ABORTION IN SOUTH AFRICA AND ATTITUDES OF NATAL MEDICAL PRACTITIONERS TOWARDS SOUTH AFRICAN ABORTION LEGISLATION

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PREFACE.

Following the passing of South Africa's first statutory legislation on abortion, in March 1975, the Abortion Reform Action Group (now A.R.A.G. National) launched two concurrent surveys. Together, the surveys were designed to investigate the effects of the new legislation. Survey 'A', the results of which are discussed in this publication, was conducted among private practitioners of the Natal Medical Profession, while Survey 'B' was conducted both among the private and public sector of the hospital services in Natal.

In this two-pronged investigation both the surveys most specifically were aimed at assessing the effect of the new law upon the incidence of illegal abortion. In Survey 'A' however, which provides the contents of this report, wider information was sought, and, as a result of the co-operation of our medical informants, certain of the problems which unwanted pregnancy presents to South African women and their families have now been recorded. In addition, a great many doctors have stated their opinion of the new law.

The response by the doctors to this survey exceeded expectations, and possibly represented one of the highest response rates in the world to a survey of this nature. This seems to be a clear reflection of the concern which unwanted pregnancy and its safe control creates in the minds of those who most closely deal with the problem in this country, and who, moreover, feel free to comment or release information.

It is because of the relatively high response to the questionnaire by doctors in private practice that some comment must be made on the co-survey which ran concurrently in both the private and public sectors of the Natal Hospital services. Since, as already stated, the two surveys were designed to form a whole, it would be both incomplete

and inaccurate to omit reference to the fate of the hospital questionnaire.

In this, figures were requested of abortion admission cases to Natal hospitals for the 12 month period before the Act, and the 12 month period after the passing of the Act. The hospitals were authorised to supply figures to the 12 months prior to the Act, and as Section 7(3)(a) of the 1975 Act demands that hospital records be kept of operations involving 'an operation connected with abortion or the removal of the residue of a pregnancy', it was assumed that information for the second half of the survey would be easily returned. However, halfway through the survey permission to complete the questionnaire was refused by the Director of Hospital Services in Natal for hospitals under his charge. This, of course, deprived the survey of figures for the 12 months following the Act.

As in Survey 'A' however, co-operation from the private sector was encouraging; fourteen private and mission hospitals in Natal and Zululand whose facilities catered for maternal care, returned figures for the entire 24 month period. On analysis, the figures reflected a 33,6% increase in hospital admission cases from spontaneous, induced or illegal abortion in the 12 months following the passing of the Act. Although the hospital survey must be regarded as incomplete, this background of information with its implications must in all fairness be recorded in conjunction with the findings of the survey analysed and discussed in this report.

For the arduous work which covered many months, resulting in the completion of this report, an acknowledgement of debt is due to the team of workers involved in the project; and above all to the constant and meticulous guidance of Professor Lawrence Schlemmer of the Centre for Applied Social Sciences, whose decision it was to publish this work. The financial assistance of the Centre in the final stages enabled the material to be more fully analysed.

Initial direction for workers involved in the survey was given by Social Anthropologist, Ms. Ann Perry. The sample of medical practitioners was drawn up by myself with the assistance of the Secretaries of the Coastal and Inland branches of the Natal Medical Association and the Director and Medical representatives of a Durban firm of medical suppliers; while the questionnaire was drafted by A.R.A.G. Vice-President, University of Natal Sociologist Ms. Clare Blatchford, and further approved by a practising gynaecologist

Ms. Solveig Candy, Honorary Secretary/Treasurer, A.R.A.G., and a team of workers was responsible for the exacting secretarial work of despatching the questionnaires. The final task of skilled analysis of the returns was accepted by A.R.A.G. survey analyst and University of Natal Sociologist, Ms. Jean Westmore.

In summarising the findings of the Survey, Jean Westmore has produced a monograph which will be an essential reference to those both in this country and overseas whose interest lies in family planning, women in society, and in particular the problems faced by South African women in the urgent matter of fertility control, as seen and recorded by the medical profession.

In this connection, final acknowledgement of gratitude is due to the men and women of Natal's medical profession who put aside time to give thought to the questions asked of them. Without such generous co-operation of these doctors, neither the survey nor this publication would have been possible.

June Cope.

President
A.R.A.G. National

Durban
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INTRODUCTION.

It is both a commonplace and an understatement to point out that the issue of abortion is a matter of controversy. On the one hand, a powerful anti-abortion body of opinion protests firmly against any invasion of the God-given right for the foetus to live. On the other, an increasingly strident demand by those in favour of liberalized abortion insists that the woman herself has equally inalienable rights, chief amongst which in this context, is the right to decide if, when, and by whom she wishes to be pregnant.

It is essential to note however, that the protagonists of both these positions support their arguments on moral grounds. In the case of the anti-abortionists, the religious origins and dimensions of the moral stance are abundantly obvious. Those in favour of liberalized abortion place greater emphasis on abstract notions of natural law, or what might loosely be called humanism. In other words, their claim for the woman's sovereignty over her body is based on the universal rights of an individual - included amongst which is the right not to be born into poverty, or the right not to be born to an unwilling or incapable parent, or parents.

With the introduction of the Abortion and Sterilization Act (1975), the great debate on abortion gained prominence in South Africa. The new law has now been in operation for over a year, and in many quarters people are posing the question: "Is it working?" Given this climate of public interest and concern regarding the incidence of abortion in South Africa, and the efficacy of the new abortion legislation, this communication paper was prepared. The contents of this report includes both a detailed discussion of the incidence of abortion in our country, and a report on the results of an exploratory study into the attitudes of Natal medical practitioners towards the newly introduced Abortion and Sterilization Act.

CHAPTER I.

ABORTION IN THE INTERNATIONAL CONTEXT.

According to a report on worldwide abortion laws and policies compiled by members of the Department of Medical and Public Affairs at the George Washington University Medical Centre, 60% of the world's population live in countries where abortion during the first trimester is legal either for social and economic reasons, or "on request" without any specific indications. Another 16% live in countries where abortion is conditional, i.e. allowed for medical, eugenic, and/or humanitarian reasons. Thirteen per cent of the rest of the world's population, live in countries where abortion is permitted only to save the woman's life, 8% where abortion is prohibited without exception, and 3% where abortion is not mentioned. Of the thirteen most populous countries in the world, the People's Republic of China, India, U.S.S.R., U.S.A., Japan, Federal Republic of Germany, and Great Britain allow legal abortion either on request during the first trimester, or for social and economic reasons.

The recent trend toward the liberalization of abortion legislation (which began since World War II), is generally speaking the result of actions taken by governments in order to improve maternal health by reducing the widespread incidence of illegal abortion. Only a few countries have explicitly liberalized abortion laws to curb population growth or to promote social and economic development. Singapore and Tunisia are examples (Population Council, 1975). According to data collected in 1971 by the International Planned Parenthood Federation, allowing for spontaneous abortions and stillbirths, nearly one in every four pregnancies is terminated by either legal or illegal abortion the world over. Obviously because of the difficulty of calculating the incidence of abortion due to the very many illegal terminations that are still performed, any statistic given can only be an estimate. The Population Council's estimate for incidence of abortions in 1975 ranged from 30 million to 55 million abortions per year, or about 40-70 per 1 000 women of reproductive age, with an abortion ratio of 260-450 per

1 000 live births. Worldwide 150 000 women die annually as a result of illegal abortion. This represents 30-50% of all maternal deaths associated with pregnancy and childbirth each year. (Population Council, New York, 1975.)

Such data have obviously had an influence on law and policy-makers, and thus have contributed towards the trend of liberalizing abortion legislation in many countries. A further impetus for change has obviously emanated from the Women's Movement whose members have campaigned for women's rights in society, including the right of sovereignty over their own bodies. Furthermore, new technological advances, such as menstrual regulation and the use of prostaglandin suppositories or injections, pose an increasing challenge to the traditional interpretation of existing restrictive abortion laws.

Liberalizing abortion laws does not necessarily imply that safe abortions performed in suitable institutions by qualified personnel automatically become available to all women who are in need of this service. The present situation in Britain and some states in the U.S.A bears evidence to this. The Population Council's report stipulates that the following prerequisites are necessary for the effective functioning of abortion services:

- Sufficient numbers of medically qualified personnel who are willing to perform abortions (e.g. Scottish Health Department reports that about 1 000 Scottish patients were forced to travel to the south of England in search of legal and safe abortions because doctors in the Glasgow region refused to perform abortions on religious and moral grounds). (I.P.P.F., 1976.)

- Medical facilities that are geographically accessible. (e.g. in some states in the U.S.A. public hospitals, on which poor women depend, have been particularly slow to set up abortion services.) (Pilpel, H.F. *et.al.*, 1975.)

- A rate schedule that excludes no one.

- A widespread communications network to inform all people, including those in rural and/or isolated areas, that these services are available.

But although these inadequacies exist in countries which have introduced liberalized abortion legislation (thus not eliminating illegal abortion completely) a number of positive trends are discernible:

- early abortion is a safe procedure - the risks associated with pregnancy termination performed during the first trimester are much fewer than those associated with most surgical procedures (see Diagram 1, p.7).

- fewer maternal deaths. In New York city the maternal death rate was 5,3 per 10 000 births in 1969. By 1972 the rate had fallen to 2,6. (Pilpel, H.F. 1975.) In England and Wales, since legal abortion became more readily available, total deaths from the various types of abortions decreased from 117 in 1967-69 to 81 in 1970-72. Deaths due to illegal operations fell from 74 in 1967-68 to 38, and those following spontaneous abortion from 25 to 6 in the 1970-72 period. The latter figures confirm the conviction that many apparently spontaneous abortions are, in fact, illegal but fortunately, uncomplicated. (H.M.S.O., 1975.)

- morbidity declines with liberalized laws, e.g. San Francisco General Hospital reported a decline in rate of septic abortions to live births since the reformed abortion law. In 1967 the rate was 68 per 1 000 live births; by 1969 the figure had dropped to 22 per 1 000 live births. This suggests a sharp reduction in unsafe, illegal procedures.

- an equalizing of opportunity to procure an abortion. Although this is still far from ideal, in some areas and countries, the less privileged woman is beginning to benefit from abortion services. According to Pilpel *et.al.* (1975), since the free-choice abortion statute was introduced in New York, the incidence of legal abortions amongst the non-White group steadily increased, whereas in the period 1965-67, the number of therapeutic abortions per 1 000 live births were about four times greater among White women than among Black women, by 1971 the ratio had

levelled out to the extent that the ratio of legal abortions to live births is now slightly higher amongst the non-White women.

- more and more abortions are being performed before 20 weeks gestation. (Population Council, 1976.) In Sweden, 80% of the 26 000 abortions performed per annum are performed during the first trimester. (I.P.P.F., 1974.)

- data suggests that relatively easy access to legal and safe abortion has not led to a progressive neglect of contraception. This is especially the case when abortion counselling includes contraceptive counselling as well, for example in some well-run abortion clinics in New York, and some National Health hospitals in Britain. (Beard, R.W. *et.al.*, 1974.)

- potential decline in population growth.

But abortion law is not always an accurate guide to a country's *de facto* practices. For example, although abortion is illegal or very restricted in countries such as Greece, Belgium and the Netherlands, it is performed without interference from the authorities. In other countries where medical personnel are reluctant to perform abortions that do not fall within the legal definition, criminal abortions are none the less rife - as estimates quoted earlier reflect. "Whether we like it or not abortion is a fact of life, and in moments of stress desperate women will continue to rush into abortion regardless of hazard, purely reflexly, in the manner of lemmings rushing into the sea." (Walker, N., 1974.)

