



Country
Factsheet

South Africa

Unsafe Abortion



Globally

The annual number of abortions worldwide is estimated at 56.3 million, with 25% of pregnancies ending in abortion (2010-2014).¹ 6.9 million women in the developing world were treated for complications from unsafe abortion in 2012,² and as many as 40% of women who need care do not obtain it.³ Globally, unsafe abortion procedures account for an estimated 13% of maternal deaths, or 47,000 women.⁴ The Sustainable Development Goals aim to reduce the global maternal mortality ratio from 216 (2015) to 70 (2030) maternal deaths per 100 000 live births.⁵ The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both.⁶

Key Issues

- **South Africa has one of the most progressive abortion laws in the world** with abortion on demand. However, it estimated that 50% of abortions in South Africa occur outside of designated health facilities.
- **Reportedly, many women who opt for illegal abortion services experience complications** and seek care in the formal health sector, adding strain to an already resource-constrained health system.
- Health care provider objections to providing abortion procedures results in **fewer than half of government designated facilities providing abortion services.**
- **Limited access to second trimester terminations in public health facilities** results in women exceeding the legal gestation period for obtaining abortions and seeking abortions outside of designated health facilities.
- **The majority of women are unaware of their legally recognised abortion rights** under South African law, meaning many women believe illegal and unsafe abortion providers are their only option.
- **Religious and cultural stigmatization of abortion** also results in women seeking discrete, clandestine abortions outside of designated health facilities.
- **Legal authorities take minimal preventative measures to control street and cyber marketing for illegal abortion services** in South Africa.
- Restrictive abortion laws in countries in southern and east Africa drive women who can afford it to access legal abortions in South Africa. However, **many of the cross-border clients unwittingly access abortions from illegal and unsafe abortion providers.**

South Africa

Unsafe abortion

The legality of abortion in South Africa affords women reproductive autonomy and the right to access safe abortion procedures on demand. As a result of this 1996 liberalisation of abortion law, studies have shown that abortion-related mortality decreased by 91% in South Africa between 1994 and 1998–2001.⁷ However, an estimated 50% of abortions in South Africa continue to occur outside of designated health facilities.⁸

The 1998 Demographic and Health Survey (DHS), which formed the baseline indicator for the Millennium Development Goal (MDG) maternal mortality target in South Africa, approximated the maternal mortality rate at 150 per 100,000 live births,⁹ though many maternal deaths are not registered. The 2015 MDG target was set at 38 per 100,000 live births. However, by 2015, the World Bank estimated South Africa's maternal mortality rate had fallen only marginally, to 138 deaths per 100,000 live births.¹⁰

The percentage of maternal deaths attributable to abortion complications is unknown. The Department of Health's (DoH) 2011-2013 'Confidential enquiries into maternal deaths in South Africa' did not provide a separate category to account for abortion-related mortality. However, the DoH estimated that between 2008 and 2010, 23% of maternal deaths resulting from septic miscarriages in public health facilities, were as a direct result of unsafe abortions.¹¹

Law & policy

Reproductive health rights are protected under the South African constitution including the right for men and women to exercise control over their bodies. The South African Choice on Termination of Pregnancy Act (CTOP) No.92 of 1996 replaced the restrictive Abortion and Sterilization Act, 1975. The CTOP Act stipulates that women have the right to access safe and effective methods of fertility control and this extends to termination of pregnancy rights.

The COTP Act came into effect on 1 February 1997. The new law intended to make abortion services accessible for all women in South Africa, particularly those who were disadvantaged and lacked access to adequate health care facilities during apartheid. Under the COTP Act, every woman has the right to access early termination of pregnancy in accordance with her beliefs. The minor-consent provision in the Act also ensures that minors have access to safe abortion services without the need for parental consent. In the first 12 weeks of gestation, a termination may be performed on request. Between the 13th and 20th week gestation period, pregnancy may be terminated if the pregnancy endangers the woman's physical or mental health, in case

of foetal physical and mental abnormalities, or if the pregnancy resulted from rape or incest. The act also takes into account a woman's social and economic circumstances and a woman can request a pregnancy termination on socio-economic grounds up until the 20th gestational week.¹²

The COTPA Act was amended in 2004 to increase accessibility to abortion services by allowing registered nurses and midwives to perform first trimester abortions, and local governments and executive councils to approve new facilities and the maintenance standards of abortion facilities. Under the 2004 amendment, facilities with 24-hour maternity services no longer required executive-council approval to perform first trimester abortions. While the amendment was ruled as invalid by the Constitutional Court in 2006, the amendment was re-enacted by parliament as the Choice on Termination of Pregnancy Amendment Act of 2008.

