

CHAPTER 4

LEGAL ASPECTS OF ABORTION

4.1 INTRODUCTION

Prior to 1996, abortion in South Africa was illegal. The decision to have a woman's pregnancy terminated was made by the medical team, primarily doctors on the basis of medical reasons. It was never thought of a woman deciding on whether she would like her pregnancy terminated or not. According to Pattinson (1996:191) the viability of a foetus is six months (26 weeks) after conception. It is important to note that nothing is being said about the viability in the new legislation. During that period, that is, prior to 1996, the abortion legislation with regard to viability in South Africa was seen to be liberal, as compared to WHO, which regarded viability to be attained at 20 weeks of gestation. Even though the viability cut off point was liberal in South Africa, abortion was only performed under restrictive laws.

The legislation of abortion in 1996 brought into being the abortion controversy in South Africa. This is confirmed by Van Rooyen (1998:295), that South African nation is involved in an enormously painful and intense struggle over legal abortion. In fact the legislation of abortion did not resolve the issue, but inflated the controversy. Due to the extreme end of the abortion debate, namely, the pro-life and pro-choice, the debate is never-ending. This was demonstrated by the comments that were made by Valerie Clarke on the programme of "Radio Pulpit" on 20/02/2001 called "Peak Time". She indicated that because God is the one who gives life, no one must take it. This was a clear statement of a pro-life person who is totally against abortion laws in South Africa. On the same programme mentioned above she interviewed a woman who chose not to go through with abortion after it was discovered that the foetus was deformed. Their arguments were based on the Christian principles. This clearly illustrates the point that, despite the liberalization of the abortion laws by the government, the population as a whole is not for the idea.

This is also a situation in other countries, as indicated by Githens and McBride Stetson (1996:1) that, since 1986 there has been evidence that

abortion law remains a hot issue in many countries, such as Ireland, Germany, Canada, Poland and the United States of America. This could be attributed to the fact that the decision has been taken over by the legal system of the countries, which leaves the opposing side of the population dissatisfied. This leads to continuous protest marches and media attacks on the ruling party by the opposing section of the population, which is not in favour of the decision.

On the other hand it could be said that the legislation of abortion has brought relief on women, especially that it gives them control over their bodies. It is also an attempt by the government to eradicate the complications of unsafe back-street abortions, which has devastating results on women.

In this chapter the focus will be on the international abortion policies with special reference to Canada, Netherlands, Israel, Ireland, Britain and USA; the South African abortion policies prior to 1996 and thereafter; the provisions of the Choice on Termination of Pregnancy Act (92/1996); and the comparison of the South African abortion legislation with the other countries.

4.2 THE INTERNATIONAL ABORTION POLICIES

According to the United Nations (1993:2), the abortion policy of a country is the product of its social, political, economic and religious context in which it is embedded. More specifically, the nature of abortion laws and policies depend upon the legal system to which the country adheres, upon the interactions of that legal system with concurrent or prior legal system and upon the ways in which the laws are interpreted and enforced. This indicates that there is a particular context in which the abortion policy is formulated, depending on a number of factors.

The abortion policies of different countries will now be discussed briefly as follows:

4.2.1 UNITED STATES OF AMERICA

When looking at the abortion legislation in the United States of America it becomes very important to first consider the historical developments, so as to have a better understanding of the current legislation

4.2.1.1 HISTORICAL BACKGROUND

When dealing with the abortion policies in the USA it is important to consider how these policies developed up to this stage. It is indicated by Githens and McBride Stetson (1996:76-77) that, by the early twentieth century abortion was indicated in the criminal codes of all fifty states of the United States, and abortion to save the mother's life was the sole exception. The pressure to reform began in 1962, when a woman had to travel to Sweden to obtain an abortion for her deformed foetus. In 1965, the reformers used newspaper accounts of personal tragedies to bring the issue before the public, as a serious health problem. The national policy on abortion came into being in 1973, when the Supreme Court nullified all state abortion laws and affirmed the right of abortion during the first trimester, after the Roe v. Wade case.

This intensified the public debate on the abortion issue. Lewis (2000:2) is in agreement with this argument by indicating that the Supreme Court created a controversy in the American legal community and gave rise to the pro-choice and pro-life movements. This clearly indicates that any decision with regard to the abortion practice will trigger a controversy.

4.2.1.2 LIMITATIONS AND RESTRICTIONS ON ABORTION PRACTICE

Whereas the abortion laws in America were changed to give the women a chance to decide about her life, there are some limitations and restrictions in the practice of abortion. According to the Medical Law (1998:124-128) the limitations and restrictions are as follows:

- Laws requiring parental consent or notification
- Limitations on government funding and the use of government facilities
- Laws requiring spousal or parental consent or notification
- Regulation of the consent process
- Regulation of medical techniques and facilities for use in performing abortion
- Record keeping requirements
- Access to reproductive medicine clinics

These limitations and restrictions will be discussed briefly as follows:

- **Laws requiring parental consent or notification**

The Medical Law (1998:124) indicates that the most common state statutory restriction on abortion in the USA is one that requires a minor wishing to have an abortion to notify and under some statutes, obtain the consent of one or both parents before abortion could be performed. The court has upheld the statutes that allow for the judicial consent when the pregnant minor can show that an abortion is in her best interest, or that she is mature enough to make the decision herself.

