



# HOW TO IMPROVE SAFE ABORTION CARE IN SOUTH AFRICA'S PUBLIC HEALTH FACILITIES

*Findings from a 2018 assessment*



## Unsafe abortion in South Africa: A persistent problem

Despite the fact that abortion is legal in South Africa under a range of circumstances and available in public health facilities throughout the country, many women and girls continue to seek clandestine, unsafe abortions that put their health and lives at risk.

Abortion-related stigma and competing public health priorities have resulted in abortion care being under-resourced and pushed to the margins of public-sector maternal health care. The public's broad mistrust of public sector health care and an expectation of low-quality care also prevent women and girls from seeking public-sector abortion and contraceptive services.

## Ipas in South Africa

The 1996 Choice of Termination of Pregnancy Act (CTOPA) gave women and girls in South Africa the right to abortion under certain conditions before 20 weeks of pregnancy. From 1995-2014, Ipas worked alongside partners to support full implementation of CTOPA, in collaboration with the National Department of Health and several provincial health



departments. Despite successes in making abortion more widely available, high-quality safe abortion services remain inaccessible to many South African women and girls. In 2014, an Amnesty International report found that fewer than 50% of public health facilities designated to offer safe abortion were actually providing the service.

3 factsheets present our strategic assessment findings from:

- Group discussions with women
- Participatory research methods
- In-depth interviews with abortion providers and health system managers



Ipas returned to South Africa in 2017, committed to finding the best ways to work with previous and new partners at the national and provincial levels to ensure all women and girls can access high-quality safe abortion care. We identified Limpopo and Gauteng Provinces as good locations to begin programming due to an acute need for expanded public-sector safe abortion services—especially for hard-to-reach women and girls.

## Assessing needs and opportunities

To ensure well-informed program design and solid support and engagement from program stakeholders and beneficiaries, Ipas conducted a strategic assessment on abortion in Limpopo and Gauteng Provinces in 2018, guided by three objectives:

1. Inform the development of interventions to increase women's and girls' confidence in safe abortion services at public facilities, as well as their knowledge and use of these services.

2. Identify barriers and facilitators to providing high-quality abortion care in public facilities.
3. Determine Ipas's potential to add value to public-sector safe abortion care at the provincial and national levels.

The accompanying factsheets present recommendations and key findings compiled from various information-gathering methods used in our assessment.

## Ipas's mission

Ipas works globally to improve access to safe abortion and contraception so that every woman and girl can determine her own future. Across Africa, Asia and Latin America, we work with partners to make safe abortion and contraception widely available, to connect women with vital information so they can access safe services, and to advocate for safe, legal abortion.



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# FACTSHEET: FINDINGS FROM GROUP DISCUSSIONS WITH WOMEN



*Improve the patient experience, reduce abortion stigma, fight unsafe abortion with activism*



Ipas's 2018 assessment of public-sector safe abortion care in Limpopo and Gauteng Provinces included small-group conversations with women of reproductive age. The discussions revealed many opportunities to better prevent unplanned pregnancy and unsafe abortion—primarily by addressing barriers that keep women from accessing public-sector contraceptive and safe abortion care.

## Recommendations

Discussions with women yielded dominant themes that were similar across communities and provinces, leading Ipas to identify the following recommendations for improving public-sector safe abortion care for South African women and girls.

- **Improve the patient experience at health facilities:** Some health worker attitudes and their treatment of patients seeking contraception and abortion in public facilities must be improved so women can trust they will not be judged or ridiculed for trying to access these services.
- **Reduce stigma so women don't fear seeking care:** Stigma surrounding abortion, contraception and sexuality creates an environment in which women often lack the social support they need to make and act on their own decisions about sexual and reproductive health.

- **Fight unsafe abortion with education and activism:** Communities need more information on the dangers of unsafe abortion so that women will be less likely to resort to risking their health and lives with an untrained, backstreet abortion provider or by using other clandestine, unsafe methods. Civil society, community partners and activists should build broad alliances to stop exploitative backstreet providers.
- **Increase number of safe abortion providers and facilities:** Growing the number of designated public-sector facilities providing safe abortion care and the number of trained providers would greatly increase women's access to this care—especially in Limpopo Province, where many women must travel great distances to reach a public health center that provides abortion care.

