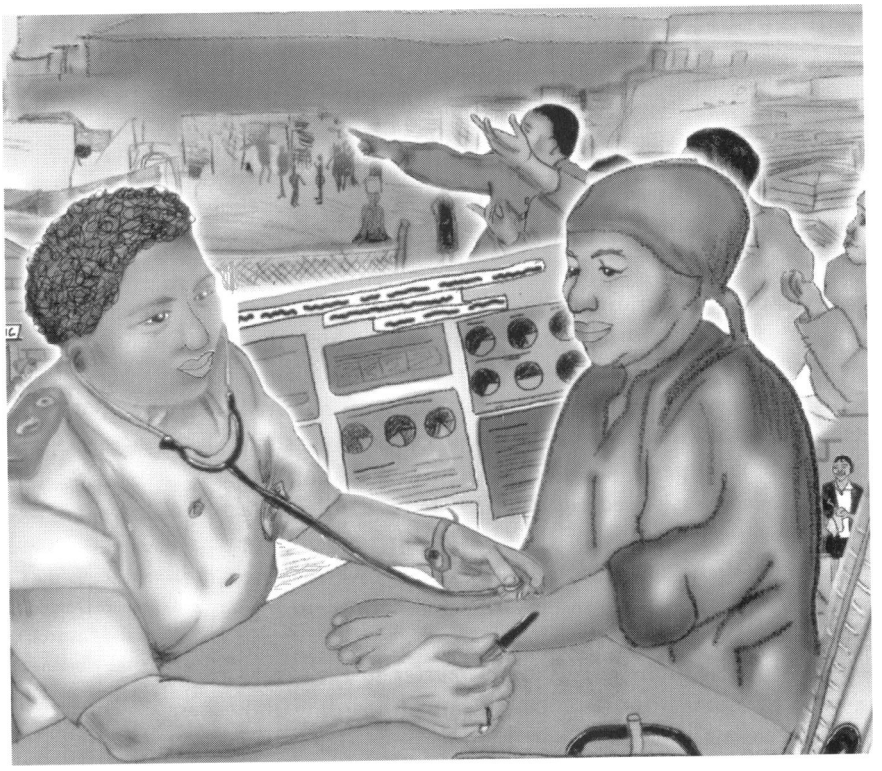
Overseas
PUBLIC HEALTH DEVELOPMENTS ABROAD
Observer

Reproductive Health in South Africa

TRUDE BENNETT, DRPH



"The separation between the world of a woman resorting to unsafe abortion and the formal health sectors is like the separation between heaven and earth—you have to die to get there."[1] This observation was made by Dr. Khama Rogo, a Kenyan physician involved in training clinicians to implement the 1997 Choice on Termination of Pregnancy (TOP) Act in South Africa. As of 1995, the official maternal mortality rate for South Africa was estimated conservatively at 32 deaths per 100,000 live births,[2] compared with a rate of 7.5 per 100,000 live births for the United States.[3] The overall South African rate reflects the stark legacy of apartheid; rates per 100,000 live births vary from 5 for women classified as Indian to 8 for women classified as white, 22 for women classified as colored, and 58 for women classified as African.[2] For socially and economically disadvantaged women with severely restricted access to legal abortion, complications of abortion have been a prominent cause of maternal death. Before 1997, approximately 200,000 illegal abortions were performed annually; 45,000 of these procedures resulted in women being hospitalized for incomplete abortions, and over 400 women lost their lives to unsafe abortion each year.[2]

During my three-week visit to South Africa in June and July 1998, I was struck by many similarities—and some important differences—between South Africa and the United States in their progress toward reproductive rights. The two countries share a tragic history of widespread illegal abortions; the existence of broad abortion rights coalitions of women activists, medical providers, and religious groups; and the experience of legalization of abortion followed by renewed attacks on the part of anti-choice forces. Entrenched racial and ethnic differentials in women's health status and access to health services exist in both countries, along with well-founded suspicion in low-income communities of color about genocidal intentions underlying reproductive health policies.

Before 1997, about 2000 legal abortions were performed each year in South Africa. Although less than 13% of the country's population is white, white women received the vast majority of all legal abortions during the apartheid years. Too frequently, women of color surviving an illegal abortion found themselves unable to bear children as a result of the procedure. And woven into the history of apartheid are numerous human rights violations stemming

from eugenic policies of coercive sterilization of African women and of childbearing incentives for white women. Thus the transition to legalized abortion is fraught with suspicion and fear about potential consequences of government-sponsored abortion services.

