

Telemedicine as tool: towards fulfilling South Africa's legal  
obligations around access to medical abortion



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Grace Brain

BRNGRA015

Supervised by Salona Lutchman

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## List of abbreviations and acronyms

CEDAW: Convention on the Elimination of All Forms of Discrimination against Women

COVID-19: coronavirus disease

CTOPA: Choice on Termination of Pregnancy Act 92 of 1996

ECTA: Electronic Communications and Transactions Act 25 of 2002

HPCSA: Health Professions Council of South Africa

ICCPR: International Covenant on Civil and Political Rights

ICESCR: International Covenant on Economic, Social and Cultural Rights

ICT: information and communication technologies

MA: medical abortion

MATM: medical abortion via telemedicine

NGO: non-governmental organisation

NHI: National Health Insurance

POPIA: Protection of Personal Information Act 4 of 2013

SRH: sexual and reproductive health

SRHC: sexual and reproductive healthcare

SRHR: sexual and reproductive health and rights

## CHAPTER 1

### 1.1 INTRODUCTION

Apartheid South Africa's laws around abortion were highly restrictive.<sup>1</sup> Unsurprisingly, illegal abortion was widespread.<sup>2</sup> The Choice on Termination of Pregnancy Act 92 of 1996<sup>3</sup> (CTOPA) significantly expanded the reasons<sup>4</sup> for which a pregnant person<sup>5</sup> could seek an abortion and removed legal obstacles to abortion access.<sup>6</sup>

Through its national laws and policies<sup>7</sup> and its being a State Party to many regional<sup>8</sup> and international legal instruments,<sup>9</sup> the post-apartheid Republic of South Africa has imposed upon itself an obligation to provide abortion access to its population. This obligation has not been fulfilled satisfactorily to date.<sup>10</sup> Insufficient personnel,<sup>11</sup> resources,<sup>12</sup> funding,<sup>13</sup> and even functional facilities<sup>14</sup> mean that a significant proportion of the South African population do not receive sexual and reproductive healthcare (SRHC) that meets the standards set by national government or the legal instruments to which the national government is a party.<sup>15</sup>

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<sup>1</sup> Sally Guttmacher, Farzana Kapadia, Jim Te Water Naude, et al. 'Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act' (1998) *International Perspectives on Sexual and Reproductive Health* 24 at 192.

<sup>2</sup> Guttmacher, Kapadia, Te Water Naude et al. op cit note 1 at 192.

<sup>3</sup> The Choice on Termination of Pregnancy Act 92 of 1996.

<sup>4</sup> Supra note 3 at s2.

<sup>5</sup> Throughout this thesis, the term 'pregnant persons' will be used to describe people including, but not limited to, cisgender women, transgender men, non-binary persons, intersex persons, and genderqueer persons, who are pregnant. This term has been chosen to recognise the gender diversity of people who may become pregnant.

<sup>6</sup> Supra note 3 at preamble.

<sup>7</sup> Constitution of the Republic of South Africa, 1996, s27; National Department of Health, *National Clinical Guidelines for Implementation of the Choice on Termination of Pregnancy Act* (2019); National Department of Health, *National Integrated Sexual & Reproductive Health and Rights Policy* (2019).

<sup>8</sup> Most notably, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 11 July 2003, 1520 UNTS I-26363 (entered into force 25 November 2005) (Maputo Protocol).

<sup>9</sup> See, for example, the Convention on the Elimination of Discrimination Against Women, 18 December 1979, UNTS 1249 (entered into force 3 September 1981); the International Covenant on Civil and Political Rights, 16 December 1966, UNTS 999 (entered into force 23 March 1976); and the International Covenant on Economic, Social and Cultural Rights, 16 December 1966, UNTS 993 (entered into force 3 January 1976).

<sup>10</sup> *National Clinical Guidelines* op cit note 7; Amnesty International, *Barriers to Safe and Legal Abortion in South Africa* (2017) at 12.

<sup>11</sup> Uta Lehmann 'Strengthening human resources for primary healthcare' in Peter Barron & Josiane Roma-Reardon (eds) *South African Health Review 2008* (2008) at 166.

<sup>12</sup> Health Systems Trust *The National Health Care Facilities Baseline Audit National Summary Report 2012* (2012) at ix – x.

<sup>13</sup> Russell Rensburg 'Healthcare in South Africa: how inequality is contributing to inefficiency' 7 July 2021, available at <https://www.wits.ac.za/covid19/covid19-news/latest/healthcare-in-south-africa-how-inequity-is-contributing-to-inefficiency.html>, accessed on 29 September 2023.

<sup>14</sup> Op cit note 12 at ix – x.

<sup>15</sup> Op cit note 11 at 166.

This lack of resources is particularly stark in non-urban areas.<sup>16</sup> Rural populations face distinct lack of access to healthcare practitioners<sup>17</sup> or facilities within reasonable distances from their residences.<sup>18</sup> Where access to healthcare at a primary level is achieved, usually through travelling a significant distance,<sup>19</sup> patients often confront a dearth of necessary resources<sup>20</sup> such as medication<sup>21</sup> or medical equipment.<sup>22</sup>

This is not a problem that is confined to a few, far-flung areas of the country. In four of South Africa's nine provinces,<sup>23</sup> over 30 per cent of women surveyed in a national survey from 2016<sup>24</sup> reported that distance prevented them from visiting a healthcare facility when they were ill or presented significant issues in doing so.<sup>25</sup> In the remaining five provinces, the level of women surveyed who reported distance issues never dropped below 11,3 per cent.<sup>26</sup> However, distance is not the primary problem that women surveyed faced in accessing healthcare. In seven of the nine provinces, women surveyed reported that paying for treatment was the primary obstacle to accessing healthcare.<sup>27</sup>

Clearly several factors, rooted in South Africa's historical context of geographical and socio-economic divisions, make accessing healthcare a difficult and expensive exercise for much of its population. These factors include the uneven distribution of healthcare facilities,<sup>28</sup> with particular scarcity in rural areas;<sup>29</sup> the ensuing and significant distances that people must travel to seek healthcare;<sup>30</sup> poverty,<sup>31</sup> which makes healthcare prohibitively expensive;<sup>32</sup> and lack of resources such as medication, particularly in rural areas.<sup>33</sup>

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<sup>16</sup> Bernhard Gaede and Marije Versteeg 'The state of the right to health in rural South Africa' in Ashnie Padarath and René English (eds) *South African Health Review 2011* (2011) at 100 – 103.

<sup>17</sup> Ibid. at 102.

<sup>18</sup> Ibid. at 101.

<sup>19</sup> National Department of Health, Statistics South Africa, South African Medical Research Council, and ICF *South Africa Demographic and Health Survey 2016* (2019) at 250, 259.

<sup>20</sup> Op cit note 15 at 102.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid. at 102.

<sup>23</sup> Op cit note 19 at 259.

<sup>24</sup> Ibid.

<sup>25</sup> Ibid. at 259.

<sup>26</sup> Ibid.

<sup>27</sup> Ibid. at 250, 259.

<sup>28</sup> Op cit note 15 at 103.

<sup>29</sup> Ibid. at 101.

<sup>30</sup> Op cit note 19 at 259.

<sup>31</sup> OECD *How's Life? 2020: Measuring Well-being* (2020).

<sup>32</sup> Op cit note 19 at 259.

<sup>33</sup> Op cit note 15 at 102.

In the sphere of sexual and reproductive health and rights (SRHR), the above factors are exacerbated by strong stigma against SRHC, particularly abortion;<sup>34</sup> by largely unregulated but prevalent conscientious objection to providing abortion care from healthcare providers;<sup>35</sup> by lack of awareness on the SRHC and rights to which women and pregnant people are entitled;<sup>36</sup> and by a lack of facilities equipped and permitted to perform abortions.<sup>37</sup> These exacerbating factors mean that access to SRHC is especially precarious.<sup>38</sup>

Many pregnant persons, unable to obtain an abortion from a recognised provider, turn to unrecognised providers.<sup>40</sup> Complications can ensue,<sup>41</sup> with some threatening the life of the patient.<sup>42</sup> Some pregnant persons may never obtain the abortion they sought, with some having children as a result. Meaningful change is needed to resolve this lack of access to a fundamental right<sup>43</sup> – the right to control one’s fertility and therefore one’s own body.<sup>44</sup>

One solution that has been proposed<sup>45</sup> in contexts similar to South Africa is that of telemedicine. Telemedicine is a method of delivering healthcare which can address geographical distance and access issues in healthcare.<sup>46</sup> It has been practiced in South Africa since the late 1990s,<sup>47</sup> although regulatory approval has not reflected its prevalence.<sup>48</sup> The

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<sup>34</sup> Elizabeth A. Mosley, Amy J. Schulz, Lisa H. Harris, et al. ‘South African Abortion Attitudes from 2007–2016: The Roles of Religiosity and Attitudes toward Sexuality and Gender Equality’ (2020) 60 *Women & Health* 7 at 2 – 8.

<sup>35</sup> Guttmacher Institute, *Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies* (2012) at 10, 13; Akinrinola Bankole, Lisa Remez, Onikepe Owolabi, et al. *From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress* (2020) at 15.

<sup>36</sup> National Integrated SRHR Policy op cit note 7 at 14.

<sup>37</sup> Amnesty International op cit note 10 at 12.

<sup>38</sup> Op cit note 11 at 166.

<sup>39</sup> Ronelle Burger & Martina Mchenga *Anticipating the Impact of the COVID-19 Pandemic on Health Inequality in South Africa: Early Evidence on Direct and Indirect Influences* (2021) PEP Working Paper Series 2021-12 at 2.

<sup>40</sup> National Clinical Guidelines op cit note 7 at 1.

<sup>41</sup> Ibid. at 22.

<sup>42</sup> Ibid.

<sup>43</sup> Constitution s27(1)(a); Pieter Carstens & Debbie Pearmain *Foundational Principles of South African Medical Law* (2007) at 92 – 99.

<sup>44</sup> Ibid.

<sup>45</sup> B A Townsend, R E Scott & M Mars ‘The development of ethical guidelines for telemedicine in South Africa’ (2019) 12 *South African Journal of Bioethics Law* 1 at 100; MSI South Africa *Increasing abortion access through tele abortion* (n.d.) at 3; Mariana Prandini Assis and Sara Larrea ‘Why Self-Managed Abortion Is so Much More than a Provisional Solution for Times of Pandemic’ (2020) 28 *Sexual and Reproductive Health Matters* 1 at 37.

<sup>46</sup> A Le Roux ‘Telemedicine: A South African Legal Perspective’ (2008) 2008 *Journal of South African Law* 1 at 104.

<sup>47</sup> S M Gulube & S Wynchank ‘Telemedicine in South Africa: Success or Failure?’ (2001) 7 *Journal of Telemedicine and Telecare* 2.

<sup>48</sup> B A Townsend, M Mars & R E Scott ‘The HPCSA’s telemedicine guidance during COVID-19: A review’ (2020) 13 *South African Journal of Bioethics Law* 2 at 98.

following section introduces telemedicine as a concept and gives a brief overview of its potential applications in the field of SRHC, particularly for the prescription of medical abortion (MA).

## 1.2 TELEMEDICINE: A BRIEF INTRODUCTION

Telemedicine has been defined by the World Medical Association<sup>49</sup> as:

the practice of medicine over a distance, in which interventions, diagnoses, therapeutic decisions, and subsequent treatment recommendations are based on patient data, documents and other information transmitted through telecommunication systems.

Telemedicine can take place between a physician and a patient or between two or more physicians including other healthcare professionals.<sup>50</sup>

Similarly, the Draft International Convention on Telemedicine and Telehealth<sup>51</sup> defined telemedicine as:

clinical or supportive medical practice delivered across distances via telecommunications or interactive video technology, performed by licensed or otherwise legally authorized individuals.<sup>52</sup>

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<sup>49</sup> The World Medical Association is a confederate organisation made up of national medical associations.

<sup>50</sup> World Medical Association 'Statement on the Ethics of Telemedicine' available at <https://www.wma.net/policies-post/wma-statement-on-the-ethics-of-telemedicine/> , accessed on 15 September 2023.

<sup>51</sup> The Draft International Convention on Telemedicine and Telehealth was an output of the International Bar Association in 1999.

<sup>52</sup> International Bar Association *Draft International Convention on Telemedicine and Telehealth* (1999) at art. 1.4.

It is important to distinguish telemedicine from related terms such as eHealth and telehealth. Telehealth encompasses telemedicine as well as ‘preventive health support, research, training, and continuing medical education for health professionals’.<sup>53</sup> Telehealth falls under the broader category of eHealth, which denotes the fields where healthcare and telephonic or internet technologies intersect. Some examples could include research, healthcare software, and electronic transmission of patient records or test results. mHealth, a category which intersects with both telemedicine and telehealth, denotes the use of mobile applications to interact with medical professionals and record medical-related data, respectively. Figure 1 below represents the relationships between the terms contained within the category of eHealth, as understood by this work.

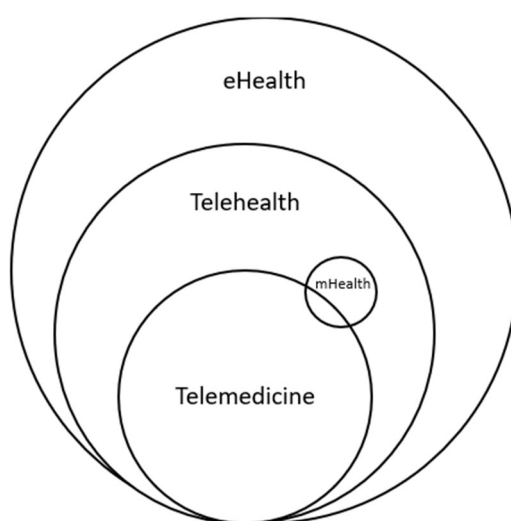


Figure 1: diagram displaying relationships between subcategories of eHealth

This work focuses on synchronous telemedicine. Synchronous telemedicine, as opposed to store-and-forward telemedicine,<sup>54</sup> is a real-time consultation between patients and medical practitioners.<sup>55</sup> Store-and-forward telemedicine (the practice of creating images, recordings, etc. of a patient, which are then forwarded to the medical practitioner for their perusal<sup>56</sup>) is extremely common in fields such as radiology,<sup>57</sup> but less so in the context of prescription of medication. This work has therefore chosen to limit its focus to synchronous telemedicine.

<sup>53</sup> Op cit note 46.

<sup>54</sup> M Mars & N Dlova ‘Teledermatology by videoconference: Experience of a pilot project’ (2008) 50 *South African Family Practice* 3 at 70a.

<sup>55</sup> Ibid.

<sup>56</sup> Op cit note 54 at 70a.

<sup>57</sup> Maurice Mars & Caron Jack ‘Why is telemedicine a challenge to the regulators?’ (2010) 3 *South African Journal of Bioethics Law* 2 at 57 – 58.

While the use of artificial intelligence may arguably be part of eHealth, although more research is needed on this topic, telemedicine by common definition<sup>58</sup> requires the significant participation of an adequately trained and licenced healthcare professional.<sup>59</sup> This work will focus only on synchronous telemedicine involving such a healthcare professional.

Telemedicine is particularly useful for triage – the procedure by which medical cases are prioritised and sent for further treatment as necessary– and for cases which require medication as opposed to a physical treatment.<sup>60</sup> This means that abortion, in the early months of a pregnancy, is suitable for prescription via telemedicine. The advent of MA (abortion induced via medication such as a combination of mifepristone and misoprostol<sup>61</sup>) makes abortion a process that can be prescribed remotely, with the patient receiving the required medication and taking it at a location of their choosing such as their residence.<sup>62</sup>

Telemedicine is particularly suitable for the prescription of MA in South Africa because geographical distance from healthcare facilities<sup>63</sup> and lack of availability of healthcare facilities performing or prescribing abortions<sup>64</sup> negatively impact access to abortion in the country.<sup>65</sup> Telemedicine could address both these issues. Preliminary findings<sup>66</sup> suggest medical abortion via telemedicine (MATM) could be a useful tool in pursuing South Africa’s legal obligations around providing abortion access for its population, although it would not necessarily replace other methods of abortion access. Experiences of

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<sup>58</sup> Op cit note 46; op cit note 48.

<sup>59</sup> Ibid.

<sup>60</sup> World Health Organisation *Maintaining essential health services: operational guidance for the COVID-19 context* (2020) at 29.

<sup>61</sup> Mifepristone terminates pregnancy through blocking hormones needed for the continuation of a pregnancy, while misoprostol induces contractions of the uterus to facilitate the completion of the termination of pregnancy (Tania Boler, Cicely Marston, Nick Corby et al. *Medical abortion in India: a model for the rest of the world?* (2009) at 10.).

<sup>62</sup> Sruthi Chandrasekaran, V. S. Chandrashekar, Suchitra Dalvie et al. ‘The case for the use of telehealth for abortion in India’ (2022) 29 *Sexual and Reproductive Health Matters* 2 at 393 – 394.

<sup>63</sup> Op cit note 19 at 259.

<sup>64</sup> Amnesty International op cit note 10 at 12.

<sup>65</sup> Ibid.; Candy Day, Andy Gray & Eric Budgell ‘Health and related indicators’ in Ashnie Padarath and René English (eds) *South African Health Review 2011* (2011) at 179.

<sup>66</sup> Y Pillay, S Pienaar, P Barron et al. ‘Impact of COVID-19 on routine primary healthcare services in South Africa’ (2021) 111 *SAMJ* 8 at 718; Patty Skuster ‘How Laws Fail the Promise of Medical Abortion: A Global Look’ (2017) 18 *Georgetown Journal of Gender and the Law* 379 at 385; Assis and Larrea op cit note 45 at 37 – 38; Gender, Health and Justice Research Unit, University of Cape Town *The right to sexual and reproductive health: challenges and possibilities during COVID-19* (2021) at 10 – 13; Carstens and Pearmain, op cit note 43 at 824; op cit note 46 at 104; op cit note 65; Sruthi Chandrasekaran, Nadia Diamond-Smith, Karthik Srinivasan et al. ‘Preparing for an increased need for abortion access in India during and after COVID-19’ (2020) 51 *Studies in Family Planning* 4 at 380 – 381; op cit note 62; Patty Skuster, Jina Dhillon & Jessica Li ‘Easing of Regulatory Barriers to Telemedicine Abortion in Response to COVID-19’ 2021 *Frontiers in Global Women’s Health* 2 at 4.

MA and MATM in India,<sup>67</sup> amongst other contexts, indicate that these procedures could improve access to abortion<sup>68</sup> via avenues such as public-private partnerships<sup>69</sup> and increased opportunities for monitoring and oversight of abortion.<sup>70</sup> These preliminary findings indicate that, at the very least, MATM deserves investigation to establish its potential utility in South African contexts.

It is important to note that, like any medical procedure, MA is recommended within limited circumstances. MA is safe and effective<sup>71</sup> in the first and second trimester of pregnancy.<sup>72</sup> In the first trimester, MA is over 95 per cent effective in inducing abortion<sup>73</sup> and is safer than childbirth in the United States of America.<sup>74</sup> This thesis has chosen to discuss MA only in the first trimester; during the first trimester, MA is the recommended form of abortion in most cases,<sup>75</sup> and can be carried out at lower-level healthcare facilities such as primary healthcare clinics.<sup>76</sup> Especially during the first trimester, MA is the safest,<sup>77</sup> most convenient,<sup>78</sup> most cost-effective,<sup>79</sup> and potentially the most accessible<sup>80</sup> form of abortion. These characteristics make it particularly suitable for under-resourced contexts where there is unmet need for abortion, such as South Africa.

### 1.3 PROBLEM STATEMENT

The state of abortion access in South Africa was only worsened by COVID-19. Following the announcement of a pandemic by the World Health Organisation in early March 2020,<sup>81</sup> the South African government announced a nationwide lockdown on 23 March 2020.<sup>82</sup> This

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<sup>67</sup> This work acknowledges that the application of MA and MATM in India and other contexts has limitations and is not perfectly analogous to the South African context. These limitations have been excluded from analysis as the details of these applications fall outside the scope of this work, which focuses on South African legal, regulatory, and ethical frameworks surrounding MATM.

<sup>68</sup> Op cit note 60 at 394.

<sup>69</sup> Susheela Singh, Rubina Hussain, Chander Shekhar et al. *Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programs* (2018) at 20.

<sup>70</sup> Op cit note 60 at 395.

<sup>71</sup> Deborah Ann Constant *Strengthening Medical Abortion in South Africa* (doctoral thesis, University of Cape Town, 2016) at 24.

<sup>72</sup> National Clinical Guidelines op cit note 7 at 16 – 19.

<sup>73</sup> Ibid. at 16.

<sup>74</sup> Bankole et al. op cit note 35 at 21.

<sup>75</sup> National Clinical Guidelines op cit note 7 at 16.

<sup>76</sup> Ibid. at 2.

<sup>77</sup> Ibid. at 16.

<sup>78</sup> Ibid.

<sup>79</sup> Guttmacher Institute op cit note 35 at 38.

<sup>80</sup> National Clinical Guidelines op cit note 7 at 16.

<sup>81</sup> World Health Organization 'Coronavirus disease (COVID-19) pandemic' available at <https://www.who.int/europe/emergencies/situations/covid-19>, accessed on 15 May 2023.

<sup>82</sup> South African Government 'COVID-19/Coronavirus' available at <https://www.gov.za/Coronavirus>, accessed on 15 May 2023.

lockdown prohibited non-essential movement,<sup>83</sup> ordered everyone except essential workers to stay in their residences<sup>84</sup> unless leaving for certain purposes such as to buy food,<sup>85</sup> and severely limited the categories of businesses or services that were permitted to operate.<sup>86</sup>

A limited list of accepted reasons for leaving one's residence was laid out by the lockdown regulations.<sup>87</sup> This list included seeking healthcare, but only in the event that the care was 'emergency, life-saving, or chronic'.<sup>88</sup> These terms were not defined in the initial gazetting of the regulations.<sup>89</sup> As a result, many pregnant persons may have been unsure if they could leave their homes to seek abortions,<sup>90</sup> which do not obviously fall under any of the above three categories. It is unclear whether government issued any statement clarifying that people would not be prosecuted for travelling in order to seek SRHC. Instead, non-governmental organisations (NGOs) were the primary source of calls for clarity regarding SRHC and whether people could travel to seek it.<sup>91</sup> These calls for clarity were seemingly not addressed.

In this period of uncertainty, in the fields of SRHC and in healthcare more generally, many healthcare practitioners turned to telemedicine to deliver services to their patients while they could not see them in person.<sup>92</sup> Despite the evident suitability of telemedicine for abortion care, amongst other branches of healthcare, South African authorities were slow to approve or endorse its use. The Health Professions Council of South Africa (HPCSA),<sup>93</sup> an organisation which regulates healthcare practitioners in the country,<sup>94</sup> did not endorse the initiation of consultations via telemedicine between a patient and a practitioner until 3 April 2020.<sup>95</sup> Before this date, the HPCSA permitted telemedicine only in the forms of consultations between two healthcare practitioners (until 26 March 2020<sup>96</sup>) or between a

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<sup>83</sup> Disaster Management Act regulations in GN R398 GG 11062 of 25 March 2020.

<sup>84</sup> *Ibid.*

<sup>85</sup> *Ibid.*

<sup>86</sup> *Ibid.*

<sup>87</sup> *Supra* note 83 at s11B(1)(a)(i).

<sup>88</sup> *Ibid.*

<sup>89</sup> *Supra* note 83.

<sup>90</sup> MSF Southern Africa 'South Africa: Providing Safe Abortion Care during a National Lockdown' 3 July 2020 available at <https://www.msf.org.za/news-and-resources/fieldworker-stories/south-africa-providing-safe-abortion-care-during-national>, accessed on 24 February 2023.

<sup>91</sup> *Ibid.*

<sup>92</sup> N Nematswerani, L Steenkamp, S Haneef et al. 'Understanding the impact of the COVID-19 pandemic on healthcare services' (2023) 113 *SAMJ* 4 at 1156 – 1158.

<sup>93</sup> The Health Professions Council of South Africa is the governing body for healthcare practitioners in South Africa, established under the Medical, Dental and Supplementary Health Service Professions Act 56 of 1974.

<sup>94</sup> Medical, Dental and Supplementary Health Service Professions Act 56 of 1974.

<sup>95</sup> Health Professions Council of South Africa *General Ethical Guidelines for Good Practice in Telehealth Booklet 10* (2021).

<sup>96</sup> *Op cit* note 48 at 97 – 99.

healthcare practitioner and a patient with whom the practitioner had an established relationship (until 3 April 2020<sup>97</sup>). Even after its amended guidelines of 3 April 2020,<sup>98</sup> the HPCSA still prefers patient-practitioner telemedicine to take place only in the context of a relationship established prior to the telemedical consultation.<sup>99</sup>

The HPCSA's hesitations caused frustration amongst the medical communities of South Africa, with many calling for reform.<sup>100</sup> Both mass media<sup>101</sup> and academic articles<sup>102</sup> decried the HPCSA's refusal to endorse a method that would allow healthcare to occur across geographical divides, with lower costs, and with zero risk of COVID-19 infection.<sup>103</sup>

In its 3 April 2020 guidelines,<sup>104</sup> the HPCSA mostly relented. It endorsed telemedicine with some major caveats. An examination of its guidelines for telemedicine reveals implicit assumptions of the inferiority of telemedicine;<sup>105</sup> there appears to be a conflation of the desire to carry out telemedical consultations with the desire to over-service or price-gouge patients.<sup>106</sup>

Healthcare practitioners in South Africa are therefore operating in a somewhat legally grey space: if adhering to the letter of the HPCSA regulations,<sup>107</sup> the spirit of telemedicine would be defeated.<sup>108</sup> While further research is needed on the prevalence of telemedicine in South Africa, telemedicine could increase access to healthcare for the most vulnerable sections of the South African population. It is in this hope that this thesis investigates the potential efficacy of telemedicine as a tool for extending access to medical abortion for pregnant people in South Africa, and therefore as a method of moving towards fulfilment of South Africa's legal obligations.