## Our method

In order to learn about women's opinions, attitudes, perceptions and experiences related to abortion, Ipas researchers facilitated 20 small-group discussions with women of reproductive age (16-44 years old). Each small group contained three women from Gauteng and Limpopo Provinces and a facilitator who used a semi-structured question guide. To create an environment in which women would feel comfortable expressing themselves on what are often controversial

issues, Ipas formed each group by recruiting one woman willing to discuss abortion and contraception and then asking her to recruit two friends also willing to engage in discussion.

"I can say that the issue that our children would choose to go and risk their lives with illegal abortions is that the treatment they get in our facilities, such as clinics and hospitals, is not ok. Our kids find themselves in situations where they are ridiculed and don't know how they can get help."

– Woman from Gauteng Province

## Key findings

### 1. Teenage pregnancy is a widespread problem.

Of the health problems women discussed, teenage pregnancy was the most commonly reported, followed by HIV/AIDS and sexually transmitted diseases. Women also identified other frequently discussed problems—such as rape, intimate partner violence, alcohol use, low contraceptive use, peer pressure for women to prove their fertility, and poverty—as causes of teenage pregnancy. Participants described poverty and unemployment as contributing to young women's decision to trade sex for money or support from men. Contraceptive use was reported as low due to lack of knowledge, conscious decisionmaking not to use a method, and poor provider attitudes and counseling on methods at public facilities—particularly affecting young women.

### 2. Women know safe abortion is legal and available, but are also aware of many unsafe options.

While all women knew public facilities offer safe abortion services, there were mixed opinions on the quality of those services, and participants consistently questioned women's likeliness to choose public facilities for this service over the many other (potentially unsafe) options available:

- *Traditional healers* who provide herbal drinks and medications were considered to be the preferred choice of older women, but also visited by young women.

- *Homemade solutions* for self-induction were more commonly reported than traditional healers and included obtaining unknown pills from a pharmacy, using a crotchet needle, and drinking things like laxatives, sulphuric chloride, bleach, or herbal beverages.
- *Backstreet abortion providers* are prevalent and women explain they are frequently chosen over public facilities despite their high cost because copious posters at bus and taxi stands advertise services as painless, confidential and quick. Women often reported these backstreet providers to be foreigners whom women contact via phone or WhatsApp. While participants varied on how safe they believed these services to be, many reported stories of rape by backstreet providers and of women who suffered health complications from a backstreet procedure.