This is not the case with the South African abortion law, where the minor is not expected to notify and obtain consent of one or both parents before the abortion could be performed. In South Africa the minor is just advised to inform her parents, guardian, family members or friends of her intentions to have her pregnancy terminated. This does not mean that if the minor does not do as advised the termination of the pregnancy will be denied (Act 92/1996 section 5(3)). In the researcher's opinion the provision of this subsection of the act does not bring any difference with regard to having the parents of the minor involved in her request for a termination of pregnancy. This is confirmed by the provisions of Act (92/1996) section 5(2), where the only consent that is considered before the procedure of termination of pregnancy could be done, is that of the pregnant woman, including the minor. Although it would be difficult for the minor to request her parents to consent for her termination of pregnancy, the researcher is of the opinion that if it was a requirement from the act it could be done. This could assist the minor not to deal with this sensitive decision in isolation, which could have devastating emotional consequences for her later in life.

- **Laws requiring spousal or partner consent or notification.**

It is indicated in the Medical Law (1998:124) that the Supreme Court has refused to counteract any requirement that the pregnant woman's husband or father of the foetus, if not husband, consent to or even be notified of the woman's intention to have an abortion. This was found to be in contravention of the right of the woman to exercise her personal choices and have control over her body. In view of the high rate of women abuse in the world, the researcher found the provision of this law proper, because it

empowers the woman to be in control of her body, in cases where the pregnancy resulted from rape or the woman's subordinate role, regarding reproductive health of family planning in the patriarchal society.

- **Limitations on government funding and use of governmental facilities.**

The Medical Law (1998:125) indicates that the Supreme Court has been willing to accept any limitation that a federal or state agency wishes to impose upon the use of its funds or facilities to perform abortions. This was confirmed when the court upheld state medical plans that refused to cover non-therapeutic abortions as well as a city restriction on the performance of abortions at municipal hospitals in 1977. The abortions are only to be performed at state hospitals, when the aim is to save the woman's life. The provision of this legislation does not assist a poor woman who is faced by an unplanned pregnancy, as she would not be provided with the service at the state hospital, and on the other hand be unable to pay for the service at the private clinic.

Unlike in South Africa, where the state hospitals are designated to perform abortions, the abortion services at the USA seem to be meant for those who can afford to pay, only. Under these laws it could be said that the abortion laws in the USA are not accessible for the poor unless it is an emergency, aimed at saving the woman's life.

- **Regulations of the consent process.**

With regard to the consent process, the court ruled that the woman be provided with information as will be prescribed by the state, before she could consent to the abortion. The information may include the printed material, which describe the foetus and provide information on the medical assistance to women who choose childbirth, access to child support from the father and adoption and other alternatives to abortion. There has to be also a 24 hours waiting period before the abortion could be performed (Medical Law, 1998:125-127). In the researcher's opinion, the provision of these regulations was aimed at discouraging women from going ahead with their decision to have abortion.

- **Regulations of medical techniques and facilities for use in performing abortion.**

According to the Medical Law (1998:127-128) before 1992 the health of the pregnant woman made her interest in having an abortion subject to state regulation only after the first trimester, but now it is the concern of the state. The courts allow the statutory requirement that all the abortions be performed by the physicians rather than by other health professionals. The choice of the technique to be used in performing the abortion rests with the physician but the regulations will be revisited to uphold a certain standard. Although there are no fast rules on which technique to use in performing abortion in the USA, the researcher is of the opinion that there is a need for such regulations to be based on the gestation period, so as to ensure that the women's lives are not endangered.

- **Record keeping requirements.**

The court permits that the records on abortion should not reflect the identity of the woman as well as the reason why she did not inform her husband, but only the identity of the physician who performed the abortion (Medical Law, 1998:128). The provision of this regulation respects the confidentiality and privacy of the woman, which the researcher found to be treating the woman with dignity.

- **Access to Reproductive Medicine Clinics.**

The Congress promulgated the Freedom of Access to Clinic Entrance Act in 1994, after the clinics, which offered abortion services were targets for demonstrations and protests (Medical Law, 1998:128). This was necessary to protect the women who needed the abortion services in the USA. This situation indicates clearly that not every citizen is happy with the legislation of abortion and the women became targets of intimidation and harassment. The abortion legislation in the U.S.A. shows to be aimed at protecting the women and also giving them a choice regarding what to do when faced with an unwanted and unplanned pregnancy.

4.2.2 CANADA

The historical background of the Canadian abortion legislation is important to provide a better understanding of how the present legislation developed.

