

## **CHAPTER 2 LITERATURE REVIEW**

### **2.1. INTRODUCTION**

The literature review will encompass investigating reasons women have for deciding to terminate a pregnancy. The relationship between reasons and sets of reasons for choosing to end a pregnancy cannot be seen in isolation to the proximate cause of conception, i.e. the non-use or failure of contraception. As this is also one of the proximate causes for contracting HIV/AIDS, it is important to view the possible impact of this epidemic on women's decision to terminate their pregnancy.

When viewing the right of women to determine their own reproductive behaviour, the alignment and reasoning for a feminist theoretical framework will be provided. The reasons for women deciding to terminate their pregnancy are placed within women's rights and the right of the women to narrate their own personal stories, true to their reality. The ethical considerations regarding abortion will also be reviewed and feminism will also be placed within this context.

The literature will look at the historical shift in attitude and perceptions toward abortion and the emergence of this as a central theme to human and women's rights. Within this, reproductive rights and the importance of what this encompasses must be seen within a change in the international arena toward population concerns and the role of women. The international arena forms the basis on South African Population Policies and on which the Choice of Termination of Pregnancy Act is based. A comparison will also be done in terms of the abortion liberalisation internationally and nationally and comparisons between countries will be provided.

### **2.2. REASONS FOR WOMEN CHOOSING TO TERMINATE A PREGNANCY**

According to a study conducted by Bankole et al (1998:2), the most common reason cited for having an abortion is that the pregnancy is unintended and unwanted. The labelling of a pregnancy being unintended and unwanted involves a myriad of social, demographical and health circumstances. These circumstances are in relation to each other and do not necessarily stand in isolation to each other where the pregnancy was either unintended or unwanted. According to Bankole et al (1998:2), in the USA and in some Eastern European countries, approximately one-half (1/2) to three-fifths (3/5) of all pregnancies were unintended, and a large proportion was resolved through abortion.

In less developed countries, the proportion of recent births that are unintended, exceeds 40% even in regions where large families were still wanted, and 10-20% of births are unplanned. According to the authors, the level of unintended pregnancies for less developed countries would be even higher if accurate abortion information were available as it is estimated that high proportions of these unintended pregnancies are resolved by abortion: 61% in Tanzania, 43% in Mexico and 63% in Chile (Bankole et al, 1998:2). Although unintendedness is the first level of explanation according to their study, for many women it covers a wide range of more specific underlying factors.

Bankole et al (1998:5) state that although it is acknowledged that all abortions result from unwanted pregnancies, it must be taken into consideration that numerous steps exist between acknowledging an unintended pregnancy and having an abortion as many women who are faced with an unintended pregnancy either do not seriously consider having an abortion or do not consider it at all. Life is fluid and conditions that was either unknown or less serious before conception may also change resulting in a pregnancy wanted at the time of conception, is no longer wanted later on. Of importance is the fact that not all women seeking to have an abortion will obtain one.

Findings from 32 studies in 27 countries were used by Bankole et al (1998:1) to examine the reasons that women give for having an abortion. Regional patterns in these reasons and the relationship between such reasons and women's social and demographic characteristics were examined. The data that they used came from a wide range of sources, including national representative surveys, official government statistics, community based studies and hospital – or clinic based research. Of importance is that the study did not draw comparisons between the current legislative aspects of countries in relation to the reasons cited or the percentages obtained. The study grouped together reasons from various sources and quantified these into the most frequently stated reasons found.

The study made use of various national studies carried out between 1967 and 1997 using various databases such as Popline, Medline, Population Indexes, and National Fertility Surveys, Official Government statistics on abortion and Sub-national Surveys on Women that included reasons for abortions, National Surveys of abortion patients as well as Sub-national hospital – or clinic based surveys of abortion patients (Bankole et al, 1998:2). The information used was information provided directly from respondents that already had a termination of pregnancy performed with a range of response alternatives as per the specific database enquiry either by making use of questionnaires, interviews or assembled by medical providers.

This again does not allow for a direct comparison as these methods of collection varied depending on the survey conducted. Reporting could also have been influenced by the legal status of abortion in certain countries and therefore women's willingness to report fully on their reasons for seeking to obtain an abortion. From the 32 published studies used, they differed in their grouping of reasons and therefore exact comparisons were not possible. The authors used similar worded reasons and used their own discretion to create nine broad and according to them comparable categories.

The study by Bankole, et al (1998:1) focused on the individual reasons given by woman and their demographical characteristics. The reasoning is still classified but the categories vary. The study also found that restrictions on responses prevents a better understanding of the reasons why women have abortions, especially when women have more than one reason or find it difficult to rank reasons in order of importance. Bankole et al, (1998:4) found that a mean of 3.7 reasons, with 63% reporting 3 – 5 reasons and 13% reporting 6 – 9 reasons. Only 7% of women in the study gave just one reason for obtaining an abortion.

The study by Bankole et al (1998:1) found numerous factors which will influence women in their decision to terminate their pregnancy and classified these as per the following themes: 1) socio-economic position, 2) relationship with partner, 3) age of the woman, 4) accessibility of abortion services: in countries where abortion is not legal, safe abortion services are scarce, 5) the pricing of abortion services result in poorer women risking their life and health to have unsafe abortions performed, 6) religious opposition, 7) values that oppose abortion, 8) community values that oppose abortion, and 9) partner's objections.

These values influenced women into making their decision to terminate their pregnancy or stood in proximate reasoning to the termination. The authors state that influencing factors such as religious opposition and values that oppose abortion were secondary to the main reasons cited but were important nevertheless.

The results from this study state that worldwide, the most commonly reported reason women cite for having an abortion is to postpone or stop childbearing. Of interest is that this is directly linked to a woman's demographic characteristics as with few exceptions, older women and married women cite limiting childbearing as their main reason for abortion. In Kazakhstan and Uzbekistan, more than one-third and approximately four-fifths of unwanted/unplanned pregnancies result in an abortion where women want to stop childbearing (Bankole et al,1998:1). It must be noted that in former Soviet states, contraceptives were not freely available and abortion was used as a form of contraception

with women having an average of 3 abortions during the lifetime. In contrast to this phenomenon, younger and unmarried women state postponement of childbearing as their main reason for abortion. The study found that 50% of women stated that birth-timing and family-size control as their most important reasons for terminating their pregnancy. In Bangladesh, India and Pakistan, one-half to two-thirds of women citing multiple reasons, cited postponing and stopping childbearing and in Czechoslovakia 49-67% of women cited the desire to postpone or stop childbearing as their most important reason. This can be ascribed to other factors in a woman's life that makes the timing of the pregnancy undesirable.

The second most common reason cited for terminating a pregnancy according to Bankole *et al.*, (1998:1), is socio-economic concerns – including the disruption of education or employment, lack of support from the father, desire to provide schooling for the existing children; and poverty, unemployment or inability to afford additional children.

In addition to these concerns, relationship problems with a husband or partner, and a woman's perception that she is too young, constitute other important categories of reasons. Economic reasons or a woman not being able to afford to properly care for a child was found to be second overall in importance. 30%-68% of women cited poverty contributing to their decision to terminate their pregnancy. Women that cited overall socio-economic reasons varied from 10%-86% depending on the country and survey in question.

Relationship problems were only indicated as a major reason in a relatively small portion of women, 4%-14% in the Czech Republic, Romania and the USA. In Australia, 19% and 16% in the Netherlands stated that problems with their husbands or partners were contributing factors. In the USA (51%) and Australia (29%), women mentioned that they did not want to be a single mother. Underlying this was the threat from partners to abandon the women if she gives birth, the partner or the women herself refusing to marry to legitimate the birth, that a break-up is imminent for reasons other than the pregnancy, that the pregnancy resulted from an extramarital relationship, that the partner mistreated the women because of the pregnancy or that the husband or partner simply does not want the child. The study found that sometimes women combine these reasons with not being able to afford the baby, which suggests the importance of having a partner who can offer both financial and emotional support.

Being young and unmarried were other reasons found. Being too young or fearing that parents or others would object to the pregnancy was found to be a common reason with

10%-37% of women gave this as their main reason, again depending on the survey and country. In Australia this was found to be true for 25% of women being too young while 15% did not want their parents or others to find out about the pregnancy.

Risk to maternal health was cited in 10%-38% of the cases. This includes risk to either the physical or mental health of the mother. This can be quite tricky as a true reason as this could either be true as identified by a medical practitioner or diagnosed by the woman herself. The other concern is that in many countries, this is one of the conditional allowances made for women to be able to terminate their pregnancy and thus supports the legislative allowance as well as the moral justification in terms of society.

Foetal defects or potential problems for the baby were rarely reported. This could stem from low actual incidence of birth defects, as women obtain an abortion before defects could be properly known or it is not generally detected in developing countries. These reasons may also have been grouped together with other reasons in some studies or been omitted all together. This was only cited as a reason in one-third of the countries with 11% in India and 5%-8% in South Korea, Taiwan and Thailand. In terms of these countries, it is assumed that sex selection plays an important role and is ascribed as a foetal defect.

Other reasons were less common with only 10% of women choosing this although this was an option across all the surveys and databanks used. These were unspecified and did not give attention to why women seek an abortion. It must be noted that this must not be seen as a uniformed meaning to all women as many may have selected this where sensitive issues such as rape or incest may be the cause of conception.

Important was the focus given to the use or non-use of contraception. The study found that women that wanted to postpone or stop childbearing were either not using contraception or were not using it correctly. This was especially true for sub-Saharan Africa. There were many reasons for women not using contraception including ambivalence about pregnancy, lack of knowledge regarding contraception, their own partner's opposition to family planning, poor access to contraceptive services, fear of side effects and woman's perception that she cannot become pregnant. The study by Bankole et al (1998:8) also state that methods used by women who want to avoid pregnancy do not necessarily provide complete protection and each method can fail even if used correctly.

The failure rate of the pill is 8%, the failure of condom is 15% and the more traditional methods such as abstinence and withdrawal are as high as 26% (Bankole *et al*, 1998:8). Many women also use less effective methods such as periodic abstinence, withdrawal and other traditional methods.

### **2.2.1. CONTRACEPTION**

Even though the planning status of an abortion does not tell us the full reason why women choose abortion, understanding the prevalence of an unplanned pregnancy and its proximate cause – non-use of contraceptives or contraceptive failure – is essential for understanding the context within which women seek abortion. In this context, abortion can be viewed as a result of the non-use of contraceptives or contraceptive failure. The opposite is also true, that abortion can be used as a method of contraceptive use.

Although abortion is not advocated to be performed as part of contraceptive use, it cannot be denied that this is true in many areas of the world, especially in less developed countries (Mangnani, Rutenburg & McCann, 1996:36) where access to safe contraceptive methods is limited. Jacobson (1994:177) concurs that abortion is the most common form of contraceptive use worldwide. The incidence of abortion of a specific population is influenced by the availability of contraceptives to the woman, access to information regarding family planning, access to effective reproductive health services and the way in which woman can empower their sexual partners to use contraception. Improved methods of contraception may help prevent unplanned pregnancies including contraceptive education and education related to abstinence.

The UNFPA (1998: 5) estimate that if resources fall short, 97 million additional individuals and couples who would have chosen contraception will not be able to do so, totalling between 130 – 170 million people who are not able to use contraception for the period 1995 - 2000. In many less developed countries, the incidence of abortion is an important indicator of the availability, accessibility and use of contraceptive services. The contraceptive prevalence for married women in less developed countries was only 9% in 1965 and it had risen to 60% by 1997. It is estimated that in 1990, 300 million couples were using what they termed as unsatisfactory contraception while 100 million couples were not using any form of contraception although they did not want children (WHO, 1998:184). A lack of accessibility as reason for non-usage of contraceptives was reported to be 9% in Uganda, 12% in Kenya and 18% in Togo (WHO, 1998:185). In Russia, only 63% of women aged 24-49 used some form of contraceptive in 1992-1993, and this figure increased to 67% in 1994 (Entwisle & Kozyreva, 1997:16).

Jacobson (1994:178) states that in Poland, only 12% of the population that can produce children use reliable methods of contraception. The UNFPA (1998:5) states that with continued inadequate contraceptive usage, the number of unintended pregnancies will increase dramatically – by 130-230 million for the period 1995-2000 worldwide.

