________________________________________________________
______________________________________________________________________
______________________________________________________________________

40.2 Clients? ____________________________________________________________
______________________________________________________________________
______________________________________________________________________

40.3 Staff? ______________________________________________________________
______________________________________________________________________
______________________________________________________________________

40.5 Facilities and equipment? _____________________________________________
______________________________________________________________________
______________________________________________________________________

40.5 Other ______________________________________________________________
______________________________________________________________________
______________________________________________________________________

41. How can these problems be solved?

41.1 Service? ____________________________________________________________
______________________________________________________________________
______________________________________________________________________

41.2 Clients? ____________________________________________________________
______________________________________________________________________
______________________________________________________________________

41.3 Staff? ______________________________________________________________
______________________________________________________________________
______________________________________________________________________

41.4 Facilities and equipment? _____________________________________________
______________________________________________________________________
______________________________________________________________________

41.5 Other ______________________________________________________________
______________________________________________________________________
______________________________________________________________________

42. What **factors** have mainly contributed to the **smooth running** of your TOP facility?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**SECTION C (TO BE ANSWERED BY PERSONS PROVIDING COUNSELLING TO TOP USERS ONLY)**

43. On average, how much time is spent on counselling a patient prior to the TOP procedure?

____________ Minutes/per patient

44. On average, how much time is spent on counselling a patient after the TOP procedure?

___________________Minutes/per patient

45. Have you received specific training to conduct counselling for persons requesting TOP?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 46** |
| No | 2 | **Go to Q 49** |

46. **If yes**, what was the content of the training you received?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

47. Was the training adequate?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 50** |
| No | 2 | **Go to Q 48** |

**48. If no**, would you like to make any recommendations in this regard?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

49. Will you be receiving training soon?

| | |
|---|---|
| Yes | 1 |
| No | 2 |
| Uncertain | 3 |

50. What are the main **problems** that **you face** when having to provide TOP counselling?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

51. How can these problems be solved?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

**SECTION D (TO BE ANSWERED BY PERSONS DOING/ASSISTING WITH THE TOP PROCEDURES ONLY)**

52. On average, how much time is spent examining the patient?

____________________Minutes/per patient

53. On average, how much time is spent on doing the TOP procedure?
MVA _____________ Minutes/per patient

54. Have you received specific training to conduct terminations of pregnancy?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 55** |
| No | 2 | **Go to Q 57** |

55. **If yes**, was this training adequate?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 57** |
| No | 2 | **Go to Q 56** |

56. **If no**, please explain…

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

57. If **no**, will you receive training soon?

| | |
|---|---|
| Yes | 1 |
| No | 2 |
| Uncertain | 3 |

58. How often do you have to deal with situations such as the following?

| | Always | Regularly | Sometimes | Seldom | Never |
|---|---|---|---|---|---|
| 58.1 Medication is not available | 1 | 2 | 3 | 4 | 5 |
| 58.2 Equipment is inadequate | 1 | 2 | 3 | 4 | 5 |
| 58.3 You don't have enough time, too many patients to see | 1 | 2 | 3 | 4 | 5 |
| 58.4 Staff for TOP not available | 1 | 2 | 3 | 4 | 5 |

59. How would you describe your emotional feelings when you are conducting/helping to conduct a TOP procedure?

| Very comfortable | Comfortable | Uncertain | Uncomfortable | Very uncomfortable |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

60. Do your emotional feelings differ from client to client, depending on the circumstances?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 61** |
| No | 2 | **Go to Q 62** |

61. **If yes**, please explain…

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

62. Has your position (i.e. working with TOPs) affected your professional relationship with your colleagues?

| Yes | 1 | **Go to Q 63** |
|---|---|---|
| No | 2 | **Go to Q 63** |

63. **If yes**, how has this affected your professional relationship?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

64. Since you have started working with TOPs, how often have you…

| | Always | Regularly | Sometimes | Seldom | Never |
|---|---|---|---|---|---|
| 64.1 felt isolated from colleagues <u>not</u> doing TOPs? | 1 | 2 | 3 | 4 | 5 |
| 64.2 been victimised by colleagues not doing TOPs? | 1 | 2 | 3 | 4 | 5 |
| 64.3 felt guilty about doing TOPs? | 1 | 2 | 3 | 4 | 5 |
| 64.4 felt resentful of patients requesting TOPs? | 1 | 2 | 3 | 4 | 5 |
| 64.5 been harassed by colleagues not doing TOPs? | 1 | 2 | 3 | 4 | 5 |
| 64.6 thought that colleagues who refuse to do TOPs are wrong? | 1 | 2 | 3 | 4 | 5 |
| 64.7 thought that TOP should not be within the scope of practice of a registered nurse? | 1 | 2 | 3 | 4 | 5 |
| 64.8 refused to assist with a TOP? | 1 | 2 | 3 | 4 | 5 |
| 64.9 been pressurised to conduct TOPs that you felt should not be done? | 1 | 2 | 3 | 4 | 5 |
| 64.10 been in disagreement with family members/friends about your involvement in TOP procedures? | 1 | 2 | 3 | 4 | 5 |
| 64.11 been in disagreement with community members about your involvement in TOP procedures? | 1 | 2 | 3 | 4 | 5 |

65. Would you like to elaborate on any of the above responses?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

66. What are the main **problems** that **you face** when having to provide TOP services?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

67. How can these problems be solved?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

68. What **factors** have mainly contributed towards the **smooth running** of your TOP facility?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

**Thank you for taking the time to participate in this survey**

| Interview Schedule for TOP Service Providers (2003) | Official use |
|---|---|

Date of interview: ______________________

Name of interviewer: ______________________

Name of facility:

| | | | |
|---|---|---|---|
| National Hospital | | Kopano Clinic | |
| Moroka Hospital | | Elizabeth Ross Hospital | |

**Section A**

**Instructions: All respondents should respond to this section of the questionnaire.**

**Section A: Part One**

**Background information**

1. Gender:

| | | | |
|---|---|---|---|
| Male | | Female | |

2. How old are you (age at past birthday)? ______________ years

3. Indicate your occupational category

| | |
|---|---|
| TOP facility manager | |
| Registered midwife | |
| Registered nurse | |
| Staff nurse | |
| Nursing assistant | |
| Social worker | |
| General practitioner | |
| Gynaecologist | |
| Other (specify) | |

4. What role do you play at this TOP facility (e.g. counsel patients; perform TOPs)?

______________________

5. How long have you been working as a health care provider/social worker?

| | |
|---|---|
| Less than 1 year | |
| 1-3 years | |
| 4-6 years | |
| 7-9 years | |
| 10 years+ | |

6. How long have you been working at this TOP facility?

______________ Years ______________ Months

7. Have you worked at any of the other TOP facilities?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If yes**:

8. Which other facility did you work at? ______________________

9. How long did you work at that facility? ______________________

10. Why did you leave the facility? ______________________

11. How did you become involved in providing TOP services?

______________________

______________________

______________________

| **Section A: Part Two<br>Quality of TOP services** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 12. Please evaluate the following services provided at the TOP facility? | | | | | | | | Official use |
| | Is it provided? Yes | No | Good | Average | Poor | Uncertain | Please explain. | |
| 12.1 Pre-counselling | | | | | | | | |
| 12.2 Post-counselling | | | | | | | | |
| 12.3 Examination | | | | | | | | |
| 12.4 Procedure | | | | | | | | |
| 12.5 Information regarding TOP given to the client | | | | | | | | |
| 12.6 After care of clients | | | | | | | | |

13. Please evaluate the following aspects of the physical structure of the TOP facility

| | How many? | Non-existent | Good | Average | Poor | Uncertain | Please explain. |
|---|---|---|---|---|---|---|---|
| 13.1 Reception area | ■ | | | | | | |
| 13.2 Waiting area | ■ | | | | | | |
| 13.3 Consulting rooms | | | | | | | |
| 13.4 Counselling rooms | | | | | | | |
| 13.5 Recovery area (beds) | | | | | | | |
| 13.6 Toilets | | | | | | | |
| 13.7 Visual privacy | ■ | | | | | | |
| 13.8 Auditory privacy | ■ | | | | | | |
| 13.9 Staff rest room | ■ | | | | | | |
| 13.10 Office space for staff | | | | | | | |

| Section A: Part Three<br>Attitudes towards TOP | | | | | | | |
|---|---|---|---|---|---|---|---|
| 14. Do you agree or disagree with the following statements | | | | | | | Official use |
| SA=Strongly agree, A=Agree, U=Uncertain, D=Disagree, SD=Strongly disagree | SA | A | U | D | SA | Please explain. | |
| 14.1 TOP should not be legal | | | | | | | |
| 14.2 TOP is justified under all circumstances | | | | | | | |
| 14.3 A woman has the right to make her own decisions concerning her body | | | | | | | |
| 14.4 TOP should be an alternative when contraceptives fail | | | | | | | |
| 14.5 People would support the right of women to have a TOP if they knew more about it | | | | | | | |
| 14.6 My religion prevents me from accepting TOP | | | | | | | |
| 14.7 TOP is justified for minors | | | | | | | |
| 14.8 A 14 year old requesting a TOP should be subject to a different set of rules compared to a 17 year old requesting a TOP | | | | | | | |
| 14.9 There should be stricter rules governing minors' access to TOP | | | | | | | |
| 14.10 Persons under 18 years of age should first consult their parents before being allowed a TOP | | | | | | | |
| 14.11 Persons under 18 years of age should first obtain the consent of their parents before being allowed a TOP | | | | | | | |
| 14.12 TOP service providers should first obtain consent of both parents before performing a TOP in a minor | | | | | | | |
| 14.13 TOP service providers should first obtain the consent of at least one parent before performing a TOP in a minor | | | | | | | |
| 14.14 Social and financial problems are sufficient reasons for adults requesting a TOP | | | | | | | |
| 14.15 Social and financial problems are sufficient reasons for minors requesting a TOP | | | | | | | |
| 14.16 Since the grounds for TOP have been extended, people have become careless with contraceptives | | | | | | | |
| 14.17 A woman should only be allowed to have a TOP if her partner agrees | | | | | | | |
| 14.18 Women should feel ashamed if they have a TOP | | | | | | | |

| 15. In general, what is your opinion about TOP on request during the first 12 weeks of pregnancy, as currently stipulated by law in South Africa? | Official use |
|---|---|
| | |
| | |
| 16. In general, what is your opinion about TOP being allowed for minors without parental consent? | |
| | |
| | |
| 17. How would you describe your work morale (**Interviewer: Probe for an explanation.**) | |
| | |
| | |
| 18. What is affecting your work morale? | |
| | |
| | |