4.2.2.1 HISTORICAL BACKGROUND

According to Githens and McBride Stetson (1996:33), Canada changed its abortion laws in 1969, converting abortion from a crime under all circumstances to a crime only under some circumstances. The Canadian parliament enacted a statute that allowed abortions to preserve the life or health of the mother, but only if it is performed in a state hospital after a hospital committee of three doctors has agreed that the abortion would be necessary. This was the first step towards performing restrictive abortion laws, which could be seen positively by the women.

Despite the statute that restricted abortions to be performed at hospitals only, Dr. Morgentaler opened abortion clinics where he performed abortions. He was repeatedly arrested because of the pressure from the Catholic Church and he was tried in 1973, but acquitted. After the appeal from the province he was found guilty and sentenced for eighteen months imprisonment with three years probation to follow. His appeal did not yield the desired results and he had to serve the sentence. (Compare Githens & McBride Stetson, 1996:33-34.) This demonstrated the determination of the state to have the restrictions on the abortion practice, even if it was challenged.

After serving the sentence Dr. Morgentaler continued with his practice and was repeatedly arrested and acquitted until the Minister of Justice announced that the province would no longer enforce the abortion laws. With this victory Dr. Morgentaler took the campaign to other provinces, followed by arrests until 1988, when the Supreme Court declared the existing abortion statutes as unconstitutional. This move was influenced by the adoption of the Canadian Charter of Rights in 1982, which declared that “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principle of fundamental justice”. (Compare Githens & McBride Stetson, 1996:34) and Duhaime, Barrister & Solicitor, 2000:1.) This marked the liberalization of the abortion laws in Canada, with the prospect of having women facing unplanned and unwanted pregnancies having a chance to have abortion.

4.2.2.2 LIMITATIONS AND RESTRICTIONS ON ABORTIONS

The Medical law (1999:97) indicates the following as the limitations and restrictions to the abortion laws in Canada:

- Limitations on governmental funding
- Regulation of medical technique and facilities for use in performing abortion
- Record keeping requirements
- Consent or notification requirements

These limitations and restrictions will be briefly discussed.

- **Limitations on governmental funding.**

The provision of the abortion laws in Canada states that all the abortions must be performed in approved hospitals and any doctor who performs or was likely to perform abortions outside a hospital was to have his/her licence suspended (Medical Law, 1999:98). The researcher is of the opinion that this law was used to control the practice of abortion and have it properly monitored. This could help in having a true indication of the problems that are encountered in abortion practice and lead to proper improvements.

- **Regulation of medical technique and facilities for use in performing abortion.**

It is indicated by the Medical Law (1999:99) that the federal government does regulate drugs manufactured in Canada, including abortifacients. All drugs that are not licensed to be used as abortifacients are not to be prescribed. On the other hand all abortion clinics are regulated and operate with guidelines formulated by the College of Physicians and Surgeons. One of the regulations is that the abortion clinics must offer pre- and post-counselling, and have emergency counseling available at all hours. The researcher found this regulation to be beneficial for the women who opt for abortion at these clinics because they receive a comprehensive service. If the drugs are regulated as well as mandatory counseling is offered, then the women will experience the abortion procedure positively and they will be able to live with their decision.

- **Record keeping requirements.**

According to the Medical law (1999:100) the Canadian courts has not been asked to rule on particular record keeping requirements for abortion facilities. There is no federal or provincial legislation as well, except for the guidelines provided by the College of Physicians and Surgeons. This implies that there are no strict rules on how the records are to be kept, which could lead to the women's identity being revealed. This could also lead to them (the women) being victimized or stigmatized by those people who are totally against abortion.

- **Consent or notification requirements.**

It is indicated in the Medical Law (1999:100-101) that the requirements for consent to abortion are the same as for any therapeutic procedure. Parental consent is required only when the minor is immature and lacks insight of what is about to happen to her. There is no consent required from the woman's husband, as this is seen as an infringement of the woman's rights and freedom. This regulation is in line with the provision of the South African abortion law, namely, Choice on Termination of Pregnancy Act (92/1996), which requires only the pregnant woman's consent before the abortion procedure could be done.

The abortion practice in Canada is done under strict regulations. The researcher is of the opinion that these regulations are important to have, so that the abortion practice could be done in an accountable manner. The government's limited funding for the abortion services is important to make the women take responsibility for their actions and also to avoid a situation where abortion would be used as a means of family planning. It is also important for the government to have control over the drugs that are used, so that no person could end up using these drugs for his/her own selfish reasons. It is very important to have the woman being the only one taken into consideration, as this would help the woman to deal with her decision, unlike when she has been forced to seek abortion.

4.2.3 NETHERLANDS

According to the United Nations (1993:166) induced abortion was classified as a capital offence under the Penal Code of the Netherlands of 1886. In 1911 the abortion law was amended to make induced abortion a crime against life and public morality. Abortion was illegal in all circumstances except when performed to save the life of the mother. All efforts which were made, to liberalize the abortion laws during 1970's were unsuccessful. This indicates that the Netherlands government was not keen to liberalize the abortion law for a long period. The abortion controversy seems to have been very strong on the pro-life side, which put pressure on the government not to liberalize the abortion laws. The Bill on the liberalization of abortion laws was passed in 1980 without any events that could have been seen to have influenced that move. (Compare United Nations, 1993:166 & Medical Law, 1995:85.) There are principles stipulated for the practice of termination of pregnancy. The abortion is permitted on request, up to 13 weeks and after this gestation period the woman must attest to a state of distress before abortion could be permitted.