The South African Abortion Survey (De Jonge, 1999:2) states that the overarching reason for an unplanned pregnancy was found to be the ignorance regarding contraceptive methods and usage. In South Africa it is estimated that contraceptive use stands at 50% (WHO, 1998:196). The UNFPA (1997:x) state that contraceptive prevalence for South African married women in 1994 was estimated to be approximately 60%. The highest usage was found to be amongst Whites (81%) and lowest amongst Africans (55%), with huge discrepancies between the high usage in urban areas and the low usage in rural areas. This discrepancy can be attributed to various factors such as the availability of contraceptives, the choice of contraceptive methods and access to information and clinics.

In addition to the increased exposure to unwanted pregnancies due to non-use of contraceptives or contraceptive failure, another factor of grave concern is the increase of exposure to HIV/AIDS. The impact of HIV/AIDS on the decision making in the case of the woman or partner being HIV positive and/or the impact of this in terms of the support structure of a family impacted with HIV/AIDS is crucial to the women deciding to terminate their pregnancy.

### **2.2.2. HIV/AIDS**

According to USAIDS (2003:1) 60 million people have lived with HIV/AIDS since the epidemic was identified more than 15 years ago, and 20 million have already died from the disease.

The figures indicated are staggering when taking into consideration that globally sub-Saharan Africa is the most severely impacted with an estimated 24 million people currently living with the disease (HSRC, 2002:1) compared to 26.6 million stated by USAIDS/WHO (2003:7) for the same region. These totals are estimated to be 30% of the globally infected people, and when taking into account that this region holds less than 2% of the world's population, it truly reflects itself as an epidemic. USAIDS/WHO (2003:7) state that an additional 3.2 million people became infected during this period with an estimated 2.3 million deaths for 2002 in the region. African women are also more prone to becoming infected, at least 1.2 times more likely than men.

This can be ascribed to the sexual activity of women starting at an early age and that young women tend to have sex with older partners (USAIDS/WHO: 2003:7). The authors also state that women are found to be 2.5 times as likely to become HIV-infected as their male counterparts and that this can be ascribed to the biological fact that HIV generally is more easily transmitted from men to women.

The following HIV/AIDS figures were reported by USAIDS/WHO (2003:2).

**GLOBAL SUMMARY OF THE HIV/AIDS EPIDEMIC**  
**December 2003**

DESCRIPTION	CATEGORY	NUMBERS
Number of people living with HIV/AIDS	<b>Total</b>	40 million (34 – 46 million)
	Adults	37 million (31-43 million)
	Children under 15 years	2.5. million (2.1-2.9 million)
People newly infected with HIV	<b>Total</b>	5 million (4.2-5.8 million)
	Adults	4.2 million (3.6-4.8 million)
	Children under 15 years	700 000 (590 000 – 810 000)
AIDS deaths	<b>Total</b>	3 million (2.5-3.5 million)
	Adults	2.5 million (2.1-2.9 million)
	Children under 15 years	500 000 (420 000-580 000)

As stated, HIV/AIDS, is more severe in sub-Saharan Africa with prevalence's varying cross the continent, ranging from less than 1% in Mauritania to 40% in Botswana and Swaziland. It is estimated that one in five pregnant women are infected in most countries within Southern Africa (USAIDS/WHO, 2003:7). A trend analysis of antenatal clinics in eight countries between 1997 – 2002 show HIV/AIDS levelling off at 40% in Gabarone, Botswana and Manzini, Swaziland; 20% in Lusaka, Zambia; 18% in Maputo, Mozambique; 16% in Blantyre, Malawi; 30% in Lesotho; 23% in Windhoek, Namibia; 25% in Harare, Zimbabwe; and exceeding 30% in Johannesburg, South Africa. USAIDS/WHO (2003:9) state that in Botswana, Lesotho, Namibia and Swaziland, the epidemic has assumed devastating proportions as seen by the percentages indicated and when taking into consideration that a decade ago, Botswana stood at 4% compared to the now 40%.

When comparing Southern Africa to Eastern and Central Africa a very different picture emerges. A decline in the prevalence of HIV infections is evident especially in Uganda where it stood at 8% in 2002 compared to 30% a decade earlier. The same is evident in Rwanda where it now stands at 13% compared to 35% in 1993.



USAIDS/WHO (2003:11) continues that in Addis Abba, among 15-24 year-old pregnant women, the prevalence has dropped to 11% from 24% in 1995. In Kenya, the prevalence among pregnant women is 10%. For these countries and their declining figures, human intervention in the form of education programmes and condom distribution proves that governments can make an impact if this is focused and targeted. It must however be noted that the prevalence of HIV/AIDS among pregnant women are much higher in urban areas compared to rural areas.

In South Africa, 2002 data show that the average rate of women attending antenatal clinics has remained at a constant high level from 1998-1999 ranging between 22%-23% and then increasing to 25% in 2000-2002 (USAIDS/WHO, 2003:9). The highest prevalence in South Africa is amongst young women between the ages of 15 – 24 years. The authors found that a slight decline in teenage prevalence (between ages 15-19) has been offset by consistent high levels among 20-24 year old pregnant women and rising levels among those aged 25-34. It is estimated that 25% of all pregnant women are now HIV positive. The epidemic varies within our country as 37% prevalence among antenatal clinic attendees in Kwa-Zulu Natal is three times higher than that recorded in the Western Cape, with a total of 5.3 million South Africans living with HIV at the end of 2002 (USAIDS/WHO, 2003:9). The authors state that South Africa is experiencing a relatively recent epidemic and when looking at current trends, deaths will continue to rise rapidly over the next five years.

The high rate of infection can be ascribed to behaviour and the risk that women and men expose themselves to. The following behavioural risks have been identified by the Nelson Mandela/HSRC Study of HIV/AIDS in 2002 (HSRC, 2002:78):

- Age of first sexual intercourse;
- Sexual experience and number of partners;
- Condom access and use;
- Socio-cultural practices; and
- Sexually transmitted diseases.

The behavioural risk factors described is crucial when the age of first sexual intercourse is taken into consideration. The average age in South Africa is 18 years which could lead to a number of sexual partners during a life time. It is also true that younger women tend to have sex with older men that have already had previous sexual partners.

The sexual experience and number of partners is crucial as this increases the risk of contracting HIV/AIDS. Various socio-cultural practices such as polygamy, dry sex, rites of

death of spouse for widows also impact on the transmission of the disease. Apart from sexual abstinence, condom use is the only other preventative method available. This relates back to knowledge regarding usage and correct usage which is only possible with education and access to condoms. Not only do condoms prevent the transmission of HIV/AIDS, it is one proximate contraceptive form that prevents conception which also prevents the transmission of HIV/AIDS to a child.

Another aspect regarding HIV/AIDS is knowledge, perception and attitudes:

- Knowledge regarding transmission and effects;
- Knowledge and prevention behaviour;
- Relationship between socio-demographic variables and HIV/AIDS knowledge;
- Attitudes and stigma toward people living with HIV/AIDS; and
- Access to information.

Knowledge regarding the transmission of HIV/AIDS is crucial especially when taking risk behaviour as well as perceptions and stereotypes into consideration. The effects of HIV/AIDS are not commonly known as people can live for a number of years without physical effects. To some, this translates that the person is not infected or sick at all until full-blown AIDS becomes evident. Knowledge regarding prevention behaviour in terms of sexual abstinence and condom usage is marred by other factors such correct usage, gender influence and “it wont happen to me”. The study also found that respondents that were younger, more educated, who live in urban areas, who are employed and who have higher household socio-economic status are more informed. The study also found that the White population group are the most informed followed by Indian, African and Coloured population groups. Access to information regarding the disease as well as the prevention thereof is crucial to combating this epidemic. It was found that the higher the level of education, the better the knowledge regarding prevention, infection, transmission and care.

Sadly, the perception and attitude toward people infected with HIV/AIDS, is negative and people tend to avoid infected or ill people. This is true where infected children are concerned as well as if the mother and/or father is infected. Due to this no support structure could possibly be in place which could result in a HIV positive mother deciding to terminate her pregnancy.

The Nelson Mandela/HSRC Study of HIV/AIDS in 2002 (HSRC, 2002:101) found that all race groups are affected by this epidemic. The differences in the rate of infection can be ascribed to social and behavioural determinants such as living in informal settlements,

access to information and education necessary for prevention, knowing people who have HIV/AIDS or who have died from AIDS, multiple partners as well as having a sexually transmitted disease. Not only does the prevalence differ among race groups but also among gender lines and age groups. Women are at a higher risk of contracting the disease as their reproductive systems make it easier for them to be infected where men are more effective at transmitting the disease due to semen being more infectious. Women are also more likely to have undetected sexually transmitted diseases and infections. Although biological differences can contribute to a higher prevalence among women, we also have to take gender inequality into consideration. This is true when taking the acceptance of multiple sexual partners for men into consideration, male control over contraceptive usage and the women's economic position which makes them and their families dependant on men. This relates back to women's reproductive health and their reproductive rights which is not a given in the South African context.

Of concern of the figures provided above by USAIDS and WHO, is the fact that these are numbers taken from antenatal clinics and are prevalent among pregnant women which are measurable. These do not include the numbers of women infected that are not pregnant, male infections and people that do not know that they are HIV positive. What is significant however is that with this high prevalence of infection amongst pregnant women, their HIV infection could be a primary factor in deciding whether or not to terminate their pregnancy. This could be seen regarding either their own HIV positive status, fear of infecting the child, concern regarding the future of the child as well as current available financial and support networks or the availability of future financial and support networks.

Unfortunately, studies regarding the relationship between abortion and HIV/AIDS have not been conducted and this phenomenon could increasingly impact on the reasons that women cite for terminating a pregnancy and abortion figures as such.

The reasons that women cite for terminating a pregnancy, can be placed within their demographic, social and economic contexts and behaviours. Within these contexts, contraceptive use and the prevalence of HIV/AIDS plays an important role as it either impacts demographic, social and economic contexts or is the result of specific demographic, economic or social behaviours. Although generally assumed by policy makers, the reason for a woman terminating her pregnancy, does not stand in isolation, but was found to be interchangeable within these three contexts. Of importance is the fact that these contexts and behaviours are directly linked to the status and value attached to women, and thus their right to decision making, the freedom to exert a personal choice and the right to adapt their behaviour to reflect the decision made.

If the woman is in a position to exercise these fundamental rights, her demographic, social and economic situation and position will be considerations as to terminate her pregnancy or not (UNFPA, 1998:24).

### **2.3. ETHICAL CONSIDERATIONS**

Although abortion is commonly practised throughout most of the world and has been practised long before the beginning of recorded history, it is a subject that arouses passion and controversy (Population Policy Data Bank, 2004:iii). Abortion raises questions about human existence, such as when life begins and what is it that makes us human. It is also at the heart of such contentious issues as the right of the women to exercise control over their own bodies, the nature of the states duty to protect the unborn, the tensions between secular and religious views on human life and the individual and society, the rights of parents and spouses to be involved in the abortion decision, and the conflicting rights of the mother and foetus.

Abortion raises moral and ethical dilemmas in our private conscience, societal spheres and public policy. Since the beginning of Christianity the church has been concerned with the ethics of abortion. Within the doctrines of different religions and churches there still remains no consensus on this. This view is still strongly supported today, it being the basis of the continuing controversy and debate on abortion. Most of these dilemmas are attributed to religious, moral and philosophical awareness that will dictate whether the abortion stance of a nation will be liberal, conditional, restrictive or illegal. This in itself creates sub-categories of groups within a country as the constitutional law may represent one stance where there exist discrepancies within members of a nation, as members take slightly different positions regarding abortion which stems from their own belief systems.

Mappes and Zembaty (1997:1) concern themselves with the ethical (moral) acceptability of abortion. The authors state that discussions on the ethical acceptability of abortion take for granted an awareness of the various kinds of reasons that may be given for having an abortion as well as an acquaintance with the biological development of a human foetus.

