

WORKING DRAFT: SHOULD NOT BE CITED

Lived Experiences of the Choice on Termination of Pregnancy Act 92 of 1996: Overcoming Obstacles at Ground Level

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1 Introduction

This paper aims to show that the full extent of the Choice on Termination of Pregnancy Act 92 of 1996 (Choice Act) is not being realised as a result a number of access barriers within the public health-care system; and considers practical recommendations to overcome this.

The Choice Act has been described as progressive, liberating and it is considered an important piece of legislation that realises equality for women.¹ Further, controlling one's reproductive capacity creates the opportunity to freely participate in economic activities.² The Act permits termination of pregnancies on demand in the first trimester and on socio-economic grounds in the second trimester.³ Termination-of-pregnancy services are also more accessible to the extent that registered midwives and nurses are authorised to perform first trimester terminations,⁴ and it is government policy that termination-of-pregnancy services are free at public health-care facilities.⁵

¹ C Ngwena 'An Appraisal of Abortion Laws in Southern Africa from a Reproductive Health Rights Perspective' (2004) 32 *J Law Med Ethics* 708 715.

² See generally D Bloom, D Canning, G Fink & J Finlay 'Fertility, Female Labor Force Participation and the Demographic Dividend' (2009) 14 *J Econ Growth* 79. The authors found that termination-of-pregnancy laws are predictive of fertility and that higher fertility reduces labour force participation of women during their fertile years.

³ S (2)(1)(a) and (b)(iv) respectively.

⁴ S 2(2) of the Choice Act.

⁵ Department of Health of the Republic of South Africa *Guidelines for Maternity Care in South Africa* (2007) 7 <http://www.doh.gov.za/docs/policy/2011/guidelines_a.pdf>.

It cannot be disputed that South Africa has a very strong legal framework for reproductive control. However, pregnant women accessing public facilities are not having their rights met, despite having this very progressive piece of legislation in place. Termination-of-pregnancy providers also face a number of difficulties when attempting to meet the demands unleashed by the Choice Act. There are a number of 'on the ground' issues surrounding the provision of termination-of-pregnancy services in the public sector.⁶ The World Health Organization reported that 120 000 women accessed unsafe termination-of-pregnancy services in 2008 resulting in 500 maternal deaths due to unsafe termination-of-pregnancy services.⁷ This figure is not being used to demonstrate that women are not able to access termination-of-pregnancy services at all, but it is used to show that there is still a substantial amount of women at risk because access to termination-of-pregnancy services is problematic.

In response to the lived experiences of women, a number of recommendations have been explored in several studies in South Africa and will be considered. This paper will show that the recommendations extracted from various studies can be drawn on to develop a socially relevant model for the provision of termination-of-pregnancy services that is sensitive to the needs of all parties involved.

2 Lived experiences

Ngwena argues that the liberalisation of termination-of-pregnancy laws is not always followed by practical implementation and that termination-of-pregnancy rights may exist as mere paper rights.⁸

⁶ Public provision of termination-pregnancy services is the point of departure for this paper because it can be accepted that if a woman cannot afford access to private health care, the only lawful mechanisms left to her is the public health-care system.

⁷ World Health Organization 'Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008' (2008) 19; 28. However, the report cautions that these figures should be regarded as the 'tip of the iceberg' since the occurrence of accessing termination-of-pregnancy services and associated mortality tends to be underreported in surveys, and unreported or underreported in hospital records, 15.

⁸ C Ngwena 'Using Human Rights to Combat Unsafe Abortion: What Needs to be Done?' (2012) <http://www.chr.up.ac.za/africlaw/charles_ngwenya.pdf>.

Despite the liberal provisions of the Choice Act, the demand for termination-of-pregnancy services is rarely adequately met as a result of poor infrastructure, and a lack of physical space and personnel.⁹ The lack of personnel is linked to provider opposition to termination of pregnancies and unwilling providers.¹⁰ The shortage of termination-of-pregnancy providers undermines the availability of safe services.¹¹ The relation between the provision of termination-of-pregnancy services and adequate access requires one to consider experiences of the women accessing these services and the service providers providing the services.

2.1 Experiences of women seeking termination-of-pregnancy services

To get an overall perspective of the reach of the Choice Act it is necessary to consider the experiences of women relying on those statutory provisions in their attempt to regain control over their bodies.

Jane Harries et al conducted in-depth interviews with 27 women terminating their second-trimester pregnancies for non-therapeutic reasons.¹² The authors found that women were accessing the health-care system in the first trimester, but that, as a result of delays, the termination procedure took place only in the second trimester.¹³ Delays experienced by women included a delay in pregnancy recognition, confirmation and response.¹⁴ Participants recalled signs of pregnancy, but did not initially link these symptoms to a possible pregnancy.¹⁵ Women reported experiencing emotional, cultural and religious pressure and manipulation.¹⁶ Most women mentioned that they were not able to have children based on their varying personal and social circumstances: they were not ready, did not have the financial means or wanted to continue with schooling; and one woman indicated that she was

⁹ J Harries, N Lince, D Constant, A Hargey & D Grossman 'The Challenges of Offering Public Second Trimester Abortion Services in South Africa: Health Care Providers' Perspectives' (2012) 44 *J Biosoc Sci* 197.

¹⁰ Ibid.

¹¹ Harries et al (note 9 above) 197

¹² J Harries, P Orner, M Gabriel & E Mitchell 'Delays in Seeking an Abortion until the Second Trimester: A Qualitative Study in South Africa' (2007) 4 *Reproductive Health* 7 8.

¹³ Harries et al (note 12 above) 11.

¹⁴ Harries et al (note 12 above) 9.

¹⁵ Ibid. One participant discussed how she bought a home pregnancy test and, even after a positive result, waited another four weeks because she was in doubt.

¹⁶ Harries et al (note 12 above) 9.

HIV-positive with limited financial means.¹⁷ Emotional responses were fear, indecision and conflict and one woman discussed the guilt she felt and stated that she knew she would be punished for her decision to terminate her pregnancy.¹⁸

Harries et al further reported that some women had difficulties in accessing termination-of-pregnancy services.¹⁹ Many women spoke of negative and judgmental attitudes displayed by staff at public facilities, of staff who were reportedly rude or hostile, and of some staff resorting to imposing religious beliefs on pregnant women by bringing the Bible to consultations.²⁰ Such an intolerant environment consequently drove women to find other clinics and, in some cases, to seek help from the private sector, which not only has a financial implication, but also causes further delay, since women first have to save money.²¹ Women were also faced with clinics that were fully booked and were placed on a waiting list, this caused delays, since women were required to wait a further two weeks for an appointment.²²

In 2006, Morroni and Moodley conducted a study of 164 women who presented themselves for termination-of-pregnancy services in the Western Cape.²³ The authors discovered that it took an average of two-and-a-half visits to health-care facilities before initiating the termination-of-pregnancy service.²⁴ This issue of delay in the provision of service is an ongoing problem. In 2011, Grossman et al conducted a study of surgical and medical second-trimester terminations in South Africa, which also discussed the fact that women experienced barriers when trying to access the health-care system for termination-of-pregnancy services.²⁵ The majority of participants reported three or more clinic or hospital visits, and substantial delays of

¹⁷ Harries et al (note 12 above) 10.

