

THE IMPACT OF THE  
**'GLOBAL GAG RULE'**  
ON MIGRANT WOMEN AND WOMEN FROM  
POOR HOUSEHOLDS IN CAPE TOWN:  
A CASE STUDY



# The Impact of the ‘Global Gag Rule’ on migrant women and women from poor households in Cape Town: A case study

Written by Zanele Mabaso, Sonke Gender Justice. Edited by Penny Morrell. We wish to acknowledge the time of several anonymous individuals who were interviewed for this case study, and the Open Society Foundation for South Africa for financial support.

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## Acronym list

<b>GBV</b>	Gender-based violence
<b>NGO</b>	Non-governmental organisation
<b>SRH</b>	Sexual and reproductive health
<b>TOP</b>	Termination of pregnancy
<b>US</b>	United States (of America)
<b>USG</b>	United States Government

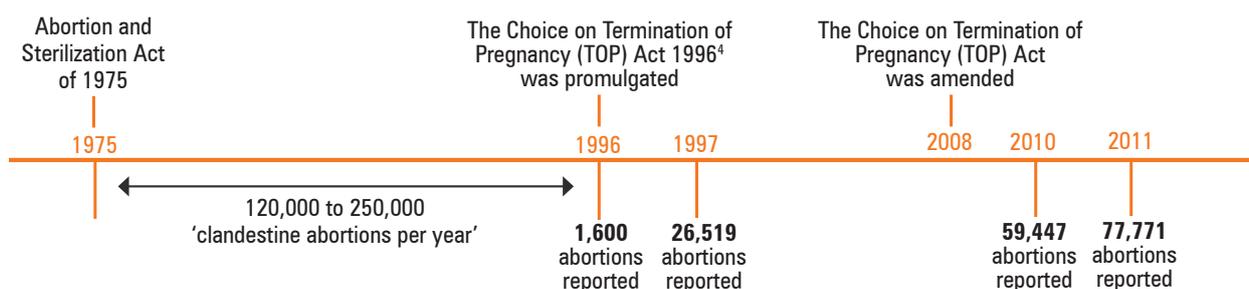
# LEGALISING ACCESS TO ABORTION IN SOUTH AFRICA

South Africa has one of the most progressive abortion laws on the continent – but this has not always been the case. Under apartheid, the Abortion and Sterilization Act of 1975<sup>1</sup> meant abortion was only offered under severely limited circumstances – contributing to ‘the number of clandestine abortions rang[ing] from 120,000 to 250,000 per year between 1975 and 1996’.<sup>2</sup>

This changed with the advent of democracy however when, in February 1997, The Choice on Termination of Pregnancy (TOP) Act 1996<sup>3</sup> was promulgated – a resounding affirmation of women’s rights to health care.<sup>4</sup> As a result, women can choose to terminate a pregnancy up until 12 weeks for whatever reason; this is free of charge at designated health facilities. Pregnancies between 13 and 20 weeks can also be terminated by a doctor if the pregnancy is a result of rape or incest, or poses a danger to a women’s physical, mental or socio-economic status.

Ten years later, the Act was amended in 2008<sup>5</sup> to include trained midwives as abortion service providers, and to prescribe punitive measures for the illegal, unregistered provision of services.

With abortion becoming “safe” and legal, there was an astronomical increase in the request for abortion services: while in 1996, the year before abortion was made legal, 1,600 induced abortions were reported this increased in 1997 to 26,519 abortions being recorded; in 2010 this had increased to 59,447 and in 2011 to 77,771.<sup>6</sup>



<sup>1</sup>Government of South Africa. The Abortion and Sterilization Act 1975. No.2 of 1975, Section 3. *Government Gazette*, 478 (1975).

<sup>2</sup>Rees H et al. The epidemiology of incomplete abortion in South Africa. *South African Medical Journal*, 1997, 87(4):432-437.

<sup>3</sup>Government of South Africa. The Choice on Termination of Pregnancy Act 1996. No. 92 of 1996. *Government Gazette*, 377(17602).

<sup>4</sup>Favier M, Greenberg JMS, Stevens M. Safe Abortion in South Africa: “We have wonderful laws but we don’t have people to implement those laws”. *International Journal of Obstetrics and Gynaecology*, 30 October 2018. 143(S4): 38-44.

<sup>5</sup>Government of South Africa. The Choice on Termination of Pregnancy Amendment Act, 2008. No. 1 of 2008. *Government Gazette*, 512 (30790).

<sup>6</sup>Johnston WR. Historical Abortion Statistics in South Africa. Last updated 25 March 2018.