While most South African telemedicine takes place in the private and NGO spheres,<sup>109</sup> this thesis has chosen to investigate the need for and potential utility of MATM in

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<sup>97</sup> Ibid.

<sup>98</sup> Op cit note 95.

<sup>99</sup> Op cit note 48 at 98.

<sup>100</sup> South African Medical Association, 'Open Letter Protesting Against the Health Professions Council of South Africa (HPCSA) Guidelines on Telemedicine' 27 March 2020, available at <https://www.samedical.org/cmsuploader/viewArticle/1098>, accessed on 3 May 2023; South African Medical Association 'Medical Organisations Reject New HPCSA Guideline on Telemedicine Calling It Wrong and Dangerous' available at <https://samedical.org/cmsuploader/viewArticle/1095>, accessed on 30 August 2023.

<sup>101</sup> Ibid.

<sup>102</sup> Op cit note 48.

<sup>103</sup> SAMA, 'Open Letter' op cit note 100; SAMA, 'Medical Organisations' op cit note 100; op cit note 48.

<sup>104</sup> Op cit note 95.

<sup>105</sup> Ibid. at iv.

<sup>106</sup> See op cit note 95 at art. 5.3(e), for example.

<sup>107</sup> Op cit note 95.

<sup>108</sup> Op cit note 48 at 97 – 98.

<sup>109</sup> Op cit note 92; MSI South Africa op cit note 45; GHJRU op cit note 66 at 9.

public healthcare in South Africa. This choice has been made because the majority of the South African population relies on public healthcare.<sup>110</sup> Those who pay for private healthcare are generally more affluent<sup>111</sup> and therefore more able to access abortion. Users of public healthcare are generally less able to access abortion because of the lack of facilities<sup>112</sup> and other factors discussed above. MATM offers greater potential for change when applied in the public sector. This thesis therefore primarily uses data and sources relating to public healthcare, although information relating to private healthcare is also used as a comparison and for the extrapolation of conclusions regarding public healthcare where data on public healthcare is less available.

#### 1.4 RESEARCH QUESTIONS

This thesis asks if telemedicine could be a useful tool in the pursuit of fulfilment of South Africa's international, regional, and national legal obligations around providing abortion access to its population. If it would be useful, to what extent? What interventions would be necessary to enable its use?

In order to answer the above questions, a number of sub-questions are explored in the course of this work. These include:

What are South Africa's international, regional, and national legal obligations with regards to provision of access to abortion? To what extent are these obligations being fulfilled?

Could MATM be a useful tool in increasing access to abortion for the South African population? What advantages and disadvantages does the practice entail? Is it a potentially beneficial addition to South Africa's public SRHC system?

What are the current legal and ethical frameworks governing telemedicine? How would these affect the use of MATM? What changes might be necessary to enable the introduction of MATM?

#### 1.5 METHODOLOGY

In researching the above questions, a number of methods have been employed, including desktop analysis of laws and regulations, and examination and analysis of data from NGOs such as MSI International<sup>113</sup> and government bodies such as Statistics South Africa.<sup>114</sup>

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<sup>110</sup> Op cit note 39 at 3 – 4.

<sup>111</sup> Ibid.

<sup>112</sup> National Integrated SRHR Policy op cit note 7 at 7.

<sup>113</sup> MSI International is an international NGO which provides SRHC services to people across the globe.

<sup>114</sup> Statistics South Africa is the official South African statistics service.

Data for this thesis has been accessed through government records, through NGO records, and through standard academic databases. All data accessed and used has been in the form of reported data. No unpublished data was accessed or used for this work.

## 1.6 LIMITATIONS OF STUDY

As this thesis aims to establish the potential utility of MATM in the South African context, rather than establishing the extent of the fulfilment of South Africa's legal obligations around abortion access, it focuses on existing data rather than its own original fieldwork. This thesis is therefore limited by the availability of data on South African healthcare, abortion access, telecommunications connectivity, and other subjects.

This thesis is also limited by its focus on synchronous telemedicine for the provision of MA in the public sector of South African healthcare. Each of these choices necessarily excludes large amounts of data from the purview of this work to enable meaningful discussion of a limited subject area.

## 1.7 JUSTIFICATION OF STUDY

Controlling one's fertility is often an avenue of controlling the trajectory of one's life. South Africa owes its population that control; it has imposed legal obligations<sup>115</sup> on itself to provide access to mechanisms enabling that control. It is not excessive to expect that the South African government live up to its self-imposed obligations.

MATM presents an opportunity to overcome some or many of the factors which decrease the South African population's access to SRHC.<sup>116</sup> While other confounding factors may be unaffected, it is possible to eliminate two major problems (distance<sup>117</sup> and travel costs<sup>118</sup>) which hinder healthcare.

This is not to say that telemedicine presents no issues of its own. Telemedicine requires access to telecommunications, be that through a mobile phone, a smartphone, or a computer, and connectivity.<sup>119</sup> MATM requires access to a pharmacy<sup>121</sup> or the ability to have medication delivered to one's residence.<sup>122</sup> There are certainly obstacles. However, MATM provides a promising possibility of moving closer towards fulfilling South Africa's

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<sup>115</sup> See chapter 2 for a detailed discussion of these obligations.

<sup>116</sup> National Clinical Guidelines op cit note 7 at 1.

<sup>117</sup> Op cit note 46 at 104.

<sup>118</sup> Ibid.

<sup>119</sup> Larisse Prinsen 'Challenges to and Regulation of Telemedicine in South Africa' (2023) 31 *African Journal of International and Comparative Law* 2 at 211.

<sup>120</sup> Ibid.

<sup>121</sup> MSI South Africa op cit note 45 at 3.

<sup>122</sup> Ibid.

legal obligations around abortion access, and towards enabling control of one's fertility, one's body, and one's future, for the country's population.

## 1.8 CHAPTER BREAKDOWN

Chapter 2 investigates South Africa's international, regional, and national legal obligations regarding access to abortion for its population. It analyses the extent to which these obligations are being fulfilled and if this fulfilment needs improvement.

Chapter 3 asks whether telemedicine could be useful in fulfilling South Africa's legal obligations around provision of access to abortion. The chapter examines the advantages and disadvantages of MATM, evaluating whether the practice is potentially beneficial.

Chapter 4 explores South African legal and ethical frameworks around MATM. Moreover, it discusses necessary changes to these frameworks to enable MATM.

Finally, chapter 5 provides some brief recommendations for enabling MATM. These recommendations are grouped into legal, ethical, and policy changes.

## 1.9 CONCLUSION

South Africa has not fulfilled its obligations around providing SHRC to its population.<sup>123</sup> Factors contributing to this situation include geographical distance,<sup>124</sup> community poverty,<sup>125</sup> lack of awareness of the laws on abortion,<sup>126</sup> stigma around abortion,<sup>127</sup> and many other component considerations. These factors need to be addressed systematically and comprehensively by government. MATM offers a chance for South Africa to move closer to fulfilling its obligations.

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<sup>123</sup> Op cit note 19 at 259.

<sup>124</sup> Ibid.

<sup>125</sup> Op cit note 31.

<sup>126</sup> Bankole et al. op cit note 35 at 15.

<sup>127</sup> National Integrated SRHR Policy op cit note 7 at 8.

## CHAPTER 2

### 2.1 INTRODUCTION

Since 1994, the Republic of South Africa has become a State Party to many international and regional legal instruments that impose significant legal obligations on the state. The state is also responsible for the fulfilment of legal obligations which originate in its Constitution, national laws, and national policies and guidelines. An analysis of these obligations reveals that the right to access abortion is well-protected legally in the Republic. However, realised access to SRHR is unequal across the South African population, where it is present.

This chapter evaluates the legal obligations – international, regional, and national – of the South African state regarding access to abortion. It uses the international normative framework regarding abortion as a benchmark in comparison with which national frameworks can be critiqued. Moreover, this chapter assesses the extent to which these obligations are being fulfilled.

### 2.2 LEGAL OBLIGATIONS REGARDING ABORTION ACCESS

#### *2.2.1 International legal obligations regarding abortion*

South Africa's membership of the United Nations<sup>1</sup> and its signature and ratification of and/or accession to many international human rights instruments have led to substantial state obligations regarding reproductive rights. This section discusses some core instruments.

##### *2.2.1.1 Convention on the Elimination of All Forms of Discrimination Against Women*

The Convention on the Elimination of All Forms of Discrimination against Women<sup>2</sup> (CEDAW), which entered into force in 1981<sup>3</sup> but was ratified by South Africa in 1995,<sup>4</sup> is concerned with discrimination against women or on the grounds of gender.<sup>5</sup> It may therefore seem that CEDAW's provisions are not directly relevant to the case of SRHR, as it is tenuously arguable that different levels of rights fulfilment between groups of women is not discrimination against women but rather between women. This argument is tenuous because

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<sup>1</sup> United Nations 'Member States' available at <https://www.un.org/en/about-us/member-states> , accessed on 10 July 2023.

<sup>2</sup> Convention on the Elimination of Discrimination Against Women, 18 December 1979, UNTS 1249 (entered into force 3 September 1981).

<sup>3</sup> United Nations Office of the High Commissioner 'Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979' available at <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women> , accessed on 10 July 2023.

<sup>4</sup> United Nations Office of the High Commissioner 'Status of Ratification' available at <https://indicators.ohchr.org/> , accessed on 10 July 2023.

<sup>5</sup> Op cit note 3 at Introduction.

discrimination does not cease if it is experienced differently or inconsistently across the affected group. Pregnant people are still being discriminated against, in being denied universal access to SRHC, even if some are able to circumvent barriers to access through affluence or other mitigating factors. CEDAW's provisions on eliminating gender-based discrimination are therefore applicable to the case of SRHR.

CEDAW mandates that signatories must ensure equality of access to healthcare across genders.<sup>6</sup> This explicitly includes reproductive healthcare.<sup>7</sup> Article 14(2)(b) adds that States Parties must ensure sufficient access to healthcare, including reproductive healthcare.<sup>8</sup> CEDAW thus emphasises that it is not acceptable for States Parties to merely ensure de jure equality of access to healthcare; de facto access on an equal basis is also required.

CEDAW also pays special attention to the needs of rural women. The Convention mandates that States Parties must implement suitable interventions to ensure rural women enjoy equality of access to their rights.<sup>9</sup> In South Africa's case, this may mean that intervention to ensure access to reproductive healthcare for rural women is necessary. As a State Party to CEDAW, South Africa is currently falling short of its de facto access obligations around healthcare. The state must intervene to rectify these shortfalls.

#### *2.2.1.2 International Covenant on Civil and Political Rights*

The International Covenant on Civil and Political Rights<sup>10</sup> (the ICCPR), which came into force in 1976<sup>11</sup> but which was ratified by South Africa in 1998,<sup>12</sup> is applicable to the case of reproductive rights in that it is concerned with the elimination of violations of certain human rights, among which it counts gender equality,<sup>13</sup> privacy,<sup>14</sup> protection from discriminatory treatment,<sup>15</sup> and freedom from 'cruel, inhuman or degrading treatment'.<sup>16</sup> All four of these rights are violated when access to reproductive healthcare is denied. Thus, the legal obligations originating in the ICCPR oblige South Africa to rectify denial of access to reproductive healthcare within its territory.

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<sup>6</sup> Supra note 3 at art. 12(1).

<sup>7</sup> Ibid.

<sup>8</sup> Ibid. at art. 14(2)(b).

<sup>9</sup> Ibid. at art. 14(1).

<sup>10</sup> International Covenant on Civil and Political Rights, 16 December 1966, UNTS 999 (entered into force 23 March 1976).

<sup>11</sup> United Nations Office of the High Commissioner 'International Covenant on Civil and Political Rights' available at <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights>, accessed on 10 July 2023.

<sup>12</sup> Op cit note 4.

<sup>13</sup> Supra note 10 at art. 3.

<sup>14</sup> Ibid. at art. 17.1.

<sup>15</sup> Ibid. at art. 26.

<sup>16</sup> Ibid. at art. 7.

The right to gender equality has been largely dealt with under CEDAW, but the ICCPR also highlights equality between men and women as a fundamental right.<sup>17</sup> The ICCPR reminds States Parties that equality across genders is key to the realisation of ICCPR rights, and that gendered discrimination within access to those rights is not acceptable.<sup>18</sup>

The right to privacy, with its implications of prohibiting unjustifiable interference with one's own affairs and one's own body,<sup>19</sup> can be used to justify protecting reproductive rights. This right infers that pregnant people's choices regarding the continuation or termination of their pregnancies is not an arena in which the state may interfere without proper justification.<sup>20</sup> Moreover, this interference may occur even through omission: if the state fails to ensure access to reproductive healthcare including abortion, it is violating the pregnant person's rights.<sup>21</sup>

Protection from discriminatory treatment, especially on certain grounds such as sex, race, or religious belief, is a core tenet of the ICCPR.<sup>22</sup> However, the ICCPR notes that legal discrimination on any grounds is unacceptable.<sup>23</sup> It mandates that States Parties must both proscribe discrimination on any grounds and ensure that all people enjoy 'equal and effective protection against discrimination'.<sup>24</sup> This means that it is not sufficient for States Parties merely to outlaw discrimination; they must also ensure that people enjoy the absence of discrimination. In the case of reproductive rights, this means that South Africa cannot merely make SRHR theoretically accessible. The state must ensure equal and realised access to reproductive healthcare across its population. To fail to do so is a violation of South Africa's obligations under the ICCPR.

The right to be free from 'cruel, inhuman or degrading treatment'<sup>25</sup> is a cornerstone of the ICCPR and is a right from which States Parties may not derogate even in times of national emergency.<sup>26</sup> The prohibition of such treatment in the realm of reproductive rights

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<sup>17</sup> Supra note 10 at art. 3.

<sup>18</sup> Ibid. at art. 3.

<sup>19</sup> Ibid.

<sup>20</sup> Patricia Palacios Zuloaga 'Pushing Past the Tipping Point: Can the Inter-American System Accommodate Abortion Rights?' (2021) 21 *Human Rights Law Review* (4) at 904 – 907.

<sup>21</sup> United Nations Committee on Economic, Social, and Cultural Rights *General Comment 14 (2000): Right to the highest attainable standard of health* 22<sup>nd</sup> Sess, adopted 11 August 2000, UN Doc E/C.12/2000/4, paras 17, 21, 30, 31, 35, 48.

<sup>22</sup> Supra note 10 at art. 26.

<sup>23</sup> Ibid.

<sup>24</sup> Ibid. at art. 26.

<sup>25</sup> Ibid. at art. 7.

<sup>26</sup> Ibid. at art. 4(2).

specifically has also been discussed<sup>27</sup> by the Human Rights Committee (HRC), the body overseeing the implementation of the ICCPR.<sup>28</sup> In particular, the HRC has held that the denial of access to abortion is a violation of the right to be free from ‘cruel, inhuman or degrading treatment’<sup>29</sup>, amongst other rights,<sup>30</sup> and that such denial is therefore a violation of a State Party’s obligations under the ICCPR.<sup>31</sup> South Africa, in maintaining its current and unequal levels of access to reproductive healthcare, violates its obligations under Article 7 of the ICCPR.<sup>32</sup>

While Article 7 is the clearest example in which South Africa is currently in violation of its ICCPR obligations, the rights to gender equality, privacy, and protection from discrimination are also violated by South Africa’s current inequalities of access to reproductive healthcare. It is imperative that government act to rectify these inequalities.

### *2.2.1.3 International Covenant on Economic, Social and Cultural Rights*

The International Covenant on Economic, Social and Cultural Rights<sup>33</sup> (the ICESCR) was only ratified by South Africa in 2015,<sup>34</sup> although it entered into force nearly forty years earlier in 1976<sup>35</sup> and was signed by South Africa in 1994.<sup>36</sup> Since ratification, South Africa has been obliged to ensure the progressive realisation of rights such as non-discrimination,<sup>37</sup> gender equality,<sup>38</sup> the enjoyment of ‘the benefits of scientific progress and its applications’,<sup>39</sup> and the enjoyment of the ‘highest attainable standard’ of health.<sup>40</sup> South Africa is currently likely to be in violation of all four rights mentioned.

The rights to non-discrimination and gender equality go hand in hand, as gender or sex is one of the grounds upon which discrimination often occurs. South Africa is obliged to ensure that ICESCR rights are enjoyed by all, irrespective of gender, race, geographical

<sup>27</sup> Such communications include United Nations Human Rights Committee, Communication No. 1608/2007, *LMR v Argentina*, UN Doc CCPR/C/101/D/1608/2007.

<sup>28</sup> United Nations Office of the High Commissioner ‘Human Rights Committee’ available at <https://www.ohchr.org/en/treaty-bodies/ccpr>, accessed on 10 July 2023.

<sup>29</sup> *Supra* note 10 at art. 7.

<sup>30</sup> *Supra* note 27 paras 9.2, 9.4, 10.

<sup>31</sup> *Ibid.*

<sup>32</sup> *Supra* note 10 at art. 7.

<sup>33</sup> International Covenant on Economic, Social and Cultural Rights, 16 December 1966, UNTS 993 (entered into force 3 January 1976).

<sup>34</sup> *Op cit* note 4.

<sup>35</sup> United Nations Office of the High Commissioner ‘International Covenant on Economic, Social and Cultural Rights’ available at <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights>, accessed on 10 July 2023.

<sup>36</sup> *Op cit* note 4.

<sup>37</sup> *Supra* note 33 at art. 2.2.

<sup>38</sup> *Ibid.* at art. 3.

<sup>39</sup> *Ibid.* at art. 15.1(b).

<sup>40</sup> *Ibid.* at art. 12.1.

location, or other factors.<sup>41</sup> In the case of SRHR, there are blatant inequalities in access.<sup>42</sup> These inequalities follow societal divides along gendered, racial, and geographical lines.<sup>43</sup> Maintaining these inequalities or failing to rectify them means that South Africa violates its obligations under Articles 2 and 3 of the ICESCR. The state remains liable for such violations whether they are violations of commission or omission.<sup>44</sup> The state must intervene in existing inequalities and also prevent the emergence of future inequalities.

The right to enjoy ‘the benefits of scientific progress and its applications’<sup>45</sup> within the ICESCR infers that the populations of States Parties have the right to reap positive outcomes from technological and scientific advancements, and that the onus is on States Parties to provide their populations with such. Should South Africa fail to utilise a suitable and safe scientific advancement in healthcare without sufficient justification, it may be in violation of its ICESCR obligations.

The right to the ‘highest attainable standard’ of health<sup>46</sup> includes access to necessary healthcare<sup>47</sup> but also reflects a larger obligation for States Parties: active intervention to improve their populations’ health.<sup>48</sup> It is insufficient to merely provide access to healthcare.<sup>49</sup> Rather, States Parties must analyse their populations’ health and intervene to improve it where applicable.<sup>50</sup> This process must begin with the identification and rectification of obvious inequalities within access to healthcare,<sup>51</sup> such as those relating to abortion.

#### *2.2.1.3.1 General Comments relevant to the right to the highest possible standard of health*

Two further sources of international law deserve attention in this consideration of the right to the highest possible standard of health. International treaty monitoring bodies are set up by international legal instruments, and these bodies issue opinions, frequently known as General

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<sup>41</sup> Ibid. at art. 2.2.

<sup>42</sup> Ronelle Burger & Martina Mchenga *Anticipating the Impact of the COVID-19 Pandemic on Health Inequality in South Africa: Early Evidence on Direct and Indirect Influences* (2021) PEP Working Paper Series 2021-12; Diane Cooper, Kim Dickson, Kelly Blanchard et al. ‘Medical Abortion: The Possibilities for Introduction in the Public Sector in South Africa’ (2005) 13 *Reproductive Health Matters* 26 at 41.

<sup>43</sup> Burger & Mchenga op cit note 42 at 3.

<sup>44</sup> Supra note 21 para 48; United Nations Committee on Economic, Social, and Cultural Rights *General Comment 22 (2016): Right to sexual and reproductive health* 49<sup>th</sup> Sess, adopted 2 May 2016, UN Doc E/C.12/GC/22 para 14.

<sup>45</sup> Supra note 33 at art. 15.1(b).

<sup>46</sup> Ibid. at art. 12.1.

<sup>47</sup> Ibid. at art. 12.2(d).

<sup>48</sup> See supra note 33 at art. 12.2 for four examples of ways in which States Parties are obliged to actively intervene in the health of their populations.

<sup>49</sup> Supra note 33 at art. 12.2.

<sup>50</sup> Ibid. at art. 12.

<sup>51</sup> Ibid. at arts. 12.1 and 12.2(d).

Comments, on the implementation of the instrument in question.<sup>52</sup> The treaty monitoring body of the ICESCR is the Committee on Economic, Social and Cultural Rights (CESCR), which has issued two opinions which are relevant for this work. These opinions are included in the category of soft law.<sup>53</sup> They are not sources of enforceable obligations, but influence the ways in which States Parties are required to implement the relevant instruments.<sup>54</sup> This section will consider General Comment 14 of 2000<sup>55</sup> and General Comment 22 of 2016,<sup>56</sup> both affecting the implementation of the ICESCR.

#### *2.2.1.3.1.1 General Comment 14 (2000)*

General Comment 14 of 2000 addresses the ICESCR's provision on the right to the highest attainable standard of health.<sup>57</sup> It lays out four necessary and interdependent aspects of the right to health, which are 'availability', 'accessibility', 'acceptability' and 'quality' (AAAQ).<sup>58</sup> These four aspects outline the core obligations of States Parties in providing their populations with the right to health, which in practice must be readily available; accessible in terms of permission for use, geographical location, affordability, and awareness; appropriate to the socio-cultural setting; and of acceptable quality.<sup>59</sup> South Africa, in failing to ameliorate vast differences in accessibility<sup>60</sup> (to take one of several examples), is non-compliant with its international legal obligations around the right to health for its population.<sup>61</sup>

There are four further elements within General Comment 14 of which notice should be taken. Firstly, the General Comment reminds States Parties of their obligation to 'respect, protect and fulfil'<sup>62</sup> the rights enumerated in the ICESCR, an obligation which South Africa is violating in maintaining its status quo with regards to healthcare access.<sup>63</sup> Secondly, the General Comment interprets the ICESCR's requirement of progressive realisation of rights<sup>64</sup> as meaning that deterioration of enjoyment of rights is unacceptable.<sup>65</sup> Progressive realisation

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<sup>52</sup> United Nations Office of the High Commissioner 'General Comments' available at <https://www.ohchr.org/en/treaty-bodies/general-comments>, accessed on 10 July 2023.

<sup>53</sup> Op cit note 52.

<sup>54</sup> Ibid.

<sup>55</sup> Supra note 21.

<sup>56</sup> General Comment 22 supra note 44.

<sup>57</sup> Supra note 21.

<sup>58</sup> Ibid. para 12.

<sup>59</sup> Ibid.

<sup>60</sup> Burger & Mchenga op cit note 42 at 3.

<sup>61</sup> This obligation arises from South Africa's being a State Party to the ICESCR (supra note 33), and specifically from article 12 thereof. The way in which the obligations within article 12 must be fulfilled is amended by General Comment 14 of 2000 (supra note 21).

<sup>62</sup> Supra note 21 para 33.

<sup>63</sup> Burger & Mchenga op cit note 42 at 3.

<sup>64</sup> Supra note 36 at art. 2.1.

<sup>65</sup> Supra note 21 paras 30 and 31.

means that enjoyment of rights must increase, even if only gradually, for a State Party to fulfil its obligations.<sup>66</sup> Should the state not act to improve its population's access to reproductive healthcare, South Africa could be found in violation of its progressive realisation obligations in this regard.

The third element of interest within General Comment 14 concerns SRHC, under which two interconnected State Party obligations are highlighted. The first of these is the obligation of States Parties to the ICESCR to enable their populations to enjoy SRHR,<sup>67</sup> with the necessary corollary of access to SRHC.<sup>68</sup> Notably, the General Comment reminds States Parties that active intervention is necessary to improve SRHC in their countries.<sup>69</sup> The General Comment affirms that rural populations' SRHR must be a priority for States Parties.<sup>70</sup>

The last element of interest within General Comment 14 regards third parties and the obstructions they may present to accessing healthcare. General Comment 14 prescribes that, if they allow third parties to impede access to healthcare, States Parties are in violation of their ICESCR obligations.<sup>71</sup> This means that the South African government may not allow other actors to obstruct healthcare that is suitable under the AAAQ<sup>72</sup> framework.<sup>73</sup> In particular, in the case of MATM, the South African state would have to act to remove third party obstacles to telemedicine (should it be accepted under the AAAQ framework)<sup>74</sup> even if those obstacles originate from bodies such as the HPCSA.<sup>75</sup>

General Comment 14, while not focused solely on SRHC, is a valuable source of guidance regarding South Africa's obligations under the ICESCR with regards to SRHC, including abortion. The above elements of the General Comment – the AAAQ framework,<sup>76</sup> the reminder to 'respect, protect and fulfil',<sup>77</sup> the mandate of progressive realisation,<sup>78</sup> the

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<sup>66</sup> Ibid.

