AUGUST 2024

BARRIERS & SOLUTIONS

ABORTION PROVIDER PERSPECTIVES

Sexual and Reproductive Justice Coalition
Working Together for Reproductive Justice

SRJC

Jess Rucell, Lucy Khofi, and Mbali Matandela. (2024). Abortion Provider Perspectives: Barriers and Solutions to Achieve Adequate Access to Safe CTOP in South Africa. Cape Town, South Africa: Sexual and Reproductive Justice Coalition (SRJC).

This Report and Companion Policy Brief were reviewed by Lynette Mudekunye and produced with the financial support of Fos Feminista, ARASA and Gender Links. The material is the sole responsibility of the Sexual and Reproductive Justice Coalition and does not necessarily reflect the views of the funders.

TABLE OF CONTENTS

GLOSSARY OF TERMS i

EXECUTIVE SUMMARY iii

1. INTRODUCTION 1

2. METHODOLOGY 3

2.1 PARTICIPANT SAMPLE

Private and Public Sectors

3. LAW, POLICY, HEALTH SYSTEM & SERVICES 6

South African Law & Policy
Conscientious Objection
Clinical Guidelines
Private Sector Costs of CTOP

4. RESULTS 10

Key Challenges, Solutions & Actions

4.1 HEALTH SYSTEM & SERVICES

Discrimination
Public Sector CTOP Infrastructure
Public & Private Care

4.2 TYPES OF & DEMAND FOR CTOP SERVICES

Medical and Surgical CTOP 23
Self-Managed CTOP

4.3 PROVIDERS MOTIVATIONS

4.4 TERMINOLOGY & NAMING

4.5 UNSAFE & ILLEGAL SERVICES

5. DISCUSSION 22

6. CONCLUSIONS & RECOMMENDATIONS 24

REFERENCES

ANNEX: RESEARCH TOOLS

GLOSSARY OF TERMS

Term	Definition
Choice of Termination of Pregnancy (CTOP)	A legal medical procedure in South Africa that allows for the termination of pregnancy upon request up to a specified gestational age, ensuring access to safe and legal abortion services.
Termination of Pregnancy (TOP)	A broader term encompassing legal and safe procedures for ending pregnancies, including CTOP services provided within the framework of South African laws and regulations.
Medical Abortion	A non-surgical procedure for terminating a pregnancy using pharmaceutical drugs.
Surgical Abortion	A medical procedure involving surgery to terminate a pregnancy.
Abortion Providers	Healthcare professionals who perform or assist in the provision of abortion servicesensuring the procedure is safe and legal.
Conscientious Objection	The right of healthcare providers to refuse participation in certain medical procedures, such as CTOP, based on personal or religious beliefs while ensuring patients' access to care.
Public Sector	Healthcare facilities and services provided and funded by the government.
Private Sector	Healthcare facilities and services are provided by for-profit companies that require out-of-pocket payments, as well as non-profit companies offering services at market rates below or on a charity basis.
Sexual and Reproductive Health (SRH) Services	A range of health services supporting the reproductive health needs of individuals, including contraception, maternal health care, and CTOP services.
Infrastructure	Physical, organisational and administrative structures supporting the delivery of CTOP services, including healthcare facilities, medical equipment and clinical and logistical systems.
Community Engagement	Collaborative efforts involving the public, organisations, and stakeholders to raise awareness, educate, and advocate for CTOP services, combating stigma and promoting informed behaviour and decision-making.

GLOSSARY OF TERMS

Term	Definition
Policy Reforms	Changes in legislation, regulations and guidelines aimed at improving legal frameworks and enhancing rights protection.
Healthcare Provider	Individuals trained and authorised to deliver healthcare services, including nursing and medical doctors; who play a critical role in ensuring safe and compassionate care for patients seeking abortion services.
Human Rights Defenders	Individuals or groups advocating for the protection and promotion of human rights, including healthcare providers involved in CTOP services who face challenges and risks due to stigma and legal restrictions.
Bodily Autonomy	The right of individuals to make decisions about their bodies, including decisions related to sexual and reproductive health and access to CTOP services without coercion or interference.
Maternal Mortality	Death during or post-pregnancy, childbirth or within 42 days of termination of pregnancy; highlights the importance of safe and accessible CTOP services in reducing maternal mortality rates.
Illegal Backstreet Operators	Unsafe and illegal procedures performed by unlicensed and untrained individuals; often carried out outside designated healthcare facilities resulting in serious health complications and death.
Equity	Fairness and impartiality in access to healthcare services, ensuring that individuals regardless of gender, race, socioeconomic status, or other status (including geographical location) can access CTOP services safely and equally.
Training	Programmes and initiatives aimed at enhancing the skills and knowledge of healthcare providers, including CTOP providers.
Systemic Barriers	Structural obstacles, including legal, financial, logistical and social factors that hinder access to CTOP services.
Monitoring and Evaluation	Processes for assessing the effectiveness and quality of staffing and referral systems, informing evidence-based interventions and improvements in healthcare delivery.

EXECUTIVE SUMMARY

The Sexual and Reproductive Justice Coalition (SRJC) has been working with nurses and clinicians to support access to abortion services since 2015. South Africa's commitment to reproductive justice and women's rights is underscored by its legal framework, yet the effective delivery of Choice of Termination of Pregnancy (CTOP) services faces significant challenges. In 2021, the SRJC consulted providers to understand the barriers to and solutions to providing adequate abortion services. In 2023, the SRJC investigated with providers to increase their knowledge about nurses' and clinicians' perspectives on improving CTOP services. This report and policy brief synthesise our findings to identify critical barriers and propose actionable solutions to enhance comprehensive abortion care nationwide.

Crucially, our findings identified facility-based stigma and discrimination, exacerbated by legal complexities and administrative practises relating to conscientious objection, and the lack of remuneration, monitoring, and support as the main drivers of poor access to abortion services.

A key finding is that most providers, from public and private healthcare systems across provinces, view themselves and their work as integral to promoting gender equality, women's rights and social justice. Importantly, we found a correlation between years of clinical CTOP provision and self-identification. The longer the CTOP provider was in practice, the more likely they were to identify themselves as a leading role player in South Africa's achievement and sustained sexual and reproductive rights.

Providers proposed solutions centred on increased investment in CTOP staff and infrastructure, including financial incentives to attract and retain skilled providers. Standardising policies and consequence management on conscientious objection, monitoring services, expanding CTOP training, and building societal acceptance are crucial to improving service delivery.

Recommendations for action include integrating CTOP services into sexual and reproductive health services packages; increasing CTOP provider remuneration, resourcing peer learning and support; robust monitoring and consequence management for stigma and discrimination carried out within health systems; and enhancing policing and punishment of illegal operators. Community engagement through targeted awareness campaigns is also recommended to challenge stigma, educate the public about safe CTOP options, and promote informed SRH decision-making.

In conclusion, implementing these recommendations can help South Africa bridge the gap between policy intentions and on-the-ground realities, ensuring equitable access to safe and legal CTOP services. By prioritising these efforts, South Africa upholds its constitutional mandates and positions itself as a global leader in reproductive justice and women's rights.

1. Introduction

SRJC's membership has 27 national and international organisations and 157 individual members. The organisational partners represent advocacy, legal, community-based and research institutions focused on reproductive health, gender-based violence, LGBTQI+, sex education, direct service provision, youth empowerment and sex work. The individual members are activists, academics, lawyers, community health workers, nurses, and doctors working in reproductive justice fields in southern Africa and globally.

Internationally, providers contribute to normalising abortion by affirming abortion as an integral part of routine healthcare and providing services *(Baird & Millar 2018; Purcell et al. 2020)*. Through our work, we have learned that abortion providers play a key role in expanding abortion services. Providers understand the narratives that create an enabling environment for clinicians and hospital managers. *(Aiken & Bloomer 2019; Dyer 2017)*. They are the professionals training others and advocating in their facilities, districts, and provinces, significantly enhancing the service's stature since the CTOP Act was passed in 1996. Our approach enhances existing data on their roles and creates platforms to support their leadership.

SRJC has been at the forefront of advocating for the protection of the right to bodily autonomy, particularly access to safe abortion services. This includes operating an informal referral network so that those who face difficulties in accessing abortion care can be referred to our national abortion provider membership for assistance. Over the years, this focus has evolved to encompass activities aimed at strengthening the abortion provider community in South Africa. By prioritizing healthcare providers, the SRJC aims to:

- Deepen understanding of barriers to accessing safe abortion services;
- Empower frontline workers to advocate for themselves and their patients;
- Develop a coordinated national advocacy strategy to improve access to safe abortion services across the country.

Annually, SRJC hosts an event called Abortion Provider Appreciation Day on March 10. Leading up to this gathering in 2021, three members facilitated consultations with over 70 abortion providers, which strengthened the abortion provider community in Malawi. The desire for a community of solidarity came across strongly in these consultations, and four priority areas were identified:

1. Stigma in the workplace;
2. Countering isolation;
3. Mentorship and sharing best practices; and
4. Advocacy to engage government.

Despite the recognition of abortion care as a basic human right by the World Health Organisation (WHO), women throughout the world are denied reproductive choices. South African law and policy are among the strongest protective frameworks for reproductive health globally. The Choice on Termination of Pregnancy Act (CTOP) of 1996, which was amended in 2008, has expanded safe abortion care to up to 20 weeks, including facilities that can provide abortions. The law introduced a rights-based framework to protect and promote women's rights and advance gender equality. Abortion is time-sensitive, and it is legislated as a time-restricted service as pregnancy progresses, increasing the risk of complications. The CTOP Act positions abortion services as necessary for comprehensive and acceptable reproductive healthcare within a constitutional framework of human rights, equality, dignity, and privacy. The Act ushered in a departure from the Abortion and Sterilisation Act of 1975, a restrictive abortion legislation and governance framework that regarded women as minors irrespective of age or marital status *(Mhlanga 2003)*.