## *Difficulties with access to state-funded services*

Despite this progressive TOP legislative framework, not all women<sup>7</sup> in South Africa who need abortions are able to access safe abortion services, however, given the limited access to legal abortion providers<sup>8</sup> and the stigma and discrimination expressed by women from some health care providers.<sup>9</sup>

Discrimination in health care settings is widespread and takes many forms, often driven by stigma such as negative beliefs, feelings and attitudes – be this towards their gender, nationality, perceived behaviour etc.<sup>10</sup> It can take the form of being subjected to physical and verbal abuse; negative reactions when disclosing a previous abortion; breaches of confidentiality; denial of autonomous decision making; making access conditional on the use of certain forms of contraception; denial of access to services to groups such as migrants, refugees, minority populations and adolescent girls that are otherwise available to others<sup>11</sup>. Discrimination against and stigmatisation of women seeking abortion is indicative of the inequitable gender burden borne by women in a society that remains deeply patriarchal and impedes abortion access and discourages positive health-seeking behaviours.<sup>12</sup>

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In terms of the availability of facilities that offer abortion, a 2017 telephonic survey found that less than 200 (or 4%) of the country's 5,048 public health facilities that could potentially offer abortion services<sup>13</sup> actually did so. This leaves pregnant women with the option of accessing the services of illegal unregistered practitioners – effectively opting for unsafe and unregulated TOP procedures. Approximately 54% of the estimated 260,000 abortions that currently take place in South Africa each year are performed illegally.<sup>14</sup> Illegal abortion providers in Cape Town use slick marketing tactics to appear sufficiently legitimate – but have been known to offer women unsafe and incorrect medical and herbal/traditional alternatives, often making them ill, placing their health at risk, and not terminating the pregnancy.

Unsafe abortions result in mortality and morbidity. Studies have shown that abortion-related mortality decreased by 91% in South Africa between 1998 and 2001.<sup>15</sup> Ten years later - between 2008 and 2010<sup>16</sup> – 4,867 maternal deaths were recorded in South Africa, nearly a quarter of which (23%) were septic miscarriages in public health facilities as a the direct result of unsafe abortions.<sup>17</sup>

<sup>7</sup>The Choice on Termination of Pregnancy Act of 1996 defines a "woman" as "any female person of any age".

<sup>8</sup>Mhlanga RG. Abortion developments and impacts in South Africa (2003). British Medical Bulletin, December 2003; (67:1) 115–126. Available at <https://bit.ly/2F6Jgmg>

<sup>9</sup>Bhekisisa Mail & Guardian Centre for Health Journalism. (Undated) Abortion in South Africa: A reporting guide for journalists.

<sup>10</sup>UNAIDS. *Background Note. Zero discrimination in health-care settings*. November 2017. Geneva: UNAIDS Programme Coordinating Board.

<sup>11</sup>Cooper D, Dickson K, Blanchard K, Cullingworth L, Mavimbela N, Von Mollendorf C, Van Bogaert L, Winikoff B. Medical Abortion: The Possibilities for Introduction in the Public Sector in South Africa. *Reproductive Health Matters*, 2005; 13(26):35–43. Available at <https://bit.ly/2ZpwlxL>

<sup>12</sup>Amnesty International. *Briefing: Barriers to safe and legal abortion in South Africa*. 2017. Amnesty International, International Secretariat, United Kingdom.

<sup>13</sup>This excludes mobile clinics and specialist hospitals for tuberculosis or psychiatric treatment

<sup>14</sup>Guttmacher Institute. *Making Abortion services accessible in the wake of legal reforms: A Framework and six case studies*. 2012. New York: Guttmacher Institute.