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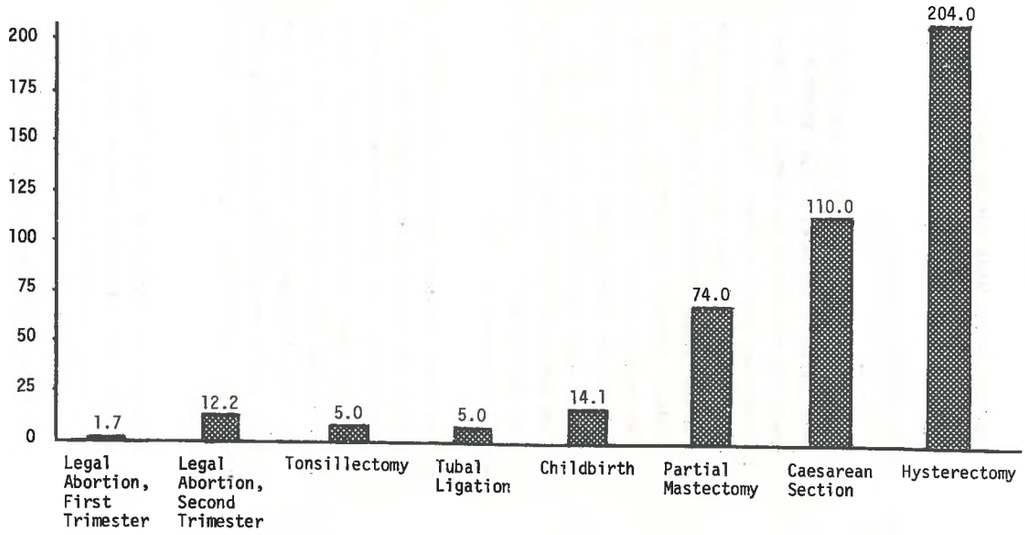
DIAGRAM I

ABORTION-RELATED DEATH RATES COMPARED TO DEATH RATES FOR SELECTED OPERATIVE PROCEDURES, U.S.A., 1972-1973 (DEATH RATE PER 100,000 PROCEDURES)



From: *Law and Policy: Abortion Law and Practice - A Status Report*, as quoted, p.27.

CHAPTER II.

ABORTION IN THE SOUTH AFRICAN CONTEXT.

1. ABORTION LEGISLATION IN SOUTH AFRICA.

Until the passing of the Abortion and Sterilization Act (1975), the question of what exactly constituted a legal abortion in South Africa could only be answered by recourse to our common-law authorities, and as such the legal position was poorly defined. The views of such common-law authorities as Matthaeus made it clear that in a situation where the continued existence of the foetus constituted a threat to the very life of the mother, the mother's interest could prevail. No further guidelines were laid down, for example, whether other interests of the mother should prevail such as to spare her severe damage to health - physical or mental, what to do in cases of foetal abnormality, rape and incest. Furthermore, four sections of the Native Territories Penal Code (1886) laid down the stipulation that an abortion was legally permitted if performed to save the life of the mother. (Strauss, S.A. 1974.)

Under the common-law legal position, many doctors performed therapeutic abortions where the extreme necessity spelt out by the common-law was not present. For example, in 1968 it was estimated that at least 28% of therapeutic abortions openly performed in hospitals in South Africa, were performed for reasons other than saving the life of the mother. (De Villiers, J.N., 1968.) Strauss has also stated that personal communication with attorneys-general revealed that they would not dream of bringing the medical practitioners performing such therapeutic abortions to court. (Strauss, S.A., 1976.)

The passing of the Abortion and Sterilization Act (1975) was designed to remove the legal ambiguities that existed under the previous legal situation. Although this Act allows for revision of the law from one indication for legal abortion (i.e. to save the very life of the mother), to seven indications, therapeutic abortion is still only allowed legally under certain very strict conditions, and with much administrative "red-tape" involved in the procedure of procuring a legal therapeutic abortion.

The present legislation is summarised in the diagram below.

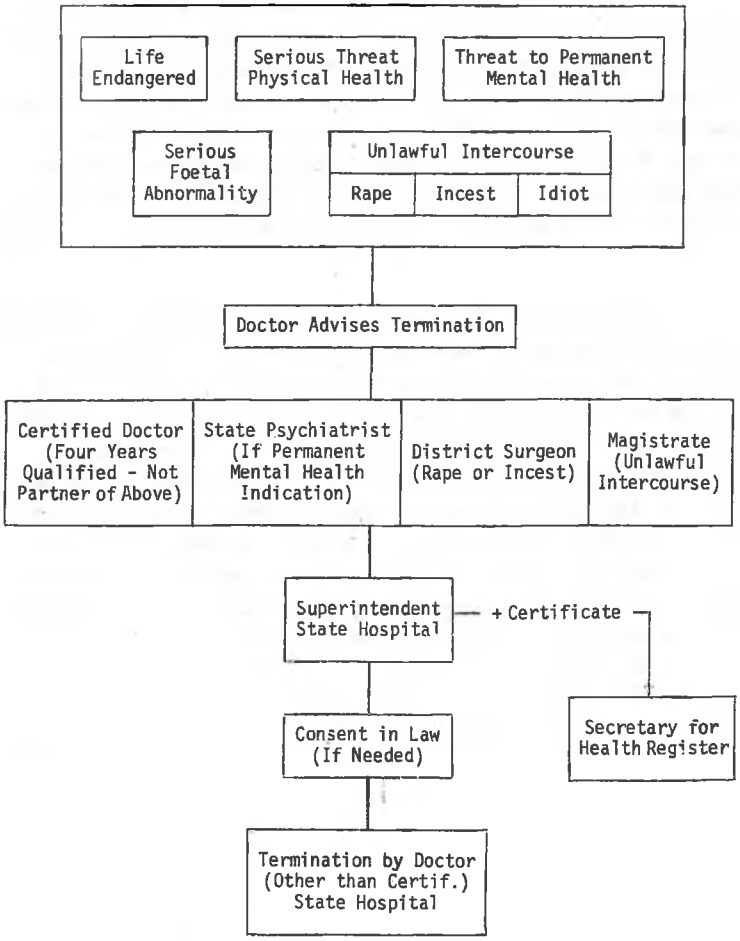
2. THERAPEUTIC ABORTIONS SINCE THE ABORTION AND STERILIZATION ACT.

By March 11th, 1976, twelve months after the new legislation had been operative, 570 legal therapeutic abortions had been performed in South Africa. Four hundred and two White women underwent legal abortions, 56 Coloured women, 8 Asian women and 21 African women. (Cope, 1976.) By the end of February 1976, 16 therapeutic abortions had been performed under the unlawful intercourse indication : 7 in the case of rape, 7 in the case of incest, and 2 in the case of carnal intercourse where the woman concerned is an idiot or an imbecile. The other abortions were performed under the psychiatric and life-endangered indications. (Strauss, 1976.)

At Groote Schuur Hospital in Cape Town 76 applications for legal termination of pregnancy were accepted during this year period; 58 of these were White women, and 18 were Black women (Coloured and African - only one African application accepted). Thus the majority of those who have obtained a legal abortion are White women. In the Johannesburg General Hospital, during the six month period from October 1975 to March, 1976, 133 legal abortions were performed. Of these 106 were performed under the psychiatric indication. Furthermore, of the 133 women involved, 60 were unmarried, 61 married, 11 divorced and 1 separated. (Feldman, 1976.) During the period June 1975 - March 1976, only 7 abortions were performed under the indication that there existed a substantial risk that the child to be born would suffer from a serious physical or mental abnormality. Of these 2 were performed because the mother had rubella, and 5 for genetic reasons. (Jenkins, T., 1976.)

DIAGRAM II

SUMMARY OF THE ABORTION AND STERILIZATION ACT (1975)
(SECTIONS RELATING TO ABORTION ONLY)



Adapted from Geldenhuys, F.G.,"Medical Aspects of Abortion", in Oosthuizen, G.C., *et.al.*, (Eds): *ibid.*,p.23.

3. EFFICACY OF THE NEW LEGISLATION : LEGAL AMBIGUITIES ERADICATED?

As pointed out earlier, the present legislation was passed in order to remove the legal ambiguities pertaining under the previous legal situation, so that the medical profession could operate with a more secure definition of what constitutes a legal termination of pregnancy. According to Strauss, the Act has had some effect on illegal abortion (i.e. abortions now performed in South African hospitals are legal in terms of the indications stipulated in the Act), whereas previously many of these were openly performed in hospitals, but strictly speaking "illegal" as the pregnancies did not constitute a threat to the very life of the mother, but has not necessarily affected the incidence of criminal back-street abortions. (Strauss, 1976.)

But some members have pointed out that:

- it is particularly difficult for a physician to define what actually constitutes a "serious risk", or a "serious abnormality" of the foetus. (Geldenhuys, 1974.)

- it is particularly difficult for a psychiatrist to make an assessment and diagnosis of his/her patient's mental state purely in terms of her abstract "mental health" without taking into account her total life situation. (Feldman, 1976.)

Finally, Strauss indicates a number of legal technicalities that arise out of the new legislation, and are not well defined in the Act:

- has the woman the right to demand that an abortion be performed if her application has satisfied the necessary conditions?

- on what bases can the superintendent of a State hospital refuse to allow facilities for the performance of an abortion?

- if the woman concerned is a married woman, is the husband's consent necessary before an abortion is performed?

- what exactly is a foetus? (not defined in Act.)

- if a woman threatens to commit suicide because she is carrying an unwanted child, must this be considered a threat to her life? (Strauss, 1976.)

4. EFFICACY OF THE NEW LEGISLATION : LAW ENFORCEMENT AND THE INCIDENCE OF CRIMINAL ABORTIONS.

Although the passing of the new legislation was not designed to eradicate criminal abortions, it seems reasonable to ask whether it will have any repercussions for the incidence of such abortions, and the conviction of criminal abortionists.

Cloete is of the opinion that given that the law "attempts to prohibit a private practice where all parties involved are anxious to avoid legal restrictions, and where the so-called victim is a willing participant, law enforcement becomes extremely difficult....Restrictive law may eliminate a certain percentage of criminal abortions, but also defects the criminal abortionist further into the underground". (Cloete, 1974.)

The following table summarises the number of individuals convicted of criminal abortion in South Africa during the period 1949-1968: it reveals only the tip of the iceberg, given that it can be estimated that even under the recent legislation, no more than 5 per cent of all abortions will be legally sanctioned; the remaining 95 per cent will still be illegally performed. (Cloete, 1974.)

TABLE I.

INDIVIDUALS CONVICTED FOR CRIMINAL ABORTION IN SOUTH AFRICA : 1949-1968.

Year	Number of convictions (all races)
1949	18
1954	19
1960	28
1962	24
1963-4	26
1967-8	29

from Bureau of Statistics : Special Report 272, Report 18-10-10, Report 08-0104, Government Printer, Pretoria, 1962-4-8.

5. EFFICACY OF THE NEW LEGISLATION : INCIDENCE OF SELF-INDUCED AND CRIMINAL BACK-STREET ABORTIONS.

From the above two sections of the discussion it is clear that the Act:

- was not designed to eradicate criminal back-street abortion in South Africa,

- nor does the reformed law offer any assistance to the thousands of women who wish to terminate an unwanted pregnancy for multifarious reasons : if the termination of these pregnancies cannot be procured legally and safely, many will continue to attempt to abort themselves, using dangerous and unhygienic methods.

Abortion is a fact of life in all societies, no matter what religious, social and cultural systems prevail. What is the extent of the practice of self-induced and back-street abortion in South Africa, and what are the consequences of this widespread practice?

(A) Estimated Incidence of Self-Induced and Criminal Back-street Abortions in South Africa.

The incidence of self-induced and criminal back-street abortions is impossible to calculate with any accuracy; all such figures must of necessity be estimates. Tietze, one of the most eminent investigators of the International Planned Parenthood Federation, at one time stated that estimating the incidence of illegal abortion in a country could be given as several hundred thousand - it might well also be one million plus that several hundred thousand.

Attempts to estimate the incidence of this practice in South Africa cannot be based on the number of convictions for criminal abortions occurring in the criminal statistics (this represents only a tiny fraction of the real number of illegal abortions) (Cloete, 1974), nor on the number of cases of septic and incomplete abortions treated in hospitals (not all such induced abortions require subsequent hospitalization). The International Planned Parenthood Federation reported that in 1971 there occurred ±200 legally and illegally induced abortions per 1 000 live births in southern Africa (this estimate, presumably, was based on the informed judgements of delegates at a conference on social and medical aspects of abortion organized by the I.P.P.F Africa Regional Committee in Accra, 1974). If, for purposes of argument, we base an estimate of the incidence of abortion in South Africa on this figure, the following emerges:

TABLE II.

ESTIMATED INCIDENCE OF ABORTION IN SOUTH AFRICA BASED ON LIVE BIRTHS TO WHITE, COLOURED AND ASIAN WOMEN IN 1970.

Race	Number of live births	Approx. 1 000's	Abortions : 200 per 1 000
White	88 886	89	(17 800)
Coloured	74 429	74	(14 800)
Asian	21 082	21	(4 200)
from *South African Statistics 1974*, compiled by the Bureau of State Statistics.			(36 800)

Furthermore, although no government statistics are available for the number of live births to African women, using the estimates of Sadie (Sadie, undated ±1973), we arrive at a number of births to African women in South Africa in 1970 of roughly 614 000. Thus the estimate for abortions in South Africa in 1970 totals the following:

White	:	(17 800)
Coloured	:	(14 800)
Asian	:	(4 200)
African	:	(122 800)
		(159 600)

How many of this estimated number of abortions were performed legally, and under clinically safe conditions in 1971? And has the number of abortions increased over the last six years?