South Africa continues to face obstacles in achieving its goal of providing CTOP services at every facility. Currently, data indicate that approximately 50% of abortions occur outside designated health facilities. *(University of Durban, 2016)*. Furthermore, while implementation of the CTOP Act has prevented large-scale maternal mortality caused by unsafe abortions, preventable deaths due to illegal and lack of access to quality abortion care continue to be reported *(Massyn, et al. 2020)*. Literature notes high rates of stigma and discrimination experienced by providers *(Jim, et al. 2023)* and unequal access to services among women and girls who are economically and geographically disenfranchised (Albertyn, 2015). Some authors have also suggested that public support for abortion provision has also waned. Certain circumstances stipulated in the law create allowances for second-trimester services, including rape and incest, and for reasons related to the health of the pregnant woman or foetus, and socioeconomic hardship access to services is often not accessible to poor, black, and rural women *(Amnesty International, 2017)*

Moreover, a national investigation in 2021 by the Commission for Gender Equality (CGE), an independent state institution, revealed little to no monitoring of CTOP services by the Department of Health. This lack of oversight affects infrastructure, management, resource distribution, reporting structures, requirements, and clinical monitoring. The CGE report also highlighted a lack of information about the service; and noted that certain districts, regions and local facilities do not offer such services resulting in denied access in these areas *(Commission of Gender Equality, 2021)*.

This Report and companion Policy Brief aim to present a factual narrative about the institutional and professional context of abortion provision in South Africa. This is a significant step towards expanding data and creating a platform for provider leadership. The two evidence-based documents provide comprehensive data on the legal and social contexts and lived experiences of Choice of Termination of Pregnancy (CTOP) service providers in South Africa. The report maps the landscape of public abortion services and, importantly, offers insights into access to abortion providers in both the private and public sectors nationwide.

We believe that these contribute key elements to understanding poor access to abortion services, one that notably includes providers' experiences, providing a complimentary perspective to routine health information, as reported by the Department of Health. We intend to use this study to strengthen our engagement with provincial and national governments to better respond to the challenges faced by girls, women and birthing people.

2. Methodology

The SRJC recognises abortion providers as crucial constituencies with the knowledge, power, and capacity to improve access to safe abortion services. This chapter outlines the study's purpose, approach and mechanics, and the sample demographics we obtained.

Aim: Gather and analyse data from abortion providers across the country on the abortion health system, including challenges and solutions to poor access.

- **Objective 1:** Analyse key barriers to meeting the demand for abortion services.
- **Objective 2:** To examine the role and leadership perception of abortion providers.

To achieve this, our research employed a mixed-methods approach. This included a literature review, Survey, Focus Group Discussions (FGDs), and In-Depth Interviews that occurred virtually between June and September 2023.

The literature reviewed included existing research, reports from Departments of Health, and other grey literature. This informed the context of abortion provision in South Africa and the region. This information is used to map public sector abortion services and identify the shifting roles of providers in expanding services over time.

All empirical data were gathered through an online questionnaire sent to providers in our coalition and partner networks and posted publicly on social media. Survey participants who provided contact information were invited to participate in one of the five FGDs, which gathered diverse perceptions from the represented provinces. Analysis of survey and FGD data informed the selection of participants for In-Depth Interviews (IDI). The IDI participants were primarily from the Western Cape Province, due to its reputation for high-quality clinical outcomes *(Gilson et al. 2017)*, and CTOP training in the public sector.

Quantitative data were analyzed using descriptive statistics, and qualitative data were analyzed through narrative analysis. Initial findings from the quantitative data informed the questions for FGDs and IDIs. A structured coding approach in framework analysis was used to establish sub-themes based on the question guide and research purpose *(Gale et al., 2013)*. This enabled the participants' experiences to be analysed for commonality, differences, and patterns.

2.1 PARTICIPANT SAMPLE

Overall, our sample distribution reflects a diverse range of levels of clinical experience, racial and gendered positionality and practice locations. This diversity enriches the depth and validity of the understanding generated from our research, thus contributing comprehensive insights into barriers to and solutions to expanding access to quality and safe CTOP services in South Africa.

Our research included 33 women and men, with 9% providing both medical and surgical abortions, 36% providing only medical abortions, and 55% providing surgical abortions. Participants comprised Registered nurses, Midwives, and Medical Doctors, with 10 in private practice, and 23 in public practice. The geographic distribution of private providers encompassed the Western Cape, Free State, KwaZulu-Natal, Gauteng, and Limpopo Provinces. Of the 33 sample participants, 24 participated in FGDs, and 6 were subsequently selected for one-on-one interviews.

Figure 1. Sample Size

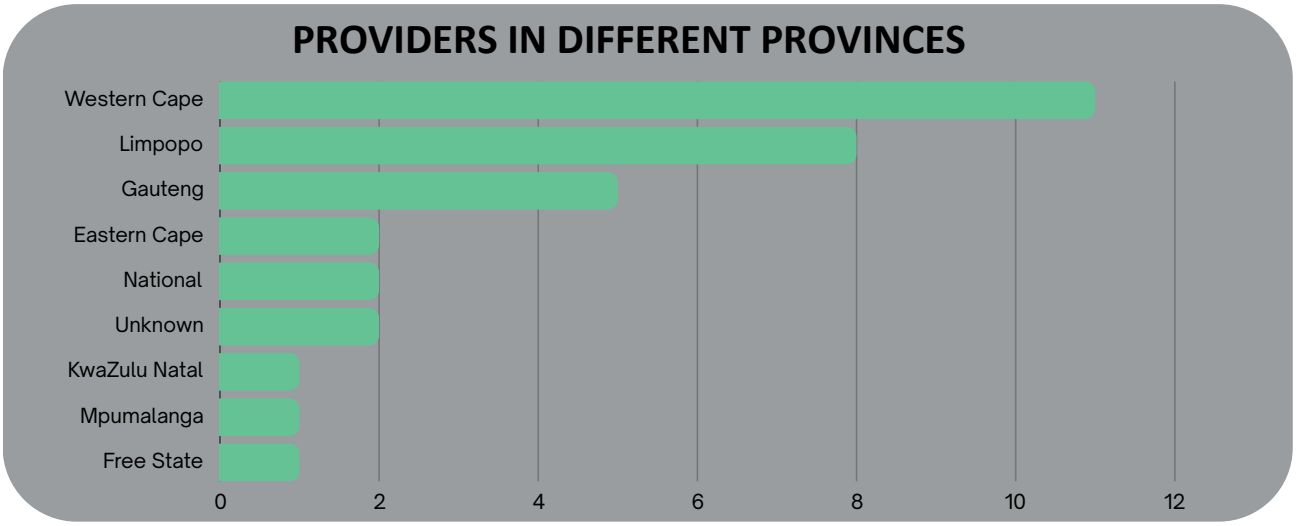


Figure 1 illustrates the provincial scope of the research. A total of 33 providers participated in the study, representing seven of the nine provinces and 14 of the 52 districts. The Western Cape province had the highest number of participants in this study with 11 providers from two districts Southern-Western and Khayelitsha; followed by Limpopo with 8 providers from Vhembe, Capricorn, Mopane, and Waterberg districts; Gauteng with 5 providers spanning Johannesburg Metro, Region F, and Ekurhuleni districts, the Eastern Cape with 2 covering Alfred Nzo, OR Tambo districts, KwaZulu Natal with 1 from Ethekwini district; Free State with 1 from Mangaung district; and Mpumalanga with 1 provider from Nkangala district. Two participants did not disclose their geographic locations, and two provided abortion services across multiple provinces or nationwide.

Private & Public Sectors

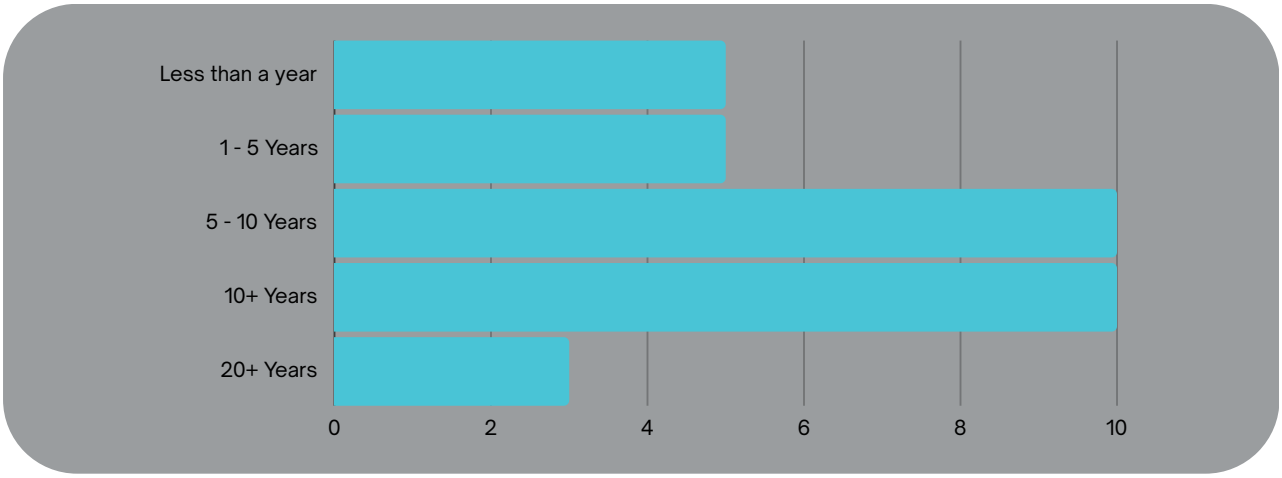
The National Department of Health (NDOH) designs and accredited health clinics and facilities in both the public and private sector. The majority (over 80%) of the population relies on public sector health services. In the private sector, abortion services are available in most provinces through for-profit clinics, health facilities, and international and national companies. Notably, in some provinces, such as the Western and Eastern Cape, the State contracts abortion services to international companies who then provide the service to public sector patients on its behalf (Medical Doctor, Western Cape IDI, 30 August 2023).

