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The Culture of Illegal Abortion in South Africa

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Abortion is a common medical experience, globally and in South Africa. Worldwide, approximately one in five pregnancies ends in abortion. But many societies understand abortion as a moral transgression, even if its benefits to public health are sanctioned legally. South Africa's abortion culture reveals this paradox: abortion is often publicly condemned – by political authorities, healthcare workers, patients and their families – but privately sanctioned. The apartheid state sought to control the sexual behaviour of its subjects, and passed laws to regulate reproduction. These laws were defied en masse, by patients, doctors and clandestine providers. This article explores the apartheid state's failure to police abortion, arguing that post-apartheid abortion culture has powerful continuities with the past. Abortion was legalised in 1996, during South Africa's transition to democracy. While the Choice on Termination of Pregnancy Act has reduced mortality and morbidity resulting from unsafe abortion, illegal abortion remains popular. Unsafe abortion is notoriously difficult to quantify. In South Africa, high rates of maternal morbidity and mortality, including from uterine sepsis, point to the persistence of unsafe, illegal abortion. Women continue to terminate unwanted pregnancies as they always have: away from the glare of public censure, in the shadows of the reproductive arena.

Introduction

This article explores the history of illegal abortion in South Africa. I explore the contestations around abortion practices in South Africa from the mid 20th century, spanning the introduction of apartheid prohibitions, to the legalisation of abortion during the democratic transition. Abortion, as practised by patients, doctors and clandestine abortion providers, has long violated the health policies and regulations of South African governments. While the legalisation of abortion in South Africa has reduced mortality and morbidity, rates of illegal abortion remain stubbornly high two decades after the Choice on Termination of Pregnancy Act (the 'Choice Act') was passed. Owing to a lack of reporting and to the complexities of clinical presentation, there is a dearth of statistics on illegal abortion in South Africa. However, findings from the Confidential Enquiries into Maternal Deaths in South Africa, combined with numerous studies on abortion provision since the Choice Act, indicate continuing and comparably high rates of illegal abortion with concomitant negative health effects.¹ The South African government has identified 'septic abortion' as among the most common causes of female death.²

1 'Saving Mothers 2011–2013: Sixth Report on Confidential Enquiries into Maternal Deaths in South Africa: short report', compiled by the National Committee for Confidential Enquiries into Maternal Deaths, available at <http://www.kznhealth.gov.za/mcwh/Maternal/Saving-Mothers-2011-2013-short-report.pdf>, retrieved 20 November 2015.

2 Office on the Status of Women, 'South Africa's National Policy Framework for Women's Empowerment and Gender Equality', p. 13, available via the 'PDF of Policy' link at http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=94056&p_country=ZAF&p_count=1051&p_classification=05&p_classcount=38, retrieved 15 October 2015.

The apartheid state was deeply invested in securing the future of white rule, and in policing the reproductive and sexual lives of its white subjects. But it was also largely unable to regulate their intimate lives. A new turn in historiography discerns the episodic and provisional nature of state control. I argue that apartheid abortion reveals how the ‘fantasies of an omnipotent and omniscient state’ were belied through popular practice.³ In the reproductive arena, the state’s striving for ‘panoptic completeness’⁴ foundered. This was in part because practices to limit black population growth cohered with apartheid demographic doctrines, but it was also due to the state’s inability to control the intimate lives of its subjects. Despite social and legal prohibitions under apartheid, women from diverse populations groups practised illegal abortion en masse. They did so in ways that upheld the secrecy surrounding the practice, mitigating the negative consequences of exposure through brazen disobedience.

The imperative to control reproduction has meant that women in South Africa have long sought to end unwanted pregnancy, despite the risks incurred. These risks include threats of public exposure, humiliation and criminal prosecution, and the physical trauma of pain, infection, sterility and death. Women have striven to assert their autonomy, but remained acutely vulnerable when these strategies falter or fail. This article explores legal and political changes concerning abortion before, during and after apartheid. I argue that, while South Africa’s abortion laws have undergone profound changes, the practice of illegal abortion remains largely impervious to regulation.⁵ Over the course of decades, illegal abortion has, like pre-marital sex, been publicly condemned in South Africa. But it has been privately countenanced, so long as it is practised in ways that uphold the norms of secrecy and concealment.

My findings are the result of a combination of ethnography and historical analysis. I interviewed doctors, nurses, illegal abortion providers and abortion patients in the Eastern and Western Capes over the course of three-and-a-half years. These interviews examined the contested place of abortion in public life before and after the legalisation of abortion in South Africa. They are part of a broader study of sexual and reproductive health among youth.⁶ Illegal abortion providers were contacted through the numbers listed on their advertisements, and were interviewed at their consulting rooms around Cape Town. In the Eastern Cape, abortion providers and patients were interviewed in a public hospital, in which I spent four months shadowing healthcare workers. Medical articles about abortion, which appeared in the *South African Medical Journal* over the course of half a century, were closely analysed, together with laws and policies issued by the state. Print journalism and, for the contemporary period, online news coverage and the social media also served as important sources.

3 D. Posel, ‘The Apartheid Project, 1948–1970’, in R. Ross, A.K. Mager and B. Nasson (eds), *The Cambridge History of South Africa, Volume 2: 1885–1994* (Cambridge, Cambridge University Press, 2012), p. 321.

4 D. Posel, ‘A Mania for Measurement: Statistics and Statecraft in the Transition to Apartheid’, in S. Dubow (ed.), *Science and Society in Southern Africa* (Manchester, Manchester University Press, 2000), p. 120.

5 For a discussion on a new turn in South African historiography, characterised by a greater confrontation with the continuities, as well as the changes, between the apartheid and post-apartheid era, see R. Ross, A.K. Mager and B. Nasson, ‘Introduction’, in Ross, Mager and Nasson (eds), *The Cambridge History of South Africa, Volume 2*, p. 14; A. Grundlingh, C. Saunders, S. Swart and H. Phillips, ‘Environment, Heritage, Resistance, and Health: Newer Historiographical Directions’, in Ross, Mager and Nasson (eds), *The Cambridge History of South Africa, Volume 2*.