<sup>67</sup> Ibid. para 14.

<sup>68</sup> Ibid. para 17.

<sup>69</sup> Ibid. para 14.

<sup>70</sup> Ibid. para 36.

<sup>71</sup> Ibid. paras 35 and 48.

<sup>72</sup> See above discussion of the availability, accessibility, acceptability, and quality framework of the right to health.

<sup>73</sup> Supra note 21 paras 35 and 48.

<sup>74</sup> Ibid.

<sup>75</sup> Health Professions Council of South Africa *General Ethical Guidelines for Good Practice in Telehealth Booklet 10* (2021).

<sup>76</sup> Supra note 16 paras 12 – 14.

<sup>77</sup> Supra note 21 para 33.

<sup>78</sup> Ibid. paras 30 – 32.

obligation to intervene to improve SRH,<sup>79</sup> particularly in rural areas,<sup>80</sup> and the responsibility to prevent third party obstructions in access to healthcare<sup>81</sup> – all emphasise South Africa’s current failure to comply with its obligations under the ICESCR with particular reference to reproductive rights. Interventions to mitigate and reverse these failures are needed.

#### *2.2.1.3.1.2 General Comment 22 (2016)*

General Comment 22<sup>82</sup> focuses more specifically on SRH as an aspect of ICESCR obligations. It has some similarities to General Comment 14, such as its emphasis of the AAAQ framework.<sup>83</sup> However, the later General Comment expands on this framework, for example in adding that the quality element of the right to health includes the incorporation of advancements in technology and medical care.<sup>84</sup> Failure to incorporate such advancements endangers the quality of healthcare.<sup>85</sup> General Comment 22 also adds to the interpretation of non-discrimination, laying out that non-discrimination and equality must be comprised of legal, formal and substantive equality.<sup>86</sup> Direct and indirect discrimination must both be prevented by States Parties.<sup>87</sup>

The most relevant provision of General Comment 22 for the purposes of this work is its enumeration of core obligations around the provision of SRHC, which include ‘universal and equitable access’.<sup>88</sup> While the General Comment provides for progressive realisation of this obligation,<sup>89</sup> this does not remove States Parties’ obligation to ensure unfettered access to SRHC, including abortion.<sup>90</sup> This reinforces the need for South Africa to improve access to abortion.

The unfulfilled obligations arising from the ICESCR are not minor. It is insufficient to use the defence of progressive realisation<sup>91</sup> in this case, as progressive realisation implies that it is unacceptable for the enjoyment of rights to decline or for a discriminatory status quo to go unaltered.<sup>92</sup> South Africa’s unfulfilled international legal obligations continue to mount with the consideration of the right to the highest possible standard of health.

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<sup>79</sup> Ibid. para 14.

<sup>80</sup> Ibid. para 36.

<sup>81</sup> Ibid. paras 35 and 48.

<sup>82</sup> General Comment 22 supra note 44.

<sup>83</sup> Ibid. paras 4 – 6.

<sup>84</sup> Ibid. para 6.

<sup>85</sup> Ibid.

<sup>86</sup> Ibid. paras 6 – 7.

<sup>87</sup> Ibid.

<sup>88</sup> Ibid. para 12.

<sup>89</sup> Ibid. para 9.

<sup>90</sup> Ibid. paras 10 – 12.

<sup>91</sup> Supra note 33 at art. 2.1.

<sup>92</sup> Supra note 21 para 32.

### 2.2.2 Regional legal obligations regarding abortion and abortion access

Regional legal obligations for the Republic of South Africa largely originate in its membership of the African Union.<sup>93</sup> The primary African Union instrument regarding women's rights is the Protocol on the African Charter of Human and People's Rights on the Rights of Women in Africa (the Maputo Protocol).<sup>94</sup> South Africa is a State Party to the Maputo Protocol.<sup>95</sup> The Maputo Protocol lays out state obligations in the advancement of women's rights, including their sexual and reproductive rights. Notably, the Maputo Protocol mandates that abortion must be legal upon several grounds, including but not limited to 'cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.'<sup>96</sup> This emphasis on mental and physical health of the pregnant person, a progressive leap forward in the liberalisation of international state obligations regarding abortion provision,<sup>97</sup> foregrounds the immense mental and physical health impacts of denying a pregnant person access to abortion.

Furthermore, the Maputo Protocol calls upon its States Parties to '[p]rovide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas.'<sup>98</sup> In the context of article XIV, this obligation clearly places the onus upon the State Party to provide reproductive healthcare, including abortion on the grounds laid out in article XIV(2)(c)<sup>99</sup> at a minimum, to its entire population – including pregnant people living far away from urban centres.<sup>100</sup> Through its signature of and accession to the Maputo Protocol in 2004,<sup>101</sup> South Africa has reinforced its obligation to provide abortion care to all members of its population who desire such care.

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<sup>93</sup> African Union 'African Union' available at <https://au.int/>, accessed on 12 July 2023.

<sup>94</sup> Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 11 July 2003, 1520 UNTS I-26363 (entered into force 25 November 2005) (Maputo Protocol).

<sup>95</sup> African Union *List of Countries Which Have Signed, Ratified/Accessed to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa* (2019).

<sup>96</sup> *Supra* note 94 at art. XIV (2)(c).

<sup>97</sup> Akinrinola Bankole, Lisa Remez, Onikepe Owolabi, et al. *From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress* (2020) at 4.

<sup>98</sup> *Supra* note 94 at art. XIV (2)(a).

<sup>99</sup> *Ibid.* at art. XIV (2)(c).

<sup>100</sup> *Ibid.* at art. XIV (2)(a).

<sup>101</sup> *Op cit* note 101.

### 2.2.3 National legal obligations regarding abortion

#### 2.2.3.1 The Constitution and its implications for access to abortion

The Constitution of the Republic of South Africa, 1996<sup>102</sup> (the Constitution), explicitly places obligations on national government regarding the population's access to SHRH care. The Constitution mandates that all should have the right to access healthcare,<sup>103</sup> and specifically mentions reproductive healthcare as an essential part of healthcare.<sup>104</sup>

Beyond the right to access healthcare, several other rights in the Constitution touch on access to reproductive healthcare. The right to human dignity<sup>105</sup> and to bodily and psychological integrity (falling under the right to freedom and security of the person)<sup>106</sup> also protect the right to access reproductive healthcare. Denial of access to reproductive healthcare is an infringement of one's bodily and psychological integrity, as such denial violates one's autonomy relating to reproduction<sup>107</sup> and one's 'security in and control over the body'.<sup>108</sup> Human dignity is also clearly violated by denial of access to reproductive healthcare.

A further right which influences state obligations regarding the population's access to reproductive healthcare is the right to equality.<sup>109</sup> To achieve the 'full and equal enjoyment of all rights and freedoms'<sup>110</sup> for its population, the state cannot ignore the unequal current realisation of access to SRHC.<sup>111</sup> Enjoyment of the right to equality necessitates the rectification of historical inequalities.<sup>112</sup>

Discussion of rights that entail access entitlements rather than immediate entitlements does entail some nuance.<sup>113</sup> The right to access healthcare, specifically SRHC such as abortion, entails an entitlement of access for the South African population.<sup>114</sup> This access entitlement arises both from the Constitution, in the case of the rights to access healthcare and SRHC,<sup>115</sup> and CTOPA, as amended.<sup>116</sup> Access entitlements imply that the population does not

<sup>102</sup> Constitution of the Republic of South Africa, 1996.

<sup>103</sup> Supra note 102 at s27.

<sup>104</sup> Ibid. at s27(1)(a).

<sup>105</sup> Ibid. at s10.

<sup>106</sup> Ibid. at s12(2).

<sup>107</sup> Ibid. at s12(2)(a).

<sup>108</sup> Ibid. at s12(2)(b).

<sup>109</sup> Ibid. at s9.

<sup>110</sup> Ibid. at s9(2).

<sup>111</sup> Burger & Mchenga op cit note 42 at 3.

<sup>112</sup> Supra note 102 at s9(2).

<sup>113</sup> Pieter Carstens & Debbie Pearmain *Foundational Principles of South African Medical Law* (2007) at 41.

<sup>114</sup> Ibid. at 25 – 37.

<sup>115</sup> Supra note 102 at s27.

<sup>116</sup> Choice on Termination of Pregnancy Act 92 of 1996; Choice on Termination of Pregnancy Amendment Act, 2004; Choice on Termination of Pregnancy Amendment Act, 2008.

have an unqualified right to a certain service or benefit, but instead has the right of access to the same.<sup>117</sup>

This section contends that there are at least three reasons for which the entitlement of access to abortion effectively requires the state to provide abortion services and not simply rely on the notion that access to abortion is theoretically available in the country. These reasons include, but are not limited to, multiple Constitutional protections of the right to abortion; the doctrine of progressive realisation; and non-hindrance of access to abortion.

First, the right to access abortion is protected by multiple sections of the Constitution, not merely section 27.<sup>118</sup> As has been contended by both scholars<sup>119</sup> and the judiciary,<sup>120</sup> the right to access abortion is dually protected by section 12(2)(a) on bodily and psychological integrity<sup>121</sup> and section 12(2)(b) on the right to control one's body.<sup>122</sup> Moreover, the right to access abortion is grounded in the additional Constitutional rights of equality;<sup>123</sup> protection from discrimination based on gender, pregnancy, and sex;<sup>124</sup> dignity,<sup>125</sup> life,<sup>126</sup> and privacy.<sup>127</sup> Carstens and Pearmain go so far as to deduce, from the above protections, a Constitutional right to abortion.<sup>128</sup> If this is accepted, the state would be required to ensure the provision of abortion services as needed. Even if the contention is not accepted, the right to access abortion is clearly well-protected by the South African Constitution, and insufficient fulfilment of the population's right to access abortion would violate each right listed above.

Secondly, the doctrine of progressive realisation,<sup>129</sup> which allows states to move gradually towards fulfilling their obligations,<sup>130</sup> does not allow for retrogression.<sup>131</sup> The doctrine requires that states, at a minimum, avoid policies which would decrease the fulfilment of their obligations. In the South African context of a growing population<sup>132</sup> and

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<sup>117</sup> Op cit note 113 at 41.

<sup>118</sup> Supra note 102 at s27(1)(a).

<sup>119</sup> Op cit note 113 at 92.

<sup>120</sup> *Christian Lawyers' Association v National Minister of Health and Others* 2004 (10) BCLR 1086 (T) at 6.

<sup>121</sup> Supra note 102 at s12(2)(a).

<sup>122</sup> Ibid. at s12(2)(b).

<sup>123</sup> Ibid. at s9.

<sup>124</sup> Ibid.

<sup>125</sup> Ibid. at s10.

<sup>126</sup> Ibid. at s11.

<sup>127</sup> Ibid. at s14.

<sup>128</sup> Op cit note 113 at 99.

<sup>129</sup> Ibid. at 58 – 59, 62 – 64, 76 – 77.

<sup>130</sup> Andy Gray, Yousuf Vawda and Caron Jack 'Health Policy and Legislation' in Ashnie Padarath and René English (eds) *South African Health Review 2011* (2011) at 8.

<sup>131</sup> Ibid. at 8; Bernhard Gaede and Marije Versteeg 'The state of the right to health in rural South Africa' in Ashnie Padarath and René English (eds) *South African Health Review 2011* (2011) at 100.

<sup>132</sup> World Bank 'Population, total – South Africa' available at <https://data.worldbank.org/indicator/SP.POP.TOTL?locations=ZA>, accessed on 3 October 2023.

therefore, by inference, a growing demand for abortion services, any failure to increase access to abortion services is effectively retrogressive. There is no evidence of any stagnation or decline in demand for abortion services in South Africa and, moreover, evidence exists that demand for abortion increased in response to COVID-19 and its accompanying contraception stockouts.<sup>133</sup> Demand for abortion is likely to be increasing, although the rate of the potential increase is unknown.

Progressive realisation requires the continuous increase of access.<sup>134</sup> Government cannot rely on the idea that abortion services are theoretically available in the country, because even this theoretical access is becoming less sufficient as the population grows.<sup>135</sup> Progressive realisation, in the context of access to abortion in South Africa, demands that government provide increased access to abortion.

Thirdly and finally – although many more justifications for this argument are possible – it is the state’s duty to, at minimum, not hinder its population’s access to their rights,<sup>136</sup> even if these rights are access entitlements and not immediate entitlements. As will be discussed below, current legal frameworks around abortion hinder access to the procedure through inappropriate blanket application of requirements designed for a specific form of abortion.<sup>137</sup> This alone would be sufficient to demonstrate that the state is violating its population’s access entitlement to abortion.

Even brief analysis of Constitutional rights reveals that the South African population is justified in seeking equal and dignified access to reproductive healthcare, but realised access is currently insufficient. The question that then arises is how, through its national laws, the South African state has endeavoured to improve such access.

#### 2.2.3.2 *Choice on Termination of Pregnancy Act, 1996*

The Choice on Termination of Pregnancy Act 92 of 1996 (henceforth CTOPA or the Act) came into effect in early 1997,<sup>138</sup> significantly altering the status of abortion in the Republic. Prior to its enactment, abortion was difficult to access legally, at least in part a reflection of

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<sup>133</sup> Gender, Health and Justice Research Unit, University of Cape Town *The right to sexual and reproductive health: challenges and possibilities during COVID-19* (2021) at 8.

<sup>134</sup> Op cit note 113 at 58 – 59, 62 – 64, 76 – 77.

<sup>135</sup> Op cit note 132; op cit note 133 at 8.

<sup>136</sup> Supra note 120 at 12.

<sup>137</sup> Choice on Termination of Pregnancy Amendment Act, 2004 at art. 2.

<sup>138</sup> Ramprakash Kaswa & Parimalarani Yogeswaran ‘Abortion Reforms in South Africa: An Overview of the Choice on Termination of Pregnancy Act’ (2020) 62 *South African Family Practice* 1 at 1.

the strongly conservative views of the apartheid regime.<sup>139</sup> Accessing an abortion required the assent of multiple medical practitioners, depending on gestational age.<sup>140</sup> In practice, this meant that illegal and unsafe abortion was widespread.<sup>141</sup> A notable proportion of maternal mortalities were attributed to complications arising from illegal abortion.<sup>142</sup>

The post-apartheid government, in enacting CTOPA, imposed upon itself an obligation to provide safe abortion to its population. The Act acknowledges that the South African population has the right to access ‘safe, effective, affordable and acceptable methods of fertility regulation’<sup>143</sup> and accepts that the state has an obligation to provide access to SRHC, including abortion, to its population.<sup>144</sup>

The Act does impose limits and regulations on abortion. These limits have been recognised internationally as reasonable and liberal.<sup>145</sup> The Act has been amended since its enactment, with 2004<sup>146</sup> and 2008<sup>147</sup> amendments that altered the constraints on healthcare providers permitted to perform abortions<sup>148</sup> and the healthcare facilities where abortions are permitted to take place.<sup>149</sup>

The impact of CTOPA on the state’s obligations around provision of abortion is clear: pregnant people are entitled to both de jure and de facto access to abortion,<sup>150</sup> subject to reasonable limits.<sup>151</sup> De jure access is largely realised in South Africa. De facto access is another case entirely. Although de facto access is discussed in detail in later chapters, for now it suffices to say that it is reflective of the unequal South African social, political, and economic context.<sup>152</sup> This lack of, or inequality within, de facto access to abortion is a key element of South Africa’s failure to meet its legal obligations around the provision of abortion access.

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<sup>139</sup> Sally Guttmacher, Farzana Kapadia, Jim Te Water Naude, et al. ‘Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act’ (1998) *International Perspectives on Sexual and Reproductive Health* 24 at 191.

<sup>140</sup> *Ibid.* at 192.

<sup>141</sup> Guttmacher Institute, *Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies* (2012) at 12.

<sup>142</sup> Rachel Jewkes & Helen Rees ‘Dramatic Decline in Abortion Mortality Due to the Choice on Termination of Pregnancy Act’ (2008) 95 *SAMJ* 4 at 250.

<sup>143</sup> Choice on Termination of Pregnancy Act 92 of 1996 at 2.

<sup>144</sup> *Ibid.*

<sup>145</sup> Bankole et al. op cit note 97 at 10.

<sup>146</sup> *Supra* note 137.

<sup>147</sup> Choice on Termination of Pregnancy Amendment Act, 2008.

<sup>148</sup> *Supra* note 137 at arts. 1(c), 1(d), and 3.

<sup>149</sup> *Ibid.* at art. 2.

<sup>150</sup> *Supra* note 143 at 2.

<sup>151</sup> *Ibid.* at art. 2.

<sup>152</sup> Burger & Mchenga op cit note 42 at 3.

Moreover, it can be argued that certain elements of CTOPA and its 2004 and 2008 amendments could be stymieing feasible avenues towards greater access to abortion for the South African population. These elements are the requirements for facilities providing access to both surgical and MA,<sup>153</sup> and the legal penalties prescribed for any person who allows an abortion to occur<sup>154</sup> or carries out an abortion in a facility not approved for abortions<sup>155</sup> under CTOPA and its amendments and designated as such by government.<sup>156</sup>

Dealing first with the requirements for healthcare facilities carrying out either or both surgical and MA, this work does not argue that such requirements are unnecessary in all cases. The requirements are set out as follows in the Choice on Termination of Pregnancy Amendment Act of 2004<sup>157</sup>:

**‘Place where termination of pregnancy may take place**

**3. (1)** Termination of a pregnancy may take place only at a facility which-

- (a) gives access to medical and nursing staff;
- (b) gives access to an operating theatre;
- (c) has appropriate surgical equipment;
- (d) supplies drugs for intravenous and intramuscular injection;
- (e) has emergency resuscitation equipment and access to an emergency referral centre or facility;
- (f) gives access to appropriate transport should the need arise for emergency transfer;
- (g) has facilities and equipment for clinical observation and access to in-patient facilities;
- (h) has appropriate infection control measures;
- (i) gives access to safe waste disposal infrastructure;
- (j) has telephonic means of communication; and
- (k) has been approved by the Member of the Executive Council by notice in the *Gazette*.<sup>158</sup>

[emphasis original]

If the above requirements from the 2004 amendment<sup>159</sup> are compared to the relevant section of the 1996 law,<sup>160</sup> it can be seen that the 1996 Act places requirements only on healthcare

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<sup>153</sup> Supra note 137 at art. 2.

<sup>154</sup> Ibid. at art. 6.

<sup>155</sup> Ibid.

<sup>156</sup> Supra note 143 at art. 3.

<sup>157</sup> Supra note 137.

<sup>158</sup> Ibid. at s2.

<sup>159</sup> Supra note 137.

<sup>160</sup> Supra note 143.

facilities carrying out surgical abortions.<sup>161</sup> Two arguments can be advanced for this difference. The first, and perhaps overly simplistic explanation, is that surgical abortion was the only method of abortion contemplated by legislators in drafting the 1996 Act. Proponents of this view could argue that surgical abortion was the dominant, if not only, method of abortion at the time of drafting,<sup>162</sup> and MA was not mentioned in the 1996 Act because it was uncommon or unknown in the South African context.

This argument ignores two faults in its own logic. Firstly, if surgical abortion was the only method of abortion contemplated by legislators, why include the term ‘surgical termination of pregnancy’<sup>163</sup> in the bill? If only one method of abortion is possible and/or practiced in a certain context, it is unnecessary to specify the method permitted because simply permitting termination of pregnancy would be tantamount to permitting the sole method. The inclusion of ‘surgical’<sup>164</sup> before ‘termination of pregnancy’<sup>165</sup> indicates that legislators were cognisant of the possibility of introducing MA, even if it was not then a common phenomenon in the country. It was thus a deliberate choice on the part of the drafters of the 1996 Act to place requirements only on facilities performing surgical terminations of pregnancy.

The second major fault in the above explanation is that MA was approved for use in South Africa by 2001.<sup>166</sup> It is unlikely that a new method for a medical procedure could have been completely unknown five years before it was legally approved in a country, particularly given the approval processes medications must pass before use in South Africa.<sup>167</sup> Even if it is assumed that the drafters of the 1996 Act were unaware of MA, the same assumption cannot be made regarding the drafters of the 2004 and 2008 Amendments. By the time the amendments were enacted, MA had been approved for several years<sup>168</sup> and interest in MA was growing.<sup>169</sup> It is therefore unlikely that the drafters of the 1996 Act were oblivious to the possibilities of MA, and exceedingly unlikely that their 2004 and 2008 counterparts were unaware of contemporaneous practice in the healthcare sector. Clearly, the 1996 Act’s placing

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<sup>161</sup> Supra note 143 at art. 3.

<sup>162</sup> Arthi Ramkissoon, Catherine Searle, Catherine Burns et al. ‘Sexual and Reproductive Health and Rights’ in Sharon Fonn and Ashnie Padarath (eds) *South African Health Review 2010* (2010) at 36.

<sup>163</sup> Supra note 143 at art. 3.

<sup>164</sup> Ibid.

<sup>165</sup> Supra note 143 at art. 3.

<sup>166</sup> Op cit note 162 at 36.

<sup>167</sup> Andrea Keyter, Joey Gouws, Sam Salek et al. ‘The Regulatory Review Process in South Africa’ (2018) 52 *Therapeutic Innovation & Regulatory Science* 4 at 451 – 457.

<sup>168</sup> Op cit note 162 at 36.

<sup>169</sup> See Cooper et al. op cit note 42 for one example of a study indicating significant and growing interest in medical abortion amongst both healthcare providers and patients.

restrictions on which healthcare facilities could perform surgical – but not medical – abortions was a deliberate one. This is the second, and far more plausible, explanation for the differentiation of requirements for surgical abortion in the 1996 Act. It is more logical to conclude that legislators placed restrictions on facilities performing surgical abortions, but not MA, because the restrictions necessary for each type of facility were recognised to be different.

(This work does not intend to argue that MA requires no minimum standards for facilities prescribing it, nor that regulation of MA is unnecessary. It is simply the case that medical and surgical abortion require different infrastructure, and therefore different regulations and requirements, for the healthcare facilities prescribing or carrying out these procedures.)

It is regrettable, therefore, that the 2004 Amendment of CTOPA ignored the differences between medical and surgical abortion, placing identical requirements on facilities involved in either method.<sup>170</sup> This is not a medical thesis and it will not attempt to assess the suitability of the requirements for healthcare facilities providing surgical abortions under the terms of the 2004 Amendment.<sup>171</sup> Instead, it asks whether there is evidence that these requirements are necessary for facilities involved in prescribing MA exclusively.

There is a dearth of research supporting identical requirements for facilities involved in medical versus surgical abortions. Instead, research spanning the decades since abortifacients were developed,<sup>172</sup> reveals that MA is safe,<sup>173</sup> effective<sup>174</sup> and, in the early stages of gestation, suitable for self-managed abortion.<sup>175</sup> MA is less invasive and presents less risk of complications than surgical abortion.<sup>176</sup> Both patients and healthcare practitioners have indicated a preference for MA in some studies,<sup>177</sup> as it is perceived as more discreet<sup>178</sup> and as presenting fewer ethical conundrums for healthcare workers.<sup>179</sup> MA is of equivalent quality to surgical abortion<sup>180</sup> and moreover provides many additional benefits for patients

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<sup>170</sup> Supra note 137 at art. 2.

<sup>171</sup> Ibid.

<sup>172</sup> Lara Bullens ‘The long and winding history of the war on abortion drugs’ 26 April 2023, available at <https://www.france24.com/en/health/20230426-the-long-and-winding-history-of-the-war-on-abortion-drugs> , accessed on 14 July 2023.

<sup>173</sup> Bankole et al. op cit note 97 at 22 – 23.

<sup>174</sup> Ibid.

<sup>175</sup> Cooper et al. op cit note 42 at 36.

<sup>176</sup> Bankole et al. op cit note 97 at 5.

<sup>177</sup> Bankole et al. op cit note 97 at 36.

<sup>178</sup> Cooper et al. op cit note 42 at 36.

<sup>179</sup> Ibid.

<sup>180</sup> Bankole et al. op cit note 97 at 5, 22 – 23.

and healthcare practitioners.<sup>181</sup> The wealth of research on the differences between medical and surgical terminations of pregnancy does not support the idea that they need identical regulation.

It is disappointing that the 2004 and 2008 amendments of CTOPA effectively took a step backwards, making a feasible path towards increasing the population's access to abortion much less workable. Projects in the NGO sector, such as those run by MSI South Africa,<sup>182</sup> demonstrate that MA is safe and effective without the need for the infrastructure required by law.<sup>183</sup> This is because MA simply does not need the same infrastructure as surgical abortion, as long as there is sufficient support available in the event of (rare) complications.<sup>184</sup> This support could take the form of information hotlines or referrals to healthcare facilities.<sup>185</sup> Requiring MA to take place in facilities with unneeded infrastructure is hampering efforts to expand access to abortion in South Africa.

