

Submission

to the

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1. Introduction

- 1.1. The Centre for Applied Legal Studies ('CALs') is a civil society organisation based at the School of Law at the University of the Witwatersrand. CALs is also a law clinic, registered with the Law Society of the Northern Provinces. As such, CALs connects the worlds of both academia and social justice. CALs' vision is a socially, economically and politically just society where repositories of power, including the state and the private sector, uphold human rights.
- 1.2. CALs operates across a range of programs including: rule of law, business and human rights, environmental justice, basic services, and gender. A specific focus of the gender program is the intersection of violence and gender with other rights in the Bill of Rights.
- 1.3. Historically CALs has engaged in gendered issues through numerous submissions to parliament. Some of CALs' submissions include submission to the Department of Women on the United Nations, Convention on the Elimination of Discrimination Against Women (CEDAW)¹, the Department of Justice and Constitutional Development on the Draft Regulations Relating to Sexual Offences Courts², and previously a submission on the MP Dudley's Legislative Proposal Pertaining to the Choice of Termination of Pregnancy Amendment Bill.
- 1.4. In light of the above CALs feels it is well placed to participate in the dialogue around the Choice on Termination of Pregnancy Amendment Draft Bill ('the

¹ <https://www.wits.ac.za/media/wits-university/faculties-and-schools/commerce-law-and-management/research-entities/cals/documents/CALS%20submission%20CEDAW%20Final-Oct%202015.pdf>.

² <https://www.wits.ac.za/media/wits-university/faculties-and-schools/commerce-law-and-management/research-entities/cals/documents/Sexual%20Offences%20Court%20November%202015.pdf>.

draft bill') and welcomes the opportunity to submit comments on the draft bill in response to a call by the Speaker of the National Assembly.

2. The Choice on Termination of Pregnancy Act 92 of 1996 - the purpose of the Act and the harm it aims to address

2.1. The Preamble of the act states that 'the Constitution protects the rights of persons to make decisions concerning reproduction and to security in and control over their bodies' and that 'both women and men have the right to be informed of and to have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice and that women have the right of access to appropriate health care services to ensure safe pregnancy and childbirth.' This recognises the constitutional right of an individual to make choices around her body and specifically her reproductive autonomy as well as the right to safe, effective and affordable healthcare to enable the individual to practice her reproductive autonomy.³ In acknowledging these rights the Preamble correctly states that 'the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm.'

2.2. The act and its implementation have shown important advances in dealing with the provision of safe termination of pregnancy. Jewkes and Rees in an article published in 2008 hailed the success of the implementation of the act in causing a 'dramatic decline' in abortion mortality.⁴ The authors compare the statistics of pre-1994 and pre-commencement of the act statistics with those of

³ These rights are contained in the Constitution, a right to reproductive health care under section 27(1)(a) and autonomy which has been read into the right to dignity under section 10 as per *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others* (CCT5/95) [1995] ZACC 13; 1996 (1) SA 984 (CC); 1996 (1) BCLR 1.

⁴ R, Jewkes and H, Rees 'Dramatic decline in abortion mortality due to the Choice on Termination of Pregnancy Act' (2008) *South African Medical Journal*. A copy of this article is available at <http://www.samj.org.za/index.php/samj/article/viewFile/1609/971>.

1998 - 2001 and find that there was a 91,1% reduction in deaths from unsafe abortions.⁵

2.3. Although the above is important in the realisation of the rights of reproductive autonomy and reproductive healthcare, there are still barriers that are increasingly preventing this realisation.⁶ CALS submits that some of the proposed amendments to the act in the form of the draft bill reinforce barriers and creates new barriers to reproductive autonomy and reproductive healthcare.⁷ Discussed below will be some of the problematic amendments suggested in the draft bill as well as why the draft bill should be considered as an instance of indirect discrimination against women. Finally, brief recommendations will be advanced in reference to the act.

3. Reflections on specific proposed amendments

3.1. Amendment to section 1 – the term ‘gestation period’

3.1.1. There are two main issues with the suggested amendment of the definition of ‘gestation period’ as it appears in the act. The first, and the most important factor, is that the amendment insinuates a lack of trustworthiness on the part of the woman in identifying when her last day of her last menstrual cycle took place. In requesting that the ultrasound examination accompany what the woman has said, there is the creation of the idea that women who go for termination of pregnancy are inherently liars and that the word of these individuals need to be

⁵ Ibid.

⁶ Some of these barriers are discussed below under paragraph 5.

⁷ In an interview with Human Rights Watch it was stated that restrictive abortion policies does in fact increase rates of unsafe abortions and therefore mortality rates. It was specifically stated ‘[t]he average unsafe abortion rate was more than four times greater in countries with restrictive abortion policies in 2011’. See <https://www.hrw.org/news/2017/07/24/qa-human-rights-law-and-access-abortion>. This supports the assertion that further restrictions, which is suggested in the draft bill, can in fact lead to further unsafe abortions and mortality rates.

confirmed by referring to the ultrasound. Furthermore, we must strive for ridding communities and the healthcare sector of prejudice against women who seek termination of pregnancy (see paragraph 5.2.1) and this amendment has the unintentional/intentional effect of imposing prejudice around the trustworthiness of women.