The week before I arrived in South Africa, the international media carried a chilling account of testimony before the Truth and Reconciliation Commission. Stranger and more evil than science fiction, a story unfolded of research on immunocontraceptive drugs conducted at the Roodeplaat Laboratories in the 1980s. According to the testimony of Dr. Daan Goosen, the intention of this research sponsored by the apartheid government was to induce infertility among Africans by introducing the drugs through water supplies. These revelations sent shock waves throughout South Africa and were especially troubling to Dr. Roland Edgar Mhlanga, head of the National Directorate for Maternal, Child and Women's Health. "We thought it was as bad as it could get, and then we find out it was actually worse," he told me in Pretoria in early July. "How can we expect people to trust us and to accept the new abortion services in public facilities?" In spite of these barriers, Dr. Mhlanga and his colleagues are currently addressing serious health needs and disparities with government support for universal human rights and reproductive rights at a level never experienced by women in the United States.

US legislation legalizing abortion was based on the right to privacy, and the subsequent experience of US reproductive health workers and advocates has been a ceaseless battle to assure public funding for low-income women. In contrast, the Choice on Termination of Pregnancy Act was based on the 1996 South African Constitution's universal guarantee of the "right to make decisions concerning reproduction" and the "right to have access to health care services, including reproductive health care." In addition, the South African Constitution mandated the creation of a Commission for Gender Equality "to promote respect for gender equality and for the protection, development, and attainment of gender equality." From this foundation, the Choice Act "repeals the restrictive and inaccessible provisions of the Abortion and Sterilisation Act, 1975 (Act No. 2 of 1975), and promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs." The Act provides for free public sector abortions on request within the first 12 weeks of pregnancy, and later under certain specific conditions. No spousal or parental consent is required, though providers must advise a patient under age 18 to discuss the procedure with her parents, guardian, family members, or friends. With termination of pregnancy firmly established as a public health service, nurse midwives as well as physicians are now eligible for training and certification to perform early abortion procedures.

Implementation of the Choice on Termination of Pregnancy Act presents tremendous challenges. In the first year since passage of the Act, values clarification workshops for providers and public awareness campaigns about family planning and abortion services have been central activities. With international support, "training of trainers" has begun to assure an adequate number of providers in every province to meet the need for safe abortion. During my short visit I was able to meet with many of the groups that have been instrumental in making these trainings a reality: the Reproductive Health Research Unit (RHRU) in the Department of Obstetrics and Gynaecology, Chris Hani Baragwanath Hospital, and the Women's Health Research Centre (Women's Health Project), both of which are part of the University of the Witwatersrand in Johannesburg; the Women's Health Research Unit in the Department of Community Health at the Medical School, University of Cape Town; and the national Reproductive Rights Alliance based in Johannesburg. I also had the opportunity to attend a working meeting of representatives from reproductive health groups to draft a National Contraception Policy, guided by the first principle that "Human rights, gender equity and rights for reproductive health care as stipulated in the Constitution should be respected and promoted."

On July 10, 1998, just after I left South Africa, the Pretoria High Court ruled that the Choice on Termination of Pregnancy Act was fully consistent with the Constitution. A challenge to the constitutionality of the Act, struck down by this decision, had been mounted by the Christian Lawyers Association, United Christian Action, and Christians for Truth in South Africa. While officially supporting the challenge, the Catholic Church maintained some distance from the repeal campaign and its broader conservative political agenda.[4] By ruling in favor of the defendants, the Department of Health, the Reproductive Rights Alliance, and the Commission on Gender Equality, the Court freed these and other groups to turn more of their energies toward pressing public health problems such as domestic violence and the escalating rates of HIV and AIDS, as well as toward longer-term strategies for increasing sexual and reproductive autonomy and health.