Mappes and Zembaty (1997:1) indicate the following catalogue that is sufficient to indicate that there is a wide range of potential reasons for women terminating their pregnancy:

- If the foetus is allowed to develop normally and come to term, the woman will die;
- If the health of the woman, physically or mentally, will be severely endangered if the pregnancy is allowed to continue;
- If the pregnancy will produce a severely impaired child;

- The pregnancy is a result of rape or incest;
- If the pregnant woman is unmarried, and there will be the social stigma of illegitimacy;
- If having a child, or having another child, will be an unbearable financial burden; and
- If having a child will interfere with the happiness of a woman, the joint happiness of the parents, or even the joint happiness of a family unit that already includes children. This category includes endless possibilities, the woman may desire a professional career, and the relationship might be damaged by the intrusion of a child. Parents may have older children and not feel up to raising another child.

In terms of the moral and ethical deliberation of abortion, most is based on the conditional grounds for allowing abortion to occur. The financial implication of children are also considered and the happiness of a woman, be it in a relationship or not, is also taken into consideration. In terms of the last mentioned, the happiness of a woman encompasses many social and personal issues that the woman might be experiencing

The determinant for deciding when it is morally acceptable to terminate a pregnancy is dependant on *up to what point of foetal development, if any, and for what reasons, if any, is abortion ethically acceptable?* This relates back to the question when does personhood start. Mappes and Zembaty (1997:3) state that some hold that abortion is never ethically acceptable or only acceptable when necessary to save the life of the mother, thus a conservative viewpoint. Others that hold that abortion is always ethically acceptable - at any point of foetal development and for any of the standard reasons, is seen as holding a liberal viewpoint. While others view that abortion is acceptable up to a certain point of foetal development and/or hold that some reasons provide a sufficient justification for abortion whereas others do not, is deemed as the moderate view.

The basis of the moral-religious argument is based on: *When does life begin?* The question forms the premise of the theoretical debate on whether abortion is morally justifiable and acceptable, and is also dependant on at what stage the foetus is viewed as having a soul, thus being classified as being "alive". This implies that abortion is either viewed as "murder" and "killing", or not, depending on the answer provided to the above question. The conservative viewpoint states that the foetus has full moral status and entitled to the same degree of moral consideration as a fully developed human being (Mappes & Zembaty, 1997:3). By assigning full moral status to the foetus, it entails that the foetus has the right to life that must be taken as seriously as the right to life of any other human being.

In direct contrast to the conservative view, the liberal view holds that the foetus has no (significant) moral status and no rights, and therefore abortion is not morally objectionable. Mappes and Zembaty (1997:5) further state that moderates may argue partial moral status and therefore the foetus has limited rights and moral status. In terms of moderate viewpoints, some abortions are morally justifiable and some morally objectionable. Thus both the alleged justifying reasons are relevant factors in assessing the moral acceptability of abortion.

It is due to the varying answers relating to when does life begin that the premise underlying whether women should have a choice to terminate their pregnancy or not, lies. A social consensus does however exist that when human personhood (or life) begins, that person must be protected. The distinction is made on what are the necessary and sufficient conditions of personhood. It is based on the conflicting beliefs of when personhood starts, that leads to the opposing beliefs of whether a woman should terminate her pregnancy or not (Religioustolerance: 2001).

To people that oppose abortion, human personhood (or life) begins at the instant of conception and stipulate that all abortion should be prohibited (Bouchier-Hayes, 1998:1). The main argument advanced against abortion is that the foetus is an innocent person and that it is morally wrong to end the life of an innocent person (Hinman, 2001:10). Ferreira (1985:12) states that from the middle of the 20<sup>th</sup> century, the abortion debate developed into a clash between the interest of the individual and those of society. This brings into context the debate between the collective good of a society versus the individual good. These resulted in a clash of rights between the rights of the foetus and the rights of the mother, or the rights of society as such, and were argued that the rights of the foetus were subservient to those of the mother. Within this classification, many members however will allow for conditional abortion, e.g. when the life of the woman or foetus is threatened or in the case of rape and incest. This conditional view point allows for exceptional circumstances to be taken into consideration.

The principle of double effect (Hinman, 2001:19) indicates justification based on moral grounds where bad consequences are weighted against morally justifiable consequences. This indicates that although abortion may be viewed as morally wrong and personhood viewed as starting at conception, allowances for terminating a pregnancy are made under certain conditions. These conditions are however based on moral perceptions and the consequences of continuing with the pregnancy. These may be more negative such as the potential death of the mother or when the conception occurred on a negative premise such as rape or incest.

It is important to note the conditional stance of abortion legislation where conception occurred due to rape or incest, is also dependent on the position of women in a society and the legislative stance taken on rape and incest.

In the case of a more liberal stance on abortion, human personhood (or life) does not begin the instant of conception but begins later in gestation or only at birth (Bouchier-Hayes, 1998:1). Historically, the time at which a person has been said to come into existence varies. Muslims date personhood from fourteen days after conception, Aristotle and his followers dated ensoulment at forty days after conception for a male foetus and eighty days after conception for a female foetus (English, 1997:21). This allows for the moral justification that abortion does not end the life of an innocent person as the foetus is not viewed to have reached personhood at the time of the termination. Within this classification, the debate as to when personhood starts, also vary and members will only support the choice to terminate a pregnancy if this occurs prior to the foetus reaching personhood. The premise is that abortion is an informed decision made by a woman based on her individual circumstances and position.

As previously stated, discrepancies exist within viewpoints as to when personhood starts. Even though it may be seen as starting from conception, a liberal stance can still be taken based on the situations and circumstances of women and their right to choose to terminate their pregnancy. Carl Sagan reasoned that "*abortion is a civil rights matter....a decision that should be left up to an informed woman and her physician*" (Religioustolerance: 2001). It is safe to say that consensus regarding abortion will never be reached due to the fundamental question of when does life begin

Central to the subject of abortion is the highly controversial social issue of sexuality as it leads to the consideration of how the pregnancy came about and the ways that the pregnancy could have been prevented by using contraception. Abortion is not a method of family planning or so it is theoretically positioned. It could be used as such where access to contraception is not freely available and leaves no other discourse for women to follow.

Regardless of which stance is taken on abortion legislation, the objectives are the same: to reduce the number of abortions. The methods of achieving these objectives are different and they are based on divergent beliefs about when abortions are justifiable or not. The difference lies in whether abortion is opposed in totality, whether it is allowed under certain conditions or whether it is liberal.

## 2.4. FEMINIST FRAMEWORK

Feminist theory has been applied in the sociological, psychological, social, economic, moral and ethical studies but not prevalent as yet within a demographical framework. Demographics are concerned with the quantitative analysis of statistics to provide us with measurable data for generalisation and comparisons. In terms of investigating reasons women have for terminating their pregnancy, it was deemed important to view this within a feminist framework as it ultimately is the woman that is impacted by terminating a pregnancy as only the woman can ultimately decide whether or not to have an abortion. In no way is the impact of abortion on partners or spouses denied, or the fact that external factors such as the opinions and actions from others or society influence women or are primary reasons in deciding to terminate their pregnancy, but it is ultimately the women and her body that undergoes a termination of a pregnancy. Mary Daly (Daly, 1973:106) states that *“one hundred percent of the bishops who oppose the repeal of antiabortion laws are men and one hundred percent of the people who have abortions are women...to comprehend accurately, they (arguments against abortion) must be seen within the context of sexually hierarchical society”*.

Sherwin (1997:49) states that because the public debate surrounding abortion has been set up as a competition between the right of the women and the rights of the foetus, feminists have often felt forced to reject claims of foetal value in order to protect women's needs. She also states that on a feminist account, foetal development is examined in the context in which it occurs, within a woman's body, rather than in isolation. Foetuses develop in specific pregnancies that occur in the lives of particular women. Sherwin (1997:49) continue that they are not individuals housed in generic wombs or full persons at risk only because they are small and subject to the whims of women. Their very existence is defined and reflects foetal development within particular women's bodies; and therefore that relationship gives those women reason to be concerned about them and themselves.

Mappes and Zembaty (1997:7) state that the following set of beliefs are common amongst feminists: 1) traditional society is patriarchal, i.e. male-dominated, 2) the institutions of contemporary society continue to advantage men at the expense of women, and 3) traditional thought patterns typically express a male point of view and often submerge and distort the experience of women. Feminist theory is mainly a response to “male-stream” theory by challenging male centred perspectives. Warren (1997:10) argues that conventional theory is about men's lives and men's worlds and is in actual fact disregarding half of the human race, that is, women as their experiences are ignored and



rather focused on that of men. This in itself distorts the truth reflected in society as women are still marginalised. McKay (1999:341) states that contrary to the conventional science that prides itself in that it is value-free and therefore a neutral science. Feminist theory argues that the commitment of conventional sociology to “value neutrality” and its endeavour to being a value-free science tends to camouflage the male political bias within the discipline.

In contrast to this, a women centred perspective attempts to present a theoretical system of ideas and features from a women centred perspective. “*What about women?*” is the underlying theme. An argument to sustain this perspective is that women’s visibility is one indicator of their inequality (McKay, 1999:342). Blackmun (1997:33) state that feminist theory has attempted to explain how the social differences between women and men have arisen and to then describe the types of social change that that would lead to equality and freedom.

Due to the increasing emphasis placed on these concerns of feminist theory, it has contributed to a theory of universal importance and produced a switch in our understanding of the world. Mappes and Zembaty (1997:7) also state that a commitment to take seriously the experience of women is also a premise for feminist theory. Of importance is the experience of women involving insistence on the importance of relationships and the responsibility in which the relationships give rise. Therefore, feminists view human beings as interconnected and interdependent individuals and not in isolation and independent of each other.

Although feminism focuses on women being central to the theme, it inexplicitly attempts to alter social institutions and situations as women are present in most social situations. Where they are not present, it is not because they lack ability or interest but because there have been deliberate efforts to exclude them. Where women are present in social situations, women’s roles are very different from the popular conception of themes, e.g. as passive wives or mother (Ritzer, 1992:310). Although women are actively present in most social situations and their roles have been essential, they still have not been identical to those of men. In this regard their roles have been different, less privileged and subordinate to those of men. Their invisibility is only one indicator of this inequality.

Apart from the first question, feminism also needs to incorporate the question of “*Why is the situation as it is?*” seeking an explanatory answer. This allows for the classification not only of the general objective of the feminist theory, but the underlying studies and expanding literature on gender (Ritzer, 1992:318).

This leads to the classification of explanations based on theoretical classifications as possible explanation. Many feminist theories are linked and based on a central point of explanation. Marxist feminism is based on capitalism being the basis of women's difference, inequality and oppression. Radical feminism is based on patriarchy being the basis of women's difference, inequality and oppression.

Due to the various answers in terms of the above questions, it is important to differentiate this further into the existence of many feminisms. McKay (1999:342) further acknowledges that the term "women" does not imply sameness amongst all women as it is aware of the theoretical invisibility and inequalities affected by class, race, age, religion, ethnicity, global location, personal volition and affectional preferences. Moore (1993:11) concurs that feminism is divided into many factions so to speak and also cuts across different schools, e.g. Marxists feminism, Psychoanalytic feminism, Liberal feminism, etc, and that we should term feminism in terms of the existence of feminisms.

Therefore not a united feminist perspective but rather a multitude of feminist theoretical deviations although the following underpin all feminist theory (McKay, 1999:342). Ritzer (1992:308) states that: 1) the major objective of feminist investigation is the situation (or situations) and experiences of women in society. This is true as the study aims to understand the situations, circumstances and experiences of a woman's life and these influences on their decision to terminate their pregnancy. Reasons for deciding to terminate a pregnancy do not stand in isolation and is an intricate relationship between reasons and sets of reasons. The current situations and circumstances of women provide the framework for their decision making and outcomes are based on past and present experiences, 2) feminist theory treats women as central subjects in the investigation process by attempting to see the world from the distinctive vantage points of women in the social world. By allowing women to narrate their decision making process and the reasons that influenced their decision in their own words, allows us to see their reasoning from their own perspective and their own lives without generalisations. It is important to hear stories that are true to women and true to their lives, and 3) feminist theory is critical and activist on behalf of women, seeking to produce a better world for women.

Only by allowing women to tell their personal stories, to try to understand their own reality and by listening and conceptualising their personal reality; and by giving women a platform on which to do so, can we provide a world true to women and true to the reality of women. It is important to provide a world true to women so that we can identify factors important to women self and not based on what men deem to be important to women.

Feminist theory provides a system of ideas about human life that features women as object and subject, doer and knower. This relates directly to the complexity of life and therefore again the importance of allowing women to tell their own stories true to their reality and perceptions. By imposing preconceived ideas and generalisation as to why women decide to terminate their pregnancy, we deny the truth as seen and understood by women from their personal reality.