It is interesting to note that this estimate compares well with other estimates of the incidence of abortion in South Africa. For example, both Strauss (1973) and the Abortion Reform Action Group (1973) claim that about 100 000 illegal abortions are performed per annum - this being a conservative estimate. Taking the estimate calculated here (i.e.

± 150 000 illegal abortions per annum), this would mean that in 1970, about 1 in every 32 women of reproductive age underwent an illegal abortion (from S.A. Statistics 1974, 4 966 650 women of reproductive age between 15-49 years of age, and deducting 1 000 000 from this figure to allow for women who cannot conceive for some reason as suggested by Shapiro (1974)). The ratio of 1 out of 32 women undergoing an abortion is a likely one if one takes into account the possibility that in our unequal society many lesser privileged women may be forced to terminate more than one unwanted pregnancy due to socio-economic hardship.

That self-induced and back-street abortions are widespread amongst the less privileged group of women in our society is substantiated by the following:

- Approximately 76% of convictions of individuals for criminal abortions in 1963-64 were African females (Strauss, 1974). (It could, of course, be argued that what this figure really indicated is that this group are less skilful in avoiding prosecution than are other operators).
- Baragwanath Hospital in Soweto runs two special wards at week-ends to treat incomplete abortions (A.R.A.G., 1975). Admittedly some of these cases of incomplete abortions are due to spontaneous abortions, but the proportion cannot be all that high as spontaneous abortions do not necessarily have a habit of occurring over week-ends only.
- King Edward VIII Hospital in Durban treats twice as many cases of septic abortions as does Groote Schuur per annum (King Edward treats African and Indian patients). (A.R.A.G., 1973).

The responses of medical practitioners in Natal in a questionnaire survey conducted by the author,[1)] only serve to reinforce what is argued above regarding the high incidence of self-induced and criminal back-street abortions in South Africa. Of the 117 doctors who responded, 104

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1) For a full discussion of the survey and the methods employed, see Chapter III.

offered numerical estimates of requests that they had received from patients who desired to terminate their pregnancies, in answer to the question:

- In the last three years, what would you estimate to be the number of requests that you have received, both directly and indirectly, for pregnancy termination?

The total of these estimates offered by the 104 doctors was 10 952 for the three year period, averaging 3 650 per year. Allowing for the possibility that many women might "shop around" for an abortion, and thus approach about three doctors with the request for pregnancy termination, we can estimate that there were at the very least over 1 000 women in Durban and surrounding areas who wished to terminate their pregnancies per year. It must naturally be borne in mind that many women do not even approach their doctors, but rather attempt to make their own arrangements to rid themselves of an unwanted pregnancy. (Note: the above is based on the responses of the 104 doctors only.)

Furthermore, in answer to the question:

- In the last three years, how many women whose pregnancies you have confirmed, have ceased to be pregnant, due, you suspect, to self-induced or procured abortion?

Eighty-two medical practitioners offered estimates which together totalled 1 825 over the three year period, averaging 608 per year. This seems to indicate that at least about half the women who had desired to terminate their pregnancies, had in fact done so, despite the risks and costs involved. The percentage might even have been higher if all the 104 doctors who offered estimates to the initial question, had replied to the latter one as well. This trend is similar to assessments for the United States, where it is claimed that two-thirds of the abortions performed legally since the liberalization of the legislation, would have been done anyway if the law had not been changed. (Pilpel, *et.al.*, 1975.)

Unfortunately the doctors did not answer the question regarding the proportion of non-spontaneous abortions due to self-inducement, inducement by medical practitioners, and inducement by others (back-street operators) very thoroughly, thus no discernible trends can even be postulated on the basis of these responses.

(B) Consequences of Self-Induced and Criminal Back-street Abortions.

What are the consequences of this widespread practice of self-induced and criminal back-street abortions, resorted to by women who are desperate to terminate an unwanted pregnancy, where such a service is not legally available?

During the period July 1958 - June 1959, 1 436 incomplete abortions were treated at Groote Schuur Hospital in Cape Town. (Strauss, 1974.) In 1970 the number was 1 820 - these cases representing 30% of all admissions to the Department of Gynaecology, which maintains a special septic abortion unit. (Sharratt, 1974, A.R.A.G 1972.) As mentioned above, King Edward VIII Hospital in Durban treats twice as many cases of septic abortions as does Groote Schuur, and Baragwanath Hospital in Soweto has two special wards at week-ends to handle incomplete abortions. Furthermore, it is estimated by informed sources that 25% of all bed space in gynaecological wards in South Africa is occupied by women suffering from the effects of self-induced, and back-street abortions. (A.R.A.G 1973.)

Although it must be pointed out that the figures quoted above include spontaneous abortions that require hospital treatment and are recorded as "abortions" in the statistics compiled by hospital authorities, a number of studies indicate that a vast majority of these recorded "abortions" are in fact, induced.

Strauss quotes a study conducted by Davies in England during which a series of 2 665 consecutive cases of recorded "abortions" was investigated and a conclusion drawn that an estimated 90% of these cases was induced. (Davies, 1950.) It is interesting to note that a similar pattern

emerges from the exploratory survey conducted in Natal. The 61 medical practitioners who responded to both the questions:

- In the last three years, what would you estimate to be the number of cases which have been referred to you, or come to you with septic abortions or other post-abortive complications?

- What proportion of the above would you surmise to be non-spontaneous?

estimated a total of 1 849 cases of post-abortive complications that they had treated over the last 3 years (i.e. an average of 616 cases came before these 61 Natal medical practitioners per year). Of these 1 849 cases, they estimated that 1 446 were due to non-spontaneous abortions (i.e. an average of 482 per year). Thus these doctors estimated that just over 78% of the cases of septic and post-abortive complications that they had treated were due to induced abortions. Also to be kept in mind in this context is the point made by one respondent that patients suffering from post-abortive complications do not necessarily go to their doctor personally, but go to the hospital. This is obviously the case with the less privileged woman who has less access to a private doctor.

(Note: Only 61 of the 117 respondents replied to both the questions. Twenty nine medical practitioners stated that they had seen no cases of post-abortive complications during the past three years; others were not prepared to offer an estimate).

It is estimated that one out of every 200 women who procure an abortion by the hands of a back-street abortionist, by means of the injection into the uterus of an irritant solution dies; one in four is rendered sterile. Other clinically unsafe methods are also used by backstreet operators. (A.R.A.G, 1973.) This estimated figure of deaths due to criminal abortion is not reflected in the official statistics released regarding the reasons for deaths in South Africa. In 1971, 29 women are recorded as having died due to illegal abortions (3 Whites, 16 Coloureds, 10 Asians; no figure given for African women). (S.A. Statistics, 1974.) The reason for this discrepancy might be that although

a woman is admitted to hospital because of complications resulting from an illegally induced abortion, many of these women develop secondary complications (e.g. pneumonia, air embolism), and thus the reason for death is recorded under the secondary complication classification. An analysis made of the records of the medico-legal laboratories of the South African Police in Johannesburg lends support to the estimated high incidence of death due to criminal abortions. During the period 1959-64, 302 deaths resulting from abortions were recorded for Johannesburg and surrounding areas alone. (Strauss, 1974.)

An obvious consequence of this high incidence of self-induced and backstreet abortions, and the attendant post-abortive complications, is the price paid in terms of finance and utilization of medical staff involved in the resuscitation of these patients. The high percentage of space occupied in gynaecological wards has previously been mentioned. Early in 1974 it was estimated that the cost of resuscitating from back-street abortion of one seriously ill Black woman was around R1 000. (A.R.A.G, 1975.)

Lastly, the woman involved might suffer a number of long-term effects after having undergone a medically unsafe abortion. Sterility often is one long-term effect, as are other forms of chronic ill-health. Many women might not be able to tolerate sexual intercourse for a lengthy period of time, often leading to strained marital and other primary relationships. Furthermore, having undergone the sordid and horrifying experience of having a back-street abortion, the woman may be subject to extreme psychological stress, and guilt feelings of having been involved in a process which policy-makers have chosen to label "criminal." Sixty-three medical practitioners in Natal, stated that they had noticed adverse psychological effects on women who had undergone backstreet operations. Thirty-eight stated that they had noticed this effect on women who had obtained legal abortions as well. (One hundred and six medical practitioners responded to the above questions.) It must be pointed out that in a society which permits abortion on very strict grounds only, the whole act of procuring an abortion acquires a meaning of being ethically unacceptable. Given this, it is obvious that even

women undergoing a legal termination of pregnancy, may well suffer from a syndrome of guilt feelings. But it is important to note that this is a socio-cultural definition of the act. When the social stigma attached to abortion begins to change, so does the experience of terminating an unwanted pregnancy become less of a tension-provoking crisis for the women concerned. This especially so when it is recognised that the act of terminating an unwanted pregnancy might in itself be considered an ethical and responsible decision.

The above data only serve to indicate that the law can drive abortion underground, but never succeeds in eliminating it. It merely ensures that abortion occurs, save for the rich and privileged groups, in the worst possible conditions, resulting in death and widespread ill-health for the women involved.

(C) Factors giving rise to the Occurrence of Unplanned and Unwanted Pregnancies.

The above discussion has made two points clear : that the incidence of abortion is high the world over, and that women wanting to terminate unwanted pregnancies will do so, no matter what risks are involved, nor what consequence may follow the termination of a pregnancy by clinically unsafe methods. The question now arises as to why so many unwanted pregnancies occur in the first place : why do women become pregnant if they do not desire the pregnancy?

According to a study of married couples conducted in 1967 in Britain by Cartwright, one-third of the pregnancies experienced by mothers in her sample were both unplanned and unwelcome, and about half of these had occurred despite the use of some form of contraception. (Cartwright, 1970.) From Cartwright's ratios, Lafitte calculated that in 1967 about 100 000 legitimate children were born as a result of definitely unwanted pregnancies, and that 50 000 out of 75 000 illegitimate births were unwanted. (Lafitte, 1973.) In 1970, a study done by the Department of Health and Social Security with a random sample of 2 500 married and 1 000 single women, indicated that about 50% of unplanned pregnancies are

also unwanted. (Bone, 1973.)

In the survey conducted in Durban and surrounding areas, the following distribution occurred in the responses of the 117 medical practitioners to the question:

- What do you estimate to be the proportion of pregnancies that you attend in your practice, that are unintentional?

TABLE III.

MEDIAN PROPORTIONS OF PREGNANCIES ADJUDGED TO BE UNINTENTIONAL AMONG DOCTORS SERVING DIFFERENT GROUPS.

	Median Proportion
Majority of Patients White (n = 75)	13%
Majority Patients Black or equal numbers (n = 42)	19%
All (n = 107)	16%

Thus these doctors did not report as high an incidence of unintentional pregnancies as the studies in Britain reflect. (The median of their estimates comes to roughly 16% of pregnancies being unintentional as against Cartwright's finding that about one-third of pregnancies to married women were unplanned.) But it is interesting to note that the median estimate among the doctors who deal primarily or exclusively with Black patients is higher than that among doctors who deal with White patients : 19% versus 13%.

(Note however, that 104 of these doctors still received an estimated average of 1 216 requests for termination of pregnancies per year over the last three years - see section (A) above.)

Why do unplanned pregnancies occur? A comprehensive analysis of reasons for unintentional pregnancies would require a whole report in itself. What is offered below is only a brief account of what are perhaps the most important factors involved.

(1) Lack of Effective Use and Implementation of Methods of Birth Control.

The lack of effective use and implementation of contraceptive measures can be attributed to a number of factors:

- A national family planning scheme which does not reach all members of the population : thus many lack knowledge of contraceptive measures. The situation is worsened if no organized sex education takes place (e.g. in the schools).

- If the distribution of, and easy access to contraceptives is not well organized (e.g. if free contraceptives are only available at clinics that operate at inconvenient times).

- Personal factors (e.g. refusal to use contraceptives for various reasons, careless contraceptive use etc.)

A recent in-depth study of women referred by their general practitioner to the Outpatient Department at King's College Hospital in London for abortions, established that out of a consecutive series of 360 women (144 married, 179 single, 37 widowed, separated or divorced), 212 (i.e. 59%) admitted that they were not using a contraceptive at the time of conception. Of these 37% had never used any form of contraception (33% of the sample had little or no knowledge of contraception - mainly the single women under 19 and women from the less privileged classes), while 63% had used some method in the past. Only 30 of the 360 were using reliable methods - the pill and intrauterine devices. (Beard, *et.al.*, 1974.)