It is thus imperative that an amendment be enacted to further amend CTOPA. This amendment should differentiate between the requirements for facilities prescribing MA and facilities performing surgical abortion. The requirements for each type of facility should reflect current best practices in healthcare. The amendment should secure the legality of current practices in SRHC insofar as they are safe, acceptable, and work to fulfil the right of access to reproductive healthcare for the South African population. Approval for methods of abortion which may emerge in the future should be allowed to be determined through policy and not through legal amendment, as is discussed later in this work.

These amendments should also deal with the 2004 amendment's prescription of legal penalties, such as fines or prison sentences of up to a decade, for any person who performs an abortion<sup>186</sup> or permits an abortion to occur<sup>187</sup> outside a healthcare facility that has been officially designated as a facility permitted to perform abortions.<sup>188</sup> Not only are these legal penalties an obstacle to increasing the prevalence of MA in South Africa, which can take place safely and effectively outside a designated medical facility,<sup>189</sup> but they are unreflective

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<sup>181</sup> Cooper et al. op cit note 42 at 36.

<sup>182</sup> MSI 'MSI Reproductive Choices: Making choice possible' available at <https://www.msichoices.org/>, accessed on 12 July 2023.

<sup>183</sup> MSI South Africa, *Increasing abortion access through tele abortion* (n.d.).

<sup>184</sup> *Ibid.*; Bankole et al. op cit note 97 at 6.

<sup>185</sup> Op cit note 183; Cooper et al. op cit note 42 at 42.

<sup>186</sup> *Supra* note 137 at art. 6.

<sup>187</sup> *Supra* note 137 at art. 6.

<sup>188</sup> *Supra* note 143 at art. 3.

<sup>189</sup> Bankole et al. op cit note 97 at 4 – 5, 22 – 23.

of government-endorsed and -recommended practice.<sup>190</sup> MA in the public sector, at the time of writing and for many years prior, is largely an outpatient procedure.<sup>191</sup> Patients present to a healthcare facility for prescription of the relevant medication, some or all of which is taken at a different location such as the patient's residence.<sup>192</sup> Although patients return to the facility for a checkup after a certain period of time,<sup>193</sup> the abortion is occurring – at least in some cases – outside the healthcare facility. This means that by following government policy,<sup>194</sup> healthcare practitioners in South Africa are exposing themselves to criminal charges.<sup>195</sup>

Again, this thesis does not argue that there should be no regulation around who may prescribe or perform an abortion, as the absence of any regulation would permit 'backstreet' or unsafe abortion providers to proliferate further. Instead, it is the contention of this work that persons who enable unsafe abortion can be prosecuted through other means.<sup>196</sup> Laws and regulations regarding who may carry out medical procedures and prescribe medications already exist in the South African legal code.<sup>197</sup> Prosecution of unsafe abortion practitioners can occur without the criminalisation of outpatient MA or MATM. Amendments drafted to address abortion facility requirements should also address this issue, securing legal protection for healthcare practitioners prescribing MA for outpatients or for telemedicine patients.

The following section demonstrates that government policies on SRHC also violate the South African population's right to access abortion.

### *2.2.3.3 National guidelines and policies*

National guidelines and policies regarding healthcare have proliferated in the years since 1994, as the state pursues its goal of universal healthcare access. This work has deliberately chosen to exclude policies and guidelines on the proposed National Health Insurance<sup>198</sup> (NHI), as this would require significant investigation in its own right.

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<sup>190</sup> National Department of Health, *National Clinical Guidelines for Implementation of the Choice on Termination of Pregnancy Act* (2019) at 16; National Department of Health, *National Integrated Sexual & Reproductive Health and Rights Policy* (2019) at 25 – 26.

<sup>191</sup> *Ibid.*

<sup>192</sup> National Clinical Guidelines op cit note 190 at 16; National Integrated SRHR Policy op cit note 190 at 25 – 26.

<sup>193</sup> *Ibid.*

<sup>194</sup> National Clinical Guidelines op cit note 190 at 16; National Integrated SRHR Policy op cit note 190 at 25 – 26.

<sup>195</sup> *Supra* note 137 at art. 6.

<sup>196</sup> Patty Skuster 'How Laws Fail the Promise of Medical Abortion: A Global Look' (2017) 18 *Georgetown Journal of Gender and the Law* 379 at 391 – 393.

<sup>197</sup> For example, see 'Chapter III: Offences by Unregistered Persons' of the Medical, Dental and Supplementary Health Service Professions Act 56 of 1974.

<sup>198</sup> National Health Insurance Bill 11B of 2019.

The most relevant national guidelines and policies for this research are the 2019 National Clinical Guidelines for the Implementation of the Choice on Termination of Pregnancy Act<sup>199</sup> and the 2019 National Integrated Sexual and Reproductive Health and Rights Policy<sup>200</sup>, both published by the National Department of Health.<sup>201</sup> Both documents initially seem to be reasonable guidelines towards expanding the provision of SRHC, including abortion, in South Africa. Upon closer inspection, however, each document reveals implicit assumptions that may hamper the increased provision of MA.

The 2019 National Clinical Guidelines for the Implementation of the Choice on Termination of Pregnancy Act<sup>202</sup> (the National Clinical Guidelines or the Guidelines) note the inconsistent access to and standards of care in legal facilities that may cause the prevalence of illegal abortion.<sup>203</sup> The Guidelines set some admirable targets for the provision of abortion in South Africa,<sup>204</sup> such as the provision of abortion on the same day that it is requested.<sup>205</sup> The Guidelines also mandate that abortions should happen at the ‘lowest appropriate level of care’<sup>206</sup> and ‘as close to home as possible’.<sup>207</sup> The Guidelines therefore reinforce the state’s obligation to provide abortion to its population where appropriate and requested, and moreover add additional obligations around realised access.<sup>208</sup> The Guidelines must lead to the conclusion that the status quo of insufficient access to reproductive healthcare,<sup>209</sup> including abortion, needs state intervention.

Close examination of the Guidelines does, however, reveal implicit assumptions of the superiority of in-facility abortion. This can be seen in the requirement of physical examination of the pregnant person prior to approval of an abortion,<sup>210</sup> and in the detailed list of equipment and systems required for a facility to be legally designated as approved to prescribe MA.<sup>211</sup> (It is also seen in the legal penalties prescribed in the 2004 amendment of CTOPA for any person who performs an abortion, or permits an abortion to occur, outside a

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<sup>199</sup> National Clinical Guidelines op cit note 190.

<sup>200</sup> National Integrated SRHR Policy op cit note 190.

<sup>201</sup> National Department of Health ‘National Department of Health’ available at <https://www.health.gov.za/>, accessed on 12 July 2023.

<sup>202</sup> National Clinical Guidelines op cit note 190.

<sup>203</sup> Ibid. at 1 – 2.

<sup>204</sup> Ibid. at 2, 30.

<sup>205</sup> Ibid. at 30.

<sup>206</sup> Ibid. at 2.

<sup>207</sup> Ibid. at 29.

<sup>208</sup> Ibid. at 2, 29.

<sup>209</sup> Burger & Mchenga op cit note 42 at 3.

<sup>210</sup> Ibid. at 13.

<sup>211</sup> Ibid. at 33 – 34; see also supra note 143.

legally designated facility.<sup>212</sup>) These underlying assumptions imply that abortions taking place outside healthcare facilities are inferior and should not be allowed. This has significant implications for the possibility of approving MA prescribed through telemedicine, or indeed outpatient MA more generally: such abortions would be against national policy and may possibly expose the healthcare professionals involved to criminal charges.

In contrast to this assumption that facility-based care is the gold standard of abortion, the Guidelines also recommend that terminations of pregnancy be, at least partially, outpatient procedures,<sup>213</sup> with a pregnant person being prescribed medication for abortion at a healthcare facility and taking the medication at home (or partially at the healthcare facility and partially at home).<sup>214</sup> After some time, the patient returns to the healthcare facility to undergo a pregnancy test, verifying the success or failure of the abortion.<sup>215</sup>

The recommendation of outpatient abortions, in which the abortion is induced or continued at the patient's residence or another location, contradicts the Guidelines' earlier assumptions. If in-facility abortions are the gold standard of care, and therefore MA cannot be prescribed and carried out remotely, then why is outpatient MA acceptable? Either physical examination and emergency equipment are always necessary, in which case all abortions should take place at a suitably equipped healthcare facility, or they are not always necessary, in which case outpatient MA and MATM are acceptable. Naturally, there will be limitations to the eligibility of patients for MA,<sup>216</sup> whether through outpatient care or through telemedicine. These limitations should not be taken to mean that the use of MATM is impermissible. Indeed, outpatient MA is already deemed permissible in some cases. The contradictions inherent in the National Clinical Guidelines will need to be examined, and the Guidelines revised, to enable the increased use of MATM in South Africa and to affirm the legality of current government regulations.

Turning secondly to the National Integrated Sexual and Reproductive Health and Rights Policy of 2019 (the National Integrated SRHR Policy or the Policy), contradiction emerges once again. The Policy acknowledges that the healthcare system in the country is 'ineffective and inefficient'<sup>217</sup> and 'overburdened'.<sup>218</sup> The Policy notes moreover that many

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<sup>212</sup> Supra note 137 at art. 6.

<sup>213</sup> National Clinical Guidelines op cit note 190 at 16.

<sup>214</sup> Ibid.

<sup>215</sup> National Clinical Guidelines op cit note 190 at 16.

<sup>216</sup> Diane Cooper, Jane Harries, Jennifer Moodley et al. 'Coming of age? Women's sexual and reproductive health after twenty-one years of democracy in South Africa' (2016) 24 *Reproductive Health Matters* 48 at 4.

<sup>217</sup> National Integrated SRHR Policy op cit note 190 at 6.

<sup>218</sup> Ibid.

healthcare facilities in South Africa, which are eligible to perform abortions, have not been registered as legally recognised abortion facilities.<sup>219</sup> In response to these issues, the Policy recommends – similarly to the National Clinical Guidelines<sup>220</sup> – that abortions take place at the lowest possible level of care that is still appropriate and practicable.<sup>221</sup>

Among the targets set by the Policy are the provision of safe terminations of pregnancy at all eligible healthcare facilities,<sup>222</sup> to ‘maximise efficiencies’.<sup>223</sup> However, the Policy also adds that all healthcare facilities able to facilitate childbirth are equipped to provide abortions.<sup>224</sup> This assertion is not explained further.<sup>225</sup> Government regulations for facilities providing maternal healthcare<sup>226</sup> do not align with the regulations for facilities performing or prescribing abortions.<sup>227</sup> It is unclear why the Policy seems to erroneously assert that a significant proportion of healthcare facilities in South Africa are equipped and permitted to perform abortions,<sup>228</sup> when reliable data demonstrates that the proportion of all healthcare facilities that were registered as approved abortion-providing facilities was lower than 7 per cent in 2016.<sup>229</sup>

Like the National Clinical Guidelines, the Policy endorses outpatient MA<sup>230</sup> and goes on to require healthcare facility managers to sustain successful home-based healthcare services.<sup>231</sup> Confusingly, and again along the lines of the National Clinical Guidelines,<sup>232</sup> the Policy also lays out somewhat inappropriate, or at least outdated, requirements for healthcare facilities prescribing MA.<sup>233</sup> This confusion in the Policy lies in the same implicit but erroneous assumptions seen in the National Clinical Guidelines, namely that in-facility abortions are the gold standard of care and that no deviations from this standard can be permitted. This logic is behind the extensive requirements for healthcare facilities to be legally permitted to perform abortions. However, this logic is revealed as faulty when it is compared to the endorsement of outpatient MA by the same national policies which

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<sup>219</sup> Ibid. at 14.

<sup>220</sup> National Clinical Guidelines op cit note 190 at 2.

<sup>221</sup> National Integrated SRHR Policy op cit note 190 at 4, 19.

<sup>222</sup> Ibid. at 20.

<sup>223</sup> Ibid. at 21.

<sup>224</sup> Ibid. at 25.

<sup>225</sup> Ibid. at 25.

<sup>226</sup> National Department of Health *Guidelines for Maternity Care in South Africa: Fourth Edition 2016* (2016) at 139 – 140.

<sup>227</sup> National Clinical Guidelines op cit note 190 at 33 – 34.

<sup>228</sup> National Integrated SRHR Policy op cit note 190 at 25.

<sup>229</sup> Amnesty International, *Barriers to Safe and Legal Abortion in South Africa* (2017) at 12.

<sup>230</sup> National Integrated SRHR Policy op cit note 190 at 25 – 26.

<sup>231</sup> Ibid. at 37.

<sup>232</sup> National Clinical Guidelines op cit note 190 at 33 – 34.

<sup>233</sup> National Integrated SRHR Policy op cit note 190 at 25.

implicitly discourage outpatient MA. Since outpatient MA is permitted and recommended by the National Department of Health, continuing to insist on the patient's physical presence at a facility, before they return home to initiate or continue an abortion themselves through the prescribed medication, seems illogical. Assumptions of the necessity of physical examination remain present in the thinking of the drafters of these guidelines and policies, but these assumptions are not borne out by current research on the efficacy of methods of abortion.<sup>234</sup>

The idea that in-facility abortions are superior to their outpatient counterparts is rooted in the history of abortion: surgical abortion was the safest and most effective method until the advent of MA.<sup>235</sup> MA was approved for use in South Africa in 2001,<sup>236</sup> yet national health policies and guidelines have not been adequately updated since then to enable the use of this method. MA, in its window of opportunity in early gestation,<sup>237</sup> is as acceptable and safe as surgical abortion<sup>238</sup> and is often preferred by both patients and healthcare providers for its ease of administration, safety, and discretion.<sup>239</sup> Both the National Clinical Guidelines and the National Integrated SRHR Policy need to be updated to reflect current medical best practices<sup>240</sup> regarding requirements for facilities prescribing MA.<sup>241</sup>

Government policies should reflect the growing use of outpatient MA and therefore remove the inappropriate or unneeded requirements for healthcare facilities that provide outpatient MA. Appropriate and necessary requirements for these facilities, such as access to emergency care if needed,<sup>242</sup> will naturally remain. The amendment of relevant policies and laws to enable MA would also move South Africa closer to fulfilling its legal obligations around realised access to SRHC.

Moreover, attention must be paid to the requirement of the patient's physical presence at a healthcare facility which is permitted to prescribe MA, even if the abortion is to take place elsewhere. The WHO recommends that ultrasounds are not required before abortion in early gestation;<sup>243</sup> they may be used if necessary, but in many cases self-assessment is sufficient for determining gestational age.<sup>244</sup> In certain circumstances, therefore, the patient's

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<sup>234</sup> Op cit note 141 at 11.

<sup>235</sup> Op cit note 196 at 380; Bankole et al. op cit note 97 at 5, 22 – 23.

<sup>236</sup> Op cit note 162 at 36.

<sup>237</sup> Op cit note 216 at 6.

<sup>238</sup> Op cit note 141 at 11.

<sup>239</sup> Bankole et al. op cit note 97 at 36.

<sup>240</sup> See, for example, World Health Organization *Abortion care guideline* (2022) at 98.

<sup>241</sup> Ibid.

<sup>242</sup> Op cit note 141 at 39.

<sup>243</sup> Op cit note 240 at 98.

<sup>244</sup> Ibid.

physical presence at a healthcare facility is unnecessary.<sup>245</sup> The criteria for these circumstances include a gestational age of less than or equal to 63 days (according to South African regulations) or less than 12 weeks (according to WHO recommendations, a period equal to 84 days).<sup>246</sup> In these limited circumstances, the prescription of abortion through telemedical consultation appears to be entirely acceptable.

The South African national policies governing abortion rely on assumptions that are outdated and inconsistent with current medical best practices. These policies and guidelines should be revised to better reflect medical best practices in SRHR, as issued by international medical organisations such as the WHO,<sup>247</sup> and the state's legal obligations.

The following section consists of a brief evaluation of the fulfilment of South Africa's legal obligations around abortion access under non-pandemic conditions and under pandemic conditions.

### 2.3 FULFILMENT OF INTERNATIONAL, REGIONAL, AND NATIONAL LEGAL OBLIGATIONS REGARDING ABORTION AND ABORTION ACCESS

As the pandemic is a fairly recent event, it is not possible to complete a comprehensive analysis of the fulfilment of legal obligations under pandemic conditions up to the present day. The analysis that is possible is limited by the availability of published data. This section therefore analyses data on impacts on the fulfilment of South Africa's legal obligations relating to the provision of abortion access gathered until end December 2021.

#### 2.3.1 *Fulfilment under non-pandemic conditions (pre-2020)*

The South African government has achieved de jure entitlement to abortion for its population. Questions remain regarding obstacles to de facto access and the quality of care received. While data on these topics remains somewhat scarce, it is possible to extrapolate information from other data sets such as healthcare questions in national surveys.<sup>248</sup>

South Africans report significant obstacles in accessing healthcare.<sup>249</sup> SRHC is beset by numerous obstacles, including lack of funds for treatment,<sup>250</sup> distance to nearest healthcare

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<sup>245</sup> Op cit note 240 at 98.

<sup>246</sup> Op cit note 216 at 6.

<sup>247</sup> Op cit note 240.

<sup>248</sup> National Department of Health, Statistics South Africa, South African Medical Research Council, and ICF *South Africa Demographic and Health Survey 2016* (2019).

<sup>249</sup> *Ibid.* at 250.

<sup>250</sup> *Ibid.* at 259.

facility,<sup>251</sup> community stigma around certain conditions,<sup>252</sup> negative attitudes of healthcare providers<sup>253</sup> around some population groups, such as adolescents, seeking SRHC,<sup>254</sup> and many others. It is difficult to establish either the level of demand for abortion, as even the request is stigmatised,<sup>255</sup> or the number of abortions performed annually, as very little data on the subject is available.<sup>256</sup> However, the data that is available demonstrates that, pre-COVID-19, the South African population had a significant unmet need for safe abortion.<sup>257</sup> This is exemplified by the high proportion of pregnant people seeking abortion who turn to informal sector providers.<sup>258</sup>

### 2.3.2 Fulfilment under pandemic conditions (2020 to end 2021)

National surveys demonstrate that people with acute healthcare needs did not always seek healthcare as needed,<sup>259</sup> especially during the months of Level 5 lockdown (the most stringent lockdown regulations, implemented from 27 March 2020 to 1 May 2020<sup>260</sup>). Moreover, 25 per cent of respondents reported that they were unable to access needed medication, contraceptives, or condoms in this period.<sup>261</sup>

The likelihood of an ensuing negative impact on SRHR is borne out by other data, such as the rise in teenage pregnancies during the higher levels of lockdown<sup>262</sup> and reports of a ‘large’, ‘robust’, and ‘significant decline’ in the population’s access to contraception.<sup>263</sup> Additional reports suggest that the amount of contraception dispensed in Gauteng, by far the country’s most populous province,<sup>264</sup> declined noticeably from February 2020.<sup>265</sup> In Gauteng in April 2020, some common forms of contraception were dispensed at a rate 45 per cent

<sup>251</sup> Ibid.

<sup>252</sup> Elizabeth A. Mosley, Amy J. Schulz, Lisa H. Harris, et al. ‘South African Abortion Attitudes from 2007–2016: The Roles of Religiosity and Attitudes toward Sexuality and Gender Equality’ (2020) 60 *Women & Health* 7 at 2–3, 6–8.

<sup>253</sup> Ibid. at 8.

<sup>254</sup> South African Medical Research Council ‘Teenage Pregnancy during COVID-19 in South Africa: A Double Pandemic’ 7 September 2021, available at <https://www.samrc.ac.za/news/teenage-pregnancy-during-covid-19-south-africa-double-pandemic>, accessed 11 August 2023.

<sup>255</sup> Op cit note 252 at 2–3, 6.

<sup>256</sup> Candy Day, Andy Gray & Eric Budgell ‘Health and related indicators’ in Ashnie Padarath and René English (eds) *South African Health Review 2011* (2011) at 178.

<sup>257</sup> Op cit note 252 at 2.

<sup>258</sup> National Clinical Guidelines op cit note 190 at 1.

<sup>259</sup> Ibid.

<sup>260</sup> Disaster Management Act regulations in GN R398 GG 11062 of 25 March 2020.

<sup>261</sup> Ibid.

<sup>262</sup> Op cit note 254.

<sup>263</sup> Ronelle Burger, Candy Day, Nicola Deghaye et al. *Examining the Unintended Consequences of the COVID-19 Pandemic on Public Sector Health Facility Visits: The First 150 Days* (2020) at 19.

<sup>264</sup> South African Government ‘South Africa’s Provinces’ available at <https://www.gov.za/about-sa/south-africas-provinces#>, accessed on 22 October 2023.

<sup>265</sup> Op cit note 263 at 4.

lower than the monthly average.<sup>266</sup> The number of abortions carried out at Gauteng healthcare facilities plummeted with the introduction of the lockdowns, dropping 30 per cent in one month alone.<sup>267</sup> Although national data cannot be extrapolated from a single province, it is obvious that access to SRHR, particularly regarding the prevention and termination of unwanted pregnancies, declined with devastating effect during the early months of the COVID-19 lockdowns.

A decrease in visits to primary healthcare facilities, first observed during Level 5 lockdown in April 2020,<sup>268</sup> did not reverse itself for many months.<sup>269</sup> In these months, people did not visit healthcare practitioners in person for a variety of reasons, including fear of contracting COVID-19 and fear of police brutality should they be perceived as violating lockdown regulations.<sup>270</sup> These fears were not unfounded. Risk of contracting COVID-19 logically will increase with exposure to more people. Reports of police brutality against those accused of contravening lockdown regulations were rife. 230 000 people were arrested during the first five weeks of the pandemic lockdown and 11 were killed by police in the same period.<sup>271</sup>

Pregnant people who might ordinarily have sought and obtained an abortion from public health facilities were less likely to obtain an abortion under lockdown.<sup>272</sup> This decrease in the chances of successfully seeking abortion, in combination with decreased access to contraception<sup>273</sup> and increased pregnancies,<sup>274</sup> means that an increase in unwanted pregnancies during the pandemic is extremely likely. NGOs estimated that 2 700 000 unsafe terminations of pregnancy and 11 000 pregnancy-related deaths could occur globally in 2020 alone.<sup>275</sup> Corresponding estimates are difficult to establish for South Africa, given chronic underreporting of abortion<sup>276</sup> and societal stigma surrounding the procedure,<sup>277</sup> but it is

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<sup>266</sup> Tsholofelo Adelekan, Belete Mihretu, Witness Mapanga et al. 'Early Effects of the COVID-19 Pandemic on Family Planning Utilisation and Termination of Pregnancy Services in Gauteng, South Africa: March–April 2020' (2020) 2 *Wits Journal of Clinical Medicine* 2 at 147–148.

<sup>267</sup> *Ibid.* at 148–150.

<sup>268</sup> Y Pillay, S Pienaar, P Barron et al. 'Impact of COVID-19 on routine primary healthcare services in South Africa' (2021) 111 *SAMJ* 8 at 714–715; op cit note 263 at 12–13.

<sup>269</sup> Pillay et al. op cit note 268 at 714–715.

<sup>270</sup> Burger & Mchenga op cit note 42 at 18.

<sup>271</sup> Simone Haysom 'South Africa's Police Problem' 4 July 2020, available at <https://www.lrb.co.uk/blog/2020/july/south-africa-s-police-problem>, accessed 5 June 2023.

<sup>272</sup> Pillay et al. op cit note 268 at 714.

<sup>273</sup> Nic Spaull, Cally Ardington, Ihsaan Bassier et al. *NIDS-CRAM Wave 1 Synthesis Report: Overview and Findings* (2020) at 8; Burger et al. op cit note 263 at 19.

<sup>274</sup> Op cit note 254.

<sup>275</sup> Burger et al. op cit note 263 at 4.

<sup>276</sup> Op cit note 256 at 178.

<sup>277</sup> Op cit note 252 at 2.

highly likely that unsafe abortions, complications from abortion or lack thereof, and maternal morbidity and mortality will have increased during the lockdown months and potentially far beyond them. Similarly, it is likely that access to abortion will have decreased during the period in question.

### *2.3.3 Legal consequences of declines in or non-fulfilment of legal obligations around access to abortion during the COVID-19 pandemic*

Denial of abortion is a violation of a state's international legal obligations to provide access to safe abortion services and therefore its obligation to refrain from cruel, inhuman or degrading treatment of persons.<sup>278</sup> South Africa has accepted these international and regional legal obligations,<sup>279</sup> and has affirmed these obligations in CTOPA as amended<sup>280</sup> and supporting policies.<sup>281</sup> Through its direct<sup>282</sup> and indirect obstruction<sup>283</sup> of access to abortion during the COVID-19 lockdown, South Africa has violated its obligations to provide safe<sup>284</sup>, timely<sup>285</sup> abortion access to its population and to refrain from conduct amounting to cruel, inhuman or degrading treatment.<sup>286</sup> The state could be held liable<sup>287</sup> for the negative impacts of any ensuing and unwanted pregnancies.

