Submission in favour of the Amendment to the
Choice on Termination of Pregnancy Act; Act 38 of 2004

1. Introduction to Ipas South Africa

Ipas is a non-profit, non-governmental organization working globally to increase women's sexual and reproductive rights and to reduce abortion-related deaths and injuries. Ipas strives to empower women by increasing access to services that enhance their reproductive and sexual health, through a focus on preventing unsafe abortion, improving the treatment of complications arising from unsafe abortion and reducing its consequences.

Ipas South Africa was established in 1995 and has worked alongside the National and Provincial Departments of Health to strengthen the provision of Termination of Pregnancy (TOP) services nationally. Over a 12-year period Ipas South Africa has provided technical assistance in training, research, and policy development in pursuance of its vision to make abortion safe and accessible in South Africa.

2. Background and focus of Ipas South Africa's submission

This submission provides a contextual background to the introduction of the Choice on Termination of Pregnancy Act, Act 92 of 1996 and an overview of Ipas South Africa's role in TOP services. It reflects on the implementation of TOP services and demonstrates why Ipas South Africa supports the Choice on Termination of Pregnancy Amendment Act, Act 38 of 2004 as an appropriate policy response to increasing women's access to reproductive health services. We conclude this submission by restating the Constitutional imperatives underpinning our abortion legislation.

3. Legislative Reform in South Africa

3.1 The Abortion and Sterilization Act; Act 2 of 1975

The Abortion and Sterilization Act; Act 2 of 1975 was repealed because it denied the majority of women in South Africa equal access to safe and legal termination of pregnancy and resulted in the wide spread use of unsafe, illegal, back-street abortion. The impact of this unequal access was not limited to the negative consequences on women's health and lives; it also created public health costs in treating the complications arising from illegal abortion.

A compelling argument for abortion legislation reform was the 1994 Study into Incomplete Abortion by the Medical Research Council, which estimated that 425 women died as a result of illegal abortion in that year. It found that of the 44 686 women that had presented with incomplete abortions at public health facilities, 34% were unsafe abortions and that 99% of the women with incomplete abortion were Black. The annual cost to the State for treating the complications that arose was estimated to be R18, 700 000. Health problems included sepsis, hemorrhage, infertility and countless physical and psychological injuries.

The introduction of the Choice on Termination of Pregnancy Act, 92 of 1996 has decriminalized abortion. The choice to terminate an unplanned pregnancy is now situated as a legitimate reproductive health service and as a human right. It affords all women, irrespective of age, location and socio-economic status the right to terminate a pregnancy within the first 12 weeks of gestation on request and thereafter under particular circumstances.

3.2 The impact of legislative reform

In 1999, the Department of Health commissioned a study to evaluate the health impact of the Choice on Termination of Pregnancy Act, by drawing a comparison between the data from the 1994 study. The results of the study found that the number of patients with high morbidity had almost halved in 2000 (9.5% in 2000 compared with 16.5% in 1994). The majority of

cases had no signs of infection on admission (90.6%). There had also been a significant downward trend (from 5.7% in 1994 to 3.9% in 2000) in women dying from complications of unsafe abortion. The 2000 study demonstrated an immediate impact of legislative reform in reducing women's morbidity and mortality.

The most significant finding to date has been a comparison between the 1994 study and the 2002 - 2004 Confidential Enquiry into Maternal Death, which found a 91% reduction in deaths from unsafe abortion. It is evident that the Choice on Termination of Pregnancy Act has been extremely successful in advancing women's health and rights. It is also in line with the Millennium Develop Goal (number 5) which seeks to reduce maternal mortality by three quarters (75%) by 2015.

4. Ipas South Africa's role in supporting the implementation of the Choice on Termination of Pregnancy Act

Ipas South Africa has collaborated with the National and Provincial Departments of Health in an effort to accelerate the availability of TOP services throughout South Africa's nine provinces. We have worked alongside a variety of stakeholders in the design and implementation of TOP provider training curriculum to enable midwives to provide safe TOP services in the first trimester of pregnancy, improve standards in the quality of care in TOP services and post-abortion care. We continue to expand the availability of instruments used in the Manual Vacuum Aspiration Technique in both the public and private health sectors. Ipas South Africa has consistently rendered Values Clarification workshops to health care providers, facility managers and the communities they serve, which are designed to encourage attitudes and behaviours that favour the protection of women's reproductive rights and greater compliance with the Act at health-facilities. The research we have undertaken has been to advance a broader approach to understanding sexual and reproductive health service provision.