The reasons why women do not use contraception, or do not use it consistently, are numerous. A report by the British Pregnancy Advisory Services includes such reasons as : ignorance of methods amongst young

women (most of whom become pregnant due to unplanned intercourse), intermittent intercourse, powerful inhibitions against using contraception (religious, romantic and idealistic set of sexual morals, and extreme reservations regarding the direct or indirect health effects of some methods of contraception), psychological reasons. (Lafitte, 1973.) The report of the Department of Health and Social Services indicates that ineffective (e.g. rhythm method) and careless contraceptive use is just as great a cause of unwanted pregnancies as failure to adopt contraception. (Bone, 1973.)

If this then constitutes the pattern of contraceptive use in Britain, what is the situation in South Africa?

The 1974 South African Yearbook reports that there has been a significant decline in the White birth-rate since the beginning of the Twentieth Century, indicating that many Whites are now practising contraception (this does not mean that all the methods being practised are equally effective). The decline in the birth-rates of Coloureds and Asians is only a recent phenomenon. According to estimates, the birth-rate of the African population is 43 per thousand - this has remained constant for a long time; thus indicating that birth control is not widely spread amongst this group. (S.A. Yearbook, 1974.)

TABLE IV.

BIRTH RATE PER THOUSAND FOR RACIAL GROUPS IN SOUTH AFRICA.

Group	Birth rate per thousand			
	1910	1930	1950	1970
Whites	32,5	26,4	25,1	23,5
Coloureds			46,9	36,2
Asians			37,9	32,7
Africans				43

adapted from 1974 South African Yearbook, p.71.

Although there seems to be a variation in the practice of birth control by racial group in South Africa, attendance at family planning clinics does seem to be increasing. For example, the Durban City Health Department claims that in 1970, 250 Coloured, 922 African, and 249 Indian women attended their clinics. (M.O.H., 1970.) From the period 1970-71, attendance at the Transvaal Family Planning Clinics increased from 56 754 to 69 632 for African women. (S.A.I.R.R., 1972.) But attendance at clinics does not necessarily mean that effective birth control measures are regularly practised by these women. Furthermore, only a small percentage of Black women are being reached by these clinics. For example, in 1970 there were 85 399 Asian women living in the magisterial area of Durban. (Population Census, 1970. Report No. 02-05-10.) If one estimates that just under half of these women are of child-bearing age, then only 249 out of about 42 000 of these women attended the family planning clinics in that year. Similarly, of the 22 112 Coloured women in Durban in 1970, only 250 of an estimated 11 000 women of child-bearing age attended clinic. No figures are available for African women residing in the urban townships, but there is no doubt that the percentage attending clinics is also very small.

Data from the Natal survey tend to support the above. In response to the question:

- To what cause would you attribute most unplanned pregnancies in your practice? (in order of incidence - 1, 2, 3?)
  Contraceptive ignorance,
  careless contraceptive use,
  contraceptive failure,
  other,

the following distribution was reflected in the responses.

TABLE V.

RELATIONSHIP BETWEEN REASONS GIVEN BY MEDICAL PRACTITIONER FOR UNPLANNED PREGNANCIES BY GROUP SERVED.

Group treated in practice	Most frequent reason for Unplanned Pregnancies				
	Contraceptive Ignorance	Careless Contraceptive use	Contraceptive Failure	Other	
Majority of patients White (n = 73)	22%	54%	5%	19%	100%
Majority of patients Black (n = 38)	63%	19%	5%	13%	100%
Equal number Black and White patients (n = 4)	75%	25%			100%

The reasons given under the category "Other" included the following:

- all 3 above are important	:	2
- both contraceptive ignorance and carelessness	:	5
- both carelessness and failure	:	2
- for Whites - careless use, for Blacks - ignorance	:	1
- unplanned intercourse	:	2
- due to 'taking a chance'	:	4
- unconscious motivation	:	1
- no pregnancy unwanted	:	1
- due to ease of obtaining an abortion	:	1
		19

The pattern that emerges from the above diagram indicates that the most frequent reason leading to an unwanted pregnancy amongst the White

group, is careless contraceptive use (52% of medical practitioners dealing primarily with White patients indicated this as constituting the main cause, as against 18% of those dealing primarily with Black patients). In the case of the Black women, ±63% of their doctors indicate that unplanned pregnancies are due most frequently to contraceptive ignorance. Notice that only 6 doctors gave contraceptive failure as the main cause of unplanned pregnancies.

Thus the trend regarding contraceptive practice indicated from the Natal study is similar to that reported by the British study mentioned earlier - that in the privileged group in South Africa unintentional pregnancies are due in the main to careless contraceptive use; in the unprivileged group to ignorance of birth control methods. This illustrates the necessity to introduce a more widely distributed and organized campaign for family planning in South Africa. The service of providing family planning guidance and free distribution of contraceptives must be made equally accessible for all persons requiring such a service. Clinics must be conveniently situated, and must operate at times when the working women, for instance, can attend them regularly. Furthermore, more research must be done into novel ways of motivating persons to practice family planning. For in order to ensure that abortion is used as a measure of last resort, it is imperative that reliable contraceptive techniques are understood by, available to, and actually used by all who are sexually active and fertile.

(2) The Permissive Society.

Many would argue that one of the most important factors influencing the high incidence of unplanned and unwanted pregnancies, especially amongst unmarried women are the rapidly changing sexual mores giving rise to more promiscuous sexual relations. On the basis of this, many then see fit to pass judgement on the women who fall pregnant under these circumstances, maintaining that such women should not be assisted in the plight, as an unwanted pregnancy is a result of their own immoral behaviour, and they should be "taught a lesson" by being forced to bear the consequences. Abortion in these cases should not be allowed. Let us look at the above argument in

some detail by posing a number of questions:

- Are the young single women who fall pregnant necessarily sexually promiscuous in their behaviour?

- Why is it that in a so-called 'permissive' society many young people are naive about sexual matters?

- Why have more permissive sexual mores developed in contemporary society?

As regards the first question, research in Britain indicates that not only is sexual promiscuity not the norm as is popularly believed, but that many young single women who find themselves pregnant are either sexually inexperienced and/or sexually naive. From statistics on pregnancies and abortions in England and Wales in 1971, Lafitte shows that in the case of 15 year old girls only 1½% became pregnant at all; over 98 in every 100 did not. In the next age group, 16 to 19, 7½ to 8½% became pregnant, but this figure includes girls of this age who are already married. Lafitte concludes that "....this does not support the view that there is a great deal of 'promiscuous' behaviour among our older teenagers". (Lafitte, 1973.) Further, the Political and Economic Planning Survey reports that, "it is popularly supposed that young unmarried women have been seeking abortions mainly as a direct result of an increase in promiscuity and immorality combined with a crude, cynical hedonistic attitude to sex. Our findings point to a directly contrary conclusion; that in fact it is the result of sexual inexperience, ignorance, an idealistic set of sexual morals and a romantic vision of sex and human relationships... The unmarried women in our abortion sample were generally sexually inexperienced. Sexual intercourse was a very infrequent occurrence. It was something that our youngest respondents had typically experienced only once or twice. Not only were they not 'promiscuous', in the sense that they did not sleep around, but moreover they did not have regular sexual activity even with one man. The sexual act giving rise to the pregnancy was usually unexpected, and certainly on their part unplanned...." (Williams and Hindell, 1972).

In South Africa there has been no comparable research into the reasons for the many illegitimate pregnancies that occur amongst all groups of women in our country, but it seems reasonable to propose that a high percentage of these are also due to sexual inexperience, and ignorance regarding sexual matters. Certainly a number of the Natal doctors responding to the questionnaire survey mentioned that many of the cases of unwanted pregnancies that they had to deal with occurred due to the sexual inexperience and ignorance of the young women involved. The high incidence of contraceptive ignorance amongst less privileged communities is another factor involved here; this has been discussed above. Whereas the young single girl or woman in Britain who finds herself pregnant with an unplanned and unwanted child can obtain a legal abortion, her counterpart in South Africa has no such option. She is forced either to procure an illegal abortion, or to give birth to the child. The incidence of illegitimate births in South Africa for 1971 is tabled below:

TABLE VI.

INCIDENCE OF ILLEGITIMATE BIRTHS TO WHITE, COLOURED AND ASIAN WOMEN IN SOUTH AFRICA, 1971.

Group	Total illegitimate births	Births to girls under 19	% of total births to teenage mothers (15-19)	Births to women to age 25	% of total births to women up to age 25
White	2634	955	36,0	2082	±79,0
Coloured	32220	8258	25,3	22774	±70,0
Asian	1928	359	18,5	1132	±58,0

from Report on Births : 1964 to 1971. Report No. 07-01-01, Government Printers, Pretoria, 1971. (No figures for African women available.)

Thus especially amongst White and Coloured women, it is the group of women 25 years and under who give birth to the largest percentage of illegitimate children. Another factor that might influence the illegitimacy

rate, is the high incidence of divorce cases in South Africa. For example, in 1972 there were 8 432 divorce cases amongst the White group; the median age of the women at the time of divorce was 33,0 (S.A. Statistics, 1974). This means that there are many sexually mature divorced women around who are thus especially vulnerable to casual sexual encounters.

If indeed many of the illegitimate pregnancies of young single women in South Africa are due to the same reasons as in Britain (i.e. sexual ignorance, inexperience, and a romantic set of sexual morals which militates against the use of contraception), then one must pose the question as to why such a large number of young girls and women remain ignorant in sexual matters in a contemporary society which is considered to be 'permissive'.

One of the most important factors at play here seems to be the contradiction in normative attitudes towards sex. On the one hand big business and advertising are permitted to exploit and manipulate sexual stereotypes of male and female, and sexual situations in order to seduce the public into buying their products. This blatant cold-blooded use of sex is evident on billboards, in magazines, and in the cinema and is seemingly tolerated. On the other hand, the individual is still expected to act in terms of the sexual mores which dictate self-control of sexual impulses, purity, fidelity and so on; the daily bombardment of sexual titillation notwithstanding.

In the case of children and young adults, the situation is even more complex due to the way in which the topic of sex is suppressed in many homes, and in the educational situation. Thus whereas they are presented daily with the mystery and the challenge of sex, little is actually done to educate them responsibly into this area of life's experiences. To many it remains a mystery until they discover the details involved too late; others learn about sex through the distorted guesswork of school friends. Some are lucky enough to have the sexual experience explained to them by caring adults. There is no doubt that the sexual mores are in a process of change, and there are many reasons why this process cannot be contained, nor is it necessarily such a disaster as some might argue. The point is simply that in a rapidly changing social situation, society must take on the task of

reacting as responsibly as possible to the changes. In this context it is imperative to release the topic of sex from its "unspoken about" shameful status, and to treat it as one of the natural ways in which two people can communicate meaningfully with each other. Furthermore, given the changing sexual norms, children must be introduced into organized and well-researched sex education programmes in the school situation. It is only through organized sex education amongst all sectors of society that people will learn to adopt a responsible attitude to sexual relations as one can only be expected to act responsibly in a situation of which one has knowledge and understanding. Such a programme will also eventually assist in decreasing the unintended but obvious repercussions of sexual and contraceptive ignorance.

Obviously a number of social forces have come into play to effect the movement towards a more 'permissive' set of sexual mores and norms in contemporary society. One of the most pertinent factors in this regard is the changing role of women in society, which has its roots in objective social conditions. With economic growth, the demand for the entrance of women into the labour market increases. This is especially the case when the tertiary and service sectors are extended (secretaries, social workers, and so on are needed, and these are considered "woman's work") but demand for their labour increases in other spheres of the commercial-industrial sphere as well. Given this, and the increase in the cost of living, a growing number of women are entering the workforce. In South Africa, although not yet as industrially advanced as some other western countries, the number of White working women has increased by 12% in three years. In 1975, 34,2% of White women were participating in the labour market. Seventy-seven per cent of these women were full-time workers, while only 23% were part-timers. Furthermore, the female labour force includes both single and married women. (All Media Products Survey, 1975.)