19. Have you attended an abortion values clarification workshop?

| Yes | |
|---|---|
| No | |

**Interviewer**: If no skip to

**20. Interviewer: If yes ask:** When did you attend the workshop (date – year and month) (**Interviewer:** If more than one workshop was attended, obtain the dates of all workshops, questions 21-26 pertain to the respondents overall opinion of the workshops)

21. How did you experience the workshop(s)?

| Indispensable | |
|---|---|
| Of limited use | |
| A waste of time | |

22. Please explain.

| | |
|---|---|
| | |
| | |
| | |

23. Did your opinions or attitudes regarding TOP change during/after the workshop(s)?

| Yes | |
|---|---|
| No | |

24. Please explain (in both cases).

| | |
|---|---|
| | |
| | |

25. Do you think that by attending this/these workshop(s), your effectiveness in dealing with TOP clients has improved or not?

| Has improved in dealing with minors | |
|---|---|
| Has improved in dealing with adults | |
| Has not improved in dealing with minors | |
| Has not improved in dealing with adults | |

| 26. Please explain (in both cases). | Official use |
|---|---|
| | |
| | |
| | |
| | |

**Section A: Part Four**
**Availability of support**

27. Is there any psychological support available for TOP service providers?

| Yes | |
|---|---|
| No | |

28. **Interviewer: If no ask:** Would you like psychological support to be available?

| Yes | |
|---|---|
| No | |

**29. Interviewer: If yes ask:** Where is this support offered?

30. Who provides this support?

31. What does this support entail?

32. Do you make use of this support?

| Yes | |
|---|---|
| No | |

33. Please explain. (in both cases)

**Section A: Part Five**
**Youth-friendly services**

34. Has your facility put any special provisions (procedures or services) in place to facilitate minors' access to TOP services?

| Yes | |
|---|---|
| No | |

**35. Interviewer: If yes ask:** What does this entail?

| **36. Interviewer: If no ask:** Why not? | Official use |
|---|---|
| | |
| | |

37. Does your facility make any provisions for representing the youth (e.g. a youth on the clinic committee)?

| | |
|---|---|
| Yes | |
| No | |

38. Does this facility have any outreach activities in place specifically for the youth?

| | |
|---|---|
| Yes | |
| No | |

**39. Interviewer: If yes ask:** Please elaborate.

| |
|---|
| |
| |

40. Do you have any difficulties with minors requesting a TOP?

| | |
|---|---|
| Yes | |
| No | |

41. Please explain.

| |
|---|
| |
| |
| |

**Section B**

**Instructions: Only TOP facility managers should complete this section of the questionnaire**

42. Please can you show me what policy documents you use for TOP? (record names)

| |
|---|
| |
| |

**43. Interviewer: If no document relates specifically to minors and TOP ask:** Do you have any policy documents regarding minors and TOP?

| | |
|---|---|
| Yes | |
| No | |

**44. Interviewer: If yes ask:** Please can you show me these documents (record names)

| |
|---|
| |

45. How many of the following members of staff (at this facility) are providing TOP services
   i) full-time
   ii) part-time

| | Full-time | Part-time |
|---|---|---|
| General practitioners | | |
| Gynaecologists | | |
| Registered midwives (Trained to do TOP procedures) | | |
| Registered midwives (Not yet trained to do TOP procedures) | | |
| Registered nurses | | |
| Staff nurses | | |
| Nursing assistants | | |
| Social workers | | |

| 46. Who is providing counselling for TOP patients at this facility? | | | | | Official use |
|---|---|---|---|---|---|
| | Full-time | Part-time | Trained to provide counselling? | | |
| | | | Yes | No | |
| Registered midwives | | | | | |
| Registered nurses | | | | | |
| Staff nurses | | | | | |
| Nursing assistants | | | | | |
| Social workers | | | | | |
| Other: _________________ | | | | | |
| Other: _________________ | | | | | |
| Other: _________________ | | | | | |

47. Has someone specifically been assigned to counsel minors?

| Yes | |
|---|---|
| No | |

48. Please explain.

49. Is your staff component sufficient to provide TOP services?

| Yes | |
|---|---|
| No | |

**50. Interviewer: If no ask:** How many additional members of staff do you need in the following categories?

| | Number of additional staff needed |
|---|---|
| General practitioners | |
| Gynaecologists | |
| Registered midwives | |
| Registered nurses | |
| Staff nurses | |
| Nursing assistants | |
| Social workers | |
| Clerks | |
| Cleaners | |
| Other (specify) | |

51. If there is a shortfall, what measures do you take to compensate for the shortfall in staff?

| 52. To what extent do you have access to the following personnel/equipment/services at your facility? | | | | | Official use |
|---|---|---|---|---|---|
| Do you have sufficient… | Yes | No | Uncertain | If no, please explain. | |
| 52.1 willing medical practitioners to perform TOPs for adults? | | | | | |
| 52.2 willing medical practitioners to perform TOPs for minors? | | | | | |
| 52.3 willing nursing personnel for to perform TOPs for adults? | | | | | |
| 52.4 willing nursing personnel to perform TOP for minors? | | | | | |
| 52.5 trained medical practitioners to perform TOPs for adults? | | | | | |
| 52.6 trained medical practitioners to perform TOPs for minors? | | | | | |
| 52.7 trained registered midwives for TOP? | | | | | |
| 52.8 counsellors for adults? | | | | | |
| 52.9 counsellors for minors? | | | | | |
| 52.10 trained counsellors? | | | | | |
| 52.11 appropriate surgical equipment? | | | | | |
| 52.12 emergency resuscitation equipment and drugs? | | | | | |
| 52.13 transport in the case of an emergency? | | | | | |
| 52.14 facilities for clinical observation? | | | | | |
| 52.15 equipment for clinical observation | | | | | |
| 52.16 inpatient facilities | | | | | |
| 52.17 appropriate infection control measures | | | | | |
| 52.18 safe waste disposal infrastructure | | | | | |
| 52.19 telephones | | | | | |

| 53. On average, per day: | Pre-counselling | Post-counselling | Examination | MVA | | Official use |
|---|---|---|---|---|---|---|
| How many adult women are seen for: | | | | | | |
| How many minor girls are seen for: | | | | | | |
| How much time is spent on: | minutes | minutes | minutes | minutes | | |
| How much time is spent on (observe): | minutes | minutes | minutes | minutes | | |

54. What are the main challenges experienced by your facility with regard to the following categories? What solutions can you suggest?

| | **Problems experienced** | **Possible solutions** |
|---|---|---|
| 54.1 Pre-counselling | | |
| 54.2 Post- Counselling | | |
| 54.3 MVA | | |
| 54.4 Inductions | | |
| 54.5 Adult clients | | |
| 54.6 Minor clients | | |
| 54.7 Staff | | |
| 54.8 Facilities | | |
| 54.9 Equipment | | |
| 54.10 Other (specify) | | |
| 54.11Other (specify) | | |

| Section C<br>**Instructions: Only persons providing counselling to TOP clients should complete this section of the questionnaire** | Official use |
|---|---|

55. On average how much time is spent on:

| | **Minutes/minor patient** | **Minutes/adult patient** |
|---|---|---|
| Pre-counselling | | |
| Post-counselling | | |

56. Have you received specific training to conduct counselling for persons requesting TOP?

| Yes | |
|---|---|
| No | |

**Interviewer: if yes please ask the following questions**:
57. When did you receive this training (month and year)
**Interviewer: If more than once, record all the dates**.

