South Africa,

A Liberal Abortion Law Doesn't Guarantee Access

- Features - Sexual politics -

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Description:

This story is part of a Pulitzer Center on Crisis Reporting collaboration between African and American journalists on reproductive health issues. The article appeared in the January 21, 2013 edition of *The Nation* and we are republishing with the permission of Agence Global.

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Seventeen years ago, as apartheid came to an end and a democratically elected government took power, South Africa seemed ready to become an abortion rights pioneer. In 1996, the post-apartheid legislature passed the first law in sub-Saharan Africa legalizing abortion without restriction in the first trimester, and with a doctor's approval thereafter. The new rules allowed women to walk into a public hospital or clinic, confirm their pregnancy and gestation period, and receive a free abortion if they were fewer than thirteen weeks along in their pregnancy. Simple and straightforward, the law is "probably the most progressive [abortion] law in the world," says Jane Harries, director of the Women's Health Research Unit at the University of Cape Town. But sixteen years on, the promise of access, no matter how liberal, "doesn't necessarily translate into services that are available." In today's South Africa, it is often faster and easier to get an illegal abortion than a legal one.

Seventeen-year-old Marie (not her real name) has a story that is all too typical. When she found out she was pregnant, "I wanted to kill my boyfriend," she told us. Equally furious and fearful, she hid the news for months from her aunt and cousins, with whom she lived just outside Port Elizabeth, a waning shipping town on South Africa's eastern coast. "I wanted an abortion," Marie says. "It took me a long time to get the R140 [roughly $16] to get to the clinic." When her belly was finally too big to hide, her aunt banished her, and Marie went to stay with her boyfriend. Once she got to a clinic, Marie says, ("I waited for a long time. When they finally did the scan, they said it was too late to abort. They could not help me."

Marie's story is repeated across the country. Free abortion is guaranteed at public hospitals and clinics designated by the government to offer the service. Yet less than half the facilities so designated actually offer the procedure. And even that's an improvement over four years ago, when only 25 percent were providing services more than a decade after legalization.

As a result, women like Marie have to run a gantlet when they need abortion services. Clinics are an expensive taxi ride away for some South Africans, those taxi fares add up to a week's wages and even women with access to a household vehicle often don't want their families or neighbors to know they need it for an abortion appointment. Plus the intake practices at these clinics, meant to streamline the high demand, mean that women have to schedule a procedure and then return later.

Last year, nearly 80,000 abortions were performed across South Africa, but women's health experts are quick to point out that these numbers reflect the state's current capacity, not the real demand.

Mfundo Mabenge, head of obstetrics and gynecology at Port Elizabeth's Dora Nginza Hospital, blames the government for creating this crisis. "Government has failed us," she says. "They compel us to offer a service for termination of pregnancy, but they give us no support." Mabenge, like other Ob/Gyn chiefs we spoke with, was simply told to make space to provide abortions and then to offer them. The government covers the cost of the procedure, but Mabenge says there's no money to add beds, mop the floors, or otherwise create and maintain a clinic space.

Meanwhile, Mabenge says, "demand is greater than we can handle." Nationally, the number of abortions performed jumped nearly a third between 2010 and '11. Joe Maila, spokesman for the national Department of Health, says the

South African government doesn't measure "demand" for abortion. But Mabenge's hospital sees as many as twenty patients a day requesting one; the number of abortions there doubled between January and June 2012, even as the staff dropped from four to two midwives.

Mabenge's colleagues across the country face similar problems. "There's a huge shortage of abortion-care providers in this country," says Harries. "Facilities are designated, but there are no people to provide the services." That's partly because abortion is a contentious topic, and nurses who oppose the procedure often elect not to work in their clinic's abortion wing. Willing nurses, meanwhile, may be discouraged by peer pressure.

Behind every abortion, of course, is an unintended or unwanted pregnancy. Lack of access to contraceptives is the most commonly cited cause of those pregnancies, according to the South African health professionals we interviewed. The World Bank has found that 60 percent of South African women use contraceptives, but access varies greatly by community. Less than half of sexually active teenagers report using condoms; nearly 20 percent report forgoing contraception entirely. Meanwhile, in the Eastern Cape, we heard stories of teens having sex for money, shoes or cellphone credit. Unemployment in South Africa hovers around 25 percent, and the recent and bloody strikes by black laborers at mining facilities have ignited a debate over the persistent social inequalities in the country nearly twenty years after the end of apartheid.