3.1.2. The second issue is that ultrasound machinery would place extra burden on an already financially burdened healthcare system. The most necessary provisions for attaining reproductive healthcare which is safe, effective and affordable must always be prioritised, and thus ultrasound machinery (which may be useful in the reproductive health care field) is simply not a foremost need when things such as medications, beds, sufficient staff and counseling are limited.

3.2. Deletion of section 2 of the Act – certain circumstances under which there can be termination

3.2.1. The proposed deletion of section 2(1)(b)(iv) due to medical practitioners allegedly being ill-equipped to determine whether the continued pregnancy would significantly affect the social or economic circumstances of the patient is shortsighted and poorly substantiated.

3.2.2. There is no reason why a doctor when presented with the patient's narrative around the socio and economic effects of a continued pregnancy would not be able to ascertain whether such factors would be significant in nature. There is the alarming assertion made in the submission that simply because a doctor is allegedly ill-equipped to ascertain whether the effect of continued pregnancy will be significant, that this section should be deleted entirely. There is no suggestion of any other individual who according to the submitter could ascertain such facts and thus the proposition is simply to limit the right of the

individual to recourse in terms of this section. This suggested amendment is without substance and unintentionally/intentionally calls for a limitation of the right to reproductive healthcare.

3.2.3. It must also be noted that the amendment also suggests that the criteria set out in section 2(1)(b)(iv) which permits a termination in the 13th to the 20th week of pregnancy based on a significant effect on the woman's social and economic well-being, should be removed from the act due to being 'arbitrary and is so broad that it is vague'. This assertion of arbitrariness and broadness is ill-informed and fails to acknowledge the position of many women in South Africa, specifically black women, as having limited access to economic opportunities, limited access to basic services as well as being the victims of violence from both the state, their communities and their intimate partners. Therefore, the inclusion of the consideration of socio and economic factors is in line with the Constitution and should not be done away with.

3.3. Insertion of section 3(1) – the provision of access to ultrasound machinery

3.3.1. The amendment suggests the provision of ultrasound machinery, yet goes on to also assert that part of mandatory counseling should be the provision of electronic photographs of the fetus (ultrasound) among other resources to ensure the woman is making an 'informed choice'. This type of amendment is an instance of indirect discrimination as discussed below at paragraph 4, furthermore the intention behind the idea for this amendment, is the dissuasion of women terminating pregnancies rather than 'informed choice'.

3.3.2. Sanger explains how this actually intrudes upon decision-making.⁸ First, by having an ultrasound or having to witness pictures of the fetus the woman is then cast into the role of a mother and it is in this light that she must proceed with this conscripted status thrust upon her.⁹ Second, a woman must use her own body to produce evidence that will be used to dissuade her from terminating the pregnancy, thus being forced to accept the political description of the fetus as a child and not a scientific description which has been accepted in the act as showing otherwise.¹⁰ Thus, the assertion that seeing electronic pictures of a fetus does not in fact lead to 'informed choice' but rather to a coerced choice based on political motivations, which are not upon that which, the act is founded.

3.4. Amendment to section 4 – mandatory counseling

3.4.1. The purpose of counseling is to provide emotional and psychological support to women who have decided or are deciding whether or not to pursue termination of pregnancy. The counseling space must be one where the woman can speak of her hesitations as well as her reliefs freely without fear of judgment or feeling forced into a certain situation. The care must be patient-centered and to the benefit of the patient as she may feel shame or feelings of vulnerability. It is furthermore important for individuals seeking to terminate a pregnancy to be offered counseling as this can prepare them for its physical effects (including cramping and bleeding) of the termination as well as helping to prepare the individual for what can be a frightening and painful experience.¹¹

⁸ C, Sanger 'Seeing And Believing: Mandatory Ultrasound And The Path To A Protected Choice' *Public Law and Legal Theory Working Paper Group*, 351. Available at <http://ssrn.com/abstract=1306460>.

⁹ Ibid, 351.

¹⁰ Ibid, 351.

¹¹ R, Hodes 'The Culture of Illegal Abortion in South Africa' (2016) 42.1 *Journal of Southern African Studies* 79, 88.

3.4.2. Counseling should not, however, be mandatory. The call for mandatory counseling violates the right of the individual to autonomy. This is also counter to modern day medical systems whereby there is the move away from doctor paternalism, or in this case counselor/psychologist paternalism, for a system where the patient has autonomy over her medical decisions. Furthermore, counseling should not attempt to dissuade the woman from going through with termination and should in no way take the form of moralistic or religious philosophies.