### 3. A perception of poor treatment and lack of confidentiality at public facilities is a top barrier.

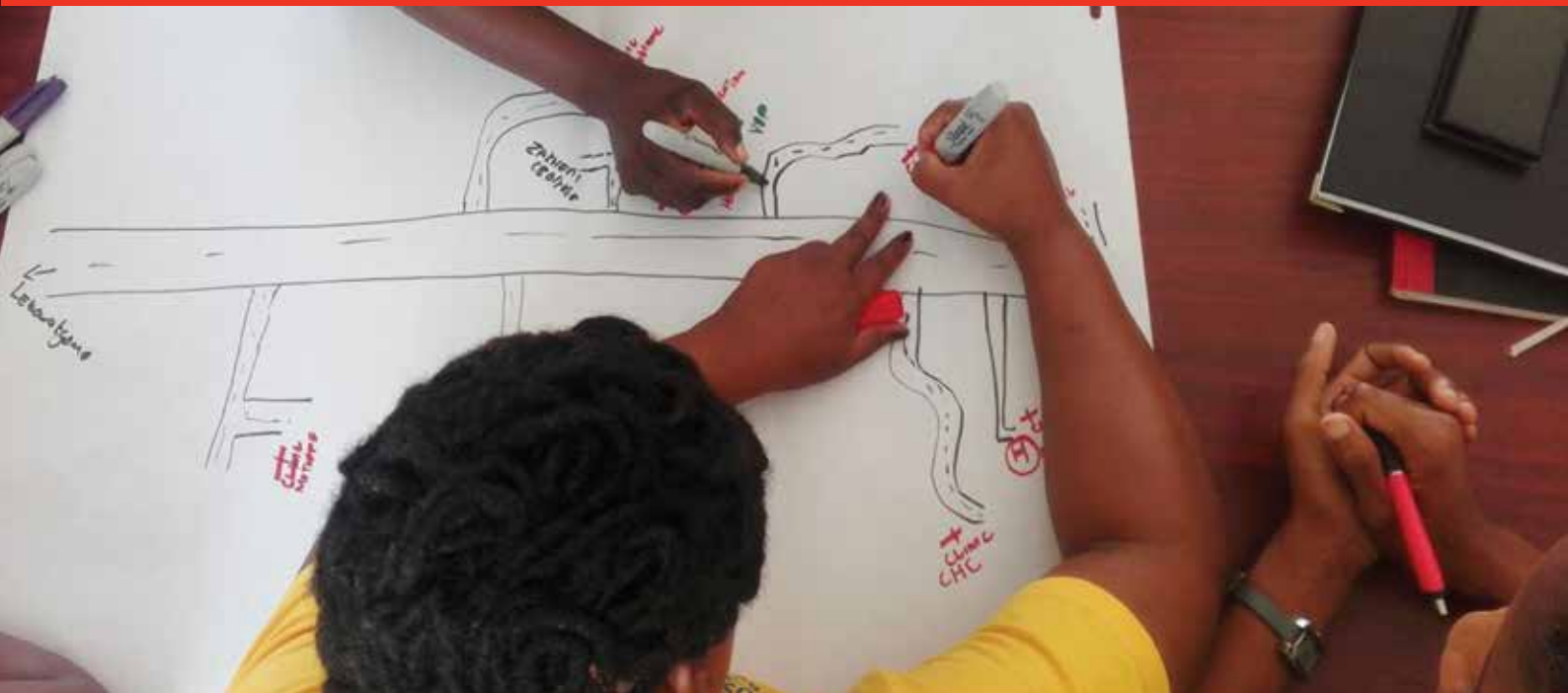
Women described health workers' judgmental attitudes, neglect of patients and rude, disrespectful behavior—especially toward young and/or unmarried women—as a primary reason why women resort to unsafe abortion. Poor treatment was also reported as a barrier for young women trying to access contraception. Further, women cited fear of being "exposed" while seeking public-sector abortion care. Women feared being recognized by community members who would spread the word, and feared that providers would not keep their information confidential. Unique to Limpopo Province was also the issue of scarce facilities offering abortion care and the need to travel great distances to reach services.

### 4. Abortion stigma is prevalent and powerful.

Abortion-related stigma is deeply felt in these communities, and women explained that while some community members may understand women's reasons to choose abortion, most will not support them. Participants frequently reported discrimination, rejection and gossip directed at women who have abortions, as well as fear that women who have unsafe abortions become infectious.



# FACTSHEET: FINDINGS FROM PARTICIPATORY RESEARCH METHODS



*Ensure nonjudgmental care, educate communities, and build leadership on safe abortion*



Ipas's 2018 assessment of public-sector safe abortion care in Limpopo and Gauteng Provinces included participatory research methods with women of reproductive age. The responses women provided offer useful insight into the main reasons why women and girls often choose unsafe abortion options and how interventions could improve their access to and use of public-sector safe abortion services.

## Recommendations

Women who engaged in participatory research activities shared similar perspectives on the top barriers to accessing abortion care, leading Ipas to identify the following recommendations for improving public-sector safe abortion services for South African women and girls.