58. What did the training entail?
**Interviewer: If more than once record the dates and what each training entailed on a separate line**

**Interviewer: This question refers to the training received in general.**
59. Has the training that you received adequately prepared you to counsel TOP clients?

| Yes | |
|---|---|
| No | |

60. If no, in what areas of counselling (pre and post) do you feel that you lack knowledge and skills?

61. Have you received specific training to conduct counselling for minors requesting TOP?

| Yes | |
|---|---|
| No | |

**Interviewer: If yes please ask the following questions**:
62. When did you receive this training (month and year)
**Interviewer: If more than once, record all the dates**.

| 63. What did the training entail?<br>**Interviewer: If more than once, record the dates and what each training entailed on a separate line** | Official use |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Interviewer: This question refers to the training received in general.**
64. Has the training that you received adequately prepared you to counsel minors requesting TOP?

| Yes | |
|---|---|
| No | |

65. If no, please specify what training needs you have.

| |
|---|
| |
| |
| |

66. Does the procedure followed when counselling a minor differ from that followed when counselling an adult woman?

| Yes | |
|---|---|
| No | |

67. Please explain.

| |
|---|
| |
| |
| |

68. What are the special needs of minors in counselling?

| |
|---|
| |
| |
| |

69. What procedure is followed if it is clear that the minor does not understand what she is doing (i.e. not mature enough to consent to the termination)?

| |
|---|
| |
| |
| |
| |
| |

| 70. What are the main problems/constraints that you face when having to provide TOP counselling for i) adults and ii) minors? | Official use |
|---|---|
| 70.1 Adults | |
| | |
| | |
| | |
| 70.2 Minors | |
| | |
| | |
| | |
| 71. How can these problems be solved? | |
| | |
| | |
| | |

**Section D**

**Instructions: Only persons doing/assisting with TOP procedures should complete this section of the questionnaire**

72. Do you take a thorough sexual history before examining a minor patient?

| Yes | |
|---|---|
| No | |

**73. Interviewer: If no ask**, what hinders you from taking a thorough history from a minor patient?

74. On average how much time is spent on:

| | Minutes/minor patient | Minutes/adult patient |
|---|---|---|
| Examination | | |
| MVA | | |

75. Have you received specific training to conduct TOPs?

| Yes | |
|---|---|
| No | |

**Interviewer: If yes please ask the following questions.**
76. When did you receive this training (month and year)
**Interviewer, if more than once, record all the dates**.

77. What did the training entail?
**Interviewer: If more than once record the dates and what each training entailed on a separate line.**

| | Official use |
|---|---|
| **Interviewer: this question refers to the training received in general.**<br>78. Has the training that you received adequately prepared you to conduct TOPs?<br>Yes [ ]<br>No [ ] | |
| 79. If no, where do you experience a shortfall in knowledge and skills?. | |
| | |
| | |
| | |
| 80. Have you received specific training to conduct TOPs for minors?<br>Yes [ ]<br>No [ ] | |
| **Interviewer: If yes please ask the following questions**.<br>81. When did you receive this training (month and year) specifically related to conducting TOPS for minors?<br>**Interviewer: If more than once, record all the dates**. | |
| | |
| 82. What did the training entail?<br>**Interviewer: If more than once record the dates and what each training entailed on a separate line.** | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| **Interviewer: This question refers to the training received in general (relating to minors).**<br>83. Has the training that you received adequately prepared you to conduct TOPs for minors?<br>Yes [ ]<br>No [ ] | |
| 84. If no, please specify what training needs you have. | |
| | |
| | |
| | |
| 85. What are the special needs of minors with regard to the TOP procedures? | |
| | |
| | |
| | |
| | |

| 86. How often do you deal with situations such as the following? | Always | Regularly | Sometimes | Seldom | Never | Official use |
|---|---|---|---|---|---|---|
| Medication is not available | | | | | | |
| Equipment is inadequate | | | | | | |
| Insufficient time, too many patients to see | | | | | | |
| Staff for TOP not available | | | | | | |

87. How would you describe your emotional feelings when you are conducting/helping to conduct a TOP procedure?

| Very comfortable | Comfortable | Uncertain | Uncomfortable | Very Uncomfortable |
|---|---|---|---|---|
| | | | | |

88. Do your emotional feelings differ from client to client depending on the circumstances?

| Yes | |
|---|---|
| No | |

**89. Interviewer: If yes ask:** Please explain.

90. Has your position (i.e. working with TOP) affected your professional relationship with your colleagues?

| Yes | |
|---|---|
| No | |

**91. Interviewer: If yes ask:** How has this affected your professional relationship?

| 92. Since you have started working with TOPs, how often have you… | | | | | | | Official use |
|---|---|---|---|---|---|---|---|
| | Always | Regularly | Sometimes | Seldom | Never | Please elaborate. | |
| 92.1 felt isolated from colleagues who are not doing TOPs? | | | | | | | |
| 92.2 been victimised by colleagues who are not doing TOPs? | | | | | | | |
| 92.3 been victimised by parents of minors wanting a TOP? | | | | | | | |
| 92.4 felt guilty about doing TOPs? | | | | | | | |
| 92.5 felt resentful of patients requesting TOPs? | | | | | | | |
| 92.6 been harassed by colleagues not doing TOPs? | | | | | | | |
| 92.7 been harassed by parents of minors who underwent a TOP without their consent? | | | | | | | |
| 92.8 thought that TOP should not be within the scope of practice of a registered nurse? | | | | | | | |
| 92.9 refused to assist with a TOP? | | | | | | | |
| 92.10 been pressurised to conduct TOPs that you felt should not be done? | | | | | | | |
| 92.11 been in disagreement with family members/friends about your involvement in TOP? | | | | | | | |
| 92.12 been in disagreement with community members where you live about your involvement in TOP? | | | | | | | |
| 92.13 been ostracised by your church because of TOP? | | | | | | | |
| 92.14 been consulted by a minor who emotionally was not ready to consent to a TOP? | | | | | | | |
| 92.15 thought that minors need parental consent to have a TOP? | | | | | | | |

| 93. What are the main problems/challenges you face when having to provide TOP services?<br>93.1 Adults | Official use |
|---|---|
| | |
| | |
| | |
| | |
| 93.2 Minors | |
| | |
| | |
| | |
| | |
| 94. How can these problems be solved?<br>94.1 Adults | |
| | |
| | |
| | |
| | |
| 94.2 Minors | |
| | |
| | |
| | |
| | |
| 95. What key factors have mainly contributed towards the smooth running of your TOP facility? | |
| | |
| | |
| | |
| 96. What key factors have mainly hampered the smooth running of your TOP facility? | |
| | |
| | |
| | |
| | |

## Delivery of TOP services in the Free State:
## User Interview Schedule (1998)

### Section A: Biographical and Background Information

1. Age:

| | |
|---|---|
| 15 years or younger | 1 |
| 16 - 18 years | 2 |
| 19 - 25 years | 3 |
| 26 - 40 years | 4 |
| older than 40 years | 5 |

2. Marital status:

| | |
|---|---|
| Single | 1 |
| Married | 2 |
| Divorced | 3 |
| Widowed | 4 |
| Separated | 5 |
| Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | |

3. In which town/city do you live?

_______________________________________________

4. Are you living with your partner?

| | |
|---|---|
| Yes | 1 |
| No | 2 |

5. What is the highest educational level that you have completed?

| | |
|---|---|
| None | 1 |
| Sub A - B/Grade 1 - 2 (Junior Primary School) | 2 |
| Std 1-5/Grade 3 - 7 (Primary school) | 3 |
| Std 6-10/Grade 8 - 12 (High school) | 4 |
| Tertiary education | 5 |
| Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | |

6. Are you currently employed?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 7** |
| No | 2 | **Go to Q 8** |

7. **If yes**, what is your occupation? (**Go to Q9**)

_______________________________________________

_______________________________________________

8. If you are unemployed, are you a …

| | |
|---|---|
| Student/scholar | 1 |
| Housewife | 2 |
| Seeking work | 3 |
| Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | |

9. How many previous pregnancies have you had (**excluding** the one that was terminated)?(**If none, go to Q 15**)

______________________________________________________________

10. Have you ever undergone an induced/spontaneous abortion prior to this one?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 11** |
| No | 2 | **Go to Q 15** |

11. **If yes**, how many previous induced/spontaneous abortions (excluding this one) have you undergone?
11.1 induced abortions:________________________ **Go to Q 12**
11.2 spontaneous abortions:____________________ **Go to Q 15**

12. Where did you undergo these terminations?

______________________________________________________________
______________________________________________________________
______________________________________________________________

13. Who performed these terminations?

______________________________________________________________
______________________________________________________________
______________________________________________________________

14. What were your reason(s) for these terminations?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

15. When did you find out that you were pregnant this time? (**i.e. how many weeks**)

______________________________________________________________

16. What were your reasons for having this pregnancy terminated?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

17. How many weeks/months were you pregnant at the time of this termination?

__________ weeks or __________ months

18. Was the procedure for MVA (Manual Vacuum Aspiration) or induction?

| | |
|---|---|
| MVA | 1 |
| Induction | 2 |
| Uncertain | 3 |

**Section B: Accessibility**

19. Which TOP facility did you make use of to terminate your pregnancy?

| | |
|---|---|
| Pelonomi Hospital | 1 |
| Elizabeth Ross Hospital | 2 |
| Kopano Clinic | 3 |
| Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | |

20. Were you referred to this facility, or did you decide to go there out of your own initiative?

| | | |
|---|---|---|
| Referred by a health worker | 1 | **Go to Q 22** |
| Referred by family/friends | 2 | **Go to Q 25** |
| Went there out of my own | 3 | **Go to Q 21** |

21. How did you come to know about this facility?(**Go to Q 26**)

____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

22. Was transport arranged for you to the TOP facility by the referring person?

| | |
|---|---|
| Yes | 1 |
| No | 2 |

23. Did you experience any difficulties with the health care provider who referred you to this facility?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 24** |
| No | 2 | **Go to Q 25** |

24. **If yes**, what difficulties did you experience with this person?