6 The Mzantsi Wakho study is a collaboration between the University of Cape Town and Oxford University which investigates adherence to antiretroviral treatment and use of sexual health services among adolescents in the Eastern Cape. For emerging findings, see L. Cluver, R. Hodes, E. Toska, K. Kidia, F.M. Orkin, L. Sherr and F. Meinck, ‘“HIV Is Like a *Tsotsi*, ARVs Are Your Guns”: Associations between HIV Disclosure and Adherence to Antiretroviral Treatment among Adolescents in South Africa’, *AIDS*, 29, 1 (2015), pp. S57–S65.

Abortion Before Apartheid

Prior to the 1970s, South Africa had no statutory definition of abortion.⁷ The one law enacted by this time appeared in the Native Territories Penal Code (1886), applicable only to the Transkei. It declared as punishable any act causing the death ‘of any living child which has not yet proceeded in a living state from the body of its mother’, with the proviso ‘that no one shall be guilty of (this) offence ... who by means employed in good faith for the preservation of the life of the mother of the child, causes the death of any such child before or after its birth’.⁸ In the 1820s, revelations about the widespread practice of abortion among Pedi and Xhosa communities dismayed missionaries and colonial officials, explaining in part why South Africa’s only attempt to legislate abortion before the 1970s pertained to this region.⁹ It was the public unmasking of abortion, its tethering to a Christian morality, and its potential threat to medical professionals who helped women to abort, that evoked an official response. The resulting law advanced a broad interpretation of therapeutic abortion, providing legal immunity to those who helped to procure abortion to save a woman’s life.

Yet South Africa’s archive is replete with cases of criminal abortion.¹⁰ British settlers relied on pills and potions for ‘regulating female disorders’ or ‘the relief of female obstructions’ – code words for emmenagogues – advertised in newspapers and available by mail order.¹¹ These remedies could be bought locally from pharmacists and shopkeepers. In addition to the druggist’s concoctions, a pharmacopia of abortifacient remedies, emetics and purgatives were in common use among diverse ethnic groupings in South Africa from the mid 19th to the early 20th century. Malays were said to favour red geraniums, while Khoi herbalists relied on a type of thornbush, and Zulu women on a peppery shrub termed *uhlungughlungu*.¹² The panoply of botanical remedies in particular included aloes, wild celery, rue, bracken fern, ‘wild dagga’ and pennyroyal (known in Afrikaans as *meidjieblaar* – ‘maidenleaf’).¹³ The insertion of sharp objects, such as umbrella spokes and sticks, into the cervix, and the injection of detergents were also used.¹⁴ The global migration of abortion methods from the metropolitan capitals of Europe to the South African colony necessitates further historical investigation. In the mimesis between the abortion practices of working-class Londoners, for example, and white settlers in South Africa, a lucrative circuit of abortion technologies and their transnational consumption emerges. Moreover, the distinction between abortifacients (which killed the foetus) and emmenagogues (which provoked a period) were not necessarily replicated in popular understandings. Prior to the development of modern obstetrics, the use of drugs or remedies to elicit menstruation before a woman experienced the ‘quickenings’ (foetal movements), may not have been construed as abortion, but rather as a form of extended contraception.¹⁵

7 S.A. Strauss, ‘Therapeutic Abortion in South African Law’, *South African Medical Journal*, 42, 28 (1968), p. 710.

8 Native Territories Penal Code Act No. 24 of 1886, as cited in Strauss, ‘Therapeutic Abortion’, pp. 711–12.

9 H. Bradford, ‘Herbs, Knives and Plastic: 150 Years of Abortion in South Africa’, in T. Meade and M. Walker (eds), *Science, Medicine, and Cultural Imperialism* (London, Macmillan, 1991), pp. 120–47.

10 See, for instance, Rex vs. Johanna Fredrika Louw, 1/CT, Cape Town Criminal Cases, June 1936, 6/442; Rex vs. Selina E. Karpakis, 1/CT, Cape Town Criminal Cases, October 1938, 6/443.

11 Bradford, ‘Herbs, Knives and Plastic’, p. 123. For a detailed account of abortion methods, including the use of drugs and chemicals, herbal remedies, instrumentation and manual manipulation, see L.A. Parry, *Criminal Abortion* (London, John Bale, Sons & Danielsson Ltd, 1932), pp. 25–72. The similarities in methods used in South Africa, as documented by Bradford and others, are evident.

12 Bradford, ‘Herbs, Knives and Plastic’, pp. 123–4.

13 *Ibid.*

14 C. Burns, ‘Controlling Birth: Johannesburg 1920–1960’, *South African Historical Journal*, 5, 1 (2004), p. 173.

15 J. Owen Drife, ‘Historical Perspectives on Induced Abortion through the Ages and its Links with Maternal Mortality’, *Best Practice and Research Clinical Obstetrics and Gynaecology*, 24, 4 (2010), p. 432; R. Petchesky, *Abortion and Woman’s Choice: The State, Sexuality and Reproductive Freedom* (Boston, Northeastern University Press, 1985), pp. 29–30.

From the 1880s, advances in modern medicine saw the beginnings of a scientific revolution in abortion practice. The introduction of the curette increased the efficacy of abortion procedures, but brought with it new dangers of uterine perforation and sepsis. It was not until the mass introduction of antibiotics in the 20th century that most abortion procedures ceased to be ineffective or dangerous, or both.¹⁶ And it was not until the development of the vacuum curette and its combination from the 1950s with anaesthesia, antisepsis and antibiotics that abortion became a safe medical procedure. Legal abortion within well-resourced health settings is now among the safest procedures in medical practice.¹⁷

Abortion Under Apartheid

During the 1960s and early 1970s, doctors and activists saw an opportunity to renegotiate the legal parameters of abortion in South Africa. Their motivation for liberalised laws were grounded in their experience of discrepancies between the law and common medical practice. Treating the harmful effects of illegal abortion consumed scarce human and health resources in emergency and gynaecology wards throughout the South African health sector. A review at Groote Schuur Hospital in Cape Town between 1965 and 1972 identified 13,681 patients with sepsis resulting from illegal abortion. During this time, 33 per cent of women admitted at the hospital for tetanus were suffering the effects of incomplete abortion. Their mortality rate was 15.8 per cent.

