# South African geneticists' attitudes to the present Abortion and Sterilisation Act of 1975

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*Study objective.* To ascertain the attitudes of clinical geneticists and genetic counsellors practising in South Africa to the current Abortion and Sterilisation Act of 1975 (the Act).

*Design.* Postal questionnaire.

*Main results.* Ninety-two per cent of the questionnaires were returned, and the responses were comparable to those of the South African Society of Obstetricians and Gynaecologists in 1990 and the Society of Psychiatrists of South Africa in 1992.

No respondent felt that the Act should be more restrictive, and only 4 (17.4%) felt that it was acceptable in its present form. Section 3(1)(c) of the Act, which relates to termination of pregnancy (TOP) on genetic grounds, was acceptable in its present form to 13 respondents (56.5%), but 16 (69.7%) considered that TOP on genetic grounds should not be curtailed in future legislation.

*Conclusion.* The geneticists' attitudes to the present Act concurred with those of the obstetricians and psychiatrists previously documented, and confirmed the need for review of the Act. All three specialist groups appeared to support an increase in the indications for legal TOP rather than the introduction of TOP on request up to a specified post-conceptual age. With regard to Section 3(1)(c), the geneticists' responses indicated an acceptance of the limitations of the present Act, coupled with concern about the implications of future changes to this section of the Act.

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It can be anticipated that the present South African government will amend the present Abortion and Sterilisation Act 2 of 1975 (the Act).[1] This has been indicated in the African National Congress's National Health Plan for South Africa,[2] as well as the recent proposals which have been placed before Parliament by a Select Committee on Abortion and Sterilisation.[3]

In 1980[4] and 1990[5] the South African Society of Obstetricians and Gynaecologists (SASOG), and in 1992[6] the Society of Psychiatrists of South Africa (SPSA), documented the attitudes of members to the Act. Both obstetricians and psychiatrists play an active role in the implementation of the present Act.

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The importance of genetics, and the role and attitudes of medical geneticists and genetic counsellors in legal termination of pregnancy, have not previously been documented. Section 3(1)(c) of the present Act permits legal termination of pregnancy on genetic grounds in certain prescribed circumstances. It states that an abortion may be procured by a medical practitioner where there exists a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will be irreparably handicapped. As the mapping of the Human Genome Project progresses and prenatal diagnosis improves, it can be envisaged that requests for the termination of pregnancy on genetic grounds will increase. The need to assess the attitudes of medical geneticists and genetic counsellors to the current legislation and to possible future amendments is therefore paramount.

In the previous studies 80% and 85% of the gynaecologists who responded to the questionnaires in 1980 and 1990, respectively,[2,3] and 89% of the psychiatrists in 1992,[4] were in favour of review and modification of the present Act. The aim of the present study was to survey the attitudes of clinical geneticists and genetic counsellors in South Africa to the Act, so that they could be compared with those of SASOG and SPSA and so that an overall perspective of the attitudes of the members of these three major specialties to the present Act could be obtained.

We present the results of a survey of the attitudes of clinical geneticists and genetic counsellors to the present Act. The survey was conducted in January 1994 and used the 14 core questions previously asked of the SASOG and SPSA members,[2-4] plus 8 additional questions to assess the respondents' current attitudes and practices with particular reference to Section 3(1)(c) of the Act (the section that deals specifically with termination of pregnancy for genetic reasons).

## Methods

A confidential questionnaire was circulated to all clinical geneticists and genetic counsellors currently involved in prenatal diagnosis of and counselling for congenital anomalies that could result in TOP in terms of Section 3(1)(c) of the Act. The questionnaire asked the 14 core questions previously asked of the members of SASOG and SPSA (Table I). The recipients were then questioned regarding their current attitudes and practice with reference to Section 3(1)(c) of the Act. These included what the recipient considered to be a significant risk, whether the doctor or the patient should decide what constituted a significant risk, and what constituted a physical or metal defect that would cause irreparable serious handicap. They were further questioned as to whether, in considering the wording of the Act, they believed that the Act allowed patients to decide these issues. Responses to further questions ascertained whether or not they concurred with the currently held ethos of non-directive genetic counselling, and whether or not they believed that non-directive counselling and free patient choice was possible, given the wording of Section 3(1)(c) of the Act. Finally, they were asked whether Section 3(1)(c) of the Act was acceptable to them, and whether, if this section was repealed, they believed that any provisions should be made for the curtailment of TOP on genetic grounds in a future Act.