Knowledge & attitudes

A combination of widespread anti-abortion religious and cultural beliefs in South Africa fuels a strong stigma around abortion, affecting abortion-seeking behaviours and service provider attitudes. Service providers are known to chastise clients, particularly minors, for early sexual debut and irresponsibility for choosing to terminate the pregnancy. Abortion is associated with social ills such as drug abuse, moral deterioration and promiscuity. The stigma associated with providing abortions can result in service provider resistance to be trained in providing termination of pregnancies, thereby limiting service provider capacity to meet the growing demand for abortions in the country. The absence of ongoing values clarification for health care workers also leads to insensitivity, isolation and stigmatisation of abortion service providers in the work place. Conscientious objections, stigma and the lack of extra remuneration for performing abortions results in short abortion staff turnover periods, with serious implications for the sustainability of abortion services. Limited understanding of how to interpret the COPTA Act grounds for legal abortion also results in service providers setting unnecessary barriers to women seeking abortions.

The lack of information dissemination and media coverage on safe abortions resulted in a 2006 study concluding that 30% of South Africans were unaware of the liberalised status of induced abortion and the gestation limits permitted by law to access abortion services.¹³ Consequently, many women fail to seek early pregnancy terminations resulting in an unnecessarily high number of second trimester abortions. Abortion stigma means abortion is treated by most as a deeply private matter and confidentiality of service providers is paramount. Public health facilities document abortion procedures and many clients fear breach of confidentiality; the shame associated with terminating a pregnancy means many women access illegal abortion services which they believe to be more discrete.

Abortion & post abortion care services

Women can obtain a state funded abortion in public health facilities at no cost to themselves. Yet, fewer than half of the public health facilities designated by government to carry out abortion procedures are offering the service. The negative perceptions surrounding abortion result in abortion services not being prioritised, and some public facilities set daily quotas for the number of abortions they are willing to perform. Consequently, women are turned away when the daily quota has been reached, resulting in missed opportunities for first trimester terminations. Only a limited number of healthcare facilities offer second trimester abortions. Women often have to travel long distances to access these facilities, with waiting periods in most public hospitals exceeding four weeks. This leads to women seeking second trimester abortions exceeding the 20-week gestation legal limit for terminating pregnancy and being referred for antenatal care services.

The cost associated with seeking abortions in designated private facilities results in the poor being unable to access these services. While the government is making efforts to subsidise these costs through public-private partnerships with private clinics such as Marie Stopes, such clinics remain inaccessible both financially and geographically to most, poor women. Illegal service providers thrive by offering affordable, same day procedures. The liberalisation of medical (i.e. non-surgical) abortions results in unregistered (and therefore illegal) service providers having easy access to Misoprostol for medical abortion. Illegal service providers do not necessarily adhere to the gestational limits for performing abortions set by the COTPA Act and may provide termination at advanced pregnancy stage, often with large doses of Misoprostol. This increases risk of incomplete abortions, pelvic infections, uterine rupture and haemorrhaging. Limited access to abortion services also results in self-induced terminations, often with the ingestion of toxic cleansers, herbal concoctions, castor oil and Magnesium sulphate. These can cause severe organ damage, and death.

Due to the highly restrictive abortion laws in most southern African countries, South Africa also receives a large number of cross-border clients who present for abortion services. Many of these women, in ignorance, respond to street advertisements for abortion services placed by illegal service providers in the false belief that they are accessing safe abortion services.

The confidentiality of postabortion care is a concern for women who seek postabortion care in public health facilities. However, in most public hospitals women are referred back to their primary health facility for postabortion care. Fear of recognition and consequent exposure at the local health facility means many women only seek postabortion care when they believe they are facing life threatening complications.

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For questions about this publication, please contact us at heard@ukzn.ac.za

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