The procedure must be performed only in a licenced clinic or hospital by a doctor. After 13 weeks abortion may only be performed in medical centers complying with special medical and nursing requirements. The doctor must ascertain that the woman's decision was made voluntarily and after the procedure, she must be provided with sufficient aftercare service, which includes education on how to prevent an unwanted pregnancy. Between the day of first consultation and the day of the procedure, there must be a period of at least five days. This waiting period is meant to give the woman a chance to reconsider her decision, but this period may be waived if the woman's life is threatened.

The researcher is of the opinion that the principle of having the doctor ascertaining first that the woman made the decision voluntarily is important. This enables the woman to face and deal with her own decision during the counseling process, which is provided during the waiting period. This principle alleviates a situation where the woman is coerced to terminate the pregnancy by her husband, partner or parents. This principle gives the woman control over her body. The abortion law in the Netherlands seems to be aimed at protecting the woman who opts for termination of pregnancy when faced with an unwanted pregnancy.

4.2.4 ISRAEL

It is indicated in the United Nations (1993:72) that before 1952 abortion was not permissible, except on medical grounds. Before this period a woman who induced her own abortion was liable for imprisonment for seven years, while the person who performed an illegal abortion could be imprisoned for fourteen years. The grounds on which abortion could be performed were extended in 1977. Abortion could be performed if the continuation of the pregnancy could endanger the woman's life. Abortion was also permitted if the pregnancy resulted from rape, incest, and extra-marital sexual intercourse or if the foetus is suspected to have a physical or mental malformation. The law further stipulates that even where official approval of the abortion has been given, such approval cannot compel a gynaecologist to terminate a woman's pregnancy if it is against his conscience or professional judgement. (Compare Medical Law, 2000:119.) This provision is the same as in the South African abortion legislation, Choice on Termination of Pregnancy Act (92/1996), that does not compel the medical practitioner or the registered midwife to perform abortion if it is against his/her conscience or religious belief. The difference is that in South Africa this particular practitioner or midwife is compelled to refer the woman to another setting where the abortion service is available.

The abortion legislation further stipulates that the approval of a three-member committee consisting of a social worker and two physicians, one of whom must be an obstetrician/gynaecologist and one of them being a woman. (Compare United Nations, 1993:72 & Medical Law, 2000:120.) This provision seems to be sensitive to the needs of women who request abortion and also to their psychosocial needs, which are taken into consideration by the social worker who serves on the committee. The researcher is of the opinion that it would best serve the women who request abortion in South Africa, if their psychosocial needs were considered prior to the abortion procedure. There is a need to have social workers involved in the abortion services as team members, especially that there is no provision in the act for the medical committee that has to approve the abortion requests.

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recommendation was stretched to suggest that the community should consider whether abortion should be legalized for social and economic reasons. The abortion law was liberalized after the court ruling in the case of a 14 years old girl, who was raped by soldiers, where she was granted permission to have abortion because her life and health were endangered by the continued pregnancy. This was the turning point in the restrictive abortion legislation in England, with the emphasis being on the woman's health.

In 1951 the abortion issue was revived by the Pope, when he repeated the Catholic Church's traditional objection to birth control, and adding that abortion was never justified, not even to save the life of the woman. (Compare Simms, 1994:33.) This was badly received and was followed by the activities that were geared towards reforming the abortion law, of which the thalidomide tragedy played a significant role. Pregnant women were in danger of giving birth to deformed children after using thalidomide and they were denied abortion. This fuelled the abortion debate, which moved from the health arena to the public arena. These developments confirmed the need to have the abortion legislation liberalized.

Simms (1994:33) further indicates that the publication in the London newspaper, the Daily Mail in 1962, which indicated that 73 percent of the public was in favour of abortion where a child might be born deformed, stirred the abortion debate further. This move confirmed the pressure to have the abortion legislation liberalized in Britain and the first abortion bill was introduced to the House of Lords in 1965. This bill was reintroduced in 1966, after its discussion was disturbed by the general election. The bill was opposed by the right-wing Conservative MPs and Roman Catholic MPs of all parties but won the majority vote. The bill was then passed in October 1967. It is evident that the public pressure to have abortion legislation liberalized played an important role in Great Britain.

4.2.6.2 THE CURRENT ABORTION LAW AND PRACTICE

According to Mason (1987:4), the Abortion Act of 1967 was passed against the background of mounting public disquiet at the prevalence of illegal abortions together with the concern for the care of large numbers of unwanted children. This is in agreement with what is indicated by Terry (1987:76) that prior to the passing of the Abortion Act of 1967, 100 000

illegal abortions were performed in Britain each year, and this act led to a significant decline in the number of illegal abortions and their physical complications. This act brought about relieve, for the women who were faced by unwanted and unplanned pregnancies, as they were able to obtain safe and legal abortion.