____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

25. How many TOP facilities did you visit before being helped at this facility?

____________________________________________________________

26. At this facility, was your name put on a waiting list before they could do the procedure?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 27** |
| No | 2 | **Go to Q 28** |
| Uncertain | 3 | **Go to Q 28** |

27. **If yes**, how long did you wait before they did the procedure? (**days**)

________________ days

28. How many times were you requested to come back to this facility before the TOP procedure was done? (**If once or twice, go to Q 30)**

___________________________________________________________________

29. **If more than twice, ask** why?

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

30. Did you have to pay any fees/anything at the TOP facility for the termination?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 31** |
| No | 2 | **Go to Q 33** |

31. **If yes**, to whom did you have to pay fees/give something? (**Not names, career categories**)

___________________________________________________________________

32. Approximately how much did you have to pay/What did you have to give?

______________________________________________________
_____________

33. Approximately how long did it take you to get to the TOP facility from your home?

__________ hours ____________minutes

34. How did you get to the TOP facility?

| | | |
|---|---|---|
| Car | 1 | |
| Bus | 2 | |
| Taxi | 3 | |
| Walk | 4 | **Go to Q 40** |
| Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | | |

35. Did you have to pay for transport?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 36** |
| No | 2 | **Go to Q 40** |

36. **If yes**, approximately how much did it cost you to get to this TOP facility and back ?

R_________________

37. Were you able to afford the transportation costs?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 39** |
| No | 2 | **Go to Q 38** |

38. **If no**, how did you deal with this problem?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

39. What problems did you experience with transportation to this TOP facility?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

40. Did you have to arrange for accommodation when you came to the TOP facility?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 41** |
| No | 2 | **Go to Q 47** |

41. **If yes**, where did you arrange to stay, when coming to the TOP facility? (**Places not names of people**)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

42. Did you have to pay to stay at this place?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 43** |
| No | 2 | **Go to Q 46** |

43. **If yes**, approximately what was the total amount that you paid for accommodation?

R___________________

44. Were you able to afford this amount for accommodation?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 46** |
| No | 2 | **Go to Q 45** |

45. **If no**, how did you deal with this problem?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

46. What problems did you experience with accommodation (if any)?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Section C: User Friendliness of the TOP Facility**

47. How were you treated at the TOP facility?

| | Very well | Well | Uncertain | Poorly | Very poorly | NA |
|---|---|---|---|---|---|---|
| 47.1 by reception | 1 | 2 | 3 | 4 | 5 | 6 |
| 47.2 by nurses | 1 | 2 | 3 | 4 | 5 | 6 |
| 47.3 by doctors | 1 | 2 | 3 | 4 | 5 | 6 |
| 47.4 by counsellors | 1 | 2 | 3 | 4 | 5 | 6 |
| 47.5 by other patients | 1 | 2 | 3 | 4 | 5 | 6 |
| 47.6 by security guards | 1 | 2 | 3 | 4 | 5 | 6 |
| 47.7 by cleaners | 1 | 2 | 3 | 4 | 5 | 6 |
| 47.8 other persons _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ | 1 | 2 | 3 | 4 | 5 | 6 |

48. **Only if very poorly/poorly**, please explain…

48.1 reception ____________________________________________________
______________________________________________________________________
______________________________________________________________________

48.2 nurses ______________________________________________________
______________________________________________________________________
______________________________________________________________________

48.3 doctors _____________________________________________________
______________________________________________________________________
______________________________________________________________________

48.4 counsellors __________________________________________________
______________________________________________________________________
______________________________________________________________________

48.5 by other patients ____________________________________________
______________________________________________________________________
______________________________________________________________________

48.6 by security guards ___________________________________________
______________________________________________________________________
______________________________________________________________________

48.7 by cleaners _________________________________________________
______________________________________________________________________
______________________________________________________________________

48.8 other persons _______________________________________________
______________________________________________________________________
______________________________________________________________________

**Section D: Services Provided at the TOP facility**

49. How satisfied were you with the following services at the TOP facility?

| | Very satisfied | Satisfied | Uncertain | Dissatisfied | Very dissatisfied | Did not want service | Service not available/not offered |
|---|---|---|---|---|---|---|---|
| 49.1 Pre-Counselling | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 49.2 Post-Counselling | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 49.3 Examination | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 49.4 TOP procedure (MVA and/or induction) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 49.5 Information on TOP that was given to you | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 49.6 Information on contraceptive methods and provision of contraceptives | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

50. **Only if very dissatisfied/dissatisfied**, please explain your answer…

50.1 pre counselling ______________________________________________

______________________________________________________________

______________________________________________________________

50.2 post counselling _____________________________________________

______________________________________________________________

______________________________________________________________

50.3 examination _________________________________________________

______________________________________________________________

______________________________________________________________

50.4 TOP procedure (MVA and/or induction)____________________________

______________________________________________________________

______________________________________________________________

50.5 information on TOP that was given to you __________________________

______________________________________________________________

______________________________________________________________

50.6 information on contraceptive methods and provision of contraceptives ______

______________________________________________________________

______________________________________________________________

51. Did you receive counselling prior to the termination?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 52** |
| No | 2 | **Go to Q 56** |

52. **If yes**, did you receive counselling in front of other people or were you alone with the counsellor?

| | | |
|---|---|---|
| In front of other people | 1 | **Go to Q 53** |
| Alone | 2 | **Go to Q 54** |

53. **If in front of other people**, please explain your answer…

______________________________________________________________
______________________________________________________________
______________________________________________________________

54. Did the counsellor explain other options, than to have a TOP, to you?

| Yes | 1 |
|---|---|
| No | 2 |

55. Approximately, how much time did the counsellor spend counselling you prior to the termination?

____________ Minutes

56. Did you receive counselling after the termination?

| Yes | 1 | **Go to Q 57** |
|---|---|---|
| No | 2 | **Go to Q 58** |

57. **If yes**, approximately how much time did the counsellor spend with you?

___________________Minutes

58. Were you examined by a midwife/doctor **in front of other people** or were you **alone** with the midwife/doctor?

| In front of other people | 1 | **Go to Q 59** |
|---|---|---|
| Alone | 2 | **Go to Q 60** |

59. **If in front of other people**, please explain your answer…

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

60. Approximately how much time did the midwife/doctor spend examining you?

___________________Minutes

61. Was the termination procedure conducted in conditions of privacy?

| Yes | 1 | **Go to Q 63** |
|---|---|---|
| No | 2 | **Go to Q 62** |

62. **If no**, please explain your answer…

______________________________________________________________
______________________________________________________________
______________________________________________________________

63. Approximately how long did the termination take to be completed?
_________________ Minutes

64. Did you at any stage, while at the TOP facility or afterwards, feel that the staff did not treat information that you gave to them as confidential?

| Yes | 1 | **Go to Q 65** |
|---|---|---|
| No | 2 | **Go to Q 66** |

65. **If yes**, please explain your answer…

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

66. Describe how you felt…
66.1 before the termination______________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

66.2 during the termination______________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

66.3 after the termination_______________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

67. **In the case of a minor (i.e. a person 18 years and younger)ask:** Were you asked to consult with parents, guardians, family members or friends prior to the termination?

| | |
|---|---|
| Yes | 1 |
| No | 2 |

**Section E: Family and Friends**

68. Do you have a male partner?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 69** |
| No | 2 | **Go to Q 73** |

69. Did you discuss with your partner that you wanted to terminate your pregnancy?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 71** |
| No | 2 | **Go to Q 70** |

70. What were your main reasons for not discussing this with your partner?
(**Go to Q 73**)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

71. What was your partner's reaction when you told him that you were considering terminating your pregnancy?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

72. How did you feel about your partner's reaction to this?

73. Did you discuss with any member of your family that you wanted to terminate your pregnancy?

| Yes | 1 | **Go to Q 75** |
|---|---|---|
| No | 2 | **Go to Q 74** |

74. What were your main reasons for not discussing this with your family?
(**Go to Q 78**)

75. With whom, in your family, did you discuss that you wanted to terminate your pregnancy?

76. What was your family member's reaction when you told them that you were considering terminating your pregnancy?

77. How did you feel about your family member's reaction to this?

78. Did you discuss with any of your friends that you wanted to terminate your pregnancy?

| Yes | 1 | **Go to Q 80** |
|---|---|---|
| No | 2 | **Go to Q 79** |

79. What were your main reasons for not discussing this with any of your friends?
(**Go to Q 82**)

80. What were your friends' reaction when you told them that you were considering terminating your pregnancy?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

81. How did you feel about your friends' reaction to this?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

82. Did you talk to anybody else (apart from the above persons) about your intention to terminate your pregnancy?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 83** |
| No | 2 | **Go to Q 86** |

83. Who did you talk to? (**Category not name**)

______________________________________________________________

84. How did they/he/she react to this?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

85. How did you feel about their/his/her reaction to this?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

86. Did you tell anyone about the termination, **after** you had had it done?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 87** |
| No | 2 | **Go to Q 89** |