Table 1: Distribution of public, private, and provincial providers

Province	Medical		Surgical		Both	Total
	Public	Private	Public	Private		
Free State					1	1
Mpumalanga			1			1
KwaZulu Natal				1		1
Unknown		1	1			2
National		2				2
Eastern cape	1		1			2
Gauteng	2		3			5
Limpopo	2		2	3	1	8
Western Cape	3	1	4	2	1	11
Total	**8**	**4**	**12**	**6**	**3**	**33**

The sample includes FGDs with 24 survey respondents. These respondents are providers with 6 months to 25 years of experience in CTOP, with most having extensive experience. They represent both men and women from diverse racial and ethnic backgrounds. Providers offering medical and surgical abortion services in both private and public sectors are well represented. The sample also includes union members, trainers, and SRH managers.

Figure 2: Provider Experience with Abortion Health Services



The data on years of CTOP practice reveals a varied distribution of experience among the surveyed healthcare professionals:

- Five participants (15%) reported nine months of experience, indicating growth in the sector and including individuals who are relatively new to the field.
- Five participants (15%) reported one to five years of experience, representing those experienced in CTOP provision but are still early in their careers.
- Ten participants (30%) reported five to ten years of experience, indicating a significant presence of mid-career professionals with substantial expertise in CTOP services.
- Ten participants (30%) reported more than ten years of experience, suggesting a substantial number of seasoned and dedicated clinicians with extensive experience in abortion provision.
- Three participants (9%) reported 23 or more years of experience, demonstrating the presence of individuals with long-standing and deeply rooted expertise in the field.

3. Law, Policy, Health System & Services

This chapter presents the legal, policy and health systems context that shapes the criminalisation and legal protection of abortion services. We also explain the clinical practice of the various types of services and the associated private sector costs. This chapter also provides an overview of the nuances of conscientious objection in South Africa.

In Africa, including the southern African region, girls' and women's reproductive freedom is very constrained. African girls and women seeking abortions, along with abortion service providers, are criminalised in many countries *(Bonkole et al. 2020)*. Legal protection for abortion in Africa is often only permitted within a limited range of social, economic, and health circumstances. For instance, pregnancy may threaten the life of the mother or foetus or may result from incest.

South African Law & Policy

South Africa has one of the strongest protective legal frameworks for reproductive health in Africa. The Choice of Termination of Pregnancy Act (CTOP) of 1996 was adopted as the nation shifted to democracy from authoritarianism. This law replaced the Abortion and Sterilisation Act of 1975, which only allowed for abortion in restricted circumstances and also permitted women as minors irrespective of age or marital status *(Mhlanga 2003)*.

The current CTOP Act removed most of these limitations and acknowledges that women are human beings with the right to request and have an abortion, albeit still under particular limiting circumstances. The 1996 law protects and promotes women's right to have an early, safe, and legal abortion. Abortion is time-sensitive and is legislated as a time-restricted service as pregnancy progresses. The CTOP Act outlines that abortions can occur upon request up to and including 12 weeks of gestation, (first trimester). At this stage, the procedure must be performed by a medical doctor, registered nurse, or Midwife who has completed a prescribed training, provided by the National Department of Health (NDoH).

Between 12 and 20 weeks of gestation, medical doctors are legally permitted to perform abortions under certain circumstances stipulated in the law. Circumstances include socioeconomic hardship, rape, and infection related to the health of the pregnant woman or foetus *(Harries & Constant, 2020)*. The law permits a girl, woman, or pregnant person to terminate a pregnancy after 20 weeks of gestation if two medical doctors determine that continued pregnancy poses a danger to her life or if the foetus will be malformed.

Conscientious Objection

Importantly, the Act positions abortion services as necessary for comprehensive and acceptable reproductive health. However, the incorrect application of the clause included in "conscientious objection" has created barriers to access to abortion. The Conscientious Objection Act as it relates to South African law raises competing constitutional rights about a woman's right to exercise reproductive autonomy and a healthcare professional's right to freedom of conscience, belief, thought and religion. The CTOP Act provides the right for every woman to choose an early, safe, and legal abortion and provides guidelines on the conditions that make this possible. It does so within a constitutional framework of human rights (Republic of South Africa, 1996), equality (Section 9), dignity (Section 10), freedom and security of the person (Section 12) and access to healthcare, including Reproductive Healthcare services (Section 27).

According to the CTOP Act, the refusal to perform an abortion only applies to the abortion itself. In terms of the law, healthcare providers who are not directly involved in the procedure are not able to use their beliefs to deny assistance to women seeking abortion services. They cannot also use their beliefs to deny routine medical care and general assistance. In order to invoke this clause, a healthcare provider has to report, in writing to the employer, their refusal to perform an abortion. In addition, if a patient requires emergency medical attention due to an abortion, a conscientious objector is required by law to assist (Harries et al, 2014).

The Act was amended in 2008 to include a greater variety of facilities that can legally provide such services. Both medical and surgical procedures are provided free of charge or at subsidised costs in designated facilities accredited by the National Department of Health (NDOH). Accredited private health facilities and clinics also offer medical, surgical, and, to a lesser extent, self-managed abortion services.

Clinical Practices

Medical abortion refers to the use of medication (pills or tablets) to induce an abortion. A patient will ideally use two different types of medication that work together to end a pregnancy: Mifepristone and misoprostol. Evidence shows the combined pill method is 98-99% effective *(Williams, 2019)*.

The combined method entails a nurse providing the first tablet, mifepristone, taken at the clinic or hospital, and then a patient will be given 4 tablets of misoprostol to be taken 1 or 2 days later at home. The mechanisms by which these medications act are as follows: Mifepristone is an antiprogestin that blocks receptors of the hormone progesterone and causes the lining of the uterus to no longer support the growing embryo. Misoprostol causes contraction of the uterus and expulsion of its contents. This option is available to girls, women, and trans men who are between 4 and 9 weeks pregnant and is administered by a registered nurse or midwife.

Those who are 10-13 weeks pregnant can receive a medical abortion administered by a Medical Doctor. A Medical Doctor we interviewed who has practised second-trimester procedures throughout the country offered this relevant insight on the two main options:

> There is a difference between medical and surgical abortion; with medical, there is pain, bleeding, and potential of incompleteness, whereas with surgical, these factors are not as significant.

Medical Doctor, IDI, 20 August 2023

Surgical abortions are same-day procedures performed by registered nurses (up to 12 weeks of pregnancy) or Medical Doctors (from 12 to 20 weeks) at a clinic or hospital. Evidence shows that they are 99% effective *(Williams, 2019)*. Those who opt for surgical abortion are given tablets to soften the mouth of the womb.

Surgical abortions include manual vacuum aspiration (MVA), Electric Vacuum Aspiration (EVA), dilatation and evacuation, or dilatation and curettage. Manual Vacuum Aspiration is a safe method of uterine evacuation that involves using a handheld plastic aspirator. The aspirator acts as a vacuum and is attached to the cannula (thin tube) and is manually activated to suction the contents of the uterus.

Another method is electric vacuum aspiration, which involves using an electric pump or suction machine connected via flexible tubing to a plastic or metal cannula. This method is used in centralised settings with higher caseloads and is not preferred in settings with irregular electricity supply.

Dilatation and evacuation or dilatation and curettage are performed after 15 weeks. This method may be used if some products of conception are still present after MVA or if surgical abortion is performed at a very late stage. A patient will be able to go home a few hours after the procedure and will be given pain medication, a patient information leaflet and a preferred method of contraception.

Private Sector Costs of CTOP

Notably, medical insurance schemes cover CTOP services as part of Prescribed Minimum Benefits (PMBs). PMBs are a legally mandated set of healthcare services that medical schemes must cover entirely, irrespective of the specific plan or option selected by the member (Willie et al., 2024)[1]. Medical and surgical abortions vary in price according to the private health facility, location, and equipment used. Pregnancies between 13 and 20 weeks of age only qualify for surgical abortions.

Table 2: Estimated costs of CTOP types

Type of abortion	Cost	Comments
Medical abortion	R1,700 - R1,800	Only up to 13 weeks, cost included consultation with provider.
Self-managed medical abortion	R700	From Pharmacy including mifepristone and misoprostol
Self-managed medical abortion	R180	From Pharmacy only including misoprostol.
Self-managed medical abortion	R2,360 - R2,610	From a clinic, including provider consultation and the latter amount including courier.
Surgical abortion up to 12 weeks	R1,500 – R5,060	From a clinic, latter amount including sedation (anaesthesia).
Surgical abortion 16 to 18 weeks	R5,050 - R7,410	From a clinic, latter amount includes sedation (anaesthesia)
Surgical 18-20 weeks	R5,060 - 7,410	From a clinic latter amount includes sedation (anaesthesia)

Data from Midwife, Durban, IDI, 14 June 2024; Green, 2023

1 Council for Medical Schemes. CMScript 4 of 2023. 17 May 2023. https://www.medicalschemes.co.za/cmscript-4-of-2023-termination-of-pregnancy/

The prices of self-managed abortions are significantly lower than those of other options because they are limited to no clinical assistance (no consultation fees, no ultrasounds , etc). However, the price varies depending on whether the pills are accessed from a pharmacy or a private clinic.