Reasons for terminating a pregnancy can also be seen in terms of power relationships between women and their partners, significant others and society in general as well as the perceived consequences and reactions. By following a conservative viewpoint in which abortion is never justified, we project a power relationship from a societal viewpoint onto women in terms of dictating what is right and what is not, regardless of women's current reality. From this perspective it also places pressure on women in terms of either justifying their decision against a society that views abortion as immoral and wrong. This relays that women cannot openly and honestly discuss their reasons when deciding whether or not to terminate their pregnancy. It is also true from a gender perspective where women may not have full control over their reproductive health either: choosing to use contraceptive methods to stop conception if this is against specific religion or cultural values, or that they do not have control to decide whether or not to terminate their pregnancy.

Power relationships also influence women in sharing their reality for fear of recrimination and persecution which could be possible depending on societal norms, values and legislation. When not allowing women to narrate their personal stories, again a projection of what is correct behaviour and what is not is enforced, which limit a woman's power over her own world and reality. This then also limits women to exert their personal choice from an empowered position.

Aligning to the characteristic of webbed accounts (Ritzer, 1992:344), feminist theorists do not adhere to the concept of relativism by allowing one account to cancel out another through the process of prioritisation. When dealing with demography and statistics per se, weighting and prioritisations are key and is evident when investigating previous studies regarding reasons for women deciding to terminate their pregnancy. Again, the value of this is not denied but it does not reflect a true relationship between reasons by women. The relationship between reasons and sets of reasons is equally important in terms of a woman's reality. Not one reason stands in isolation to another unless this is true to a woman's personal situation or experience. Women's reality is linked through their experiences, situations and circumstances and reasons are related to each other in terms of primary or secondary concerns.

Although reasons and sets of reasons may be common across women's stories, it is not replicated verbatim as the concerns are relative to each woman's personal reality and cannot be generalised to be true for all women that decide to terminate their pregnancy. All accounts should hold equal weighting and the accounts are woven together by reporting all the respondents' versions of their experience and describing their situations from which they came, to create these versions or understandings.

Women find themselves caught up in agendas that shift and change in relation to others and the situations of others (Moore, 1993: 5). This is very true for women that decide to terminate their pregnancy as causal factors do not remain constant and as one situation in their lives change, so it affects the decision that they make. Many factors are unpredictable although some stay constant, but based on the constant, additional liquid factors come into play. For example, a woman that falls pregnant might have the constant situation of "I am too young" but liquid factors would include relationships with her parents, partner, religious and moral values, and personal aspirations. These factors are unpredictable and open to constant change. Her knowledge and understanding of these factors would inevitably guide her decision to terminate her pregnancy or not. This is substantiated by Ritzer (1992:349) as the model presents actors in their daily lives responsively located at the centre of a web of other's actions and who find themselves part of one or more situations by forces that they cannot predict or control. The factors that cannot be controlled can be numerous and again indicates the importance of allowing women to narrate their own stories as to what constants are not malleable and which reasons can be controlled to either make the decision to terminate a pregnancy or not.

The meaning that is ascribed to actions and behaviour is based within social situations and pre-defined definitions. Male dominant viewpoints and standards can trivialise women's viewpoints and render women's experiences insignificant or trivial. This is true when taking into consideration the historical viewpoint of abortion as being wrong and not taking the importance of women's reality into consideration. The personal circumstances and situations of women are fundamental in terms of their reproductive rights but also in terms of the importance that they attach to their experience. Women's reasons cannot be trivialised or ignored as this is fundamental in whether a pregnancy will be terminated or not. Of importance when women's stories are trivialised, each abortion is then seen in isolation where this is not necessary. By allowing a platform for women to narrate their personal stories, a bond can be created where women in similar situations can communicate. This may not be true as yet, but the platform should start to be created and by at least narrating their stories to the researcher, a first step has been taken. This could assist and lead to the creation of interactions between women to share and create

meanings that depict their life experiences which are true for women. Due to power relationships and perceptions, women fear sharing their experiences as it could be trivialised and judged according to pre-conceived ideas and historical perceptions.

Another factor than needs to be taken into consideration is that women are ascribed various roles which is often seen as less important than the roles of men. Within the context, women that choose to terminate their pregnancy can view their decision as a “failure” to conform to societal norms and thus inferior to what societal expectations of women as a mother and homemaker are.

The right of women to choose whether or not to terminate their pregnancy must be seen within the evolution of feminism and the voice of women emerging within an international context. Historically abortion was viewed in terms of what men deemed as appropriate and correct in terms of women’s behaviour and terminating a pregnancy was viewed and wrong and therefore illegal. Only through a strong emergence of human rights and therefore emphasis on women’s rights, did the historical perspective change regarding abortion. Again, this is not as simple as just the emergence of human rights, but the voice of women regarding their reproductive behaviour came to the foreground in terms of population concerns raised internationally and the role of women within this paved the way for women being able to decide whether they want to terminate a pregnancy or not.

## **2.5. HISTORICAL PERSPECTIVE**

Historically abortion has been viewed as deviant and pathological behaviour as it was largely concerned with the moral and religious values of abortion (Ferreira, 1985:11). Although it is accepted that abortion is as old as civilisation itself, it is true for illegal abortions. A shift in attitude toward abortion and abortion research were only experienced in the mid-sixties for Western countries. The Population Reports (1973a) in Ferreira (1985:20) states that the year 1973 is taken as a starting point of significant abortion law liberalisation. Five of the most populous countries – China, India, the Soviet Union and the United States – already permitted legal abortion in early pregnancy. During 1973 and 1974 policies in Austria, Denmark and Tunisia were liberalised to permit abortion upon request during the first trimester of pregnancy. The new statute in 1973 in Korea permitted abortion if the pregnancy jeopardised the woman’s health. At the same time Guatemala and El Salvador permitted abortion to save the life of a woman. Abortion upon request was permitted in France in 1975, and in the same year abortion for economic indications become legal in West Germany.

Although abortion laws were still restrictive the historical liberalisation of these laws are quite significant and even more so the exceptions. The use of abortion as a method of contraception was already prominent and accepted in the former Soviet Union from the turn of the twentieth century. Abortion on request has been available in Russia under the decree of Stalin since 1920. Various satellite countries in Eastern Europe also legalised abortion from approximately 1920. All Scandinavian countries began to liberalise their abortion laws from 1938 (Ferreira 1985:20).

The visibility that abortion received during the sixties was two-fold: Firstly, the voice of feminism became very strong although feminism has existed since 1650. Only during this period did it gain enormous momentum in terms of publications and the emergence of different feminisms. Feminism upholds the idea of bodily self-determination and that reproductive consciousness is continuous and integrative, constantly affirming women's unity with nature (Humm, 1995:240). It also upholds the argument that because being women, they are most affected by reproduction and the choice should be theirs. And secondly, physicians became more aware of the complications that were associated with illegal abortions, a move from the collective-good toward individual-good, a decreased religious adherence and morality and a shift toward abortion being more legitimate and visible.

Since the 1940's, health care professionals began to voice concern at the prevalence of illegal abortion. This evidence, combined with social, demographic and medical developments, started the move to legitimating abortion. New medical advances in the development of safe, simple and inexpensive vacuum aspiration techniques challenged existing restrictive laws. In a study by Tietze and Murstein (1975) it was found that abortion done under medical supervision involved less risk than continuing a pregnancy to term. In addition the new techniques made early terminations of pregnancy available on an outpatient basis. Ferreira (1985:15) states that many laws originally enacted to promote reproduction or to protect women from unsafe practices were amended in the light of national recognition of the benefits derived from reduced population growth and from constantly improving medical technology. The liberalisation of abortion refers not necessarily to the legalisation of abortion laws but to the relaxation of the former more restrictive laws. The trend towards liberalisation of abortion laws began after the Second World War and gained vast momentum during the seventies (Ferreira, 1985:13).

Various societal trends in the sixties further contributed significantly to the growth of abortion reform, amongst these were the emergence of civil rights movements, feminism and the growing openness in regards to human sexuality.

Sarvis and Rodman (1973:44) cite the re-emergence of the women's movements, the first signs of interest in a consumer approach to health care delivery, and growing alarm over the rapid increasing world population amongst these trends. Of importance was the focus given to a greater appreciation of reproductive rights and women's rights to control her own body and privacy, and the emphasis on the importance of bearing children who are wanted and who can be properly cared for.

Feminism states that reproductive rights include the right to become a mother, the right to contraception and the right to an abortion. Humm (1995:241) states that control over the termination of pregnancy is central to the future of women as it is essentially a political struggle about a woman's right to self-determination. Abortion on demand is central to feminist theory and politics. It is the most visible sign of an "anti-women" healthcare system as it limits women's access to safe abortion services. Legal rights do not give women material rights (Humm, 1995:1). Ferreira (1985:14) states that these factors combined with an increasing recognition of demographic pressure and awareness of the demographic impact of abortion increased the change in attitudes and approaches towards abortion.

Although there was a change in the moral-religious ethics of society and a change in attitude toward abortion, it must be noted that this would not have been possible without the emergence of human rights. It is in this context that women's rights were given prominence and as such led to the legalisation of abortion laws. This was borne out of the fundamental principle of reproductive rights that emerged in the international arena. It must be noted that human rights are not limited to reproductive rights but encompass numerous factors (Ferreira 1985:14).

Holistically viewed, the emergence and acceptance of human rights changed the role of women in society and this has also contributed to a significant change in position that women hold in society. When viewing the change from the historical figure of wife and mother, liberalised women fulfil various roles and responsibilities, and this directly contributes to the fact that women have a choice regarding their reproduction and that this choice is different for each woman based within their personal context.

To understand the importance of the change in women's reproductive lives, it is important to understand the emergence of women's rights and the arena which contributed to the acceptance of women exerting an individual choice regarding the termination (or not) of their pregnancies.

## 2.6. HUMAN RIGHTS AND REPRODUCTIVE RIGHTS FRAMEWORK

Up until 1974, the international arena was fraught with contradiction regarding human rights and population growth. Regardless of the establishment of the Universal Declaration of Human Rights in 1948 by the United Nations, population growth was still viewed in terms of a threat (Homan, 1991:118). The 1948 Declaration underlined the principles of equality and non-discrimination and members that undersigned the declaration are bound by it to promote and to protect fundamental human rights. Homan (1991:120) states that the most significant responsibility placed on governments is the rights given to an individual to allow each individual to make their own decisions based on non-discrimination and equality.

The context of human rights is selective depending on each nation's moral, religious and philosophical values. Human rights are certainly not universal and nations are selective in their implementation of human rights, especially human rights regarding the freedom of individual choice. This is most prominent in the implementation of reproductive rights. In the 1968 Tehran conference regarding human rights, emphasis was placed on the inclusion of reproductive rights within the framework of human rights (UNESCO, 1997:326), and that the slogan of "*parents have the right to determine freely and responsibly the number and spacing of children and the right to adequate education and information*", was born.

From the 1940's up until the World Population Conference in 1974 in Bucharest, the international arena was underlined by the Malthusian threat: the earth's resources cannot sustain or contain the world's rapid population growth. The international focus was on rapid population growth, thus high fertility creating strong barriers to economic development.

The solution was lowering fertility rates through the implementation of family planning programmes and thus promoting the use of contraceptives to reach demographically set targets (Cohen, 1995:76). Many may argue that these view points significantly impede the evolution of human rights, but contrary to this, this created a greater freedom of choice regarding individual reproductive rights and thus human rights. Ironic in the approach of curbing fertility through government programmes, and the promotion of contraceptives to deal with the collective-good rather than the individual-good and freedom, it paved the way for women to exert their individual preference regarding their fertility and reproduction.



By governments focusing on the provision of contraceptives to curb population growth, contraceptive methods became more advanced and available to women and assisted them with making personal decision based on personal circumstances (UNESCO, 1997:326).