87. Who did you tell?

______________________________________________________________

88. How did they/he/she react to this?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

## Section F: Knowledge of the ACT and TOP

89. Where did you first hear about the new law permitting TOPs?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

90. I am going to put a number of statements to you. Tell me whether you believe the statement to be true or false.:

| | True | False | Uncertain |
|---|---|---|---|
| 90.1 Abortion is **only** available during the first twelve weeks of pregnancy and not thereafter. | 1 | 2 | 3 |
| 90.2 Your partner must give consent for a termination to be conducted. | 1 | 2 | 3 |
| 90.3 Minors do not have to obtain the consent of their parents to have a TOP | 1 | 2 | 3 |
| 90.4 TOP from the thirteenth week of pregnancy is allowed if certain requirements are met. | 1 | 2 | 3 |
| 90.5 TOP after the twentieth week is available if the continued pregnancy would endanger the life of the woman. | 1 | 2 | 3 |

91. Did you know what the clinical procedure for the termination would entail?

| | | |
|---|---|---|
| Yes | 1 | **Go to Q 92** |
| No | 2 | **Go to Q 94** |

92. **If yes**, what did it entail?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

93. Who explained this procedure to you? (**Categories not names**)

______________________________________________________________________
______________________________________________________________________

94. Now that you have had a termination, would you consider it as an option again in the future?

| | |
|---|---|
| Yes | 1 |
| No | 2 |

95. Please explain your answer…

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

## Section G: Problems and Recommendations

96. What were the most important problems that you experienced while deciding whether or not to have a termination?

______________________________________________________________

97. How did you deal with these problems?

______________________________________________________________

98. What were the most important problems that you experienced when making arrangements for the termination?

______________________________________________________________

99. How did you deal with these problems?

______________________________________________________________

100. What were the most important problems that you experienced at the TOP facility?

______________________________________________________________

101. How did you deal with these problems?

______________________________________________________________

102. What recommendations could you make that would make it easier for women who want to terminate a pregnancy?

______________________________________________________________

**Thank you for agreeing to participate in this study and for the time that you have granted for this interview**

## Questionnaire for TOP Clients (2003)

Official use

Questionnaire number
Date of interview: ______________________
Name of interviewer: ______________________

1. Name of facility:

| | |
|---|---|
| National Hospital | |
| Moroka Hospital | |
| Kopano Clinic | |
| Elizabeth Ross Hospital | |

### Section A: Biographical and background information

2. Age at last birthday (**Interviewer: Ask:** How old are you?)

______________ Years

3. Home language (**Interviewer: Ask:** What is your home language?)

4. Place of residence (**Interviewer: Ask:** Where do you live?)

5. Please name the town/city/village nearest to where you live.

6. Marital status

| | |
|---|---|
| Single | |
| Married | |
| Divorced | |
| Widowed | |
| Separated | |
| Other (specify) | |

7. Highest level of education (What is the highest standard/grade that you passed?)

| | | | |
|---|---|---|---|
| Sub A/Grade 1 | | Std 5/Grade 7 | |
| Sub B/Grade 2 | | Std 6/Grade 8 | |
| Std 1/Grade 3 | | Std 7/Grade 9 | |
| Std 2/Grade 4 | | Std 8/Grade 10 | |
| Std 3/Grade 5 | | Std 9/Grade 11 | |
| Std 4/Grade 6 | | Std 10/Grade 12 | |

**Interviewer: If the respondent has never attended school, skip to Q11**

8. School attendance (**Interviewer: If not Std 10/Grade 12, ask:**
Are you still attending school?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If yes, skip to Q14**

9. **Interviewer: If the respondent is no longer attending school, ask:**
When did you leave school? (month and year)

10. Why did you leave school?

| 11. **Interviewer: If the respondent is not attending school, ask:** Are you currently employed? | Official use |
|---|---|

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q14**

12. **Interviewer: If the respondent is currently employed, ask:**
What is your occupation?

13. What is your take home income (i.e. after tax deductions) per month?

| | |
|---|---|
| <R500 | |
| R500-R1 000 | |
| R1 001-R1 500 | |
| R1 501-R2 000 | |
| R2 001-R2 500 | |
| R2 500+ | |

Who lives in the same house as you?

| 14. Relationship to respondent | 15. Age | 16. Attending school | 17. Earning an income | 18. Amount after deductions |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**Section B: Sexual history and contraceptive use**

19. How old were you when you were first told about sex?
____________ Years

20. How old were you when you engaged in sexual intercourse for the first time?
____________ Years

21. Have you been told about contraceptives?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q24**

22. **Interviewer: If yes, ask:**
Who first told you about contraceptives?

23. How old were you when you were first told about contraceptives?
____________ Years

24. Do you currently use a contraceptive method?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q26**

25. What method do you currently use? ________________________

26. How old were you when you first started using contraceptives? | Official use

Years ______ **Interviewer: If the respondent indicates never using a contraceptive skip to question 32**

27. Have you changed contraceptive methods?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q29**

28. **Interviewer, if yes ask**,
Why did you change contraceptive methods?

29. Were you using contraceptives when you became pregnant with **this** pregnancy that was terminated?

| Yes | |
|---|---|
| No | |

30. Do you have easy access to contraceptives?

| Yes | |
|---|---|
| No | |

**Interviewer: If yes, skip to Q32**

31. **Interviewer, if no ask**,
Please explain

32. Do you know about emergency contraceptives that should be taken within 24 hours after sexual intercourse to prevent becoming pregnant?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q36**

33. Have you ever used emergency contraceptives?

| Yes | |
|---|---|
| No | |

34. Do you have easy access to emergency contraceptives?

| Yes | |
|---|---|
| No | |

35. Please explain

**Section C: Accessibility of family planning services**

36. What family planning facility do you use?

| 37. How regularly is this family planning service available? (**Interviewer: Name the facility mentioned in the response to the previous question**.) | Official use |
|---|---|

38. How do you get to the family planning facility?

| | |
|---|---|
| Car | |
| Bus | |
| Taxi | |
| Walk | |
| Other | |

39. How long does it take you to get to the family planning facility?

________________ hours ________________ minutes

40. Do you have to pay for transport to the family planning facility?

| | | |
|---|---|---|
| Yes | | |
| No | | **Interviewer: If no, skip to Q44** |

41. **Interviewer: If yes, ask:**
Approximately how much does it cost you to get to the family planning facility and back home again?

R ____________

42. Are you able to afford the transportation costs?

| | | |
|---|---|---|
| Yes | | **Interviewer: If yes, skip to Q44** |
| No | | |

43. **Interviewer: If no, ask:**
How do you deal with this problem?

44. Do you experience any other transportation problems (except money)?

| | | |
|---|---|---|
| Yes | | |
| No | | **Interviewer: If no, skip to Q46** |

45. **Interviewer: If yes, ask:**
Please explain

46. On average, how long do you wait at the family planning facility before being helped?

______________ Minutes

47. Does your partner visit the family planning facility with you?

| | | |
|---|---|---|
| Yes | | |
| No | | **Interviewer: If no, skip to Q49** |

48. **Interviewer: If yes, ask:**
What are your partner's thoughts on you using a contraceptive method?

| Section D: User friendliness of family planning services | | | | | | Official use |
|---|---|---|---|---|---|---|

49. How were you treated at the family planning service by:

| | Well | Uncertain | Poorly | Did not see | Please explain |
|---|---|---|---|---|---|
| 49.1 reception staff | | | | | |
| 49.2 nurses | | | | | |
| 49.3 doctors | | | | | |
| 49.4 other patients | | | | | |
| 49.5 security guards | | | | | |
| 49.6 cleaners | | | | | |

50. Do the hours that the family planning service is available suit you?

| | |
|---|---|
| Yes | |
| No | |

51. Please explain ______________________________

52. Does the family planning facility offer sufficient privacy for you?

| | Auditory privacy | | Visual privacy | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| 52.1 Waiting area | | | | |
| 52.2 Consultation room | | | | |
| 52.3 Examination area | | | | |

53. **Interviewer: If no, ask:** Please explain.

53.1 Waiting room (auditory privacy) ______________________________
53.2 Waiting room (visual privacy) ______________________________
53.3 Consultation room (auditory privacy) ______________________________
53.4 Consultation room (visual privacy) ______________________________
53.5 Examination area (auditory privacy) ______________________________
53.6 Examination area (visual privacy) ______________________________

| Section E: Services provided at the family planning facility | | | | | | | |
|---|---|---|---|---|---|---|---|
| 54. How satisfied were you with the following services provided at the family planning facility? | | | | | | | Official use |
| | Satisfied | Uncertain | Dissatisfie d | Service not needed | Service not available | **Interviewer: If dissatisfied ask:** Please explain | |
| 54.1 Information given to you about contraceptive methods | | | | | | | |
| 54.2 Examination | | | | | | | |
| 54.3 Provision of contraceptives | | | | | | | |

| 55. Did you have to pay for the family planning service? | | | |
|---|---|---|---|
| | Yes | No | **Interviewer: If yes, ask:** Please explain (also include the amount/type of payment) |
| 55.1 To see the nurse | | | R |
| 55.2 To see the doctor | | | R |
| 55.3 For a contraceptive method | | | R |

## Section F: Pregnancy and termination history

Official use

56. How many previous pregnancies have you had (excluding the most recent one that was terminated)? (All pregnancies, including those that did not result in childbirth)
**Interviewer: If none skip to question 61**

57. Have you ever undergone an induced or spontaneous (miscarriage) abortion prior to this one?

| | Yes | No |
|---|---|---|
| 57.1 Induced abortion | | |
| 57.2 Spontaneous abortion | | |

58. **Interviewer: If yes for either induced or spontaneous abortions, ask:**
How many previous induced or spontaneous abortions (excluding the current one) have you undergone?
58.1 Induced abortions ______________
58.2 Spontaneous abortions ______________

59.1 **Interviewer: If the respondent has had previous induced termination, ask:**
Where did you have the induced termination(s) of pregnancy?