In the pages of the *South African Medical Journal*, doctors requested that abortion as already practised be made lawful. As one obstetrician wrote: ‘I am merely asking that modern “approved” medical procedure as currently practised in South Africa should be legalized.’¹⁸ Doctors were often implored to provide ‘therapeutic abortion’ to their patients within the narrow confines of the law.¹⁹ By the 1960s, many were doing so. Others were advising patients to induce abortion outside the public health sector, and then completing the procedure within the safety of their own wards. The best-known case of this involved one of South Africa’s most acclaimed gynaecologists, Derk Crichton, a professor at the University of Natal.²⁰ Crichton collaborated with a self-trained illegal abortion provider, James Watts, to procure abortions for many hundreds of women over several years. Crichton and Watts were arrested and tried in 1972, and ultimately convicted. Watts was given a prison sentence of six years, while Crichton was barred from practising medicine in South Africa.

The media’s coverage of the trial featured salacious details about the sex lives and appearances of Crichton and Watts’ abortion clients, exposing these young white women to the glare of prurient public scrutiny. The arrest, prosecution and disbarment of one of South Africa’s pre-eminent medical specialists for providing abortions sent a warning from the apartheid state to abortion seekers and those who aided them. But the true target audience for this message

16 K. Luker, *Abortion and the Politics of Motherhood* (Berkeley, University of California Press, 1984), p. 4; Drife, ‘Historical Perspectives on Induced Abortion’, p. 437.

17 U. Hogberg and I. Joelsson, ‘Maternal Deaths Related to Abortions in Sweden, 1931–1980’, *Gynecologic and Obstetric Investigation*, 20, 4 (1985), pp. 169–78.

18 J.N. de Villiers, ‘The Indications for Therapeutic Abortion: An Obstetrician’s Point of View’, *South African Medical Journal*, 42, 28 (1968), p. 721.

19 See S. Klausen and J. Parle, ‘“Are We Going To Stand By and Let These Children Come Into The World?”: The Impact of the Thalidomide Disaster in South Africa’, *Journal of Southern African Studies*, 41, 4 (2015), p. 738, for accounts of doctors’ recommendations for therapeutic abortion in cases of thalidomide use.

20 For a rich historical account of this case, see S. Klausen, ‘“The Trial the World is Watching”: The 1972 Prosecution of Derk Crichton and James Watts, Abortion, and the Regulation of the Medical Profession in Apartheid South Africa’, *Medical History*, 58, 2 (2014), pp. 210–229.

was highly specific. In the thousands of illegal abortion cases that occurred each year, the state had chosen to censure and expose cases where violation of abortion laws was too flagrant, and which demonstrated that young white women in particular, who violated the social and sexual controls, would be singled out and punished.²¹

In the mid 1970s, the police and the courts sought to prevent and punish white women who procured abortions. New methods of surveillance and restriction extended to doctors, but these did not succeed in stopping abortion among affluent white women. From the 1970s, a stream of health tourists flowed to other countries, including the United Kingdom and Holland, to procure safe, legal operations.²² In London, the number of patients warranted the creation of a private service catering to South Africans seeking safe, discreet, legal abortions.²³ But women able to afford overseas trips represented only a fraction of the total number who ended unwanted pregnancies illegally. The majority resorted to clandestine providers, and presented in the formal health sector only if side-effects were severe, or if the illegal provider had merely initiated rather than completed the procedure. One study of illegal abortion culture found that many patients felt that the role of health workers was merely to 'finish the job'.²⁴

By the mid 1970s, most nations in the global north had legalised abortion within the first trimester of pregnancy. During this time, however, most African states – whose abortion laws traced their roots to the colonial era – upheld laws that permitted abortion only under exceptional circumstances.²⁵ The liberalisation of abortion laws across the globe, and the possibilities for the passing of new abortion laws in South Africa, were discussed at length in the pages of the *South African Medical Journal*. Arguments in favour of legal abortion were made by obstetricians and gynaecologists, among them senior figures of South African medical schools.

One rationale was that legal abortion would provide a powerful weapon against the 'population explosion'. In an article titled 'Therapeutic Abortion', A.C. Keast, president of the Border Coastal branch of the Medical Association of South Africa, described legal abortion as a means of dousing the flames of the population explosion: '[e]ither the birth rate of the world must come down or the death rate must go up'.²⁶ Aware of the political salience of this argument, and of its deep resonance with the desire of apartheid authorities to curb black population growth – feared as a threat to white political dominance in South Africa – proponents of legalisation framed abortion strategically as a means of countering overpopulation.²⁷

The elimination of foetal abnormalities was another argument made in support of liberalised abortion laws. Revelations about the harms of thalidomide rippled through South African society in the 1960s and early 1970s. Coalescing anxieties – about 'pharmacopollution' and the slow rate of natural increase among white South Africans – provided a powerful new rationale for revamping South African abortion law. More robust legal provisions were conceived to shore up

21 Klausen provides a detailed study of the Crichton case, and of its social significance: S. Klausen, *Abortion under Apartheid: Nationalism, Sexuality, and Women's Reproductive Rights in South Africa* (Oxford, Oxford University Press, 2015).

22 Anonymous research participant 11, private residence, Cape Town, 23 June 2012. All interviews for this article were conducted by the author with anonymous participants.

23 Anonymous research participant 6, University of Cape Town, 15 June 2011.

24 R. Jewkes, K. Wood and N. Maforah, 'Backstreet Abortion in South Africa', *South African Medical Journal*, 87, 4 (1997), pp. 417–8.

25 E. Brookman-Amissah and J. Banda Moyo, 'Abortion Law Reform in Sub-Saharan Africa: No Turning Back', *Reproductive Health Matters*, 12, 24 (2004), pp. 227–34. For a discussion on colonisation and the criminalisation of abortion in Africa, see C. Ngwena, 'Using Human Rights to Combat Unsafe Abortion: What Needs to be Done?', *AfricLaw* (24 April 2012), available at <http://africlaw.com/2012/04/24/using-human-rights-to-combat-unsafe-abortion-what-needs-to-be-done/>, retrieved 1 September 2015.