According to Terry (1987:79) and Mason (1987:4), the core provisions of the Act of 1967 are as follows:

- (a) Subject to the provisions of this section, a person shall not be guilty of an offence related to abortion when the pregnancy is terminated by a registered medical practitioner, if two registered medical practitioners are of the opinion, formed in good faith-
 - (i) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy was terminated; or
 - (ii) that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Furthermore, there were three constraints that were introduced in the practice of abortion with this act, namely:

- All abortions had to be notified to the chief medical officer at the Department of health
- Not one, but two doctors had to agree to the abortion and sign the necessary documents
- The abortion had to be carried out in a National Health Service hospital or a private clinic approved by the minister. (Compare Simms, 1994:37.)

It is important to note that the regulations of the act were not welcomed by everybody, which resulted in the continued abortion controversy. It is evident from the provisions of section (1) that abortion was only justified through specific reasons. This implies that every woman who requested abortion would be provided with that service. The decision to have the pregnancy terminated was not made by the pregnant woman, but by the registered medical practitioners. This is unlike in South Africa, where the woman's decision is the only thing considered, before a pregnancy could be

terminated. Of importance again is the fact that nothing is mentioned concerning counseling, as part of the abortion service. The researcher is of the opinion that women would fully benefit from the abortion service if counseling forms part of the service.

4.3 THE SOUTH AFRICAN ABORTION LEGISLATION

After looking at the international abortion legislation it becomes relevant to now look at the South African abortion legislation, beginning with the historical background.

4.3.1 THE HISTORICAL BACKGROUND

It is indicated by Van Oosten and Ferreira (1988:416) that prior to 1975 the South African abortion law was governed by the Roman-Dutch common law. Abortion was illegal and a criminal offence, except when the life of the woman was endangered by the continuation of the pregnancy. In 1975 the Abortion and Sterilization Act (2/1975) came into operation, after extensive investigations and lengthy debates in parliament. The act was designed to legalize therapeutic abortion that had been long practiced.

The Abortion and Sterilization Act (2/1975) stipulates that, for abortion to qualify as lawful, there has to be specific circumstances. These circumstances as summarized by Clarke & Van Heerden (in Van Rooyen, 1998:276) are:

- Where continued pregnancy was seen to endanger or constitute a threat to the life of the pregnant woman
- If the pregnant woman's mental health would be permanently damaged by the continued pregnancy
- If a serious risk existed that would result in the child in utero suffering from a mental or physical defect that would result in the child being irreparably and seriously handicapped
- If a woman had been raped, provided that the rape had been reported to the police and where, after investigation, a magistrate is convinced that the pregnancy was a result of the rape
- Where the pregnancy is the result of illegitimate carnal intercourse with a woman who, due to a permanent mental handicap or defect, was unable to comprehend the consequential implications of or bear the parental responsibility for the fruit of coitus.

The above stipulations clearly indicate that not every woman could qualify for abortion prior to 1997, as strict considerations were made based on the country's policies.

The Abortion and Sterilization Act (2/1975) also stipulated who should perform the abortion, as well as who should be involved in the decisions and recommendations regarding abortion. This clearly indicates how restrictive the abortion law in South Africa was. Not every woman could decide on having abortion and have the service. The decision was solely made by the medical practitioners, based on the provisions of the Act (2/1975), without taking the woman's decision and circumstances into consideration. The social workers were only involved in doing assessment on the women and providing recommendations to the medical practitioners, but the final decision was made by the medical practitioners. In the researcher's opinion, it is the restrictive abortion laws that contributed to a large extent, to the unlawful and unsafe abortion practice in the country, where many women paid with their lives. This is confirmed by Van Rooyen (1998:296), that in a country where the law is kept within the formal health sector, back-street abortions were bound to flourish, with a negative bearing on the health resources of the country.

It becomes very clear from the Abortion and Sterilization Act (2/1975) that the government was totally against abortion, except when the woman's life was endangered. The woman did not have any say with regard to the decision, as the act clearly stipulated that the decision had to be made by medical practitioners. This disempowered the women and made them the passive recipients of the abortion service that was not responsive to their needs.

4.3.2 THE INCIDENCE OF ABORTION PRIOR TO 1997

It is important to note that even though the abortion laws were restrictive, prior to the Choice on Termination of Pregnancy Act (92/1996), there were abortions performed on women. According to Van Oosten & Ferreira (1988:418) the total number of the legal abortions on women of any age and for all ethnic groups performed in 1976 were 625, 539 in 1977, 541 in 1978, 423 in 1979, 347 in 1980, 381 in 1981 and 464 in 1982. of the abortions performed during each three consecutive years, 1983-85, an average of 40 percent were performed on unmarried women, 52 percent on married women

and 8 percent on divorced or widowed women. Four-fifths of the abortions performed during each of the same three years were performed on white women, 3 percent on Asian women, 4 percent on black women and 13 percent on coloured women.