59.2 Who performed this/these terminations? (**Interviewer: determine whether it was a qualified doctor or midwife, or someone unqualified, i.e. not names but professional capacity**)

59.3 When did you have this/these termination(s)?

60. What was your reason(s) for this/these terminations?

61. When did you find out that you were pregnant this time (i.e. at how many weeks)?
______________ Weeks

62. How many weeks/months were you pregnant at the time of this termination
______________ Weeks or ______________ Months

63. **Interviewer: If the respondent was more than 12 weeks pregnant, ask:**
Why did you delay in seeking a termination of pregnancy?

## Section G: Health seeking behaviour

64. How did you know that you were pregnant this time?

| 65. Whom did you first consult when you discovered that you were pregnant this time? | Official use |
|---|---|

66. Why did you consult this person?

67. **Interviewer: If the father of the baby was not mentioned in Q65, ask:**
Did you discuss this pregnancy with the father of the baby?

| Yes | |
|---|---|
| No | |

68. Please explain.

69. **Interviewer: If peers/friends were not mentioned in Q65, ask:**
Did you discuss this pregnancy with your peers?

| Yes | |
|---|---|
| No | |

70. Please explain.

71. Why did you decide to terminate this pregnancy?

72. Were you i) referred to *facility* (**Interviewer: Name the facility)** where you terminated your pregnancy, or ii) did you decide to go there out of your own?

| Referred by a health worker | |
|---|---|
| Referred by family (specify relationship) | |
| Referred by friend | |
| Went there out of my own | |

73. **Interviewer: If the respondent went to the facility out of her own, ask:**
How did you come to know about this facility?

| Section H: Accessibility of the TOP facility | |
|---|---|
| | Official use |

74. **Interviewer: If the respondent was not referred to the TOP facility by a health worker, skip Questions 74-78.**
Did you experience any problems with the health worker who referred you to the TOP facility?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q76**

75. **Interviewer: If yes, ask**,:
What difficulties did you experience with this person?

76. Did you have to ask more than one health worker to refer you to a TOP facility?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q78**

77. **Interviewer: If yes, ask:**
Please explain

78. Did the health worker arrange transport for you to the TOP facility?

| | |
|---|---|
| Yes | |
| No | |

79. Did you have to visit other TOP facilities before you were helped at *facility* (**Interviewer: Name the facility**)?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q81**

80. **Interviewer: If yes, ask**:
Please explain

81. Was your name put on a waiting list at *facility* (**Interviewer: Name the facility**) before the procedure was done?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q83**

82. **Interviewer: If yes, ask:**
How long did you wait (in days) before they did the procedure?
________________ Days

83. How many times were you asked to return to the TOP facility before the procedure was done?

| | Official use |
|---|---|
| 84. **Interviewer: If more than twice, ask**:<br>Why did you have to return so many times? | |

85. Did you have to pay any fees/give anything at the TOP facility for the procedure to be done?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q88**

86. **Interviewer: If yes, ask**:
To whom did you have to pay fees/give something? (Not names, job category e.g. clerk)

87. Approximately how much did you pay/what did you give?

88. How did you get to the TOP facility?

| Car | |
|---|---|
| Bus | |
| Taxi | |
| Walk | |
| Other | |

89. How long did it take you to get to the TOP facility?
__________________ Hours __________________ minutes

90. Did you have to pay for transport to the TOP facility?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q94**

91. **Interviewer: If yes, ask**:
Approximately how much did it cost you to get to the TOP facility and back home again?
R ______________

92. Were you able to afford the transportation costs?

| Yes | |
|---|---|
| No | |

**Interviewer: If yes, skip to Q94**

93. **Interviewer: If no, ask:**
Who paid for the transportation costs or were other arrangements made (explain)?

94. Did you experience any other transportation problems?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q96**

| | Official use |
|---|---|
| 95. **Interviewer: If yes, ask**:<br>Please explain | |
| | |
| | |
| | |
| 96. Did you have to arrange for accommodation when you came to the TOP facility? | |

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q104**

97. **Interviewer: If yes, ask:**
Where did you arrange to stay? (Places not names, e.g. at family)

98. Did you have to pay to stay at this place?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q102**

99. **Interviewer: If yes, ask:**
Approximately what was the total amount that you paid for accommodation?
R _____________

100. Were you able to afford the accommodation costs?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If yes, skip to Q102**

101. **Interviewer: If no, ask:**
Who paid for your accommodation or were other arrangements made (explain)?

| |
|---|
| |
| |
| |

102. Did you experience any other accommodation problems (except money)?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q104**

103. **Interviewer: If yes, ask:**
Please explain

| |
|---|
| |
| |
| |
| |

| Section I: User friendliness of the TOP facility | | | | | | Official use |
|---|---|---|---|---|---|---|
| 104.To what degree are you satisfied with the manner in which you were treated by: | | | | | | |
| | Satisfied | Uncertain | Dissatisfied | Did not see | Please explain | |
| 104.1 reception staff | | | | | | |
| 104.2 nurses | | | | | | |
| 104.3 doctors | | | | | | |
| 104.4 counsellors | | | | | | |
| 104.5 other patients | | | | | | |
| 104.6 security guards | | | | | | |
| 104.7 cleaners | | | | | | |

105. Did the hours that the TOP service was available suit you?

| Yes | |
|---|---|
| No | |

106. Please explain (**Interviewer: In both cases ask for an explanation.**) ________________

107. Did the TOP facility offer sufficient privacy for you?

| | Auditory privacy | | Visual privacy | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| 107.1 Waiting area | | | | |
| 107.2 Counselling room | | | | |
| 107.3 Consultation room | | | | |
| 107.4 Examination area | | | | |
| 107.5 Procedure room | | | | |
| 107.6 Recovery room | | | | |

| 108. **Interviewer: If no, ask:** Please explain. | | Official use |
|---|---|---|
| 108.1 Waiting room (auditory privacy) | | |
| 108.2 Waiting room (visual privacy) | | |
| 108.3 Counselling room (auditory privacy) | | |
| 108.4 Counselling room (visual privacy) | | |
| 108.5 Consultation room (auditory privacy) | | |
| 108.6 Consultation room (visual privacy) | | |
| 108.7 Examination area (auditory privacy) | | |
| 108.8 Examination area (visual privacy) | | |
| 108.9 Procedure room (auditory privacy) | | |
| 108.10 Procedure room (visual privacy) | | |
| 108.11 Recovery room (auditory privacy) | | |
| 108.12 Recovery room (visual privacy) | | |

**Section J: Services provided at the TOP facility**

109. To what degree are you satisfied with the following services provided at the TOP facility?

| | Satisfied | Uncertain | Dissatisfied | Service not needed | Service not available | **Interviewer: If dissatisfied ask:** Please explain | |
|---|---|---|---|---|---|---|---|
| 109.1 Pre-counselling | | | | | | | |
| 109.2 Post- counselling | | | | | | | |
| 109.3 Examination | | | | | | | |
| 109.4 TOP procedure | | | | | | | |
| 109.5 Information on TOP | | | | | | | |
| 109.6 Information and provision of contraceptives | | | | | | | |

110. Did the health worker ask you to bring someone with when the procedure was conducted?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q112**

111. **Interviewer: If yes, ask:** Please explain.

112. Did you receive counselling prior to the termination?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q127**

113. **Interviewer: If yes, ask:**
Did you receive counselling in the presence of other people or were you alone with the counsellor?

| In the presence of other people | |
|---|---|
| Alone with the counsellor | |

**Interviewer: If alone, skip to Q115**

114. **Interviewer: If in the presence of other people, ask**:
Please explain your answer.

115. When you were counselled, could other people hear what was being said?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q117**

116. **Interviewer: If yes, ask**:
Please explain your answer.

117. Did the counsellor explain other options than to have a TOP, to you?

| Yes | |
|---|---|
| No | |

118. Did you understand what the counsellor was telling you?

| Yes | |
|---|---|
| No | |

119. Is there anything that you would have liked the counsellor to have discussed in more detail with you?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q121**

Official use

120. **Interviewer: If yes, ask:**
Please explain.

Official use

121. Approximately how much time did the counsellor spend with you prior to the termination?
__________________ Minutes

122. Did the counselling prepare you sufficiently for the termination procedure?

| Yes | |
|---|---|
| No | |

123. Did you receive counselling somewhere other than at the TOP facility?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q127**

124. **Interviewer: If yes, ask:**
Please explain (**Interviewer: probe for who provided this counselling**.)

125. Is there anything that you would have liked this counsellor to have discussed in more detail with you?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q127**

126. **Interviewer: If yes, ask**:
Please explain.

127. Were you examined by a midwife/doctor in front of other people or were you alone with the midwife/doctor?

| In front of other people | |
|---|---|
| Alone with the midwife/doctor | |

**Interviewer: If alone, skip to Q129**

128. **Interviewer: If in the presence of other people, ask**:
Please explain your answer.