¹⁸ Harries et al (note 12 above) 11.

¹⁹ Ibid.

²⁰ Harries et al (note 12 above) 11.

²¹ Ibid.

²² Ibid. Also see P Omer, M de Bruyn, J Harries & D Cooper 'A Qualitative Exploration of HIV-Positive Pregnant Women's Decision-Making Regarding Abortion in Cape Town, South Africa' (2010) 7 *SAHARA* 44 47. One interviewed woman falsified her home address since it was the only way she could obtain termination-of-pregnancy services at a facility that did not fall within the jurisdiction of her actual residential area.

²³ C Morroni & J Moodley 'Characteristics of Women Booking for First and Second Trimester Abortions at Public Sector Clinics in Cape Town' (2006) 2 *SAJOG* 81.

²⁴ Morroni & Moodley (note 23 above) 82.

²⁵ D Grossman, D Constant, N Lince, M Ablas, K Blanchard & J Harries 'Surgical and Medical Second Trimester Abortion in South Africa: A Cross-Sectional Study' (2011) 11 *BMC Health Serv Res* 224 227.

up to thirty days occurring between the date of the first clinic visit to the date of admission for the termination services.²⁶ Roughly 40 per cent of women who required termination-of-pregnancy services were at 12 weeks' gestation or earlier at the time of the first clinic visit.²⁷

In a study conducted by Orner et al, the authors reported that a woman complained of feeling insulted by the lack of care received after completion of the termination-of-pregnancy procedure, where she was “chased out the room because other people must come in”.²⁸ Another woman described how she delivered the products of conception alone in the lavatory; afterwards she was required to “wrap the whole thing” and proceed to “go inside for cleaning”.²⁹ A counsellor has also been reported as describing termination of pregnancies as murder and that he or she does not support the decision to terminate a pregnancy but later concedes that the decision lies with the woman concerned.³⁰

During a study conducted by Harries et al, a nurse revealed that many staff, including non-nursing staff (cleaners and administrative personnel) refuse to assist or provide basic nursing care to termination-of-pregnancy patients.³¹ In one instance an administrative staff member blocked a woman's access to termination-of-pregnancy services by throwing her referral letter way.³² Admission clerks have also refused to open patient files for termination-of-pregnancy services.³³

Jewkes et al conducted a study to determine why women were still terminating their pregnancies outside designated facilities in Gauteng and interviewed a number of women admitted to hospital for incomplete termination of pregnancies.³⁴ The authors found that some women were turned away because the pregnancy was too

²⁶ Ibid.

²⁷ Grossman et al (note 25 above) 227.

²⁸ Orner et al (note 22 above) 48.

²⁹ Ibid.

³⁰ Orner et al (note 22 above) 48.

³¹ J Harries, K Stinson & P Orner 'Health Care Providers' Attitudes Towards Termination of Pregnancy: A Qualitative Study in South Africa' (2009) 9 *BMC Public Health* 296.

³² Harries et al (note 31 above) 299.

³³ Ibid.

³⁴ R Jewkes, T Gumebe, M Westaway, K Dickson, H Brown and H Rees 'Why are Women Still Aborting Outside Designated Facilities in Metropolitan South Africa?' (2005) 12 *BJOG* 1236.

advanced for a termination-of-pregnancy procedure at that particular clinic.³⁵ In some instances the waiting list was too long, reporting a four week waiting list, this was problematic for women that were already in the second trimester.³⁶ Some women approached general clinics for help but in these circumstances staff did not inform women of the Choice Act nor were they referred to the correct facility that provides termination-of-pregnancy services.³⁷ It was found that women wanted to avoid poor quality of care found at public facilities, this was based on previous personal experiences or general knowledge of the services reputation.³⁸ In one instance a woman explained that she was told that the termination of a pregnancy amounts to murder.³⁹ The same woman reported that a relative was confronted by nurses explaining the rights of children and had to undergo questioning concerning whether the woman's partner was aware that she planned to murder his child.⁴⁰ Women were concerned about "staff gossip" and the general lack of privacy found at public facilities.⁴¹ A common concern among the women interviewed was that there was a fear of abuse by nurses and hospital staff.⁴²

A number of studies have been considered here and the same problems are being described. What is significant is the fact that these problems have now been identified as motivating factors for the use of illegal and unsafe termination-of-pregnancy services that are known to place women at risk. Termination-of-pregnancy services are inaccessible and unacceptable.⁴³

2.2 Experiences of termination-of-pregnancy providers

The aim of this paper is to find practical recommendations to improve on women's experiences of the provision of termination-of-pregnancy services. To do so it is

³⁵ Jewkes et al (note 34 above) 1240.

³⁶ Ibid.

³⁷ Jewkes et al (note 34 above) 1240. This is in contravention with s 6 of the Choice Act which provides that a woman who requests a termination of pregnancy from a medical practitioner or registered nurse or midwife must be informed of her rights under the Act. Further s 10(1)(c) provides that any person who prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy shall be guilty of an offence.

³⁸ Jewkes et al (note 34 above) 1240.

³⁹ Ibid.

⁴⁰ Jewkes et al (note 34 above) 1240.

⁴¹ Ibid.

⁴² Jewkes et al (note 34 above) 1240.

⁴³ Ibid.

necessary to consider the people involved in the provision of that service. This approach will draw an informed and complete picture of the extent of the problem concerning inaccessibility and unacceptability.

Section 2(2) of the Choice Act identifies three role players in the provision of termination-of-pregnancy services, namely registered nurses, registered midwives and medical practitioners. Registered midwives and nurses may perform a termination-of-pregnancy procedure in the first trimester (up to and including 12 weeks' gestation).⁴⁴ In the case where the pregnancy has developed beyond 12 completed weeks, the procedure must be carried out by a medical practitioner;⁴⁵ however nurses and midwives also assist the medical practitioner.⁴⁶ Registered nurses and midwives will be considered separate from medical practitioners.

2.2.1 Registered nurses and midwives

Nurses⁴⁷ are generally involved with patients prior to, during and after termination-of-pregnancy procedures. Nurses receive women into the health-care facility and see them out after completion of the termination-of-pregnancy procedure.

A study was conducted by Mayers et al with the aim to explore the lived experiences of midwives who assist with termination of pregnancies in a tertiary hospital.⁴⁸ Five themes emerged from interviews with the midwives concerned: there were a number of obstacles when assisting with termination-of-pregnancies, a number of negative feelings were evoked by the experience of assisting with termination of pregnancies, some conflicts were encountered, coping mechanisms and the need for support were explored.⁴⁹

⁴⁴ S 2(2) of the Choice Act.

⁴⁵ Ibid. S 1 defines a medical practitioner as 'a person registered as such under the Medical, Dental and Supplementary Health Service Provisions Act 56 of 1974'.

⁴⁶ P Mayers, B Parkes, B Green & J Turner 'Experiences of Registered Midwives Assisting with Termination of Pregnancies at a Tertiary Level Hospital' (2005) 10 *Health SA* 15 16.