26 A.C. Keast, 'Therapeutic Abortion', *South African Medical Journal*, 45, 32 (1971), p. 889.

27 De Villiers, 'The Indications for Therapeutic Abortion', p. 720.

the biological ‘inviolability’ of white South Africa: both through preventing the birth of disabled infants and restricting the abortion of healthy ones. A phalanx of formal and informal abortion providers were colluding with women to evade these reproductive regulations. However, from the late 1960s, as the apartheid state sought to expand its reach into the private lives of white citizens in particular, doctors grew more anxious about the disconnection between abortion law and practice. As the state’s fantasy of biopolitical omniscience over the white population bloomed, and as the state’s stake in reproductive control were raised, doctors performing abortions at their patients’ request exposed themselves to greater risk.

In arguing for legalised abortion to protect a woman’s health or prevent foetal abnormality, doctors and abortion advocates claimed broad-based support among medical professions, the general public and even ministers of religion.²⁸ But in 1975 parliament passed the legislative lodestar of apartheid reproductive policy, the Abortion and Sterilisation Act. The Act provided for the greater surveillance and monitoring of illegal abortions, so that those who violated the law would be discovered and punished. Its impact on the actual procurement of abortions was provisional, however. Doctors continued to help women to terminate pregnancies in large numbers at public hospitals, pouring state resources into the treatment and completion of illegal abortions.

Abortion and the Democratic Transition

Prior to the late 1970s, women’s organisation across the political spectrum was largely separate from mainstream party politics. Women’s organisation held powerful symbolic value for political groups – within both the apartheid government and the anti-apartheid resistance movement – but was located in a distinct nexus of political power: the domestic and social spheres. While a group of committed women’s rights advocates had lobbied for the legalisation of abortion from the 1960s, they were active on the progressive fringe, their ideology premised on liberal feminism.²⁹ During the late 1970s and 1980s, as resistance to apartheid gathered momentum, the mass movement of women into grassroots politics meant that matters previously consigned to the domestic realm became part of the national political agenda. Feminism was perceived by many in the ANC – both within the party leadership and within the broad-based ‘comrades movement’ – as a western imposition, a divisive distraction from liberation politics.³⁰ From the 1980s onwards, women’s rights activists within the anti-apartheid movement worked to reframe feminism as an ideology of political emancipation. Whereas apartheid isolationism and social conservatism had shrouded abortion in denial and silence, support for legal abortion was written into key policies of the African National Congress (ANC). During the democratic transition, reproductive regulation assumed a new public life in discussions about gender equality. Women’s rights advocates, public health experts and high-ranking officials within the ANC, and the more broad-based civic movement of the United Democratic Front, formed coalitions to develop new reproductive health policies. As the ANC sought to remodel itself from a liberation movement to a government-in-waiting, plans and policies were written in preparation for its assumption of power.

The National Health Plan (1994), the guiding document for the restructuring of the public health sector, committed the government-in-waiting to an ambitious revision of ‘all

²⁸ *Ibid.*

²⁹ C. Eley, ‘The Abortion Reform Action Group: Funding a Pro-Abortion Group During 1970s Apartheid South Africa’, paper presented at the Southern African Historical Society Conference, Stellenbosch, 3 July 2015.

³⁰ S. Hassim, *Women’s Organizations and Democracy in South Africa: Contesting Authority* (Scottsville, University of KwaZulu-Natal Press, 2006), pp. 28–9; A. Sitas, ‘The Making of the “Comrades” Movement in Natal, 1985–91’, *Journal of Southern African Studies*, 18, 3 (1992), pp. 629–41; J. Seekings, ‘Gender Ideology and Township Politics in the 1980s’, *Agenda*, 7, 10 (1991), pp. 77–88.

legislation, organisations and institutions related to health'.³¹ The National Health Plan described contraception as 'a necessary, but not sufficient factor in promoting fertility decline'. It stated that 'contraception should not be provided independently of broader reproductive health care within a comprehensive primary health care system'.

After the National Health Plan was published, the government set about redrafting its population policy. Public comment was invited, and many hundreds of submissions were made by women's rights advocates, religious organisations, and health workers – indicative of public investment in the nation's biological capital: the generation of future citizens. In the early 1990s, various interest groups began advocating a stronger 'pro-choice' impetus to forthcoming South African health legislation. Foremost among these was the Reproductive Rights Alliance, a coalition of 30 organisations established in 1995 to lobby for 'acceptable, accessible, affordable, cost-effective and user-friendly termination of pregnancy services for women ... integrated into comprehensive health services'.³²

During the years in which the laws were under review, the Reproductive Health Research Unit, based at Wits University, conducted a study of 56 randomly selected public hospitals, representing all of South Africa's nine provinces, at which gynaecological emergencies were treated. The aim of the study was to measure the morbidity and mortality associated with incomplete abortions.³³ One of the study's investigators, and a later author of the national protocol on the termination of pregnancy, recounted how many of the women in the study 'were severely sick, severely septic, and how many died'.³⁴ The study provided empirical evidence in support of the legalisation of abortion on broader grounds than permitted by the Abortion and Sterilisation Act. It found that the management of unsafe abortion placed considerable strain on health resources, and recommended that abortion laws be rewritten.³⁵

During the early years of the democratic transition, a host of new laws sought to establish the legal foundations for South Africa's social and political transformation. In 1995, as the Choice Act made its way through parliament, key figures within the ANC – including Eddie Mhlana – leaned on the findings of the study to argue for legalised abortion to protect women's health. The study was thus used as a means of neutralising the abortion debate, replacing emotional appeals regarding the 'right to choice' versus the 'right to life' with epidemiological accounts of the negative effects of illegal abortion on women's health. To counter both public and internal opposition to the legalisation of abortion, the ANC's *Parliamentary Bulletin* published a communiqué on the Choice Bill, outlining objections to its content and providing detailed rebuttals with reference to ANC ideology and policy.³⁶ It stated: '[t]his is not a morality Bill, but a health Bill ... The Government has not taken a moral position, but has introduced this Bill on health grounds alone'. On 31 October 1996 the National Assembly passed the Bill, one of the most liberal abortion laws in history. Over 50 parliamentarians absented themselves on the day of voting in a show of resistance to the Bill, opposing what many perceived as a morally

31 African National Congress, 'A National Health Plan for South Africa' (1994), available at http://www.africa.upenn.edu/Govern_Political/ANC_Health.html, retrieved 31 August 2015.

32 D. Cooper, C. Morroni, P. Orner, J. Moodley, J. Harries, L. Cullingworth and M. Hoffman, 'Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status', *Reproductive Health Matters*, 12, 24 (2004), p. 76.