It is important to note that the majority of women who had undergone legal abortion during the era of the Abortion and Sterilization Act (2/1975) were white and a very small percentage were the other racial groups combined. The fact that more white women had access to the abortion service, as compared to the other racial groups could be attributed to the uneven distribution of resources in the country during that period, which were based on the principle of inequality. This could also be attributed to the ignorance of the non-white women, specifically the black women, who constitute a large number of illiterate persons in the country.

It is indicated by Van Oosten and Ferreira (1988:419) that an estimate of 200 000 illegal abortions a year in South Africa has been cited. The admissions in gynaecological wards at major hospitals indicated that many of the admissions were for illegal abortions that resulted in medical complications. Ninety percent of the operations in these wards indicated to be as a result of back-street abortions, where the residues of a pregnancy were removed. For the period of three consecutive years, 1983-85, 95 000 operations for the removal of the residues of a pregnancy, were performed. The average percentage of the total number of these operations on women of the four ethnic groups was: twenty-one percent whites; thirteen percent coloureds; six percent Asians and sixty percent blacks. These statistics clearly show that black women opted for back-street abortions more than any other ethnic groups in the country. This could be attributed to the unequal distribution of services that prevailed during that political era, which had a negative impact on the black women.

The above-mentioned statistics indicate that even if there were restrictive abortion laws in the country, many women opted for abortion, when they were faced with unplanned and unwanted pregnancies. According to Van Oosten & Ferreira (1988:420), this state of affairs made medical practitioners realize the necessity to have the abortion law reviewed. The other reasons being the high mortality rate, permanent infertility and a drain on the medical resources, including funds. When looking at the statistics of illegal abortions that were performed in the country, that resulted in

complications, it becomes evident that the funds were spent on the service that could have been prevented.

4.3.3 MOVES TOWARDS CHANGE

It was during 1990 that the Department of National Health and Population Development recognized the need to reconsider legislation regarding abortion. (Compare Van Rooyen, 1998:297.) Interested parties were called to make representation for possible changes to the existing legislation. This indicates that it was no longer possible to uphold the restrictive abortion laws, which resulted in unacceptable numbers of back-street abortions. With the advent of democracy in 1994, a strong culture of rights became evident. The input from the general public into the issues related to the constitution stirred the abortion controversy, because the emphasis was on the freedom of choice. Van Rooyen (1998:297) is of the opinion that after the Termination of Pregnancy Bill (80/1996) was published, much heated discussion and debate ensued. This Bill marked a major move from the restrictive abortion legislation, where the rights of women were recognized for the first time. The Bill was followed by the Choice on Termination of Pregnancy Act (92/1996), which is the law that regulates abortion practice in South Africa.

The preamble of the act states that the Act repeals the restrictive and inaccessible provisions of the previous act; and promotes reproductive rights and extends 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 (act 92/1996). This act recognizes the woman's right to choose and provides her with a choice over what she would like to happen with her own body.

4.3.4 THE CURRENT ABORTION LEGISLATION

The dawn of the democratic era in South Africa was accompanied by a recognition of human rights, including women's rights. The rights of women to choose whether they wanted to have abortion was also recognized, followed by the Choice on Termination of Pregnancy Act (92/1996). Van Oosten (1999:62) is of the opinion that the Act (92/1996) affords every woman freedom of choice to have an early, safe and legal termination of an unwanted and unplanned pregnancy, according to her beliefs. The

without the medical practitioner or a registered midwife taking a leading role. After the 13th week the medical practitioner has to consult with the pregnant woman, but the exact role that he/she is playing here is not clear. After the 20th week of gestation, the medical practitioner consults with another medical practitioner or a registered midwife, and the pregnant woman is not consulted.

It would seem that after the 20th week of gestation the decision lies with the medical staff and no longer with the pregnant woman. This is confirmed by Van Oosten (1999:68) when he indicates that “it would appear that the decisive factor in determining whether or not the continued pregnancy would pose a risk of injury to the woman’s physical or mental health...; will be a matter of clinical judgement rather than consultation with the pregnant woman.” This seems to be removing all the decisive power from the woman. The researcher is of the opinion that this provision is aimed at protecting the pregnant woman.

Section 2(2) provides that the termination of a pregnancy may only be carried out by a medical practitioner, except for the termination of a pregnancy during the first twelve weeks, which may also be carried out by a registered midwife, who has completed the prescribed training course. This condition is aimed at protecting the woman against unsafe procedure and it is for the pregnant woman to request abortion at the institutions that are designated to perform abortions, to ensure that they receive an appropriate service.

The researcher has observed that in practice this provision is not completely observed as stipulated. For example, at GaRankuwa hospital, near Pretoria, second trimester abortions are performed by the registered midwife and not the medical practitioner. The reason behind this situation is not known but could be attributed to the shortage of experienced medical staff in the country or to the medical practitioners’ ethical choice not to be involved in termination of pregnancy but rather to preserve life.

