Barriers and Facilitators in the Health System Influencing Access to Safe Abortion Care in South Africa: a framework analysis of the existing literature

Isabel Emília Remane Abdul

Master of Science in International Health

KIT (Royal Tropical Institute)
Vrije Universiteit Amsterdam (VU)

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A thesis submitted in partial fulfilment of the requirement for the degree of
Master of Science in International Health

by

Isabel Emília Remane Abdul

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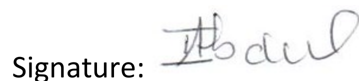
Signature: 

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Abstract

Background: Despite the progressive legal framework in South Africa, access to abortion services remains difficult for women. The barriers to accessing abortion services are complex and include fragilities in the health system. The aim of this thesis is to identify the main barriers and facilitators in the health system influencing access to abortion care in South Africa.

Methods: To respond to the thesis objectives, a literature review was conducted. Advanced research for scientific articles was conducted on the *PubMed* database and Google *Scholar*. All the searches took place from July 2022 to February 2023. The analysis was carried out using the conceptual framework for abortion care developed by the World Health Organization.

Results: The barriers found included provider-related factors such as stigma and objection to rendering services, a lack of staff, the unavailability of services, and a lack of commodities and effective chain supply management. The facilitators identified were a legal framework, a national guideline for termination of pregnancy, a clear pathway for abortion care, a referral system, and abortion services provided at no cost.

Conclusion: The framework identified both barriers and facilitators, although barriers were more prominent. Barriers were found on the pathway for abortion care at the level of health providers, type of services provided, and how services are delivered. The health system needs adjustments in relation to the health workforce and their attitudes, commodities, and supply chain to create an enabling environment for comprehensive abortion care and meet women's needs and preferences.

Key words: Abortion, health system, barriers, South Africa, WHO guidelines

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Abbreviation

CTOPA	Choice of termination of pregnancy act
D&E	Dilatation and evacuation
DoH	Department of Health
Ipas	Partners for Reproductive Justice
MEC	Member of the executive council
MVA	Manual vacuum aspiration
RSA	Republic of South Africa
SAC	Safe abortion care
TOP	Termination of pregnancy
WHO	World Health Organization

Glossary

- **Gestational age:** is the duration of pregnancy expressed in number of days or weeks since the first day of the woman's last menstrual period for those with regular cycles. For women with irregular cycles or when the last menstrual period is not known, the gestational age is the size of the uterus, estimated in weeks, based on clinical examination or ultrasound, that corresponds to a pregnant uterus of the same gestational age dated by last menstrual period (1).

- **Medical abortion:** use of pharmacological agents to terminate a pregnancy (2).

- **Safe abortion:** termination of pregnancy carried out using a method recommended by the World Health Organization (WHO) appropriate to pregnancy duration and by someone with the necessary skills (3).

- **Self-management of abortion**: personal handling of the entire process of medical abortion or one or more component steps, namely, evaluation of eligibility for medical abortion, auto-administration of medicines without direct supervision of a health worker, and self-assessment of the success of the abortion process (1).

- **Surgical abortion:** use of transcervical procedures as vacuum aspiration and dilatation and evacuation, for terminating a pregnancy (2).

- **Values clarification:** is an ongoing process of defining what one values, and how one acts on those values in daily life (4).
  Training on abortion values clarification assists health providers to be involved and reflect on their feelings and beliefs about abortion at both personal and professional level (5).

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Introduction

I am a Mozambican medical doctor. Since 2016, I've been working for the National Institute of Health of Mozambique as a researcher and project manager.

I chose this topic for my thesis because I have always been passionate about sexual and reproductive health. I intend to work in this field, specifically in programs to improve sexual and reproductive health in low-income settings.

Abortion has been legal in Mozambique since 2014, yet unsafe abortion is a public health problem and one of the main causes of maternal mortality. My initial intention was to do my thesis in Mozambique and conduct primary data collection. Due to the lengthy process of requesting ethical approval and the lack of evidence needed to conduct a literature review, I decided to change the setting to South Africa. The reason for choosing South Africa was because, when I was writing the problem statement about Mozambique, I found some articles about abortion in South Africa. I was intrigued by the fact that the country had legalized abortion so long ago—earlier than many developed countries—and was still struggling to provide quality care services.

This thesis is a literature review and is focused on barriers and facilitators of abortion care in the South African public health system; however, information about other countries is discussed only to fill information gaps.

With this thesis, I expect to develop a document that could be used to guide South Africa or any other country with similar conditions to improve abortion care services and to align it with the recent guidelines of the WHO.

1. Background

With a total area of 1 221 037 Km^2, South Africa, officially known as the Republic of South Africa (RSA), is the southernmost country in Africa. The Indian Ocean and the Atlantic Ocean border the nations along about 3000 km of coastline. The country borders with Namibia, Botswana, and Zimbabwe to the north, and Mozambique, Eswatini to the east and northeast, respectively, and an enclave of the Kingdom of Lesotho. The RSA has three capital cities: Pretoria is the executive capital, Cape Town is the legislative capital, and Bloemfontein is the judicial capital (6).

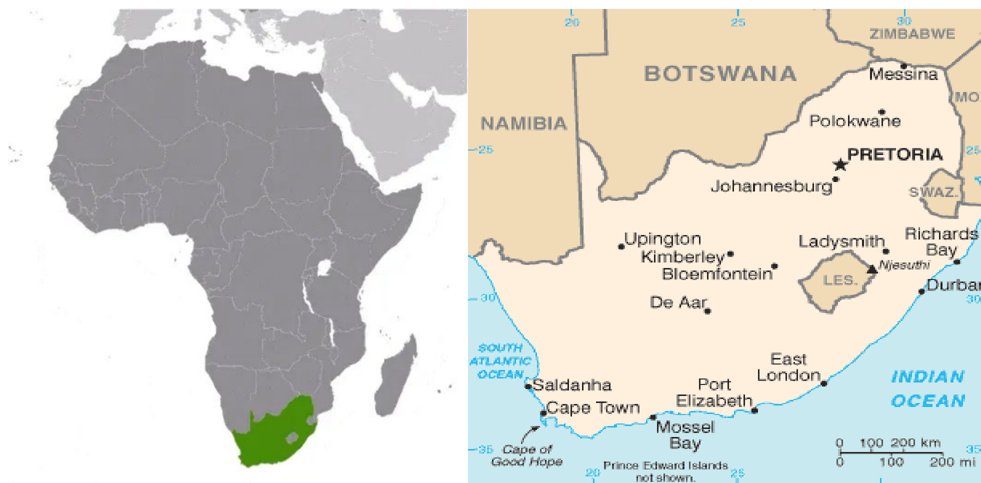

Figure 1 - Map of South Africa (7)

With a population of almost 60 million, it is the world's 23rd most populated country. The population is composed of roughly 51.1% women and 48.9% men. With about 80.7% of the population being black South Africans, 7.9% being white South Africans (of European descent), 2.6% being Asian (of Indian and Chinese origin), and 8.8% being coloured, (multiracial ancestry). The country has eleven official languages derived from its multiethnicity and multiculturalism (8).

1.1 History

South Africa was officially colonized by the Netherlands between 1652 and 1806 and by Great Britain between 1795 and 1961 (9).

Even after becoming a union in 1910 and establishing its own white people-led government, the nation was nonetheless viewed as a British colony until 1961. In 1948, the National Party officially established apartheid as a law. Apartheid was a system of racial segregation and denial of human rights with the aim of oppressing black South Africans. The historical resistance movements, numerous violent confrontations, and militarism of South African society all played a pivotal role in the abrogation of the apartheid law, which was in effect until 1991 (6),(10).

The first non-racial democratic elections in the RSA took place on April 27th of 1994. It marked the end of more than 300 years of colonialism, and the establishment of a new democratic government led by Nelson Mandela governed by a new constitution (8),(10).

1.2 Economy

According to the World Bank the RSA is categorized as an upper-middle-income country, with a gross domestic product of 6,994.2million in 2021, a growth rate of 23.6% from the year before (11). It is considered a dual economy, agriculture and manufacturing industries are the main drivers of economic growth (12). However, the country has one of the highest rate of inequalities worldwide (13), with a *Gini* score of 63 in 2014-15. A report from the World Bank found that approximately 55.5% of the population lives in poverty at the national upper poverty line (14).

The unemployment rate in 2022 was 34.5%, being higher for individuals aged 15-24 years (63.9%), and 42.1% for individuals aged 25-34 years (15).

1.3 Education

According to the South African Schools Act 1996, compulsory education in the RSA begins at the age of six and continues until the age of fifteen (grade 9). The country has made progress in implementing the right to education since 1994, rapidly constructing an efficient, accessible, and high-quality education system for children and adolescents (16).

Despite these accomplishments, poverty and inequality remain harsh determinants that restrict so many children from receiving a fundamental education. In 2020, the percentage of people over the age of 20 who might be considered functionally illiterate was 10%. The illiteracy levels were higher for women (10.7%), compared to men (9.3%) (17). Reports reveal

that learner dropout becomes a severe issue after ninth grade, but that the underlying factors accumulate in earlier grades. This access disparity is exacerbated by a gender disparity that disproportionately affects young girls. Only 28.5% of youths graduating from postsecondary institutions in Science, Technology, Engineering, and Mathematics related occupations are women (18).