5. The Choice on Termination of Pregnancy Amendment Act, 38 of 2004 as a policy response to increasing access

In the main, the amendments are geared towards increasing women's access to safe TOP services and better governance of those services. It was envisaged that this could be achieved by accelerating the process of designation of facilities to provide abortion services as a provincial competency and by increasing the pool of trained providers through extending TOP training to registered nurses in order to render first trimester services. Another important amendment is to ensure that services are rendered by TOP personnel and that they are located in environments found suitably equipped to do so. Furthermore, the amendment also seeks to improve the monitoring of TOP services by stipulating the frequency and manner in which TOP statistics should be collected and submitted and making this process mandatory.

5.1 Designation of Termination of Pregnancy Services (section 2 of the amendment)

The current regulation undoubtedly is a protracted process (ranging from 6 months to 3 years) to approve an application by the National Minister of Health. By making the designation of TOP services a provincial responsibility it reduces the time taken to 3-6 months. Despite shortening the period of designation, the regulation provides that facilities be inspected to determine compliance with the conditions and requirements that must be met before a facility is authorised to provide services.

5.2 Decentralization of abortion care services (section 2 of the amendment)

Ongoing monitoring of TOP services reveals that although much progress has been made, the challenge to improve service delivery and access remains. A review of implementation conducted by the National Department of Health in 2007 found that 70% of services were located at secondary levels of care. Distribution of services remains uneven across provinces, with women, particularly in rural areas, having little or no access. The designation of services at a provincial level adds impetus to the target set by the National Department of Health that 70% of primary health care and community health centres render TOP services to ensure the greatest possible access for the majority of women. Under the 2004 amendment act, the Gauteng Department of Health has designated all Community Health Centres as TOP facilities. Similar initiatives are underway in other provinces.

5.3 Submission of statistics (section 3 of the amendment)

In order to improve access and the quality of care rendered to women seeking to terminate their pregnancy the submission of accurate statistics becomes an imperative. By making the submission of statistics mandatory and prescribing both the frequency and submission process of statistical collection the amendment provides another mechanism for the management of TOP services.

5.4 Compliance with the Act (section 6 of the amendment)

Throughout our work Ipas South Africa has promoted the need for greater compliance and meticulous practice in an effort to protect the vulnerability of women from unscrupulous practitioners. We support the interpretation and application of the addition to the penalty clause, which makes it an offence to allow a TOP to be performed at a facility that is not approved for this purpose, in as far as it seeks to broaden women's access to safe and qualitative abortion services.

5.5 Increasing the pool of trained providers by extending this to registered nurses (section 7 of the amendment)

The amendment Act provides that in addition to registered midwives who have undergone the prescribed training, registered nurses who undertake training in terms of the Act may perform TOP's up to 12 weeks gestation of pregnancy. A review of the number of TOP's rendered between February 1997 to 31 January 2006 reflected that 529 410 women accessed safe, legal termination of pregnancy services. 76% of these were provided in the first trimester and primarily rendered by midwives, trained in the Manual Vacuum Aspiration Technique. The technique is not only a major cost-saving measure; it has demonstrated the ease with which capacity to provide safe, efficient and accessible services are possible. The South African experience provides a sound basis on which to confidently support extending this training to registered nurses and as effective strategy to make accessibility at the lowest appropriate level of care. Having said this, we would motivate that, where a doctor must make consultation for second trimester terminations. He/she must only do so with the registered midwives and not registered nurses.

6. Conclusion

Reproductive Rights (derived from our Constitution) have been given meaning through this legislation. All women irrespective of historic inequalities have the right to access a safe, legal termination of pregnancy under this law. Undoubtedly women's lives are being saved, women's health is protected and women's status lifted, as the discrimination based on denying women this right (which only affects women) has been addressed. These advances have been made against an international context where the space for reproductive rights is shrinking. South Africa has stood its ground in successfully defending the reproductive

autonomy of women and minors against two previous legal challenges. Albeit that the current process of public consultation to the amendments is as a result of a third legal challenge to the Act, it presents an opportunity within which to broaden and deepen our democracy.

Ipas South Africa believes in the inalienable right of women to make choices about their bodies. Women, particularly young, poor and rural women are often living in realities in which choice in relation to bodily autonomy is denied. Many women find themselves in violent relationships and/or are confronted with unplanned pregnancy that results from coercive circumstances such as rape. It is therefore important for South African's (who do not support this legislation) to separate their own beliefs and values from the needs of others. The Constitutional imperatives enshrined in the bill of rights that underpin the Choice Act are the right to equality, freedom and security of the person, access to healthcare and information, the right to freedom of religion and belief and to freedom of expression. As we overcome years of denying choice and human rights, we have a moral obligation to protect, uphold and advance the exercise of full human rights to all South Africans.