⁴⁷ The terms 'nurse' and 'midwife' will be used interchangeably.

⁴⁸ Mayers et al (note 46 above) 15.

⁴⁹ Mayers et al (note 46 above) 19.

The obstacles described by the nurses were found to influence the quality of the provision of care and the ability of the nurses to cope with the situations they faced.⁵⁰ Nurses felt emotionally unprepared for the experience of being involved with termination-of-pregnancy procedures.⁵¹ Nurses found the need to counsel patients as burdensome since there is a duty on the nurse to inform women about what to expect from the procedure and provide emotional support.⁵² Generally, the provision of emotional support was seen to fall beyond the scope of the midwives' employment.⁵³ Nurses felt that patient's fear of the unknown in addition to inadequate preparation for the procedure caused patients to be rude and obnoxious towards the staff.⁵⁴ The negative responses by patients were found to lead to their physical and mental isolation by attending midwives.⁵⁵

Nurses also expected patients to display feelings of sadness and loss, when this did not occur, patients were perceived as being indifferent to the significance of terminating a pregnancy.⁵⁶ Nurses described patients as “demanding” and “seeking attention”.⁵⁷ In this context patients were perceived to have little regard for the feelings of the staff and lacked any appreciation for the difficult feelings the staff faced because they had to provide this sort of service.⁵⁸ The midwives also reported having difficulty dealing with the apparent lack of responsibility shown by patients, since some patients refused to consider contraception.⁵⁹ Under these circumstances patients are viewed as using termination-of-pregnancy services as a contraceptive method.⁶⁰

Concerning the conflicts encountered by nurses, a number of nurses have reported instances where they have been present where a nonviable but 'live foetus' is delivered and having to cut the umbilical cord.⁶¹ These situations introduced the

⁵⁰ Ibid.

⁵¹ Mayers et al (note 46 above) 19.

⁵² Ibid.

⁵³ Mayers et al (note 46 above) 19.

⁵⁴ Ibid.

⁵⁵ Mayers et al (note 46 above) 19.

⁵⁶ Ibid.

⁵⁷ Mayers et al (note 46 above) 19.

⁵⁸ Ibid

⁵⁹ Mayers et al (note 46 above) 19.

⁶⁰ Ibid.

⁶¹ Mayers et al (note 46 above) 20.

conflict between life and death, because nurses are being confronted with life where death is anticipated.⁶² This is said to place an enormous ethical burden on midwives because nurses take a pledge to preserve life.⁶³ Nurses were also found to experience moral and religious conflicts, since termination of pregnancy was perceived to constitute 'murder' and this goes against their principles and religion.⁶⁴

Further conflict was encountered when treating teenage women since these young women are permitted to terminate their pregnancies without parental consent but when offered contraception the young women refused family planning since they need parental consent.⁶⁵ Nurses also experienced conflict in the notions of confidentiality and truth; in some instances nurses are required to 'stand by while the women told their families that they had "miscarriages"'.⁶⁶

Coping mechanisms include emotional and physical distance, considering termination of pregnancy as merely being part of the job, mechanically proceeding through termination-of-pregnancy procedures, actively deciding not to judge the women who present for termination-of-pregnancy services and striving to work in teams of two.⁶⁷ Nurses expressed a lack of support, especially from management staff and support was generally received from colleagues and in some cases spouses or partners.⁶⁸

In 2010 Mamabolo and Tjallinks conducted a study at a community-health centre near Pretoria with the aim to determine the experiences of registered nurses in the provision of termination-of-pregnancy services.⁶⁹ Nurses reported feelings of frustration and stress, particularly when the termination-of-pregnancy procedure

⁶² Mayers et al (note 46 above) 21.

⁶³ Mayers et al (note 46 above) 22.

⁶⁴ Ibid.

⁶⁵ Mayers et al (note 46 above) 22.

⁶⁶ Ibid.

⁶⁷ Mayers et al (note 46 above) 22.

⁶⁸ Mayers et al (note 46 above) 23.

⁶⁹ L Mamabolo & J Tjallinks 'Experiences of Registered Nurses at One Community Health Centre Near Pretoria Providing Termination of Pregnancy Services' (2010) 12 *Afr J of Nurs Midwifery* 73.

takes longer than expected or when women break down.⁷⁰ Feelings of rejection were also experienced as a result of negative comments from colleagues.⁷¹

Nurses reported being labelled. Two types of labelling were identified by the study: perceived and received labelling.⁷² For instance a nurse felt that she was “killing and doing diabolical things that people were talking about” and nurses complained of being called “serial killers” and their conduct is described as “killing children”.⁷³

The study also identified a lack of human resources and an inadequate provision of suitable equipment.⁷⁴ These deficiencies were found to hamper efficient service delivery which results in experiencing high levels of stress.⁷⁵ There is also an issue of lack of support from colleagues and management and nurses felt undervalued by management.⁷⁶ Nurses expressed the need for emergency debriefing since formal debriefing only occurred once a month leaving the nurses little choice but to rely on informal methods of debriefing.⁷⁷ Nurses regularly discussed their experiences informally among themselves without any formal guidance or direction.⁷⁸

Potgieter and Andrews conducted a study to determine what motivated nurses to participate in the provision of termination of pregnancy procedures and found that nurses reported that their decision was based on public health concerns.⁷⁹ The provision of termination of pregnancy services was viewed as aiding in reducing the number of illegal termination-of-pregnancy procedures.⁸⁰ The nurses had a comprehensive understanding of the social issues concerning high morbidity and mortality rates associated to unsafe termination of pregnancies.⁸¹ This reinforced their role of preventing death.⁸² The nurses used positive and progressive language,

⁷⁰ Mamabolo & Tjallinks (note 69 above) 79.

⁷¹ Mamabolo & Tjallinks (note 69 above) 80.

⁷² Mamabolo & Tjallinks (note 69 above) 79.

⁷³ Ibid.

⁷⁴ Mamabolo & Tjallinks (note 69 above) 80.

⁷⁵ Ibid.

⁷⁶ Mamabolo & Tjallinks (note 69 above) 81.

⁷⁷ Ibid.

⁷⁸ Mamabolo & Tjallinks (note 69 above) 81.

⁷⁹ C Potgieter & G Andrews ‘South African Nurses’ Accounts for Choosing to be Termination of Pregnancy Providers’ (2004) 9 *Health SA* 20 24.

⁸⁰ Potgieter & Andrews (note 79 above) 25.

⁸¹ Potgieter & Andrews (note 79 above) 24.

