Since passing the Choice on Termination of Pregnancy Act (CTOP) in 1996, South Africa has had the most liberal abortion law in sub-Saharan Africa. Although women are guaranteed the right to abortion on demand up to 12 weeks gestational age, myriad factors prevent a majority of South African women from actualizing this right. Since the law’s inception, stigma, lack of enforcement, inadequate support to health providers to deliver abortion services, and overburdening of the small number of facilities that provide the service have combined to make safe abortion largely inaccessible. Recognizing this, Pathfinder’s Comprehensive Abortion Care Project has worked in South Africa since 2007 to secure access to safe abortion for all women, placing particular emphasis on reaching young women, who are disproportionately affected by restrictive abortion climates. This technical update discusses Pathfinder South Africa’s experience supporting youth-friendly CAC service delivery in public sector facilities, providing recommendations for future such efforts.

Context

At the time of Pathfinder’s efforts to support access to safe abortion services in South Africa, the circumstances surrounding abortion were complex. Though maternal deaths due to unsafe abortion had fallen an estimated 91 percent in the four years after CTOP was passed, unsafe abortions still outnumbered safe abortions by a ratio of 2 to 1. The national media portrayed a growing public concern about the perceived high number of abortions provided by the South African health system, however, an estimated 58 percent of all abortions in Southern Africa (of which South Africa constituted the majority of the region) were deemed unsafe according to most recent estimates—a reflection of women’s continued difficulty in accessing safe services.

Pervasive stigma posed a significant barrier to access in South Africa. Conscientious objection was frequently invoked by providers to refuse women services, despite there being no legal grounds for this refusal.

Since 1996, measurement of the contribution of unsafe abortions to maternal deaths has become more difficult, in part owing to a change in national monitoring, subsuming abortion-related deaths with miscarriages and combining them with HIV-related maternal deaths. For more information, see the fifth Saving Mothers Report available at http://www.doh.gov.za/docs/reports/2012/savingmothersshort.pdf or Trueman et al.’s 2013 article in the American Journal of Public Health, “Abortion in a Progressive Legal Environment: The Need for Vigilance in Protecting and Promoting Access to Safe Abortion Services in South Africa.”
amendment had attempted to make services more widely available by legalizing provision of abortion at the primary care level, fewer than half of all facilities licensed to provide abortions did so.9 Women thus had to travel long distances to reach the country’s limited number of facilities providing safe abortions. Facing overburdened systems once there, they waited in long lines, experienced frequent delays, and were often requested to return for services—creating further barriers to access. Misconceptions about the law compounded the situation, with the majority of South African women unaware of their right to the service on demand up to 12 weeks.10 Together, these conditions led many to enter the second trimester before seeing a provider. As legal restrictions made abortion after 12 weeks more difficult to obtain,11 many women instead turned to unsafe abortions at the hands of unskilled providers or themselves.12 Combined, these factors created a hostile environment for women’s health—particularly for young and poor women.13

Pathfinder’s Global CAC Approach
Pathfinder efforts to secure access to safe abortion center on a systems approach. Programs work to ensure a holistic response to the structural, social, and service delivery realities that determine abortion access. With the ultimate goal of creating a complete enabling environment for positive sexual and reproductive health and rights (SRHR) outcomes, Pathfinder’s global CAC approach works at the health system, community system, and political levels to advance rights, timely access to care, and meaningful integration with other SRHR services. To this end, the approach employs a three-pillar strategy: advocacy at the national, provincial, and district levels to promote necessary policy and operational changes in support of access to safe abortion; support to the health system for high-quality, comprehensive, and compassionate CAC service provision; and targeted community mobilization to build supportive, stigma-free local contexts in which women can seek safe abortion services.

Implementing CAC in South Africa
Pathfinder efforts in South Africa have focused on capacity building of communities and health systems to enable free and early access to safe abortion services. Efforts began in 2007 in Western Cape, where three sites were selected in collaboration with the Western Cape Department of Health (DOH) and the City of Cape Town, prioritizing Khayelitsha township. Following the project’s close in 2009, Pathfinder efforts shifted to Eastern Cape in 2010. At the invitation of the Eastern Cape DOH, Pathfinder worked in Amathole district14 to support efficient CAC service delivery at the district hospital, and introduction of youth-friendly CAC at five primary care-level community health centers. Figure 2 presents the key components of Pathfinder’s efforts in these two SAAF-funded projects.

COMMUNITY SYSTEM STRENGTHENING
At the community level,15 project efforts stemmed from an understanding of the particular need to address community stigma and misinformation surrounding abortion. Baseline assessment revealed widespread misunderstandings about the rights afforded by CTOP. In addition to limited knowledge about the availability of services on demand during the first trimester, the majority of respondents incorrectly reported that spousal and/or parental consent were required to qualify for abortion services. Combined with an overall fear of discrimination, these factors led many women to seek abortions from unskilled local providers instead. In light of this, the project’s community efforts prioritized saturating home and community environments with supportive stakeholders, reaching

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**FIGURE 1. PATHFINDER’S GLOBAL CAC APPROACH**

<table>
<thead>
<tr>
<th>Structural Advocacy</th>
<th>Health System Strengthening</th>
<th>Community System Strengthening</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Promote broad interpretation of abortion law</td>
<td>• Support quality CAC service provision at provider and institutional levels</td>
<td>• Ensure capacity to demand access to quality services, in accordance with national law</td>
</tr>
<tr>
<td>• Prioritize vulnerable groups’ legal access to abortion</td>
<td>• Ensure services are comprehensive across facilities and integrated into all SRH services</td>
<td>• Support community-led stigma reduction efforts</td>
</tr>
<tr>
<td>• Establish national protocols and curricula</td>
<td>• Create compassionate, stigma-free service delivery environments</td>
<td>• Promote sustained community involvement through key leaders, norm influencers, and vulnerable groups</td>
</tr>
<tr>
<td>• Engage professional and civil society organizations</td>
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</tbody>
</table>

**Enabling environment supportive of women’s access to quality CAC**

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[2] Under CTOP, women have the right to abortion on demand and without need for reason up to 12 weeks. Second trimester abortions are restricted to situations where: there is a risk to the woman’s mental or physical health or economic security; the pregnancy is the result of rape or incest; or there is fetal impairment.