This participation of women in the labour market brings with it a number of consequences. Firstly, women find themselves occupying two roles in society that sometimes have contradictory expectations attached to them. They are participants in the labour market which demands certain responsibilities, and they are wives, mothers and domestic workers in the home

which brings with it another set of responsibilities. Thus women are agitating for an equal share of responsibilities between the sexes in the sphere of work and in the sphere of the home. Secondly, with the movement of women into the labour market comes the possbility of women gaining financial independence. This new independence promises the prospect of independence and equality in other spheres of life as well. Thus women are demanding a more active and equal role with men in the economic, political and social sphere. This changing woman's role must also have consequences for the type of sexual relationships entered into by men and women. Woman's new-found independence puts her on a more equal par with men because she need no longer be completely dependent on a man for her livelihood. The woman if she so desires can thus be liberated from the conditions which tied her sexually to one man, and can enjoy the same sexual freedom which has traditionally been the male's privilege. Obviously with both males and females now in a position to decide how they wish to conduct their personal sexual relationships, the traditional sexual mores based on stereotypical expectations of male and female behaviour are being challenged, and alternative definitions of the situation are emerging. Given this then, it is meaningless to attempt to turn back the clock. The more responsible path seems to be to deal rationally with the changes taking place, and especially to educate the new generation into an understanding of these social changes.

(3) Other Social Factors Influencing the Incidence of Unplanned and Unwanted Pregnancies in South Africa.

South Africa is a society where social inequality pervades all areas of social and economic life. It is a society in which the material benefit of the privileged few is enjoyed at the cost of socio-economic hardship for the majority. The South African economy is dependent on the availability of a large supply of cheap labour. This labour force is largely supplied to the urban industrial sector by the system of migrant labour. It is this system of migrant labour, and the social anomalies regarding conventional family life that come in its wake, that plays an important role in the incidence of unplanned and unwanted pregnancies amongst the group of people in South Africa who are directly affected by it.

That the system of migrant labour disrupts conventional family life is a commonplace. What we are interested in here is how the operation of the system plays a role in the incidence of unwanted pregnancies, and also the high birth rate amongst the Africans in both urban and rural areas in South Africa.

Firstly, as the majority of migrant workers are men who leave their families, wives, and children in the rural areas, there are many more men residing in the urban Black townships than there are women. This unnatural sex ratio must affect the relationship between these 'single' migrant workers and single women in these areas. The result is often blatant exploitation of these women. Many male migrants find themselves 'girl friends' in the urban areas. Often is the case that these women fall pregnant, give birth and then find that the man involved is not interested in assisting them to support the child. Others are forced to give birth to the child because there seems to be no way of terminating the unwanted pregnancy. These babies might be abandoned by their mothers in some or other place where hopefully somebody will find them and care for them. Or the baby is 'dumped' in the boy friend's room, and woman 'gets lost' - 'he gives me babies but no money'. (Thomas, 1973.) But the sexism of the men in the townships must be understood in terms of the social factors influencing these attitudes. The migrant worker has to deal with two different socio-cultural definitions of the male-female relationship : the traditional definition of an association which is defined partly in terms of economic and lineage norms, and the western concept of an association based more exclusively on sexual norms and love. If he has left his wife in the rural areas, he is also lonely. Furthermore, all the men in the township are emasculated under a system of White domination; thus there is need to prove their manhood on the one hand, and to release frustrations emanating from their position of subservience on the other. Both these needs are satisfied by the way in which they relate to women, extreme frustration often taking the form of sexual assault. Sexual exploitation is reportedly rife in many high schools, many of the girls having to leave school because they are pregnant.

Secondly, the woman migrant worker is also in the urban areas for economic reasons. Amongst these migrants are women who are the sole supporters of their children and old parents in the reserves, as well as young girls trying to escape the poverty of the reserves. If these women fall pregnant with an unwanted child, and cannot procure an abortion, the baby is sent back to the rural areas for grandmother to tend. In some cases, chiefs of rural areas have appealed to the State authorities to extend family planning programmes and clinics, so as to counter the high rate of illegitimate births occurring in the townships. The rural areas, just cannot support the increasing number of babies being sent home by their mothers for other members of the family to tend while they work in the urban areas.

With few exceptions, most women in the townships' migrants and residents are workers; few stay at home as housewives. These women work out of dire economic necessity. Many are the sole breadwinners of their family. To these women an unwanted and unplanned pregnancy means more than inconvenience. It poses a threat to their families' socio-economic existence as it might well mean the loss of their jobs. For example, in a recent Industrial Council agreement for the Textile Industry, no allowance is made for maternal leave for the mother who must leave work to have her child. (Westmore and Townsend, 1975.) Furthermore, because there is a ready supply of labour, the woman worker often fears that she will indeed lose her job if she goes off to have her child, as management might decide to replace her, not wanting a slowdown of work. Thus an unwanted pregnancy puts these women in a real dilemma - does she continue with the pregnancy and risk her job, or does she try to procure a criminal abortion from a backstreet operator, and risk her life?

Thirdly, the women left behind in the reserves live sexually and emotionally deprived lives when their men are in the towns working. They too are lonely and in need of male company; thus another group of illegitimate children are brought into the world, increasing the population in an already poverty stricken and malnourished area. Furthermore, although the majority of these women remain faithful to their husbands, the birth rate of legitimate children remains high. A rural mother needs extra children to provide the services a resident father would otherwise provide. She also

desires many children as a tie which will draw her husband back to her. The main reason for a high birth rate among these communities, and among other less privileged groups in South Africa stems from the lack of social security benefits afforded them. Children are seen as promising social security - someone to care for them in their old age. Especially in the poverty stricken rural areas where the infant and child mortality rate is high because of depressed social conditions and malnutrition, birth is given to many children in the hope that a few will survive to care for the parents.

It is difficult to visualize how family planning programmes motivated on the basis of more material prosperity (e.g. one can afford a bigger car if one has a smaller family) can hope to have much success, when the communities that one is appealing to either do not enjoy either permanency of residence (e.g. lack of ownership of land in urban townships), or future security in terms of social security benefits (which applies both in the urban and rural situations). Furthermore, as was pointed out at the Africa Regional Conference of the I.P.P.F in Accra, a successful family planning scheme is dependent upon the promise of socio-economic advancement of the community to which one is appealing. In the South African context, it seems highly unlikely that such a programme will even be effective amongst communities who are denied an equal and responsible share in the future.

(4) Psychological Factors.

There are obviously psychological factors involved in the incidence of unplanned and unwanted pregnancies to individual women. Many kinds of unconscious factors might play a role in the lives of individuals which motivate them to become pregnant, although they maintain that they did not desire this. These factors will not be discussed here, but attention just brought to the fact that in some individual cases, they constitute important reasons for so-called "unplanned" pregnancies.

(D) Some Consequences of Unwanted Pregnancies.

These will not be discussed in any depth here, but just mentioned:

- Desperate women resort to any means in order to procure the termination of a pregnancy that is unwanted.

- If an abortion cannot be obtained, some women are known to commit suicide.

- If the child is born, he/she might/or might not be eventually loved by his/her parent(s) : there are about 45 000 children in institutions in South Africa : one White child in 100 is in a children's home. (A.R.A.G., 1973.)

- Studies indicate that unwanted children are more likely to evince behavioural disorders than wanted children. (Forssman and Thuwe, 1966.)

- The child might be born into poverty : with his/her birth might come more severe poverty for the whole family as there is an extra mouth to feed.

- The mother herself might suffer psychologically due to bearing an unwanted child : this might cause a strain on married life, and could lead to a broken marriage.

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CHAPTER 3.

ATTITUDES OF NATAL MEDICAL PRACTITIONERS TOWARDS THE NEW ABORTION LEGISLATION.

(1) INTRODUCTION.

In the former chapter, the question of abortion in the South African context was discussed in some detail, and some of the consequences of permitting legal abortions only on restrictive conditional grounds were examined. The Abortion and Sterilization Act (1975) has now been in operation for over a year. This chapter presents the results obtained from the study referred to earlier, which was conducted between October 1975 - April 1976. The investigation covered the attitudes of medical practitioners in Natal towards the new legislation and elicited various estimates and judgements on the problem of unwanted pregnancies.

(2) RESEARCH APPROACH.

(A) Population and Sample.

A random sample was drawn from a list of doctors practising privately in Durban and surrounding Natal areas, compiled from the membership lists of the Natal Medical Association (Coastal), and the Natal Medical Association (Inland). In order to obtain a more comprehensive list of the population to be studied, the assistance of 5 representatives of medical suppliers was sought to provide a further list of medical practitioners not appearing on the former lists. A random sample of 200 doctors was drawn from a final list of 700. The sample consisted of:

TABLE VII.

DISTRIBUTION OF THE CATEGORIES OF MEDICAL PRACTITIONERS IN THE POPULATION AND THE SAMPLE.

Category	Population	Sample
Psychiatrists	6	6
Gynaecologists	35	35
General Practitioners	659	159
TOTAL	700	200

Of the 200 medical practitioners approached during the study, 117 responded to the postal questionnaire which was sent to them. These responses consisted of:

TABLE VIII.

DISTRIBUTION OF THE CATEGORIES OF MEDICAL PRACTITIONERS IN THE SAMPLE AND RESPONDENT SAMPLE.

Category	Sample	Responses
Psychiatrists	6	3
Gynaecologists	35	24
General Practitioners	159	90
TOTAL	200	117

The sampling loss of 83 (117 out of 200) is, however, misleading. Of this non-response figure of 83, a substantial proportion was not of such a nature to constitute a bias in the results. An indication of this is obtained from the responses to a follow-up telephone enquiry, discussed presently and in the Appendix, pp.3-4. The telephone follow-up revealed that at least 22 of the non-responders were sample cases which could be

regarded as non-applicable or outside of the defined universe : 6 were out of practice or deceased, 7 were on leave, and 9 did not deal with maternity cases at all. Hence we may subtract at least 22 from the total sample of 200, giving a "true" sample size of 178. In relation to this figure the non-response rate which could constitute a bias falls to 34% (66% response rate). However, we should also remember that among the doctors who could not be contacted by telephone a proportion would also have been outside of the universe as described above. Therefore, the response rate can probably be regarded as somewhat higher than the figure of 66% suggests.

The figures given in the block above do reveal an over-representation of gynaecologists in the response group. However, the direction of this bias is by no means clear. Gynaecologists may be approached by women desiring termination of pregnancy more frequently because of their speciality or they may be approached less frequently than other doctors because of their prominence in the community. The position is unknown.

(B) Brief Description of Characteristics of Respondents.

Of the 117 medical practitioners responding to the questionnaire:

- 3 were psychiatrists, 24 gynaecologists, 90 general practitioners.
- 15 had spent under 5 years in their practice.
  31 had spent between 5 - 10 years in their practice.
  70 had spent over 10 years in their practice.
  (1 did not respond to this question.)
- 75 treated mainly White patients in their practice (i.e. 70% - 100% White patients).
  38 treated mainly Black patients in their practice (i.e. 70% - 100% Black patients).
  4 had about equal contact with Black and White patients.

(C) Research Method.

The research was carried out in a number of stages:

- the population was compiled, and the sample drawn, from a table of random numbers,

- a short postal questionnaire was sent to all the doctors in the sample. This included a covering letter, and self-addressed envelope in which the replies could be returned. The questionnaire was anonymous. Two weeks later the same questionnaire was sent out to the doctors again as a reminder,

- in an attempt to increase the response rate, a third batch of questionnaires was sent to all the doctors, including a form which they could return stating whether they had responded to the previous questionnaire or not,

- brief telephone interviews were conducted with those doctors in the sample who had not indicated whether they had responded or not. They were asked whether they had indeed responded to the questionnaire, and, where possible, their reasons for not doing so, if they had not responded.

The telephone check-up revealed the following:

TABLE IX.

SUMMARY OF THE RESULTS OF THE TELEPHONE CHECK-UP INTERVIEWS.

Category	Not responded: no reason given	Not responded: reason given	Definitely responded	Total
Psychiatrists	2	1	3	6
Gynaecologists	3	8	24	35
General Practitioners	40	29	90	159
TOTAL	45	38	117	200

Therefore just under one-quarter of the sample was not contacted regarding why they had not responded to the questionnaire.

- finally, the data were analysed, and the report written.

(Note: A more detailed discussion of the research method appears in the Appendix.)

(3) RESULTS OF THE STUDY.

The responses of the psychiatrists, gynaecologists, and general practitioners will be discussed separately.

(A) Attitudes of Psychiatrists to the new Abortion Legislation.

Of the 6 psychiatrists in the sample, 3 responded to the questionnaire (i.e. 50% response rate). The 3 that did not respond were contacted by telephone. One had not responded to the questionnaire, but was in favour of liberalized abortion. The other 2 psychiatrists expressed interest in completing the questionnaire schedule, but no reply was received from them. The 3 psychiatrists who did respond all dealt primarily with White patients, 2 having practised for over 10 years and one for between 5 and 10 years.

All 3 respondents were in favour of more liberalized abortion than is permitted in terms of the present legislation. As regards the modifications that they would like to see introduced into abortion legislation, their suggestions included:

- Far more responsibility to be given to the specialists in their fields to use their clinical knowledge and experience WITHOUT filling in delaying forms, and submitting requests to a State authority.