### **2.6.1. THE WORLD POPULATION CONFERENCE, BUCHAREST, 1974**

The 1974 World Population Conference in Bucharest was characterised by a debate between the countries of the northern and southern hemisphere (Ashford, 1995:9). Northern governments advocated demographic targets and supported the idea that family planning programmes should be the primary means to control population growth. The premise of the argument was that rapid population growth created barriers to economic development. This was vehemently contradicted by the Group 77 (G77), a non-aligned association of southern countries, who stated that rapid population growth was not the cause of underdevelopment, but rather a result of the lack of development. The G77 argued that “*development was the best contraceptive*” and that equitable socio-economic development would lay aside demographic threats (Ashford, 1995:9).

The conference led to the establishment of the World Population Plan (WPPA), which according to Ashford (1995:7) and Sen (1994:4), was the first ever formal international document addressing population policies and programmes. The WPPA compromised between the need to control population growth and the need to regard population issues as one of many variables affecting development. Of importance was the inclusion of the equality of women and their potential contribution to development.

The reference to the equality of women was unfortunately only fleeting and the WPPA advised that government actions should be taken within the framework of development, but no responsibility was placed on governments to adhere to the framework provided (Ashford, 1995:13; Sen, 1994:6).

### **2.6.2. THE INTERNATIONAL CONFERENCE ON POPULATION, MEXICO CITY, 1984**

A reversal of views held 10 years earlier occurred. Southern countries now also advocated family planning programmes to curb high birth rates and thus rapid population growth characterised the International Conference of Population in Mexico City.

The change was based on results achieved by family planning programmes in various countries to achieve demographic targets, none more famous than China's one-child policy, reversing their previous slogan of "*China's wealth is her people*" (Ashford, 1995:7).

Ashford (1995:7) states that the Mexico City Declaration focused on the promotion of the equality of women and their potential contribution to development. This had more impact than the WPPA as the declaration also argued that nations must make safe and accessible family planning services universally available in the context of non-discrimination. The declaration was the first to note the relationship between population, resources, environment and development, and also gave more prominent attention to the rights and equality of women by stating that this must be taken into consideration during all phases of development (Ashford, 1995:8).

The withdrawal in the support of the UNFPA and the IPPF from the United States of America (USA) shocked the international arena. The USA, under the Reagan administration stated that population was a neutral phenomenon and as such withdrew funding from all agencies assisting in abortion-related services (Ashford, 1995:8-9). Characteristic of the WPPA and the Mexico City Declaration is that very little focus was placed on human rights and by extent individual rights. Individual rights were subject to the general and social well being of the community. Once again the age old debate between the collective-good versus the individual-good. Despite this, the fact that emphasis was placed on the equal status of women, paved the way for future development.

### **2.6.3. THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT, CAIRO, 1994**

The International Conference on Population and Development (ICPD) held in Cairo in 1994, was the breakthrough in the international arena by not only moving away from the idea of the collective, but also by emphatically emphasising reproductive health in the context of human rights. Johnson (1994:451) states that the ICPD based its arguments on the 1993 Women's Health Coalition, which stated that "*women have the individual right and social responsibility to decide freely when/if and how many children they desire*". This conference also focused on the fundamental sexual and reproductive rights of women and emphasised that family members, religion, policy makers, ethnic groups or governments may not dominate these rights.

Since 1974, attention was given to the status of women and their potential contribution to development, but only in 1994, was this aspect embraced by the international arena. The strength of the ICPD lies in the fact that this was the first international document or policy to be consented to by all parties present, including the Holy See (The Vatican), although accepted with objections and reservations regarding language referring to unnatural methods of contraceptive use and abortion on demand.

The World Plan of Action was drawn up by 180 governments, 1200 non-governmental organizations (NGO's) and various private organisations of which feminist groups were the most prominent (Johnson, 1994:324). Another breakthrough was that for the first time NGO's gained recognition for their role in the development of policies and for their work at grass-root levels, by affording them official participation at the conference and official involvement in the drawing up of the World Plan of Action. This revoked their observer status that was afforded them previously. The criticism of the ICPD is that the World Plan of Action is not decreed to the nations that consented to it. No government is obliged to enforce the Plan of Action, thus resulting in each government retaining their sovereign rights. This stems from the fact that many countries view human rights to be a purely western phenomenon and that it disregards their religious, moral and philosophical values.

According to Johnson (1994:326), the theme decided on prior to the ICPD was defined as "*population, sustained economic growth and sustainable development*". The importance of the ICPD does not only lie in its focus on individual rights but on the various topics brought to the foreground.

The topics as laid out in Johnson (1994:326) and the IUSSP (1995:18) are as follows:

- Population growth;
- Policies and programmes;
- Population – development - environment;
- Population distribution;
- Women-population, and
- Family planning programmes, health and family well being.

Relevant to this report is the focus on sexual and reproductive health of women, strongly advocated by women's rights groups and feminist groups. Support in their plight came in the reversal of the USA's stand on population being a neutral phenomenon.

The USA also defied attempts made by the Vatican to restrict the inclusion of abortion on demand, by declaring, “*Access to safe, legal and voluntary abortion is the fundamental right of all women*” (Johnson, 1994:327).

Sen (1994:4) state that criticism of population problems was that the previous top-down approach was target driven and according to a “*single-minded goal of fertility limitation which at times induced ethical violations, ineffective programmes, programmes with little regard for the health of women and coercive policies violating women’s rights to reproductive freedom*”. Target driven population policies view women as entities, and as part of the collective, thus disregarding their individual decision making with regard their own reproductive behaviour. The move away from the individual rights being subordinate to the collective well being of the community, promoted individual decision-making. Lane (1994:1310) states that women have borne the brunt of unethical population policies and this not only disregards their individual rights but also violates their bodily integrity.

It must be noted that individual rights are accompanied by the responsibility on the part of the individual regarding their reproductive behaviour. The focus on individual rights does not advocate demographic targets and as such does not address the population issue in terms of numbers. A vacuum that exists regarding human rights is that it does not address biological and reproductive differences between the genders and is solely based on decision-making (Lane, 1994:1307).

Reproductive and sexual rights do not only include the freedom of choice to exercise individual rights, but includes the provision of services provided. This includes access to family planning services, access to safe and legal abortion, access to safe maternal health care as well as safe and accessible health care services to all women, and access to the basic right of education. This change in focus brought about in the international arena sparked violent attacks on many nations for their existing population policies, which are still target driven. Sen (1994:4) and Ashford (1995:7) state that the underlying principle in the conference was summarised as “*a broad range of voluntary family planning programmes and services integrated into a program of reproductive and sexual health care that would include access to safe and legal abortion, based on the women’s right to control her own fertility*”.

As concluded from the above, abortion on demand is an integral part of reproductive rights; and the provision of adequate abortion services, an integral part of reproductive health. Unfortunately for feminist groups, the abortion debate at the conference was placed in medical terms, and taken out of the context of women’s rights.

This argument was a rational one as it incorporated the premise that abortion is not a form of contraception, but rather a medical issue as in most countries where access to safe abortion is restricted by legislature, high maternal mortality rates prevail. This led to a greater acceptance of the incorporation of the advocacy of safe and legal abortions in the Plan of Action (Lane, 1994:1317).

The ICPD's Plan of Action is not binding to any government and all countries remain sovereign in their rights to determine their own population policies within the framework of the Plan of Action (Lane, 1994:1318). This allows governments to place their religious, ethical and cultural heritage in a superior position to individual and human rights. The Plan of Action recommendations take on the form and quality of international norms that exercise pressure on nations who do not conform to the framework provided.

Due to the fact that the Plan of Action is not international legislation, not binding all governments to the implementation thereof, it restricts the freedom of individual reproductive rights of certain women. When taking the historical emergence of the plight of individual freedom of women into account, it is significant to note that although a major breakthrough has occurred, it is sadly limited to specific nations. The population conferences contributed significantly to giving prominence to women's rights and reproductive rights, and have allowed women to exert a personal and individual choice regarding their reproductive behaviour. Due to the fact that abortion was accepted by many countries, liberalisation, and in some instances, legalisation of abortion laws followed. This has led to women being able to make a decision regarding abortion without fear of legal recourse and to consider their personal situations in their decision making.

Of importance is that South Africa did not stand in isolation during the emergence of human rights and reproductive rights in the international context. South Africa was very much part of the adherence to the international framework and this is evident in both the previous government legislation and our constitution. South African abortion laws has adhered to the guidelines stipulated in the international arena as is evident from the Abortion and Sterilisation Act no. 2 of 1975 which was viewed as liberal, though conditional. Our legislation regarding abortion has also followed the evolution process of becoming legal, and this is evident in our current Termination of Pregnancy Act no. 2 of 1996. It must be noted that this process must be viewed in terms of our own human rights and population policies that paved the way for the legalisation of abortion.

## **2.7. SOUTH AFRICAN POPULATION POLICIES**

The National Family Planning Program, which was implemented in 1974, aimed at limiting the population growth rate. This was perceived to be a political move, to curb the population growth rate of the black population within the context of the white minority (UNHCF, 1997:24). Within the context of the program, static and mobile family planning clinics were established and contraceptive commodities were provided free of charge. The program however came under much pressure, both for its ideological focus and for the inadequacy of its services (UNHCF, 1997:24).

In the early 1980's, the decision was made by government to implement a policy aimed at explicitly lowering the national population growth rate. This was based on the grounds that the country's resources (especially water) could not sustain the prevailing high levels of population growth (PDP, 1984:2). The 1984 Population and Development Program (PDP) conformed to the international arena in that it was a target driven population policy by attempting to reduce population growth. The PDP strongly supported the Mexico City Declaration by aligning and accepting the Malthusian threat of population growth. Strong support was given to family planning services and the use of contraceptives to reach demographic set targets. The PDP set a demographic target of achieving a total fertility rate (TFR) of 2.1 by the year 2010 (PDP, 1984:7). In recognition of the fact that family planning by itself would not achieve this objective, the policy included interventions in other areas that impact fertility levels, namely: education, primary health care (including family planning), economic development, human resource development and housing (PDP, 1984:4).

The recognition of the broader dimensions of population growth marked a significant shift in government's attitudes to the population problem. However, the PDP was still viewed by some as a political plot by the apartheid government to target specific population groups to lower their population numbers in fear of strong opposition coming to the foreground. This fact is debatable when one takes into consideration the context of the international arena. Problems experienced with the PDP are that it centred only on the provision of contraceptives and did not involve various aspects of reproductive health, such as the provision of safe and accessible health care services.

Changes in the above attitudes towards population issues became discernable by the early 1990's as the African National Congress (ANC) and various NGO's got more involved in the population issue. This is indicated by their involvement in both the 1984 Mexico City, and the 1994 ICPD conferences (Ashford, 1995:9).

After the 1994 ICPD, a need arose to replace the PDP with a service that focuses on the provision of welfare services, aimed at improving the quality of life of the whole population rather than reaching demographic targets. A desperate need existed for a policy that focused on the socio-economic development of the country as a whole.

Since 1994, under a new democratic dispensation, a turn-around in the perception of and attitudes towards population issues has occurred. Recognition of the role of population in development is viewed as inseparable from democracy, development and basic human rights.

The development of the new national population policy commenced in June, 1994 when the African Government of National Unity initiated a review of the population policy adopted during the apartheid era as well as the functions of the population units at national and provincial levels (Population Policy for South Africa, 1998: vi).

The Green Paper for Public Discussion: Population Policy for South Africa was borne in April 1995 within the context of the ICPD and within the framework of a human rights approach. The Green paper was widely advertised and written submissions were requested from interested parties and the general public. Unfortunately, response rates were low and a total of only 749 submissions were received from academics, community groups, government departments, NGO's and the private sector (Population Policy for South Africa, 1998: vi). From these responses, proposals were formulated regarding the approach that the population policy should take to reflect the findings.

According to the Population Policy for South Africa (1998:vi), the predominant view expressed was that a new population policy for the country was necessary, and that the policy should:

- Form an integral part of national development strategies;
- Have as a major goal the provision of a broad range of social services to improve the quality of life of the entire population, instead of the achievement of demographic targets;
- Ensure the establishment of effective mechanisms for the collection, analysis and interpretation of demographic and related socio-economic data and their use in policy formulation, planning, programming, monitoring and evaluation processes in various sectors; and
- Lay the basis for the construction of interventions that should receive attention as part of the implementation of specific programs in sectoral departments.