3.4.3. There is a further issue in the suggested amendment for mandatory counseling, this is that it places further burden on the state to provide such counseling and therefore the creation of additional expenses on a financially challenged health care system. The unintentional/intentional result of requiring counseling to be mandatory is that it excludes certain clinics from providing termination of pregnancy due to the inability to provide counseling based on insufficient resources.

3.5. Amendment to section 4 – mandatory counseling of spouse/ guardian/ legal guardian/ *curator personae* of a ‘severely mentally disabled or unconscious woman’

3.5.1. As mentioned above at paragraph 3.4 offering counseling is supported by CALS, yet the issue of mandatory counseling is problematic as this infringes upon the autonomy of the individual to make her/his decision.¹²

¹² *Christian Lawyers Association v Minister of Health* 2005 (1) SA 509 (T) 518.

3.5.2. Counseling may be discussed as an option and the individual could be advised on the benefits of psychosocial support, yet attending any counseling must be voluntary.

4. Indirect discrimination

4.1. It is important to highlight that the intended amendment to the act should be considered as an act of indirect discrimination. Indirect discrimination has been described by the Constitutional Court as ‘conduct which may appear to be neutral and non-discriminatory [but] may nonetheless result in discrimination.’¹³ The suggested amendments on the face of it may appear to be suggesting certain provisions that are in the interest of the woman choosing termination, yet the substance of these proposed amendments actually seem to be inclined to placing barriers in the way of the woman’s right to reproductive healthcare in the form of termination. These proposed amendments are prejudicial to women and are attempting to dissuade women from exercising reproductive rights.

4.2. Furthermore, these suggested amendment recreate prejudice and stigmatisation around women who elect to terminate a pregnancy and are an act of attempted limitation on the rights of women to bodily autonomy.

5. Recommendations for the Act

5.1. Unsafe abortions

5.1.1. In 2008, the World Health Organization (WHO) reported that an estimated 120,000 women in southern Africa had accessed unsafe termination of pregnancy services, resulting in 500 maternal

¹³ *City Council of Pretoria v Walker* (CCT8/97) [1998] ZACC1; 1998 (2) SA 363; 1998 (3) BCLR 257 at para 31.

deaths.¹⁴ According to Pickles, possible reasons for turning to unsafe terminations include, but are in no way limited to the following factors:

- Long waiting periods for procuring a termination of pregnancy at health care facilities. In 2006 a study found that it took an average of 2.5 visits at a health care facility before the termination was initiated, furthermore in a study in 2011 it was reported that women would need to make 3 or more visits to the health care facility before the termination was initiated.¹⁵ Women have also reported that the waiting period between the first visit to the healthcare facility and the time of termination can be as long as 30 days. This is a very serious issue, especially in terms of section 2 of the Act which sets out the different requirements for termination during twelve weeks, from 13 weeks to 19 weeks and from 20 weeks on, if the healthcare facility creates the delay in termination this can create the situation where the woman will need to meet further requirements which she may not be able to do and thus will affect her rights to autonomy in being able to choose a termination as well as putting her in a situation that may be dangerous to her health.
- Concerns around the termination of pregnancy procedure. Women have expressed that generally there is little to no privacy at healthcare facilities. Pickles quoted a doctor in one of the healthcare facilities where she/he said women 'hang around in rooms... waiting and having fetuses between their

¹⁴ C, Pickles 'Lived Experiences of the Choice of Termination of Pregnancy Act 92 of 1996: Bridging the Gap for Women in Need' (2013) 29 *SAJHR* 515, 516.

¹⁵ *Ibid*, 520.

legs for hours and nobody cares [but that] at least the procedure gets done.’¹⁶

- Staff attitudes towards patients. Staff attitudes towards women who have chosen to terminate their pregnancies have been cited as problematic.¹⁷ In one instance Pickles explains that a woman expressed that after the termination procedure she was forced to deliver the product of the termination alone in a bathroom and was afterwards required to wrap the ‘whole thing’ and proceed to ‘go inside for cleaning’.¹⁸ Women have also reported being afraid of abuse by staff at the health care facilities.¹⁹ Hodes notes that in South Africa only 20% of women were given pain medication of any kind, she states that research suggests that the refusal to give pain medication may be a form of punishment by staff and/or a means of trying to dissuade women from having repeat terminations.²⁰
- Stigmatisation of women and staff. Both women choosing to undergo a termination of pregnancy and staff in healthcare facilities explain the stigmatisation they experience.

5.2. Counseling

In reference to paragraphs 3.4 and 3.7 above, there should be counseling made freely available for all staff involved in Termination of Pregnancy units, this will help these individuals deal with the trauma they experience in the workplace as well as help shift attitudes of the staff towards patients.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Hodes, 88.

5.3. Community education – destigmatising abortion

There is a dire need to educate both the medical community as well as communities more generally around the act as trying to develop sensitivity around termination of pregnancy in order to address the issue of discrimination against women who elect to have such procedures.