Furthermore, the impacts of denial of timely and safe abortion access go beyond unwanted pregnancies. The slowing and sometimes absence of visits to healthcare facilities will have both immediate and longer-term impacts on South Africans' health. Mild cases may become severe or complicated with delays in care; routine healthcare may become an emergency case.<sup>288</sup> Delays in care have a demonstrable negative impact on the healthcare system.<sup>289</sup> Morbidity and mortality rates will also rise.<sup>290</sup> Pregnant people are especially

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<sup>278</sup> Supra note 27 paras 9.2, 9.4, 10.

<sup>279</sup> See chapter 2's sections on international and regional legal obligations for a demonstration of this acceptance.

<sup>280</sup> Act 92 of 1996.

<sup>281</sup> National Integrated SRHR Policy op cit note 190; National Clinical Guidelines op cit note 190.

<sup>282</sup> Op cit note 271.

<sup>283</sup> MSF Southern Africa 'South Africa: Providing Safe Abortion Care during a National Lockdown' 3 July 2020 available at <https://www.msf.org.za/news-and-resources/fieldworker-stories/south-africa-providing-safe-abortion-care-during-national>, accessed on 24 February 2023.

<sup>284</sup> Ibid.

<sup>285</sup> H Cheadle & Dennis Davis 'Chapter 22: Health and Social Security' in H Cheadle & Dennis Davis (eds) *South African Constitutional Law: The Bill of Rights* (2023) at 22-8.

<sup>286</sup> Supra note 10 at art. 7; supra note 27 paras 9.2, 9.4, 10.

<sup>287</sup> Op cit note 4; United Nations Office of the High Commissioner 'Optional Protocol to the International Covenant on Civil and Political Rights' available at <https://www.ohchr.org/en/instruments-mechanisms/instruments/optional-protocol-international-covenant-civil-and-political>, accessed on 10 July 2023.

<sup>288</sup> Pillay et al. op cit note 268 at 719; N Nematswerani, L Steenkamp, S Haneef et al. 'Understanding the impact of the COVID-19 pandemic on healthcare services' (2023) 113 *SAMJ* 4 at 1159 – 1164; Burger et al. op cit note 263 at 26 – 27.

<sup>289</sup> Pillay et al. op cit note 268 at 719; Burger et al. op cit note 263 at 26 – 27.

<sup>290</sup> Pillay et al. op cit note 268 at 719.

vulnerable to these impacts, as pregnancy is by its nature time-sensitive: complications and issues need to be diagnosed as early as possible, with later diagnosis having exponentially greater chances for harm to the pregnant person and/or the foetus.<sup>291</sup> In effectively disallowing access<sup>292</sup> to safe abortion for even part of its population during the COVID-19 lockdown, the South African state not only violated the rights of its population to access SRHC<sup>293</sup> and violated its own legal obligations to provide access to abortion: it has also harmed its own healthcare system by increasing future burdens thereon and future mortality rates.<sup>294</sup>

South Africa's legal obligations around access to abortion and its population's reproductive rights are both being violated. Scholars who have reported on these violations commonly recommend telemedicine as one possible component of a solution.<sup>295</sup> The next chapter investigates this possibility.

## 2.4 CONCLUSION

South Africa has imposed upon itself a plethora of legal obligations around reproductive healthcare and rights, which are currently unfulfilled. Where they are somewhat fulfilled, the level of fulfilment is unequal. This insufficient access to abortion constitutes a violation of South Africa's legal obligations and could expose the state to legal liability.

Beyond the legal ramifications, however, lie the detriments to the South African population. Pregnant people in South Africa are being failed in that they are not able to access their reproductive rights. It is essential that government intervene to address these issues.

Chapter 3 evaluates MATM as one possible intervention to improve access to abortion, assessing the advantages and disadvantages of MATM in the South African context.

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<sup>291</sup> Burger & Mchenga op cit note 42 at 16 – 17.

<sup>292</sup> Op cit note 271; op cit note 283.

<sup>293</sup> Supra note 102 at s27(1)(a); op cit note 113 at 99.

<sup>294</sup> Pillay et al. op cit note 268 at 719; Burger et al. op cit note 263 at 26 – 27.

<sup>295</sup> Pillay et al. op cit note 268 at 718 – 719; Nematswerani et al. op cit note 288 at 1159 – 1164.

## CHAPTER 3

### 3.1 INTRODUCTION

The South African context, even before the pandemic, was one of highly stratified and largely inaccessible medical care for the majority of the population.<sup>1</sup> Abortions were performed by less than 7 per cent of healthcare facilities.<sup>2</sup> Access to healthcare reflected the country's apartheid past, with most of the population relying on government-funded public healthcare for their medical care.<sup>3</sup> A small minority – mostly wealthy and white – were able to afford self-funded private healthcare.<sup>4</sup> Public healthcare, especially SRHC, was chronically underfunded and largely inaccessible.<sup>5</sup> The situation was worse in rural areas.<sup>6</sup> National government itself described public healthcare as 'ineffective', 'inefficient' and 'overburdened'.<sup>7</sup>

In this context, access to abortion was limited, with half of all annual abortions estimated to take place in the informal sector.<sup>8</sup> This reflects the fact that abortion is not adequately accessible in public healthcare facilities.<sup>9</sup> The situation constituted violations of the South African state's legal obligations around abortion access.

The above situation was only worsened by the COVID-19 pandemic. Unclear communication from government left both patients and healthcare practitioners unsure whether they would be arrested for seeking or performing abortions.<sup>10</sup> (Strict movement limitations applied for several weeks in the first six months of 2020,<sup>11</sup> and communications regarding these limitations were unclear regarding whether SRHC was allowed as an

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<sup>1</sup> Ronelle Burger & Martina Mchenga *Anticipating the Impact of the COVID-19 Pandemic on Health Inequality in South Africa: Early Evidence on Direct and Indirect Influences* (2021) PEP Working Paper Series 2021-12 at 3.

<sup>2</sup> Amnesty International, *Barriers to Safe and Legal Abortion in South Africa* (2017) at 12.

<sup>3</sup> *Ibid.*

<sup>4</sup> *Op cit* note 2 at 12.

<sup>5</sup> Uta Lehmann 'Strengthening human resources for primary healthcare' in Peter Barron & Josiane Roma-Reardon (eds) *South African Health Review 2008* (2008) at 166; Candy Day, Andy Gray & Eric Budgell 'Health and related indicators' in Ashnie Padarath and René English (eds) *South African Health Review 2011* (2011) at 178 – 179.

<sup>6</sup> Diane Cooper, Kim Dickson, Kelly Blanchard et al. 'Medical Abortion: The Possibilities for Introduction in the Public Sector in South Africa' (2005) 13 *Reproductive Health Matters* 26 at 41.

<sup>7</sup> National Department of Health, *National Integrated Sexual & Reproductive Health and Rights Policy* (2019) at 6.

<sup>8</sup> National Department of Health, *National Clinical Guidelines for Implementation of the Choice on Termination of Pregnancy Act* (2019) at 1.

<sup>9</sup> *Op cit* note 2 at 12; Day et al. *op cit* note 5 at 178 – 179.

<sup>10</sup> MSF Southern Africa 'South Africa: Providing Safe Abortion Care during a National Lockdown' 3 July 2020 available at <https://www.msf.org.za/news-and-resources/fieldworker-stories/south-africa-providing-safe-abortion-care-during-national>, accessed on 24 February 2023.

<sup>11</sup> Disaster Management Act regulations in GN R398 GG 11062 of 25 March 2020 at s11B 1(a)(i).

essential healthcare service, or whether it was non-essential and therefore disallowed.<sup>12</sup> Travelling without an accepted justification, such as seeking essential healthcare, could lead to arrest and criminal charges.<sup>13</sup>) In response, some healthcare facilities shut down their abortion facilities for several weeks or even months.<sup>14</sup> Some patients, unsure whether they would risk sanction for travelling, did not seek abortions during this period.<sup>15</sup> It is likely that some people who would otherwise have chosen an abortion were forced to continue their pregnancies during the months of Level 5 lockdown. This is reflected in the surge of teenage pregnancies reported by NGOs.<sup>16</sup> It is also likely to have been exacerbated by frequent stockouts of contraceptives during the pandemic.<sup>17</sup>

These circumstances meant that pregnant persons seeking abortions were unable to prevent pregnancy due to contraceptive stockouts,<sup>18</sup> unable to leave home to seek an abortion due to unclear national regulations<sup>19</sup> and fear of arrest<sup>20</sup> or police brutality,<sup>21</sup> and unable to access abortion through any other legal means. With few available options, it is likely that at least some pregnant persons chose illegal abortion, with its associated high risk of infection or complications,<sup>22</sup> as an alternative to continuing their pregnancies.

This situation could very possibly occur again during a future pandemic or other State of Emergency where movement is limited. Given the lessons of the COVID-19 pandemic, government should act to strengthen SRHC so that pregnant people in the future are not forced to make the choice between an unwanted pregnancy and an illegal abortion with its concomitant risks.<sup>23</sup> SRHC is often the first area of healthcare to be weakened by pandemic responses, as resources and personnel are redeployed to frontline care.<sup>24</sup> It is not acceptable to

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<sup>12</sup> Supra note 11 at s11B.

<sup>13</sup> Ibid.

<sup>14</sup> Op cit note 10.

<sup>15</sup> Y Pillay, S Pienaar, P Barron et al. 'Impact of COVID-19 on routine primary healthcare services in South Africa' (2021) 111 *SAMJ* 8 at 714.

<sup>16</sup> South African Medical Research Council 'Teenage Pregnancy during COVID-19 in South Africa: A Double Pandemic' 7 September 2021, available at <https://www.samrc.ac.za/news/teenage-pregnancy-during-covid-19-south-africa-double-pandemic>, accessed on 11 August 2023; ReliefWeb 'Teen Pregnancies in South Africa Jump 60% during COVID-19 Pandemic' 23 August 2021, available at <https://reliefweb.int/report/south-africa/teen-pregnancies-south-africa-jump-60-during-covid-19-pandemic>, accessed on 31 May 2023.

<sup>17</sup> Op cit note 15 at 715.

<sup>18</sup> Ibid.

<sup>19</sup> Supra note 11 at s11B.

<sup>20</sup> Ibid.

<sup>21</sup> Simone Haysom 'South Africa's Police Problem' 4 July 2020, available at <https://www.lrb.co.uk/blog/2020/july/south-africa-s-police-problem>, accessed 5 June 2023.

<sup>22</sup> Akinrinola Bankole, Lisa Remez, Onikepe Owolabi, et al. *From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress* (2020) at 4, 24.

<sup>23</sup> Ibid.

<sup>24</sup> Op cit note 15 at 717.

maintain this lower level of SRHC. Government must intervene to return SRHC to a state of strength and utility.

One of these interventions could be the approval, funding, and implementation of MATM. This chapter does not argue that MATM is a perfect solution to the crisis surrounding SRHC in South Africa, nor that telemedicine should be used in all situations. Like any other medical process, it requires regulation and limitations. However, in a weighing-up of the advantages and disadvantages of telemedicine within reasonable limitations, MATM could be a useful tool in expanding access to SRHC in South Africa and therefore in moving closer to the fulfilment of the state's legal obligations around abortion access (specifically, regarding medical abortion in the first trimester).

### 3.2 ADVANTAGES OF IMPLEMENTING MEDICAL ABORTION VIA TELEMEDICINE IN SOUTH AFRICA

Telemedicine has distinct advantages in many contexts, but in a country as socio-economically and geographically divided as South Africa,<sup>25</sup> those advantages become even more apparent. This section will discuss six of the many advantages that are offered by MATM.

#### *3.2.1 Accessibility*

The first advantage that MATM presents is one of easier access to care that is of equivalent quality to in-facility care. MA, when prescribed by an appropriate healthcare practitioner such as a nurse or doctor and initiated at a place of the patient's choosing, usually their residence, produces similar results to MA performed in a healthcare facility.<sup>26</sup> This means that MATM is, like in-facility MA, safe and effective.<sup>27</sup> MATM therefore offers an opportunity for more patients to access necessary care of similar quality,<sup>28</sup> and an opportunity to improve South Africa's fulfilment of its legal obligations around abortion access.

#### *3.2.2 Reaching rural populations*

The second advantage is the ability of telemedicine to cross geographical divides and distance. Because so few healthcare facilities offer terminations of pregnancy,<sup>29</sup> access to the procedure is severely limited.<sup>30</sup> Much of the South African population struggles to access

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<sup>25</sup> Op cit note 1 at 3.

<sup>26</sup> Mariana Prandini Assis and Sara Larrea 'Why Self-Managed Abortion Is so Much More than a Provisional Solution for Times of Pandemic' (2020) 28 *Sexual and Reproductive Health Matters* 1 at 38.

<sup>27</sup> *Ibid.*

<sup>28</sup> *Ibid.* at 38.

<sup>29</sup> Op cit note 2 at 12.

<sup>30</sup> Day et al. op cit note 5 at 179.

even general healthcare;<sup>31</sup> when 93 per cent of healthcare facilities do not offer abortion, chances of accessing this procedure are very low. Building and staffing new healthcare facilities, to rectify apartheid's unequal allocation of facilities,<sup>32</sup> will take years. MATM offers the opportunity to provide abortions to pregnant persons wherever they are. Combating apartheid division, even if only in one small way, is possible through MATM. Moreover, MATM provides the opportunity for continued or increased access to healthcare during times of crisis or periods in which travel is difficult or impossible, such as pandemics. Studies on the effects of COVID-19 on primary healthcare in South Africa<sup>33</sup> recommend the implementation of telemedical interventions,<sup>34 35</sup> as solutions to the impacts of both COVID-19 and potential future crises.<sup>36</sup>

### 3.2.3 Privacy and confidentiality

Thirdly, MATM offers privacy and confidentiality for patients. Community stigma and fear of judgement play a role in dissuading pregnant persons from seeking abortions.<sup>37</sup> MATM can be achieved with privacy and confidentiality, whereas physically going to a healthcare facility that provides abortions does not offer the advantage of privacy even if confidentiality is presumed. Telemedical consultations can be carried out from one's residence, potentially reducing the opportunities for community stigma or judgement to be exercised. This may make pregnant people more comfortable with the process of seeking abortion.

MATM also offers patients confidentiality, as long as medical best practices are followed. While attention must be paid to protecting patients' data and avoiding any breaches in confidentiality, it is also true that these breaches are equally possible in face-to-face healthcare consultations.

### 3.2.4 Convenient care

The fourth advantage presented by MATM is convenience. The opportunity to have a medical consultation remotely, at the place of one's choosing, and the opportunity to induce abortion at a time and place that is selected by the patient, both mean that MATM is far more

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<sup>31</sup> Lehmann op cit note 5 at 166.

<sup>32</sup> Bernhard Gaede and Marije Versteeg 'The state of the right to health in rural South Africa' in Ashnie Padarath and René English (eds) *South African Health Review 2011* (2011) at 103.

<sup>33</sup> Ronelle Burger, Candy Day, Nicola Deghaye et al. *Examining the Unintended Consequences of the COVID-19 Pandemic on Public Sector Health Facility Visits: The First 150 Days* (2020).

<sup>34</sup> Ibid. at 31.

<sup>35</sup> Ibid. at 32.

<sup>36</sup> Ibid.

<sup>37</sup> Elizabeth A. Mosley, Amy J. Schulz, Lisa H. Harris, et al. 'South African Abortion Attitudes from 2007–2016: The Roles of Religiosity and Attitudes toward Sexuality and Gender Equality' (2020) 60 *Women & Health* 7 at 2–3, 8–10.

convenient for the pregnant person than the in-person alternatives.<sup>38</sup> There is a significant possibility of reduction in time, effort, and travel costs. The opportunity to choose the timing of an abortion based solely on one's own preferences and not on available clinic appointments means that the opportunity costs of seeking abortion may decrease.<sup>39</sup> Especially for pregnant people who are disadvantaged in many or intersectional ways, this decrease in opportunity costs is important because these are the people who can least afford to lose income by spending time waiting for a healthcare practitioner.<sup>40</sup>

People are more likely to choose to pursue healthcare if it is convenient for them.<sup>41</sup> People may not have the time, money, or other resources to go to a clinic and wait in line to get their blood pressure checked but, when offered the opportunity to get it checked while waiting for payment of their social grant, many people were willing to do so.<sup>42</sup> Convenience is clearly an important consideration regarding the South African population's access to healthcare. MATM is one avenue towards making access to abortion much more convenient, potentially cheaper, and with lower opportunity costs.

### *3.2.5 Increased control*

A corollary of convenience is control over the process of abortion, which forms the fifth advantage this chapter will discuss. MATM increases patients' control over the abortion process. From determining the time and location of the abortion to inducing the procedure themselves through taking the medication required,<sup>43</sup> patients have far greater control over the process of abortion than they would in an in-person healthcare setting. This has the potential to further reduce direct and opportunity costs for patients,<sup>44</sup> as terminations of pregnancy can be scheduled for a convenient time.

### *3.2.6 Increased fulfilment of legal obligations*

The sixth advantage of MATM is a culmination of the results of the other advantages discussed above. It is that more people who want abortions will have access to that care. South Africa could therefore make progress towards the fulfilment of its legal obligations regarding the provision of access to abortion. As admirable as this progress is, it is a

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<sup>38</sup> Op cit note 26 at 38.

<sup>39</sup> Op cit note 22 at 28; Arthi Ramkissoon, Catherine Searle, Catherine Burns et al. 'Sexual and Reproductive Health and Rights' in Sharon Fonn and Ashnie Padarath (eds) *South African Health Review 2010* (2010) at 43.

<sup>40</sup> Ramkissoon et al. op cit note 39 at 43.

<sup>41</sup> South African Medical Research Council 'Taking Healthcare to SASSA Queues: Pensioners Screened for Hypertension' 10 February 2022, available at <https://www.samrc.ac.za/news/taking-healthcare-sassa-queues-pensioners-screened-hypertension>, accessed on 11 August 2023.

<sup>42</sup> Ibid.

<sup>43</sup> Ibid.

<sup>44</sup> Op cit note 22 at 28.

reflection of success rather than a success in its own right. The success in this situation would be that pregnant people have a better chance of accessing the healthcare they need.

### *3.2.7 Summary of advantages*

The advantages that have been discussed in this section – access to quality healthcare, the ability to cross geographical and socio-economic barriers, privacy and confidentiality, convenience, control over the abortion process, and increased fulfilment of legal obligations indicating increased access to SRHR – present a strong case for the benefits of introducing or expanding MATM. However, it would be remiss to ignore the potential disadvantages of any intervention. This next section turns its attention to these disadvantages.

## 3.3 DISADVANTAGES OF IMPLEMENTING MEDICAL ABORTION VIA TELEMEDICINE IN SOUTH AFRICA

This section discusses eight disadvantages of MATM. Many of these disadvantages are not unique to telemedicine. They may occur in face-to-face MA as well. Where the disadvantages are unique to MATM, this section argues that the disadvantage is slight or that it can be mitigated. If neither of these are true, this section contends that the potential disadvantages are outweighed by the potential advantages of MATM.

### *3.3.1 Potential for complications*

The first disadvantage addressed by this section is that of potential complications with the MA process. MA is a medical procedure like any other, and therefore comes with concomitant risks.<sup>45</sup> These risks, such as excessive bleeding or allergic reactions to the medications used,<sup>46</sup> are rare,<sup>47</sup> but patients must be informed of them and given information on how to recognise them and where or how to seek help if they occur. However, the level of risk for patients is no different to outpatient MA, which uses precisely the same medications and referral processes in the event of complications.<sup>48</sup> This disadvantage is therefore slight if present.

### *3.3.2 Patient anxiety*

The second disadvantage concerns patient fears and anxieties. Patients using MATM receive the same care as they would if they were to engage in a face-to-face MA process.<sup>49</sup> However, it is possible that patients will experience greater levels of anxiety when engaging in MATM,

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<sup>45</sup> MSI South Africa *Increasing abortion access through tele abortion* (n.d.) at 5.

<sup>46</sup> *Ibid.*

<sup>47</sup> In outpatient settings, medical abortion typically has complications in 3 per cent or less of cases (op cit note 8 at 16).

<sup>48</sup> Op cit note 8 at 16.

<sup>49</sup> Op cit note 45 at 5; op cit note 8 at 16 – 22.

as the process is more autonomous than in-facility MA. These anxieties can be mitigated by the provision of 24-hour advice hotlines for patients undergoing MATM. These hotlines, already used both for MATM<sup>50</sup> and emergency contraception,<sup>51</sup> can triage patients remotely and determine whether they require medical assistance. If no assistance is required, the patient can be reassured that their experience is not a cause for concern; if assistance is required, the patient can be directed to the nearest or most convenient healthcare facility for treatment. While some level of anxiety regarding the procedure is always likely to be present, there are measures that can be taken to minimise it.

### 3.3.3 Requirement of connectivity

The third disadvantage is the essential requirement of some form of telecommunications connectivity on the part of both the healthcare practitioner, or their healthcare facility, and the patient. This should be less of an issue for the healthcare practitioners, as healthcare facilities are meant to have telephone connections.<sup>52</sup> Many, however, lack connectivity, as demonstrated by the fact that over 45 per cent of South African fixed primary healthcare facilities do not meet government-issued requirements regarding infrastructure and best practices.<sup>53</sup> Two solutions can be proposed to meet this shortfall. Firstly, government should provide connectivity for its healthcare facilities, whether they engage in telemedicine or not. A clinic cannot call an ambulance for a patient experiencing a life-threatening medical condition if the clinic does not have any telecommunications capacity, in just one of many possible examples. The prospect of telemedicine exposes the dearth of connectivity of healthcare facilities, particularly in rural or underserved areas, but it remains the responsibility of the state to ensure that this is rectified.

The second solution is to emulate the models, already successful in the NGO sector,<sup>54</sup> of specialised telemedicine facilities.<sup>55</sup> This specialisation means that healthcare practitioners prescribing MA, usually but not necessarily doctors,<sup>56</sup> can serve wider populations. In allocating patients seeking abortion to the telemedical facilities, two results are possible. First, capacity could be opened up at local primary healthcare facilities. Abortions are dealt

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<sup>50</sup> Op cit note 45 at 12.

<sup>51</sup> Op cit note 5 at 42.

<sup>52</sup> Op cit note 8 at 34.

<sup>53</sup> Ronel Steinhobel, 'Percentage Ideal Clinics' in Naomi Massyn, Candy Day, Noluthando Ndlovu (eds) *District Health Barometer 2019/20 (2020)* at 127.

<sup>54</sup> Op cit note 45.

<sup>55</sup> *Ibid.*

<sup>56</sup> Under South African law, nurses and some other medical practitioners are permitted to prescribe medical abortion providing that they have received necessary training. This is in addition to medical doctors, who are also permitted to prescribe medical abortion to their patients.

with elsewhere, in a more convenient fashion for the patient, and primary healthcare facilities' burdens could be somewhat reduced. Secondly, streaming patients according to their concerns or desired outcomes, such as abortion, means that the telemedical facilities can handle cases efficiently and potentially more quickly than a physical healthcare facility.

The obstacle of telecommunications capacity may be more problematic for patients than healthcare practitioners, as ICT access is not universal in the country.<sup>57</sup> However, mobile phone usage is present and growing, as seen in the 2021 statistics which report that over 36 million people in South Africa have internet access via a mobile phone<sup>58</sup> and around 22 million have access to a smartphone.<sup>59</sup> This means that, while it is unlikely that everyone will be able to access telemedical consultations, a high number of patients could have the necessary connectivity. It is true that access to telemedicine will be limited to those with mobile phones or landlines, but this is not an insurmountable obstacle. It will naturally limit the reach of telemedicine, but the limitation is not as significant as might be assumed.

#### *3.3.4 Requirement of access to medication: discussion and four exemplar solutions*

The fourth disadvantage that this section will discuss is based on ability to access medication. MA is initiated via taking medication, and that medication must be accessible to the patient. Many MATM programmes provide this access through collection from a local pharmacy or courier delivery.<sup>60</sup>

This model of MATM, while it presents an opportunity to bridge some geographical and socio-economic divides in South Africa, is not infallible. Distribution of pharmacies is highly likely to reflect apartheid spatial planning: most pharmacies are situated in urban areas and serve those who pay for healthcare, whether through a medical aid scheme or out of pocket.<sup>61</sup> Courier services also present challenges. The government-owned postal service is unreliable if not defunct<sup>62</sup> and therefore cannot be used in time-sensitive or important deliveries such as the delivery of urgent medication. Moreover, a large proportion of the population lives in informal settlements, where houses without street numbers are common

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<sup>57</sup> Mareike Rabe 'Telehealth in South Africa: A Guide for Healthcare Practitioners in Primary Care' (2022) 64 *South African Family Practice* 1 at 2.

<sup>58</sup> Ibid.

<sup>59</sup> Ibid. at 2.

<sup>60</sup> Op cit note 45.

<sup>61</sup> Andy Gray, Jane Riddin & Janine Jugathpal 'Health Care and Pharmacy Practice in South Africa' (2016) 69 *The Canadian Journal of Hospital Pharmacy* 1 at 39.