129. When you were examined, could other people hear what was being said?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q131**

Official use

130. **Interviewer: If yes, ask**:
Please explain your answer.

______

______

______

131. Approximately how much time did the midwife/doctor spend examining you?
131.1 First time: ____________ Minutes
131.2 Second time: ____________ Minutes
131.3 Third time: ____________ Minutes

132. Was the termination procedure conducted at the facility or were you sent home to start the termination?

| At the facility | |
|---|---|
| At home | |

**Interviewer: If at home, skip to Q137**

133. **Interviewer: If at the facility, ask**:
Was the termination procedure conducted in private?

| Yes | |
|---|---|
| No | |

**Interviewer: If yes, skip to Q135**

134. **Interviewer: If no, ask:**
Please explain.

______

135. Approximately how long did the termination procedure take to complete?
__________________ Minutes

136. Were you given pain medication?

| Yes | |
|---|---|
| No | |

137. **Interviewer: If the respondent was sent home to start the termination procedure, ask:**
Was there someone at home to help you once the induction began?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q139**

138. **Interviewer: If yes, ask:**
Who helped you (not names but relationships e.g. my sister)

139. **Interviewer: If no, ask:**
Did you wish to keep the termination a secret?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q141**

**Interviewer: If yes, ask:**
140. How did you manage to do this?

______

______

______

______

| 141. What did you do with the products of conception? | Official use |
|---|---|
| | |
| | |
| | |

142. Did you return to a health facility for an examination once the termination was over?

| Yes | | **Interviewer: If yes, skip to Q144** |
|---|---|---|
| No | | |

143. **Interviewer: If no, ask:**
Please explain.

| |
|---|
| |
| |
| |

144. Did you receive counselling after the termination procedure?

| Yes | | |
|---|---|---|
| No | | **Interviewer: If no, skip to Q152** |

145. **Interviewer: If yes, ask:**
Did you receive counselling in the presence of other people or were you alone with the counsellor?

| In the presence of other people | | |
|---|---|---|
| Alone with the counsellor | | **Interviewer: If alone, skip to Q147** |

146**. Interviewer: If in the presence of other people, ask**:
Please explain your answer.

| |
|---|
| |
| |
| |

147. When you were counselled, could other people hear what was being said?

| Yes | | |
|---|---|---|
| No | | **Interviewer: If no, skip to Q149** |

148. **Interviewer: If yes, ask**:
Please explain your answer.

| |
|---|
| |
| |
| |

149. Did the counsellor discuss contraception with you after the TOP procedure?

| Yes | |
|---|---|
| No | |

150. Are you using a contraceptive method since the termination?

| Yes | | **Interviewer: If yes, skip to Q152** |
|---|---|---|
| No | | |

151. **Interviewer: If no, ask:**
Please explain.

Official use

152. Did you at any stage, while at the TOP facility or afterwards, feel that the staff did not treat the information that you gave them as confidential?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q154**

153. **Interviewer: If yes, ask:**
Please explain.

154. Please describe how you felt before the termination.

155. Please describe how you felt during the termination.

156. Please describe how you felt after the termination.

**Section K: Family and friends**

157. Did you discuss with the “father of the baby” that you wanted to terminate your pregnancy?

| Yes | |
|---|---|
| No | |

**Interviewer: If no, skip to Q159**

158. **Interviewer: If yes, ask:**
What was the outcome of your discussion?

**Interviewer: Skip to Q 166**

159. **Interviewer: If no, ask:**
Please explain.

| 160. Did the “father of the baby” find out about the termination before you went for the procedure? | Official use |
|---|---|
| Yes ☐ | |
| No ☐ **Interviewer: If no, skip to Q162** | |
| 161. **Interviewer: If yes, ask:** What was his response? | |
| | |
| | |
| | |
| **Interviewer: Skip to Q166** | |
| 162. **Interviewer: If no, ask:** Has the “father of the baby” found out about the termination since you had the procedure? | |
| Yes ☐ | |
| No ☐ **Interviewer: If no, skip to Q164** | |
| 163. **Interviewer: If yes, ask:** What was his response? | |
| | |
| | |
| | |
| 164. **Interviewer: If no, ask:** Can you live with this secret? | |
| Yes ☐ | |
| No ☐ | |
| 165. Please explain. (**Interviewer: Probe for how the respondent copes**.) | |
| | |
| | |
| | |
| 166. Did you discuss with any member of your family that you wanted to terminate your pregnancy? | |
| Yes ☐ **Interviewer: If yes, skip to Q168** | |
| No ☐ | |
| 167. **Interviewer: If no, ask:** What were your main reasons for not discussing this with a family member? | |
| | |
| | |
| | |
| 168. **Interviewer: If yes, ask:** With whom in your family, did you discuss that you wanted to terminate your pregnancy? (relationship not name e.g. my sister) | |
| 1. ______ | |
| 2. ______ | |
| 3. ______ | |

Official use

169. How did your (Interviewer insert “relationship” e.g. sister) react when you told him/her that you wanted to terminate your pregnancy?
1. ____
2. ____
3. ____

170. Did you discuss with any of your friends that you wanted to terminate your pregnancy?

| Yes | | **Interviewer: If yes, skip to Q172** |
|---|---|---|
| No | | |

171. **Interviewer: If no, ask:**
What were your main reasons for not discussing this with any of your friends?

172. **Interviewer: If yes, ask:**
How did your friend(s) react when you told them you wanted to terminate your pregnancy?

173. Did you discuss with any one else (apart from those already mentioned) that you wanted to terminate your pregnancy?

| Yes | | |
|---|---|---|
| No | | **Interviewer: If no, skip to Q176** |

174. **Interviewer: If yes ask:**
With whom did you discuss that you wanted to terminate your pregnancy? (relationship not name e.g. my employer, priest, pastor, etc.)
1. ____
2. ____
3. ____
4. ____

175. How did they/he/she react when you told them you wanted to terminate your pregnancy?
1. ____
2. ____
3. ____
4. ____

176. Did you tell anyone about the termination after you had it done?

| Yes | | |
|---|---|---|
| No | | **Interviewer: If no, skip to Q179** |

177. **Interviewer: If yes, ask:**
Who did you tell? (relationship not name e.g. my sister, priest, etc.)
1. ____
2. ____
3. ____
4. ____

| 178. How did they/he/she react when you told them about the termination? | Official use |
|---|---|
| 1. ______ | |
| 2. ______ | |
| 3. ______ | |
| 4. ______ | |

**Section L: Knowledge of contraceptives, pregnancy, TOP and the Act**

179. Have you heard of the following contraceptive methods, and if yes, how do they work?

| | Yes | No | **Interviewer: If yes, ask:** Please explain. |
|---|---|---|---|
| 179.1 Pill | | | |
| 179.2 IUD (loop) | | | |
| 179.3 Diaphragm | | | |
| 179.4 Condom | | | |
| 179.5 Female Sterilisation | | | |
| 179.6 Male Sterilisation | | | |
| 179.7 Rhythm method | | | |
| 179.8 Withdrawal method | | | |

180. What are the first signs of pregnancy?

181. How can you prevent a pregnancy before intercourse?

182. How can you prevent a pregnancy after intercourse?

183. Do you know anyone else who has terminated a pregnancy?

| | |
|---|---|
| Yes | |
| No | |

| 184. How did you find out where the facilities that provide TOP services are located? | Official use |
|---|---|
| | |
| | |
| | |

185. Please indicate whether the following statements are true or false

| | True | False | Uncertain |
|---|---|---|---|
| 185.1 TOP is **only** available during the first 12 weeks of pregnancy and **not** thereafter | | | |
| 185.2 Minors have to obtain the consent of their parents to have a TOP | | | |
| 185.3 TOP from the 13th week of pregnancy is allowed if certain requirements are met | | | |
| 185.4 TOP after the 20th week is available if the continued pregnancy would endanger the life of the woman | | | |
| 185.5 TOP is available free of charge at government facilities | | | |

186. When did you first hear that it was legal to terminate a pregnancy? (**Interviewer: The date - month and year.**)

187. Were did you first hear that it was legal to terminate a pregnancy?

| |
|---|
| |
| |
| |

188. Was the clinical procedure for the termination explained to you?

| | |
|---|---|
| Yes | |
| No | |

**Interviewer: If no, skip to Q191**

189. **Interviewer: If yes, ask:**
What were you told?

| |
|---|
| |
| |
| |

190. Who explained the procedure to you? (job categories and not names e.g. the doctor)

| |
|---|
| |

**Section M: Attitudes towards TOP**

191. Now that you have had a termination of pregnancy, would you consider it an option again in the future?

| | |
|---|---|
| Yes | |
| No | |

192. Please explain.

| |
|---|
| |
| |
| |
| |

| 193. Do you think that women would rather choose a backstreet abortion, rather than a legal abortion? | Official use |
|---|---|
| | |

| | |
|---|---|
| Yes | |
| No | |

194. Please explain.

## Section N: Problems and recommendations

195. What were the most important problems/constraints that you experienced when deciding whether or not to have a termination?

196. What were the most important problems/constraints that you experienced when making arrangements for the termination?