At Chris Hani Baragwanath Hospital, where I spent most of the time

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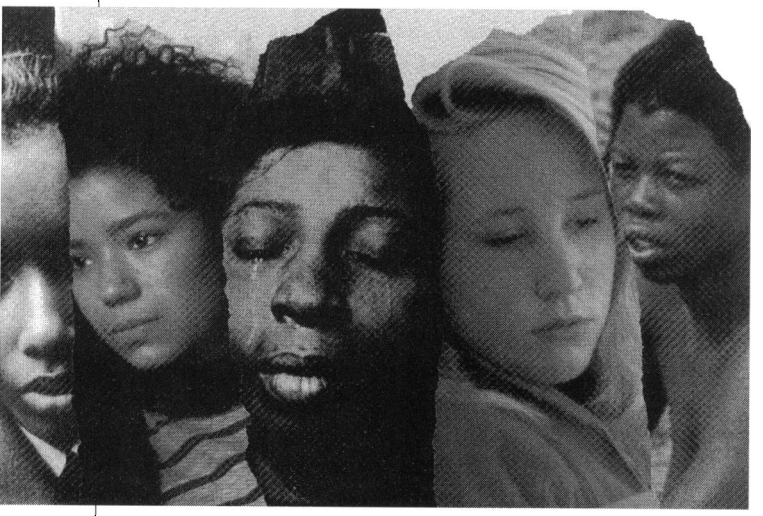
during my visit, I was witness to an incredible amount of activity. In the Reproductive Health Research Unit, in addition to the TOP provider training sessions, ongoing projects included research on maternal mortality, acceptability of the female condom, emergency contraception, side effects of injectable contraceptives, Norplant and its applications in South Africa, maternal mortality, community-based HIV prevention, and the feasibility of patient-retained health cards. In the Department of Obstetrics and Gynaecology, where all patients arrive as high risk referrals from primary care centers, 16,000 deliveries took place in 1996–1997 yet no money is available to replace outdated fetal monitors and the sole utrasound machine is unreliable and lacks a vaginal probe. Emergency gynecology patients, at the rate of 10 to 25 a day, are admitted primarily for complications of abortion; the TOP legislation is expected to reduce the number of these emergency admissions.



A Croatian doctor, who decided to stay in South Africa and continue working at Baragwanath after completing his ob/gyn residency there, told me that in addition to the clinical challenge, he found the hospital compelling because of the supportive and noncompetitive milieu and the sense of shared commitment among the staff. Amidst the intense clinical demands and training activities, the technical assistance provided to community clinics, and the collaborative research with RHRU, the staff finds time to meet weekly over a cup of tea and conduct rigorous peer review of cases. After listening to a spirited clinical debate at one of these departmental meetings concerning a maternal death, I mentioned that in the US concerns about liability had nearly shut down the maternal mortality review process and that considerable effort had been required to revive the committees currently operating in about half the states. All eyes turned to me, and one doctor voiced the shocked question on all of their minds: "How else can you learn from your mistakes?"

Addressing the Eleventh Commonwealth Health Ministers Meeting in Cape Town in December 1995, South African Minister of Health Dr. Nkosazana Dlamini-Zuma said, "The main reason why we need to discuss Women and Health is because there is gender discrimination in every one of our countries. We in South Africa, because of our recent history, are particularly conscious of discrimination. But we are also aware of the real possibility of overcoming discrimination and all its ramifications. If we can overcome apartheid, we can find a solution to gender discrimination."[5] Such optimism is humbling and inspiring. If a solution to gender discrimination can be found, a major impediment to reproductive health and optimal population health will be removed. I went to South Africa expecting to find a great deal of despair. The *rand* was falling rapidly and inexplicably; the Truth and Reconciliation Commission was opening up painful wounds as well as opportunities for healing; and problems of inadequate housing, unemployment, pollution, and violence were everywhere evident. Yet, as Dr. H. Jack Geiger observed in *Public Health Reports* in 1995, "Despite recurring crises, the overriding feeling in South Africa, I thought, was hope."[6]

Obs Scene, *an unofficial journal of the Department of Obstetrics and Gynaecology of the University of the Witwatersrand and Chris Hani Baragwanath Hospital, is available on the website* ***www.medi-net.co.za.***

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Dr. Bennett is an Assistant Professor, Department of Maternal and Child Health, School of Public Health, University of North Carolina at Chapel Hill.

Address correspondence to Dr. Bennett, Dept. of Maternal and Child Health, CB#7400, 401 Rosenau Hall, School of Public Health, Univ. of North Carolina at Chapel Hill, Chapel Hill NC 27599; tel. 919-966-5977; fax 919-966-0458; e-mail <trude_bennett@unc.edu>.