⁸² Ibid.

for instance nurses were reported saying “no woman can be blamed for pregnancy”, “contraception fails”, “it is their right”.⁸³ The nurses considered their participation in the provision of termination-of-pregnancy services as assisting women in accessing one of their fundamental rights and helping women achieve their goals as women as a group and as individuals.⁸⁴ The nurses also argued that, historically, women in African societies have used herbs and other traditional medicines to terminate pregnancies.⁸⁵ One nurse noted that “culture changes ... before we used traditional medicine to help women, now we use the modern way.”⁸⁶

Contrary to the usual pro-life discourse concerning the role of religion in the termination-of-pregnancy debate, some nurses reported that their ministers support them and considered their God to be a “practical God”.⁸⁷ The authors observed that this approach allowed the nurses to still adhere to their culture and religion and countered the discourse which ‘othered’ the nurses as outsiders.⁸⁸

Harries et al report that nurses found it challenging to progress through the transition of never providing termination of pregnancy services to being expected to perform these sorts of services.⁸⁹ Other nurses reported viewing this transition as an opportunity to broaden their skills and felt empowered.⁹⁰ However, nurses have reported leaving the service because “they cannot endure the comments or attitudes of their colleagues”.⁹¹ There is a sense of isolation from the community and nurses have described feelings of fear of victimisation and stigmatisation.⁹²

Nurses were found to be more willing to assist in cases where the pregnancy is a result of rape, incest or foetal abnormality.⁹³ Further, socio-economic reasons also elicited sympathy towards patients, however, other nurses were of the opinion the

⁸³ Potgieter & Andrews (note 79 above) 25.

⁸⁴ Potgieter & Andrews (note 79 above) 26.

⁸⁵ Ibid.

⁸⁶ Potgieter & Andrews (note 79 above) 27.

⁸⁷ Ibid.

⁸⁸ Potgieter & Andrews (note 79 above) 27.

⁸⁹ Harries et al (note 31 above) 299.

⁹⁰ Ibid.

⁹¹ Harries et al (note 31 above) 301.

⁹² Ibid.

⁹³ Harries et al (note 31 above) 300.

termination of pregnancies on demand is an unacceptable practice.⁹⁴ Late-second-trimester terminations were described as traumatic because once the pregnancy has developed to that point, the foetus already resembles a human being.⁹⁵ Consequently, the authors found very strong opposition to second trimester terminations.⁹⁶

The study also highlighted that post-termination-of-pregnancy counselling was extremely difficult and given 'on the run' because providers are very busy meeting the demand for their services.⁹⁷ It was also found that some staff were not adequately trained in family planning either.⁹⁸

The issue of 'repeat abortions' also featured frequently among the nurses interviewed.⁹⁹ It was found that women who use termination-of-pregnancy services repeatedly were perceived to be using this service as a contraceptive method and considered sexually irresponsible.¹⁰⁰ However, in some instances, nurses linked this issue to a breakdown in family planning services, inadequate family planning counselling and difficulty accessing the services.¹⁰¹

Nurses described the provision of termination-of-pregnancy services as overburdened and fragmented, there is a lack of general counselling and they experienced difficulties with staff recruitment and retention.¹⁰² A nurse reported that at her facility only a certain number of women could be helped a day because there are not enough staff available to meet the demand.¹⁰³ The nurse explained that sometimes women cannot afford the cost of transport to attend another facility and then seek out illegal and unsafe termination-of-pregnancy services.¹⁰⁴

⁹⁴ Harries et al (note 31 above) 301.

⁹⁵ Ibid.

⁹⁶ Harries et al (note 31 above) 301.

⁹⁷ Ibid.

⁹⁸ Harries et al (note 31 above) 301.

⁹⁹ Ibid.

¹⁰⁰ Harries et al (note 31 above) 301.

¹⁰¹ Ibid.

¹⁰² Harries et al (note 31 above) 302.

¹⁰³ Ibid.

¹⁰⁴ Harries et al (note 31 above) 302.

Concerning the issue of training, nurses describe it as sporadic and frequently subjected to cancellations due to insufficient interest from providers.¹⁰⁵ Staff shortages also make it difficult to attend training because there are often no staff replacements.¹⁰⁶ Nurses also expressed concern over showing an interest in attending training because of “finger pointing” and the stigma attached to the provision of the service.¹⁰⁷

2.2.2 Doctors

Very few studies have looked at the experiences of doctors in the provision of termination-of-pregnancy procedures; nevertheless some studies have been able to shed light their experiences. This discussion falls in the sphere of second-trimester termination of pregnancies.

Harries et al report that a doctor described seeing women “hang around in rooms ... waiting and having foetuses between their legs for hours and nobody really cares”.¹⁰⁸ However, he or she was ‘delighted’ by the fact that “at least it gets done”.¹⁰⁹ Doctors identified a number of health-service barriers such as, infrastructure barriers, stigma and perceptions about why women were seeking termination-of-pregnancy procedures.¹¹⁰

In the context of second-trimester termination of pregnancies, providers were found to be more uncomfortable with the surgical method of termination of pregnancies (dilatation-and-evacuation procedure) because it elicited more physical and emotional responses to the termination procedure.¹¹¹ The dilation-and-extraction procedure exposes staff to the aborted foetus.¹¹² However, the only alternative method available is medical induction (the use of prescribed medication) that takes

¹⁰⁵ Ibid.

¹⁰⁶ Harries et al (note 31 above) 302.

¹⁰⁷ Ibid.

¹⁰⁸ Harries et al (note 31 above) 302.

¹⁰⁹ Ibid.

¹¹⁰ Harries et al (note 31 above) 302.

¹¹¹ Harries et al (note 9 above) 201.

¹¹² Ibid.

up bed space and requires a stay in hospital since it takes roughly 24 hours to terminate the pregnancy and deliver the products of conception.¹¹³

Caldas da Costa and Donald conducted a study of the experience of conflict that doctors experienced when expected to participate in the provision of termination-of-pregnancy services and found a number of areas of conflict.¹¹⁴ Some doctors reported that despite their personal values against termination of pregnancies, they nevertheless provide the service.¹¹⁵ However, those that did compromise their personal values report that they experience conflict, discomfort and difficulty with the compromise.¹¹⁶

The study found that doctors experience short term feelings of anxiety, guilt, depression, tension and trauma.¹¹⁷ A doctor found that the later the termination procedure takes place, the more traumatic the experience is because there is a chance that a nonviable but 'live foetus' is delivered and may 'move' about.¹¹⁸ As a result of these feelings doctors have reported negative attitudes towards women including less patience, attention, time and compassion being demonstrated towards elective termination-of-pregnancy patients.¹¹⁹

Doctors reported that they consider themselves as 'technicians' who are equipped with the expertise to provide termination of pregnancies but they did not consider themselves responsible for the decision reached by the patient.¹²⁰ Some doctors perceived their medical responsibility to include uplifting the community and consequently required to provide safe termination-of-pregnancy services.¹²¹ Contrary to this position, a number of doctors reported that the Hippocratic Oath implied a dual responsibility towards the interests of pregnant women and fetuses.¹²²

¹¹³ Harries et al (note 9 above) 202.

¹¹⁴ P Caldas da Costa & F Donald 'The Experience of Person-Role Conflict in Doctors Expected to Terminate Pregnancies in South African Public Sector' (2003) 33 *S Afr J Psychol* 10.

¹¹⁵ Caldas da Costa & Donald (note 114 above) 14.

¹¹⁶ Caldas da Costa & Donald (note 114 above) 15.

¹¹⁷ Ibid.

¹¹⁸ Caldas da Costa & Donald (note 114 above) 15.

¹¹⁹ Ibid.

¹²⁰ Caldas da Costa & Donald (note 114 above) 13.

¹²¹ Ibid.

¹²² Caldas da Costa & Donald (note 114 above) 13.