**Table I. Responses of gynaecologists, psychiatrists and geneticists to the core questions (%)**

| Statement | Gynaecologists (1990) | Psychiatrists (1992) | Geneticists (1994) | Combined average of SASOG (1990), SPSA (1992) and geneticists (1994) |
|---|---|---|---|---|
| The abortion act should be more restrictive, allowing TOP only if the mother's life is at risk | 1.7 | 7.6 | 0 | 4.2 |
| The present Act is acceptable and does not require review | 15.0 | 11.0 | 17.4 | 14.4 |
| Support TOP in girl under age 14 | 84.9 | 87.6 | 91.3 | 87.9 |
| Support TOP in girl under age 16 | 75.8 | 77.6 | 73.9 | 75.8 |
| Support TOP in woman over age 40 | 63.0 | 59.0 | 60.9 | 61.2 |
| Support TOP after 6 or more pregnancies | 61.5 | 60.0 | 60.9 | 60.8 |
| Support TOP after failed sterilisation | 78.5 | 71.4 | 60.9 | 70.3 |
| Support TOP after failed vasectomy | 70.2 | 68.8 | 56.5 | 65.2 |
| Support TOP after failed IUCD | 62.3 | 59.5 | 43.5 | 55.1 |
| Support TOP after failed depot injection | 48.4 | 59.4 | 43.5 | 50.6 |
| Support TOP after failed oral contraceptive | 55.7 | 53.7 | 39.1 | 49.5 |
| Support TOP after failed other contraceptive | 47.8 | 47.7 | 39.1 | 44.9 |
| Support TOP on request before 12 weeks | 40.5 | 50.8 | 39.1 | 43.5 |
| Support TOP on request after 12 weeks | 6.9 | 28.2 | 17.4 | 17.5 |

## Results

A total of 25 questionnaires were mailed and 23 (92%) were returned completed. The respondents' replies to the 14 core questions are listed in Table I and compared with the responses of the previous studies involving SASOG and SPSA. Not one of the respondents felt that the Act should be more restrictive, and only 4 (17.4%) felt the Act was acceptable in its present form. TOP on request for girls under 14 years and 16 years of age was supported by 21 (91.3%) and 17 (73.9%) of respondents, respectively. Fourteen (60.9%) of those questioned supported TOP for women over 40 years of age or women who had had 6 or more pregnancies.

With regard to failed contraception, 14 respondents (60.9%) supported TOP on request for failed female sterilisation, 13 (56.5%) for failed vasectomy, 10 (43.5%) for failed intra-uterine contraceptive device, 10 (43.5%) for failed depot injection, and 9 (39.1%) for failed oral and other contraceptives. Only 9 respondents (39.1%) supported TOP on request before 12 weeks of pregnancy and 4 (17.4%) after 12 weeks of pregnancy.

In response to the questions on the implementation of Section 3(1)(c) of the Act, 19 (82.6%) of the respondents felt that a 1 in 20 (5%) or higher risk constituted a serious risk. Two each answered that 1 in 50 (2%) and 1 in 100 (1%) constituted serious risks. Considering who should make decisions, 14 (60.9%) felt that the patient(s) should decide what constituted a serious risk, and 7 (30.4%) the doctor; 2 (8.7%) abstained. In comparison, 11 (47.8%) felt that the patient(s) should decide what constituted a physical or mental defect that would cause irreparable serious handicap, 9 (39.1%) felt that the doctor should decide, and 3 (13.1%) considered that it should be a joint decision. With due consideration of the Act, only 5 respondents (21.8%) felt that the Act entitled the patient(s) to decide what constituted a serious risk and what constituted a physical or mental defect which would cause irreparable serious handicap. Twenty-two (95.7%) of the respondents confirmed that they concurred with the currently accepted ethos of 'non-directive' genetic counselling, but only 10 (43.5%) believed that non-directive counselling was possible considering the wording of Section 3(1)(c) of the Act.

Section 3(1)(c) of the Act was acceptable in its present form to 13 of the respondents (56.5%), and 16 (69.7%) felt that there was no need to curtail TOP on genetic grounds in future legislation, as opposed to 6 (26%) who would include some form of curtailment and 1 (4.3%) who abstained.

## Discussion

The number of clinical geneticists and genetic counsellors practising in South Africa (25) is small. However, the response rate to this questionnaire (92%) was very high, ensuring that the results of the survey could be considered as the body opinion of this group.