197. What were the most important problems/constraints that you experienced at the referral facility?

198. What were the most important problems/constraints that you experienced at the TOP facility?

199. What recommendations would you make that would make it easier for women who want to terminate a pregnancy?

200. What recommendations would you make to improve the following services at your TOP facility:
200.1 Pre-counselling

| | Official use |
|---|---|
| 200.2 Post-counselling ___ | |
| | |
| | |
| 200.3 Examination ___ | |
| | |
| | |
| 200.4 MVA procedure ___ | |
| | |
| | |
| 200.5 Induction procedure ___ | |
| | |
| **Interviewer: Thank the respondent for her time and for being willing to assist in gathering this data.** | |

# APPENDIX B

- Classification of the world's abortion laws.

Key for Table75:

| | |
|---|---|
| † | Gestational limit of eight weeks. |
| ‡ | Gestational limit of ten weeks. |
| * | Gestational limit of 14 weeks. |
| ** | Gestational limit of 18 weeks. |
| *** | Gestational limit of 24 weeks. |
| V | Law does not limit pre-viability abortions. |
| o | Law does not indicate gestational limit key for additional grounds, restrictions and other indications |
| R | Abortion permitted in cases of rape. |
| R1 | Abortion permitted in cases of rape of a woman with a mental disability. |
| I | Abortion permitted in cases of incest. |
| F | Abortion permitted in cases of foetal impairment. |
| SA | Spousal authorisation required. |
| ◊ | Federal system in which abortion law is determined at state level; classification reflects legal for largest number of people. |
| X | Recent legislation eliminated all exceptions to prohibition on abortion; availability of defense of necessity highly unlikely. |
| S | Sex. |
| U | Law unclear. |

**Table 75: Classification of the world's abortion laws**

| | | | |
|---|---|---|---|
| **Abortion prohibited altogether or permitted only to save the woman's life*** (72 countries, 26.1% of the world's population) | | | |
| **Afghanistan** | Gabon | Malta | Sao Tome & Principe |
| Andorra | **Guatemala** | Marshall Islands[U] | Senegal |
| Angola | Guinea-Bissau | Mauritania | **Solomon Islands** |
| **Antigua & Barbuda** | Haiti | Mauritius | Somalia |
| **Bangladesh** | Honduras | **Mexico**[◊ R] | **Sri Lanka** |
| Bhutan[U] | **Indonesia** | Micronesia | **Sudan**[R] |
| **Brazil**[R] | Iran | Monaco | Suriname |
| **Brunei Darussalam** | Iraq | **Myanmar** | Swaziland |
| Central African Republic | **Ireland** | **Nicaragua**[SA/PA] | **Syria**[SA/PA] |
| Chile[X] | **Kenya** | Niger | **Tanzania** |
| Colombia | **Kiribati** | **Nigeria** | Togo |
| Congo (Brazzaville) | Laos | Oman | **Tuvalu** |
| **Côte d'Ivore** | **Lebanon** | Palau[U] | **Uganda** |
| Dem. Rep. of Congo | Lesotho | **Panama**[PA/R/F] | **United Arab Emirates**[SA/PA] |
| **Dominica** | **Libya**[PA] | **Papua New Guinea** | |
| Dominican Republic | Madagascar | **Paraguay** | **Venezuela** |
| Egypt | **Malawi**[SA] | Philippines | **West Ban & Gaza Strip** |
| El Salvador[X] | **Mali**[R/I] | San Marino | **Yemen** |
| **Abortion permitted to preserve the woman's life (also to save the woman's life)** (35 countries, 9.9% of world's population) | | | |
| Argentina[R1] | Costa Rica | Kuwait[SA/PA/F] | Rep. of Korea[SA/R/I/F] |
| Bahamas | Djibouti | Liechtenstein | Rwanda |
| Benin[R/I/F] | Ecuador[R1] | Maldives[SA] | Saudi Arabia[SA/PA] |
| Bolivia[R/I] | Equatorial Guinea[SA/PA] | Morocco[SA] | Saint Lucia |
| Burkina Faso[R/I/F] | Eritrea | Mozambique | Thailand[R] |
| Burundi | Ethiopia | Pakistan | Uruguay[R] |
| Cameroon[R] | Grenada | Peru | Vanuatu |
| Chad[R/I/F] | Guinea[R/I/F] | Poland[PA/R/I/F] | Zimbabwe[R/I/F] |
| Comoros | Jordan | Qatar[F] | |
| **Abortion permitted preserve mental health (also to save the woman's life and physical health)** (20 countries, 2.7% of world's population) | | | |
| Algeria | Israel[R/I/F] | Nauru | Samoa |
| Botswana[R/I/F] | Jamaica[PA] | New Zealand[I/F] | Seychelles[R/I/F] |
| Gambia | Liberia[R/I/F] | Northern Ireland | Sierra Leone |
| Ghana[R/I/F] | Malaysia | Portugal[PA/R/F] | Spain[R/F] |
| Hong Kong[R/I/F] | Namibia[R/I/F] | Saint Kitts & Nevis | Trinidad & Tobago |
| **Abortion permitted on socio-economic grounds (also to save the woman's life, physical and mental health)** (14 countries, 20.7% of world's population) | | | |
| Australia[◊] | Fiji | India[PA/R/F] | Saint Vincent & Grenadines[R/I/F] |
| Barbados[PA/R/I/F] | Finland[R/F] | Japan[SA] | |
| Belize[F] | Great Britain[F] | Luxembourg[PA/R/F] | Taiwan[SA/PA/I/F] |
| Cyprus | Iceland[R/I/F] | | Zambia[F] |
| **Abortion permitted without restriction as to reason** (54 countries, 40.5% of world's population) | | | |
| Albania | Cuba[PA] | Italy[ÂPA] | Slovak Rep.[PA] |
| Armenia | Czech Rep.[PA] | Kazakhstan | Solvenia[PA] |
| Austria[*] | Dem. People's Rep. of Korea[o] | Krygyzstan | South Africa |
| Azerbaijan | | Latvia | Sweden[***] |
| Bahrain | Denmark[PA] | Lithuania | Switzerland |
| Belarus | Estonia | Moldova | Tajikistan |
| Belgium[*] | France[*] | Mongolia | Tunisia |
| Bosnia-Herzegovina[PA] | Fmr. Yugoslav Rep. Macedonia[PA] | Nepal[S] | Turkey[‡SA/PA] |
| Bulgaria | | Netherlands[V] | Turkmenistan |
| Cambodia[*] | Georgia | Norway[PA] | Ukraine |
| Canada | Germany[*] | Romania[*] | United States[V◊PA] |
| Cape Verde | Greece[PA] | Russian Fed. | Uzbekistan |
| China[S] | Guyana[†] | Serbia & Montenegro[PA] | Vietnam[o] |
| Croatia[PA] | Hungary | Singapore[***] | |

Source: Centre for Reproductive Rights 2004.

* Countries in bold make an explicit exception to save a woman's life.

Note All countries have a gestational limit of 12 weeks unless otherwise denoted. Gestational limits are calculated from the first day of the last menstrual period, which is generally considered to occur two weeks before conception. Statutory gestational limits calculated from the date of conception have thus been extended by two weeks.

# APPENDIX C

- Interpretation of conscientious objection based on the 1996 *Constitution*.

**Table 76: Interpretation of conscientious objection based on the 1996 *Constitution***

| Constitutional Clause | Rights of health care providers | Women's rights |
|---|---|---|
| Section 9 Right to equality | | Provides that all women should have equal benefit and protection of the law. In terms of the *Choice on Termination of Pregnancy Act*, Act No. 92 of 1996, it provides that all women should have equal benefit of the law which translates into access to TOP services. |
| Section 9 (3) Provides that the State may not unfairly discriminate directly on one or more of the prohibited grounds (sex, gender, conscience, religion) | The state may not discriminate against health care providers on the basis of their conscience. | The State may not discriminate against women on the basis of their conscience or gender. |
| Section 9 (4) prohibits discrimination between persons | Health care providers should not be discriminated against by other health care providers because of their conscientious belief that they should provide termination services. | Women seeking TOP services should not be discriminated against by health care providers. |
| Section 12 – freedom and security of the person: protects the right to bodily and psychological integrity including the right to make decisions concerning reproduction and to security in and control over their bodies. | It protects health care providers who are involved in service delivery from threats of community members and those opposed to safe legal TOPs. | It protects women's right to terminate a pregnancy and the means to secure a termination. |
| Section 15 – Freedom of religion, belief and opinion | Affords health care providers freedom of conscience in their decision whether or not to participate in performing TOPS. | Gives women the right to freely decide whether or not they wish to terminate or continue a pregnancy. |
| Section 16 – Free of expression | Affords the freedom to health care providers to receive and impart information and ideas | |
| Section 27 – Right to health care, food, water and social security | | Women have the right to access health care services, including reproductive health care services. The state is compelled to take reasonable steps to ensure progressive realisation of this right. |
| Section 32 – right of access to information | | Protects women's right of access to information that is held by another person and required for the exercise of their rights. This includes information about TOP services. |
| Section 36 – limitation of rights: provides that no right is absolute – that all rights can be limited in terms of a law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity. | Section 10 of the CTOPA: Any person who prevents a lawful termination or obstructs access to a facility shall be guilty of an offence and liable on conviction to a fine or imprisonment for a period not exceeding 10 years – which limits a health worker's right to freedom of conscience. | Section 6 of the CTOPA: A woman who requests a TOP from a medical practitioner must be informed of her rights in terms of the Act by the person concerned. |

Source: Women's Legal Centre in Reproductive Rights Alliance 2000: 4