Some doctors felt that they received pressure from a number of role players.¹²³ For instance, doctors reported feeling pressurised by colleagues to perform elective termination of pregnancies because hospitals function in a 'team-based manner'.¹²⁴ Therefore, when some doctors refuse involvement in termination-of-pregnancy procedures it inevitably increases the work load for others.¹²⁵ This was found to lead to resentment and being labelled as lazy and uncooperative.¹²⁶ Doctors reported pressure of perceived discrimination in the granting of speciality posts.¹²⁷ Doctors expressed concerns that the participation in the provision of termination-of-pregnancy services is considered when speciality posts are granted in obstetrics and gynaecology.¹²⁸ The perception is that those doctors who refuse to participate in the provision of termination-of-pregnancy services are less likely to be accepted into the speciality of obstetrics and gynaecology and jeopardise their career advancements.¹²⁹ Doctors have also reported feeling pressure from patients, particularly women who have been denied access to elective termination-of-pregnancy procedures based on medical grounds or because of advanced pregnancy.¹³⁰ A doctor reported feeling "emotionally blackmailed" with women often threatening suicide.¹³¹

The picture projected by the Choice Act is far from the reality women face when accessing or attempting to access safe and lawful termination-of-pregnancy services. This system is hushed, shaped by negative personal and communal perceptions and stigmatisation, completely overloaded and is best described as a septic environment.

Those women that do get access to termination-of-pregnancy services may do so in exchange for their rights to dignity, privacy, equality and bodily integrity. Without proper access to the provisions of the Choice Act, women miss the opportunity to gain control over the consequences of an unwanted pregnancy and consequently

¹²³ Ibid.

¹²⁴ Caldas da Costa & Donald (note 114 above) 14.

¹²⁵ Ibid.

¹²⁶ Caldas da Costa & Donald (note 114 above) 14.

¹²⁷ Ibid.

¹²⁸ Caldas da Costa & Donald (note 114 above) 14.

¹²⁹ Ibid.

¹³⁰ Caldas da Costa & Donald (note 114 above) 14.

¹³¹ Ibid.

lose the ability to fully participate as active economic members of society beyond the home environment. This has a knock-on-effect since these women will then be unable to meet any pre-existing financial responsibilities they may hold. Where the drive to unburden themselves of unplanned pregnancies is strong enough, women will be forced to access illegal and unsafe termination-of-pregnancy services.

2.3 Comments on the current provision of termination-pregnancy services

Section 27(1)(a) of the Constitution of the Republic of South Africa, 1996 provides that everyone has the right to have access to health-care services including reproductive-health care. Subsection (2) obliges the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.

Bilchiz provides a neat summary of the application and extent of section 27.¹³² Socio-economic rights do not embrace an individual entitlement to the immediate provision of any service or resource.¹³³ In *Soobramoney v Minister of Health*¹³⁴ the Constitutional Court held that the obligations imposed on the state to progressively realise socio-economic rights are dependent upon the resources available for such purposes and socio-economic rights are limited by reason of the lack of resources. In *Government of the Republic of South Africa v Grootboom*¹³⁵ the Constitutional Court held that this limitation means that both the content of the obligation in relation to the rate at which realisation of rights is achieved, as well as the reasonableness of the measures employed to achieve the result are governed by availability of resources. However, there is a positive obligation on the state to devise a comprehensive and workable plan to meet its obligations.¹³⁶

Bilchiz states that socio-economic rights require the state to develop a systematic and comprehensive programme that is designed to realise these rights progressively

¹³² D Bilchitz 'Health' in S Woolman et al (eds) *Constitutional Law of South Africa* (3 Rev 2011) 56A-i, 56A-2.

¹³³ Ibid.

¹³⁴ 1998 1 SA 765 (CC) para 11 (*Soobramoney*).

¹³⁵ 2001 1 SA 46 (CC) para 46 (*Grootboom*).

¹³⁶ *Grootboom* para 39

within available resources.¹³⁷ *Grootboom* found that progressive realisation means that 'accessibility should be progressively facilitated: legal, administrative, operational and financial hurdles should be examined and, where possible, lowered over time.'¹³⁸

To determine whether the state has discharged its duty to progressively realise socio-economic rights, the courts will contextually evaluate the reasonableness of the state's programmes.¹³⁹ The court in *Grootboom* found that legislative measures on its own are not enough to constitute constitutional compliance with section 27 obligations.¹⁴⁰ The state is obliged to act to achieve the intended result; legislative measures will have to be supported by appropriate, well directed policies and programmes.¹⁴¹ These policies and programmes must also be reasonably implemented.¹⁴² Further, the state must be aware that conditions do not remain static, thus requiring continuous review of devised programmes and policies.¹⁴³

Referring to the implementation of the Choice Act, it is clear that the state has responded systematically to the pressing social need of curbing unplanned and unwanted pregnancies and consequently reducing maternal morbidity and mortality rates linked to unsafe and illegal termination of pregnancies. The Choice Act is applied throughout South Africa, termination-of-pregnancy services are available for first and second trimester pregnancies and this is provided for free at public health-care facilities for women of all ages. However, there is still a missing link between the Choice Act and women in need of termination-of-pregnancy services because an estimated 120 000 women are still accessing illegal and unsafe termination-of-pregnancy procedures. With such liberal provisions in place, illegal termination-of-

¹³⁷ Bilchitz (note 132 above) 56A-2.

¹³⁸ para 45.

¹³⁹ Bilchitz (note 132 above) 56A-2. Bilchitz identified criteria previously used by the Constitutional Court when evaluating a state programme: The programme must ensure that appropriate financial and human resources are available, it must be capable of facilitating the realisation of the right concerned, the programme must be flexible and attend to a 'crises', it must not exclude a significant segment of the affected population and the programme must balance short, medium and long-term needs

¹⁴⁰ *Grootboom* para 42.

¹⁴¹ *Ibid.*

¹⁴² *Grootboom* para 42

¹⁴³ *Grootboom* para 43.

pregnancy providers should not be thriving, in fact there should be no need for them at all.

The experiences described by the studies discussed above mirror the contents of a study commissioned by the Department of Health of the Republic of South Africa that was released in 2000.¹⁴⁴ The study highlighted the very same complaints concerning long waiting lists, a poor understanding of the provisions of the Choice Act, negative staff attitudes, a lack of resources and women's willingness to prefer unsafe and illegal termination-of-pregnancy services over lawful services.

The study made a number of recommendations. Concerning increased access to termination-of-pregnancy services, the report recommends that norms for service provision for first and second trimester termination of pregnancies should be set for all provinces.¹⁴⁵ These should include the number of services according to the proportion of the female population of reproductive age who live within a certain distance of the service, and the capacity of services which should be measured by the average number of termination of pregnancies performed per month per 100 000 women.¹⁴⁶ The report recommended that there should be annual monitoring of each province in reaching the norms for the provision of termination-of-pregnancy services.¹⁴⁷ Plans should be developed to enhance the provision of termination-of-pregnancy services at primary-care level and this should include training midwives and general practitioners.¹⁴⁸ Provinces should develop plans for improving services based on an understanding of local circumstances and barriers to more widespread service provision.¹⁴⁹

On the issue of unsafe and illegal termination of pregnancies, the report recommended that further efforts need to be made to meet the current unmet need for legal termination-of-pregnancy services.¹⁵⁰ It was found that this could be

¹⁴⁴ Department of Health of the Republic of South Africa *An Evaluation of the Implementation of the Choice on Termination of Pregnancy Act (2000)*.