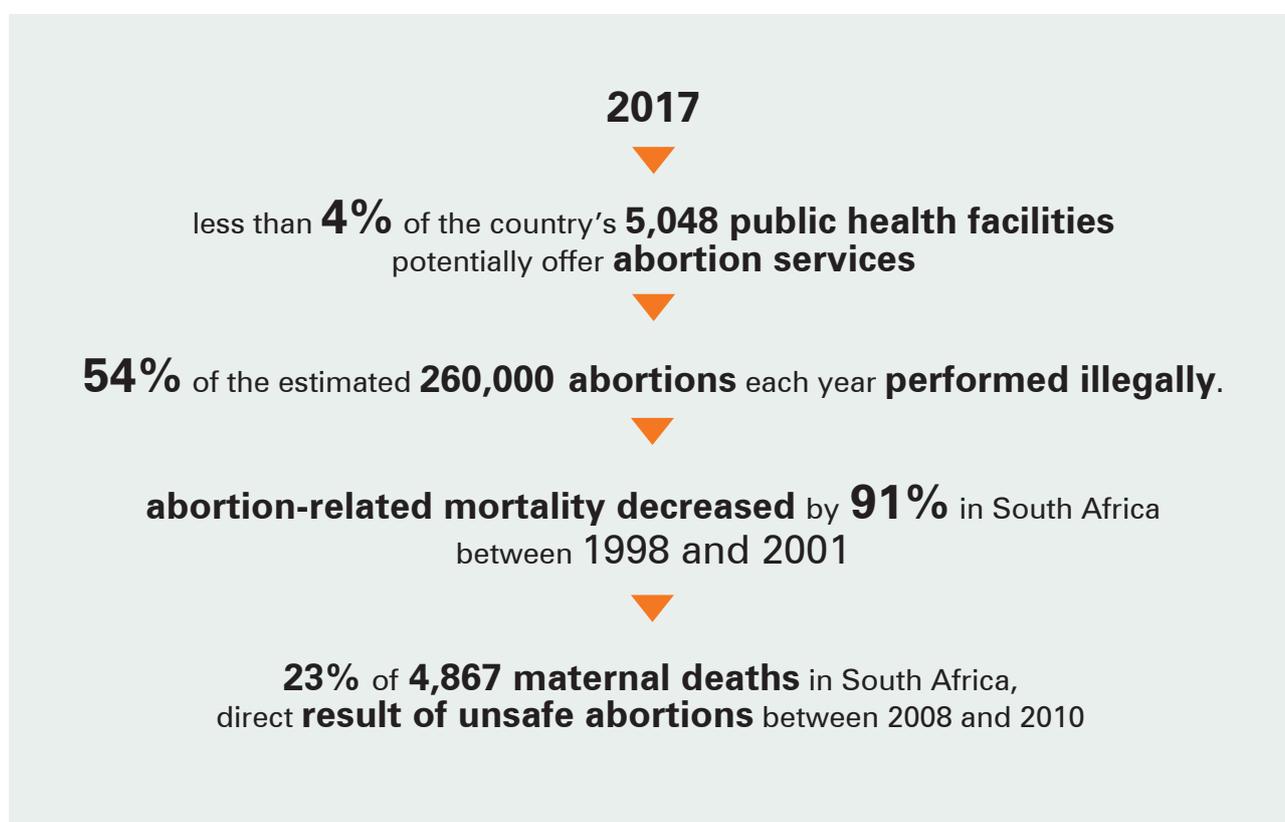
<sup>15</sup>Jewkes R, Rees, H. Dramatic decline in abortion mortality due to the Choice of Termination of Pregnancy Act: scientific letter. *South African Medical Journal*, 2005; 95(4): 250.

<sup>16</sup>Saving Mothers Report: National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) in South Africa. National Department of Health. *South African Medical Journal*

<sup>17</sup>Moodly, J. *Saving Mothers 2014-2016: Seventh triennial report on confidential enquiries into maternal deaths in South Africa: Short report*. Pretoria: Department of Health.

Worldwide, unsafe abortion is one of the top five causes of severe post-partum medical conditions like haemorrhage, sepsis, and hypertensive disorder<sup>18</sup> and women are often hospitalised for complications.<sup>19</sup> In addition, women suffer from immediate and medium-term complications like tearing of the cervix, severe damage to the genitals and abdomen, blood poisoning and reproductive tract infections, among others – while long-term complications include increased risk of infertility and ectopic pregnancy, and miscarriage or premature delivery in subsequent pregnancies.

Given that the South African national health system has been unable to adequately provide comprehensive TOP services, poor and migrant women are still accessing illegal services, with dire health consequences. The funded non-profit health providers who have been providing supplementary legal TOP services to help remedy this problem may now be threatened by the ‘Global Gag Rule’.



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<sup>18</sup>Médecins sans Frontières (MSF). Q&A on consequences of unsafe abortion. (2015).

<sup>19</sup>Harris J. Abortion Services in South Africa: Challenges and barriers to safe abortion care. Health care providers' perspectives. PhD thesis. (2010). University of Cape Town.

# THE 'GLOBAL GAG RULE'

The USA's 'Global Gag Rule', officially called 'Protecting Life in Global Health Assistance', was reinstated in 2017 when the Republican administration returned to office.<sup>20</sup>

This policy "prohibits U.S. global health assistance from being provided to foreign non-governmental organisations (NGOs) that perform abortion in cases other than a threat to the life of the woman, rape or incest; provide counselling (including advice or information) and/or referral for abortion; or lobby to make abortion legal or more available in their own country, even if these activities are performed with funding from other, non-U.S. government (USG) sources".<sup>21</sup>

## *Impacts and responses*

In South Africa, as in other developing countries, many non-profit health care providers rely on international funding to provide comprehensive sexual and reproductive health (SRH) services and information to girls and women.

The 'Global Gag Rule' has pernicious and far-reaching impacts on organisations that accept funding from the USG, however – especially as this policy has been expanded to prohibit USG-funded organisations from accepting any other funding to finance their SRH work. Organisations are thus forced to make hard choices about which funding to accept and which services remain affordable: accepting USG funding completely jeopardises their SRH and TOP-related work, while rejecting it can mean the closure of other USG-funded programmes.