Although self-managed medical abortion is not specifically detailed in the CTOP Act, it is accessible through some pharmacies and private clinics.[2] Additionally, as abortion access becomes more restrictive and criminalised across the globe, self-managed abortion is becoming an accessible challenge to these restrictions. Although the CTOP is regulated by law, and not criminalised these products are not offered by the public sector. The National Department of Health is in negotiations with the Affordable Medicines Directorate for these medications to be included in the Essential Medicines List (EML), and they are piloting a self-managed programme for sexual and reproductive health services. The NDOH plan is to have pilots in Kwa-Zulu Natal, the eastern Cape, the western Cape, and Mpumalanga. Two sites are currently operating in OR Tambo and Mthatha districts in the Eastern Cape.

2 There is strong anecdotal data showing that pharmacy's do not, as matter of routine, dispense the necessary medications, even when proscriptions are provided.

4. Results

This chapter presents our research findings, including the lived experiences of healthcare providers working in this sector. This section begins by detailing what abortion providers reported to be the key challenges, solutions, and actions to be taken to improve access to CTOP services in South Africa.

4.1 KEY CHALLENGES, SOLUTIONS & ACTIONS

The research identified the following challenges and respondents also suggested solutions and actions that should be taken. Providers were then asked to identify and discuss the key challenges, solutions, and actions to be taken by key stakeholders to improve access to safe CTOP care. Table 3 below shows priority order based on providers' experiences.

	Challenge	Solutions	Actions
1	**Lack of Government & Departmental Support & Resourcing**	Integrate CTOP into SRH, NHI service package esp at PHCs	Normalise CTOP healthcare as basic human rights.- Government & Departments
2	**Lack of Managerial, Facility, Mentorship and Collegial Support**	All MCWH provincial, district and facility managers VCAT. Supervisors trained on gender responsive planning & budgeting	Supervisors and staff Training, M&E, Held Accountable for Fulfilling Scope of Duties - District Directors Departments of Health
3	**Limited clinical and support staffing**	Increase Remuneration	Advocate Human Rights Defenders/Professionalisation & Funding CTOP providers - Unions, NGOs, Providers, & Professional Associations
4	**Societal stigma**	Change Societal Perspective: Values Clarification, Action & Transformation (VCAT)	National Public Information Campaigns & Local Outreach - DoH, DSD, DoE, TVET, Providers, and Community Leaders
5	**Facility-based Discrimination**	Bi-annual VCAT & debriefing budgeted for DoH, Province, Districts	Training, M&E, Held Accountable - District Directors Departments of Health, IPAS
6	**Illegal Back Street Operators**	Clear National Strategy Policing & Punishment	Investigations, Arrest and Punishment - SAPS, DoJ, Public Works
7	**Isolation, Burn Out**	Peer Provider Debriefing Network Budgeted For	Quarterly Provider Meetings - Departments of Health, Providers, Unions, NGOs

Table 3 shows the primary barriers providers note are:

1. Lack of State resourcing,
2. Collegial and managerial support, and
3. Limited clinical staffing.

The table also shows the perceived solutions to these three barriers: integrating abortion services into the sexual and reproductive healthcare package, key staff valuing the service, and increased payment. Providers identified the state as the main stakeholder to bring about these solutions, and unions, professional associations, and NGOs. Importantly, providers also identified themselves as significant players in ensuring adequate CTOP services in South Africa.

The next five sections illustrate the providers' perspectives in several areas. The first illustrates providers' perception of service delivery and experiences of discrimination, outlines the public sector CTOP infrastructure, outlines the different operating constraints and opportunities between public and private service and offers perspectives on addressing limitations. The second section shows what CTOP methods participants offer, providers' perspectives on demands for different methods, and reasons patients seek different methods. This section also presents providers' perspectives on self-managed abortion. The third section analyzes providers' motivation to provide critical health services. The fourth section discusses perspectives on framing and terminology of CTOP care, and the fifth section discusses providers' perspectives and experiences with illegal and unsafe operators.

4.2 HEALTH SYSTEM & SERVICES

Dialogue in all Focus Group Discussions (FGD) revealed a common understanding that existing abortion health systems do not meet legal standards. This assessment was based on respondents' collective experience of poor investment in health services. The following excerpts illustrate the consensus identified among the providers.

A midwife working in Gauteng similarly illustrated the overarching situation.

> In my facility, I need assistance because the workload becomes too much with admin. Because I'm alone and I'm trying to maximise access. The problem that I'm having is that I'm providing medical TOP. I'm providing surgical TOP. I'm providing long-term reversible contraceptives and providing management of complete side effects and complications and whatnot. There are a lot of different tasks including counselling which is an integral part of TOP services.
>
> **Midwife, Eastern Cape, FGD, 24 July 2023**

> The issue is with us as a region. There is a lack of capacity and resources. The demand is more than what we can provide, because I have a lot of clients per day. I need to book them for other days so it's hard to say no to them when they are already in the hospital. Some travel from far and they do not have transport money to come back to the clinic again.
>
> **Registered Nurse, Gauteng, FGD, 24 July 2023**

In most of the FGDs, participants raised having no clinical colleagues.

> I am the sole provider [supporting] the entire District.
>
> **Midwife, Eastern Cape, FGD, 24 July 2023**

These findings on inadequate resourcing were consistent with our earlier survey. Out of 33 respondents asked what is needed to improve the service, 36% (N=12) said financing, including incentives and better pay. 54% (N=18) noted support from the health department, including active managerial support, debriefing, and training. The additional 3 noted specific actions related to public awareness and education. One Registered Nurse working in Limpopo reflected on the challenge:

> "[We need] more awareness in the healthcare system, they [the State] needs to take provision of CTOP services seriously, and not treat it as just a program for political purposes"

Public Sector CTOP Infrastructure

To illustrate the "limited clinical staffing" challenge highlighted in Table 1, Table 2 presents the current CTOP healthcare infrastructure. Table 2 shows the geographical scope, clinical human resource capacity, and use of abortion services in the public sector based on the most recent, comprehensive, and accessible data.

Table 2. Public Sector CTOP Infrastructure

Province	No. of Active Facilities	No. of Providers	TOP Services Provided in 2018–2019	TOP Services Provided in 2019–2020
Free State	12	23	8,862	8,239
KwaZulu-Natal	53	83	27,937	7,066
Mpumalanga	30	56	5,559	8,127
Limpopo	55	71	12,439	14,681
Northern Cape	4	–	1,621	1,497
Eastern Cape	46	–	12,267	12,597
Northwest	26	39	16,676	19,447
Western Cape	92	–	18,171	19,160
Gauteng	60	–	20,768	23,048
Total	**9**	**378**	**272**	**124,300**

Data from the Commission of Gender Equality, 2021; and Deputy Minister of Health Sibongiseni Dhlomo, 2022.

While data on provider numbers for the four provinces are unavailable, it is notable that there appears to be a low ratio of providers and facilities offering the CTOP service. For instance, 39 providers serve over 19,000 women and girls in the North West province. These statistics show a limited number of people and healthcare facilities; however, it is important to note that some facilities provide an early form of CTOP service that would not be characterised as part of this infrastructure. That is facilities that only offer medical abortion before (9 weeks), as they are not required to apply for the NDoH facilities designation (CGE, 2021). It is also important to note that the information provided does not differentiate between first- and second-trimester services. This blinds us to where 2nd trimester is unavailable. Several providers in this study explained the weight of these gaps in essential services in their regions, for example.

> In Durban, there is only one facility that provides second-trimester abortion for the government, and they have one or two beds that are accessible to the doctor. Durban is huge; how do we accommodate this volume?
>
> **Midwife, Kwa-Zulu-Natal, FGD, 22 August 2023**

Although we couldn't investigate the budgetary allocations and expenditures in the abortion healthcare sector, the 2021 investigation by the Commission for Gender Equality (CGE) reported that CTOP infrastructure was funded through an "equitable share" portion of the NDoH budget distributed to provinces. Permanent and disposable equipment, resourcing 285 facilities, was reported to be furnished by the National Department through donations (CGE, 2021). The CGE noted additional limitations, including a lack of a standardised funding model for abortion services across provinces, as well as a lack of education about, and formalisation of, the 'Conscientious Objection" legal clause, which provides a loophole for healthcare professionals to opt out of directly providing CTOP services (2021).

We could not find any comprehensive literature on private-sector CTOP infrastructure in South Africa. We know that for-profit services are offered by Nurses operating private clinics, as well as by international non-governmental companies (Church et al, 2020) and General Practitioners (Blanchard et al, 2006). However, the scale at which this information is accessed and the predominance of service availability provincially and nationally is unclear.

Public & Private Care

The data collected reveals overlapping and distinct experiences of providing services in the public and private care sectors. The investigation also uncovered differing perspectives on addressing health system inequality and bifurcation.

Public sector providers across provinces reported a widespread lack of institutional support, including deficiencies in training, debriefing, resources, supervision, and collaboration. The following excerpts describe these common experiences:

> The government gives no support. NGO's that are supporting TOP provision, once they leave or the project ends, they leave with the capacity and the support, and everything collapses. It's too much of a burden to carry on your own because there is no debriefing or support. [Registered Nurse, KwaZulu-Natal, FGD, 22 August 2023]
>
> ...Right now the government is not doing anything to improve the service. I don't remember when last I heard of TOP training, and remember we are getting old. We'll be going on pension soon. So, this service might go on pension with us, because no one is being trained. [Midwife, Limpopo, FGD, 23 August 2023]
>
> I work for the Department of Health, [in the public sector] and there is no support, and there are no debriefing sessions. They only want statistics on abortion. They don't visit and as long as you do the service, they [think they] have done their part.
>
> **Registered Nurse, Limpopo, FGD, 22 August 2023**

Despite noting the same pattern of isolation and lack of supervision, a provider in the Cape Town Metropolitan public sector had different experiences in terms of medical commodities.