- **Ensure confidential, nonjudgmental, convenient abortion services:** There is widespread knowledge that abortion is legal and that safe services are available in public health facilities. However, community perceptions of poor-quality care at public facilities and pervasive fear of being stigmatized, judged and rejected for having an abortion are formidable barriers for women and girls. Consequently, many opt for unsafe abortion methods and backstreet providers who claim to offer desirable same-day, confidential and nonjudgmental services.
- **Build communities' ability to include abortion content in educational programs:** Community-based organizations and local media need to be able to integrate accurate information about safe abortion and contraception into their educational programs. Such programs should also highlight the dangers of unsafe abortion methods and backstreet providers, as well as offer women and girls support such as counseling, early pregnancy testing and/or gestational age self-assessment to encourage them to seek care earlier.
- **Strengthen leaders' ability and desire to improve abortion care:** South Africa needs leaders at every level—national, provincial, district and community—who are committed to improving public-sector safe abortion services and implementing health policies to the highest standard. While poor-quality care is a clear barrier for women and girls, many safe abortion providers are passionate and committed, and there are ample opportunities to support them in efforts to improve services.

## Our methods and findings

In order to learn about women's opinions, attitudes, perceptions and experiences related to abortion, Ipas researchers used a variety of participatory methods to facilitate 27 group activities, with group sizes of 3-20 participants. A total of 161

women from Gauteng and Limpopo Provinces participated, having been recruited by local community-based organizations; six men who were interested also joined. While only women and girls of reproductive age (16-44 years old) were targeted for recruitment, men and women above the desired age range were not turned away if they wished to participate. No adolescent women were successfully recruited. Group facilitators used the following four participatory activities, selected based on each group's unique characteristics.

**Method 1: Community resource mapping.** In this activity, participants create a map of local resources for sexual and reproductive health, including abortion. Participants identified and drew many sources of information about sexual and reproductive health in their communities, including police stations, health clinics, hospitals, schools, churches, libraries, bus stations and stops, and health department buildings.

**Method 2: Listing and ranking.** This activity allows participants to list, explain and then rank in order of importance and prevalence categories such as common health problems for women and girls, the role of men in sexual and reproductive health, options for women and girls facing unintended pregnancy, methods of contraception and abortion, and community sources of sexual and reproductive health information. Key findings included:

- All groups knew that safe abortion is legal and available at certain public health facilities.
- A consistently poor perception of health-care quality at public facilities was identified as a primary factor pushing women to seek abortion services elsewhere.
- Participants identified a great need in their communities for contraceptive services and information about modern methods of contraception.

**Method 3: Evaluation wheel.** This activity had participants identify and evaluate the key factors desired for a positive and acceptable health-care seeking experience at a public facility. Participants consistently identified four main factors:

- Respectful, nonjudgmental, positive and empathetic health-care providers

- Timely care without long wait times due to limited hours of operation and idling or insufficient staff
- Affordable and available medicines and contraceptive methods
- Privacy and confidentiality throughout and after care

Participants then rated their local health facilities against each of these factors. While rankings varied based on individuals' experiences, no factor was consistently ranked as being achieved by local health facilities. Consequently, backstreet abortion providers are able to exploit women's fears and perceptions of poor care at public facilities by aggressively advertising confidential, same-day abortions.

*"Even if you are in the process of [having an abortion procedure] ... [providers] will even make remarks about the fact that you will reap what you sow, and you will feel the pains."*

*– Woman from Gauteng Province*

**Method 4: Girl path.** In this activity, participants visually represented a woman's path to obtaining an abortion using words or pictures that indicate challenges women face in four distinct spheres: mental/emotional, family and peers, seeking care, and the actual health-care experience. Participants then discussed root causes and possible solutions for each.

Identified challenges included worry about being stigmatized, fear of judgement from providers, concern that family or friends would find out about an abortion, lack of sufficient health information and counseling, lack of social support for dealing with unintended pregnancy, long distances to health facilities, cost of transportation, and poor-quality health services. Participants recognized all these challenges as reasons women may delay seeking abortion care and resort to unsafe methods and backstreet providers.