The completed draft discussion was presented to the Minister of Welfare and Population in September 1996. The following month Cabinet approved that the document be gazetted and released for public comment as the first Draft White Paper for a Population Policy for South Africa (Population Policy for South Africa, 1998: vii). This was widely distributed and public comments on the contents were invited until the end of February 1997. The Cabinet Committee approved the final draft of the White Paper for Social and Administrative Affairs in August 1997 and public hearings were held in October 1997 to offer the public an opportunity to air their views on the policy.

The White paper was tabled in Parliament in April 1998 (Population Policy for South Africa, 1998:vii). The population policy described in the White paper is designed to provide a comprehensive and multi-sectoral framework. The approach is that population concerns are multi-faceted and inter-sectoral. The policy further conforms with the Bill of Rights contained in the Constitution of the Republic of South Africa and forms an integral part of the strategies to enhance the quality of life of the entire population. The program is also inclusive of South Africa's endorsement of the Program of Action of the ICPD and thus the strategy for development that focuses in the interdisciplinary relationship between population, development and the environment. We can clearly see that South Africa adhered to the international road paved by the ICPD, and adopted the principles of the Plan of Action.

According to the Population Policy for South Africa (1998:x), twenty-four strategies covering ten broad areas were identified namely:

- Coordination and capacity building for integrating population and development planning;
- Advocacy and population information, education and communication (IEC);
- Poverty reduction;
- Environmental sustainability;
- Health, mortality and fertility;
- Gender, women, youth and children;
- Education;
- Employment;
- Migration and urbanisation; and
- Data collection and research.



The guiding principles of the policy are based on the following (Population Policy for South Africa, 1998: 7):

- All South Africans are born free and equal in dignity and rights. Everyone is entitled to all the rights and freedoms set forth in the Universal Declaration of Human Rights and the Bill of Rights of the Constitution of South Africa. Population policies must therefore respect human rights.
- The right to development is a universal, inalienable and integral part of fundamental human rights. The people are the country's most important and valuable resource as well as the central subject of development. The role of government in the development process is to facilitate people's ability to make informed choices, and to create an environment in which they can manage their lives.
- Population, sustained economic growth and sustainable development are closely interrelated. Population policy should therefore be an integral part of an integrated system of development policies and programs in a country. Its ultimate goal should be enhanced human development.
- A population policy is more comprehensive than a fertility policy and includes such consideration as fertility, mortality and migration as well as their economic, social, cultural and other determinants.
- Timely and reliable data and information are basic prerequisites for the design, monitoring and implementation of an appropriate population policy.
- *Advancing gender equality, equity and the empowerment of women, are fundamental prerequisites for sustainable human development, and thus constitute cornerstones of population and development programs.*
- *All couples and individuals have the right to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so.*
- People have the right to move freely within the boundaries of their country. Refugees may seek asylum from persecution in countries other than their own.
- Poverty is one of the most formidable enemies of choice. Therefore, one of the most important objectives of a population policy is to contribute towards the eradication of poverty and all forms of social and economic exclusion of people.
- People have the right to be informed about all matters relating to their daily lives. Consequently, the South African public should have access to relevant information concerning government policies, and an appropriate understanding of this information and its implications for all facets of their lives. This includes information on population and development issues.
- The overall well being of children should be given the highest priority by government.

- Civil society should be involved in the design and implementation of population policies and programs.

It is ardently clear that the White Paper is based on human rights and the freedom of choice. It thus moved away from the focus of lowering population numbers and fertility rates as a goal in itself, but towards the improving of the quality of life for South African citizens in the post-apartheid era. The White Paper evolved from the very restricted and limiting PDP program by taking into account that fertility does not stand in isolation to development but that various other factors such as mortality and migration are also key factors in population trends. The White Paper also moved away from the top-down governmental policy implementation to a more middle ground approach by asking for public and expert opinions and advice from across South Africa. The population policy as set out above is a holistic policy taking numerous factors that affect population as a whole into consideration and resulting in a multi-faceted approach which corresponds to the international arena. Of importance to this paper, is the inclusion of human rights, gender equality and equity, and the freedom of choice of individuals and couples regarding their own reproductive behaviour.

The importance of these factors led to a revision of reproductive rights and especially abortion rights in South Africa that focused on population policies and abortion legislation corresponding to the World Plan of Action as stipulated by the international community. This ultimately led to South African women being able to assert their personal decisions regarding their reproductive behaviour free of fear of legal recourse and to make their decisions based on individual and personal circumstances.

It must be noted that this is true for certain nations including South Africa, but not binding to nations, as the World Plan of Action was not dictatorial and differences exist in international abortion legislation (Lane, 1994:1318).

## **2.8. ABORTION LEGISLATION**

Abortion laws in countries are adapted to their own cultural and religious views, thus allowing different nations to all adopting different forms of abortion laws. Laws also differ to the degree in which they permit a woman to choose to have an abortion. Although there is no uniformity among international abortion laws, the official justification for the termination of a pregnancy is in virtually each case concerned with the physical, mental, social and economic well being of the woman. The World Health Organisation (1990:20) states that most abortion laws have one or more clauses pertaining to procedures for the

approval of application, medical certification for the necessity of and reasons for the abortion, prescriptions regarding the locale where, when and how an abortion may be carried out, prescription regarding the handling of emergency situations, and the reporting of legal statistics for statistical and other purposes. Abortion legislation is part of every nation's legislative channel, and due to the moral-religious debate, very emotive with various groups within a nation supporting this or not. Of importance is the fact that where abortion is liberal, it does not dictate that women have to exert this choice, but only makes the choice available to women (Bankole et al, 1998:2).

Abortion legislation and can be defined as per the following four categories:

STATUS	DESCRIPTION
Illegal	Abortion is prohibited with no exception.
Restrictive	Abortion is only permitted in life-threatening circumstances.
Conditional	Grounds for abortion include eugenic (genetic) factors, humanitarian factors (rape or incest) and broad health indications.
Liberal	Abortion is permitted "on request", this being the decision of the woman and her doctor, for social indications, where the doctor considers the relevance of social factors when evaluating the threat of a continued pregnancy to a woman's health

According to the Population Policy Data Bank (2004: iii), reporting on the worldwide legal status of abortion is fraught with practical difficulties: Legal materials for especially less developed regions are difficult to obtain. The legal infrastructure of some countries are not well developed, laws in force have not been collected or brought up to date and information regarding laws is not widely disseminated even within the country itself. Other social and economic problems consume scarce resources that could be used for the publication and consolidation of legal and court decisions. Wars, civil disturbances, dramatic changes in governments, changes in governmental policies and legal systems contribute to the problem. In some countries language is also a problem and complications also arise from the federal nature of certain countries. In certain situations, in individual sub-jurisdictions (states or provinces) different laws may exist within a country. Legal provisions governing abortion are also not always held within a central text as some could be held in the criminal code while a law on abortion could describe the circumstances under which abortion is allowed.

The majority of countries follow three major legal systems: civil law, common law and Islamic law, and based within these legal systems, abortion laws can be seen as illegal, restrictive, conditional or liberal.

Civil law which derives from Roman law and more recently of from the Napoleonic Code, is a system based on codified laws such as civil codes, penal codes, family codes and commercial codes (Population Policy Data Bank; 2004: v). These codes are designed to serve as a general guide for individual conduct, with the goal of projecting justice and morality in a society.

The emphasis is on social responsibility and the rights of people are viewed within a social context. According to the Population Policy Data Bank (2004: v) a branch of civil law is socialist law which is based on the codification of socialist principles and which allows little room for interpretation, except to conform to these principles. It emphasises the good of society as a whole and not the rights of individuals.

Common law has its origin in court determinations made by judges within lands governed by the English crown. Law is not viewed as a guide for conduct but rather a means of resolving disputes by individuals (Population Policy Data Bank: 2004: v). It emphasises individual rights more than the order and welfare of society. It is therefore more fluid and less static as judges are given greater leeway to interpret statutes.

Islamic law, also known as Shariah, is a religious law. It is inseparable from religion so that no distinction exists between the secular and the religion which is the case under civil and common law systems. Islamic law is based on the text of the Quran and the sunnah, the collection of acts and statements made by the prophet Mohammed which is considered the guide for human conduct (Population Policy Data Bank: 2004: v). These laws are fixed and unchanging.

Even though these are the three basic laws, in very few cases do countries only conform to only one of these models, but most legal systems contain elements of more than one model. Laws in many countries have been strongly influenced by local legal and cultural traditions. Despite the hybrid of laws, the legal systems can still be broadly classified under the three major systems. It is within these three systems that the liberalisation of abortion legislation lies and whether the legislation can be seen as illegal such as the case under Islamic law, restrictive, conditional or liberal under either common law or civil law.

### **2.8.1. WORLD SITUATION**

In 1987, 22 million legal abortions were reported whilst between 4-9 million were not reported, totalling 26-31 million legal abortions alone in 1987 (Abortionfacts: 2001).

A report from the Alan Guttmacher Institute continues that in conjunction with the above legal abortions, 10-22 million “clandestine” abortions were performed, bringing the total worldwide figure to 36-53 million abortions in 1987. Jacobson (1994:177) states that in 1994, 50 million abortions are performed annually, of which 20 million were performed illegally. The UNFPA (1998:5) estimate that abortion figures could increase dramatically from 50 million extra abortions to more than 90 million over the period 1995-2000.

In terms of investigating the legislative stance regarding abortion in terms of restrictive, conditional and liberal abortion laws, the most commonly cited instances in which abortion is permitted include the following:

- a) Intervention to save the life of the woman (life grounds);
- b) Preservation of the physical health of the woman (narrow health grounds);
- c) Preservation of the mental health of the woman (broad health grounds);
- d) Termination of pregnancy resulting from rape or incest (juridical grounds);
- e) Suspicion of foetal impairment (foetal defect);
- f) Termination of pregnancy for economic or social reasons (social grounds); and
- g) On request.

To better understand the classification of abortion laws and to make a comparison between nations available, a common understanding of what is classified within each of these categories is important as per the Population Policy Data Bank (1997:vii):

a) Intervention to save the life of the woman

The performance of abortions is most commonly permitted on the grounds of saving the life of the pregnant woman. Although some countries provide detailed lists of what they consider life-threatening situations, in general, these situations are not specified but left to the judgement of the physician or physicians performing and/or approving the performance of the abortion. Almost all countries allow abortions to be performed to save the life of the pregnant woman either explicitly or under the general criminal law principle of necessity.

b) Preservation of the physical health of the woman

In the majority of countries, abortion is permitted when it is necessary to preserve the physical health of the pregnant woman. The term “physical health”, however, has been defined in a number of different ways. In some countries, the definition is narrow, often encompassing lists of conditions that are considered to fall under this category. In other countries, the term “physical health” is broadly defined, allowing much room for interpretation.

In a number of countries, the abortion law does not specify whether the term “health” encompasses both physical and mental health, but merely provides that an abortion is permitted when it averts a risk of injury to the pregnant woman’s health.

c) Preservation of the mental health of the woman

Many abortion laws specifically provide for the legal performance of abortions in cases involving a threat to the mental health of the pregnant woman. What constitutes a threat to “mental health,” however, varies significantly. In some countries, no definition exists, while in others, most of them Commonwealth countries, mental health is defined to include emotional distress caused to children of the marriage or emotional distress caused to the pregnant woman as a result of her environment.

d) Termination of a pregnancy resulting from rape or incest

Permitting abortions to be performed in cases of rape or incest is a common provision of the world's abortion laws. Even in countries with restrictive abortion legislation, such as the Latin American countries, abortion is often allowed on these grounds. This is not true for Islamic countries. Such justifications for the performance of abortions take several forms. Some countries specifically mention rape and incest in their legislation. Other countries refer to these as cases in which the pregnancy is the result of a “criminal offence”, with no specification to the nature of the offence. This phrasing of the law is somewhat broader, encompassing statutory rape (consensual sex with a minor) as well as forced rape and incest. Procedural requirements also vary. Some countries require the case to be brought to court or to be reported to the authorities before permission for an abortion can be granted, thus discouraging many women from seeking to obtain an abortion on these grounds.

e) Suspicion of foetal impairment

As is the case with the juridical grounds for abortion, abortions are often permitted on the grounds of foetal impairment in countries with restrictive abortion laws. Several countries specify the type and level of impairment necessary to justify this ground.

f) Termination of pregnancy for economic or social reasons

The phrasing of laws permitting abortion on socio-medical, social or economic grounds varies widely. Some specifically mention social or economic conditions while others only imply them. Most laws that permit abortions to be performed on social and economic grounds are interpreted quite liberally and, in practice, differ very little from laws that allow abortions on request.

g) Availability upon request - abortion permitted on all grounds

In countries that allow abortions to be performed on request, a pregnant woman seeking an abortion is not required to justify her desire to have an abortion under the law. She needs only to find a physician who is willing to perform the abortion. Even in countries where abortion is allowed on request, time limits are usually set for the performance of the abortion, often within the first trimester. After this stage of pregnancy, the woman must present a valid ground for the abortion to be permitted.