> In terms of stock, I always have what I need, I won't lie. As much as they [management and staff] are anti, in terms of making sure that I have everything that I need. They make sure. With pharmacy, I have never had stock outs. I always have every medication that I need... I just say how many, it is always available. They will order and I will have everything but I'm just in my corner. But it doesn't bother me, as long as I have everything that I want.
>
> **Midwife, Western Cape, IDI, 24 August 2023**

Payment is an important issue that is shared across provinces. The following excerpt highlights particular problems and the different approaches that provinces are taking.

> In the Western Cape, like all other provinces, there are few providers who perform CTOP and especially surgical. Despite this being a scarce skill, unlike other provinces we don't get any incentivised remuneration, even when it becomes an issue of retaining staff. Nursing Council made it clear to us that the course is too short to make it a specialised remunerable skill. Nurses must do work over and above doing abortions and in this province we don't get placed on a higher salary scale for it when we need it, and when other provinces understand. That's the challenge that we are facing.
>
> **Midwife, Western Cape, IDI, 22 August 2023**

The following remarks from the private sector participants contrast the public sector resourcing context illustrated above.

> For me as a private provider, [operating a clinic] it is up to me, so I'm the one that needs to know how much stock I need to use and how many patients I see at a time... It's unlike the hospital where I have to submit a list of things and they procure for you. So, when you are independent you need to do things on your own. It's about your own management.
>
> **Midwife, Gauteng, FGD, 24 August 2023**

Providers who work privately demonstrate how their independence depends on support from the Department, facility managers, and medical doctors, often in the public sector.

> ...When registering the [private] clinic I had to have everything in place like a Memorandum of Understanding (MOU) with a doctor, or a hospital that I am going to refer the patients to should there be any complications. I struggled ...because the hospital that is closest to the clinic is Wynberg Hospital, but I had issues where they did not want to sign the MOU.
>
> **Midwife, Western Cape, FGD, 24 August 2023**

> Now that I'm working independently, I have good support from doctors that I used to work with at Marie Stopes [international private co.] in case I need to purchase stock. When you are on your own they don't allow you to buy certain medication so there is a doctor that stocks things like the implants and IUDs. So whenever going to stock I tell them what and the amount I need. That's the support that I get, even if I get a complicated situation with a client, they are just a phone call away.
>
> **Midwife, Gauteng, FGP, 24 August 2023**

> As a private practitioner, there is no support from Department of Health at all. I buy my own medication and drugs, but they still want you to pay for permits and submit data for the Department. You don't even get invited to relevant meetings but still want to keep up to date with the guidelines.
>
> **Midwife, KwaZulu-Natal, FGD, 22 August 2023**

The participants were exposed to an overlap between the two health systems, which is mainly related to institutional environments. Differences are shown in access to clinical and collegial support and medical commodities and equipment. However, the following narratives expose a clash of perspectives about how to address the bifurcation of the healthcare system and the distribution of South Africa's resources.

> [In the public sector] we don't have a problem [delivering] medical, but we have a problem with surgical abortions. How the Western Cape is dealing with it is quite disgusting. At facilities where the service is not provided, the Western Cape is paying Marie Stopes[3] [private provider] per patient to provide the service. No one is looking for a solution for the services to be rendered. All I'm pleading for is for providers to be acknowledged, to be supported, and remunerated adequately.
>
> **Midwife, Western Cape, IDI, 22 August 2023**

3 Marie Stopes International (now MSI Reproductive Choices) is an international "social business" offering contraception and safe abortion services in 37 countries around the world.

> If the government... don't have the capacity to provide, they should partner with us [Marie Stopes, private]. We ...are not here to compete with them. We're here to complement them....I tried to negotiate with government. ...Because I charge for contraceptives, it becomes too much when the client has to pay for TOP and family planning. [I said] "please provide me with contraceptives. I can give those clients for free." ...They tell me, "no, you're going to charge it and going to make a profit". It became too expensive for me to buy them [contraceptives] and give them out for free. If I charge, the price becomes high, [clients] they can't afford you. ...It would be great to partner with the public sector. I know the Western Cape government has partnered with Marie Stopes. I think other [provinces] and other clinics operating in the private sector also need to partner to increase the numbers.
>
> **Midwife, Limpopo, FGD, 23 August 2023**

These excerpts show that there is a difference in opinion among providers regarding how to ensure equal and adequate access to CTOP. Some public service providers view SRH services as a right to be protected. They argue that the state's further subsidising of the private sector by procuring CTOP services from them undermines women's right to affordable SRH services, as well as the security State employment provides its workforce. Some private opinion is that cross-sector partnerships should be increased to expand access, during this period. The private sector especially offers fewer referrals, thus less waiting time, and greater privacy.

DISCRIMINATION

The following illustrates the providers' reporting on discrimination and stigma. Providers reported varied experiences of discrimination in their workplaces. In addition to workplace stigma, some providers reported receiving peer pressure from community members demanding that they give up the practice. While most providers described discrimination, others noted that “Values Clarification” training facilitated by IPAS had a positive impact, while a few reported working in relatively supportive environments[4]. Discrimination was noted in many forms, for example:

> The sad thing is that they are calling us names in the streets, they call us evil people, that we create mortuary, even people who did TOP are called names.
>
> **Midwife, Limpopo, FGD, 24 July 2023].**

> I still have a problem with records staff – [they] won’t open files [for patients] that are coming [for CTOP, instead they ask]... Why are you going to that clinic?
>
> **Midwife, Eastern Cape, FGD, 24 July 2023**

> **...**The other day there was a lady going out of the clinic. Apparently, this lady was crying. And the manager came into the kitchen and said, 'I know this one was coming from CTOP, you know, because you kill babies
>
> **Registered Nurse, Gauteng, 24 July 2023**

4 IPAS is an international NGO that operates in South Africa, and globally to advance access to safe abortion services. https://www.ipas.org/where-we-work/africa/africa-southern-region/south-africa/

This excerpt speaks to the general sentiment we found about the impact of the interpretation of "conscientious objection" and how it impacts providers:

> [At] the Department of Health...everyone is looking out for themselves, no one cares about people who do wrong. [They] are not held accountable. We have the CTOP Act, and I'm not quite sure whether the policy makers are aware about who can conscientiously object or not.
>
> **Midwife, Western Cape, FGD, 22 August 2023**

4.3 DEMAND FOR DIFFERENT TYPES OF CTOP SERVICES

This section provides an overview of the CTOP services providers in our sample as well as their perspectives on the state's exploration of self-managed abortion care. The graph below shows the percentage of participants in our sample who provided medical, surgical, or both forms of legislated abortion services.

Medical and Surgical CTOP

Figure 3 Medical and Surgical CTOP

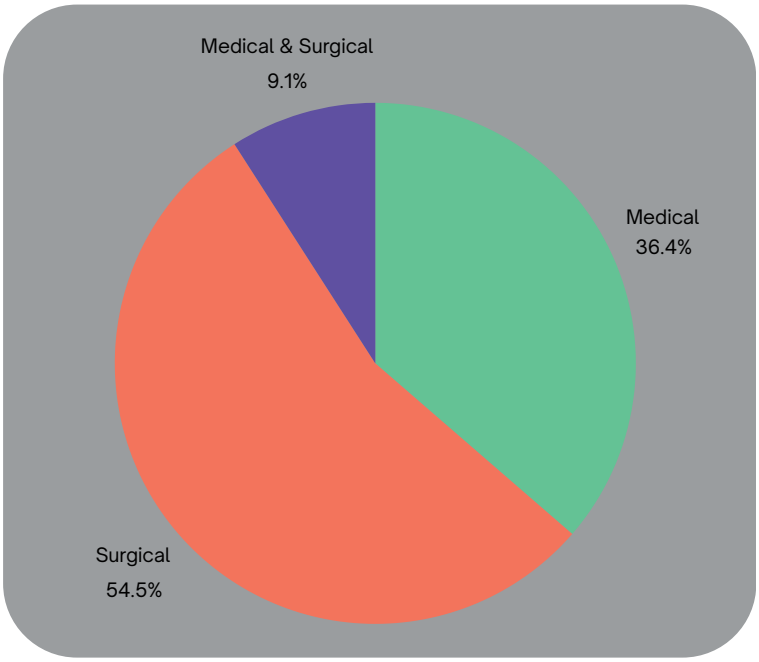


Figure 3 shows that the majority of our participants (55%) provided surgical abortion services, while 36% offered medical, and 9% offered both forms of CTOP. This is interesting as second trimester surgical abortions have been limited in South Africa.

Patients who seek abortion services after the 12-week gestational threshold are limited to the surgical method of abortion alone. Everyone seeking CTOP before this threshold has a method choice. When asked which procedure was preferred when the choice was offered, participants offered nuanced perspectives, for instance.

In the public sector, for some reason medical is more in demand. When they don't qualify for medical, only then they do surgical. Most of my patients in the private space they want surgical. Most of them want it done at the clinic and by the time they leave they want to be sure that they are not pregnant.

Midwife, Western Cape, IDI, 24 August 2023

Midwifes echoed the same reasons for preference as other providers:

It could be that the husband doesn't know or I need to be at work so this whole bleeding business is going to inconvenience the patient. They want to get it over and done with at the clinic. The young ones as well. Mom doesn't know so by the time they leave they want it all done.