1.4 Health

In 2021, the life expectancy at birth was 59.3 years for males and 64.6 years for females (19). Maternal mortality rate was 119 per 100 000. Abortion and miscarriages are the fifth cause of maternal mortality contributing with 7.4% of all deaths (20).

The infant mortality rate was 24.1 per 1000 live births in 2021 (19). The neonatal mortality rate declined from 14 per 1000 live births to 10.8 per 1000 from 2014 to 2019, which is one of the lowest rates in sub-Saharan Africa (21),(22).

The health system is divided into three levels: (1) primary care facilities, with a range of different sub-categories (health posts, mobile clinics, satellite clinics, clinics, community day centre and specialized health centre). They are more nurse-staffed, serve as the patient's first point of contact and provide predominantly ambulatory care; (2) district hospitals, which are more specialized and larger than primary care facilities and offer inpatient services; and (3) tertiary hospitals, which are larger in infrastructure and more advanced in terms of services and technology offered, and patients can only be referred or present themselves in case of an emergency (23),(24).

In 2020, the health system expenditure was composed by approximately 62 % of the domestic government transfers, 30% of voluntary health insurance contributions and 5.4% of out-of-pocket spending and less than 2% of external aid (25). The funds are allocated and managed at the municipal level (23).

The government has implemented a national health insurance system to ensure that all South Africans, regardless of their socioeconomic background, have access to high-quality healthcare services supplied by both the public and private sectors (11). It includes family planning, screening and treatment for breast and cervical cancer, and free antenatal care in the form of 8 visits (19).

HIV/AIDS is the major cause of disability-adjusted life years in the country (27). The RSA has the highest number of people with HIV, contributing to 17% of the global burden of HIV infections (23), with approximately 7.5 Million people infected (28).

1.4.1 Abortion

In 1996, during the transition from apartheid to independence and democracy, the Republic of South Africa legalized abortion. The act was influenced in part by the findings of a nationwide research on the epidemiology of incomplete abortions conducted in 1994 and the need to address sexual and reproductive health rights disparities. The 1975 Abortion and Sterilization Legislation, which limited access to abortion services by requiring a physician's and, in certain situations, a court magistrate's authorization for the operation, was repealed by the act (29). In 2008, the legislation was changed to let registered nurses conduct abortions after receiving training and certification and to expand the types of institutions that might offer safe abortion services (30).

The Choice on Termination of Pregnancy Act (CTOPA) of 1996 addressed the imperative need to eliminate disparities in maternal mortality by establishing a rights-based strategy (29),(30). The CTOPA grants women the right to obtain abortion services upon request throughout the initial 12 weeks of pregnancy, regardless of their age or marital status. In circumstances where a medical practitioner considers that the pregnancy endangers the woman's physical or mental health, if it resulted from rape or incest, or if there is risk of severe physical or mental abnormality of the fetus the pregnancy can be terminated from the 13th to the 20th week. The act also grants women the right to terminate the pregnancy after 20th week after a consultation with two medical practitioners or a medical practitioner and a registered nurse in the circumstance that it would constitute a severe threat to women's life; would result in severe malformation of the fetus; or would constitute a risk of injury to the fetus (31),(32).

2. Problem statement and justification

Worldwide, it is estimated that approximately 73 millions of induced abortions occur every year (3) and around 45% of these are unsafe, meaning that they are not performed by a trained person or by using a safe method (33). Unsafe abortion is particularly reported in countries with restrictive laws, and it is expected that in countries where women have legal access to safe abortion care (SAC) services the casualties to be virtually absent (34). However, even in countries with liberal legal frameworks, personal values, religion and social reservations can negatively influence women's care seeking behaviour as well as influence healthcare workers attitudes towards women seeking abortion care and consequently affect the accessibility and the quality of services (35).

The barriers to women accessing abortion services are complex, and include besides law restrictions, fragilities of the health system such as opposition of the providers' to deliver abortion services due to religious or moral beliefs, also known as conscientious objection; lack of standards and guidelines (35),(36), and unavailability of services (37) especially in rural areas. On the other hand, women, especially adolescent women, lack information about the legal status of abortion, and on where to seek safe abortion care (35), not to mention the role that traditional values, fear of stigma, and socio-economic restrictions play (38).

The Office of the High Commissioner for Human Rights has stated that denying women access to SAC does not only constitute gender-based violence, torture, or a violation of their right to health but also a violation of their right to life (39).

In South Africa, abortion-related mortality decreased by 91.1% between 1998 and 2001 as a result of legislation (5). Despite the progressive legal framework, many women still struggle to access SAC services, especially in marginalized communities, where sometimes recur to unsafe abortion. Unsafe abortion remains a public health concern in the country as it is one of the main causes of maternal mortality (20), not to mention the financial burden that it constitutes for the health system to treat the complications of unsafe abortion.

According to an Amnesty International report from 2014, less than half of public health institutions designated to provide safe abortions do so and there are differences between and within the RSA's nine provinces and 52 health districts. These relate to disparities in health-care spending and health-system administration (40). In 2016/7, the public health system,

which serves 80% of the population, rendered only 20% of the total number of abortions, 54% was provided in private sector and the remain 26% in informal sector (41).

Some authors attribute it to a lack of political willingness from the Department of Health (DoH) leadership, considering that termination of pregnancy (TOP) might not be at the top of the list of health concern priorities of the DoH and to a lack of formalized and operational guidelines in all facilities (30). Because of abortion-related stigma and competing public health agendas, abortion care has been under-resourced and pushed to the margin of public-sector maternal health care. The widespread public scepticism of public health care and expectation of poor quality of care prevent women from seeking services in public sector to obtain abortion and contraceptive services (42), leading to unwanted birth or women seeking informal abortion services. This lack of political will along with health care providers attitudes can shape the quality of care of abortion care services in the public health system. There is currently a paucity of published literature on assessment of public abortion care services in South Africa, despite its legalization for more than 25 years. This thesis, through literature review will identify the main barriers and facilitators influencing access to SAC in South Africa. The findings from this thesis therefore will provide a valuable reference for policy makers and decision-makers as well to improve the quality of services of SAC in the RSA.

2.1 Study objectives

2.1.1 Main objective

- To identify the main barriers and facilitators in the health system influencing access to safe abortion care in South Africa.

2.1.2 Specific objectives

- To analyse the experiences that women or couples have in the health system when seeking abortion care;
- To determine the different models of care, including who delivers, where, and how services are delivered;
- To analyse the components of the health system that support or restrict the effective delivery of safe abortion care;

- To draw recommendations to relevant national and international stakeholders to refine the strategies to improve the abortion services at a national and subnational level.

3. Methods

To respond to the thesis objectives, a literature review was conducted. Advanced research for scientific articles was conducted on the *PubMed* database and the *Google Scholar* search engine.

The main key words “abortion” AND “South Africa” were combined with different terms, chosen according to the WHO conceptual framework for abortion care. This framework was also used to analyse the data. The search terms are described in table 1.

The selection of the articles was conducted in different phases. It started with a screening of the abstracts to assess if the articles were relevant to respond the thesis objectives. Once this was done, a second screen on the initially selected articles in full was done to ensure that they met the inclusion criteria.

Snowballing was used to find additional and relevant articles that might not have been found at first. For each selected article, the reference list was scanned to identify other articles that might be relevant for the topic, and an additional scan was conducted to ensure the articles fulfilled the study objectives. When adding these references, the published date and other inclusion criteria (described below) were taken into consideration.

All relevant articles were catalogued in an Excel spreadsheet, emphasizing each one’s author, date of publication, methodology, title, and key findings.

The references information was logged in the reference management software *Zotero*. All the searches took place from July 2022 to February 2023.

Grey literature from relevant international organizations such as WHO and United Nations, as well as non-governmental organizations like Partners for Reproductive Justice (Ipas) and Marie Stopes Institution working in the field of safe abortion in South Africa, was also searched using the key words. The South African government websites were accessed for the national decree, guidelines on abortion, and other relevant information about the country.

Inclusion criteria

- Articles in English since it is relevant for South Africa.
- Articles from 2012 onwards were preferably selected.
- Peer-reviewed articles as well as gray literature from relevant international and national institutions and organizations in the field of safe abortion as well as South African government websites.