33 H. Rees, J. Katzenellenbogen, R. Shabodien, R. Jewkes, S. Fawcus, J. McIntyre, C. Lombard, H. Truter and the National Incomplete Abortion Reference Group, 'The Epidemiology of Incomplete Abortion in South Africa', *South African Medical Journal*, 87, 4 (1997), p. 432.

34 Anonymous research participant 5, Mowbray Maternity Hospital, Cape Town, 29 March 2011.

35 Rees *et al.*, 'The Epidemiology of Incomplete Abortion', p. 437.

36 African National Congress, 'Termination of Pregnancy Bill', *Parliamentary Bulletin*, 29 October 1996, available at <http://www.anc.org.za/show.php?id=2760>, retrieved 31 August 2015.

abhorrent practice. However, the pressure for ANC MPs to act in concert, together with the party's numerical dominance in parliament, secured majority support.

The Choice on Termination of Pregnancy Act came into effect on 1 February 1997, legalising abortion in South Africa on a much broader basis. The Act provided that a medical doctor or registered nurse, trained to provide termination of pregnancy, may end a pregnancy on request by a woman until 12 weeks of gestation. It mandated that between 13 and 20 weeks of gestation, only a medical doctor may perform a termination of pregnancy after consultation with the woman. The termination may be performed only if the doctor believes that the pregnancy poses a risk to a woman's mental or physical health, that the foetus is malformed, that the pregnancy resulted from rape or incest, or that the pregnancy would have a harmful effect on the woman's social and economic status. It ruled that a doctor may perform a termination of pregnancy after 20 weeks of gestation if a woman's life is in danger, or if the foetus is severely malformed. The law leaves considerable scope for interpretation by medical professionals. This is due largely to its wording around the provision of abortion on socio-economic grounds. The most frequently cited reason for abortion in South Africa falls within this last category.³⁷

The 'Choice Act' was later challenged through the courts. In 1998, the Christian Lawyers' Association of South Africa brought a case against the minister of health to the Transvaal High Court on the basis that the Constitution protected the right to life, and that the Choice Act violated this right. The Association lost the case, as the Court ruled that the word 'everyone' in section 11 of the Constitution, describing bearers of the right to life, excluded a foetus. In 2004, the Association brought a second case against the minister of health, arguing that the Choice Act allowed women younger than 18 to terminate their pregnancies without the consent of parents or guardians, without mandatory counselling, and without sufficient time to reflect on their decision. It lost again, when the Court ruled that, so long as a woman is capable of consenting to abortion herself, no further consent is required.

Abortion After the Choice Act

The legalisation of abortion in South Africa has significantly improved the health of women. One study found a 91 per cent decrease in abortion-related mortality between 1998 and 2001, due to the provision of legal abortion in the public health sector.³⁸ Another found reductions in both the number of women presenting with incomplete abortions and the number of deaths due to abortion.³⁹ These findings show the public health benefits of the Choice Act. However, despite the positive effects of legalising abortion, women continue to procure illegal abortions in high numbers. The prevalence of severe morbidity as a result of unsafe abortions has remained steadfast. A study that examined the causes behind this found that a lack of knowledge of the Choice Act, and where to find access to a safe, legal abortion in the public health sector, together with fear of mistreatment by

37 Cited from *Barometer*, 'Implementation of the New South African Abortion Law: A Six-Month Overview from Hospital Reports', *Reproductive Health Matters*, 6, 11 (1998), p. 145.

38 R. Jewkes and H. Rees, 'Dramatic Decline in Abortion Mortality Due to the Choice in Termination of Pregnancy Act', *South African Medical Journal*, 95, 4 (2005), p. 250.

39 A. Mbele, L. Snyman and R. Pattinson, 'Impact of the Choice on Termination of Pregnancy Act on Maternal Morbidity and Mortality in the West of Pretoria', *South African Medical Journal*, 96, 11 (2006), p. 1198.

healthcare workers and abortion-related stigma within communities, were the main reasons for continued high rates of illegal abortion procurement.⁴⁰

In South Africa, the personal politics of many healthcare workers are profoundly at odds with the legal commitment and the public health imperative to provide comprehensive reproductive healthcare, including abortion.⁴¹ One result is a critical shortage of healthcare workers who are willing to either provide or assist in abortions, to play any role in the procedure whatsoever – whether taking a patient’s temperature, issuing prostaglandin pills, or supporting a patient through the later stages of abortion. The dearth of abortion providers undermines women’s access to safe abortion services, and fosters the reliance on clandestine abortion providers.⁴² One informant described how, at rural clinics in three South African provinces – KwaZulu-Natal, Limpopo and Mpumalanga – the nurses ‘are not offering any second trimester terminations of pregnancy. Only first trimester. And they report very difficult staff who don’t do them [abortions]’.⁴³

The Choice Act mandates counselling and support to offset the psychological impacts of abortion, and analgesia to mute its somatic effects. But these palliative measures remain in scarce supply in the public health sector, lending substance to the claim made by anti-choice advocates in the mid 1990s, but equally applicable almost two decades after South Africa’s legalisation of abortion: that health systems are too weak, clinics too overloaded, and healthcare workers too resistant, to fulfil the requirements of the Choice Act.⁴⁴ By 1997, approximately 50,000 legal abortions were performed annually in South Africa. However, a similar number of illegal abortions continued to be performed.⁴⁵

Reports of pain and suffering form a refrain in studies about the treatment of women in South Africa’s public health sector, spanning a number of decades.⁴⁶ While laws and policies regarding women’s health have changed in post-apartheid South Africa, the practice of healthcare workers and the experiences of patients hold many similarities with apartheid health practices. The lack of pain prevention for abortion patients is widely reported. As one healthcare worker stated: ‘[t]he women are in a lot of discomfort They should be giving them pain medication, but it doesn’t always happen’.⁴⁷ One of the ways in which healthcare workers may protect themselves from the trauma of providing an abortion, particularly in the second trimester, is effectively to transfer this trauma to the patient. This transfer assumed two principal forms: promoting abortion methods that minimised the role of the healthcare provider in removing the foetus; and punishing, brutalising and humiliating abortion patients themselves. In four months of observation at health facilities

40 R. Jewkes, T. Gumedé, M.S. Westaway, K. Dickson, H. Brown and H. Rees, ‘Why Are Women Still Aborting Outside Designated Facilities in Metropolitan South Africa?’, *BJOG: An International Journal of Obstetrics and Gynaecology*, 112, 9 (2005), pp. 1236–42.