# FACTSHEET: FINDINGS FROM IN-DEPTH INTERVIEWS WITH ABORTION PROVIDERS AND HEALTH SYSTEM MANAGERS



*Build commitment to safe abortion, improve efficiency of services, train and support providers*



Ipas's 2018 assessment of public-sector safe abortion care in Limpopo and Gauteng Provinces included in-depth interviews with safe abortion providers, facility managers and health system district managers. The information collected offers detailed insight into how interventions could dramatically improve the quality of public-sector safe abortion and contraceptive care, leading Ipas to identify the following recommendations for improving and increasing access to these services for South African women and girls.

## Recommendations

- **Build health department commitment to safe abortion:** As public-sector safe abortion services face serious threats to sustainability—such as lack of trained providers, lack of essential drugs for medical abortion, and health facility-level stigma—leadership is essential from the provincial and national departments of health to ensure recommended interventions are prioritized.
- **Increase number and efficiency of facilities offering abortion care:** Expanding the number of facilities, as well as the quality and efficiency of safe abortion services at these sites, is the most immediate action that can be taken to help reduce unsafe abortion in Limpopo and Gauteng Provinces. Addressing areas of inefficiency could greatly increase the number of women that facilities are able to serve. For example, eliminating providers' use of ultrasound for gestational dating of pregnancies under 10 weeks would greatly streamline services.
- **Train—and support—abortion providers:** Training for new abortion providers and refresher trainings for those with experience would increase the number of trained providers per facility and thereby increase women's access to services. Further, providers need improved and consistent support from district, provincial or Ipas staff in the form of regular debriefing retreats and in-person visits to health facilities so providers can share their problems and get help finding solutions. Stigma-reduction activities with all staff at abortion facilities would also help by reducing harassment of providers and bolstering their colleagues' support for the important work they're doing.
- **Ensure procurement of mifepristone and roll-out of medical abortion services:** Provincial health departments need support to procure a sustainable supply of mifepristone for medical abortion. Subsequently, abortion providers will

need support implementing recommended medical abortion regimens to allow for a roll-out of these services. Provincial health departments also need to monitor the introduction of medical abortion services and to document the impact and challenges.

## Our method

In order to better understand the various threats to the sustainability and quality of South Africa's public-sector safe abortion services, Ipas researchers conducted in-depth interviews with 32 safe abortion providers, 24 facility managers and seven district health system managers from a total of 30 designated safe abortion facilities in Limpopo and Gauteng Provinces. Researchers used two semi-structured interview guides to ask subjects about their experiences supporting or providing safe abortion services, the quality of the services, related challenges and successes, and the impact of making these services available. They also asked what kind of support interview subjects would like to receive from Ipas and the national and provincial departments of health, as well as administered a structured questionnaire to collect data on abortion services at each facility.

## Key findings

Health providers and managers in both provinces reported significant challenges to providing quality safe abortion services and meeting client demand.

- 1. The shortage of trained safe abortion providers is a principal challenge.** This results in women not being able to access services because of high demand and long waits for appointments—plus some facilities designated to provide abortion care do not offer any services. Only 10% of providers interviewed felt there were enough trained abortion providers at their facility. Only 43% of providers in Gauteng Province and 80% in Limpopo Province worked at facilities that offer abortion services at least five days per week during all outpatient hours. The provider shortage, combined with no apparent succession plan to train and replace retiring providers, leads to high workloads for abortion providers and a high likelihood of burnout.
- 2. Inefficient service delivery causes long waits for appointments.** Medical abortion, which requires less health provider time and fewer clinic resources, is almost nonexistent because one of the two necessary drugs, mifepristone, is difficult to procure. Only 21% of providers interviewed offer medical abortion services. This means providers must perform manual vacuum aspiration services for nearly all women seeking

abortion, and this limits the number of patients that providers can serve each day. Further, providers are over-relying on ultrasound to confirm gestational age for all pregnancies, which can increase service delays when ultrasound machines are being used by other units or are unavailable. The result: Women are forced to wait—sometimes weeks—for abortion services as providers must prioritize seeing patients with later gestational ages and those who must travel far to reach the facility.