¹⁴⁵ Department of Health (note 144 above) 37.

¹⁴⁶ Ibid.

¹⁴⁷ Department of Health (note 144 above) 37.

¹⁴⁸ Ibid.

¹⁴⁹ Department of Health (note 144 above) 37.

¹⁵⁰ Department of Health (note 144 above) 71.

achieved through improving accessibility through enhanced service provision in under serviced areas and through the provision of public information campaigns on termination-of-pregnancy rights and increase knowledge about the Choice Act.¹⁵¹ It was recommended that the quality of care in public health-care services needs to be improved so that women can access termination-of-pregnancy services without fear of harassment by staff.¹⁵² Further, safe involvement of general practitioners should be encouraged.¹⁵³ Public education on emergency contraception should be undertaken and its availability must be ensured.¹⁵⁴

Twelve years on, not much else can be found concerning state involvement in reported initiatives for the effective implementation of the Choice Act. It is not clear whether provinces have followed through with the recommendations of the study and nothing can be found concerning annual evaluations of the performance of each province in the provision of termination-of-pregnancy services.¹⁵⁵ Perusal of official websites of national and provincial departments of health reveals that no new studies have been completed on termination-of-pregnancy services even though the same complaints are being repeated year after year.¹⁵⁶ In the KwaZulu-Natal Department of Health Strategic Plan 2010-2014 it was indicated that in 2008-2009 12 528 termination of pregnancies were performed, compared with 14 435 in 2007-2008.¹⁵⁷ During 2008-2009, 305 septic termination of pregnancies and 11 343 incomplete termination of pregnancies were reported, leading the provincial department of health to concede that services to prevent unwanted pregnancies were inadequate.¹⁵⁸ However, the report failed to consider any remedial steps.

¹⁵¹ Ibid.

¹⁵² Department of Health (note 144 above) 97.

¹⁵³ Ibid.

¹⁵⁴ Department of Health (note 144 above) 97.

¹⁵⁵ In this regard, the official websites of each province's health department were search (those what were in working order) with the aim of finding official reports on the topic of termination of pregnancies.

¹⁵⁶ The Free State released a quarterly report on termination of pregnancies for April-June in 2006, however this report does not consider access barriers. Free State Department of Health *TOP Report* (2006)

<<http://www.fshealth.gov.za/portal/page/portal/fsdp/DOCUMENTS/corporate/reports/top/all/TOP%20Report%20April%20to%20June%202006.pdf>>.

¹⁵⁷ KwaZulu-Natal Department of Health *Strategic Plan 2010 – 2014* (2010) <www.kznhealth.gov.za/stratplan2010-14.pdf>.

¹⁵⁸ Ibid 79.

The lack of frequent and visible interaction by the national and provincial departments of health with the implementation of the Choice Act is worrisome and leads one to question whether the state is adequately meeting its constitutional obligations in terms of section 27 of the Constitution. The state is required to progressively lower barriers (administrative and operational) to access termination-of-pregnancy services over time; this cannot be achieved without regular and continuous review of the state's policy concerning the free provision of termination-of-pregnancy services. An estimated 120 000 women who access illegal and unsafe termination-of-pregnancy services need the policy to be continuously reviewed and consequently renewed or revised.

3 Recommendations

With the aim to make termination-of-pregnancy services more accessible and acceptable a number of recommendations will be considered. This is done in the hope that the state, when reviewing the current termination-of-pregnancy policy, will take these recommendations into account.

3.1 Educating women and girls

Women and girls accessing the service and the wider community need to be actively engaged in education programmes concerning reproduction and the provision of termination-of-pregnancy services. Schools and community forums need to vigorously participate in the distribution of information concerning these aspects of women's lives. Adequate education will aid with all recommendations to follow and positively impact improving the quality of service provision. There is a need to remove the stigma attached to termination of pregnancies and this can be achieved through open dialogue in a supportive environment.

Lang et al suggest that counselling on family planning and the education of target groups such as school children should be given greater priority.¹⁵⁹ The authors argue that each encounter by a health-care provider with a woman of reproductive age

¹⁵⁹ F Lang, G Joubert & E Prinsloo 'Is Pregnancy Termination being Used as a Family Planning Method in the Free State?' (2005) 47 *SA Fam Pract* 52 55.

should be considered an opportunity for family counselling.¹⁶⁰ Women and girls need to be informed about how their menstrual cycles function, sexual responsibility and the importance of early pregnancy recognition.¹⁶¹ There is a need to develop the correct knowledge about when to present for termination-of-pregnancy services and also be informed about the time limitations of the service.¹⁶²

Early detection of pregnancies will reduce the demand for second trimester termination of pregnancies, which seems to be the most problematic and ethically challenging issue in the provision of termination-of-pregnancy services. These ethical conflicts are a very visible barrier to access to termination-of-pregnancy services.

Once women have accessed termination-of-pregnancy services, they need to have sufficient information made available, particularly concerning their rights as a termination-of-pregnancy patients and what the termination-of-pregnancy procedure entails. Orner et al point out that the medical and surgical termination-of-pregnancy procedures need to be explained properly to women, this will help reduce feelings of confusion and anxiety women experience.¹⁶³ It is submitted that without this information it cannot be accepted that these women or girls have reached an informed decision.

3.2 Increase access to urine pregnancy testing

Morrone and Moodley recommend greater access to urine pregnancy testing at public sector clinics.¹⁶⁴ The authors reported that the timing for presentation for pregnancy-related treatment (antenatal care or termination of pregnancies) is influenced by access to urine pregnancy testing.¹⁶⁵ Consequently, access to urine pregnancy

¹⁶⁰ Ibid.

¹⁶¹ Morrone & Moodley (note 23 above) 82.

¹⁶² Ibid; Harries et al (note 12 above) 11.

¹⁶³ Orner et al (note 22 above) 50.

¹⁶⁴ C Morrone & J Moodley 'The Role of Pregnancy Testing in Facilitating Access to Antenatal Care and Abortion Services in South Africa: A Cross Sectional Study' (2006) 6 *BMC Pregnancy Childbirth* 26.

¹⁶⁵ Ibid 29.

testing has the potential to curb the demand for second trimester termination of pregnancies.