In 1990 the response rate of the SASOG members was 76%, and the 1992 report on SPSA members noted that although the response rate (50%) was disappointing, 77.7% of those who replied had been involved with patients referred for possible TOP. Thus, to a large extent, the combined opinions of the 1990 SASOG, 1992 SPSA and 1994 geneticists' surveys (Table I) could be considered to represent the views of the three major medical specialties involved in the implementation of the Act.

Not one geneticist who responded felt that the present Act should be more restrictive, and only 17.4% felt that the Act was acceptable in its present form. These attitudes concur with those of the SASOG and SPSA members, and confirm the need for review of the Act.

With regard to pregnant adolescents, and the woman over 40 years of age or who has had 6 or more children, there was a remarkable similarity of opinion between all three specialist groups, supporting TOP in these circumstances (Table I).

The questions that surveyed attitudes towards TOP for reasons of failed contraception indicated that, on all the grounds noted, the geneticists were more conservative than the gynaecologists or the psychiatrists. A majority of geneticists did support TOP on request after failed female sterilisation and vasectomy, but not on the grounds of other failed methods of contraception. The more conservative response of the geneticists was possibly because they would have had limited experience with counselling women who request TOP for this reason.

The geneticists' responses to TOP 'on request' before and after 12 weeks' gestation were similar to those of the

gynaecologists; only 39.1% supported TOP before 12 weeks and 17.4% after 12 weeks. Overall, even though 50.8% of psychiatrists supported TOP before 12 weeks' gestation and 28.6% after 12 weeks' gestation, less than half (43.5%) of all the specialists who responded to the surveys supported TOP 'on request' before 12 weeks' gestation. Considerably fewer (17.5%) gave support to TOP 'on request' after 12 weeks' gestation.

Revision of the present Act is currently under consideration by Parliament. The Ad Hoc Select Committee Report on Abortion and Sterilisation[3] has recently recommended that abortion on request should be permitted up to 14 weeks' gestation and abortions should further be permitted between 14 and 24 weeks under certain broadly specified conditions. This is in contrast to the limited overall support of the three groups of specialists involved in implementation of the present Act for TOP on request, both before and after 12 weeks' gestation. Reviewing the specialists' responses in general, it appears that they would support an increase in the indications for legal TOP rather than the introduction of TOP on request up to a designated post-conceptual age.

The implementation of Section 3(1)(c) is that part of the current Act with which a geneticist may become involved.

When asked what they felt constituted a significant risk, 19 (82.6%) felt this was 1 in 20 (5%) or more, and 60.9% of geneticists considered that the patient(s) should decide what constituted such a serious risk. This was a higher figure than the 48.7% who also considered that the patient(s) had the *right* to decide what constituted a physical or mental defect which would cause irreparable serious handicap. However, only 5 respondents (21.8%) felt that the Act entitled the patients to decide on both these issues. The latter response concurs with the fact that only 10 of the geneticists (43.5%) believed that it was possible to practise non-directive counselling with free patient choice when considering the wording of the Act. As 22 respondents (95.7%) replied that they concurred with the currently held ethos of non-directive genetic counselling, and considering the responses to the other questions related to Section 3(1)(c), it was difficult to explain why 13 (56.5%) still found this section to be acceptable. This was in further contrast to the 16 respondents (69.7%) who felt there was no need for curtailment of TOP on genetic grounds in a future Act. These responses appear to indicate an acceptance of the limitations of the present Act with regard to non-directive genetic counselling, coupled with concern about the implications of future changes to this section of the Act.

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**REFERENCES**

1. The Abortion and Sterilisation Act 2 of 1975. *Government Gazette* 1975; No. 478, Mar.
2. African National Congress. *A National Health Plan for South Africa*. Johannesburg: ANC, 1994.
3. Parliamentary Ad Hoc Committee Report on Abortion and Sterilisation, 29 June 1995.
4. Dommisse J. South African gynaecologists' attitudes to the present abortion law. *S Afr Med J* 1980; **57**: 1044-1045.
5. Dommisse J. Current attitudes of members of SASOG to the present law on abortion. *S Afr Med J* 1990; **78**: 702-703.
6. Nash EH, Brink JH, Potocnik FCV, Dirks BL. South African psychiatrists' attitudes to the present implementation of the Abortion and Sterilisation Act of 1975. *S Afr Med J* 1992; **82**: 434-436.

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