<sup>62</sup> Ray Mahlaka 'Business Rescue Paves Way for R6.2bn Bailout of SA Post Office — and Axing of 7,000 Workers' *Daily Maverick* 16 July 2023, available at <https://www.dailymaverick.co.za/article/2023-07-16-business-rescue-paves-way-for-r6-2bn-bailout-of-sa-post-office-and-axing-of-7000-workers/>, accessed on 15 August 2023.

enough to mean that residents of informal settlements must use a letter from their ward councillor as legal proof of address.<sup>63</sup> Courier services may refuse to deliver parcels to such residences without street numbers.<sup>64</sup> The patient's location may be so rural or ill-connected via road that couriers will not reach them. These obstacles mean that the above MATM models may not work in context.

However, innovative solutions to these obstacles already exist and can be developed further. The following sections will discuss four examples of such innovation: decentralised medication collection points, locker collection points, mobile clinics, and possible future delivery methods.

### 3.3.4.1 Decentralised medication collection points

The first of these four examples is modelled along the lines of the Central Chronic Medicine Dispensing and Distribution programme of South Africa's National Department of Health.<sup>65</sup> This programme was launched in 2014<sup>66</sup> and operates in eight of the nine South African provinces;<sup>67</sup> the Western Cape has its own, comparable programme, known as the Chronic Dispensing Unit (CDU),<sup>68 69</sup> which was launched in late 2005.<sup>70</sup> The National Department of Health's programme is known as 'CCMDD',<sup>71</sup> 'Get Checked Go Collect',<sup>72</sup> or 'DablapMeds',<sup>73 74</sup> depending on the context.

These programmes involve the centralised packing of chronic medications for registered patients.<sup>75</sup> The prepackaged parcels are delivered to the patient's preferred

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<sup>63</sup> Western Cape Mobility Department 'Verification Requirements: Motor Vehicle or Driving Licence Transactions' available at <https://www.westerncape.gov.za/tpw/verification-requirements-motor-vehicle-or-driving-licence-transactions>, accessed on 15 August 2023.

<sup>64</sup> Stephan Basson 'Pargo Creates Access To Ecommerce For Informal Settlements Across South Africa' 29 October 2020, available at <https://pargo.co.za/blog/pargo-creates-access-to-ecommerce-for-informal-settlements-across-south-africa/>, accessed on 15 August 2023.

<sup>65</sup> National Department of Health 'CCMDD' available at <https://www.health.gov.za/ccmdd/>, accessed on 6 October 2023.

<sup>66</sup> Thabo Molelekwa 'How Well Is SA's Chronic Medicines Distribution System Working?' *Spotlight* 20 August 2021, available at <https://www.spotlightnsp.co.za/2021/08/20/how-well-is-sas-chronic-medicines-distribution-system-working/>, accessed 6 October 2023.

<sup>67</sup> Ibid.

<sup>68</sup> Bvudzai Priscilla Magadzire, Bruno Marchal & Kim Ward 'Improving Access to Medicines through Centralised Dispensing in the Public Sector: A Case Study of the Chronic Dispensing Unit in the Western Cape Province, South Africa' (2015) 15 *BMC Health Services Research* 1 at 2.

<sup>69</sup> The Chronic Dispensing Unit is also sometimes referred to as the Central Dispensing Unit.

<sup>70</sup> Op cit note 68 at 2.

<sup>71</sup> Op cit note 65.

<sup>72</sup> Get Checked Go Collect 'CCMDD | Get Checked Go Collect | Free Chronic Medication' 3 July 2019, available at <https://getcheckedgocollect.org.za/ccmdd/>, accessed on 6 October 2023.

<sup>73</sup> Op cit note 65.

<sup>74</sup> 'Dablap' is a South African slang term for a shortcut.

<sup>75</sup> Op cit note 68 at 4.

collection point,<sup>76</sup> where the patient can collect the parcel quickly.<sup>77</sup> Collection points, which include pharmacies,<sup>78</sup> grocery shops,<sup>79</sup> places of worship,<sup>80</sup> community centres,<sup>81</sup> workplaces,<sup>82</sup> and mobile clinics,<sup>83</sup> have extended opening hours so that collections can happen when convenient for the patient.<sup>84</sup> In 2019, a total of 2037 external (i.e., non-healthcare facility) collection points had been registered under CCMDD,<sup>85</sup> and official statements place the number of active users at 2 million as of 2018.<sup>86</sup> The CDU had 2724 collection points by end 2014<sup>87</sup> and, as of September 2015, was dispensing 300 000 medication parcels per month.<sup>88</sup>

These models, despite having challenges such as patient non-collection of medication,<sup>89</sup> have demonstrated that the prescription, dispensing, and collection of medications are not necessarily simultaneous processes. Decentralisation saves healthcare practitioners time and space in healthcare facilities, therefore allowing them to treat more patients and spend less time dispensing medication.<sup>90</sup> The CCMDD/CDU programmes demonstrate that allowing patients to collect their medication at times and locations which are convenient for them saves time and money<sup>91</sup> and reduces interruptions in patients' supplies of chronic medication.<sup>92</sup> While both the CCMDD and CDU programmes currently serve patients with chronic medical issues,<sup>93</sup> some proposals for expanding available medications and mechanisms of delivery have been proffered.<sup>94</sup> The medications most commonly suggested

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<sup>76</sup> Ibid.

<sup>77</sup> National Department of Health *Evaluation of Phase 1 implementation of interventions in the National Health Insurance (NHI) pilot districts in South Africa* (2019) at 61 – 62.

<sup>78</sup> Simangele I Hlongwana & Andrew L. Gray 'Barriers and Facilitators to Medicine Collection through the CCMDD Programme at a Durban Hospital' 2022 *Health SA Gesondheid* 27 at 2.

<sup>79</sup> Lilita Gewabe 'CCMDD: "The Right Medicine, for the Right Patient, in the Right Parcel, in the Right Place, at the Right Time."' *Health-e News* 3 May 2021, available at <https://health-e.org.za/2021/05/03/central-chronic-medicine-dispensing-and-distribution-ccmdd-programme/>, accessed on 6 October 2023.

<sup>80</sup> Ibid.

<sup>81</sup> Op cit note 78 at 2.

<sup>82</sup> Op cit note 68 at 4.

<sup>83</sup> Ibid.

<sup>84</sup> Laura M. Bogart, Zinhle Shazi, Sarah MacCarthy et al. 'Implementation of South Africa's Central Chronic Medicine Dispensing and Distribution Program for HIV Treatment: A Qualitative Evaluation' (2022) 26 *AIDS and Behavior* 8 at 2601; op cit note 66.

<sup>85</sup> Lingrui Liu, Sarah Christie, Maggie Munsamy et al. 'Expansion of a National Differentiated Service Delivery Model to Support People Living with HIV and Other Chronic Conditions in South Africa: A Descriptive Analysis' (2021) 21 *BMC Health Services Research* 1 at 3.

<sup>86</sup> Op cit note 77 at 61.

<sup>87</sup> Op cit note 68 at 4.

<sup>88</sup> Tania Mathys *The Chronic Dispensing Unit* (2015) at 5.

<sup>89</sup> Op cit note 78 at 2; op cit note 68 at 5 – 6.

<sup>90</sup> Ibid.

<sup>91</sup> Bogart et al. op cit note 84 at 2603.

<sup>92</sup> Op cit note 79; op cit note 66; op cit note 72.

<sup>93</sup> Op cit note 66; op cit note 88 at 4.

<sup>94</sup> Op cit note 33 at 31 – 32.

for future inclusion are contraceptives.<sup>95</sup> This implies that the CCMDD/CDU models could be adapted for use as collection points for prescribed abortifacients.

This section does not argue that the dispensing of medication for MA could be simply added to the models discussed above. There are relevant differences between the characteristics of collection systems for irregularly-used medications, such as abortifacients, and those for chronic medications. However, the successes of the above programmes suggest that decentralised medication collection points are a possible solution to the issue of lack of access to pharmacies and/or courier services, and that the possibility merits further investigation.

#### *3.3.4.2 Locker collection points*

Many business initiatives, particularly in the e-tail space, have developed solutions for customers who would like to have parcels delivered to them but, for one or another reason, cannot receive the parcel at their residence.<sup>96</sup> There seems to be no obvious reason why these e-tail delivery solutions cannot be applied to the case of delivering medication for medical treatments, including MA. In South Africa, the commonly-available solutions within this model consist of relatively central collection points, located in or near high-traffic areas such as shopping malls,<sup>97</sup> community centres,<sup>98</sup> or primary health clinics.<sup>99</sup> At the collection point, locker-style containers protect the parcel until the recipient or an authorised proxy releases the parcel with a personal identification number.<sup>100</sup> These lockers are known as, for example, smart lockers,<sup>101</sup> Peleboxes,<sup>102</sup> container collection points,<sup>103</sup> or Pargo Pickup Points,<sup>104</sup> depending on context and service provider.

Smart lockers could improve delivery systems across South Africa, not least in the context of health products such as medication. The CCMDD programme has begun to incorporate smart lockers as one method of collection within their existing system: at certain collection points, patients can choose whether to collect their parcels from a smart locker or

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<sup>95</sup> Bogart et al. op cit note 84 at 2609.

<sup>96</sup> Op cit note 64.

<sup>97</sup> Ibid.

<sup>98</sup> Op cit note 78 at 2.

<sup>99</sup> Bogart et al. op cit note 84 at 2609.

<sup>100</sup> Ibid.

<sup>101</sup> Op cit note 66.

<sup>102</sup> Ibid.

<sup>103</sup> Ibid.

<sup>104</sup> Op cit note 64.

through the conventional process.<sup>105</sup> Although teething problems are extant in the CCMDD's use of smart lockers,<sup>106</sup> the concept is a promising one.

The smart locker model, while still a relatively new development, provides a potential opportunity to circumvent the obstacles of lack of pharmacy or courier access for MATM. However, the application of this model to healthcare deliveries will naturally require stringent regulation and monitoring to minimise the possibility of misappropriation of medications.

#### 3.3.4.3 Mobile clinics

Mobile clinics, which visit certain geographical areas at set times or on set days,<sup>107</sup> present an opportunity for increasing access to abortifacients needed for MA. This is true whether the MA is prescribed via telemedicine or not. Mobile clinics could serve as mobile pharmacies,<sup>108</sup> offering one potential solution to the issue of inadequate pharmacy access.<sup>109</sup> If a mobile clinic or mobile pharmacy visits one's area on a set day, one can access needed medication such as abortifacients without a pharmacy or clinic being built in the area.<sup>110</sup> (This is not to say that increasing access to permanent clinics is unimportant. On the contrary, the South African population should have reliable access to healthcare when they need it,<sup>111</sup> not merely on the days when a mobile clinic visits their area. However, in the years before universal healthcare access is achieved, mobile clinics may provide a stopgap measure for access to medication and/or healthcare.<sup>112</sup>) The potential utility of mobile clinics as a means of increasing access to healthcare in under-served populations is demonstrated by the success of mobile clinic and testing programmes in South Africa.<sup>113</sup>

In the light of these successes, more research is needed into the potential for relationships between telemedicine and mobile clinics. The need for research should not, however, discourage belief in mobile clinics as a potentially useful element of the MA supply chain.

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<sup>105</sup> Bogart et al. op cit note 84 at 2609.

<sup>106</sup> Op cit note 66; Bogart et al. op cit note 84 at 2609.

<sup>107</sup> For one example of a mobile clinic programme, see the mobile services programmes run by the Desmond Tutu Health Foundation (Desmond Tutu Health Foundation 'Mobile Services', available at <https://desmondtutuhealthfoundation.org.za/what-we-do/mobile-services-tutu/>, accessed on 19 October 2023).

<sup>108</sup> Desmond Tutu Health Foundation 'Make Way for the Tutu Tester!' available at [https://desmondtutuhealthfoundation.org.za/blog\\_post/make-way-tutu-tester/](https://desmondtutuhealthfoundation.org.za/blog_post/make-way-tutu-tester/), accessed on 19 October 2023.

<sup>109</sup> Ibid.

<sup>110</sup> Ibid.

<sup>111</sup> Constitution of the Republic of South Africa, 1996 at s27.

<sup>112</sup> City of Cape Town 'City to Roll-out New Mobile Clinic Fleet' available at <https://www.capetown.gov.za/Media-and-news/City%20to%20roll-out%20new%20mobile%20clinic%20fleet>, accessed on 19 October 2023.

<sup>113</sup> Op cit note 108.

#### 3.3.4.4 Possible future delivery methods

It is likely that coming years will bring continued innovation in the field of improving access to healthcare. It would be unproductive to give a long list of potential future access innovations in this section, as the field is changing rapidly and unpredictably. To take one example, remote Rwandan public health clinics are now receiving blood deliveries by drone, a method which avoids impassable road networks and reduces waiting time for blood donation deliveries to as little as fifteen minutes.<sup>114</sup> This example, only recently developed, demonstrates that it would be foolish to dismiss the potential utility of MATM simply because mechanisms for delivery of the relevant medication are still emerging.

#### 3.3.4.5 In summary: access solutions

The four examples discussed above demonstrate that, while the issues of lack of access to pharmacies or courier delivery services are significant obstacles to MATM, potential solutions to these issues and obstacles do exist and additional solutions are likely to emerge in the future. Interventions – such as the introduction of MATM – to improve the enjoyment of rights are important and worthwhile even if they will not correct a situation overnight. This thesis does not claim that MATM is a panacea, nor an immediate solution, but pursuing its implementation remains valuable.

#### 3.3.5 Language barriers

The fifth disadvantage of MATM that this section will address is a problem born of South Africa's multitude of cultures and languages – the issue of language barriers. Specialised telemedicine facilities are likely to be at least somewhat centralised. The issue that then arises is how to ensure that patients and healthcare practitioners can communicate adequately, so that information regarding the patient's options and rights can be appropriately conveyed and the patient can ask any necessary questions they may have. This issue is a thorny one because, although it is not unique to telemedicine, it is likely to occur more often in specialised and therefore centralised telemedical facilities' interactions with patients than in, for example, a local clinic.<sup>115</sup>

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<sup>114</sup> World Health Organization 'Drones Take Rwanda's National Blood Service to New Heights' 12 June 2019, available at <https://www.who.int/news-room/feature-stories/detail/drones-take-rwandas-national-blood-service-to-new-heights>, accessed on 17 October 2023.

<sup>115</sup> While the official languages of the National Department of Health are isiZulu, Sesotho sa Leboa and English, the Department's language policy of 2015 states that all 11 official languages (as of 2015, South African Sign Language was not an official language of the Republic of South Africa) must be used in oral communication with members of the public, where appropriate, practicable and cost-effective (National Department of Health: Language Policy in GN 442 GG 38827 of 27 May 2015 at s9.3 and 10).

Partial solutions to this issue are possible. Telemedical facilities could employ healthcare practitioners conversant in all 12 official languages,<sup>116</sup> but this would be expensive and potentially wasteful if only one or two languages are commonly used. Translation is another option, but this is time-consuming and has implications for patient privacy. At the present moment, the best solution seems to be that telemedical facilities should offer consultations in South Africa's major languages, and provide documents (or verbal renditions of the documents, should the patient be illiterate) regarding patient consent (or refusal thereof) and instructions for the process of MA in every official South African language except sign language.<sup>117</sup> It may also be useful to provide these documents (or verbal renditions) in languages commonly spoken in the country even if they are not official languages. This combination of consultation in a lingua franca and provision of documents in the patient's first language could mitigate some of the obstacles presented by language barriers.

### 3.3.6 *Technical issues*

The sixth disadvantage of MATM is one of technical issues such as lags in connection or unreliable internet connectivity. In-person healthcare does not have these issues, and telemedicine will have to deal with them. It is reasonable to expect a small proportion of consultations via telemedicine to be delayed or cancelled due to technical issues, and planning for these issues is essential to avoid frustration for both patients and healthcare practitioners. Just as companies have accepted some of their employees working from home despite technical difficulties with online meetings,<sup>118</sup> for example, medicine needs to adapt and accept telemedicine even if it comes with accompanying technical issues.

### 3.3.7 *Data security*

The penultimate disadvantage of MATM relates to data security and compliance with privacy legislation. It is important that telemedical consultations take place on secure platforms and that the data generated from such consultations is stored securely. This is necessary for compliance with legislation such as the Protection of Personal Information Act 4 of 2013

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<sup>116</sup> As of July 2023, the 12 official languages of the Republic of South Africa are (in alphabetical order) Afrikaans, English, isiNdebele, isiXhosa, isiZulu, Sepedi, Sesotho, Setswana, siSwati, South African Sign Language, Tshivenda, and Xitsonga (*Business Tech* 'South Africa's new official language becomes law this week' 18 July 2023, available at <https://businesstech.co.za/news/lifestyle/704783/south-africas-new-official-language-becomes-law-this-week/>, accessed on 15 August 2023).

<sup>117</sup> South African Sign Language, or SASL, is the most recent addition to South Africa's official languages. This work presumes that patients conversant in SASL will be able to read at least one other official language, if they are literate.

<sup>118</sup> International Labour Office *The Next Normal: The Changing Workplace in Africa Ten Trends from the COVID-19 Pandemic that are Shaping Workplaces in Africa* (2022) at 10 – 14.

(POPIA),<sup>119</sup> but it is also needed in order to protect patients from data security breaches. Terminations of pregnancy are controversial in many countries, including South Africa,<sup>120</sup> and it is likely that patients seeking terminations of pregnancy could be discriminated against or persecuted for having sought or gone through the procedure.<sup>121</sup> Government, in consultation with the relevant health authorities, must therefore develop guidelines for telemedicine and data security.

Telemedicine's prevalence means that banning it because it has the potential for security breaches is unlikely to have a significant impact.<sup>122</sup> Instead, the HPCSA and government should work to develop best practice guidelines for telemedicine which could reduce the likelihood of data security breaches and protect patients as far as possible. Data breaches are unlikely to ever be eradicated, but steps can be taken to both minimise risk and decrease the severity of breaches should they occur.

### *3.3.8 Legal and ethical approval of medical abortion via telemedicine*

The last disadvantage of MATM is perhaps one of the weightiest discussed in this section. It concerns legal and ethical approval, which at the time of writing was not obviously extant for MATM.<sup>123</sup> While the following chapter will discuss the legal and ethical landscape surrounding MATM in more detail, it should be noted here that healthcare practitioners who prescribe MATM – or indeed in an outpatient setting, which is common in the public healthcare sector<sup>124</sup> and likely to also be common in private healthcare – run the risk of legal sanction<sup>125</sup> and the loss of their medical license or other chastisement from the HPCSA.<sup>126</sup> At present, government's guidelines and policies<sup>127</sup> and common medical practice in all sectors of healthcare<sup>128</sup> contradict national legislation on the locations in which abortions may

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<sup>119</sup> Protection of Personal Information Act 4 of 2013.

<sup>120</sup> Op cit note 37 at 2 – 3, 6.

<sup>121</sup> Ibid. at 8.

<sup>122</sup> Ibid.

<sup>123</sup> Choice on Termination of Pregnancy Act 92 of 1996; Choice on Termination of Pregnancy Amendment Act, 2004; Choice on Termination of Pregnancy Amendment Act, 2008; Health Professions Council of South Africa *General Ethical Guidelines for Good Practice in Telehealth Booklet 10* (2021).

<sup>124</sup> Op cit note 8 at 16.

<sup>125</sup> Choice on Termination of Pregnancy Act 92 of 1996 at s10.1; Choice on Termination of Pregnancy Amendment Act, 2004 at s6; Choice on Termination of Pregnancy Amendment Act, 2008 at s6.

<sup>126</sup> Medical, Dental and Supplementary Health Professions Act of 1974 at 'Chapter IV: Disciplinary Powers of the Council'.

<sup>127</sup> Op cit note 8 at 16.

<sup>128</sup> Deborah Constant, Katherine de Tolly, Jane Harries et al. 'Assessment of completion of early medical abortion using a text questionnaire on mobile phones compared to a self-administered paper questionnaire among women attending four clinics, Cape Town, South Africa' (2014) 22 *Reproductive Health Matters* 44 at 83.

occur.<sup>129</sup> The best route forward for the protection of patients as well as healthcare practitioners is for lawmakers and health authorities to develop best practice guidelines within an enabling legal environment for MATM.

### *3.3.9 Summary of disadvantages*

This section has discussed eight disadvantages of MATM: the potential for medical complications, patient anxieties, the need for telecommunications connectivity, mechanisms for accessing medication, language barriers, technical issues, data security, and lack of legal and regulatory approval or protection. These disadvantages form relevant considerations when assessing the suitability of MATM for the South African context. However, this section has established that many of these disadvantages are shared with conventional prescription of MA. Where the disadvantage is unique to MATM, the disadvantage can be mitigated through appropriate interventions, or is outweighed by accompanying advantages.

## 3.4 CONCLUSION

This chapter therefore concludes that, in a weighing-up of the advantages and disadvantages of MATM in the South African context, the practice is on the balance advantageous and should be implemented within appropriate circumstances and with necessary regulation. The issue then arising is how to determine appropriate regulation and restrictions for MATM. The following chapter assesses South African legal and ethical frameworks for MATM.

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<sup>129</sup> Choice on Termination of Pregnancy Act 92 of 1996 at s3; Choice on Termination of Pregnancy Amendment Act, 2004 at s2; Choice on Termination of Pregnancy Amendment Act, 2008 at s2.

## CHAPTER 4

### 4.1 INTRODUCTION

Telemedicine has long been a topic of interest within the communities of healthcare professionals, government, and NGOs in South Africa. However, interest in telemedicine seems to have dwindled in the mid- to late 2010s. There is less evidence of new projects emerging in the field, and existing projects seem to have ended or disappeared from the record.<sup>1</sup> It is possible that enthusiasm waned due to the South African healthcare community's authorising body, the HPCSA, expressing both tacit<sup>2</sup> and explicit<sup>3</sup> disapproval of telemedicine. The HPCSA's minimal guidelines on telemedicine prior to 2020 disapproved of the practice in all but the most exceptional of circumstances.<sup>4</sup> Should they engage in telemedicine, healthcare practitioners in South Africa pre-2020 ran the risk of sanction from the HPCSA,<sup>5</sup> which could lead to the loss of their medical licence and even to prosecution. There is evidence that some telemedicine was taking place prior to 2020, but it is difficult to assess the extent thereof, as medical practices unsanctioned by the HPCSA are likely to have been severely underreported.

This remained the case until early 2020. The COVID-19 pandemic, which prevented people all over the world from moving freely and therefore from seeking medical care as they normally would, had noticeable impacts on telemedicine in South Africa. Telemedicine use in the country's private sector jumped 5708 per cent in 2020 compared to 2019.<sup>6</sup> NGOs such as MSI South Africa initiated telemedicine programmes in early 2020 as a response to the pandemic lockdowns limiting movement.<sup>7</sup>

While the HPCSA did (with some reluctance<sup>8</sup>) endorse telemedicine in certain circumstances in their April 2020 guidelines on telemedicine ethics,<sup>9</sup> the majority of

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<sup>1</sup> For example, despite extensive Internet research, no recent traces of the South African Telemedicine Association are forthcoming, despite references thereto in publications from the early 2010s and prior.

<sup>2</sup> B A Townsend, R E Scott & M Mars 'The development of ethical guidelines for telemedicine in South Africa' (2019) 12 *South African Journal of Bioethics Law* 1 at 21, 23 – 25.

<sup>3</sup> Sapa 'Telemedicine Criticism Unfair: Doctors Body' *News24* 6 May 2011, available at <https://www.news24.com/fin24/telemedicine-criticism-unfair-doctors-body-20110506>, accessed on 8 June 2023.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

<sup>6</sup> N Nematswerani, L Steenkamp, S Haneef et al. 'Understanding the impact of the COVID-19 pandemic on healthcare services' (2023) 113 *SAMJ* 4 at 1158.

<sup>7</sup> MSI South Africa, *Increasing abortion access through tele abortion* (n.d.).

<sup>8</sup> Health Professions Council of South Africa *General Ethical Guidelines for Good Practice in Telehealth Booklet 10* (2021) at arts 3.7, 3.8.

<sup>9</sup> Op cit note 8.

telemedicine discussed above occurred without explicit approval from the HPCSA. Even after the dissemination of the April 2020 guidelines, the limited approval of telemedicine therein meant that most telemedicine as practiced in South Africa likely remained outside HPCSA-approved circumstances.

In light of the conclusions reached in previous chapters – that South Africa has legal obligations to achieve progressive realisation of access to abortion; that the country is currently failing to meet this obligation; and that MATM could be a useful tool in the pursuit of said realisation – this chapter asks what legal and ethical frameworks exist for MATM in South Africa. This chapter also investigates what changes may be needed to enable and expand the use of MATM in South Africa.

## 4.2 EXISTING FRAMEWORKS AFFECTING TELEMEDICINE

### 4.2.1 Existing legal frameworks affecting telemedicine

The South African government has demonstrated significant interest in and approval of telemedicine. It is true that there is little said in national law which actively endorses telemedicine; however, the absence of condemnation or strict legal regulation could indicate that lawmakers look approvingly on telemedicine.

As leading scholars in the study of telemedicine<sup>10</sup> in South Africa have argued, telemedicine is not in fact a new practice:<sup>11</sup> it includes the use of the telephone for medical purposes and, earlier, the use of the telegraph and similar technologies.<sup>12</sup> The use of the internet or mobile phones for telemedicine does not necessitate harsher restrictions on the practice, which is after all a method of conducting medical consultations and not a medical practice in itself.<sup>13</sup> This does not mean that no restrictions are required. However, overly strict regulation of an existing method of communication is unnecessary.