- The decision to be left to a medical practitioner in consultation with the mother and, where applicable, husband. Where there is evidence that the woman requesting an abortion is suffering from mental disorder, or illness, a psychiatrist must be consulted.

- An improvement of the grounds for termination, but not extended to include social factors, nor to include cases where there is a mild reactive depression to an unwanted pregnancy. Abortion must not be used as a method of contraception.

What emerges from these comments by the psychiatrists is the following:

- A dissatisfaction with the delay of obtaining an abortion legally due to the bureaucratic red tape involved in the procedure - the longer the delay, the more advanced the pregnancy, the more complicated, unpleasant and dangerous the operation for terminating the pregnancy becomes. (See Diagram I, p.7.)

- A dissatisfaction with the involvement of State authorities in the procedure for obtaining a legal abortion.

- The need for broader and/or more well-defined indications for the legal termination of pregnancies. (Compare Feldman's comments regarding what constitutes a "permanent threat to mental health", p.11.)

Thus of the 6 psychiatrists in the sample, 3 respondents and 1 non-respondent are in favour of more liberalized abortion legislation in South Africa (i.e. 66,7% of the sample).

(B) Attitudes of Gynaecologists to the new Abortion Legislation.

Twenty four of the 35 gynaecologists included in the sample responded to the postal questionnaire which was sent to them (i.e. 68,9% response rate). Of the 11 non-respondents:

- 3 did not give any reason why they had not responded.
  2 were not in private practice any more.
  1 had left his practice.
  1 said that the questions were too vague to answer adequately.
  1 would reply only if the questionnaire was sent through the Medical Association.
  2 did not reply, but thought existing legislation adequate.
  1 was away on leave when the schedules were sent out, but favours liberalized abortion.

  11 Total.

(Note: 2 of the gynaecologists were not in private practice, and 1 had left his practice, thus sample becomes 32.)

Of the 24 respondents, 4 had been in practice for under 5 years, 8 for between 5 and 10 years, and 12 for over 10 years. Sixteen dealt mainly with White patients, and the remaining 8 treated mainly Black patients in their practice. In reply to the question:

- Do you feel the new Act is : (a) too liberal?
  (b) just right?
  (c) not liberal enough?

seven stated that they were of the opinion that the Abortion and Sterilization Act (1975) was "just right", and 17 that it was "not liberal enough".

(1) Those who replied "just right" : Although most of these gynaecologists offered no further comments in response to the question:

- What modifications to the Act would you like implemented?

two did indicate that, although they agreed with the indications for the termination of pregnancies stipulated in the Act, they felt that the bureaucratic procedures should be modified in order to facilitate earlier

legal termination of pregnancies. Another commented that what was required was "greater responsibility in sexual relations rather than liberalized abortion laws".

It is interesting to note that,

- Six out of 7 of these gynaecologists deal primarily with White patients (i.e. 90% - 100% of their practice is White), the other reported a 95% Black practice. (Thus the majority of gynaecologists dealing with Black patients maintained that the present legislation was not liberal enough.)

- The latter respondent recorded the highest incidence of requests for termination of pregnancies amongst this group of gynaecologists (i.e. 100 over a 3 year period). Of the other 6,

- 2 reported no requests
  3 between 10 - 30
  1 was unable to state.

- The total number of cases of septic and post-abortive complications treated by these 7 gynaecologists over the last three years was 20, a surprisingly low number for a group of such specialists. Furthermore, they estimated that 6 of these cases were due to unspontaneous abortion. (Note: One of these gynaecologists reported no cases of post-abortive complaints, another said that he was unable to state an estimation.)

(2) Those who replied "not liberal enough" : The following responses were given by these 17 gynaecologists as to the modifications they would like to see introduced regarding abortion legislation:

- 6 offered no further comment than that the Act was not liberal enough
  3 came out in support for abortion on demand/request until the first trimester. (One gynaecologist expanded that thereafter abortion should only be permitted up to ±22 weeks of gestation if:

  (i) woman was obviously ignorant of or lacked access to having her pregnancy terminated on request during the the first 12 weeks of gestation,
  (ii) cases of foetal abnormality,
  (iii) cases where there would be significant risk of serious maternal disease (organic)).

  1 that control of abortions performed should lie with the Medical and Dentist Council : that abortions should be procured on the recommendation of any psychiatrist (i.e. not only State psychiatrist).

  10 Total.

The other 7 gynaecologists included more than one modification in their comments. Of these:

- 2 called for less bureaucratic control of the procedure of procuring a legal abortion
  1 stated that abortions should be performed on the recommendation of any psychiatrist, not only State employees
  2 mentioned that only one doctor's recommendation should be required
  2 stated that the indications stipulated in the Act are too narrow, especially psychiatric indication should be liberalized
  3 indications should include contraceptive failure - in married couples, and in cases where the patient has had contraceptives from a doctor, clinic, or medical officer
  2 indications should include socio-economic factors (e.g. unmarried mothers)
  2 legal abortion should be permitted to limit family size (i.e. if family is already over 3-5 members)
  1 legal abortion for menopausal women
  1 clinical rubella included as an indication.

The opinions from two of the respondents should be quoted in full:

- "Gynaecologists should be permitted to perform terminations at their own discretion taking into account the patient's background, age, marital status, socio-economic conditions, and psychological stability over and above that laid down by the new Abortion Act. Care should be taken that the situation is not abused, and that the fee for such a procedure should be minimal."

- "I would like a specialist to make an honest opinion as to whether the patient requires an abortion or not. Not abortion on demand, but a considered opinion. Some may need an abortion for many reasons, but many require an abortion for convenience. These cases should not be done - but a genuine case such as a schoolgirl, university student, unmarried mother, or a mother of say 4 children should be done."

Thus the reasons given by these gynaecologists for stating that the abortion legislation is not liberal enough vary widely - from dissatisfaction with the bureaucratic control and procedures involved in obtaining a legal abortion under the present legislation, to a call for abortion on request up to the first trimester of pregnancy. But their responses do indicate a consistent appeal that the present restrictive conditional indications for legal abortion be liberalized to include broader indications, thus alleviating much of the unhappiness caused by having either to bear and bring into the world an unwanted child, or to seek an illegal abortion. Clearly another issue of concern amongst these doctors, is the delay caused in obtaining an abortion due to the complicated bureaucratic procedure involved. The gynaecologist is especially aware of the unpleasantness and danger of performing an abortion when a pregnancy is in its later stages of development. Understandably then, 70,83% of the gynaecologists who responded indicated that they favoured more liberal modifications to the present legislation.

A summary of the results indicates:

TABLE X.

SUMMARY OF THE ATTITUDES OF NATAL GYNAECOLOGISTS TO THE ABORTION AND STERILIZATION ACT.

Category	In favour of liberalized legislation	Present legislation just right	Attitude not known	TOTAL
Respondents (n = 24)	71%	29%		100%
Non-respondents (n = 11)	9%	18%	73%	100%
TOTAL (n = 35)	51%	26%	23%	100%

Thus of the 35 gynaecologists in the sample:

- 18 are known to be in favour of liberalized legislation (i.e. 51%.)
  9 are known not to be in favour of liberalized legislation (i.e. 26%.)
  8 doctors whose attitudes to the legislation are not known (i.e. 23%.)

(Note: 1 had left practice, 2 were not in private practice, therefore population becomes 32. Then

- 56% are in favour of liberalized abortion
  28% are satisfied with present legislation
  16% where attitude is not known.)

(C) Attitudes of General Practitioners to the new Abortion Legislation.

Of the 159 general practitioners in the sample, 90 replied to the interview schedule (i.e. 56,6% response rate). The telephone check-up phase of the research revealed the following:

- 36 doctors did not respond; the reason why they did not do so is unknown
  29 doctors did not respond, but their reason for not doing so is known
  82 said that they definitely did respond
  12 were unobtainable/could not be contacted, therefore it is not known if they responded or not. (But 90 completed questionnaires were received, therefore 8 - 12 must have responded.)

  159 Total

The reasons why the 29 doctors mentioned above did not complete the schedule include:

- 6 said that the information that they could provide would not be useful as they see too few maternity cases/or have given up maternity completely.
  4 would not commit themselves on paper.
  3 were specialists (therefore included in sample by error).
  3 did not respond, but stated that they were in favour of more liberalized abortion legislation.
  5 were away on leave, or ill.
  3 were not practising any more (2 moved away, 1 had died).
  2 found questionnaire too vague.
  3 other reasons (forgot, too busy studying, only reply if sent through Medical Association).

  29 Total.

(Note: As 3 of the general practitioners are not practising any more, and 3 were actually specialists, therefore included in the sample in error, actual sample thus becomes 153.)

Eleven of the 90 respondents had been in practice under 5 years, 22 for between 5 and 10 years, and 57 had been practising for over 10 years. Furthermore, 56 treated mainly White patients, 30 mainly Black patients, and 4 had contact with about an equal number of White and Black patients. In reply to the question:

- Do you feel that the new Act is : (a) too liberal?
  (b) just right?
  (c) not liberal enough?

- 6 answered "too liberal"
  10 answered "just right"
  71 answered "not liberal enough"
  2 indicated that they had not studied the Act
  1 did not reply
  90 Total.

(1) Those who replied "too liberal" : These doctors gave evidence of the conventional anti-abortion attitude based on religious and ethical grounds. Two stated that they were against abortion on religious grounds (Christian and Islam), except in cases where the life of the mother was threatened. Three argued on the grounds of ethical and moral considerations (e.g. murder, encourages promiscuity). One maintained that we should revert back to the same indications that held under the common law, except that rape should be included as an indication.

(2) Those who replied "just right" : Of these 10 respondents, only one added a further comment in his reply, namely that he supports the present legislation as "it safeguards against abortion on demand".

(3) Those who replied "not liberal enough" : The vast majority of the replies fell into this category of response (71 out of 90).

- 19 offered no further comment then that the Act should be liberalized.
  1 was not sure of what modifications should be introduced : "this is a difficult issue".
  3 maintained that the Act required rephrasing (one stated "in its entirety").
  36 called for the introduction of abortion on request.
  12 mentioned other modifications not as liberal as abortion on request.
  71 Total.

The comments of the 36 general practitioners advocating abortion on request are interesting, and thus are presented in some detail below:

- 8 just stated "abortion on request/demand" (some stipulating that this must take place within the first trimester).
  3 suggested that South Africa should follow the British enactments.

More specific opinions regarding abortion on request included:

- 9 stressed that the woman has a right to decide if, when and by whom she wanted to be pregnant. Of these, 7 stressed that the choice to terminate a pregnancy lay primarily with the woman, while 2 mentioned the need for the decision to be based on consultations with her doctor, although the decision was ultimately the woman's.
  9 specified in detail the nature of the professional advice that they considered necessary before an abortion on request was performed. These recommendations varied from the opinion that abortion was a matter between the woman and her doctor (6 responses), to the suggestion that abortion be performed on the recommendation of two doctors (3 responses). The need to keep records of abortions performed, and for fees to be controlled and scaled in terms of the woman's motivating need and financial situation was stressed.
  3 stipulated where abortions on request should be performed - one suggested in provincial hospitals only, one in medically controlled clinics, and one recommended the use of both institutions.
  2 stressed the need for abortion on request, especially in the interests of Black women.
  1 abortion on demand - but consent of parents required if the girl is under 18.
  1 abortion on request for one pregnancy only - if a woman desires another termination, then this must only be performed under the indications included in the Abortion and Sterilization Act (1975).

A further 12 general practitioners called for more liberal legislation, but not abortion on request:

- 5 stated that legal abortion should be available on much broader medical, psychological, socio-economic grounds (e.g. unmarried mothers), and in cases of contraceptive failure.
  2 maintained that each case should be considered on its own merits, in consultation with a team of social worker/marriage counsellor, family doctor, and perhaps psychologist/psychiatrist.
  1 abortion must be made more freely available in order to reduce the incidence of backstreet abortions. Furthermore, the pill must be available free of charge at all chemists and doctors, and not just at family planning clinics which are sporadically situated, and operate at inconvenient hours.
  1 pointed out that abortion must not be used as a form of contraception - but indications must be liberalized, and irksome bureaucracy done away with.
  2 stated that abortion should be available if recommended by the family doctor and another senior medical practitioner, and/or gynaecologist.
  1 suggested that the number of doctors involved in the procedure of obtaining a legal abortion be reduced to two in order to maintain some privacy in the matter. Also the inclusion of clinical rubella as an indication.