Exclusion criteria

- Thesis dissertations

Table 1 - Search Terms combined with key words "Abortion" AND "South Africa"

Category	Terms searched
What interventions are available	"Abortifacient agents"[MeSH]
	"Pain management" [MeSH]
	"Contraceptive agents" [MeSH]
	"Counseling" [MeSH]
Who provides the services	"Self-management" [MeSH]
	"Women" [MeSH]
	"Health personnel" [MeSH]
	"Epistemology" OR "Knowledge" [MeSH] AND "Attitude" [MeSH] AND "Practice"
	"Pharmacists" [MeSH]
	"Community health workers"
Where services can be provided	"Home"
	"Pharmacy" [MeSH]
	"Primary health care" [MeSH]
	"Health facilities" [MeSH]
	"Community outreach centers"
	"Telemedicine" [MeSH]; OR "mobile health" [MeSH]
How are services delivered	"Delivery of health care' [MeSH]
	"Comodities"
	"Finances" OR "finance" OR "funding"
	"Health services" [MeSH]
	"Telemedicine" [MeSH]; OR "mobile health" [MeSH]
	"Hotlines" [MeSH]
Enabling environment	"Human rights" [MeSH]
	"Health information"
	"Health system"
	"Policy" [MeSH]
	"Jurisprudence" [MeSH] OR "Law" OR "constitutional law"
	"Legislation" [MeSH]
	"Education" [MeSH]

3.1 Analytical Framework

The analysis of the literature has been carried out thematically using a framework. The conceptual framework for abortion care of the WHO abortion care guideline was selected as a guide for describing the many factors impacting abortion care in the RSA (Fig.1). This framework was selected since it is quite contemporary and has a significant health system emphasis. This approach is applicable for program development, implementation, and monitoring. As the framework demonstrates, the WHO guideline is centered on the values and preferences of women concerning abortion and views them as both active participants

and recipients of health care. According to this concept, when a woman progresses through the abortion care pathway (pre-abortion, abortion, and post-abortion), services must be integrated into the health system to fulfill her requirements. As each woman progresses along this pathway, recommendations on the exact approaches required (i.e., the "what") as well as information on the kind of personnel who may safely provide them (i.e., the "who") are provided. Also shown are areas where services may be rendered (the "where") and service-delivery mechanisms that can be used (the "how"). The enabling environment offers the context essential for the successful execution of these actions (1).

Consequently, the components of the enabling environment are linked with those of the other framework levels. Elements of the enabling environment for data analysis were included in other framework parts.

Even though not all persons seeking abortions may identify as women, the word "women" will be used.

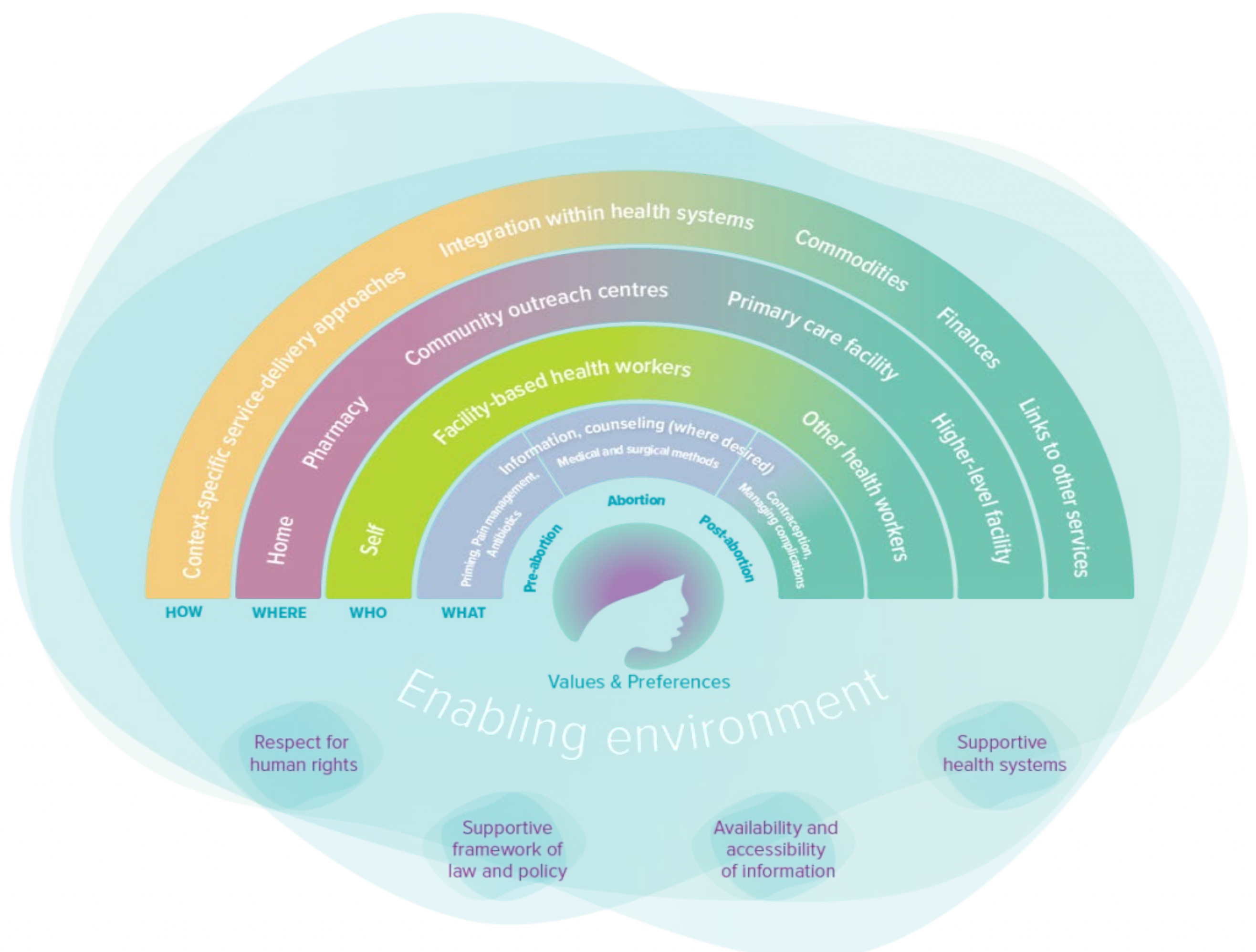

Figure 2: WHO conceptual framework for abortion care (1)

4. Results

The results are organized according to the framework, in the form of four layers. The first layer considers the services provided at each stage of abortion: pre-abortion, abortion, and post abortion. The second considers who provides the abortion services and their attitude towards women. The third layer is about different places where abortion services are provided. Finally, the last layer considers models of service delivery and how they are integrated into the health system. For all four layers, women's experiences and opinions are described. To ease comprehension, background information on the local TOP decree and guidelines, as well as the WHO guideline on abortion care, is provided.

4.1 "What" services are provided?

CTOPA – The Right to information

According to the CTOPA every pregnant woman seeking TOP should be offered pre- and post-abortion counselling from trained healthcare professionals. Pre-TOP counselling provides women information about: (1) methods for TOP available for their gestational age; (2) pain management options available before, during, and after the TOP procedure; (3) contraceptive methods and (4) HIV and HIV testing services. The post-TOP counselling includes the following information: (1) oral and written instructions for follow-up care; (2) complications that need medical attention; (3) health care facilities for emergencies, if needed; (4) offer of a contraceptive method and prescription on request; and (5) when to resume normal activities, including sexual intercourse (29),(32).

Abortion Guideline

The policy guideline of the CTOPA of the national DoH recommends what different abortion methods should be available according to gestational age: for up to 10 weeks, medical TOP with *Mifepristone* and *Misoprostol* as an outpatient; after that period, medical abortion should be undertaken in a health facility; up to 14 weeks and 0 days: surgical TOP with manual vacuum aspiration (MVA); over or equal to 14 weeks and 1 day– surgical TOP by dilatation and evacuation (D&E) (43).

4.1.1 Pre-abortion

A report of the *Health Systems Trust* published in 2012 found that only 76% of the national primary health care facilities were providing TOP counselling (24). Sometimes the providers conducted group counselling before abortion procedures to prevent turning women away, due to shortages in staff and infrastructure limitations (42),(44). In a study conducted among health facilities providing abortion services in KwaZulu-Natal province, women reported being uncomfortable with group counselling, because they could not speak openly and discuss their concerns with health providers without other women listening. However, there were some study participants who showed no constraints with group counselling (45).

Harries et al. found that around half of the women that participated in their study were aware of the legal status of abortion in South Africa, and of those who were aware of the law, 17% had been discouraged from obtaining assistance due to an anticipated fear of hostile behaviour of medical staff and a prediction of low service quality. Some women reported distress and frustration when they were denied TOP services for being beyond the legal gestational age limit. Others reported that they had to return to the health facility because there was no medical doctor available. When questioned about the reason for delayed seeking for TOP, some women disclosed not seeking first for public health facilities for abortion due to past negative experiences but most of them replied being aware of the pregnancy right before seeking for TOP services (44).

In their research, *Somefun et* al. identified late detection of an unplanned pregnancy as one of the leading causes of second-trimester abortions. Even though many women recognized pregnancy signs and symptoms, they did not immediately associate them with the potential of pregnancy and instead waited for more instruction on how to interpret them. Deferral was often the consequence of a prior missed period unrelated to pregnancy, irregular periods, or failure to monitor the menstrual cycle. There were a variety of reasons for the initial reluctance to seek confirmation through testing. Some wanted to wait for their period to begin, while others were apprehensive about the chance of pregnancy. (46).

In an exploratory study conducted in the Western Cape, *Harries et al* found that some health providers attributed this delay to limitations of the health system, such as system for making appointments, the capacity of health facilities to respond to TOP demand, and the scarcity of enthusiastic and skilled providers, while other health providers blamed women for late presentation (47).

Meanwhile, in other studies, women mentioned fear of judgment, privacy and confidentiality concerns (48) and a lack of adequate health information (44) as reasons for delaying looking for TOP services.