South African medical law scholars<sup>14</sup> have also argued that South Africa's existing laws enable telemedicine. Carstens and Pearmain<sup>15</sup> contend that the Electronic Communications and Transactions Act 25 of 2002 (ECTA),<sup>16</sup> while not explicitly mentioning

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<sup>10</sup> Maurice Mars & Caron Jack 'Why is telemedicine a challenge to the regulators?' (2010) 3 *South African Journal of Bioethics Law* 2.

<sup>11</sup> Op cit note 8 at 55.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid. at 55 – 58.

<sup>14</sup> Pieter Carstens & Debbie Pearmain *Foundational Principles of South African Medical Law* (2007).

<sup>15</sup> Ibid.

<sup>16</sup> Electronic Communications and Transactions Act 25 of 2002.

telemedicine, can easily be read as approving telemedicine within relevant limitations and guidelines.<sup>17</sup>

At the time of writing, little to no scholarly analysis exists which comments on the permissibility of telemedicine in light of ECTA. A brief evaluation of the Act's impact on MATM follows.

#### *4.2.1.1 The Electronic Communications and Transactions Act 25 of 2002 and its impacts on the permissibility of medical abortion via telemedicine*

The Electronic Communications and Transactions Act 25 of 2002, despite its promulgation during the infancy of modern telemedicine, is formulated in a manner that allows for the practice of telemedicine insofar as it complies with relevant regulations on electronic communication. This subsection will discuss three key takeaways from the Act as it relates to the permissibility of MATM: definitional inclusion, the national e-strategy, and issuance of documentation by public bodies.

##### *4.2.1.1.1 Definitional inclusions and their impact on the permissibility of telemedicine*

ECTA includes definitions of terms such as 'personal information'<sup>18</sup> through which it can be inferred that telemedicine is protected under the Act. Although ECTA includes many categories in its definition of personal information, the inclusions which concern this work are that of pregnancy status;<sup>19</sup> health;<sup>20</sup> general wellness;<sup>21</sup> medical history;<sup>22</sup> identifying information such as an identification number;<sup>23</sup> and any other correspondence deemed private.<sup>24</sup> The inclusion of these categories of information as part of the definition of personal information is important because personal information receives specialised protections under Chapter VIII<sup>25</sup> of ECTA. Such protections lead to two major conclusions for the purposes of this section: firstly, telemedical communications will be protected under ECTA because they contain personal information as defined in the Act. Secondly, MATM is by no means banned by ECTA. Indeed, the Act seems generally permissive of future developments involving the exchange of electronic information.

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<sup>17</sup> Op cit note 14 at 826 – 827.

<sup>18</sup> Supra note 16 at s1.

<sup>19</sup> Ibid. at s1, 'personal information' definition subsection (a).

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid. at s1 'personal information' definition subsection (b).

<sup>23</sup> Ibid. at s1 'personal information' definition subsection (c).

<sup>24</sup> Ibid. at s1 'personal information' definition subsection (f).

<sup>25</sup> Ibid. at chapter VIII.

#### *4.2.1.1.2 The national e-strategy and its impacts on the permissibility of telemedicine*

The national e-strategy is a policy initiative of the South African government which aims to increase the participation of disadvantaged groups in information and telecommunication technologies (ICT).<sup>26</sup> For the purposes of this work, it is relevant that ECTA commits the national e-strategy to three relevant goals, although many other goals are included in the e-strategy. These three goals are the expansion of access to ICT;<sup>27</sup> the promotion of ICT innovations;<sup>28</sup> and the intentional inclusion of marginalised populations in ICT programmes.<sup>29</sup>

These three goals confirm that the South African government has placed upon itself an obligation to provide ICT access, including access to new and developing ICT technologies, to its population.<sup>30</sup> Such access clearly includes access to telemedicine where medically appropriate. The introduction of MATM into the South African public healthcare system would fulfil the three goals mentioned above in that it provides the possibility of expanding access to useful ICT, makes use of newer ICT innovations, and intentionally increases the inclusion of marginalised communities to their benefit. MATM therefore fits easily into the national e-strategy.

#### *4.2.1.1.3 Issuance of documentation by public bodies: the allowance of electronic issuance and its impacts on the permissibility of telemedicine*

Chapter IV<sup>31</sup> of ECTA allows public bodies to issue ‘permit[s], licence[s] or approval[s] in the form of a data message’<sup>32</sup> if the body in question issues such documents pursuant to a relevant law.<sup>33</sup> While ‘permit’, ‘licence’, and ‘approval’ are not defined by the Act, this section of the Act implies that the permissibility of issuing licences or the like by means of data message means that medical prescriptions may also be issued via data message. This implication supports the legality of telemedicine within public sector healthcare. The Act lays out that physical document issuances may be fulfilled via data message.<sup>34</sup> No exceptions are considered so vital as to require inclusion in this provision.<sup>35</sup> One cannot therefore conclude

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<sup>26</sup> Ibid. at s6 to s9.

<sup>27</sup> Ibid. at s6.

<sup>28</sup> Ibid. at s6(c).

<sup>29</sup> Ibid. at s7.

<sup>30</sup> Ibid. at s6(c).

<sup>31</sup> Ibid. at chapter IV.

<sup>32</sup> Ibid. at s27(c)(ii).

<sup>33</sup> Ibid. at s27(b).

<sup>34</sup> Ibid. at s27(c)(ii).

<sup>35</sup> Ibid. at s27.

that medical prescriptions arising from telemedical consultations are inherently inferior or indeed different to those arising from face-to-face consultations.<sup>36</sup>

The following section comprises a brief discussion of the legal position of MATM with reference to CTOPA, as amended.

*4.2.1.2 Beyond ECTA: alternative and complementary arguments for the legality of telemedicine*

CTOPA, as amended, and read in conjunction with national guidelines on the Act's implementation, places requirements on healthcare facilities where abortions 'take place'.<sup>37</sup> Chapter 2 of this work has demonstrated that these requirements, in the context of MA in the first trimester, are unreasonable, unsupported by evidence, and obstruct access to abortion for the South African population. The conclusion of Chapter 2's discussion could be that MATM is either illegal or non-compliant with government policies. This section offers an alternative answer to the question of whether MATM is legal in South Africa. This second answer is of a somewhat more philosophical nature: what does it mean for MA to 'take place'?<sup>38</sup> Does MA take place at the moment of prescription of the medication? At the moment of ingestion of the abortifacient? In contrast to surgical abortion, where the pivotal moment seems easier to identify, MA's point of onset is much more difficult to isolate.

This means that – if MATM's legality were to be challenged in court, on the basis that the procedure is not occurring in a healthcare facility approved under the relevant laws and guidelines – then one of many possible defences that could be offered would be that the MA could have taken place (in the sense of being prescribed) in a compliant facility. The patient may not be physically present in that facility at the moment of prescription, and the abortifacient may not have been ingested in that facility, but the facility where the abortion was prescribed could theoretically have been fully compliant with all relevant legal requirements. Unless the National Department of Health chooses to define the moment at which an abortion takes place – a fraught process, complicated by philosophical, ethical, medical, and scientific conflicts of opinion – a challenge of the legality of MATM will likely fail due to definitional issues.

This work therefore holds that MATM lies within the bounds of legal abortion as defined by the National Department of Health and by national legislation. It is therefore

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<sup>36</sup> Ibid. at s11 to s20.

<sup>37</sup> National Department of Health, *National Clinical Guidelines for Implementation of the Choice on Termination of Pregnancy Act* (2019) Annex 1 at 33.

<sup>38</sup> Ibid.

submitted that healthcare practitioners and medical organisations would be acting legally in participating in MATM. The following three sections offer three additional rationales for the legality of MATM.

*4.2.1.2.1 Telemedicine's legality in its increased fulfilment of the right to the highest attainable standard of health*

It is submitted that MATM is in fact legal due to its possible increased fulfilment of the right to the highest attainable standard of health.<sup>39</sup> As a means of increasing access to safe MA, telemedicine does the most good because, as discussed in chapter 3, it provides an avenue for the provision of safe MA in a way that is convenient, accessible for many (including disadvantaged or rural populations), private, confidential, and desirable for patients.

Telemedicine does the least harm in providing access to safe MA because it allows access without many of the risks or barriers that accompany seeking in-person abortion care, such as contracting communicable diseases, long waiting times, inaccessibility or insufficient supply of healthcare facilities and/or practitioners, insufficient medication supplies, travel costs, and opportunity costs. In providing convenient, wider access to MA, telemedicine represents one possible avenue towards increasing the fulfilment of the right to the highest attainable standard of health. MATM is therefore aligned with the Constitutional right to access healthcare.

This section has argued for the legality of telemedicine in its role of increasing fulfilment of the right to the highest attainable standard of health. The following section discusses an additional rationale based on South African medical malpractice jurisprudence.

*4.2.1.2.2 Telemedicine's legality in its exclusion from the category of medical malpractice*

Medical decision-making, especially in the context of choosing which treatment to pursue in a given case, is no exact science. For every diagnosis there will be competing schools of opinion.<sup>40</sup> Some may argue that deviating from the most widely accepted treatment method is problematic.<sup>41</sup> To take this argument to its logical conclusion, choosing a non-standard treatment method for a given diagnosis could constitute an action against the patient's best interests and possibly therefore medical malpractice.<sup>42</sup> This latter term is a subcategory of the

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<sup>39</sup> International Covenant on Economic, Social and Cultural Rights, 16 December 1966, UNTS 993 (entered into force 3 January 1976) at art. 12.1.

<sup>40</sup> John Saner *Medical Malpractice in South Africa: A Guide for Medical and Legal Practitioners* (2018) at chapter 3.

<sup>41</sup> *Ibid.* at 3-1.

<sup>42</sup> *Ibid.*

‘improper or disgraceful conduct’<sup>43</sup> of medical practitioners, regulated by the HPCSA and its subsidiary professional boards. In this hypothetical scenario, it would seem justified that the HPCSA disallow treatment methods that are not favoured by a majority of the medical professionals in the relevant field.

This hypothetical and monolithic approach to treatment is neither common practice nor supported by case law in the field of medical malpractice.<sup>44</sup> Regarding common practice, the HPCSA does not disallow alternative methods of treatment for the same diagnosis; indeed, it recognises that several approaches may have benefit in treating the same patient or condition.<sup>45</sup> In addition, seminal South African case law regarding medical malpractice<sup>46</sup> supports the prerogative of a healthcare practitioner, in consultation with their patient, to select an acceptable, appropriate treatment method that is not the dominant treatment method for the diagnosis in question.<sup>47</sup> The use of uncommon, or even rare, methods of treatment does not constitute medical malpractice unless the treatment method is in itself unacceptable or otherwise inappropriate.<sup>48</sup>

Thus, MATM – arguably an uncommon or non-dominant method of practicing medicine – is not necessarily medical malpractice. It therefore should not be automatically subject to sanction from the HPCSA unless it can be demonstrated to be inherently harmful. MATM is not inherently unsafe<sup>49</sup> or inappropriate<sup>50</sup> and may thus be eligible for inclusion within a healthcare practitioner’s options when treating patients. There is at present no demonstrable reason, according to South African common medical practice and jurisprudence on medical malpractice, why MATM should be completely prohibited by the HPCSA or by law.

The above demonstrates that MATM should not be banned by default by national regulatory frameworks. However, there is an additional motivation for its being permitted: case law around medical negligence<sup>51</sup> demonstrates that unjustified prohibition of MATM could constitute wrongdoing and medical negligence.

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<sup>43</sup> Medical, Dental and Supplementary Health Service Professions Act 56 of 1974 at s41 and s42; op cit note 40 at 8-6.

<sup>44</sup> Op cit note 40 at 3-1 to 3-2.

<sup>45</sup> Health Professions Council of South Africa *Ethical and Professional Rules of the Health Professions Council of South Africa Booklet 2* (2016) at s27A(d).

<sup>46</sup> *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* 2016 1 SA 325 (CC)

<sup>47</sup> Op cit note 40 at 3-2 to 3-4.

<sup>48</sup> Ibid.

<sup>49</sup> Op cit note 37 at 16.

<sup>50</sup> Rishita Nandagiri, Ernestina Coast & Joe Strong ‘COVID-19 and abortion: making structural violence visible’ (2020) 46 *International Perspectives on Sexual and Reproductive Health* 1 at 86.

<sup>51</sup> Supra note 46.

#### 4.2.1.2.3 *Telemedicine's legality in that its banning could constitute wrongdoing and/or medical negligence*

The case of *Oppelt v Department of Health, Western Cape*<sup>52</sup> extends South African jurisprudence on medical negligence in finding that the unbending application of inappropriate protocols can equate to medical negligence and wrongdoing on behalf of medical practitioners and those involved in enforcing said protocols.<sup>53</sup> If a protocol demands a certain set of actions, and those actions are followed despite detriment to the patient, following the protocol constitutes medical negligence and the practitioners involved may be sanctioned.<sup>54</sup> The most appropriate method or protocol should be used in medical cases, even if the most appropriate method is not the prescribed norm.<sup>55</sup> This means that the prohibition of MATM by the HPCSA could constitute medical negligence. This arises from the possibility that pregnant persons who could have accessed abortions via telemedicine – possibly the most appropriate mechanism for their accessing an abortion – may have failed to access abortion due to the HPCSA's actions. It is irrelevant whether the HPCSA prefers that MA is not performed via telemedicine or whether a majority of healthcare practitioners in the field of abortion favour face-to-face MA. MATM is safe and effective within appropriate circumstances,<sup>56</sup> and therefore does not constitute medical malpractice or necessarily merit rebuke from the HPCSA. Moreover, in cases where MATM is the most appropriate mechanism by which treatment can be achieved, the HPCSA's continued discouragement of the practice could constitute medical negligence and therefore legal liability.

It is true that courts cannot and do not determine the professional conduct guidelines of the medical field; the HPCSA's professional boards have that prerogative.<sup>57</sup> However, the boards lack a definition of the 'improper or disgraceful'<sup>58</sup> conduct that they are mandated to penalise.<sup>59</sup> The definition thereof is decided on a case-by-case basis.<sup>60</sup> It is therefore submitted that MATM by no means fulfils the criteria for medical malpractice, nor the wider category of 'improper or disgraceful conduct'<sup>61</sup> by a healthcare practitioner. Moreover, the HPCSA's continued discouragement or banning of MATM could constitute negligence, in

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<sup>52</sup> Ibid.

<sup>53</sup> Ibid. paras 68 and 82; op cit note 40 at 3-4.

<sup>54</sup> Ibid.

<sup>55</sup> Op cit note 40 at 3-4.

<sup>56</sup> Op cit note 8 at 10.

<sup>57</sup> Op cit note 40 at 3-2.

<sup>58</sup> Medical, Dental and Supplementary Health Service Professions Act 56 of 1974 at s41 – 42.

<sup>59</sup> Ibid.

<sup>60</sup> Op cit note 40 at 8-4 to 8-8.

<sup>61</sup> Supra note 58 at s41 – 42.

that it blocks a mechanism of providing medical treatment that is arguably the best suited mechanism for some cases. This section therefore argues that the HPCSA would be wise to remove all unjustifiable regulatory obstacles to the practice of MATM.

Should the HPCSA choose to retain its position on telemedicine, it is possible that hypothetical cases could arise where healthcare practitioners, chastised by the HPCSA's professional boards for practising MATM, could pursue legal action against the HPCSA to challenge the applied sanction. In these hypothetical scenarios, it is possible that courts may find the HPCSA's disdain of telemedicine to be unfounded and therefore insufficient grounds for reprimanding healthcare professionals. Moreover, these judgements could find that the HPCSA itself is negligent in its banning or discouragement of a treatment mechanism which in some circumstances would be the most appropriate mechanism. Quite beyond the idea that the HPCSA should approve MATM because it would be in the best interests of the South African public whom the HPCSA is mandated to serve, it is in the self-interest of the HPCSA to take these same actions, if only to protect itself from allegations of medical negligence and the perpetuation of structural violence.<sup>62</sup>

#### *4.2.1.3 Concluding remarks on the current legal position of telemedicine*

The above discussion has argued that it is in the best interests of the South African public and the HPCSA to enable MATM. However, it remains true that there is presently no law which explicitly endorses the practice. The practice remains in a space of legal liminality: it is desirable and useful, and its non-approval could lead to severe detriment, but it is technically still able to be condemned by the HPCSA or the state as an unsanctioned or illegal practice. The following subsection considers the extant South African ethical frameworks around MATM, attempting to clarify this area of liminality.

#### *4.2.2 Existing ethical frameworks affecting telemedicine*

##### *4.2.2.1 The HPCSA's telemedicine guidance*

The HPCSA, tasked as it is with regulating medical practice in the country,<sup>63</sup> has taken an extended period of time to define and regulate telemedicine. Telemedicine in South Africa was a focus point for national government even from the late 1990s,<sup>64</sup> yet the HPCSA lacked guidelines on telemedicine until 2014.<sup>65</sup> When guidelines were published by the body, they

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<sup>62</sup> Op cit note 50 at 86.

<sup>63</sup> The HPCSA's mandate originates from its establishment under the Medical, Dental and Supplementary Health Service Professions Act 56 of 1974.

<sup>64</sup> S M Gulube & S Wynchank 'Telemedicine in South Africa: Success or Failure?' (2001) 7 *Journal of Telemedicine and Telecare* 2.

<sup>65</sup> Op cit note 2 at 21.

received scholarly critique for their vagueness, imprecise formulation, and unrealistic requirements.<sup>66</sup> The HPCSA's long-awaited definition of telemedicine,<sup>67</sup> which was published as a draft in 2008,<sup>68</sup> would include any medical communication at a distance, from patients calling a doctor to request a prescription to doctors emailing one another;<sup>69</sup> yet the HPCSA also placed burdensome requirements regarding informed consent, amongst other elements, on any activity which it saw as taking place within the boundaries of the definition of telemedicine.<sup>70</sup> These requirements would not only stymie any useful development of telemedicine, but they were also unreflective of current practices in either telemedicine or face-to-face consultation and therefore unrealistic.<sup>71</sup>

This seems to reflect the HPCSA's attitude towards telemedicine as being undesirable. Certainly, the HPCSA's guidelines, as applicable from publication in 2014<sup>72</sup> until early April 2020, both tacitly<sup>73</sup> and explicitly<sup>74</sup> discouraged healthcare professionals from engaging in telemedicine. The guidelines reveal many negative assumptions regarding telemedicine, such as the assumption that face-to-face medicine is a gold standard against which telemedicine will always be an inferior substitute.<sup>75</sup> Many of these assumptions were not grounded in medical best practices<sup>76</sup> at the time of publication of the guidelines. Additionally, the guidelines placed burdensome requirements on health practitioners engaging in telemedicine,<sup>77</sup> which arguably defeated the spirit of telemedicine – increased access to healthcare, especially for underserved populations.<sup>78</sup> An example of such requirements includes that of a pre-existing doctor-patient relationship before telemedicine can commence.<sup>79</sup> This requirement, unreflective of international practice,<sup>80</sup> effectively renders telemedicine significantly less useful. Requiring a physical interaction before telemedicine

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<sup>66</sup> Op cit note 8 at 55.

<sup>67</sup> Ibid.

<sup>68</sup> M Kekana, P Noe, and B Mkhize 'The Practice of Telemedicine and Challenges to the Regulatory Authorities' (2010) 3 *South African Journal of Bioethics and Law* 1 at 34.

<sup>69</sup> Op cit note 8 at 55.

<sup>70</sup> Ibid. at 57 – 58.

<sup>71</sup> Ibid. at 58.

<sup>72</sup> Susan Meyer & Simone Nel 'Telemedicine: Band-Aid or Long-Term Solution?' 17 May 2021, available at <https://www.cliffedekkerhofmeyr.com/en/news/publications/2021/Healthcare/healthcare-and-pharmaceuticals-alert-17-may-telemedicine-band-aid-or-long-term-solution.html>, accessed on 30 August 2023.

<sup>73</sup> Op cit note 2 at 21, 23 – 25.

<sup>74</sup> Op cit note 3; op cit note 2 at 21, 23 – 25.

<sup>75</sup> Op cit note 2 at 21 – 22.

<sup>76</sup> B A Townsend, M Mars & R E Scott 'The HPCSA's telemedicine guidance during COVID-19: A review' (2020) 13 *South African Journal of Bioethics Law* 2 at 99.

<sup>77</sup> Op cit note 72.

<sup>78</sup> Op cit note 8 at iv, art. 1.2.

<sup>79</sup> Op cit note 72.

<sup>80</sup> Op cit note 76 at 99.

may begin increases direct and opportunity costs of telemedicine, is inconvenient for the patient, and may render the telemedical consultation entirely unnecessary. Much of the HPCSA's pre-2020 guidance on telemedicine does not seem to further the aims or the purpose of telemedicine.

After years of criticism for its lack of workable telemedicine guidelines,<sup>81</sup> the HPCSA (under significant pressure from other medical bodies and society at large<sup>82</sup>) did disseminate revised guidelines for telemedicine in April 2020.<sup>83</sup> This publication was likely spurred on by the advent of the COVID-19 pandemic in early 2020 and by the renewed fervour of criticism of the HPCSA's stance.<sup>84</sup>

The April 2020 guidelines on telemedicine (*General Ethical Guidelines for Good Practice in Telemedicine Booklet 10*, henceforth Booklet 10) did make some concessions to the longstanding critiques levelled against the HPCSA's stance on telemedicine. Telemedicine is allowed in circumstances wider<sup>85</sup> than the previous guidelines, where it was allowed only as an exception.<sup>86</sup> A pre-existing relationship doctor-patient relationship is no longer strictly required for telemedicine, although it is still recommended.<sup>87</sup> However, these concessions are not sweeping. Booklet 10 still forbids healthcare practitioners from practicing only via telemedicine;<sup>88</sup> requires the presence of a healthcare practitioner in physical proximity to the patient,<sup>89</sup> although this requirement is later contradicted without clarification of the rule;<sup>90</sup> and assumes throughout that the healthcare practitioner engaging in telemedicine is prone to over-servicing patients,<sup>91</sup> lowering the quality of their care,<sup>92</sup> and acting solely in pursuit of their own interests.<sup>93</sup> The above requirements and assumptions demonstrate that the HPCSA's stance on telemedicine has not changed significantly, despite the widened circumstances in which telemedicine may be practiced.

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<sup>81</sup> See, for example, op cit note 8; Caron L Jack & Maurice Mars 'Ethical considerations of mobile phone use by patients in KwaZulu-Natal: Obstacles for mHealth?' (2014) 6 *African Journal of Primary Health Care & Family Medicine* 1; op cit note 4; op cit note 76.

<sup>82</sup> South African Medical Association 'Medical Organisations Reject New HPCSA Guideline on Telemedicine Calling It Wrong and Dangerous' available at <https://samedical.org/cmsuploader/viewArticle/1095>, accessed on 30 August 2023.

<sup>83</sup> Op cit note 8.

<sup>84</sup> Op cit note 82.

<sup>85</sup> Op cit note 8 at art. 4.

<sup>86</sup> Op cit note 82.

<sup>87</sup> Op cit note 8 at art. 3.7.

<sup>88</sup> Ibid. at art. 3.8.

<sup>89</sup> Op cit note 76 at 97.

<sup>90</sup> Ibid.

<sup>91</sup> Op cit note 8 at art. 4.2(b).

<sup>92</sup> Ibid. at art. 4.1(b).

<sup>93</sup> Ibid. at art. 5.3(e).

#### 4.2.2.2 *Evaluating the HPCSA's telemedicine guidelines according to the 'four principles plus scope' framework*

The 'four principles plus scope' framework, developed by Beauchamp and Childress in the late 20<sup>th</sup> century,<sup>94</sup> is an approach to thinking through ethical issues in medical fields that has attained widespread use.<sup>95</sup> The impact of the framework can be seen in many medical associations' ethical guidelines.<sup>96</sup> As the HPCSA guidelines take inspiration from the Beauchamp and Childress approach,<sup>97</sup> this section will discuss the 'four principles plus scope' framework with the conclusions reached being transferable to the comparable HPCSA guidelines.<sup>98</sup>

'Four principles plus scope' denotes a framework of four guiding principles (autonomy, beneficence, non-maleficence, and justice) and a consideration of the scope of their application.<sup>99</sup> This section will briefly address each principle in the context of MATM.

##### 4.2.2.2.1 *Autonomy or respect for autonomy*

Autonomy requires that healthcare practitioners treat patients with the respect due an autonomous being, including the obtaining of informed consent, the assurance of confidentiality, and the use of effective communication.<sup>100</sup> Notably, respect for autonomy generally requires that the patient may make choices regarding the treatment they undergo, and the mechanisms by which those treatments are performed.<sup>101</sup> This implies that a patient who wishes to have MATM should be allowed to have such a procedure, providing it is medically appropriate. Barriers to such a procedure – namely, the HPCSA's non-allowance of MATM – should be removed unless sufficient justification for them exists.

##### 4.2.2.2.2 *Beneficence and non-maleficence*

The second and third principles of the framework are closely related. The goal of medical treatment, in some formulations, is to do the most good for a patient (beneficence) with the least harm incurred (non-maleficence).<sup>102</sup> As has been demonstrated above, MATM is a possible avenue for providing access to abortion, and could be the most beneficent and least

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<sup>94</sup> Raanan Gillon 'Medical Ethics: Four Principles plus Attention to Scope' 1994 *BMJ* 309.