As in the case of the gynaecologists, the reasons why this group of general practitioners feels that the present abortion legislation is not liberal enough vary widely indeed : from the desire to see the bureaucratic procedure involved in legal pregnancy termination modified, to the recommendation that abortion on request within the first trimester be introduced in South Africa. The majority of the responses though do indicate that these general practitioners are well aware of the high incidence of unwanted pregnancies, and illegal abortions occurring in our country. General practitioners, in their role as the family doctor, are perhaps more aware of the numerous repercussions that the birth of an unwanted child, or the tensions and problems caused by the mother's experience of an illegal abortion has for the whole family than are gynaecologists, because the latter usually deal only with the woman. This concern is reflected in the fact that over half of those doctors calling for more liberal legislation (i.e. 50,7%) are prepared to recommend

abortion on request. All in all, 78,9% of the general practitioners who completed the schedule favoured more liberal legislation.

(4) SUMMARY OF ATTITUDES OF ALL THE MEDICAL PRACTITIONERS TO THE NEW LEGISLATION.

The 117 responses from a sample of 200 included:

Those answering "too liberal":

no psychiatrists
no gynaecologists
6 - 90 general practitioners
6 - 117 who responded

therefore, 5% of the medical practitioners who responded thought the legislation too liberal.

Those answering "just right":

no psychiatrists
7 - 24 gynaecologists
10 - 90 general practitioners
17 - 117 who responded

therefore, 15% of the medical practitioners who responded were satisfied with the legislation.

Those answering "not liberal enough":

3 - 3 psychiatrists
17 - 24 gynaecologists
71 - 90 general practitioners
91 - 117 who responded

therefore, 78% of the medical practitioners who responded called for more liberal abortion legislation in South Africa.

(Note: 3 of the respondents did not supply responses to this question on attitude to new legislation; hence the percentages above do not sum to 100%.)

CHAPTER 4.

CONCLUSION AND COMMENT.

The above investigation into and discussion of abortion in the South African context leads to three broad conclusions:

- that the new Abortion legislation introduced in 1975 is not operating effectively in terms of its own stipulated aim - legal ambiguities are not totally removed by the new clauses of the Act.

- that the legal position notwithstanding, abortion is a widespread fact of life in South Africa. To quote the words of one Natal gynaecologist: " ... the undeniable fact remains that any South African woman finding herself unwillingly pregnant, can, if she so chooses, obtain the services of an abortionist with the greatest of ease. In short, abortion on demand already exists in this country!" (Walker, 1974). It would seem that the new legislation is having little effect on the incidence of illegal and criminal abortion in South Africa.

- that the majority of medical practitioners interviewed in the study expressed the opinion that they were not satisfied with the Abortion and Sterilization Act: 78% called for more liberal abortion legislation. Thus it seems that many professionals who are directly involved with the abortion issue are dissatisfied with the present situation.

In addition to the inefficacy of the legislation, and the dissatisfaction that it has caused in many circles, there would seem to be a number of powerful social pressures operative in contemporary society that will necessitate a change in the present attitude towards the abortion issue in the years to come.

The most obvious force for change is the alarming increase in

population growth rate. It has been estimated that by the year 2000, there will be over 50 million people living in South Africa. This will mean that there will only be an estimated 0,32 hectare per person, which is less than the 0,4 hectare which one author considers necessary to provide a person with sufficient food. (Verbeek, 1974.) Whether this is true or not, the consequences of a high population growth rate are alarming. Urgent action needs to be taken, and the following considerations are relevant.

Leaving evaluative considerations aside for the moment, methods of birth control can be assessed in terms of two factors: effectiveness and cost. Given these variables, contraceptive devices are usually regarded as the most effective and least costly method of birth control. Inter-uterine devices and condoms are effective and low in cost, whereas oral contraceptive pills are more costly, but more highly effective than the former.

In order for this method of birth control to be really effective, the national family planning scheme in South Africa requires re-evaluation. It is important to conduct research into and experiment with innovative strategies for motivating different communities in South Africa to practise contraception: not all communities will be responsive to a single programme of birth control. Furthermore, contraceptives must be made freely available to all communities in our country. They should be much more freely accessible - often clinics are inconveniently situated, and operate at times which are inconvenient for the working woman. But the point still remains, that even well organized and well motivated family planning programmes will not meet with the required success amongst communities which do not enjoy any social and economic security. If communities are not accorded the right of responsible participation in social and political affairs, it is unreasonable to expect them to comply with programmes in whose development they have had little or no decision-making role. Furthermore, it has been consistently the case that with an increase in economic standard of living, family size has decreased.

Another important component of a comprehensive family planning programme would be the introduction of sex education at schools. Many unplanned pregnancies and illegitimate births occur to young girls who are partially or wholly ignorant regarding sex, never mind methods of preventing pregnancies. It would seem extremely important to introduce scholars at a reasonably early age to the biology of sex, contraception, family planning and marriage guidance. Although sex is now generally being spoken about more openly, in many family circles the subject of sex is still taboo. Many parents, for a variety of reasons, either provide their children with only the minimal essentials of sex education, or with no sex education at all. Thus it seems imperative that a programme of sex education in schools be introduced on a national level in order to eradicate widespread ignorance of this important aspect of human life and interaction. The argument that young unmarried girls who fall pregnant should go through with an unwanted pregnancy as a form of "punishment" for their promiscuous behaviour is a fallacious one if one bears in mind that so many of these girls find themselves pregnant due to sexual ignorance and naivety. If members of the ruling establishment are indeed serious in their concern regarding the issue of birth control, then they must substantiate their statements with evidence by introducing policies that will actively work towards this goal. I suggest that sex education in all schools is one positive measure that must be introduced.

An effective birth control programme which relies completely on the prevention of unwanted and unplanned pregnancies is the ideal towards which we should all be working. But whether such an idealistic programme will ever be achieved on a practical level is another question. No form of contraception to date is 100% effective; as human beings we are all fallible, and as the position stands at the moment, ignorance regarding birth control measures is rife. A programme to combat this ignorance will require massive organization and skill, and many years of implementation before it reaches a viable standard of effectiveness. During this period a large number of unplanned and unwanted pregnancies will still occur. Thus it seems that abortion must of necessity be

included in a comprehensive birth control programme that is to meet its aims, viz. minimising and rationalising the population growth rate.

One common argument usually suggested for excluding abortion from a birth control programme is its high cost. With the introduction of modern medical techniques of terminating an early pregnancy, this argument has been outdated. Such techniques as menstrual regulation are safe, quick and not costly, especially if one compares this with the cost involved either of terminating a well-developed pregnancy (which is usually the case of legal abortions under the present legislation), or of treating a woman who has suffered serious complications after having undergone a criminal abortion in clinically dangerous conditions because a safe legal abortion was denied her.

A large group of people still argue against the incorporation of abortion into a birth control programme on moral grounds. But with the introduction of such techniques as the morning-after pill, any strict distinction between contraception and abortion is becoming clouded. The time is drawing near when contraception and abortion will be viewed as a continuum, rather than as two exclusively defined alternatives.

A second very important social force for change in the present attitude towards the abortion issue in South Africa is the changing role of women in society. The trend towards the greater participation of women in the socio-economic and political spheres in other industrialized countries is now slowly becoming a reality in South African society. More and more women are entering the labour market, either to satisfy personal aspirations, or because the developing economy requires their labour, or because of financial necessity. (In South Africa, the largest group of working women obviously fall into the last-mentioned category.) According to a recent All Media Products Survey, 34 per cent of adult White women in South Africa are working. Sixty-two per cent of these women are married; almost half of these women are mothers of children and babies as well. Seventy-seven per cent of the female working force is engaged in full-time employment (AMPS, 1975). Although no

comparable research has been conducted into the percentage of Black women who are employed, one can hypothesize that this figure will be much higher than that for White women; very few Black women remain housewives only.

Given this trend, Fourie's argument is indeed a strong one: "... where the working woman's income is of vital importance for the economic welfare of the household, and to maintain the family's standard of living, nutrition, health and education, the working woman might claim that she must be allowed an abortion, in the case of an unplanned pregnancy, to safeguard the interests of her living children, or to safeguard her employment. This claim would be particularly strong if she is the sole or chief breadwinner for her family." (Fourie, 1975.) I would extend this argument further and state that as women assume more and more responsibility in the sphere of work, and participate more readily in other spheres of social life to serve the society in a more productive way, they will be in a position to expect society to recognise them as responsible individuals capable of making their own decisions regarding important aspects of their lives. Thus the decision of whether to continue with a pregnancy or not should be a decision made by women in professional consultation with a doctor. Furthermore, it is important to note that it has been the experience in some other advanced Western societies that the more women become integrated into the social, economic and political life of their countries, the more there is a decline in the birth rate (Dahlström, 1962). Thus one of the consequences of the recognition of women as equal social partners with men is a reduction of the country's population growth rate.

The third force which may well effect a change in the official South African attitude to abortion is the international trend towards the introduction of liberal abortion legislation. More and more countries are accepting that abortion is a fact of life, and that legislating against it does not eliminate the practice. Thus measures are being taken to make abortion a legal and clinically safe operation in order to reduce the suffering that is a consequence of criminal abortions. Other

countries have incorporated abortion into their birth control programmes. South Africa does not exist in a vacuum, and thus must be responsive to international trends (sometimes difficult for the authorities to accept). The changing international attitudes to the abortion issue might well have some effect on the rigid attitudes at present pertaining in some influential circles in our country.

At present the attitude of the South African policy-makers to the issue of abortion is characterised by two elements, both evidencing some inconsistencies:

- a set of attitudes based on a religious doctrine which sanctifies life as a gift from God, thus maintaining that all steps must be taken to preserve life, and not destroy it. Abortion is not acceptable as it involves the destruction of life. Obviously the philosophical debate of what constitutes "life" is relevant here, as well as the debate regarding the time at which a foetus becomes a human being. These issues have not as yet been resolved. But this notwithstanding, it is startling to note that the same group of people who argue strongly against abortion on the basis that it destroys human life, still maintain the death sentence on their statute books.

- a set of beliefs based on a religious doctrine that condones sexual intercourse only if it occurs within a legal marriage, and which defines sexual activity in terms of rigid traditional stereotypes. Sexual relationships outside of the marriage partnership are condemned as promiscuity, and are therefore punishable (it is especially the woman who is punished). Yet side by side with this moralistic attitude goes a tolerance of the exploitation of the female body and of sexual experience by mass media and advertising. Furthermore, the assumption is made that women are not capable of making rational decisions for themselves, and that therefore the male establishment must dictate the conditions of the women's existence.

With these rigidly authoritarian and traditional attitudes

among policy-makers in our country, what are the prospects for changing the present legal position of abortion in South Africa? A number of tensions within the system that were discussed above will no doubt have the effect of exerting pressure for a change in policy. But a piece of legislation that results in human suffering and hardship can never be changed too soon. Already South African women have voiced their extreme dissatisfaction with the present legal position. At the conference on the legal status of women held in Pretoria in 1976, a resolution was passed calling for abortion to be considered as an issue affecting a woman and her doctor only. If indeed members of the medical profession are dissatisfied with the restrictive Abortion and Sterilization Act, then they too could join the women in exerting pressure for change. The policy-makers have heeded their call before: they might indeed do so again - if the call is strong enough.

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4. Verbeek, W.A. — "How much Land do we have Left?", in pamphlet by Cape Department of Nature and Environmental Conservation: *Too Many People*, 1976.

Bibliographical Note:

Most of the references quoted in this work and others relevant to the topic are available in the A.R.A.G. archives, which are open to the public for reference and research.

APPENDIX.

RESEARCH APPROACH.

(1) POPULATION AND SAMPLE.

A simple random sample of 200 was drawn from a total population of 700 doctors practising privately in Durban and surrounding areas in Natal. The population was compiled from the membership lists of both the Natal Medical Association (Coastal) and the Natal Medical Association (Inland). In order to compile a more comprehensive list of the population to be studied, the assistance of five representatives of medical suppliers was sought. The lists of their clients were then cross-checked with those of the two branches of the Natal Medical Association. The final list of medical practitioners in the Natal area was obviously not totally complete, as the population to be studied does not remain static. Over time doctors retire from private practice, move to other areas, and change the nature of their practice (e.g. they might stop treating maternity cases). Furthermore, some doctors might not join the relevant Medical Associations in their districts.

The total population of 700 medical practitioners included psychiatrists, gynaecologists, and general practitioners of all races in the Natal area. These doctors were chosen for study as they are obviously the professionals who are directly involved in the issue of abortion. The population included 6 psychiatrists, 35 gynaecologists, and 659 general practitioners. All the psychiatrists and gynaecologists were included in the sample because they were few in number, but a simple random sample of 159 general practitioners was drawn from the total of 659 in the population. The distribution of the various categories of medical practitioners in the population, sample, and respondent numbers is illustrated in the table below.