Long waits to obtain safe abortion care services are also a barrier that women commonly encounter. In the assessment conducted by Ipas in the provinces of Gauteng and Limpopo, the health providers and managers reported overdependence on ultrasound to determine the gestational age as an important reason for long waiting between the appointment and service delivery (42).

In a qualitative study conducted in the Western Cape, *Sullivan et al* found that women perceived their pathway through abortion care as disorganized and replete with discomfort, criticism, and uncertainty. They reported that the process of pregnancy confirmation was carried out in a primary care clinic, then they were referred to a second facility to receive an ultrasound, prior to the abortion procedure, and it involved long walking distances. In addition to that, they received poor directions over the addresses of referral clinics, misinformation about how to access abortion services , and no transparency on the available and suitable procedures (49).

4.1.2 Abortion

In a retrospective study conducted in the Johannesburg Academic Hospital, in Gauteng province, women reported that their first assessment of the pregnancy was always conducted by a medical doctor. An ultrasound was performed to determine the gestational age, followed by counselling. The abortion method commonly used was MVA, not often D&E, and evacuation of the uterus was performed in cases of incomplete abortion or managed with MVA and *Misoprostol*. After the TOP procedure, women were sent to a 10- to 15-minute recovery room. However, the average rate of performed TOP procedures in this health facility were about 100 procedures a month (50).

In the assessment conducted by Ipas in the provinces of Gauteng and Limpopo, the health providers and managers reported a frequent absence of pain management provision for clients undergoing MVA. Only 21% of TOP providers conducting MVA provided paracervical blocks for pain management. Some TOP providers reported being bothered by performing MVA, as well as by the related pain that women suffer throughout the procedure (42). In a qualitative study to explore the challenges of performing second trimester abortion in the

public health system in the Western Cape, some health providers had a different opinion about pain management. They felt that TOP should be an unpleasant experience in order to discourage women from seeking abortion in the future (47). In an exploratory study to assess women's perceptions on abortion services in Kwazulu-Natal, study participants complained not receiving any analgesic to help them cope with pain during the surgical procedure of abortion. Women classified it as barbaric (51).

The Ipas report stated that the provision of medical abortion was somehow limited due to difficulties in acquiring *Mifepristone*. Only 21% of the interviewed providers offered medical abortions. As a result, almost all women seeking abortions underwent MVA procedures (42). Favier *et al.* reported that for years Ipas has played an important role in medication and equipment procurement for the public health system (30).

When it comes to second trimester abortion, medical induction was frequently the selected procedure due to a lack of trained doctors willing to perform D&E procedure. Health providers also reported that surgical procedure was emotionally traumatic for those who performed especially between 17 and 20 weeks. However, the health providers recognized that medical abortion also comes with limitations, such as insufficient beds for hospitalization (47). A study conducted in KwaZulu-Natal corroborated these findings, women reported being discharged right after the procedure because the hospital did not have sufficient beds (51).

According to the Amnesty International report, there were no public clinics in the Eastern Cape province that provided second-trimester abortions (40). *Harries et al.* found that there were around nine health facilities rendering second trimester abortion in the Western Cape public health system, and it was the only province rendering D&E. However, it was only provided in three of the hospitals by private medical doctors hired by the provincial DoH (47).

4.1.3 Post-abortion

In a cross-sectional study to analyse the contraceptive uptake trends among women who had legal TOP, conducted in a hospital in Johannesburg, the overall contraceptive uptake prevalence from 2010 to 2019 was 74%. From 2010 to 2014, there was a 15.1% yearly reduction in contraceptive uptake per 100 customers, followed by an 11.1% annual increase from 53.45 per 100 clients in 2014 to 98 per 100 clients in 2019. In the same study, women reported that after undergoing TOP procedures, they received counselling for contraception and were offered the contraception of their choice. In case it was not available they were

either referred to another health facility or asked to return on another day. Either way, they were always counselled to use a barrier method until they could have access to their method of choice (50).

In a qualitative study conducted in health facilities performing second trimester abortion in the Western Cape, TOP providers reported that contraceptives were not available in one of the facilities, and clients frequently complained that they had to walk around 200 meters after finishing the abortion procedure to access family planning (47). *Netshinombelo et al.* corroborated that long-distance can be a barrier to accessing postabortion services, especially for women living in rural areas, where the estimated long-distance to access a tertiary hospital in case of an emergency is approximately 300 Km. In the same study, 48% of women were not taking any contraceptive method. The barriers pointed out by study participants as a reason for delay and inaccessibility to post abortion contraception despite the long distance were experiences of stigma and mistreatment (51).

4.2 “Who” provides the services?

CTOPA - timelines and personnel assigned to provide the services

Registered medical practitioners, registered nurses, and registered midwives who have undergone the training can perform TOP up to 12 weeks and 6 days of pregnancy. For 13 weeks and above, the procedure should be performed only by a registered medical practitioner (29),(43).

CTOPA – Conscientious objection, offenses, and penalties

The CTOPA contains no explicit provision for the exercise of conscientious objection. However, the South African constitution recognizes the right to freedom of conscience and indirectly allows for conscientious objection to TOP in some instances (29).

According to the law, healthcare providers who are not directly involved in the abortion procedure or decide to conscientiously object to performing abortions cannot use their personal beliefs and opinions to refuse to offer information and suitable referrals to a woman seeking abortion services (29),(52). However, there are instances in which the right to conscientious objections cannot be invoked: (1) when a pregnancy threatens a woman's life or health, regardless of gestational age; (2) in circumstances of life-threatening emergencies related to TOP services; and (3) ancillary personnel and staff involved in a patient's general care (32),(53). Any person who is not a medical practitioner or a registered midwife and performs or prevents the lawful TOP or obstructs access to a facility for the TOP on conviction of a crime faces a fine or incarceration for up to ten years (32).

4.2.1 Facility-based health workers and other health workers

Different studies pointed to a variety of factors that influence healthcare providers’ perceptions of abortion, including personal, moral, and religious beliefs. Abortion is perceived by some healthcare workers as a murder or a sin, whereas others see it as an important component of a woman’s right to reproductive autonomy, preventing abortion-related morbidity and mortality (5).

In a study conducted among abortion providers in Gauteng and Limpopo Province, TOP providers reported experiencing judgmental attitudes from their co-workers and being called

names such as “murderers” and “baby killers.” Study participants provided examples of TOP providers who departed because they could not deal with stigma and discrimination from co-workers and health facility managers (54).

An evaluation undertaken by Ipas in 2018 yielded similar results, with providers claiming a hostile atmosphere in which they were humiliated, called names, and lacked support from co-workers; in some institutions, cleaning employees even refused to clean the procedure room (42). TOP providers stated that in certain instances, their colleagues discouraged and stigmatized clients from receiving TOP services and often refused to assist or offer services to TOP clients, despite receiving TOP training (42),(54). In different studies women corroborated this information. They reported a feeling of relative disempowerment as health providers frequently tried to discourage them undergoing TOP procedures (49), as well as being called bad names such as “killers, sinners and mother of devils”, and mocked as bad influences for other women in the community (51). Similarly, on the assessment conducted by Ipas, women reported health staff harsh attitudes, neglect of patients, and unpleasant, disrespectful behaviour, particularly toward young and/or unmarried women, as a key cause for women seeking unsafe abortions (42), and sometimes this mistreatment is perpetrated by other cadre not directly involved in TOP procedures such as administrative personnel and cleaning crew. Some pharmacists refuse to hand out abortifacients (30).

Not uncommonly, women ended up terminating their pregnancies outside of the formal health system based on concerns about mistreatment and privacy (55).

Some TOP service providers complained that medical assistance for TOP services was insufficient, with very few medical doctors available to help with emergencies, not to mention that not infrequently doctors declined to be labelled as TOP providers and sometimes delegated responsibilities for managing complications and second trimester TOP to nurse providers (54).

The practice of conscientious objection is not standardized among TOP providers in the same health facility or between different health facilities. *Harries et al.* reported that some medical professionals assisted with the procedure and/or provided pre- and post-abortion counselling, including contraception, while others limited their involvement to responsibilities related primarily to pre-abortion care, such as abortion counselling or referral. In addition, some clinicians go so far as to refuse to deliver cervical priming agents, pain medicine, and other abortion-related medications (5). In a qualitative study to examine the

practice of conscientious objection and its effects, done in the Western Cape Province, it was discovered that there was a lack of knowledge about the scenarios in which health care personnel could use their right to refuse to render TOP or even assist in abortion services in most of the the assessed public health facilities. In other cases, providers refused to offer abortion services while being aware of the circumstances and constraints placed on conscientious objection, and the policies and processes for dealing with conscientious objection were neither formalized nor documented. The same study found that there is a lack of clear understanding among health care providers about the grounds on which conscientious objection can be claimed and the procedures (36).

A qualitative study conducted in Western cape found that the practice of conscientious objections was more dramatic in rural areas, where entire health facilities refuse to provide TOP services. Some TOP providers believed that the objection of some health providers has nothing to do with moral beliefs, but rather with the health providers' workload and the fact that they can simply object rendering the service. Some objectors started to perform TOP procedures when they were offered some kind of monetary incentive (30).