Sharon Hobo, a nurse in the Dora Nginza abortion facility, says teens in particular have difficulty gaining access to family planning services. "They say, 'My mom doesn't want me to go,' or 'The school hours clash with the clinic hours,' " Hobo says. There's a broad social denial about teens' sexual activity, but there's also a stigma. "In the culture, you know, [contraception] is a taboo," Hobo says.

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The Hillbrow Community Health Centre is a first-(trimester abortion provider in the heart of Johannesburg. The clinic, in a low-income neighborhood, looks more like a military installation, surrounded by high walls and rings of concertina wire, with uniformed security agents monitoring public waiting areas and intercepting visitors at every threshold. The security guards and reception staff ask patients to announce their destination, which means that at Hillbrow, as at the other hospitals and clinics we visited, every woman who comes for an abortion has to say so in front of a crowd.

On a late March morning, Hillbrow's basement clinic was crowded. The waiting room was lined with posters advertising birth control pills, injectables and a variation on the NuvaRing. The women in the ads were cheerful, diverse and mature: one black, one white and one Asian woman, all laughing with post-adolescent confidence. The women staring back at them from the vinyl chairs in the waiting room were mostly young, all quiet and all black. They exuded uncertainty; a few seemed downright afraid. A sign at the reception area warned them: "You will wait 2 hours and 30 minutes on average with the available staff resources." Judging from what little chatter there was, the women seemed to know they'd be there all day.

If national patterns are any clue, some of those women arrived here too late. The law sets the cutoff for first-(trimester abortions at twelve weeks. Many women don't realize they're pregnant until eight or nine weeks go by, and the first appointment they're offered may put them in the thirteenth or fourteenth week. At that point, they need to seek out a second-trimester facility.

For that, many Hillbrow patients turn to the Charlotte Maxeke Johannesburg Academic Hospital. The hospital sees 3,000 women a year and turns two-thirds of them away, usually because they're too far along in their pregnancy (the cutoff for second-trimester procedures is twenty weeks). Norma Bustard, nurse manager at Johannesburg Academic, says that women routinely tell her staff they've waited days at different clinics, across the span of their pregnancies.

"Then they came back another day, and the clinic was still full," she says. By the time they make it to Bustard's ward, "this may be their third or fourth clinic."

We heard similar stories of confusion in the other clinics we visited. The law itself further complicates the issue. Public health facilities may perform either first- or second-trimester procedures, depending on the training of their staff. A first- trimester procedure, available without restriction for the first twelve weeks of pregnancy, requires midwives trained in either manual vacuum aspiration or medication abortion ((or both). A second-trimester procedure is most often surgical and must be performed by a doctor. These procedures are restricted to cases of rape or incest, likely physical or mental harm to the mother or the fetus, or significant impact on the socioeconomic status of the woman a category that some midwives say covers everything from a fear of impoverishment to a desire to continue one's education.

Women who lack this perseverance have another, easier option: illegal abortion. Across the street from the Hillbrow clinic, a brick apartment building is plastered with brightly colored posters advertising fast, cheap and confidential services. The same posters line the streets of nearby Soweto township; they paper Port Elizabeth's bus depots, roughly 650 miles away on the eastern coast; and they've been affixed to electric poles in the rural, northernmost province, Limpopo. In short, they're everywhere.

Like midwives performing abortions or doctors inducing labor, illegal abortion providers use misoprostol. The drug detaches the fetus from the uterus, which means its safety depends entirely on the dose and accompanying medical oversight. Illegal providers simply hand over the pills, and the women hope for the best.

For people who have been turned away from the clinics or couldn't get there in the first place back alley providers are a last-ditch hope. Karen Trueman, country leader of Ipas, an international organization that aims to curb deaths from unsafe abortions, says flatly, "When a woman makes a decision to terminate, she's going to terminate." That's especially true for young women. According to the South African Medical Research Council's most recent youth-risk behavior survey, nearly half the girls ages 13 to 19 who had an abortion in 2008 did not use a hospital or clinic.

Franco Guidozzi, head of obstetrics at Johannesburg Academic, says there's no real way to know if a woman who ends up in his hospital has had an illegal abortion. Unless a patient admits she's sought out misoprostol on her own, or ends up septic in the emergency room at a hospital where she'd earlier requested an abortion (and where a nurse might remember that), there's no real way to know. Besides, doctors and nurses say, no one has asked them to track that information in the first place.