41 K. Wood and R. Jewkes, ‘Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa’, *Reproductive Health Matters*, 14, 27 (2006), p. 116.

42 D. Grossman, D. Constant, N. Lince, M. Alblas, K. Blanchard and J. Harries, ‘Surgical and Medical Second Trimester Abortion in South Africa: A Cross-Sectional Study’, *BMC Health Services Research*, 11, 224 (2011), pp. 1–9; J. Harries, N. Lince, D. Constant, A. Hargev and D. Grossman, ‘The Challenges of Offering Public Second Trimester Abortion Services in South Africa: Health Care Providers’ Perspectives’, *Journal of Biosocial Science*, 44, 2 (2012), pp. 197–208.

43 Anonymous research participant 5, Mowbray Maternity Hospital, Cape Town, 29 March 2011.

44 H. Ward, ‘Major Problems with Proposed New Abortion Law’, written submission to the Portfolio Committee on Health, National Assembly, 2 October 1996, available at <http://www.consciencelaws.org/background/procedures/abortion014-004.aspx>, retrieved 20 December 2014.

45 L. van Bogaert, ‘“Failed” Contraception in a Rural South African Population’, *South African Medical Journal*, 93, 11 (2003), p. 860.

46 Bradford, ‘Herbs, Knives and Plastic’, pp. 134–141; Wood and Jewkes, ‘Blood Blockages’, pp. 109–118; K. Dickson, R. Jewkes, H. Brown, J. Levin, H. Rees and L. Muvuya, ‘Abortion Service Provision in South Africa Three Years after Liberalisation of the Law’, *Studies in Family Planning*, 43, 4 (2003), pp. 277–8.

47 Anonymous research participant 7, School of Public Health, Cape Town, 30 March 2011.

in the Eastern Cape, no analgesia – which is mandated by the termination protocol – was provided to abortion patients. The most comprehensive epidemiological study of second trimester abortion in South Africa to date found that only 20 per cent of patients were given pain medication of any kind.⁴⁸ Research participants described how the denial of analgesics to abortion patients may be a strategy to punish women for having abortions, and to discourage them from seeking ‘repeat’ abortion in the public health sector. As one doctor stated, ‘I do think that the pain medication, the analgesia, is not optimal ... If you make it too comfortable, then people are going to come back ... It’s like wanting to offer a disincentive as if an incentive exists’.⁴⁹ Another informant, with decades of experience in treating medical abortion patients, explained: ‘[t]he women don’t get pain medication. They abort at home, they abort on the way [to hospital] or they abort while waiting there’.⁵⁰

In many South African clinics and hospitals, first trimester medical abortion patients are given misoprostol pills and then leave the clinic to abort elsewhere. This may afford women greater confidentiality and help to offset the costs of multiple clinic visits and time away from work. Aborting at home may also help to protect women from the public stigma. There is little privacy in the waiting and recovery rooms of public abortion facilities. Patient confidentiality is breached by the architecture of the waiting and recovery rooms.⁵¹ Thin walls between counselling and procedure rooms mean that private conversations are easily audible to other patients and healthcare workers. In one abortion facility, the recovery room had only three beds, but routinely admitted more than nine patients a day. These patients therefore shared the beds, sometimes four to a single bed, or lay down ‘in shifts’ while others stood or sat elsewhere. However, if patients are not counselled well before a medical abortion, and prepared for its physical effects (including cramping and bleeding), it can be a frightening and painful experience. As a provider explained: ‘[t]hey are scared and they are panicking’.⁵² This abortion provider had adapted the clinical protocol in response to the trauma and anxiety that patients reported when initiating medical abortions outside the clinic. Instead, this nurse required abortion patients to arrive early in the morning, when she would issue misoprostol tablets. The nurse would then counsel and scan the next day’s abortion patients, and return to her current patient cohort to complete the manual vacuum aspiration (MVA) procedure. The hours between the patients arrival and the MVA procedure provided enough time for the oxytocic pills to take effect. This nurse was the sole full-time employee of a family planning facility. Her patient load was roughly equal to, and often heavier than, the antiretroviral treatment clinic at the same healthcare facility. However, the antiretroviral clinic was much better staffed, with a complement of two data capturers, a receptionist, two community health workers, two social workers, a nurse and a nurse manager. The nurse providing abortion attributed staff and resource inequalities to abortion stigma. Describing the dismissive attitudes of senior hospital staff, she explained:

People here are demotivating. I never even see a supervisor ... They are anti-abortion. They don’t say it loud. But they don’t like it. That’s how I perceive them. They see you in the corridor and ask you [imitating a high-pitched voice], ‘How are you doing in that corner of yours?’ They are demotivating, very demotivating. I’ve been crying and crying until I stop crying and work. Now

48 Grossman *et al.*, ‘Surgical and Medical Second Trimester Abortion’, p. 6.

49 Anonymous research participant 7, School of Public Health, Cape Town, 30 March 2011.

50 Anonymous research participant 11, private residence, Cape Town, 23 June 2012.

51 D. Benatar, ‘Indiscretion and Other Threats to Confidentiality’, *South African Journal of Bioethics and Law*, 3, 2 (2010), p. 59.

52 Anonymous research participant 19, Eastern Cape, 13 February 2014.

I've learnt to just enjoy it the way it is. If I complain every day I'll be frustrated and not do my work. And I will be frustrated with the patients.⁵³

By 2003, healthcare workers and women's rights advocates had begun to sound alarms about barriers to family planning services. A study conducted in a large rural hospital in Mpumalanga showed that the majority of abortion seekers had discontinued contraceptives because of side-effects, pointing to the necessity of improved pre-contraception counselling and better monitoring of patients.⁵⁴

In response to repeated complaints by health workers and women's rights advocates that the Choice Act's mandates were not being fulfilled, and in an attempt to expand legal abortion services, further legislation was drafted. The Choice on Termination of Pregnancy Amendment Act was passed in 2004. It extended facilities that may provide abortions and allowed registered nurses with appropriate training to perform first-trimester abortions (in addition to doctors and midwives, stipulated in the original Act). According to the Health Systems Trust, the percentage of facilities designated to provide abortion which were actually functioning rose from 31.5 per cent in 2000 to 61.8 per cent in 2003.⁵⁵ However, the perception of both proponents and opponents of the Choice Act by the mid 2000s was that healthcare workers' opposition to providing abortion was escalating. Numerous studies documented the punitive attitudes of doctors and nurses, and their obstruction of abortion procedures.⁵⁶ The Amendment Act was challenged in the Constitutional Court, which found that parliament had failed to follow due process in consulting the public during the drafting of the Act. The judgment was suspended for 18 months to allow parliament to consult further, but the media's coverage of the trial fostered confusion among health workers and the public as to the legal status of abortion.