Midwife, Western Cape, IDI, 24 August 2023

Other experiences and justifications for method preferences included:

Most in demand is the medical because of the pain of the surgical abortion.

Registered Nurse, Limpopo, FGD, 22 August 2023

Where I work it is more surgical abortions. Clients choose surgical because they don't believe that medical abortion works.

Midwife, Limpopo, FGD, 24 August 2023

The teenagers especially like medical abortion. The ones that are working though don't want time-consuming, they ask for something that will be done today.

Registered Nurse, Western Cape, FGD, 24 August 2023

Importantly, providers in the private sector raised the issue of affordability affecting girls', and women's choices.

It will depend on whether they can afford it or not. And most of the ones that prefer surgery are the ones that want that. Those that want to be on the street [sex workers], they prefer to do surgery. Those that can afford, and don't mind bleeding for a couple of days, will opt for medical.

Midwife, Limpopo, FGD, 23 August 2023

These excerpts represent the report of differing demand patterns within and between the public and private sectors. For example, medical abortion services in the public sector may be requested more often. However, providers noted a shortage of clinicians to provide surgical care, so this could be the health system itself rather than a preference driver. In contrast, private sector providers reported higher demand for surgical abortions. Similarly, the justifications for differing demands also varied.

Self-Managed CTOP

Providers expressed mixed feelings about the increasing discussion about and opportunity for self-managed abortion. Participants recognised both the potential benefits and challenges of the self-managed medical approach.

> I've seen firsthand how staff shortages can result in turning away patients who require medical abortion. Self-managed services could help this and reduce the burden on providers.
>
> **Registered Nurse, Limpopo, FGD, 22 August 2023**

> Self-managed abortion has the potential to revolutionise access to abortion services, but we must ensure patients understand the importance of seeking care at facilities to avoid complications.
>
> **Midwife, Free State, FGD, 24 July 2023**

The above excerpts show that the majority sentiment among providers regarding self-managed care is that it expands access to the service. Some providers base their support for self-managed care on empathy for patients who may be deterred from facility-based care due to social stigmas. Many providers voiced concerns about the implications of self-managed care on their roles. They emphasised the importance of CTOPs as essential workers and CTOP services that require ongoing training. For example:

> While self-managed abortion may help the process, it's essential that providers receive comprehensive training to show their continued importance in abortion care provision.
>
> **Midwife, Eastern Cape, 21 August, 2023**

Importantly, many providers raised issues about how self-managed care will impact the continued prevalence of backstreet illegal peddlers.

> As providers, we understand the potential benefits of self-managed abortion in expanding access to care. However, we also worry about it increasing patients' vulnerability to resorting to back-street providers, which could lead to complications requiring surgical intervention.
>
> **Midwife, Western Cape, IDI, 5 September 2023**

Conversely, some providers expressed optimism about the potential for self-managed abortions to reduce reliance on backstreet providers and alleviate their workload. They particularly noted that self-managed services could streamline access and reduce the frequency of facility-based stock shortages, which resulted in turning away patients who were eligible for medical abortion (before 12 weeks). Therefore, the need for surgical abortions can be reduced.

4.4 PROVIDERS MOTIVATIONS

When asked to describe their motivation for joining the profession, most providers expressed a deep commitment to women's rights and gender equality. Providers explained that they were driven by a sense of social justice and a desire to address systemic barriers to access, particularly for oppressed communities. FGD providers often state that they view their as a medical service and a form of activism because the contested healthcare service challenges stigma, discrimination, and inequities.

Figure 4: What motivated you to take this role?

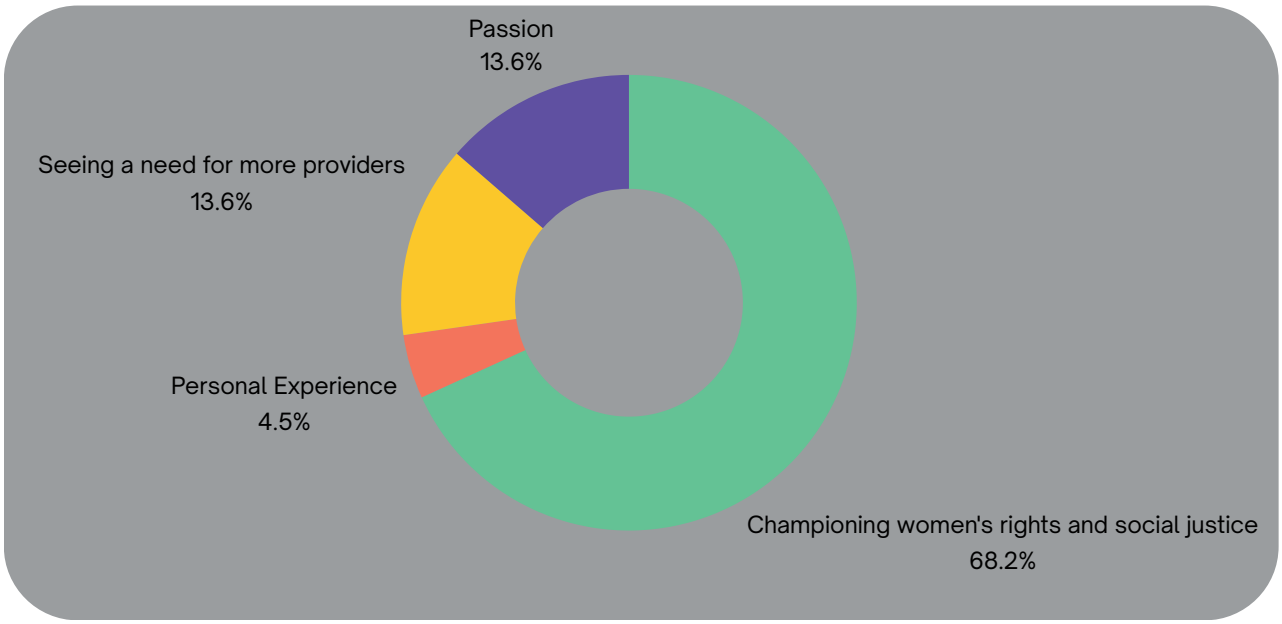


Figure 4 illustrates perspectives on what inspired CTOP providers to take up this clinical practice. The data provide insights into the diverse motivations of providers. Among the participants surveyed, 75% (N=24) stated that their motivation stemmed from a desire to "champion women's rights and social justice". This finding highlights abortion providers' profound commitment to upholding reproductive rights and addressing gender discrimination. This excerpt is an example of the general sentiment we found:

> When I began working in reproductive health I noticed a need for SRH services including abortion care. In the Eastern Cape access is limited to overall health care services. People are uneducated when it comes to abortion services. However, there are a lot of individuals needing abortion services and they end up on backstreet abortion. My pledge is to support these marginalized communities when it comes to access to abortion services
>
> **Midwife, Eastern Cape, FGD, 24 July, 2023**

Additionally, a notable proportion of participants 15% (N=5) were motivated to become abortion providers after recognising a dire need for such providers. In particular, nurses who witnessed gynaecological emergencies resulting from unsafe abortions reflected this motivation.

> We had 3 CTOP providers in our clinic. Unfortunately, one of the Sisters died last year. When the training came, I decided. I went to the matron and said, "Can I join in"?
>
> **Registered Nurse, Gauteng, FGD, 24 July, 2023**

> When I did my Community Service training in a gynaecology ward. I started seeing patients with sepsis from illegal abortions. There was no one in the clinic providing the safe and legal service so I stepped in. I believe in saving women's lives, lowering maternal mortality even though the Department provides almost no support.
>
> **Midwife, Limpopo, FGD, 22 August 2023**

5% (N=2) of participants cited personal experiences with accessing abortion services as a motivating factor, reflecting their desire to prevent others from facing gender discrimination and the lack of access and its dangers. Similarly, another 5% expressed a passion for providing abortion care and chose to undergo training to make a positive impact.

> A personal experience [motivated me]. When I wanted to terminate [I was 19 years old, young and confused] I had no option, it was hard to access TOP. I had a horrible abortion experience, this encouraged me to make change and advocate for access to TOP services. To date, I still have trauma from my TOP. I'm working in Orange Farm where girls and women are still going through this; they do not just go around making babies and aborting them. Some are raped, molested, forced by partners to do TOP, do not have the financial stability to raise a child, and other reasons. It is important to consider that there are various reasons for TOP
>
> **Registered Nurse, Gauteng, FGD, 22 August 2023**

The perspectives shared by providers illustrate their leadership and profound insights into gender discrimination, and how power dynamics can exacerbate or mitigate these inequities. By assuming leadership roles in the health profession, CTOP providers demonstrate their commitment to safeguarding reproductive rights.

Years of Service & CTOP Provider Motivation

Interestingly, our analysis revealed a correlation between years of experience providing abortion services and provider motivation. Providers with more clinical experience (5+ years or more) were 30% more likely to be motivated to champion women's rights and social justice when compared with providers with less experience (4 years or less).

4.5 TERMINOLOGY & NAMING

The terms and language we use impact educating stakeholders and the success of our advocacy efforts. In this study, we sought to understand how providers think stigmatised medical procedures and human rights should be framed. We asked whether the term "Abortion" or "Choice of Termination of Pregnancy" (CTOP), or both, should be used, and why. 11 FGD respondents stated CTOP as their preference, 6 said abortion, and 3 said either and 1 said none of the above conveys that this is an option for pregnancy.