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Though illegal abortions are safer now than they were in what some healthcare workers bluntly call "the coat-hanger years," they're still anything but foolproof. In March, a woman attending the University of Johannesburg died in her student hostel, a death that police attributed to an illegal abortion. Nearly 25 percent of maternal deaths, according to the latest national inquiry into maternal health, are caused by conditions that specialists say correlate with an illegal abortion.

If that language sounds vague, it's for a reason: the most recent biannual inquiry into maternal mortality has all but dropped any mention of abortion as a cause of death. "Nobody's really happy with the term 'abortion' in South Africa, so they've decided that they're not going to use 'unsafe abortion,'" says Trueman. "It's all obfuscated in the newest report with terms like 'unsafe miscarriage.'" Mabenge, the Ob/Gyn chief at Dora Nginza Hospital, is also a member of the national panel that produces the maternal health report. He says other code words include "septic miscarriage" and "acute collapse." But rather than confront the continuing lack of access to legal abortion services, government

officials lament the availability of illegal ones. "Newspapers and municipalities should be ashamed of allowing advertisements for fly-by-night abortion practitioners," says Eddie Mhlanga, the former head of the Maternal Child and Women's Health Unit of the National Department of Health.

Church groups blame teenage "promiscuity," and public officials wring their hands over teens' alleged use of abortion as a contraceptive. Both are theories for which hospitals and health departments can't produce data and which coincide with anti-abortion talking points. "There is an increasing demand for abortion because teenagers do not want to use contraceptives," said Sizwe Kupelo, spokesman for the Eastern Cape's health department. "Instead, they use termination of pregnancy."

Trueman calls this a "paternalistic, stigmatizing attitude.... Apart from being ludicrous and not supported by the statistics, it puts women in the light of being totally irresponsible." Harries, meanwhile, says researchers have been asking for precisely the data that might back up the government's claims about the use of abortion as a contraceptive. What gets collected, she says, "isn't great...[and] the numbers don't always add up."

Even the government's own independent statistical authority calls the official figures questionable. The Health Systems Trust said in its 2011 report that the government's abortion statistics are "increasingly unreliable." Just as it did during the AIDS (crisis, when then-President Thabo Mbeki denied the relationship between HIV and AIDS, the government seems to be perfecting an alibi of plausible deniability: if there aren't any numbers to prove there's an abortion crisis, then there must not be a crisis.

Other numbers don't disappear so easily. National and international statistics suggest a general pattern of neglect concerning the issue of women's health. The maternal mortality rate in South Africa is up more than 20 percent in as many years, according to the UN Population Fund. Though South Africa boasts one of the continent's most robust economies and spends more per capita on health than any other African country, its maternal mortality numbers are on par with the Republic of Congo. Even Pakistan is doing better.

But the lack of access to abortion services is only one of the systemic problems in South Africa's healthcare sector. "Termination of pregnancy has always been the Little Orphan Annie left behind, but we have issues related to cervical cancer screening, breast cancer screening, access to contraceptives," says Trueman. At the same time, South Africa is facing a fiscal crisis in its healthcare sector: five of its nine provinces are directly supervised by the national health ministry a significant intervention in a highly decentralized country because their fiscal management has been so poor. To cut costs early last year, the Eastern Cape's health director implemented a hiring freeze, even as the province was facing a staff shortage (the province had less than half of the nurses it needs) all of which made it even more difficult for women seeking to terminate an unwanted pregnancy.

One solution to the crisis may be medication abortions. Unlike current procedures, which require several hours in a clinic and manual "evacuation" of the uterus by a trained staff, medication abortions induce termination with a combination of drugs. Women take the first drug at the hospital and the second at home, and return to the hospital ten to fourteen days later for a checkup. Medication abortions are already an option in the Western and Eastern Cape, and three other provinces are slated to offer them this year, with help from Ipas. They are also a popular choice: in one province, Ipas found that more than 75 percent of women intending to terminate preferred that option over the rest.

But the country's medical establishment has been wary. "Medical people in South Africa are not very happy about women doing things on their own," Trueman says. "But women are pretty sensible, believe it or not. And they know their bodies."

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