While rates of legal abortion had evidently increased, this was inconsistent – characterised by rapid expansion in certain years and precipitous decline in others, interspersed with years of apparent stasis. In 1997, 26,455 legal abortions were performed, increasing to 52,172 by 2000.⁵⁷ In 2001, the rate of legal abortions seemed to have flatlined, with 53,967 legal terminations reported. Between 2006 and 2007, reported legal abortions declined from 83,913 to 58,041. In these tabulated results, dashes represent a dearth of data. For certain years, provinces were unable to account for the number of legal terminations provided. The most comprehensive data on legal abortions revealed alarming inadequacies in the delivery of services, as well as the state's struggle to capture, analyse and report patient information. Many healthcare workers continued to refer patients to private or subsidised services, such as Marie Stopes, and public access to abortion remained haphazard. Delays in service provision pushed women into the second trimester, in which abortion becomes more specialised and even more difficult to procure. Connections between delays in service provision and comparably high rates of both second trimester and illegal abortion appeared in medical reports.⁵⁸

53 Anonymous research participant 18, Eastern Cape, 12 February 2014.

54 Van Bogaert, 'Failed' Contraception', p. 860.

55 Health Systems Trust, Health Systems Trust, 'ToP Facilities Functioning (%)', date unspecified, available at <http://indicators.hst.org.za/healthstats/151/data>, retrieved 11 December 2015.

56 J. Harries, K. Stinson and P. Orner, 'Health Care Providers' Attitudes towards Termination of Pregnancy: A Qualitative Study in South Africa', *Biomedical Central Public Health*, 9, 296 (2009), pp. 1–11; Dickson *et al.*, 'Abortion Service Provision', pp. 277–84; R. Hodes, '“You Know What a Bad Person You Are?” HIV, Abortion, and Reproductive Health Care for Women in South Africa', in R.A. Smith (ed.), *Global HIV/AIDS Politics, Policy and Activism: Persistent Challenges and Emerging Issues* (Santa Barbara, Praeger, 2013), pp. 239–41.

57 Health Services Trust, 'ToPs (Terminations of Pregnancy) Indicator Data: 1997–2010', available at <http://indicators.hst.org.za/healthstats/47/data>, retrieved 14 October 2015.

58 C. Bateman, 'Maternal Mortalities 90% Down as Legal TOPs More than Triple', *South African Medical Journal*, 97, 12 (2007), p. 1240.

On 10 June 2013, the *Daily Sun* published a front-page article titled ‘House of Abortion Horror’ (see Figure 1). It recounted how an illegal abortion provider, known as Professor Kute, had been arrested after the boyfriend of a would-be client reported him to the police. The police had arrived at Kute’s flat in Soweto just in time to stop the 19-year-old woman, who had gone there to procure an abortion, from taking the ‘killer pills’.⁵⁹ The nature of these pills was not described, but they were likely to have been off-label misoprostol, the prostaglandin drug used in medical abortion, which is the staple issue of unlicensed abortion providers. In South Africa, unlicensed and illegal abortion providers are known as ‘lamp-post providers’, because they advertise through flyers and posters at taxi ranks, retail centres and along city walls and thoroughfares (see Figure 2).



Figure 1. The front page of the *Daily Sun*, Monday 10 June 2013.

59 G. Nkhwashu, ‘House of Abortion Horror’, *Daily Sun*, Johannesburg, 10 June 2013, pp. 1–2.



Figure 2. An advertisement for a ‘lamp post provider’ outside a large hospital in the Eastern Cape, 8 December 2014.

The photograph that accompanied the Sun article showed a dirty consulting room, described as a ‘fully-functioning surgery’, stocked with abortifacient drugs and instruments. Kute, described in the article as ‘a so-called doctor from Uganda’, was due to appear at the Pretoria magistrates’ court for contravening the Medicines Act.

Read together with the comments by readers on the *Daily Sun* website, the story reveals much about the politics of abortion in post-Apartheid South Africa. It illustrates how abortion functions as a symbolic catch-all for an array of perceived social problems and public anxieties – including the sexual irresponsibility of young women, the failure of public health policies and regulations, and the criminality of foreign nationals in South Africa.⁶⁰ In the *Daily Sun*’s Facebook forums, readers interpreted the story of a teenager seeking an abortion at a late stage of pregnancy, and her assistance by a foreigner, as indicative of more entrenched and broad-ranging threats to national morality. Abortion was combined with same-sex marriage and prostitution as the gravest of moral transgressions, their legal sanction a fundamental flaw of democracy. South Africa’s nationhood was equated symbolically with foetal development, and abortion prefigured as a threat and violation against both. The theme of irresponsibility and of the abuse of rights and freedoms loomed large: ‘family planning is free in mzansi, yet we still got this going on’; ‘[t]hese girls should stop opening their legs and getting pregnant and then opening up their vulnerable lives to these false doctors’.⁶¹

The *Daily Sun* story illustrates many of the medical realities of abortion in present-day South Africa. The woman was young, her pregnancy was unwanted, and its advanced stage precluded access to legal abortion in the formal health sector. South Africa has a relatively high teenage pregnancy rate of 330 per 1,000 for women under the age of 19.⁶² Approximately 50

60 While caution should be applied in interpreting comments made on social media, online forums do provide insights into public opinion, not least because of the anonymity and freedom that these virtual spaces permit.

61 Readers’ responses to the *Daily Sun* article, ‘House of Abortion Horrors’, available at <https://www.facebook.com/sadailysun/posts/554843617904541>, retrieved 31 August 2015.