- **PLACE WHERE SURGICAL TERMINATION OF PREGNANCY MAY TAKE PLACE**

Section 3 of the Act (92/1996) stipulates the following:

at GaRankuwa hospital where only one registered midwife is responsible for the clinic. Under these circumstances it is impossible to expect a comprehensive abortion service to be rendered.

It is unfortunate that the designated clinics/hospitals are not well equipped with the necessary personnel to see to it that a comprehensive service is provided to the women who come for abortion. The researcher is of the opinion that the abortion service that is provided to the women at the state hospitals/clinics is more mechanical, because of the lack of the mandatory counseling, that is, before and after the procedure. This could lead to a society of women with emotional disturbances in future, especially that the majority of the women receive the abortion service at the state facilities, due to lack of money to pay at the private facilities. This could have devastating results on the society as a whole, because of the important role that is played by women.

If the social worker could be part of the team that render the abortion service at the state hospital/clinics, the women who come for abortion would benefit. The social worker would provide pre- and post-abortion counseling which the researcher see as crucial in the rendering of abortion service.

- **CONSENT**

The provisions of section 5 are as follows:

- (1) The termination of a pregnancy may only take place with the informed consent of the pregnant woman
- (2) No consent other than that of the pregnant woman is required for the termination of a pregnancy
- (3) A medical practitioner or a registered midwife has to advise a minor to consult with her parents, guardian, family member or friends; before the termination of her pregnancy; but the termination of the pregnancy should not be denied because the minor chooses not to consult. This provision raises some questions because under no circumstances does a minor have to consent for her medical treatment, especially surgical procedures, where her parents has to consent. With abortion it is only her consent that is considered. One would wonder what would happen in the case if the procedure for the termination of the pregnancy would require some administration of an anaesthetic. This argument is also raised by

Van Oosten (1999:67) that whether a pregnant girl under the age of eighteen years is legally capable of giving consent to an anaesthetic, should a need arise, during the procedure of termination of pregnancy, is open to debate.

This indicates that not everybody is convinced that a pregnant minor is capable of giving consent to her termination of pregnancy. The reason being that the person under eighteen years is still regarded as a child, according to the Child Care Act (74/1983). To make the situation more complex is that the minor in-question here is facing an unplanned and unexpected pregnancy, which is assumed to be emotionally traumatic, for any woman. The pregnant minor who does not choose to tell anybody about her intentions of having her pregnancy terminated, will live with this burden for the rest of her life. This could lead to the minor experiencing emotional turmoil later in life, specifically as the counseling service is lacking at the state abortion facilities.

The pregnant woman who is severely mentally retarded or in a state of continuous unconsciousness has to have a consent for the termination of her pregnancy given by her natural guardian, spouse, legal guardian or *curator personae*. This consent will only be considered unless two medical practitioners or a medical practitioner and a registered midwife consent thereto. This provision does not clarify the exact role of the medical practitioner and the registered midwife here, whether they are to confirm the woman's mental state or her state of consciousness, or to confirm the woman's period of gestation. The researcher is of the opinion that the consent of the woman's natural guardian, spouse, legal guardian or *curator personae* would be sufficient for the pregnancy to be terminated, without involving the medical practitioner or a registered midwife.

(4) In a situation where two medical practitioners and a midwife are of the opinion that:

- During the period up to and including the 20th week of the gestation period of a pregnant woman who is severely mentally disabled or who is in a state of continuous unconsciousness, 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 physical or mental abnormality; or
- After the 20th week of the gestation period of a pregnant woman who is severely mentally disabled or who is in a state of continuous

unconsciousness, the continued pregnancy would endanger the woman's life; would result in a severe malformation of the foetus or would pose a risk of injury to the foetus; the two medical practitioners and the registered midwife have the authority to consent for the termination of the pregnancy of the woman described above.

This provision further indicates that this consent may be done after consultation with the natural guardian, spouse, legal guardian or *curator personae* of the said woman. It is not clear whether this consultation is aimed at having the natural guardian, spouse, legal guardian or *curator personae*, as the case may be, also consenting or approving the consent. It would seem that in this provision the two medical practitioners and the registered midwife has the final say with regard to the consent. This is confirmed by the last statement that indicates 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. This provision shifts the decision from the incapacitated woman's guardian, spouse, legal guardian or *curator personae*, to the medical personnel.

• INFORMATION CONCERNING TERMINATION OF PREGNANCY

The provision of section (6) states that a woman who in terms of section 2 (1) requests termination of pregnancy from a medical practitioner or a registered midwife, as the case may be, shall be informed of her rights under this act, by the person concerned. As it has already been indicated earlier in this chapter, there is a considerable shortage of personnel at the state clinics/hospitals, which makes it difficult to fully provide the women with the necessary information. The situation is in such a way that the personnel at the TOP Clinic are only able to provide the women with termination of pregnancy, and nothing more. This was observed at Kalafong Hospital, where at some point there was only one registered midwife to run the clinic for the day. Under these circumstances it won't be possible for this registered midwife to provide individual attention to each woman who request termination of pregnancy. This put the women who request termination of pregnancy at such facilities at risk of receiving an incomplete service.