<sup>95</sup> *Ibid.* at 184.

<sup>96</sup> See the Health Professions Council of South Africa's publications *General Ethical Guidelines for the Healthcare Professions Booklet 1* (2021); *op cit* note 45; *National Patients' Rights Charter Booklet 3* (2016); and *General Ethical Guidelines for Reproductive Health Booklet 8* (2016), for four examples.

<sup>97</sup> Booklet 1 *op cit* note 96 at art. 2.

<sup>98</sup> Such comparable guidelines include Booklet 1 *op cit* note 96 and Booklet 8 *op cit* note 96.

<sup>99</sup> *Op cit* note 94 at 184.

<sup>100</sup> *Ibid.* at 184 – 185.

<sup>101</sup> *Ibid.* at 185.

<sup>102</sup> *Ibid.*

maleficent avenue. To comply with the core tenets of medical ethics as expressed in this framework,<sup>103</sup> the HPCSA should allow MATM within reasonable limits.

#### 4.2.2.2.3 *Justice*

Justice is a complex principle; some commentators<sup>104</sup> have chosen to discuss it in three iterations, namely distributive justice, the promotion of patients' human rights, and legal adherence.<sup>105</sup> All three of these iterations support the permitting of MATM.

##### 4.2.2.2.3.1 *Distributive justice*

Distributive justice refers to the ethical issues arising from the allocation of scarce resources in a context of great need.<sup>106</sup> These ethical issues are addressed by the approval of MATM, which allows for cost-effective<sup>107</sup> and convenient<sup>108</sup> provision of MA. It expands access to abortion within a context of lack of access,<sup>109</sup> insufficient resources,<sup>110</sup> and significant demand.<sup>111</sup> The approval of MATM would fulfil the principle of justice in its iteration as distributive justice.

##### 4.2.2.2.3.2 *The promotion of patients' human rights*

Promoting the human rights of one's patients is a core obligation of any healthcare practitioner.<sup>112</sup> This work contends that MATM promotes the human rights of pregnant persons seeking abortion, and therefore that the practice should be allowed. Moreover, HPCSA guidelines require healthcare practitioners in fields affecting women's health to research and publish information regarding detriments to women's health, the possible causes thereof, and potential solutions.<sup>113</sup> The guidelines add that extreme detriment could result from a failure to engage in such advocacy.<sup>114</sup> The guidelines also oblige professional organisations, including medical associations, to make core healthcare services available to

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<sup>103</sup> Ibid. at 184.

<sup>104</sup> Op cit note 94.

<sup>105</sup> Ibid. at 185.

<sup>106</sup> Op cit note 94 at 185 – 187.

<sup>107</sup> Guttmacher Institute, *Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies* (2012) at 38.

<sup>108</sup> Op cit note 37 at 16; Mariana Prandini Assis & Sara Larrea 'Why Self-Managed Abortion Is so Much More than a Provisional Solution for Times of Pandemic' (2020) 28 *Sexual and Reproductive Health Matters* 1 at 38.

<sup>109</sup> Elizabeth A. Mosley, Amy J. Schulz, Lisa H. Harris, et al. 'South African Abortion Attitudes from 2007–2016: The Roles of Religiosity and Attitudes toward Sexuality and Gender Equality' (2020) 60 *Women & Health* 7 at 2; op cit note 37 at 1.

<sup>110</sup> Amnesty International, *Barriers to Safe and Legal Abortion in South Africa* (2017) at 12.

<sup>111</sup> Op cit note 37 at 1.

<sup>112</sup> Op cit note 94 at 185 – 187.

<sup>113</sup> Booklet 8 op cit note 96 at art. 2.2.

<sup>114</sup> Ibid. at art. 2.3.

women in disadvantaged or marginalised communities.<sup>115</sup> In the context of its non-approval of MATM, the HPCSA can fulfil these obligations by approving the procedure.

The absence of MATM is potentially and likely detrimental to the health of pregnant people. Approving the procedure could ameliorate the situation and improve the access of marginalised populations to essential healthcare. In not approving MATM, the HPCSA is violating its own guidelines on health practitioners' roles as advocates for women's health.<sup>116</sup> The HPCSA should therefore approve MATM within reasonable conditions.

#### *4.2.2.2.3.3 Legal adherence*

Defined by some commentators as 'respect for morally acceptable laws',<sup>117</sup> legal adherence is a component of justice which could present MATM healthcare practitioners with an ethical conundrum.<sup>118</sup> This work has argued that MATM should be legal and is likely to already be legal. Similarly, the practice ought to be approved by the HPCSA. Legalised MATM therefore would fall within the category of morally acceptable laws and the question of its unapproved practice would potentially become moot.

Opponents to this view may argue that MATM is illegal, that it ought not be legal, that it is immoral, that it ought to be permanently banned by the HPCSA, or any combination of these arguments. For the sake of argument, this section considers a hypothetical situation in which it has been definitively decided that MATM is illegal, unacceptable to the HPCSA, or both. It is nevertheless the argument of this thesis that it would be morally justifiable to engage in MATM. The practice of MATM offers such potential benefit, with such minimal potential detriment when practiced within appropriate limits, that a ban on the practice is, at best, difficult to comprehend. The principle of justice, in its iteration as legal adherence,<sup>119</sup> arguably would require healthcare practitioners to illegally engage in MATM, should that be the procedure that would best fulfil the interests of the patient and the principles of autonomy, beneficence, non-maleficence, and justice. This conundrum could be avoided through the definitive approval of MATM.

#### *4.2.2.3 Concluding remarks on the state of ethical frameworks affecting telemedicine*

The HPCSA's requirements regarding the practice of telemedicine do not reflect the reality of telemedicine or its potential for use with beneficial results. MATM is, when practiced with

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<sup>115</sup> Ibid. at art. 2.4.

<sup>116</sup> Ibid. at art. 2.

<sup>117</sup> Op cit note 94 at 185.

<sup>118</sup> Ibid. at 185 – 187.

<sup>119</sup> Op cit note 94 at 185 – 186.

proper regulation and in appropriate circumstances, at least potentially an ethical activity. The HPCSA's regulations do not seem to recognise this.

This adherence to prior understanding of telemedicine as potentially, if not already, malicious in nature means that telemedicine in South Africa is severely hampered by the assumptions implicit in Booklet 10. It is unlikely that telemedicine could reach its full potential with regards to improving accessibility of healthcare when governed by the guidelines in Booklet 10. The following section suggests some necessary alterations to the extant South African legal and ethical frameworks regarding telemedicine.

#### 4.3 NEEDED ALTERATIONS TO LEGAL AND ETHICAL FRAMEWORKS AFFECTING TELEMEDICINE

There are elements of telemedicine that need greater regulation than exists under current legal and ethical frameworks in the South African context. Conversely, there are also elements of telemedicine which have been frustrated by unnecessary or inappropriate regulation. This section examines several elements falling into either category.

Booklet 10 does have some notable gaps. The introduction of complex methods of communication such as video conferencing necessitates the drafting of detailed standards of care with which healthcare practitioners must comply. These standards concern data stewardship, informed consent, the location of responsibility for the patient, and many other elements of telemedicine.<sup>120</sup> This is not to say that such standards must be rigid or unable to adapt to the advent of new technologies for communication: on the contrary, the guidelines must be stringent enough to protect patients as far as is possible, but flexible enough to incorporate emerging communication methods. These guidelines will need to be specialised to each of many medical professions.<sup>121</sup> Professional boards or organisations within each field will need to draft guidelines for their own speciality,<sup>122</sup> although the HPCSA may be involved in some capacity.

Within the elements of MATM which require less stringent regulation than is extant, the most obvious change needed is an amendment to the Choice on Termination of Pregnancy Act of 1996,<sup>123</sup> as amended in 2004<sup>124</sup> and 2008.<sup>125</sup> The amended Act specifies the characteristics of healthcare facilities where lawful abortions may occur.<sup>126</sup> These

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<sup>120</sup> Op cit note 4.

<sup>121</sup> Op cit note 10 at 58.

<sup>122</sup> Ibid.; op cit note 2 at 22.

<sup>123</sup> Act 92 of 1996.

<sup>124</sup> Choice on Termination of Pregnancy Amendment Act, 2004.

<sup>125</sup> Choice on Termination of Pregnancy Amendment Act, 2008.

<sup>126</sup> Supra note 123 at art. 3; supra note 124 at art. 2; supra note 125 at art. 2.

characteristics include the availability of medical equipment for monitoring and resuscitation, amongst other purposes;<sup>127</sup> infection control and waste disposal mechanisms;<sup>128</sup> available transport to other healthcare facilities, should it be required in a medical emergency;<sup>129</sup> and telecommunications connectivity.<sup>130</sup> Only in the presence of all these characteristics can the healthcare facility be designated by government as an approved abortion facility.<sup>131</sup>

There are three major issues with these requirements. First, they are not all necessary for MA. Secondly, they therefore hinder access to MA. Thirdly, even state medical policies<sup>132</sup> recommend against compliance with these requirements in the case of MA, as MA is frequently initiated by the patient at their residence or another location which is not a healthcare facility approved to perform abortions.<sup>133</sup> The fact that even government is non-compliant<sup>134</sup> with legal requirements regarding the location of abortion services<sup>135</sup> implies that the requirements are unnecessarily burdensome and stymie the possibility of increasing access to abortion.

In the light of these three issues and their implications, it becomes clear that the utility of MA – a safe,<sup>136</sup> effective,<sup>137</sup> and affordable<sup>138</sup> method of abortion – is lessened through the persistent application of legal requirements designed for surgical and not MA. CTOPA, as amended, along with relevant government policies, should be further amended to reflect the different requirements for facilities performing surgical abortions as opposed to facilities prescribing MA. Such amendments should also enable MATM by removing provisions which imply the necessity of physical proximity between healthcare practitioner and patient in a routine MA.<sup>139</sup> It is also possible that the amendment to CTOPA could simply indicate that the requirements for an approved abortion facility will be determined and disseminated through policy and not through legal amendment. This strategy, which will be discussed in greater detail in chapter 5's recommendations, could reduce bureaucratic delays and allow for greater flexibility in incorporating new developments in the field of safe abortion methods.

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<sup>127</sup> Supra note 124 at art. 2; op cit note 37 annex 1 at 33 – 34.

<sup>128</sup> Ibid.

<sup>129</sup> Ibid.

<sup>130</sup> Ibid.

<sup>131</sup> Ibid.

<sup>132</sup> Op cit note 37 at 16; National Department of Health, *National Integrated Sexual & Reproductive Health and Rights Policy* (2019) at 25 – 26.

<sup>133</sup> Ibid.

<sup>134</sup> Op cit note 37 at 16; National Integrated SRHR Policy op cit note 132 at 25 – 26.

<sup>135</sup> Supra note 123 at art. 2.

<sup>136</sup> Op cit note 37 at 16.

<sup>137</sup> Ibid.

<sup>138</sup> Op cit note 109 at 38.

<sup>139</sup> Op cit note 82.

Lastly, the HPCSA's guidelines on telemedicine need amendments regarding the implicit assumption of inferiority of care<sup>140</sup> and malicious intent<sup>141</sup> on behalf of the telemedicine practitioner. The HPCSA's telemedicine guidelines ought to be a supportive, enabling set of requirements with which telemedicine practitioners must comply, but the guidelines should only impose restrictions where they are scientifically sound and medically relevant. The HPCSA is mandated<sup>142</sup> to place restrictions on telemedicine where they can be demonstrated to be necessary and/or prudent, but many of the existing restrictions lack a clear link to either necessity or prudence.

#### 4.4 CONCLUSION

The history of telemedicine in South Africa, particularly for MA, is marked by significant variation in interest and government support. The frameworks governing telemedicine reflect these vagaries. While legally there is tacit support for the practice, the HPCSA has demonstrated tacit<sup>143</sup> and explicit<sup>144</sup> disapproval of telemedicine. Only under significant pressure<sup>145</sup> from medical bodies and civil society did the HPCSA produce guidelines<sup>146</sup> which approved of telemedicine in some circumstances. These guidelines, however, betray the continued existence of disapproval of telemedicine, and need amendment to enable its growth. Likewise, the laws governing abortion in South Africa<sup>147</sup> must be amended to reflect current medical best practices,<sup>148</sup> to allow government guidelines<sup>149</sup> regarding MA to fall into line with the law,<sup>150</sup> and to enable MA both in person and through telemedicine. The next chapter turns to some recommendations for the way forward for MATM.

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<sup>140</sup> Op cit note 10 at art. 4.1(b), art. 5.3(e).

<sup>141</sup> Ibid. at art. 5.3(e).

<sup>142</sup> Op cit note 10 at iv, art. 1.

<sup>143</sup> Op cit note 2 at 21, 23 – 25.

<sup>144</sup> Op cit note 3.

<sup>145</sup> Op cit note 82.

<sup>146</sup> Op cit note 10.

<sup>147</sup> Supra note 123; supra note 124; supra note 125.

<sup>148</sup> Op cit note 109 at 11.

<sup>149</sup> Op cit note 40; National Integrated SRHR Policy op cit note 132.

<sup>150</sup> Supra note 123; supra note 124; supra note 125.

## CHAPTER 5

### 5.1 INTRODUCTION

Having concluded that MATM presents an opportunity for increasing access to safe abortion in South Africa and therefore for increasing fulfilment of the country's legal obligations around reproductive rights, this work now turns to a consideration of the changes that are needed to enable MATM. The recommended changes are grouped into three categories: legal, ethical, and policy changes.

### 5.2 RECOMMENDATIONS FOR LEGAL CHANGES TO ENABLE MEDICAL ABORTION VIA TELEMEDICINE

The first and most vital recommendation to be taken from this work is the necessity of amending CTOPA,<sup>1</sup> as amended.<sup>2 3</sup> At present, the requirements of the amended Act are suitable for surgical abortion but not for MA. This cross-application of unsuitable requirements leads to requirements being ignored even by the state<sup>4</sup> and to the stymieing of safe and effective methods of abortion. It is imperative that CTOPA, as amended, is amended once more to allow for requirements suited to specific methods of abortion. This may take the form of an amendment allowing the regulation of methods of abortion through policy and not through law. Allowing national government to regulate abortion methods through policy, rather than requiring legal amendments each time a new method of abortion emerges, is likely to be more efficient.<sup>5</sup> Such an approach will also allow for increased flexibility, as methods of abortion can be approved more quickly<sup>6</sup> if they can be demonstrated to be safe, effective, and useful in context. While the core framework of CTOPA should remain as a cornerstone of reproductive freedom in South Africa, the mechanisms through which the Act works can be a matter of policy and not law.

### 5.3 RECOMMENDATIONS FOR ETHICAL CHANGES TO ENABLE MEDICAL ABORTION VIA TELEMEDICINE

Four recommendations for ethical changes emerge from this work, regarding government guidelines on abortion, general telemedicine guidelines, telemedicine guidelines for specialist

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<sup>1</sup> Act 92 of 1996.

<sup>2</sup> Choice on Termination of Pregnancy Amendment Act, 2004.

<sup>3</sup> Choice on Termination of Pregnancy Amendment Act, 2008.

<sup>4</sup> National Department of Health, *National Clinical Guidelines for Implementation of the Choice on Termination of Pregnancy Act* (2019) at 16; National Department of Health, *National Integrated Sexual & Reproductive Health and Rights Policy* (2019) at 25 – 26.

<sup>5</sup> Patty Skuster 'How Laws Fail the Promise of Medical Abortion: A Global Look' (2017) 18 *Georgetown Journal of Gender and the Law* 379 at 392.

<sup>6</sup> *Ibid.*

fields, and telemedicine's approval post-pandemic respectively. First, government guidelines on the implementation of abortion legislation (such as the National Clinical Guidelines<sup>7</sup> and the National Integrated SRHR Policy<sup>8</sup>) must be amended to reflect the differences between medical and surgical abortion. While government guidelines recognise some differences between the procedures in terms of the resources they require and therefore in the equipment and personnel that must be available for the procedures to be performed safely,<sup>9</sup> they do not take into account the fact that most MA are carried out at least partially outside healthcare facilities.<sup>10</sup> The requirements placed on facilities prescribing MA assume that all MA are initiated in the healthcare facility in question.<sup>11</sup> The healthcare facility is therefore required to have certain personnel and infrastructure available, such as monitoring equipment.<sup>12</sup> These requirements are not grounded in evidence; moreover, they hinder access to MA. Government guidelines and policies should be updated to reflect the differing needs of MA vis a vis surgical abortion. These updates will both enable increased access to MA and bring current public health practice into line with government policies. Specifically, the updates should be evidence-based and remove requirements such as the presence of resuscitation equipment<sup>13</sup>, for example, from the essential elements of a healthcare facility exclusively prescribing MA, as long as the patient has access to emergency medical care should it be needed.<sup>14</sup>

The second regulatory recommendation concerns the further development of general guidelines for telemedicine practice. The HPCSA should rescind the elements of its April 2020 telemedicine guidelines<sup>15</sup> which have been identified as hindering the development of telemedicine in the country.<sup>16</sup> These elements, including the focus on physical examination of the patient as a gold standard of care,<sup>17</sup> should be retained in the new guidelines on telemedicine only if they can be demonstrated to be necessary or prudent for the protection of

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<sup>7</sup> National Clinical Guidelines op cit note 4.

<sup>8</sup> National Integrated SRHR Policy op cit note 4.

<sup>9</sup> National Clinical Guidelines op cit note 4 at 33 – 34.

<sup>10</sup> Ibid. at 16; National Integrated SRHR Policy op cit note 4 at 25 – 26.

<sup>11</sup> National Clinical Guidelines op cit note 4 at 33 – 34.

<sup>12</sup> Ibid.

<sup>13</sup> Supra note 2 at art. 2; National Clinical Guidelines op cit note 4 at 33 – 34.

<sup>14</sup> Diane Cooper, Kim Dickson, Kelly Blanchard et al. 'Medical Abortion: The Possibilities for Introduction in the Public Sector in South Africa' (2005) 13 *Reproductive Health Matters* 26 at 36.

<sup>15</sup> Health Professions Council of South Africa *General Ethical Guidelines for Good Practice in Telehealth Booklet 10* (2021).

<sup>16</sup> B A Townsend, M Mars & R E Scott 'The HPCSA's telemedicine guidance during COVID-19: A review' (2020) 13 *South African Journal of Bioethics Law* 2 at 97 – 98.

<sup>17</sup> Op cit note 15 at art. 3.1.

the patient and/or the healthcare practitioner.<sup>18</sup> Assumptions regarding the inferiority of telemedicine care<sup>19</sup> and the malicious intent of its practitioners<sup>20</sup> ought not be retained. The general telemedicine guidelines must be an enabling yet prudent steward of the best interests of the patient and the healthcare practitioner.

Thirdly, the development of guidelines for specialist telemedical care is needed, but the HPCSA is not best suited to develop guidelines for highly diverse medical disciplines.<sup>21</sup> Instead, the responsibility for the development of specialist telemedicine guidelines should fall to the relevant medical boards.<sup>22</sup> These guidelines, as above, should be sufficiently restrictive to protect patients and healthcare practitioners, but not so restrictive as to unnecessarily block the growth of telemedicine.

Fourthly, the HPCSA's widened approval of telemedicine in its April 2020 guidelines<sup>23</sup> was designed as a temporary measure in response to the COVID-19 pandemic.<sup>24</sup> The HPCSA has indicated that it intends to return to the general prohibition of telemedicine, except in certain limited circumstances, once the pandemic has ended.<sup>25</sup> This intention, although it may seem reasonable, ignores the existing and emerging evidence<sup>26</sup> around the utility of telemedicine for providing access to SRHC amongst many other categories of healthcare. The potential held by telemedicine for increasing access to abortion, in just one example, will not disappear with the end of the COVID-19 pandemic.<sup>27</sup> Telemedicine should be allowed to continue, within relevant evidence-based limitations, even after the pandemic has ended.

#### 5.4 RECOMMENDATIONS FOR POLICY CHANGES TO ENABLE MEDICAL ABORTION VIA TELEMEDICINE

The recommendations which this work classes as policy recommendations are somewhat less specific than their legal and ethical counterparts. This reflects the many possible ways in

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<sup>18</sup> Op cit note 16 at 100.

<sup>19</sup> Op cit note 15 at art. 4.1(b).

<sup>20</sup> Ibid. at art. 5.3(e).

<sup>21</sup> Op cit note 16 at 58.

<sup>22</sup> Ibid.

<sup>23</sup> Op cit note 15.

<sup>24</sup> Health Professions Council of South Africa 'Notice to Amend Telemedicine Guidelines during COVID-19 – Dated 3 April 2020' 3 April 2020, available at <https://www.hpcsa-blogs.co.za/notice-to-amend-telemedicine-guidelines-during-covid-19/>, accessed 31 March 2023.

<sup>25</sup> Ibid.

<sup>26</sup> For example, see Skuster et al.'s discussion of the utility of telemedicine medical abortion post-pandemic in Patty Skuster, Jina Dhillon & Jessica Li 'Easing of Regulatory Barriers to Telemedicine Abortion in Response to COVID-19' 2021 *Frontiers in Global Women's Health* 2.

<sup>27</sup> Ibid. at 4.

which each policy recommendation could be implemented, many of which would be useful and workable.

The first of these policy recommendations concerns a renewed focus from government on telemedicine projects. The declining focus on telemedicine from the 2010s<sup>28</sup> should not be continued. Telemedicine presents an opportunity for providing increased access to healthcare for marginalised communities, and it deserves renewed attention and funding.

The following three recommendations all concern methods by which MATM can be developed as part of the South African public health system. The first of these three recommendations is around funding. International donors, whether government-related or private, could potentially be interested in providing funding for telemedicine projects, as such projects present the opportunity for increased compliance with international human rights standards and instruments.

The next recommendation around methods of developing telemedicine concerns public-private partnerships. The private sector and NGOs are sometimes better placed than the public healthcare system in providing services to vulnerable or marginalised populations such as rural women, for example.<sup>29</sup> Where the private sector and/or NGOs can demonstrate that they are better placed to provide services to a certain community, public-private partnerships could increase service delivery for the relevant community. Government-funded but private- or NGO-delivered healthcare services<sup>30</sup>, as have been successful in India,<sup>31</sup> are one example of such partnerships.

The next policy recommendation relates to the preponderance of pilot projects and studies in the fields of telemedicine and SRHR access. Pilots are fairly common in both fields in South Africa.<sup>32</sup> More rarely are any of the pilots developed into functional programmes. It is in national government's interest to monitor the outcomes of pilots, learn from the results thereof, and incorporate the results into their own programmes.

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<sup>28</sup> See chapter 4 for details.

<sup>29</sup> Susheela Singh, Rubina Hussain, Chander Shekhar et al. *Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programs* (2018) at 8 – 10.

<sup>30</sup> *Ibid.* at 20.

<sup>31</sup> *Op cit* note 29 at 20.

<sup>32</sup> See, for example, Deborah Ann Constant *Strengthening Medical Abortion in South Africa* (doctoral thesis, University of Cape Town, 2016); Deborah Constant, Katherine de Tolly, Jane Harries et al. 'Assessment of completion of early medical abortion using a text questionnaire on mobile phones compared to a self-administered paper questionnaire among women attending four clinics, Cape Town, South Africa' (2014) 22 *Reproductive Health Matters* 44; *op cit* note 14; World Health Organization *MAMA South Africa: Putting the Power of Health in Every Mama's Hand* (2013); World Health Organization *Supporting Pregnant Women and New Mothers in South Africa: Cell-Life's MAMA SMS* (2013).

Lastly, it is entirely possible that the health policy landscape in South Africa will change dramatically with the possible enactment and implementation of NHI.<sup>33</sup> At the time of writing, it is unclear how implementation of NHI may affect telemedicine projects, or how it may impact abortion access. NHI's impact on healthcare is a developing field; MATM in the context of NHI will require further research, should NHI be enacted and implemented.

## 5.5 CONCLUSION

MATM has been demonstrated to be a safe,<sup>34</sup> effective,<sup>35</sup> and useful<sup>36</sup> method of providing increased access to reproductive rights, such as safe abortion. This work does not argue that MATM is a perfect solution for the mammoth challenges facing South Africa in achieving its legal obligations regarding the provision of access to abortion. Telemedicine has its limitations; additionally, several legal, ethical, and policy changes are recommended for MATM to be enabled within appropriate circumstances. However, these changes are relatively minor when compared to the potential held by MATM for improving the lives of people seeking abortion in South Africa. This work therefore concludes that – within certain, evidence-based circumstances – MATM is an avenue towards fulfilling the SRHR of South Africans that should be pursued.

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<sup>33</sup> National Health Insurance Bill 11B of 2019.

<sup>34</sup> Constant, *Strengthening Medical Abortion* op cit note 32 at 24.

<sup>35</sup> Ibid.

<sup>36</sup> Op cit note 26 at 4; Sruthi Chandrasekaran, V. S. Chandrashekar, Suchitra Dalvie et al. 'The case for the use of telehealth for abortion in India' (2022) 29 *Sexual and Reproductive Health Matters* 2 at 393 – 396.

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