62 Republic of South Africa, Ministry for Welfare and Population Development, ‘Population Policy for South Africa: A Green Paper for Public Discussion’ (Pretoria, 1995).

per cent of pregnancies are either unplanned or unwanted.⁶³ Women who decide to terminate their pregnancies confront numerous challenges, including the widespread belief that abortion is morally wrong.⁶⁴ South Africa also has a comparably high prevalence of second-trimester abortions, at approximately 25 per cent.⁶⁵ In the US, by comparison, fewer than 12 per cent of abortions occur in the second or third trimester.⁶⁶ The continued preponderance of illegal abortions, with up to half of abortions procured in the illegal sector, is another enduring feature of South Africa's reproductive landscape. And, as with the *Daily Sun's* front-page story, public scandals about illegal abortion have a rich historical record in South Africa.

There are marked similarities between the current practices of abortion patients in South Africa's public health sector and the historical practices of women seeking to end unwanted pregnancies in the apartheid era. Patients frequently present in the later stages of an induced, illegal abortion, in which they have purchased off-label misoprostol from a lamp-post provider. In addition to abortion, some lamp-post providers offer 'womb cleaning', code for a complete evacuation of the uterus. The term, however, is purposely ambivalent, tapping into popular beliefs about the necessity of ritual cleansing to improve fertility, both for abortion clients and for women wishing to conceive. Despite the promises made by some illegal providers that the pills they give will ensure a complete abortion, thus aiding the client to circumvent clinical care, other illegal providers instructed their patients to go to the hospital or clinic once bleeding has commenced, a marked similarity with clandestine abortion during the apartheid era. As one illegal provider explained, 'I advise the women to go to the hospital after they have been bleeding for a few hours to make sure that the baby has been removed completely. The hospital will help to do this'.

Conclusion

Although abortion is now legal and freely accessible under South Africa law, women continue to procure illegal abortions in similar numbers to those preceding the Choice Act. The enduring popularity of illegal abortion reveals how experiential realities and social experiences have diverged from legislative commitments and policy proscriptions in South Africa, in both the present and the past. A long history of illegal abortion shows how private practices of reproductive control and autonomy have resisted formal regulation over the course of recent history. This history reveals how secrecy provides the potential for practical subversion, countenancing popular practices so long as these uphold ideological strictures.⁶⁷ When their violation becomes too overt, when the boundaries of morality and legal compliance are breached too publicly – as in the case of Derk Crichton and his patient base of young, white women – the apartheid state reacted to authenticate its biological inviolability, and to reassert reproductive control over women. But the vast majority of illegal abortion cases were ignored by the state, their health consequences managed by a phalanx of formal and informal healthcare workers and borne largely by black women.

Advocates for safe, legal abortion provision in South Africa have been active for decades, their ideologies staked to changes in medicine and society over the course of the last century. Modern medicine, the eugenics movement, feminism and the intertwining of human rights, health and gender equality have all influenced pro-choice advocacy in South Africa during

63 P. Orner, M. de Bruyn and D. Cooper, "'It Hurts, but I Don't Have a Choice, I'm Not Working and I'm Sick': Decisions and Experiences Regarding Abortion of Women Living with HIV in Cape Town, South Africa', *Culture, Health and Sexuality*, 13, 7 (2011), p. 782.

64 *Ibid.*, p. 790.

65 Harries, Stinson and Orner, 'Health Care Providers' Attitudes'.

66 Guttmacher Institute fact sheet, 'Induced Abortion in the United States', October 2013, available at http://www.guttmacher.org/pubs/fb_induced_abortion.html, retrieved 20 December 2014.

67 A. Hardon and D. Posel, 'Secrecy as Embodied Practice: Beyond the Confessional Imperative', *Culture, Health & Sexuality*, 14, 1 (2012), pp. S1–S13.

the 20th century and after. But it was the move of women into mass political organisation that provided for rhetorical commitments to reproductive rights within the anti-apartheid resistance movement. The 1980s saw a fundamental shift in women's activism, in which advocates for reproductive rights moved from the margins into the political mainstream. From the late 1980s to the early 1990s, as plans for the ANC's transition from liberation movement to government were laid, influential political actors lobbied for reproductive rights. But it was their strategic advocacy, rather than a broad-based, popular commitment to reproductive rights, that ensured the legalisation of abortion in 1996. As with the Civil Unions Act, which legalised gay marriage, the Choice Act is often publicly cast as a piece of legislation that was shunted through parliament by a well-connected minority, with powerful political supporters.

The fact that many thousands of South African women terminate their pregnancies every year, and have been doing so for decades – even centuries – poses questions about the simplistic pro-natalism that has historically been ascribed to black women in particular.⁶⁸ But while abortion rates convey that the practice is commonplace, this does not translate into public support for legal abortion, or to changes in collective, verbal adherence to moral codes that define abortion as wrong. Despite the fact that abortion is a common gynaecological experience in South Africa, and that it remains inaccessible for many, and painful and punitive for others, the issue has never garnered widespread support. While the rates of abortion access convey that many women continue to procure abortions, this does not translate into pro-choice social mobilisation, or to changes in verbal adherence to moral codes that define abortion as wrong and immoral. A lack of knowledge about how to access a safe, legal abortion in the public health sector, together with the fear of mistreatment by healthcare workers, are among the main reasons for the continued high rates of illegal abortion procurement.⁶⁹ Illegal abortion providers advertise their services outside public health facilities across South Africa, including the National Department of Health in Pretoria – the seat of reproductive regulation. Women continue to use these providers because they promise what is often lacking in the public sector – succour, immediacy and privacy ('pain-free', 'same-day', '100% safe', 'cleaning'). But the risks inherent in this –through both public exposure and physical harm, remain. Masses of women terminate their unwanted pregnancies in South Africa, but usually in ways that uphold the norms of silence and secrecy. The nation's 'biological capital' remains heavily invested in reproductive control, even as popular recourse to illegal abortion, in both the past and the present, reveals its limits.

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68 R. Hodes, 'The Medical History of Abortion in South Africa, c.1970–2000', *Journal of Southern African Studies*, 39, 3 (2013), p. 541.

69 Jewkes *et al.*, 'Why Are Women Still Aborting?'