• REGULATIONS

Section (9) of the Act (92/1996) indicates that the Minister of Health may make regulations relating to any matter which he/she may consider necessary or expedient to prescribe for achieving the objects of this act. For this provision to be implemented to the benefit of the women who request termination of pregnancy, it is important for the minister to see to it that a comprehensive service is rendered. This would be achieved by making regulations that would fill the gaps that have been discussed earlier, for example, having a mandatory pre- and post-abortion counseling for all women who come for termination of pregnancy at the state clinic/hospital; by providing the necessary resources. Regulations that would make this service user-friendly, for the women not to hesitate to seek the service, immediately when they are faced with unplanned and unwanted pregnancies are needed. If this could be achieved, second trimester termination of pregnancy would be eliminated, together with all the complications that accompany it. In establishing such regulations there is a need to have the needs of the women in mind and engage in extensive consultation with all the stakeholders, including the women.

4.4 SUMMARY

The abortion controversy all over the world is a never-ending debate because of the extreme ends of the continuum, namely, the pro-life and the pro-choice. In all the countries it is evident that not everybody will be satisfied with the abortion laws in a given country at a given time. Many countries had restrictive abortion laws until a certain section of the population pressurized the government to revise them. This pressure led to the abortion legislation in different countries revised to address the needs of the women to have legal abortion. In many countries the abortion legislation is accompanied by the regulations that stipulate how the procedure should be done. This is seen positively as a means to protect the women who find themselves in need of the abortion service.

Abortion in South Africa, like in other countries, was illegal for quite a considerable period, until the state could no longer bear to witness the high percentage of women losing their lives due to unsafe abortions. Until February 1997, abortion by choice in South Africa was illegal, that is, prior to the Choice on Termination of Pregnancy Act (92/1996). Prior to this era

the decision to terminate a pregnancy was solely in the hands of the medical personnel. With the legalization of abortion not everybody is satisfied, which makes the abortion controversy a never-ending debate, like in other countries all over the world.

Although abortion was illegal in South Africa prior to February 1997, it was practiced. A large percentage of women who were receiving the service came from the white population and the blacks did not have access to the service. This led to a large percentage of black women opting for illegal and unsafe abortions. This is attributed to the laws of the country during that period, which were based on unequal distribution of resources to different racial groups.

The dawn of the democratic era in South Africa gave birth to a variety of rights and the women's right to choose is included. This was confirmed by the Choice on Termination of Pregnancy Act (92/1996), which recognizes the woman's right to choose whether to have an unplanned child or to have the pregnancy terminated.

There are a number of loopholes with regard to the Choice on Termination of Pregnancy Act (92/1996), which put the women, as the consumer of the service, at a disadvantage. There is still a need to have the service coordinated and made responsive to the needs of the women. This could be achieved by providing a mandatory pre- and post-abortion counseling, as part of the abortion service, to assist the women to live with the decision, irrespective of the reasons that led to their opting for abortion.

The issue of consent in the Choice on Termination of Pregnancy Act (92/1996), also raises concern, especially with regard to the minor's consent and the informed consent. This is not unique to South African abortion legislation. In other countries, like Israel, the minor is expected to give informed consent before an abortion procedure could be performed. Unlike in South Africa, the law in Israel stipulates that before the abortion procedure is done, the woman has to be provided with all the necessary information pertaining to the abortion procedure. Due to lack of human resources at the state abortion facilities informed consent cannot be a reality. Therefore there is a need to have the state abortion facilities well staffed with appropriate personnel, to provide this information, for informed consent to be realized.

CHAPTER 5

With regard to the minors who request termination of pregnancy it is their sole consent that is required. Although they are advised to talk to someone they trust, this does not happen and could lead to a situation where the society in the near future is concentrated with adult women having emotional problems, because of the unresolved issues in their lives.

Unlike in Israel, where the social worker is serving in the abortion committee, in South Africa, the act does not say anything regarding the role of the social worker at the TOP Clinic. This results in the psychosocial aspects of the women who request termination of pregnancy at the state abortion facilities not taken into consideration. There is a need to have the social workers form part of the team that provides the abortion service at the state clinics/hospitals, so that the women could be provided with a service that is responsive to their needs.

The state abortion clinics/hospitals are not well-resourced, and this deprives women who request termination of pregnancy at these facilities an opportunity of getting the necessary information pertaining to abortion, as stipulated in the Act (92/1996).

There is need for the Minister of Health to establish regulations that would ensure that the abortion service in the country is comprehensive and responsive to the needs of the women.

The following chapter will deal with the quantitative empirical findings.

3. RESEARCH FINDINGS

The data that was collected by means of questionnaires will be presented and reported. The most important findings are presented graphically.