Within this context, comparisons in terms of the legal standing across countries can be made. The comparisons are made in terms of an evolution in the liberalisation of laws as per the international arena.

Ferreira (1985:21) states that by 1976, 60% of the world's population lived in countries where abortion during the first trimester of pregnancy was legal, either for social and economic reasons, or on request. Another 16% were residing in countries where abortion was permitted on extended medical grounds, for genetic indications, and/or for humanitarian reasons associated with rape or incest. Most of the countries that permit abortion under a broad range of conditions are located in Asia, Europe and North America. In most Latin American countries, abortion is either completely illegal or permitted only to protect the woman's life or health. At this time South Africa was viewed as a country with a more liberal stance under the Abortion and Sterilization Act no. 2 of 1975 as this act allowed for abortion on certain conditionals.

Table 1, as per Ferreira (1985:23) (see Appendix), indicates the legal status of abortion in 108 countries covering a total of 4001.2 million people for which information was available in 1978. The figures represent 96% of the world's population and categorises the status of abortion laws for 73 countries with population numbers exceeding 5 million in terms of Liberal-, Conditional-, Restrictive- and Illegal abortion legislation.

Countries with a liberal abortion legislation totalled 27, constituting 61% of the world population. These countries constituted mostly European countries, e.g. Austria, West Germany, Italy, France and the United Kingdom. Of interest is that Italy has a very strong religious and family basis as determined by the Roman Catholic Church and population growth has declined to below replacement level. Former Soviet states that were identified included the USSR, Bulgaria, Poland, Romania, Czechoslovakia, Hungary and Yugoslavia. It must be noted abortion in the former east block countries has been prevalent since the 1920's and was used as a form of contraception with 1 out of every 3 pregnancy ending with an abortion. Only Japan and the Peoples Republic of China represented Asia.

This can be ascribed to China's one child policy due to the high population density and growth. The Nordic countries included Denmark and Sweden, while only Zambia and Tunisia in Africa was deemed to have a liberal population policy as well as the USA representing the America's.

Countries with conditional abortion legislation totalled 36, representing 15% of the world's population. Africa and the America's were significantly represented in this category with countries in Africa being Cameroon, Ethiopia, Ghana, Kenya, Morocco, Uganda and South Africa. South American countries included Argentina, Brazil, Cuba, Chile, Ecuador, Mexico and Peru. This can be ascribed to the South American countries also having a very strong Roman Catholic basis and only allowing for abortion on certain conditions. Unlike the USA, Canada only adhered to conditional abortion laws in 1978. Asia also having a strong family and religious basis was represented by Nepal, The Republic of Korea and Thailand. Middle Eastern countries such as Syria and Turkey also allowed for conditional abortion even under very strong Muslim religious doctrines.

The majority of the world's population (2568.3 million people) lived in countries where abortion laws were liberal, but only constituted 27/108 countries, whereas the majority of the world's countries (36/108) adhered to conditional abortion laws but only included 614.1 million people.

A total of 30 countries, being the second highest after conditional abortion laws, constituted only 11% of the world's population is categorised as restrictive. African countries included in this category were Algeria, Ivory Coast, Malawi, Nigeria, Senegal and the Sudan. South American countries included Guatemala and Venezuela while Middle Eastern countries included Iraq, Pakistan and Sri Lanka. This corresponds more to the restrictive Muslim religious views on abortion. Of interest is that the only European countries that had restrictive abortion laws were The Netherlands and Spain.

Countries with illegal abortion laws, whereby abortion is prohibited with no exception, included Belgium, Burma, Colombia, Egypt, Indonesia, the Philippines, Portugal, Taiwan and Zaire. This category only constitutes 9% of the world's population and totalled a number of 15 countries.

It is clearly indicated that abortion laws are influenced by a nation's moral-religious ethics, but this does not solely determine whether these laws are liberal, conditional, very restrictive or illegal.



It is clear that countries that adhere to a strong religious base, whether it is the Roman Catholic or Muslim religion, are not just influenced by the religious argument of abortion. Legislative bodies also take numerous other factors into consideration and abortion laws are based on a holistic view of population dynamics while not disregarding the religious base. Although the legislative frameworks provided indicates the level to which abortions may be obtained, it is still a highly emotive issue within different sectors of a nation. It is ardently clear that the promotion of rights and reproductive rights in the international arena has made a significant impact on abortion legislation worldwide. A significant shift in the liberalisation has taken place when comparing the abortion legislation of 1978 with that of 1999.

Table 2 (see Appendix) indicates the grounds on which abortion is permitted in various countries. The ground for abortion as indicated includes to save a woman's life, to preserve physical health, to preserve mental health, rape or incest, foetal impairment, economic or social reasons and upon request. In terms of the figures indicated, abortion is viewed as legal when abortion services are provided upon request. Where this is not indicated, abortion is viewed on a conditional basis.

For the purpose of the study, countries which have liberal abortion laws are indicated as this represents the greatest shift in attitude when compared to the abortion legislation in 1978.

A total of 193 countries were included in the review. Out of a total of 193 countries, only 52 countries allowed abortions to be preformed upon request. This however is a significant change when taking into consideration that in 1978, only 20 countries had liberal abortion laws. 63 Countries cited that abortion is allowed on economic and social grounds, 76 countries allowed for abortion where foetal impairment was evident, only 83 countries allowed for abortion where rape or incest was involved, 120 allowed for abortion to preserve mental health, 122 allowed for abortion to preserve physical health and 189 allowed abortion to save the woman's life. It is clear that most countries still adhere to conditional abortion legislation when taking these factors into account. This in itself is also a significant change as only 4 countries still adhere to abortion laws that are illegal compared to 15 countries in 1978. It must be remembered that conditional abortion laws also differ from country to country depending on the conditions defined in the legislation, but it is still classified as conditional abortion laws (World Abortion Policies: 1999).

Abortion upon request is more evident in more developed countries (totalling 48 countries) as 31 countries allow for these compared to only 21 countries in less developed regions

(totalling 145 countries). Abortion based on economic or social grounds is allowed by 36 more developed countries compared to only 27 less developed countries. The majority of countries in both more developed and less developed regions allow abortions where the woman's life is at risk (World Abortion Policies: 1999).

Of interest is that where rape or incest is cited as a condition for abortion, 39 more developed countries allow for this whereas only 44 less developed countries. This can be ascribed to human rights and reproductive rights, as the position of women in less developed countries are usually inferior and tend to be less significant than those of men. Cultural and traditional views of women are more adhered to in less developed countries and in many countries rape is not deemed as a crime due to the gender position of women in society.

Table 3 (see Appendix) indicates countries that have liberal abortion laws. Since the Termination of Pregnancy Act no. 92 of 1996, South Africa is now the third African country with liberal abortion legislation. Tunisia has remained constant in their abortion legislation as it was already classified as liberal in 1978. In 1978 in Asia, only the Peoples Republic of China and Japan had liberal abortion legislation but compared to 1999, this has increased to 15 countries, including Mongolia, Cambodia, and Vietnam. The Democratic Peoples Republic of Korea and Syria has also evolved from conditional legislation to that of liberal legislation. Included under Asia is former East Block countries comprising of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan and Armenia, even though these countries comprise of a large Muslim religious base. In Europe, the number of countries has increase from 13 in 1978 to 39 in 1999 (World Abortion Policies: 1999). The greatest evolution is indicated by Belgium who moved from illegal abortion legislation in 1978 to that of liberal in 1999. The same can be said for The Netherlands who had a restrictive legislation in 1978, and who by 1999 has the world's most liberal abortion policy. Countries that adhered to liberal abortion legislation in 1978 did not regress to conditional, very restrictive or illegal abortion legislation. Countries that included the transition from conditional legislation to liberal abortion legislation included Australia, Canada, Cuba, Greece and Syria.

The majority of countries not indicated to have liberal abortion legislation, is still classified as conditional or very restrictive as only four countries still deem abortion illegal (World Abortion Policies:1999).

Although abortion legislation is classified as either being liberal, conditional, restrictive or illegal, the conditions for each also varies in the terms and conditions stipulated in their

abortion acts. As noted earlier, moral-religious factors influence the classification of abortion laws but do not determine them. Various factors involving human and population dynamics as depicted throughout the history of a nation, all contribute toward the compilation of legislation.

## **2.8.2. SOUTH AFRICAN LEGISLATION**

The statistics regarding the number of abortions performed in South Africa vary although the details were obtained from the Department of Health. This leads to greater confusion as to the exact state of abortions in our country and can be ascribed to a poor collection of abortion data from the 269 (The Citizen, 5 June 2000:7), compared to 247 (The Citizen, 7 June 2000:5) hospitals and clinics that are designated to perform abortions. There are even discrepancies regarding the number of hospital and clinics that provide abortion services. What is apparent though in the results, is that the number of abortions is on the increase. This can be ascribed to an increase of women exerting their personal choice regarding their pregnancy in context of their personal position and circumstances, an increase in the need for abortion, a decrease in the stigma attached to illegitimate children, a better understanding of women that opt to terminate their pregnancy or a combination of these and other factors.

During the first 18 months (February 1997 – July 1998) 48 321 abortions were conducted and from 1997 – 2000, 160 000 were performed with 39 334 in 1998 (The Citizen, 7 June, 2000). This increased to 45 000 in 1999 and 51 132 in 2000 (Rapport, 24 June, 2003:4). It is estimated that to date approximately 350 000 abortions have been performed (Love Life, 26 March, 2004:18) with 50% of abortions having been performed in Gauteng followed by 13.5% in the Western Cape.

The perception that exists and that are expressed by members of society and in various studies is that women that terminate their pregnancy are unmarried, uneducated, irresponsible and promiscuous teenagers (The Citizen, 5 June, 2000: 7). Furthermore, the perception exists that these women are selfish, immoral and use abortion as a method of family planning with no remorse or emotion. These perceptions are stereotypical and not necessarily substantiated. It does not take the personal situations of women into consideration. The liberalisation of South Africa's abortion law is aimed at providing abortion services to all women, regardless of age, race, education levels, marital status or other characteristics.

The Choice of Termination of Pregnancy Act no. 92 of 1996 is classified as a liberal abortion law. The basis of the development of this act is within the context of the Program of Action of the ICPD and the White paper for a Population Policy.

The premise on which the act was passed is set out in the Choice of Termination of Pregnancy Act no. 92 of 1996 (Government Gazette. No 17602, 1996:2) and recognises the following:

- The values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the achievement of human rights and freedoms which underlie a democratic South Africa;
- That the Constitution protects the right of persons to make decisions concerning reproduction, and to security in and control over their bodies;
- 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 a safe pregnancy and childbirth;
- That the decision to have children is fundamental to women's physical, psychological and social health and that universal access to reproductive health care services include family planning and contraception, termination of a pregnancy, as well as sexuality education and counselling programs and services;
- That the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm;
- Believing that the termination of a pregnancy is not a form of contraception or population control; and
- Promoting reproductive rights and extending freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs.

The following are circumstances in which and conditions under which pregnancy may be terminated (Government Gazette no. 17602, 1996:4):

- A pregnancy may be terminated –
  - Upon request of a woman during the first 12<sup>th</sup> weeks of the gestation period of her pregnancy;
  - From the 13<sup>th</sup> up to and including the 20<sup>th</sup> week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that –

- The continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
- There exists a substantial risk that the foetus would suffer from a severe or mental abnormality; or
- The pregnancy resulted from rape or incest; or
- The continued pregnancy would significantly affect the social or economic conditions of the woman; or
- After the 20<sup>th</sup> week of the gestation period if a medical practitioner, after consultation with another medical practitioner or registered midwife, is of the opinion that the continued pregnancy-
  - Would endanger the woman's life; or
  - Would result in a severe malformation of the foetus; or
  - Would pose a risk of injury to the foetus.
- The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1) (a), which may also be carried out by a registered midwife who has completed the required training.