In a qualitative study to explore the challenges of providing second trimester abortion services in public health facilities, gestational age emerged as a leading indicator of willingness to deliver services, and clinicians reported that it was more traumatic to manage an abortion conducted between 17 and 20 weeks than an abortion performed at 12 weeks or earlier. The physical and emotional reactions of providers toward later stage abortions, formed by the visual encounter with a more developed fetus, were a key feature in second trimester abortion discourse. Many providers found second-trimester abortions to be traumatic and, hence, chose not to participate in the second trimester abortion provision. With second trimester abortion possibilities, the scarcity of trained providers was exacerbated. Managers' reported having a hard time finding medical doctors willing to render second trimester abortions, especially to perform D&E (47).

The scarcity of skilled providers is evident throughout the country. The report of Ipas pointed out the lack of a clear succession plan to train and replace retiring physicians', and as a consequence abortion providers face heavy workloads and a significant risk of burnout (42). While there is a general shortage of health care workers in South Africa, the shortage of abortion providers is especially visible due to the stigma associated with abortion provision (5).

The motivations for women seeking abortion have been investigated as potentially impacting clinicians' views and decision-making towards abortion services. In a qualitative study to explore providers' perceptions, study participants reported seeing an unwanted pregnancy caused by rape or incest as a legitimate reason to obtain an abortion (5),(44). In a similar study, providers were found to be more sympathetic and supportive to a woman seeking an abortion due to congenital abnormalities since this was considered a legitimate medical reason for obtaining an abortion and something over which women had little control. Recognizing the difficulty of having a child with little financial resources or having to discontinue studies, most providers were compassionate and understanding of the situation and the difficulties connected with an unexpected pregnancy (5).

Sneeringer et al. argued that pharmacists and pharmacy personnel may have moral objections to abortion and refuse to supply drugs, even if the client has a prescription. Pharmacists may be reluctant to counsel and inform women about abortifacients. Concerns about job security; ethical, moral, and religious concerns; fear of retaliation from anti-abortion groups; and attitudes that physicians, rather than pharmacy staff, should deliver such information are among the reasons given (56).

4.2.2 Self

WHO guideline - self-management of abortion

The WHO guideline for abortion care recommends self-management of parts or all the abortion process for reasons linked to circumstances and preferences. It includes self-evaluation of eligibility (determining pregnancy duration and stating out contraindications); self-administration of abortion medicines outside of a health-care facility and without the direct supervision of a qualified health worker; management of the abortion process; and self-evaluation of the abortion's success. All individuals who self-manage medical abortion must also have access to correct information, quality-assured drugs, including those for pain management, the assistance of skilled health workers, and access to a health-care facility and referral services if they require or choose it (1).

In South Africa, the legal limit for using abortion medicines at home is up to 10 weeks of gestation. Women are provided *Mifepristone* at the health facility, followed by home use of

Misoprostol (43). No literature on women's experiences with abortion self-management has been found.

In a review of the literature conducted in several countries (with both legal and restrictive laws) to explore women's experience with self-management of abortion, the authors found that most women who described their experiences with medical abortion preferred the ability to self-manage, while others voiced a wish for more medicalized care. Reasons included concerns about correct medicine administration, convenience, the ability to manage difficulties, having assistance during the process, and keeping privacy (57).

4.3 "Where" are services provided?

CTOPA - Health facility designated for TOP

As stipulated by the national abortion decree, TOP can take place in designated facilities with the following criteria: (1) medical and nursing personnel; (2) operating room; (3) surgical equipment, supplies of intravenous and intramuscular medicines; (4) emergency resuscitation equipment and an emergency referral centre; (5) appropriate transport for emergency transfer; (6) inpatient facilities and equipment for clinical observation; (7) appropriate infection control measures; (8) safe waste disposal infrastructure; (9) communication equipment; and (10) approval of the Medical Executive Council (MEC) (29),(31),(32). However, any facility with a 24-hour maternity service that meets the first nine requirements may be eligible to provide TOP services for up to 12 weeks without the need for MEC approval (29).

4.3.1 Primary care facilities, community outreach centres and High-level facilities

The report of the Amnesty International in 2013 found that out of 3880 public health facilities designated to provide TOP services, fewer than 50% were providing first- and second-trimester TOP (58), the main reason cited was the unregulated objection by healthcare providers and managers to rendering TOP services (40).

According to the national guideline for implementation of the CTOPA, clients requesting the service should enter the health system at the primary care level. The first trimester TOP should take place at a primary health care facility that meets minimum criteria. Second

trimester TOP should take place at district or at a specialist level (secondary hospital or appropriate service with specialist backup) (43).

Women living in rural areas struggle to access safe abortion care. The rural areas are served by only 12% of the national medical doctors and 19% of the nurses (40). Many women seeking second-trimester abortions are turned down by public health facilities. According to a 2015 study conducted in Cape Town (Western Cape Province), 20% of women wanting TOP in their second trimester of pregnancy were denied this service (59). Another study conducted in Gauteng and the Northwest provinces found that only 77% of the designated facilities on the national database were providing TOP services. The reported reason was human resources scarcity, deficiencies of the health system as well as lack of management support. The health professionals claimed that insufficient management support and the delayed or non-supply of essential equipment led to the perception of a debilitating work environment. Due to the absence of management support for TOP services, managers were often hesitant to hire personnel or acquire equipment and supplies for TOP service delivery (54). Some managers, for example, were unaware about the timing of TOP services, the average number of clients seen per day, the sort of psychological support TOP providers get, if any, and the distinction between first- and second-trimester protocols (40),(42),(54).

4.3.2 Pharmacy

In a review of studies conducted in Africa, Asia, and Latin America, the authors concluded that regardless of the setting (liberal or restrictive), whenever women want to end an unwanted pregnancy, they seek guidance at pharmacies. There was a lack of awareness and knowledge concerning medical abortion among pharmacy employees, which was frequently worsened by the fact that *Misoprosto*l is not registered or labeled for abortion in some countries. Even pharmacists and pharmacy staff who were eager to provide information and sell pharmaceuticals frequently provided incorrect or inadequate information to consumers about the mode of administration, doses, side effects, and gestational restrictions for medications used for medical abortion (56).

In the RSA, abortion medication is safely available in public facilities and is subject to prescription; however, there is a plethora of sellers providing medication without a prescription (60).

4.4 "How" are services delivered?

4.4.1 Integration within health system and Links to other services

WHO abortion care guidelines - service integration

To offer quality care, health facility services should be accessible to adolescents, gender minorities, persons with disabilities, and any other vulnerable or marginalized populations. Services should be integrated with other pertinent care, such as HIV testing and treatment, contraception, and other sexual and reproductive health services, as well as support services for victims of gender-based violence. Abortion must be integrated into primary health care to facilitate both abortion access and the realization of universal health coverage (1).

To request TOP services, women should enter the health system through the primary healthcare level. The health facility assesses and refers women (if needed) to the closest facility providing TOP at the individual's gestation according to the referral algorithm. As per the national guideline for implementation of CTOPA, regular laboratory testing is not a requirement for TOP services and should not delay the TOP procedures. Depending on the specific risk factors or results of the physical examination, some tests might be carried out: Haemoglobin, Rhesus testing, HIV counselling and testing, sexually transmitted infections, cervical cancer screening, etc. are a few examples; additionally services should be able to identify any issue that make women seeking abortion vulnerable such as being victims of domestic abuse, or gender-based violence, etc and refer to appropriate services for support (43).

4.4.2 Commodities

In the RSA, TOP services are provided free of charge in public sector health care facilities that have been accredited by the National Department of Health (5).

In a cross-sectional study conducted in health facilities in Gauteng and the Northwest Province, the healthcare workers pointed to the absence of an enabling environment, which included medicine shortages, malfunctioning or unavailable equipment, particularly sonar machines, a lack of working space, and staff shortages. They stated that it was not unusual

that healthcare workers providing TOP services had to share workspace and/or sonar machines with other units, and that they were sometimes required to transport clients to other units to perform sonars (54).

Harries et al. outlined that there was a lack of infrastructure and trained staff to meet the demand of TOP services as some of the challenges of providing second trimester abortion care in public health facilities (47).

Different studies conducted in the RSA found that human resources are one of the most critical challenges. The problem with human resources ranges from a deficiency of trained providers to the unwillingness of trained providers to assist women seeking TOP. TOP providers resigning or retiring without being replaced, and nurses being transferred to other health programs or sent for training to assist other programs (such as primary health care) since TOP services were not deemed a priority. In other situations, women had to wait until the TOP doctors returned from sick leave before obtaining an abortion, which was distressing, and respondents felt that this increased provider workload (54),(59).

In a study to assess the quality of the structure of CTOP services in public health facilities in Gauteng province, managers and professional nurses/midwives had different opinions about the structure of the health facilities. With 50% of managers indicating that the space for rendering CTOP services was enough to allow for the delivery of quality and safe services, 68.5% of nurses found the space inadequate; 85% of the managers reported that the CTOP unit was not well-ventilated, while 68.5% of the nurses agreed it was the case. When questioned about staffing, 53.9% of managers said enough professionals were allocated to TOP units, while 75% of the nurses felt the TOP units did not have enough staff. However, when asked about the equipment, there was no difference in the opinions of managers and nurses, approximately 40% of them agreed that the equipment available was not enough (61).

4.4.3 Context-specific service-delivery approaches

Mobile health services

The South African health system has mobile health services available. With the majority engaged on HIV/AIDS, women's health, and children's health (62).