- 3. Quality of care is hurt by provider shortages and facility limitations.** Providers described having to conduct group counseling before procedures to avoid turning women away, thereby limiting patient privacy. Inadequate space for waiting, counseling, procedures and recovery further limits patient privacy—particularly for clients receiving manual vacuum aspiration. Another component of high-quality care that is lagging is pain management for manual vacuum aspiration, which isn't being consistently offered. Among providers performing manual vacuum aspiration, only 21% surveyed were providing paracervical block for pain management.
- 4. Negative attitudes of facility staff toward abortion providers is a problem.** Providers reported traumatic work environments and being called "Lucifer," "serial killer," and "Satanist" by their colleagues—and sometimes even by their own managers. Cleaning staff in some facilities refuse to clean the abortion procedure room. Managers and providers both recognized debriefing retreats as extremely helpful for providers to destress and feel supported by a community of their peers, but lack of funding means that debriefing sessions have become infrequent. The same stigmatizing behaviors and discrimination from facility staff that affect providers also impact patients seeking care: Providers reported patients being shamed or pushed to leave the facility, sometimes driving women to seek unsafe abortions instead.

"Improve the space; it is too small. There is no confidentiality. After the [procedure] there is no space for the client to rest, so they sleep on a mattress on the floor, in the adjoining toilet. The management has indicated finding a suitable space but this has not materialized—there is no place to counsel women privately."

– Provider from Limpopo Province



## Challenges in safe abortion facilities— and recommendations for improvement

Ipas’s 2018 assessment of public-sector safe abortion care in Limpopo and Gauteng Provinces included in-depth interviews with safe abortion providers, facility managers and health system district managers. This table provides a summary of challenges reported by providers and managers, along with suggested recommendations for how to address each.

CHALLENGE	RECOMMENDATIONS
Shortage of trained safe abortion providers who perform the service and no succession plan for retiring providers	<ul style="list-style-type: none"> <li>• More facilities need to be providing services</li> <li>• Train new providers and offer refresher clinical trainings for existing providers</li> <li>• Include on-the-job and pre-service trainings for providers and support staff</li> </ul>
Limited availability of medical abortion and exclusive use of manual vacuum aspiration limit patient choice and cause service delays and inefficiencies	<ul style="list-style-type: none"> <li>• Provide support to provincial health departments on procurement of medical abortion drugs</li> <li>• Provide refresher trainings on medical abortion for existing providers once drugs become available</li> <li>• Organize a study tour to Western Cape to help providers visualize how they might reorganize services to include medical abortion</li> </ul>
Inefficient service delivery causes long waits for appointments	<ul style="list-style-type: none"> <li>• Explore organizational changes to promote efficiency, including simple research to document quality improvement efforts</li> <li>• Reconsider reliance on ultrasound for gestational age confirmation for early pregnancies</li> <li>• Make medical abortion available to allow providers to treat more patients each day</li> </ul>
Safe abortion providers are vulnerable to demotivation, trauma from stigma, and burnout	<ul style="list-style-type: none"> <li>• Provide more frequent debriefing sessions and retreats for providers</li> <li>• Offer debriefing more than once annually, through a combination of support during site visits and retreats</li> <li>• Debriefing sessions should include second-trimester abortion providers</li> <li>• Set up and/or support existing WhatsApp groups that connect providers to share experiences, challenges, and solutions</li> </ul>
Stigma and discrimination by facility staff toward abortion providers and patients	<ul style="list-style-type: none"> <li>• Provide values clarification training and whole site orientations on the importance of abortion care for facility staff, including social workers, other providers, managers and support staff</li> <li>• Work closely with facility managers and hospital leadership to ensure their buy-in and support</li> <li>• Provide education on policy/laws around conscientious objection</li> <li>• Hold providers accountable for incorrectly applying the conscientious objection policy</li> <li>• Provide doctors with clinical abortion care training to bolster their support for these services</li> </ul>
Inadequate facility space for waiting, counseling, procedures and recovery limits patient privacy	<ul style="list-style-type: none"> <li>• Explore better ways to use existing facility space and provide facility upgrades where most urgently needed to create separate rooms or private areas for abortion patient waiting, counseling, procedures, and recovery (for example: through infrastructure changes or adding more beds and privacy screens)</li> <li>• In appropriate facilities, create integrated women’s health units to better cost-share among women’s health services rather than separating abortion services, which may be last to get funding and upgrades</li> <li>• Introduce medical abortion to increase privacy because the service entails shorter visits and no invasive procedure</li> </ul>