Providers who strongly felt that using CTOP is more useful argued it's "gentler" because it carries less stigma compared to the term "abortion". They noted that the term "abortion" is often used by anti and illegal and unsafe backstreet operators, while CTOP refers to safe and legally protected health services. Some youth use the term "terminate" and they follow them and say CTOP. They mentioned "Choice of Termination of Pregnancy," is explicit by accurately describing the procedure.

Providers who felt using "abortion' was important were of the view that both terms refer to the same medical procedure, and medical professionals should re-claim the term from the stigma placed upon it. Others raised that if providers do not use the term most widely known, they will buy into the shame rather than challenge it. Some have said that the public understands what abortion is and should be used because it is well known.

The three providers who said they use the terms interchangeably said they view this as important to educate people that they refer to the same situation, desire, and medical procedure. Furthermore, one provider pointed out that both terms are used in legal documents.

4.6 UNSAFE & ILLEGAL SERVICES

In our sample, abortion providers, across provinces, expressed significant concerns about the common illicit backdoor operators.

> Because of conscientious objection, people refuse to give the service and because of this people resort to backstreet abortions, you find babies in the bin and incomplete or septic abortions which are more expensive to manage
>
> **Registered Nurse, Kwa-Zulu Natal, FGD, 22 August 2023**

> Everywhere you go, you see these posters where they put abortion pills. And every time I go to meetings with the doctors, I hear that they're having problems with women who are having backstreet abortions. Women and girls' lives are at risk and in danger at all times
>
> **Registered Nurse, Gauteng, FGD, 24 July 2023**

Participants described different tactics illegal operators use to gain clients. These included setting up shops near public and private authorised clinics to lure and confuse girls and women, as well as identity theft where licenced providers' names and professional credentials are used to fake legitimacy.

The reported costs of private provision of CTOP services are not readily available.

Illegal operators attempt to undercut prices to attract clients. Providers drew parallels between the complications of illegal services they witnessed during apartheid and the democratic eras, including severe infections, life-threatening conditions, and maternal death.

5. Discussion

Our findings strongly suggest that abortion providers in South Africa see themselves as key actors in expanding access to abortion healthcare. Indeed, we found that they view themselves and their work as integral to promoting women's rights, social justice, and gender equality. We also found that providers with longer experience clearly view themselves as protecting women's rights.

This finding stands out among the existing research. For example, a systematic review of literature on "disrespect and abuse" in "abortion and post-abortion care" in 20 countries, including South Africa, illustrates the narrative that healthcare professionals, including clinical providers, perpetuate the shaming of individuals seeking abortion care (Munnangi et al., 2023). Although there is some basis to the perception of healthcare professionals perpetuating stigma in abortion services, it is refreshing and inspiring that our findings tell another narrative of providers who exhibit dedication and willingness to identify themselves as key actors in championing reproductive rights.

Although our findings are not representative of all CTOP providers attitudes, they echo those from other contexts. Recently, there has been a growing recognition of abortion care providers as "human rights defenders" on a global scale (Amnesty International 2023). This framing acknowledges the vital role that providers play because CTOP services are often not recognised as healthcare. Highly criminalised and stigmatised providers navigate complex legal, social and ethical landscapes to protect and deliver healthcare with compassion and dignity.

Our reporting on providers' deep, personal motivations for doing their job, including stating that they felt proud of enabling women in their communities to exercise their freedom to choose and saving lives, adds to research that found similar results in South Africa and globally (WHO 2010; Ipas CAM 2021). Our findings add to the literature that demonstrates that abortion providers not only have a strong commitment to supporting individuals seeking abortion services, but they continue to do so while being discriminated against by managers and colleagues, often with limited security, resources, and little reward.

Our research supports other studies showing the significant need for much better data on abortion healthcare infrastructure in both the public and private sector. It is our argument that the limitations of available information and monitoring that enable the privatisation of public services and the lack of human resources result in inadequate and unequitable CTOP services. This evidence is congruent with the Commission on Gender Equality (CGE) investigation that revealed gaps in information and infrastructure leading to inequalities in CTOP services (2021). The CGE investigation revealed the State's approach to resourcing CTOP services is through equipment donations, the equitable share of the budget. The investigation also found that government efforts to educate the public are inadequate and that there is a lack of public knowledge about the service. This undermines abortion rights and does not promote reproductive health.

Further reflections on our findings within the context of the evidence on existing abortion infrastructure in the private and public sectors show that the lack of a clear demand pattern for particular CTOP methods may arise from a general lack of public information about such services. Kanstrup and her colleagues noted a lack of information as one of the reasons for choosing a method in a systematic review of literature on what drives demand for abortion methods (2017). Similar to this research, our findings show that process length, fears of efficacy, and safety are all factors (Kanstrup, et al, 2017).

Importantly, there seems to be some resonance if not consensus in the literature on the provider's reporting of key barriers and solutions to offering services at all healthcare facilities across the country. Namely, providers put forward 1) lack of State resourcing, 2) collegial and managerial support, and 3) limited clinical staffing. These and the corresponding suggested solutions were echoed in a 2010 WHO-sponsored study on CTOP in South Africa. Its recommendations were, "knowledge and understanding of the 1996 abortion legislation, including conscientious objection, needs to be strengthened among all healthcare providers, including health managers; values-clarification workshops need to be expanded; support programmes that attract prospective abortion care providers and retain existing providers need to be developed. Financial compensation and a scarce skills allowance for abortion providers needs to be considered" (WHO, 2010, p.5).

Additionally, the key actors identified by providers to carry forward the expansion of abortion services have been named by providers globally (Amnesty International, 2023). These include: States' human rights obligations, employers, professional associations, unions, donors, and media companies (Amnesty International, 2023, p. 54). Notably, the Commission for Gender Equality's general recommendations go beyond the providers in terms of monitoring and evaluation of the service; however, they also reiterate the need for increased financing, human resources and staff sensitisation programmes (2021).

6. Conclusion & Recommendations

CONCLUSION

South Africa's constitutional guarantee of reproductive rights, dignity, and freedom from discrimination enables the State to exemplify leadership and the protection of rights. This leadership is significant, especially given the regional and global gains in anti-rights. However, the lack of investment in and monitoring abortion services reveals a policy-practise gap, and an inability to demonstrate the significance of this global leadership. South Africa must take an opportunity to be the beacon of protection for women and birthing people's freedom and dignity, values that our democracy is founded on.

Our findings highlight that abortion providers in the public and private sectors view themselves as champions of gender equality and women's rights. Importantly, we found proud providers interested in playing a leading role in the expansion of CTOP services despite the stigmatisation and discrimination they and abortion services endure.

These results demonstrate that duty bearers and responsible actors have partners in CTOP providers. Ensuring that bodily autonomy is respected and protected requires investment, standardisation and monitoring. In conclusion, training and enforcement measures addressing facility-based stigma and illegal operators should be coupled with strengthening South Africa's key role in expanding reproductive justice by investing in the service.

RECOMMENDATIONS

- **Invest in Services & Staff:** Increase remuneration, training, and debriefing.
- **Align Law & Policy:** Enact and monitor standardized law-based policy on refusal to care to ensure alignment in practice and law at the facility level.
- **Enhance Public Sector SRH Services:** Enact standard monitoring, including retirements, training new staff, and integrating CTOP into broader SRH services.
- **End Stigma:** Widespread use of VCAT at the facility and community levels through staff and CHWs.
- **Foster Collaboration & Support:** Establish digital peer support nationally among CTOP providers, including public-private monitoring, collaboration, and best practice training.
- **Ensure Medication & Information Availability:** Ensure Essential Medicine List (EML) commodities and medications are procured and distributed; provide information on CTOP provisions and the dangers of backstreet operators.

REFERENCES

- Aiken, A. R., & Bloomer, F. (2019). Abortion decriminalised in Northern Ireland. bmj, 367.
- Albertyn, C. Claiming and defending abortion rights in South Africa (2015). Revista Direito GV, 11(2), 429-454. https://doi.org/10.1590/1808-2432201519.
- Amnesty International (2017) 'The South African Government's Human Rights Obligation to Ensure Access to Safe and Legal Abortion Services'.; Harries, J. and Constant, D. (2020). Safe abortion services: Experiences and perspectives of providers in South Africa. Best Practise & Research Clinical Obstetrics and Gynaecology, 62, 79-89.
- Baird, B. and Millar, E. (2019). More than stigma: interrogating counter-narratives of abortion. Sexualities, 22(7-8), 1110-1126.
- Bankole A. et al., (2020). From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress, New York: Guttmacher Institute, https://www.guttmacher.org/report/from-unsafe-to-safe-abortion-insubsaharan-africa
- Blanchard, K., Schaffer, K., McLeod, S., and Wyckoff, B. (2006). Medication abortions in the private sector in South Africa. The European journal of contraception and reproductive health care : the official journal of the European Society of Contraception, 11(4), 285–290.
- Church, K., Gassner, J. and Elliott, M. (2020). Reproductive health under COVID-19: challenges in responding to a global crisis. Sexual and Reproductive Health Matters, 28(1).
- Commission for Gender Equality. (2021). Investigation into Choice of Termination of Pregnancies in South Africa. https://cge.org.za/wp-content/uploads/2021/08/Investigation-into-choice-on-Termination-of-Pregnancies-in-SA.pdf
- De Londras, F., Cleeve, A., Rodriguez, M. I., Farrell, A., Furgalska, M., & Lavelanet, A. F. (2022). Impact of provider restrictions on abortion-related outcomes: a synthesis of legal and health evidence. Reproductive Health, 19(1), 1-10.
- Dunn, C. (2017). Abortion care: Our responsibility. Obstet Gynaecol. 2017, 16-19.
- Gilson, L., Brady, L., Naldedi, T., Schneider, H., Pienaar, D., Hawkridge, A. and
- Vallabhjee K. 2017. Development of the health system in the Western Cape: Experiences since 1994. In: ararath, A. & Barron, P. South African Health Review
- 2017. Health Systems Trust.
- Green, A. (2023). What is the situation with self-managed abortions in SA? 1 December 2023, Spotlight. https://www.spotlightnsp.co.za/2023/12/07/in-depth-what-is-the-situation-with-self-managed-abortions-in-sa/
- Harries, J., & Constant, D. (2020). Safe abortion services: Experiences and perspectives of providers in South Africa. Best Practise & Research Clinical Obstetrics and Gynaecology, 62, 79-89.
- Ipas CAM and Safe 2 Choose (2020). International survey of abortion providers and companions. Ipas, North Carolina, USA.
- Jim A, Magwentshu M, Menzel J, Küng SA, August SA, van Rooyen J, Chingwende R and Pearson E (2023) Stigma towards women requesting abortion and association with health facility staff facilitation and obstruction of abortion care in South Africa.
- Front. Glob. Women Health 4:1142638.
- doi: 10.3389/fgwh.2023.1142638
- Kanstrup C, Mäkelä M, Hauskov Graungaard A. (2018). Women's reasons for choosing abortion methods: A systematic literature review. Scandinavian Journal of Public Health. 46(8):835-845.
- Massyn N, Day C, Ndlovu N, Padayachee T. District Health Barometer 2019/20. Durban: Health Systems Trust; December 2020.
- Munnangi M., Shreedhar P., Lippus H., et al. "One's life becomes even more miserable when we hear all those hurtful words." A mixed methods systematic review of disrespect and abuse in abortion care., 12 December 2023, PREPRINT (Version 1), available at Research Square.
- Maxwell KJ, Hoggart L, Bloomer F et al. (2021).Normalising abortion: what role can health professionals play? BMJ Sexual Reproductive Health 2021; 47:32-36.

