POLICY REVIEW

Bridging the Gap: How South Africa's Guidelines on Self-Managed Abortion Fall Short of WHO Standards

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Introduction

Self-managed abortion (SMA) with drugs such as mifepristone and misoprostol is widely recognised as a safe and successful method of terminating pregnancies, especially in the first trimester (Foster et al. 2020). The World Health Organization (WHO) has developed guidelines to encourage SMA, emphasising access, safety and respect for women's autonomy (WHO 2022). By contrast, South Africa has progressive abortion legislation, yet its National Clinical Guidelines for the Implementation of the Choice on Termination of Pregnancy Act restricts access to SMA, thus contradicting WHO recommendations.

The policy review aims to recommend how South Africa's guidelines can be aligned with international standards to better support women's reproductive rights and health.

Overview of the WHO guidelines for SMA

According to the WHO's complete standards for abortion treatment, countries should:

- make it easier to share correct information on the use of medical abortion medicines;
- empower community health workers to assist with SMAs (WHO 2022);
- eliminate legal sanctions for anyone seeking or conducting abortions outside of established health institutions (WHO 2022); and
- allow women to safely manage abortions outside of clinical settings if they have access to quality information and support services (Ganatra et al. 2017).

South Africa's abortion policy: Context and current guidelines

South Africa's Choice on Termination of Pregnancy Act (CTOPA) of 1996 permits abortion up to 12 weeks after conception, with provisions for up to 20 weeks for specified cases. While the Act is a major step forward for reproductive rights, it has restrictions that limit SMA. Although abortion is a legal right, safe abortion services are primarily facility-based, posing challenges for women who want or require SMA (Guttmacher Institute 2020).

> **... legal restrictions drive women to unsafe abortion practices, increasing health risks and mortality.**

> **Stigma not only hinders women from using facility-based treatments but also makes them unwilling to seek help for SMA.**

Analysis of Gaps Between National Abortion Guidelines and WHO 2022 Guidelines

In 2019, the National Clinical Guidelines on the Implementation for the Choice on Termination of Pregnancy Act ('National Abortion Guidelines') were introduced by the National Department of Health. The guidelines are a key regulatory instrument that provides a clinical framework for abortion care and aims to operationalise legal provisions for abortion. This instrument may thus either inhibit or facilitate the availability, accessibility and acceptability of abortion services.

Legal and regulatory barriers

Although CTOPA does not criminalise SMA, ambiguity in overlapping regulations might result in prosecution and stigma for women who perform abortions outside of health institutions (Morroni et al. 2022). For example, the Medicines and Related Substances Act restricts the availability of abortion-inducing medications to licensed institutions and skilled healthcare practitioners (Kumar 2013).

The WHO's position: The WHO asserts that legal restrictions drive women to unsafe abortion practices, increasing health risks and mortality (WHO 2022). South African guidelines do not provide specific legal protection for women who self-manage abortions, in contrast to WHO recommendations that call for full decriminalisation (Berer 2017).

In South Africa, home use of misoprostol is limited to pregnancies up to 10 weeks + 0 days' gestation. Beyond this period, facility-based termination-of-pregnancy (TOP) care is required for managing medical TOPs and addressing severe complications. The South African guidelines emphasise that individuals must have access to professional medical advice and emergency care in case of complications, restricting the use of abortion medications to clinical settings supervised by health-care professionals.

The WHO's position: The WHO supports a flexible approach, recommending that individuals with gestational ages of less than 12 weeks can safely manage medical abortions on their own using a combination of mifepristone and misoprostol or misoprostol alone. The WHO argues that this method improves access to safe, timely, and affordable abortion care, particularly in contexts where formal health-care facilities are inaccessible.

Mandatory facility-based abortion services

Current South African guidelines prioritise in-clinic procedures for medical abortions (Rasweswe-Choga et al., 2023). Although this strategy is consistent with the purpose of safety, it may be a barrier for some who would prefer home-based care owing to privacy concerns or practical problems, such as travel expenses and stigma.

The WHO's position: The WHO advocates for SMA with adequate support for women up to 12 weeks pregnant, as long as they have access to credible information and referral services (Ganatra et al. 2017). According to research, SMAs can be just as safe and successful as those performed in clinical settings (Foster et al. 2020). Lack of comprehensive information and counselling services

While South African policy requires pre- and post-abortion counselling, it focuses on facility-based treatments, leaving little guidance for SMA (Rasweswe-Choga et al., 2023). Many women do not have access to evidence-based information about the use of mifepristone and misoprostol for SMA.

The WHO's position: The WHO supports comprehensive information campaigns to help people make informed decisions about abortion treatment (WHO 2022). According to research, when women are properly educated, they can safely manage abortions with medication (Constant et al. 2014). South Africa's inability to give this information demonstrates a severe policy gap that jeopardises women's capacity to safely self-manage abortions.

Social, cultural and stigma barriers

Despite the legalisation of abortion, societal stigma remains strong in South Africa, resulting in judgment

of and discrimination against women seeking abortion services (Harries et al. 2019). Stigma not only hinders women from using facility-based treatments but also makes them unwilling to seek help for SMAs.

The WHO's position: The WHO emphasises the need for comprehensive efforts to decrease abortion stigma by pushing for legislation and public health campaigns that normalise and promote abortion as a valid element of reproductive health care (Berer 2017). South Africa's present legislation does not aggressively tackle widespread stigma, limiting women's access to safe SMA services and support networks.

Policy recommendations for South Africa

South Africa should take the following steps to harmonise its national policy with WHO standards and enhance access to SMA services:

- Develop updated guidelines that aim to both mitigate documented barriers to abortion and be aligned with WHO recommendations, including those on SMA.
- Implement policies that equip non-clinical health-care personnel to give counselling and support for SMAs, based on the WHO's task-shifting model (Ganatra et al. 2017).
- Launch nationwide public health initiatives to spread correct information about SMA and prepare health-care practitioners to give nonjudgmental assistance. This technique would help women make educated decisions regarding their reproductive health (Constant et al. 2014).
- Create community engagement activities to reduce social stigma and educate the public on abortion rights and self-management safety. This could contribute to a friendlier atmosphere for women seeking SMA services (Harries et al. 2019)

Conclusion

Despite South Africa's progressive abortion regulations, its existing SMA guidelines do not meet the WHO's requirements fully. Legal ambiguity, restricted access to medical abortion medication, required facility-based services, and cultural stigma all impede women's autonomy and access to safe abortion management. South Africa would improve reproductive equity and SMA practice safety by implementing a more supportive policy framework in line with WHO recommendations.

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