The authors argued that, theoretically, urine pregnancy testing is freely available at all public clinics, however there have been reports that women have been sent away to purchase their own urine pregnancy tests from private facilities.¹⁶⁶ Even though it was found that obtaining a urine pregnancy test of the patients own accord from a private source is associated with a significant decrease in the gestational age at presentation for termination-of-pregnancy services the practice of sending women to purchase their own test will contribute to delays in presenting for care.¹⁶⁷ The authors found that greater access to private sector urine testing alone will not lead to a decrease gestational age at the time of presenting for care.¹⁶⁸ It is required that urine pregnancy testing should be made routinely available at public facilities in order to significantly decrease gestational age at first visit.¹⁶⁹ The authors argue that this is not a difficult policy to implement since urine pregnancy testing is inexpensive and it is not staff intensive.¹⁷⁰

3.3 Curb the demand for second-trimester termination-of-pregnancy services

Grossman et al state that every additional week of gestation confers a significant increase in the risk of mortality with termination of pregnancy and it is critical that health systems work to improve the referral process in order to minimise delays in access to termination-of-pregnancy services.¹⁷¹ The general provider opposition to second trimester termination of pregnancies requires the need for this service to be minimised.¹⁷²

Second trimester terminations are costly to the health care system. The risks associated to second trimester termination leads to an increased demand on already

¹⁶⁶ Morroni & Moodley (note 164 above) 29.

¹⁶⁷ Ibid.

¹⁶⁸ Morroni & Moodley (note 164 above) 29.

¹⁶⁹ Morroni & Moodley (note 164 above) 30.

¹⁷⁰ Ibid.

¹⁷¹ Grossman et al (note 25 above) 229.

¹⁷² Harries et al (note 12 above) 14.

scarce resources and requires substantial training investments,¹⁷³ particularly because the procedure must be performed or prescribed by a medical practitioner.

In cases where women do present for termination-of-pregnancy services in the second trimester, Jewkes et al recommends that they are given priority since any further delay will result in her being denied access to lawful and safe termination-of-pregnancy services due to advanced pregnancy.¹⁷⁴

3.4 Values-clarification workshops, client-centred training and distribution of information relevant to termination of pregnancies

As with the wider community, there is a need in the medical field to remove the stigma associated to termination of pregnancies. Harries et al states that values-clarification workshops and other training is designed to convey the patients' perspective and can improve on providers' perceptions of women accessing termination-of-pregnancy services.¹⁷⁵ Further, Harries et al mentions that values-clarification and client centred training may also improve on providers' emotional support to patients.¹⁷⁶

Mitchell et al state that the purpose of values clarification workshops is not to change opinions overnight, but to inform participants and help build an attitude of tolerance.¹⁷⁷ The aim of values clarification workshops is to allow health-care providers an opportunity to clarify their values and attitudes and bring about changes in attitude and behaviour towards women accessing the service.¹⁷⁸ Harries et al recommends the use of values-clarification workshops for termination-of-pregnancy providers and all health-care providers in the areas of reproductive health.¹⁷⁹ Mitchell et al reported on a study of values-clarification workshops that also included

¹⁷³ Grossman et al (note 25 above) 231.

¹⁷⁴ Jewkes et al (note 34 above) 1241.

¹⁷⁵ Harries et al (note 9 above) 205.

¹⁷⁶ Ibid.

¹⁷⁷ E Mitchell, K Trueman, M Gabriel, A Fine & N Manentsa 'Accelerating the Pace of Progress in South Africa: An Evaluation of the Impact of Values Clarification Workshops on Termination of Pregnancy Access in Limpopo Province' (2005) 10 <<http://www.ipas.org/~media/Files/Ipas%20Publications/SAvcEval.ashx>>.

¹⁷⁸ Harries et al (note 31 above) 302.

¹⁷⁹ Harries et al (note 12 above) 12.

traditional leaders, traditional healers, members of faith-based organisations and municipal councillors, since these stakeholders play leading roles within the community.¹⁸⁰

Some providers have suggested that values-clarification workshops helped them define their role as facilitators who guided rather than directed women.¹⁸¹ Mitchell et al reported that as a consequence of values-clarification workshops, attendees have begun 'new activities' that range from diverse forms of advocacy and personal efforts to enhance the quality and quantity of reproductive-health care.¹⁸² For instance, community-orientated initiatives focused on disseminating information or providing support to facilities.¹⁸³ Health-care providers reported making incremental improvements in the quality and quantity of services.¹⁸⁴ For instance a new ward was created for the provision of termination-of-pregnancy services and others reported allocating more staff or increasing designated beds for termination-of-pregnancy patients.¹⁸⁵ Several health-care providers and community leaders reported that they began providing individual client counselling.¹⁸⁶ Collectively, an effort was made to meet with and positively influence non-attending health professionals in their approach to and provision of termination-of-pregnancy services.¹⁸⁷ Further, a religious leader reported that his church holds regular youth rallies to speak about termination-of-pregnancy services since the Council of Churches are supportive of spreading the message of accessing safe termination-of-pregnancy services.¹⁸⁸ Changes at health-facility levels were also identified to the extent that staff demonstrated a positive change in attitude towards termination of pregnancies, service providers and the women using the service.¹⁸⁹ It was reported that health-care providers experienced enhanced communication among themselves and

¹⁸⁰ Mitchell et al (note 177 above) 13.

¹⁸¹ Harries et al (note 31 above) 302.

¹⁸² Mitchell et al (note 177 above) 29.

¹⁸³ Mitchell et al (note 177 above) 30.

¹⁸⁴ Ibid.

¹⁸⁵ Mitchell et al (note 177 above) 30.

¹⁸⁶ Ibid.

¹⁸⁷ Mitchell et al (note 177 above) 31.

¹⁸⁸ Ibid.

¹⁸⁹ Mitchell et al (note 177 above) 31.

between themselves and termination-of-pregnancy patients, allowing for everyone to talk freely about termination of pregnancies.¹⁹⁰

In order to develop a positive attitude towards termination of pregnancies generally Potgieter and Andrews identify a number of valuable markers to include in education material.¹⁹¹ Knowledge about the impact of unsafe termination of pregnancies on women's mortality and morbidity needs to be developed.¹⁹² When engaged in an education programme it is necessary to work through judgmental attitudes towards termination-of-pregnancy services.¹⁹³ It is required that people are encouraged to have a flexible and wide interpretation of religion and culture and recognise that one person's interpretation of an aspect of religion may be different to their own.¹⁹⁴ Those that are directly or indirectly involved in the provision of termination-of-pregnancy services must develop a good sense of their role as active citizens and view a woman's right to control her body as a fundamental right.¹⁹⁵ Potgieter and Andrews also argue that people's attitudes about certain issues may change as a result of personal experiences such as interacting with others who hold different opinions.¹⁹⁶ The authors suggest providing a non-threatening environment in which different opinions on the topic can be shared.¹⁹⁷

Mayers et al recommend that termination-of-pregnancy providers be trained in appropriate counselling skills since opportunities may exist to offer counselling, information and support for women while they wait for Misoprostol to take effect.

3.5 Free-standing, all-inclusive termination-of-pregnancy clinics

Some providers suggested developing dedicated centres for termination-of-pregnancy services in order to create a more supportive environment for patients and staff.¹⁹⁸ It was suggested that this may offer a solution to the negative attitudes

¹⁹⁰ Ibid.

¹⁹¹ Potgieter & Andrews (note 79 above) 28.

¹⁹² Ibid.

¹⁹³ Potgieter & Andrews (note 79 above) 28.

¹⁹⁴ Ibid.

¹⁹⁵ Potgieter & Andrews (note 79 above) 28.

¹⁹⁶ Potgieter & Andrews (note 79 above) 29.