TABLE XI.

DISTRIBUTION OF CATEGORIES OF MEDICAL PRACTITIONERS IN THE POPULATION, SAMPLE, AND RESPONDENT NUMBERS.

Category of Practitioner	Population	Sample	Responses
Psychiatrist	6	6	3
Gynaecologist	35	35	24
General Practitioner	659	159	90
TOTAL	700	200	117

(Note: The metropolitan area of Durban was sub-divided into the following categories:

Central Business District
Durban Central (Indian)
Rest of City (White and African)
Durban North
Bluff
Out of City (Indian and African)
Westville/Pinetown/New Germany/Mariannhill
Hillary/Bellair/Malvern/Escombe.)

Eighty-three of the 200 medical practitioners included in the sample did not respond to the questionnaire sent to them. Brief telephone interviews with the doctors conducted at a later stage of the research programme revealed the following:

- 22 out of 38 doctors who had not responded and were reached during the telephone interview stage, indicated that they had not responded to the questionnaire because they were either not in private practice any more, or were specialists, or had given up maternity cases, or had been away

on leave or due to illness when the study was conducted. These do not constitute a source of bias because they fell outside of the universe at the time of the study.

- 7 of the 38 respondents (among the 22 mentioned above) offered their opinions regarding the abortion legislation during the telephone interview (2 thought the legislation "just right", and 5 maintained that it was "not liberal enough ").

- the other reasons given by doctors who refused were: doctor too busy, not wanting to commit his opinions on paper, found questionnaire too vague, and willingness to respond only if the study was conducted through the Medical Association.

A further 45 doctors were unavailable for the telephone check-up.

Given the reasons supplied by the doctors for not responding to the questionnaire, it seems fair to conclude that these non-respondents did not fail to reply because they were totally against the investigation into the issue of abortion. One could hypothesize however, that a possible bias in the respondent sample could derive from the respondents constituting that group of doctors who have more definite opinions regarding the abortion issue. Thus the respondent sample might include those doctors who either are strongly against more liberalized abortion, or who strongly support a change in the present abortion legislation, and therefore might exclude that group of doctors who either do not hold strong attitudes either way, or who are as yet undecided regarding the issue.

(2) RESEARCH APPROACH.

Because of limited funds and manpower, it was decided that the study should take the form of a postal survey, with the possible use of telephone interviews at a later stage if this was necessary. Furthermore, because of these limitations, plus the limitations inherent in the postal survey as a research method (e.g. questionnaires need to be short, thus no in-depth information can be collected), it was acknowledged that the study could only

be considered as exploratory research. Its role is that of indicating main trends in the issues being investigated, and illuminating aspects of the problem that require more detailed research. Given this, the research was not designed to test a formal hypothesis, but must rather be viewed, in collaboration with Chapter II, as a fact-seeking study.

The response rate of 58,5% is unusually high for this type of research method. This high response rate was achieved, however, by conducting the research in a number of stages:

1) A questionnaire with a covering letter explaining the nature and aims of the study was sent to all 200 doctors in the sample. (A copy of the questionnaire appears at the end of the Appendix.)Included was a self-addressed envelope for the replies. The questionnaire was anonymous, but some respondents did sign their completed schedules.

2) Two weeks later another batch of questionnaires was sent to all the doctors, with another covering letter urging them to reply if they had not yet done so.

3) In order to increase the response rate still further, the same questionnaire was again sent to the doctors after articles had appeared in the daily press appealing to them to participate in the study. With these questionnaires, a form was included on which the doctor could indicate whether he had replied to the previous questionnaire or not.

4) Telephone interviews were conducted with those doctors who had not indicated that they had responded to the questionnaire. Doctors were asked whether they had responded or not, and if not, whether there was a particular reason why they had not done so. As mentioned before, 41 doctors were unavailable for this stage of the research. Sixteen of these doctors were from the Zululand, North and South Coast, northern Natal, and Midlands regions, thus they were not contacted by telephone at this stage due to the cost involved. Additional questionnaires were sent to some doctors at their own request, and the response rate was

still further increased as some of the completed responses were returned to the survey analyst. The telephone interviews were conducted in an attempt to establish whether there was a bias in the respondent sample. The conclusions drawn from this have been discussed above.

A number of criticisms of the research method must be mentioned at this stage.

Firstly, the study was conducted over the period October 1975 to April 1976. This means that those doctors responding to the questionnaire in April 1976 might have been influenced in their opinions regarding the efficacy of the Abortion and Sterilization Act (1975) by the fact that the Act had by then been in operation for just over a year, whereas those responding in October 1975 had only the experience of the repercussions of the legislation over a 7 month period to go by. This might, or might not, have influenced the responses.

Secondly, as was pointed out earlier, a postal questionnaire can usually only hope to have success if it is short. Thus not much in-depth information can be collected from such a schedule. This enables one only to collect rather superficial information. Furthermore, because the interpersonal situation of an interview is missing, the respondent might reply to a question without giving it too much thought, and there is obviously no possibility to "probe" the respondent on an answer or opinion which seems important and interesting.

Finally, many of the questions asked the doctors to "estimate" the incidence of one or other occurrence, and some doctors warned in their responses that the figures which they provided were indeed estimates. However, in view of the predictable refusal by doctors to provide "facts", the assumption made was that estimates would provide a valid reflection of reality, particularly since high and low estimates from a sample tend to be self-cancelling. Given these features of the study, the information gathered from deliberately vaguely phrased questions was used to illustrate trends regarding the issues investigated (e.g. incidence of estimated non-spontaneous abortions); the data cannot be regarded as strictly factual, although it is broadly illustrative. However, the questions referring to

attitudes to the abortion legislation were unambiguous; thus responses to these questions can be taken as reliable and valid (but note the possible influence of time mentioned above).

(3) ANALYSIS OF DATA.

There are two main reasons why the data collected in this study were not subjected to any rigorous statistical analysis.

Firstly, given the above discussion of the nature and the aims of the study, this seemed neither possible nor necessary. The limitations and shortcomings of the postal survey gave the data collected the status of providing illustrative trends of aspects of the problem being investigated, thus not lending itself to statistical analysis. And since the aim of the study was to give an exploratory insight into the abortion issue in the South African context, statistical formulation of the data was not indicated.

Secondly, as regards the attitudes of medical practitioners towards the new abortion legislation results indicated that responses tended to represent a "saturated category" (i.e. 78% of the doctors who responded favoured more liberal abortion legislation). Given this correlations between this attitude and other variables (e.g. group treated in doctor's practice etc.) were statistically unstable.

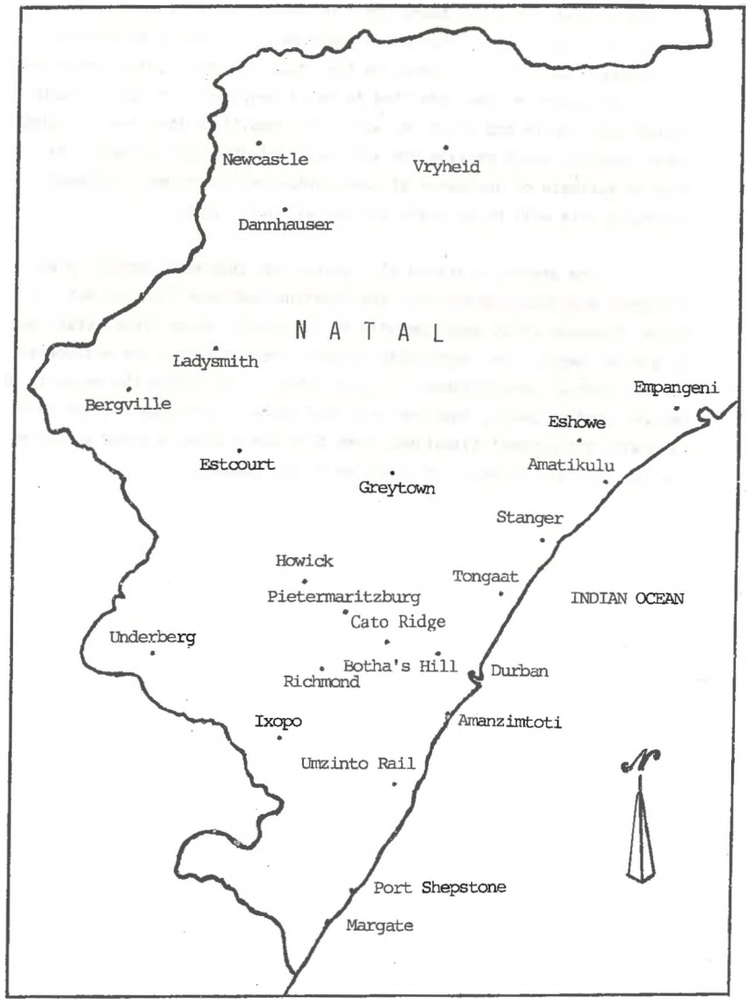
(4) CONCLUDING COMMENT.

The trends regarding the incidence and consequences of illegal abortion that are illustrated by this study, in conjunction with the other documentary research included in Chapter II, constitute enough evidence of the enormity of the social fact of abortion in South Africa. In every country the task of investigating the exact incidence of illegal abortions has proved impossible. But there are various ways in which one can arrive at a more reliable estimate of the exact position. For example, if the help of the various Medical Associations can be obtained, a much larger study could be initiated to gather information about non-spontaneous abortions.

All members could be alerted to conscientiously record cases of suspected non-spontaneous abortions among their patients. After a period of six months, or a year, this information could be collected by researchers and analyzed to form a follow-up to the study presently being conducted by A.R.A.G. of abortion cases admitted to Natal hospitals for the 12-month period both before and after the act. The results of both such studies taken together could provide one with more reliable data on which to base an estimate of incidence of non-spontaneous abortions, although obviously this will by no means include all such cases.

The present research also points out that many medical practitioners are dissatisfied with the Abortion and Sterilization Act. A better financed study would be able to illuminate these dissatisfactions in greater depth, and investigate whether these opinions are widespread amongst medical practitioners in South Africa. If indeed the majority of persons professionally involved with the issue of abortion are not satisfied with the present situation, then this constitutes a sound platform for the call for liberalized abortion in our country.

Map of Natal showing the areas from which the 117 Respondents came.



QUESTIONNAIRE.

(Note: Code refers to, for example: CBD : Central Business District (Durban)
G : Gynaecologist
3 : White.)

* For how many years have you held your present practice?

Less than 5 years	Between 5 and 10 years	More than 10 years

* What percentage of your practice is White? Black?

White ... % Black ... %

* What percentage of your practice is composed of women of child-bearing age? (approximately) ... %

* What do you estimate to be the proportion of pregnancies that you attend in your practice, that are unintentional? ... %

* To what cause would you attribute most unwanted pregnancies in your practice? (in order of incidence - 1,2,3?)

Contraceptive ignorance ...

Careless contraceptive use ...

Contraceptive failure ...

Other, please specify, e.g. unconscious motivation.

---

* Of women who go to full term with an unwanted pregnancy, what proportion of psychological ill-effects are noticed?

On the mother? ... % On the other members of the family? ... %

* Have you ever noticed behaviourial problems in children whom you knew to be unwanted?

YES | NO | NOT SURE

* In the last three years, what would you estimate to be the number of requests that you have received, both directly and indirectly, for pregnancy termination? [ ]
* In the last three years, how many women whose pregnancies you have confirmed, have ceased to be pregnant, due, you suspect, to self-induced or procured abortion? [ ]
* In the last three years, what would you estimate to be the number of cases which have been referred to you, or come to you with septic abortions or other post-abortive complications? [ ]
* What proportion of the above would you surmise to be non-spontaneous? [ ] %
* Of these non-spontaneous abortions, what proportion would you surmise to be self-induced? [ ] %

  Induced by medical practitioners? [ ] %

  Induced by others? [ ] %

* Have you ever noticed adverse psychological effects on a woman:

  whose pregnancy has been terminated by non-clinical or "back-street" operators;

  YES | NO

  whose pregnancy has been terminated for reasons generally accepted as therapeutic by the medical profession?

  YES | NO

* Do you feel the new Act is:
  a Too liberal?
  b Just right?
  c Not liberal enough?
* What modifications to the Act would you like implemented?

KINDLY RETURN YOUR COMPLETED QUESTIONNAIRE IN THE ENCLOSED ADDRESSED ENVELOPE BY WEDNESDAY, 22nd OCTOBER 1975.

THANK YOU.