More recently, efforts have been made to use this technology to improve abortion services in the country. In 2014, a study was conducted in two health facilities in Cape Town to evaluate the feasibility of mobile health technology approaches to calculate gestational age. In the pilot study, 90% of women found the online gestational age calculator easy to use, 86% believed in its accuracy, and 94% found it helpful (63).

Another study was conducted to assess the feasibility and efficacy of text messages to instruct women through medical abortion and family planning information. About 97.9% of the women reported that the text messages helped them through medical abortion, and 85% of women found the family planning information useful, especially as a reminder to take their contraception pills (64).

In a randomized controlled trial, the authors assessed the efficacy of computerized text messages in reducing anxiety and pain and informing women undergoing medical abortions about the symptoms they may feel. The authors found that the text message intervention decreased women's anxiety and emotional stress. Most women (98%) said that the messages supported them throughout the TOP process and that they would suggest it to a friend. Thus, the authors concluded that text messages sent after the ingestion of abortion pills could benefit women having a medical abortion in controlling their symptoms (65).

Telemedicine

In 2020, the Marie Stopes Institute, a non-profit provider of services related to sexual and reproductive health, launched a telemedicine service channel to give access to safe abortions during the COVID-19 pandemic. At first, the services were provided by the organization's clinic nurses, but more recently, telemedicine hubs with specialized telehealth medical staff have been made accessible in Cape Town and Sandton (in the Western Cape and Gauteng provinces, respectively). There was an option to have a package sent or picked up. The package included *Mifepristone, Misoprostol,* a pregnancy test, a brochure with instructions and aftercare information, and analgesics. However, there have been some reported difficulties, including: (1) a preference for face-to-face services; (2) logistical delays in package

delivery; (3) challenges getting written informed consent; and (4) challenges calculating the gestational age as some clients did not know their date of last period (66).

A randomized clinical trial was carried out between 2020 and 2021 to evaluate the efficacy and acceptability of a modified telemedicine technique for abortion. In the telemedicine group, 95.4% of the women underwent full abortions, compared to 96.6% of the women receiving conventional treatment. *Endler et al*. found that, in terms of effectiveness, safety, adherence, or satisfaction, online consultation and instruction for medical abortion and self-management of abortion at home were equivalent to in-clinic conventional abortion care (67).

5. Discussion

This literature identified several barriers and facilitators that women encounter when seeking TOP services in the public health system in the RSA. The barriers and facilitators were identified at the level of health providers, services provided, and where and how abortion services are delivered. The following discussion will cover the main barriers and facilitators found and will explore key strategies that might be implemented to improve abortion care services in South Africa.

Abortion-related stigma seems to play a huge influence on the quality of care of abortion services. Its influence can be seen at various levels, including the providers and leadership. At the leadership level, there seems to be a lack of will to improve the quality of care. There is a shortage of health providers, inefficient supply chain management, a shortage of commodities, and an incorrect practice of conscientious objection. These are elements that require good leadership and management to be addressed. Another factor that reiterates that is the fact that the country had its first national guideline for CTOPA more than 20 years after the legalization of abortion. Before that, the only guideline available and used by many health facilities was the guideline of the Western Cape DoH.

At the level of providers, the literature demonstrated objections to performing TOP as well as to providing analgesics for pain management. Knowledge about the correct practice of conscientious objection seems to be limited among health providers. They frequently fail to provide other TOP package services and refer women to other health facilities to obtain the services. The discrimination does not occur only from providers to clients, but also between providers or other cadres and TOP providers. Because of it, some providers refuse to perform TOP or to work in abortion services, worsening even more the problem of a shortage of workers.

The WHO recommends the participation of other health workers (not only medical doctors and nurses/midwives) for the provision of some services in the abortion package. There is no evidence of the role of community health workers and pharmacists in the RSA.

Another recommendation of the WHO is self-management of abortion. In the RSA, this topic is highly debated among TOP providers. Some believe that women should not self-manage abortion, while others defend it as a way of empowering women. Self-management of

abortion requires a permissive law, an accepting health system, and supportive health professionals; otherwise, it may remain the privilege of those who find out how to do it safely. Even in developed settings such as Great Britain, where abortion has been legally available for just over 50 years, health professionals are sceptical about the idea of women self-managing abortion. The evidence of women's experiences with abortion self-management is limited. However, in a qualitative evidence synthesis of countries with liberal and restrictive laws, some women preferred this method due to its convenience and the possibility of having the support of their loved ones, but the opposite was also found. Some women were not sure when the process was completed or how they could manage a complication in case they encountered one (57). Nevertheless, women should have the right to choose among the different available options.

Another barrier that women encounter on their pathway to abortion care is the unavailability of commodities. To meet the demand for abortion services, the chain supply management system appears inefficient. The literature illustrated a shortage of abortifacients, contraception, and equipment in some health facilities. The shortage of abortifacients limits the right of women to choose a TOP method according to their preferences. Some health facilities did not have the contraception packages integrated into their abortion services; consequently, women had to be referred to other facilities to obtain contraception. It prevented them from starting contraception right away, as it implied traveling to another facility, booking an appointment, and perhaps facing financial hardships as there are extra costs involved. Similarly, evaluations conducted in seven different regions of the world concluded that postabortion counseling and contraceptive services were usually missing in abortion services, despite the fact that it is well known that access to these services is crucial to reducing unintended pregnancy (70).

Regarding the availability and accessibility of information, the literature has shown a large amount of knowledge about the abortion law among women and health providers in South Africa; however, there is a knowledge gap among both women and health providers about the correct practice of conscientious objection and the obligation to refer women to another health facility to obtain the services.

Moreover, the literature has evidenced that women recognize the symptoms and signs of pregnancy late, suggesting a limited knowledge of sexual and reproductive health. This is one of the main reasons why so many women have abortions in the second trimester: they wait too long to get help.

In terms of service delivery approaches in the country, there was evidence of evaluation and implementation of other models to improve abortion services and make TOP more convenient and pleasant. However, it is important to evaluate the feasibility and sustainability of these models and adjust them to the different settings of the country. Telemedicine was recently added to the WHO recommendations as an alternative to an in-person appointment. Telemedicine could be convenient in a setting where women have to travel long distances, such as in rural areas. Despite some logistical constraints, these models are well accepted among women seeking abortion care in the RSA. In the United States of America, this modality has been reported to be very useful because it alleviates women's problems with logistical arrangements such as taking time off from work, finding childcare and company, traveling long distances, and other arrangements required for in-facility abortions. Not to mention the comfort and privacy (71).

Relevance of the framework

To the best of my knowledge, this thesis is one of the first to use this new framework to assess the health system for abortion care in the RSA. The framework proved to be effective for analyzing the health system's barriers and facilitators. It could be because the centerpiece of this framework is the health system. Nevertheless, the framework does not allow for the analysis of important factors at the community level, such as socio-cultural factors and stigma, which have a huge influence.

Limitations

This thesis is not without limitations. Throughout the presentation of the results, the barriers are more emphasized than the facilitators. This is probably because of the tendency to identify problems. However, some facilitators have been identified.

There was no specific information found about the financing of abortion services. However, general information about health financing is provided in the background chapter.

Evidence was scarce in many areas of the country, especially in rural areas, and the information gathered came mainly from the same provinces (Gauteng and the Western Cape).

Information related to places where abortion should be provided (primary health facilities, community health centers, etc.) was not disaggregated by different levels of health facilities in most studies, as the framework requires. Finally, no evidence was found among the vulnerable population.

The data limitation could have been avoided if another method to triangulate the information had been used. Unfortunately, this constraint was not anticipated.

6. Conclusion and Recommendations

The literature identified both barriers and facilitators, although barriers were more prominent. The results found demonstrate that legalization is not enough. Effective abortion access initiatives must be carefully planned, strategically executed, and routinely monitored and reviewed. A coordinated national effort to improve abortion education and service delivery is required, involving the public and private sectors, the provincial DoH's, research institutions, and nongovernmental health organizations.

The country has a national guideline for CTOPA in place, a clear pathway for abortion services within the health system, a referral mechanism, and TOP services provided at no cost; however, the health system needs some adjustments in relation to the health workforce and their attitudes, commodities, and supply chain management to create an enabling environment for comprehensive abortion care that meets women's needs and preferences.

6.1 Recommendations:

1. The CTOPA as well as the providers and facilities authorized to provide TOP should be made universally known to health professionals, policymakers, women, and the population at large. The act should be part of the curriculum of health professionals' training. For women and the general population, it could be by using social media as a tool and through lectures in the community and schools. The provincial DoH's can launch awareness campaign in each province.
2. Inform women and the general community about the availability of free abortion services in the public health sector and educate them on sexual and reproductive health so women can learn to prevent pregnancy, identify early signs of pregnancy, and understand the risks of unsafe methods of TOP. It could be through lectures or workshops in the community and at school; counselling, curriculum-based lessons, and social media. It is also important to address stigma related to abortion. Values clarification workshops in the community should also be conducted to address socio-cultural values and stigma around abortion.
3. Develop more evidence on women's and their partners' experience and preferences related to safe abortion care in the RSA and strengthen abortion services to meet the preferences and needs of women.