CHALLENGE	RECOMMENDATIONS
Women seeking second-trimester safe abortion services are turned away due to lack of willing and trained providers	<ul style="list-style-type: none"> <li>• Provincial health departments and Ipas should work together with health facilities to use local radio and local venues (community meetings, health fairs, schools, social media) to educate women on contraception and the importance of coming early for abortion services</li> <li>• Train more doctors to provide second-trimester abortion services</li> </ul>
No recognition, incentives, or promotions for abortion providers	<ul style="list-style-type: none"> <li>• Work with the provincial department of health to consider monetary or non-monetary incentives for abortion providers, similar to the structure used for providers treating patients with HIV/AIDS</li> <li>• Revise the abortion provider certification process in ways that will lead to more recognition, promotions, potential salary increases, and educational or professional development opportunities</li> <li>• Find ways to engage trained providers in Ipas and other NGO programs, including training, mentoring, and advocacy efforts, as well as opportunities to present to stakeholders</li> </ul>
Heavy reliance on ultrasound for gestational age dating, compounded by the lack of consistently available ultrasound machines for most abortion providers	<ul style="list-style-type: none"> <li>• Train and support abortion providers to use bimanual exam for gestational age dating of early and uncomplicated pregnancies</li> <li>• Help procure ultrasound machines for hospitals performing second-trimester abortion services</li> </ul>
Infrequent to no use of paracervical block for pain management for patients receiving manual vacuum aspiration	<ul style="list-style-type: none"> <li>• Train and support abortion providers to administer paracervical block</li> <li>• Introduce medical abortion to reduce the number of women receiving manual vacuum aspiration and who therefore need paracervical block</li> </ul>

## PROVINCE-SPECIFIC CHALLENGES AND RECOMMENDATIONS

CHALLENGE	RECOMMENDATIONS
In Limpopo, difficulties with infection prevention due to lack of supplies and cleaning staff	<ul style="list-style-type: none"> <li>• Provide infection prevention materials and include instrument processing in refresher trainings</li> <li>• Observe infection prevention processes and supplies during facility visits</li> </ul>
In Limpopo, equipment, commodities, and consumables delays, shortages and stock outs, particularly for manual vacuum aspiration equipment	<ul style="list-style-type: none"> <li>• Provide support to facility managers with supply chain and procurement of essential drugs and equipment where needed, with a focus on acquiring manual vacuum aspiration equipment</li> </ul>
In Limpopo, abortion providers are overloaded with referrals for long-acting reversible contraception (LARC) removals and insertions due to other providers unwilling to provide the service despite being trained	<ul style="list-style-type: none"> <li>• Provide LARC training to more providers, including non-abortion providers if possible</li> <li>• Make LARC services available at clinics and community health centers so abortion providers at hospitals receive fewer referrals</li> <li>• Speak with facility managers about how to best address this issue at each facility</li> </ul>
In Gauteng, some LARC-trained abortion providers need support to start providing LARC services	<ul style="list-style-type: none"> <li>• Offer individualized provider support to build clinical confidence and competence providing LARC, especially for IUDs</li> </ul>
In Gauteng, frequent rotation of support staff results in unsupportive staff being rotated into abortion service teams	<ul style="list-style-type: none"> <li>• Work with facility management to improve attitudes of all support staff and discourage rotation of supportive and committed staff from the abortion service team</li> </ul>