From these conditions specified, the liberal stance can be credited to the fact that a termination may be performed *upon request* of the woman during the first 12 weeks of her gestation period and also the fact that from the 13<sup>th</sup> up to and including the 20<sup>th</sup> week of her gestation period “*if the continued pregnancy would significantly affect the social or economic circumstances of the woman*” (Government Gazette no. 1760, 1996:4).

Most conditional abortion laws are restricted by the medical situation of the woman and/or foetus, but this mentioned loop-hole leaves a large room for abortions to be carried out up to and including the 20<sup>th</sup> week of the woman's gestation period. This fact has come under severe attack from various fields as this “allows” women to resort to abortion at a late stage in the pregnancy. It must be noted that no designated institution or healthcare worker may be forced to perform an abortion, and may exercise the right not to perform one free of coercion and force. Abortion practitioners limit themselves to abortions that are within the 12 week gestation period with very few institutions performing abortions on patients who have exceeded this gestation period.

Of interest in the act, is the specification that the State shall promote the provision of non-mandatory and non-directive counselling, before and after the pregnancy. This however is not compulsory and very few of the designated institutions provide post-abortion counselling. De Jonge (1999:2) states “*results indicated that levels of emotional distress in the short term after a TOP are much lower than before a TOP and as a result most*

women do not want post-abortion counselling". This statement will be revisited during the findings and recommendations of the study.

Another insert in the act is that "*no consent other than that of the pregnant woman shall be required for the termination of a pregnancy*" (Government Gazette no 17602, 1996:6). This includes a pregnancy in the case of a minor. Assumptions exists that a minor does not have the insight to make a rational choice regarding her pregnancy termination. The act clearly states that "*In the case of a minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because the minor chooses not to consult them*" (Government Gazette no 17602, 1996:4). The reason for allowing a minor to terminate her pregnancy without consent is that the decision should be made free of coercion, discrimination and fear.

The following are the circumstances in which and conditions under which a pregnancy may be terminated where a woman cannot make a rational decision herself (Government Gazette no 17602, 1996:6):

- Subject to the provisions of subsection (5), in the case where a woman is -
  - (a) severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of a termination of pregnancy; or
  - (b) in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy in terms of section (2), her pregnancy may be terminated during the first 12 weeks of the gestation period, or from the 13<sup>th</sup> up to and including the 20<sup>th</sup> week of the gestation period on the grounds set out in section 2(1)(b) –
    - (i) upon the request of and with the consent of her natural guardian, spouse or legal guardian, as the case may be; or
    - (ii) if such persons cannot be found, upon the request and with the consent of her curator personae:  
Provided that such pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course consent thereto.
- Where two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course, are of the opinion that –

(a) during the period up to and including the 20<sup>th</sup> week of the gestation period of a pregnant woman referred to in subsection (4)(a) or (b) –

(i) the continued pregnancy would pose a risk or injury to the woman's physical or mental health; or

(ii) there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality; or

(b) after the 20<sup>th</sup> week of the gestation period of a pregnant woman referred to in subsection (4)(a) or (b), the continued pregnancy -

(i) would endanger the woman's life;

(ii) would result in a severe malformation of the foetus; or

(iii) would pose a risk of injury to the foetus,

they may consent to the termination of pregnancy of such a woman after consulting her natural guardian, spouse, legal guardian or curator personae, as the case may be:

Provided that the termination of pregnancy shall not be denied if the natural guardian, spouse, legal guardian or curator personae, as the case may be, refuses to consent thereto.

The South African Termination of Pregnancy Act is a very liberal abortion act aligned to the democratic dispensation of our constitution. The act does not encourage abortion as many may argue, but was passed to align to the international arena and to promote human and reproductive rights. South African abortion legislation had moved from a conditional to a liberal policy and this is evident when comparing our current termination of Pregnancy Act no. 92 of 1996 with the conditional Abortion and Sterilisation Act no. 2 of 1975.

This act only allowed abortion under clearly stipulated and defined conditions and variance from this was upheld as a breach of legislation, thus illegal. This however did not stop illegal abortions from being performed which negatively influenced maternal mortality. Under the new governments, a revision of this act followed, not just to align to the international arena but also because of the significant number of illegal abortions being performed as well as the high incidence of maternal mortality and morbidity due to the high number of illegal abortions. The maternal mortality and morbidity rate of unsafe abortions are extremely high in Africa and including South Africa as the continent of Africa was estimated to have the second highest recorded deaths due to unsafe abortions, 23 000 per annum (Pathways to Health Magazine, 1998:24).

The National Incomplete Abortion Reference Group (Department of Health, 1997:435) found that a large number of women that reported to state hospitals nationally did so as

result of incomplete illegal abortions. The group found that 8% of these abortions were definitely unsafe and that 39% were as a result of attempted abortions in the second trimester of a woman's pregnancy. According to their research, it was found that in 1994, 425 women died as a result of unsafe abortions.

Pathways to Health (1998:26) states that in a 1994 study, it was estimated that 44 686 women in South Africa had been admitted to hospitals with complications due to incomplete abortions and agree with the National Incomplete Abortion Reference Group (Department of Health, 1997:435) that 425 women died every year as a result of incomplete abortions.

In 1995 alone, it is estimated that approximately 4 000 legal abortions were performed. Unfortunately, the number of illegal abortions can only be determined by the admittance of women to hospitals due to the effect of unsafe abortions. Taking these figures into consideration, the need for the protection of women deciding to have an abortion, is significant. This scenario led to the formulation of a liberal abortion law by replacing the conditional Abortion and Sterilisation Act no. 2 of 1975 (Government Gazette no. 4608, 1975:2).

Under the Abortion and Sterilization Act no. 2 of 1975, abortion was only allowed under certain terms and conditions, such as the health/life of the mother/child, if pregnancy resulted from rape or if a pregnancy resulted from incest. For the purposes of this report, only the sections pertaining to abortion will be set forth as per The Government Gazette no. 4608 (1975:2):

No person shall procure an abortion otherwise than in accordance with the provisions of the Act.

- Abortion may only be procured by a medical practitioner only, and then only-
  - Where the continued pregnancy endangers the life of the woman concerned or constitutes a serious threat to her physical health, and two other medical practitioners have certified in writing that, in their opinion, the continued pregnancy so endangers the life of the woman concerned or so constitutes a serious threat to her physical health and abortion is necessary to ensure the life or physical health of the woman;
  - Where the continued pregnancy constitutes a serious threat to the mental health of the woman concerned, and two other medical practitioners have certified in writing that, in their opinion, the continued pregnancy creates danger of permanent



damage to the woman's mental health and an abortion is necessary to ensure the mental health of the woman;

- Where there exists a serious risk that the child to be born will suffer from physical or mental defects of such a nature that he will be irreparably seriously handicapped, and two other medical practitioners have certified in writing that, in their opinion, there exists, on scientific grounds, such a risk; or
- Where the fetus is alleged to have been conceived in consequence of unlawful carnal intercourse, and two other medical practitioners have certified in writing –
  - aa. In the case of alleged rape or incest, after such interrogation of the woman concerned as they or any of them may have considered necessary, that in their opinion the pregnancy is due to the alleged rape or incest, as the case may be; or
  - ab. In the case of alleged unlawful carnal intercourse where the woman concerned is an idiot or imbecile.
- A medical practitioner who has issued a certificate referred to in subsection (1) shall in no way participate or assist with the abortion in question, and such a certificate, or such certificates issued for the same purpose, shall not be valid if issued by members of the same partnership or by persons in the employ of the same employer,
- The provisions of paragraph (a) shall not apply to the performance by any person of his functions in the service of the state.
- At least one of the two medical practitioners referred in subsection (1)-
  - Shall have practiced as a medical practitioner for four years or more since the date of his registration as a medical practitioner;
  - Shall be a psychiatrist employed by the state, if the abortion is to be procured by virtue of the provisions of subsection (1) (b);
  - Shall be the district surgeon concerned where the fetus is alleged to have been conceived in consequence of rape or incest.

It is evident from the Abortion and Sterilisation Act no. 2 of 1975 that certain conditions and requirements had to be met before consent was given to a woman to have an abortion. Not only did the woman have to meet these requirements, but it had to be determined by a medical practitioner, a psychiatrist or the district surgeon. The conditions under which an abortion was permitted was where the pregnancy endangered the life of a woman or posed a serious threat to her physical health, where the pregnancy constituted a serious threat to the woman's mental health and where there exists a serious risk that the child will suffer from a severe physical or mental defect to then be considered seriously handicapped, and where the pregnancy could be contributed to rape or incest.

In all the posed conditions, two medical practitioners had to certify in writing that this was valid grounds for the termination of a pregnancy.

The Act of 1975 also made provision for the termination of a pregnancy where it was found that the pregnant woman was of limited intellect or mentally handicapped. The legislation, although conditional, was very strictly imposed and any deviance from the stipulated guidelines for both the pregnant woman and the medical practitioner could result in a criminal offence. In terms of establishing alleged rape or incest cases, the time period required for investigations could exceed the safety period for the woman of having an abortion. Many of these conditions were intricately linked to other legislative acts such as determining when a woman's mental capacity could be defined as being that of an "idiot or imbecile". These factors led to frustration as women could not exert their personal choice regarding their reproductive behaviour and led to a high incidence of illegal and back street abortions. Resorting to back street or illegal abortions were the only choice many women could exert in terminating their pregnancy as they did not have ground for abortion offered by legislation, but their reasons for terminating their pregnancies were sufficient to resort to abortions performed in clandestine conditions and by unskilled providers. Many conditional abortion laws cater for the social and economic conditions of the pregnant woman as reason for terminating a pregnancy. This was however not the case with the Abortion and Sterilisation Act no. 2 of 1975.

When compared to the Termination of Pregnancy Act no. 92 of 1996, the age of a woman was not specified. The conditions stipulated were regardless of age whereas the current abortion law caters for pregnant minors. Many may argue that you cannot give freedom of choice to a minor; although it does align to the human and reproductive rights given to women. In the case of minors, reasons for terminating a pregnancy also vary but the most common reasons cited for terminating a pregnancy is age, completing schooling and a lack of support infrastructure. In many cases, the pregnancy was either forced and the woman is left without the support of the partner, thus placing pressure on the extended family for financial support. Another significant difference is that in the Abortion and Sterilisation Act no. 2 of 1975, abortion was allowed on the grounds of a woman's mental incapacity, whereas as this is not even noted in the new legislation.

When comparing the conditional abortion law of 1975 and our current liberal law of 1996, it is evident that a transition has occurred corresponding to international trends.

Under our new constitution, abortion legislation was aligned to human rights and reproductive rights as set out in the World Plan of Action of 1994 and also was introduced

as a medical concern. This paved the way for women to exert their personal choice regarding their reproductive behaviour in so far their cultural, religious, moral and philosophical values will allow them. Although individual rights are based on non-discrimination and equality, cultural values will dictate the actions of women when placed in the context of a patriarchal society.

## **2.9. SUMMARY**

Within the context of reproductive behaviour, access to safe abortion services is crucial, but does not necessitate women to make use of them. This remains a personal choice and is based on the current emotional, economical and social circumstances that the woman is faced with. The choice to terminate a pregnancy is based on a rational decision making process and is dependent of the circumstances that the woman is facing. Most decisions are based on the woman's economical, social and demographical circumstances, but this classification deprives the woman of her individual reasoning and decision making as reasons are intricately linked and combined.

The investigation of reasons free from classification and ranking is imperative for us to gain an understanding of the reasons and sets of reasons that women have for terminating their pregnancy. Only by allowing women to narrate their own stories, do we get a true reflection of their reality and what is important to them.

By investigating the historical evolution of abortion legislation and the emergence of the rights of women to exert a choice regarding their reproductive behaviour, it has to be seen within the change in the international arena regarding women's rights and their positioning in terms of population. Within this context, abortion legislation is imperative to whether or not a woman can decide to terminate her pregnancy free of fear from legal recourse. Illegal, restrictive and conditional abortion laws does not stop women from obtaining an abortion if she decided, it just makes it unsafe as women then turn to illegal or back street abortions.