4. Strengthening the health system’s capacity by increasing the workforce, especially in areas with unmet needs. It is important that DoH destigmatize working in TOP services.
5. Regular training on values clarification is needed to address stigma and bias among policymakers, decision-makers, managers, health professionals, and community health workers.
6. Ensure the implementation of the national guidelines for TOP and the practice of conscientious objection throughout the country. Develop tools to conduct regular monitoring and evaluation at the abortion care services and ensure that the guidelines are systematically revised to incorporate updated recommendations and evidence-based information.
7. Enhance the supply chain management of abortifacients, pain medications, and equipment procurement: stablish a pull system that gives each facility a line of credit to purchase high-quality medicines at low cost, improve the distribution network, develop efficient tools to optimize stock control, and if not already in place, create a supply chain council dedicated to abortion services.

7. References

1. World Health Organization. Abortion Care Guideline [Internet]. Geneva; 2022. 170 p. Available from: https://www.who.int/publications/i/item/9789240039483

2. World Health Organization. Safe abortion: technical and policy guidence for health systems [Internet]. 2nd ed. Geneva; 2012 [cited 2023 Feb 13]. Available from: https://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf

3. World Health Organization. 2021 Nov [cited 2022 Mar 25]. Available from: https://www.who.int/news-room/fact-sheets/detail/abortion

4. Mackenzie R. Fritz, Kathy L. Guthrie. Values clarification: Essential for leadership learning. Jole [Internet]. 2017 [cited 2023 Jun 2];16(1):17. Available from: https://journalofleadershiped.org/jole_articles/values-clarification-essential-for-leadership-learning/#:~:text=Values%20clarification%20is%20an%20on,process%20of%20defining%20one's%20values.

5. Harries J, Constant D. Providing safe abortion services: Experiences and perspectives of providers in South Africa. Best Practice & Research Clinical Obstetrics & Gynaecology [Internet]. 2020 Jan 1;62:79–89. Available from: https://www.sciencedirect.com/science/article/pii/S1521693419300483

6. Government of South Africa. Geography and climate [Internet]. 2022 [cited 2022 Sep 13]. Available from: https://www.gov.za/about-sa/geography-and-climate#land

7. Google maps. South Africa Google Map [Internet]. Driving Directions & Maps. 2023 [cited 2023 Feb 13]. Available from: https://www.drivingdirectionsandmaps.com/south-africa-google-map/

8. Vigne R. Encyclopedia Britannica [Internet]. 2022 [cited 2022 Aug 31]. Available from: https://www.britannica.com/place/South-Africa

9. Oliver E, Oliver WH. The Colonisation of South Africa: A unique case. HTS Theological Studies. 2017;73:1–8.

10. Government of South Africa. 2022 [cited 2022 May 9]. Available from: https://www.gov.za/about-sa/history

11. World Bank. World Bank Open Data [Internet]. 2022 [cited 2022 Sep 9]. Available from: https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=ZA

12. Department of statistics of South Africa. Economic growth [Internet]. Stats SA. 2022 [cited 2023 Feb 14]. Available from: https://www.statssa.gov.za/?p=15991#:~:text=After%20contracting%20by%200%2C7,expanding%20by%201%2C6%25.&text=The%20agriculture%2C%20finance%2C%20transport%20and,supply%20side%20of%20the%20economy.

13. The World Bank. The World Bank in South Africa [Internet]. 2022 [cited 2023 Feb 14]. Available from: https://www.worldbank.org/en/country/southafrica/overview

14. World bank. Poverty & Equity Brief- Sub-Saharan Africa South Africa [Internet]. South Africa: World bank; 2020 p. 2. Available from: https://databankfiles.worldbank.org/public/ddpext_download/poverty/33EF03BB-9722-4AE2-ABC7-AA2972D68AFE/Global_POVEQ_ZAF.pdf

15. Rpublic of south Africa. South Africa's youth continues to bear the burden of unemployment. [Internet]. Statistics SA. 2022 [cited 2023 Feb 14]. Available from: https://www.statssa.gov.za/?p=15407

16. Government of South Africa. About South Africa- Education [Internet]. 2016 [cited 2022 Aug 9]. Available from: https://www.gov.za/about-sa/education

17. Khuluvhe M. Adult illiteracy in South Africa [Internet]. Department of Higher Education and Training; 2022 [cited 2023 Jan 25]. Available from: https://www.dhet.gov.za/Planning%20Monitoring%20and%20Evaluation%20Coordination/Fact%20Sheet%20-%20Adult%20illiteracy%20in%20South%20Africa_March%202022.pdf

18. UNICEF. Education - South Africa [Internet]. 2012. Available from: https://www.unicef.org/southafrica/education

19. South African Government. Health [Internet]. 2022 [cited 2022 Aug 9]. Available from: https://www.gov.za/about-sa/health

20. World Health Organization. Abortion Health Profile -South Africa [Internet]. 2019 [cited 2022 Sep 7]. Available from: https://www.afro.who.int/publications/who-african-regions-countries-abortion-health-profiles

21. NDP. South African Maternal, Perinatal, and Neonatal Health Policy [Internet]. 2021 [cited 2023 Jan 25]. Available from: https://www.knowledgehub.org.za/system/files/elibdownloads/2021-06/SA%20MPNH%20Policy%2023-6-2021%20signed%20Web%20View%20v2.pdf

22. World Health Organization. Neonatal Mortality Rate [Internet]. 2022 [cited 2023 Jan 25]. Available from: https://www.who.int/data/gho/data/themes/topics/sdg-target-3_2-newborn-and-child-mortality

23. Columbia Public health. South Africa- Summary [Internet]. Comparative Health Policy Library. 2019 [cited 2023 Jan 13]. Available from: https://www.publichealth.columbia.edu/research/comparative-health-policy-library/south-africa-summary

24. Health Systems Trust. The National Health Care Facilities Baseline Audit -National Summary Report [Internet]. South Africa; 2012 [cited 2023 Jan 17] p. 59. Available from: https://www.hst.org.za/publications/HST%20Publications/NHFA_webready_0.pdf

25. World Health Organization. Health Expenditure Profile- South Africa [Internet]. [cited 2023 Jan 13]. Available from: https://apps.who.int/nha/database/country_profile/Index/en

27. World Health Organization. Global health estimates: Leading causes of DALYs [Internet]. 2022 [cited 2023 Jan 14]. Available from: https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/global-health-estimates-leading-causes-of-dalys

28. UNAIDS. Country FactSheets- South Africa 2021 [Internet]. 2021 [cited 2023 Jan 16]. Available from: https://www.unaids.org/en/regionscountries/countries/southafrica

29. Kaswa R, Yogeswaran P. Abortion reforms in South Africa: An overview of the Choice on Termination of Pregnancy Act. South African Family Practice; Vol 62, No 1 (2020): Part 4 [Internet]. 2020; Available from: https://safpj.co.za/index.php/safpj/article/view/5240

30. Favier M, Greenberg JMS, Stevens M. Safe abortion in South Africa: “We have wonderful laws but we don’t have people to implement those laws.” International Journal of Gynecology & Obstetrics [Internet]. 2018 Oct 1 [cited 2022 Aug 31];143(S4):38–44. Available from: https://doi.org/10.1002/ijgo.12676

31. Government Gazette. CHOICE ON TERMINATION OF PREGNANCY AMENDMENT BILL. Creda Communications; 2017.

32. Republic of South Africa. Choice on Termination of Pregnanct Act. 1996.

33. World Health Organization. Worldwide, an estimated 25 million unsafe abortions occur each year [Internet]. 2017 Sep [cited 2022 Mar 25]. Available from: https://www.who.int/news/item/28-09-2017-worldwide-an-estimated-25-million-unsafe-abortions-occur-each-year

34. Khan KS, Wojdyla D, Say L, Gülmezoglu AM, Van Look PF. WHO analysis of causes of maternal death: a systematic review. Lancet. 2006 Apr 1;367(9516):1066–74.

35. Rehnström Loi U, Gemzell-Danielsson K, Faxelid E, Klingberg-Allvin M. Health care providers’ perceptions of and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia: a systematic literature review of qualitative and quantitative data. BMC Public Health [Internet]. 2015 Feb 12;15(1):139. Available from: https://doi.org/10.1186/s12889-015-1502-2

36. Harries J, Cooper D, Strebel A, Colvin CJ. Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. Reprod Health. 2014 Feb 26;11(1):16.