¹⁹⁷ Ibid.

¹⁹⁸ Harries et al (note 31 above) 302.

of health-care providers and support staff. A more supportive environment may have the added benefit of retaining trained nurses and midwives,¹⁹⁹ since the clinic will be staffed by people who choose to work in that specific area of health care instead of general gynaecology.²⁰⁰

3.6 Making contraceptive services available at the site of termination-of-pregnancy services and improve on these services

It has been suggested that rather than expanding termination-of-pregnancy services, there needs to be an increased focus on broader reproductive-health services, especially contraceptive services.²⁰¹ It was argued that this will assist with reducing the demand for termination-of-pregnancy services.

A number of barriers to accessing contraceptive services were identified by Harries et al: women were offered limited contraceptive choice, condom promotion is over emphasised, little or no pre- or post-termination-of-pregnancy counselling taking place and general problems accessing family planning clinics.²⁰² Problems with access to family planning clinics were associated to restricted operating hours and contraceptive services are not always available at the site of termination-of-pregnancy services.²⁰³ As a result of this disjointed setup, sometimes women have to take a number of days leave from work in order to obtain contraceptive counselling after the termination-of-pregnancy procedure.²⁰⁴

3.7 Reconsider the methods of termination-of-pregnancy procedure

Participants in a study conducted by Harries et al recognised that second-trimester medical termination of pregnancy (intake of Misoprostol) was a lengthier termination process than surgical termination-of-pregnancy procedure (dilation and extraction) and consequently required longer hospitalization in a bed-restricted environment.²⁰⁵

¹⁹⁹ Harries et al (note 31 above) 303.

²⁰⁰ Jewkes et al (note 34 above) 1241.

²⁰¹ Harries et al (note 9 above) 204.

²⁰² Ibid.

²⁰³ Harries et al (note 9 above) 204.

²⁰⁴ Ibid.

²⁰⁵ Harries et al (note 9 above) 205.

However, it was conceded that a combination of Mifepristone and Misoprostol²⁰⁶ would have good results in medical termination of pregnancies. Although Mifipristone is more expensive, it may still be cost effective since it is found to reduce the duration of hospitalisation since the termination procedure is faster. Harries et al argues that introducing a low-cost Mifepristone product into health-care facilities that do not have trained or willing surgical termination-of-pregnancy providers might significantly improve the capacity of termination-of-pregnancy services to meet the demands of women.²⁰⁷ The benefit of this method is that the termination-of-pregnancy procedure can be completed as a day procedure.²⁰⁸

3.8 Support, recognition and morale boosting

There is a need for the adequate provision of counselling and psychological support that will give termination-of-pregnancy providers the opportunity to work through their experiences of trauma, stress, depression and anxiety.²⁰⁹ If these issues can be properly addressed, providers will be in a better position to perform according to the required professional standard.²¹⁰

Mamabolo and Tjallinks recommend management should encourage an open-door policy so that termination-of-pregnancy providers get help whenever needed, especially in cases of required emergency debriefing.²¹¹

Support from management can also come in the form of monitoring service provision through quarterly reviews to check adherence to set standards, availability of termination-of-pregnancy equipment and availability of psychological support.²¹² Management should also take on the responsibility to maintain quality protocols such

²⁰⁶ These medications are only indicated for first-trimester termination-of-pregnancy procedures. It is standard procedure that Misoprostol is used on its own in the first trimester.

²⁰⁷ Harries et al (note 9 above) 206.

²⁰⁸ Ibid. The authors state that this depends on whether a pharmaceutical company will attempt to register Mifepristone for the use in second trimester termination-of-pregnancy procedures or if the Department of health will allow wide-spread off-label use of the product.

²⁰⁹ Mamabolo & Tjallinks (note 69 above) 82.

²¹⁰ Ibid.

²¹¹ Mamabolo & Tjallinks (note 69 above) 83.

²¹² Ibid.

as quarterly termination-of-pregnancy reviews and psychological assessment tools to ensure that a holistic service is rendered.²¹³

Harrison recommends a number of methods to increase morale among health-care providers generally: increase the provision of study leave, preferential admission for specialisation and a work environment respectful of professional autonomy and conducive to personal growth and development.²¹⁴

3.9 Compensation

Harries et al found that termination-of-pregnancy providers were more willing to be involved in the provision of termination-of-pregnancy services if offered financial compensation.²¹⁵ Mamabolo and Tjallinks suggest that termination-of-pregnancy providers should receive incentives in the form of 'scarce skills' allowance to encourage working in the provision of termination-of-pregnancy services.²¹⁶

3.10 Work load and staff rotation

In the case where sufficient staff is available for the provision of termination-of-pregnancy services, Mayers et al recommend that staff should be offered the option of rotation.²¹⁷ This gives providers the opportunity to share the work load and may also encourage emotional support among staff.

3.11 Criminal sanctions

A number of experiences described by women when attempting to access termination-of-pregnancy services may very well constitute a criminal offence in terms of the Choice Act. Section 10(1)(c) provides that any person who prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination

²¹³ Mamabolo & Tjallinks (note 69 above) 83.

²¹⁴ D Harrison 'An Overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains' (2009) <<http://www.doh.gov.za/docs/reports/2010/overview1994-2010.pdf>>.

²¹⁵ Harries et al (note 31 above) 299.

²¹⁶ Mamabolo & Tjallinks (note 69 above) 83.

²¹⁷ Mayers et al (note 46 above) 24.

of a pregnancy shall be guilty of an offence and liable on conviction to a fine or imprisonment for a period not exceeding ten years.

It is submitted that, although this provision serves a valuable role in the overall implementation of the Choice Act, it is recommended that this avenue not be explored within the context of this topic. An all-inclusive approach is recommended were the concerns of all parties are considered in order to advance the needs of women and girls trying to access termination-of-pregnancy services. If one uses criminal sanctions as the starting point one may inevitable lose much needed support from the health-care system.

4 Conclusion

The preamble of the Choice Act makes specific reference to the furtherance of the values of dignity, achievement of equality and security of the person. Further, the preamble recognises that the decision to have children is fundamental to women's physical, psychological and social health and that the state has the responsibility to provide reproductive health in safe conditions to all persons. This right of choice should not be exercised with fear or harm.

Having considered the experiences of women and the conditions described by health care providers does not accurately portray the aims of the Choice Act. In fact women trade their rights in a desperate attempt to get control over their reproductive capacity. In some instances, the same can be said for termination-of-pregnancy providers. The attitude of 'at least it gets done' is not enough and it is unacceptable that it 'gets done' under those sorts of conditions.

In order to increase the accessibility of services, the needs of termination-of-pregnancy providers should be addressed. Attracting and retaining trained termination-of-pregnancy providers cannot be achieved if the providers are expected to function in an over-burdened, under-resourced and hostile environment. As long as these conditions persist, the quality of care will be compromised and women will be at risk of having their rights violated and health compromised. The state is required to actively adopt a leadership role and continually review and revise the

current termination-of-pregnancy policy. The state should consider and include all role players in the solution-finding operation, thereby improving the quality and accessibility of termination-of-pregnancy services.