- Malanga, R. E. (2003). Abortion: developments and impact in South Africa. British medical bulletin, 67(1), 115-126.
- Minisini, V. 2021. South Africa's Secondary Pandemic: A Gender-Based Violence. Global Risk Insights. [Online]. 21 March. [Accessed 33 March 2023]. Available: https://globalriskinsights.com/2021/03/south-africas-secondary-pandemic-a-crisis-of-gender-based violence/#:~:text=Prior%20to%20the%20pandemic%2C%20femicide,World%20Health%20Organisation%20in%202016
- Purcell, C., Hilton, S. and McDaid, L. (2014). The stigmatisation of abortion: a qualitative analysis of print media in Great Britain in 2010. Culture, health, and sexuality, 16(9), 1141-1155.
- Purcell, C., Maxwell, K., Bloomer, F., Lowlands, S., & Boggart, L. (2020). Towards normalising abortion: findings from a qualitative secondary analysis study. Culture, health & sexuality, 22(12), 1349-1364.
- The South African Government. (2022). Deputy Minister Sibongiseni Dhlomo: Illegal abortion awareness campaign. https://www.gov.za/speeches/deputy-minister-sibongiseni-dhlomo-illegal-abortion-awareness-campaign-12-may-2022-0000, 2018.
- Spencer, L., & Alvarez, R. (2014) "Analysis in Practise," in Qualitative Research Practise: A Guide for Social Science Students and Researchers, 2nd ed. London: Sage Publications. pp. 269-345.
- University of Kwazulu-Natal. (2016). Health Economics and HIV/AIDS Research Division 'Unsafe abortion in South Africa: country factsheet." HEARD University of Kwazulu-Natal.
- Williams, C. (2019). Everything you need to know about Safe Abortions in South Africa. 11 December, News24.
- https://www.news24.com/life/archive/everything-you-need-to-know-about-safe-abortions-in-south-africa-in-2019-20191210
- Willie, M.; Maqbool, M.; Kubheka, B.; Popovic, B. & Kabane, S. (2024). An analysis of medical scheme-related pregnancy terminations in South Africa in 2022. Open Health, 5(1).
- World Bank (2022) "South Africa: Gender Assessment." Washington, D.C.: World Bank.
- World Health Organisation. (2010). What healthcare providers say about providing abortion care in Cape Town, South Africa: findings from a qualitative study (WHO/RHR/HRP/10.18, Geneva, Switzerland.
- World Health Organisation. (2012). WHO recommendations: optimising health worker roles to improve access to key maternal and newborn health interventions through task shifting. World Health Organisation. Geneva.
- World Health Organisation. (2015). Health workers play a role in providing safe abortion care and post abortion contraception. World Health Organisation.
- World Health Organisation. (2022). Abortion care guideline. Geneva
- World Health Organisation. (2024). Abortion Fact Sheet. 17 May. Geneva.

ANNEX 1

2023 Abortion Provider Survey South Africa

Demographic Information

Province: _____

Facility: _____

District: _____

1. Do you provide medical or surgical abortions?

- ☐ Medical
- ☐ Surgical
- ☐ Other, specify

_____

2. How long have you been an abortion provider?

- ☐ 1 - 5 years
- ☐ 5 - 10 years
- ☐ 10 + years
- ☐ Other, specify

_____

3. What motivated you to take this role?

- ☐ Experience at work motivated me
- ☐ Championing women's rights
- ☐ Seeing a need for more providers
- ☐ Other, specify

_____

4. What do you think needs to be done to improve your life as a provider, and what do you think needs to be done to improve the service?

_____

_____

Name: _____

Phone: _____

Email: _____

Added Comments: _____

ANNEX 2

Focus Group Discussion Guide

Research Aims: To deepen understanding of the key activities coalition partners can play to protect abortion services and expand access.
To understand the role of abortion providers in driving expanded access, and to determine if a peer provider network is a useful tool to address barriers, and why.

Research Objectives

1. Mapping abortion service care.
2. Identifying what the different ways that women, girls, and people access safe services, and what challenges are faced.
3. Examining various ways in place aimed in expanding or increasing access to abortion.
4. Exploring possible solutions and peer support by providers.

Facilitator and note taker open the session
Providers information

Facilitator: Please introduce yourselves 1 by 1 stating your:

- First Name,
- The district, and province you practice in
- The kind of abortion services you provide
- How long you have been working in this area of health service.

THEME I: Providers personal motivations and perspectives [15 min]

1. In your survey, each of you mentioned several reasons that inspired you to take up abortion provision. Please share this in detail, including what has kept you in the role?
2. Are there any risks/challenges or opportunities in being an abortion provider?
3. In your experience of the needs, do you think access to CTOP services is adequate?

How do you think service in your district and province could be expanded?

- Who are the key people or groups that can bring this about? Trade Unions, are you member of?
- What role, if any, can providers play in expanding the services?

4. What is the best term to use, "CTOP" or "Abortion"?

Why? Are there particular spaces one term should be used rather than the other, Why?

THEME II: Provider facility assessment

5. What is the state of CTOP provision in your facility?

- Staffing/ outages?, what are daily, monthly no. of patients served, how often is service given?
- How is providers moral, and *peer support*; burn out?

6. Have you come across conscientious objectors? (peers, or administrators who prevent CTOP)? If so, how have you worked around it?

7. What do you think there is more demand for, Medical or surgical abortions?

8. Do patients face access challenges?

- If yes, what do you think are the 3 key challenges they face?
- How could these challenges be better overcome?

THEME III: Provider's support system (well-being and mental health) [10min]

9. How do you get meaningful support for your work challenges (personal and professional)? (personal being well-being/ professional being best service ambition)

- Any support from the facility/district/provincial department?
- Any support from your peers, or other parts of your community?

10. What support would you benefit from?

THEME IV: Institutional and Organisational Context [15min]

11. What is needed to increase access to abortion services?
- What do providers, or other key groups need, to play a leading role in increasing access?

12. Do you think "Clinical Associates" should be able to provide 2nd trimester CTOPs?

13. As a CTOP provider, do you have a relationship with SRHR civil society groups, women's movements, Trade Unions, or activists?
- What do you think these groups can do for you?

14. Would *you*, *your profession and your service* benefit from a CTOP provider peer network? [CONSENSUS]
- Why, or why not?
- And if yes, how?

15. Would you be interested in staying in touch with SRJC as this project develops?

ANNEX 3

In-Depth Interview Questions

Map Service & Access

1. How many facilities in your district or province provide medical abortion? surgical abortion?
2. How do your patients find their way to you? Are there any useful referral groups, resources?
3. Are there any groups you see most? (girls under 12; sex workers)

- How often do sex workers use your services? (estimate no. per month/ per year)?
- Do they normally receive surgical or medical?
- Do sex workers take up contraception? And if so, which kind(s)?
- Any sense of hiding their pregnancies from their clients or partners?

4. What ways has your facility/district/province succeeded in making CTOP available?

Solutions and Peer Support

5. What is needed to improve your life as a provider?
(Prompts: increase in pay? education/stigma? increase Ministerial/political support for CTOP?)

6. What is most needed to improve the service?

- Who needs to be involved to achieve that?

7. If you had a group of CTOP providers to support you, and work with, what kind of support would you want to build? and for what purposes?

8. How could providers working together, (maybe across districts, across provinces) improve the situation of providers? What would they need to do?

9. What would be the best way to organise a peer support network of providers, and why?

10. What relationship would be best between a peer network and Trade Unions, women's movement, SRHR groups? And why?

BARRIERS & SOLUTIONS

ABORTION PROVIDER PERSPECTIVES

JULY 2024

Researched & Written by: SRJC

www.srjc.org.za
coordinator@srjc.org.za

Editing & Layout by: RR Comms

www.reoagilerising.com
howzit@reoagilerising.com