37. de Vries I, van Keizerswaard LJ, Tolboom B, Bulthuis S, van der Kwaak A, Tank J, et al. Advocating safe abortion: outcomes of a multi-country needs assessment on the potential role of national societies of obstetrics and gynecology. International Journal of Gynecology & Obstetrics [Internet]. 2020 Mar 1 [cited 2022 Mar 21];148(3):282–9. Available from: https://doi.org/10.1002/ijgo.13092

38. Burtscher D, Schulte-Hillen C, Saint-Sauveur JF, De Plecker E, Nair M, Arsenijević J. “Better dead than being mocked”: an anthropological study on perceptions and attitudes towards unwanted pregnancy and abortion in the Democratic Republic of Congo. null [Internet]. 2020 Jan 1;28(1):1852644. Available from: https://doi.org/10.1080/26410397.2020.1852644

39. UN_ohchr. Abortion [Internet]. 2020 [cited 2022 Mar 25]. Available from: https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf

40. Amnesty International. Barriers to safe and legal abortion in South Africa [Internet]. Amnesty international publications; 2017 [cited 2022 Sep 22]. Available from: https://www.amnesty.org/en/documents/afr53/5423/2017/en/

41. Lince-Deroche N, Harries J, Constant D, Morroni C, Pleaner M, Fetters T, et al. Doing more for less: identifying opportunities to expand public sector access to safe abortion in South Africa through budget impact analysis. Contraception [Internet]. 2018 Feb 1 [cited 2023 Jan 20];97(2):167–76. Available from: https://doi.org/10.1016/j.contraception.2017.07.165

42. Ipas. HOW TO IMPROVE SAFE ABORTION CARE IN SOUTH AFRICA’S PUBLIC HEALTH FACILITIES. USA: Ipas; 2018 p. 10.

43. National Department of Health. NATIONAL CLINICAL GUIDELINE FOR IMPLEMENTATION OF THE CHOICE ON TERMINATION OF PREGNANCY ACT. 1st ed. Pretoria, Republic of South Africa: National Department of Health; 2019. 38 p.

44. Harries J, Gerdts C, Momberg M, Greene Foster D. An exploratory study of what happens to women who are denied abortions in Cape Town, South Africa. Reproductive Health [Internet]. 2015 Mar 21;12(1):21. Available from: https://doi.org/10.1186/s12978-015-0014-y

45. Birdsey G, Crankshaw TL, Mould S, Ramklass SS. Unmet counselling need amongst women accessing an induced abortion service in KwaZulu-Natal, South Africa. Contraception [Internet]. 2016 Nov 1 [cited 2023 Jan 20];94(5):473–7. Available from: https://doi.org/10.1016/j.contraception.2016.07.002

46. Somefun OD, Harries J, Constant D. Reproductive awareness and recognition of unintended pregnancy: young women, key informants and health care providers perspectives in South Africa. Reproductive Health [Internet]. 2021 Oct 26;18(1):211. Available from: https://doi.org/10.1186/s12978-021-01262-0

47. HARRIES J, LINCE N, CONSTANT D, HARGEY A, GROSSMAN D. THE CHALLENGES OF OFFERING PUBLIC SECOND TRIMESTER ABORTION SERVICES IN SOUTH AFRICA: HEALTH CARE PROVIDERS’ PERSPECTIVES. Journal of Biosocial Science [Internet]. 2011/11/17 ed. 2012;44(2):197–208. Available from: https://www.cambridge.org/core/article/challenges-of-offering-public-second-trimester-abortion-services-in-south-africa-health-care-providers-perspectives/948D697009337DADB5666008C6729749

48. Harries J, Daskilewicz K, Bessenaar T, Gerdts C. Understanding abortion seeking care outside of formal health care settings in Cape Town, South Africa: a qualitative study. Reprod Health. 2021 Sep 23;18(1):190.

49. Sullivan ME, Harrison A, Harries J, Sicwebu N, Rosen RK, Galárraga O. Women's reproductive decision making and abortion experiences in Cape Town, South Africa: A qualitative study. Health Care for Women International [Internet]. 2018 Nov 2;39(11):1163–76. Available from: https://doi.org/10.1080/07399332.2017.1400034

50. Baffour-Duah K, Olorunfemi G, Shimange-Matsose L. Pre- and intra -COVID-19 trends of contraceptive use among women who had termination of pregnancy at Charlotte Maxeke Johannesburg Academic Hospital, Johannesburg South Africa (2010-2020). PLoS One. 2022;17(12):e0277911.

51. M Netshinombelo, Maputle M, Ramathuba D. Women's Perceived Barriers to Accessing Post-Abortion Care Services in Selected Districts in KwaZulu Natal Province, South Africa: A Qualitative Study. Annals of Global Health. 2022;1–12.

52. Wheeler SB, Zullig LL, Reeve BB, Buga GA, Morroni C. Attitudes and intentions regarding abortion provision among medical school students in South Africa. Int Perspect Sex Reprod Health. 2012 Sep;38(3):154–63.

53. Western Cape Department of Health. Policy Guidelines and Protocols for Choice on Termination of Pregnancy Service. Department of Health; 2016.

54. Teffo ME, Rispel LC. 'I am all alone': factors influencing the provision of termination of pregnancy services in two South African provinces. null [Internet]. 2017 Jan 1;10(1):1347369. Available from: https://doi.org/10.1080/16549716.2017.1347369

55. Gerdts C, Raifman S, Daskilewicz K, Momberg M, Roberts S, Harries J. Women's experiences seeking informal sector abortion services in Cape Town, South Africa: a descriptive study. BMC Women's Health [Internet]. 2017 Oct 2;17(1):95. Available from: https://doi.org/10.1186/s12905-017-0443-6

56. Sneeringer RK, Billings DL, Ganatra B, Baird TL. Roles of pharmacists in expanding access to safe and effective medical abortion in developing countries: A review of the literature. Journal of Public Health Policy [Internet]. 2012 May 1;33(2):218–29. Available from: https://doi.org/10.1057/jphp.2012.11

57. Wainwright M, Colvin CJ, Swartz A, Leon N. Self-management of medical abortion: a qualitative evidence synthesis. Reprod Health Matters. 2016 May;24(47):155–67.

58. HEARD. Unsafe Abortion in South Africa: Fact Sheets [Internet]. Durban: HEARD; 2016 [cited 2023 Jan 17] p. 4. Available from: https://www.heard.org.za/wp-content/uploads/2016/06/south-africa-country-factsheet-abortion-20161.pdf

59. Kaswa R. Barriers to access second-trimester abortion: A case report. South African Family Practice; Vol 63, No 1 (2021): Part 1 [Internet]. 2021; Available from: https://safpj.co.za/index.php/safpj/article/view/5028

60. HowToUseAbortionPill. Abortion Laws in South Africa [Internet]. [cited 2023 Jan 27]. Available from: https://www.howtouseabortionpill.org/abortion-laws-by-country/southAfrica/

61. Nkosi L, Mulaudzi F, Peu M. Challenges Related to the Structure of the Choice on Termination of Pregnancy Services in Public Health Facilities in the Tshwane District of Gauteng. African journal of reproductive health. 2020 Mar 1;24:106–14.

62. Ojo AI. mHealth Interventions in South Africa: A Review. SAGE Open [Internet]. 2018 Jan 1 [cited 2023 Jan 29];8(1):2158244018767223. Available from: https://doi.org/10.1177/2158244018767223

63. Momberg M, Harries J, Constant D. Self-assessment of eligibility for early medical abortion using m-Health to calculate gestational age in Cape Town, South Africa: a feasibility pilot study. Reproductive Health [Internet]. 2016 Apr 16;13(1):40. Available from: https://doi.org/10.1186/s12978-016-0160-x

64. de Tolly KM, Constant D. Integrating Mobile Phones into Medical Abortion Provision: Intervention Development, Use, and Lessons Learned From a Randomized Controlled Trial. JMIR Mhealth Uhealth [Internet]. 2014 Feb 14;2(1):e5. Available from: http://mhealth.jmir.org/2014/1/e5/

65. Constant D, de Tolly K, Harries J, Myer L. Mobile phone messages to provide support to women during the home phase of medical abortion in South Africa: a randomised controlled trial. Contraception [Internet]. 2014 Sep 1;90(3):226–33. Available from: https://www.sciencedirect.com/science/article/pii/S0010782414001930

66. Chinogwenya W. Self-Managed Termination of Pregnancy via Telemedicine: Making safe abortion services available during the Covid-19 Pandemic [Internet]. [cited 2023 Jan 27]; South Africa. Available from: https://www.rhsupplies.org/fileadmin/uploads/rhsc/Uploads/Other/SELF_MANAGED_ABORTIONS_Marie_Stopes.pdf

67. Endler M, Petro G, Gemzell Danielsson K, Grossman D, Gomperts R, Weinryb M, et al. A telemedicine model for abortion in South Africa: a randomised, controlled, non-inferiority trial. The Lancet [Internet]. 2022 Aug 27;400(10353):670–9. Available from: https://www.sciencedirect.com/science/article/pii/S014067362201474X

68. Berer M. Reconceptualizing safe abortion and abortion services in the age of abortion pills: A discussion paper. Best Practice & Research Clinical Obstetrics & Gynaecology [Internet]. 2020 Feb 1;63:45–55. Available from: https://www.sciencedirect.com/science/article/pii/S1521693419301166

69. Aiken ARA, Guthrie KA, Schellekens M, Trussell J, Gomperts R. Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain. Contraception. 2018 Feb;97(2):177–83.

70. Faundes A, Comendant R, Dilbaz B, Jaldesa G, Leke R, Mukherjee B, et al. Preventing unsafe abortion: Achievements and challenges of a global FIGO initiative. Best Practice

& Research Clinical Obstetrics & Gynaecology [Internet]. 2020 Jan 1;62:101–12. Available from: https://www.sciencedirect.com/science/article/pii/S1521693419300793

71. Aiken ARA, Starling JE, Gomperts R. Factors Associated With Use of an Online Telemedicine Service to Access Self-managed Medical Abortion in the US. JAMA Netw Open. 2021 May 3;4(5):e2111852.