Activists have highlighted the negative impact this policy is having on the health of girls and women, given its threat to the holistic SRH services offered by externally funded non-profit organisations which supplement the resource-constrained services offered by the state.

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<sup>20</sup>This policy is discontinued by each Democrat Administration.

<sup>21</sup>PAI. *What you need to know about the protecting life in global health assistance restrictions on U.S. Global Health Assistance. An Unofficial Guide.* 30 September 2017.

# CAPE TOWN CLINIC: A CASE STUDY

This case study focuses on a Cape Town-based NGO that has been directly affected by the 'Global Gag Rule'. The NGO works in the gender-based violence (GBV) sector, providing survivors of domestic and sexual violence with access to justice, psycho-social support and SRH services. It is located in a mixed-income suburb, serving beneficiaries from the surrounding community as well as other low socio-economic communities in Cape Town.

## *Offering TOP services*

From inception, the organisation offered access to justice services to survivors of domestic violence – but these women were also interested in accessing integrated health services. With the financial assistance of international partners, the organisation established an on-premises clinic providing comprehensive SRH services including HIV counselling and testing, contraception, termination of pregnancies, pap smears and breast examinations – as well as SRH information to adolescent girls from surrounding schools.

Since opening in the mid-2000s, the clinic saw about 2,000 clients per year, most of whom were cross-border migrants or women from poor households, including those affected by GBV. An average of 100 to 120 women per month accessed surgical abortions, making this one of the most accessed SRH services. The women received TOP counselling, the TOP procedure, and a follow-up family planning consultation. The clinic did not offer medical TOP<sup>22</sup> however, which was only offered safely in public health facilities and private clinics like Marie Stopes.

The NGO was clear that it did not view TOP services as a form of contraception. The clinic did not perform repeat TOP services generally, except under very specific circumstances – like after an act of sexual violence, or after complications and symptoms from a failed abortion attempt by illegal practitioners.

## *Cost of service*

As many women seeking SRH services were economically challenged, the organisation's TOP service was initially offered at no cost – but with reduced external funding, the clinic started charging a minimum standard service fee for surgical TOP of R250 in 2008; by 2016, this was R800.

In 2018, Marie Stopes' prices were much higher than the organisation's clinic however. Medical TOP was R1,850 while surgical TOP ranged from R2,900 to R5,130, depending on how advanced the pregnancy was and the procedure used.

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<sup>22</sup>Medical abortions use medication (pills or tablets) only and can be done up until 10 weeks after the first day of a woman's last menstrual period. A first trimester surgical abortion refers to a procedure known as aspiration and can be performed up to 12 weeks after a woman's last period.

## *Migrant women*

Many migrant women in South Africa avoid public health services, given the range of structural barriers they face – including anti-foreigner sentiment, being asked unnecessarily to produce documents to access services; and the long waiting times in some public health facilities.

Migrant women accessed the NGO's SRH services as the cost of TOP in private clinics was unaffordable. In addition, the NGO offered an environment where women were able to access services without discrimination or prejudice, and where clients were treated with respect, confidentiality and dignity.

## *Funding*

The NGO was generally supported by a range of international donors.

In 2017, a funding proposal to the USG seeking continued support for its law and justice programme was rejected as, in disclosing its programmes and services they mentioned that they ran a clinic providing abortion services. This resulted in their proposal being rejected. Although the clinic was self-sustained, it would need to be closed if they were to accept the USG funding for the law and justice programme.

In an attempt to re-establish the funding relationship and sustain its broad reaching access to justice services, the organisation decided to close the clinic.

## *Closure*

The impact of the 'Global Gag Rule' thus resulted in the organisation ending its provision of safe abortions. In addition, it had to fundamentally alter its services as well as its materials and education and it had to discard all printed materials containing any information on SRH. Key clinical personnel were retrenched or their contracts terminated.

The termination of clinic services was a major setback for the people it was serving. Instead of making a public announcement the organisation referred those enquiring about the service to a range of alternative services such as nearby public health facilities and general practitioners providing termination of pregnancies at approximately R800 as well as to Marie Stopes. It is possible that economic and institutional barriers might prevent them from accessing these services, however, and receiving the often life-saving services they need.

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# CONCLUSION

The closure of this clinic affects the most vulnerable and under-served populations: migrants, adolescent girls and women from poor households and those who have been abused.

This is an example of the impact of the 'Global Gag Rule' on SRH in South Africa – and these effects are likely to expand with the closure of more services.

Denying women the right to a safe TOP conflicts with South Africa's Constitution and domestic legislation. A collective advocacy response in South Africa is needed. Key stakeholders and civil society should work collectively with allies in the US and elsewhere to oppose the Global Gag Rule – with its far reaching damage to women's health.



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