[3] With high rates of pregnancy among women aged 15–19 and a similarly high HIV prevalence, the Eastern Cape DOH selected Amathole district for introduction of Pathfinder’s CAC efforts, which ensured provision of a holistic package of SRHR services.

[4] This section discusses activities in Western Cape. Due to logistical constraints, the community system strengthening component of the project’s CAC approach was not implemented in Eastern Cape.
out to local community-based organizations to promote contraceptive uptake, foster supportive male involvement, and engage peer educators to promote knowledge of the law, the importance of early HIV and pregnancy testing after unprotected sex, and uptake of abortion services prior to the second trimester.

HEALTH SYSTEM STRENGTHENING

Before initiating CAC services at any facility, Pathfinder’s capacity building approach begins with inquiry to determine local need. Baseline assessments revealed that barriers to CAC service delivery extended beyond clinical skills to provider motivation. In addition to some providers’ reported discomfort with abortion, there was a particular need to address the considerable burden providers faced in delivering abortion services. Providers reported experiencing hostility in both their personal and professional lives due to their work, with many reporting clinic environments in which managers discouraged abortion clients from seeking services, and were at times aggressive toward providers who attempted to serve these clients. These conditions took a significant toll on providers’ motivation and overall sense of wellbeing.

In response, project staff and the DOH collaborated to conduct values clarification workshops for all facility staff—from providers and managers to receptionists and security guards—as well as district and provincial health management officers. Workshops brought together clinic staff with local government officers to engage meaningfully around barriers to provision of quality CAC services. Together, trainees learned the tenets of CTOP, interrogated personal biases against abortion, and explored safe abortion as part of a larger spectrum of services for improved SRH outcomes. To further address the challenges providers faced, the project supported the creation of local provider exchange networks. Networks offered providers a platform for ongoing, collective troubleshooting of day-to-day barriers to abortion service delivery, as well as for professional and emotional support to better cope with the difficulties of working in a hostile environment.

After the values clarification workshops, interested providers received clinical training for quality CAC provision in accordance with provincial standards. Trainings ensured up-to-date skills in manual vacuum aspiration procedures, emphasized the importance of same-day service provision to mitigate loss-to-follow-up, and oriented providers on compassionate one-on-one counseling techniques to enable honest exchange between client and provider about other SRH needs such as contraception, sexually transmitted infections (STIs), HIV risk, and gender-based violence (GBV). As part of the Pathfinder CAC approach, all providers were supported to provide rapid HIV testing, followed by provision of contraceptives after the procedure. Project-supported facilities helped providers make service linkages by introducing streamlined stocking protocols so that commodities were located in the procedure rooms themselves. Following provision of contraception, all women screening positive for GBV were connected with social support services.

All clinics also received support to establish YFS. Providers received training in YFS provision, while clinic managers learned processes for inclusion of youth in program design and evaluation, and facilities received low-cost renovations to ensure welcoming environments for young people. By establishing separate waiting areas to ensure
confidentially, convenient hours of operation to accommodate clients’ school and work needs, and service provision protocols to ensure discrimination-free environments, clinics were supported to reach all those in need, regardless of age.

To address service delivery inefficiencies that contribute to women’s difficulty accessing services, the project also focused on improved client flow. To help clients better identify the level of care at which to seek services, facility-wide information campaigns were conducted highlighting the availability of first trimester services at community health centers and second trimester services at the district hospital. The project also helped facilities strengthen existing referral systems to more quickly connect second trimester clients at community health centers to appropriate services at the district hospital. The combined interventions improved facilities’ efficiency, rendering them better able to cope with community demand despite limited staffing.

The project then focused on building facilities’ capacity to sustain efficiency and quality of service delivery. All project-supported facilities implemented anonymous client feedback processes, enabling clients to evaluate clinics’ performance and giving facilities a cost-effective source of ongoing client-generated data regarding services. Applied in conjunction with newly established participatory quarterly review processes, facilities gained a sustainable structure for collaborative, evidence-based problem solving for quality improvement.

GOVERNMENT SUPPORT

Today, project and Eastern Cape DOH staff are working closely to explore how best to draw upon lessons from this collaborative implementation experience, applying Pathfinder’s youth-friendly CAC approach more broadly. Through Eastern Cape DOH endorsement of project-supported facilities as centers of excellence, service providers and clinic managers throughout the province are participating in study tours to learn how to introduce youth-friendly CAC in their own facilities. Building on this experience, the partners will continue to identify new mechanisms to ensure expanded safe abortion access for vulnerable and underserved groups, as part of a larger SRHR improvement agenda.

Performance

Since service delivery support efforts began in Eastern Cape in 2011, Amathole district has gained an additional six facilities providing CAC services. Of the 882 clients who received abortions at the project-supported facilities, nearly 80 percent were aged 24 years or younger and a quarter of these were adolescents younger than 18, reflecting the project’s emphasis on reaching this particularly vulnerable segment of the population. Moreover, delivery of abortion as part of a larger SRH care spectrum has seen particularly strong results across clients of all ages. A full 99 percent of women who received abortions accepted a contraceptive method following the procedure, with the majority choosing injectable methods. Indicating the service delivery model’s contribution to HIV prevention goals, 98 percent of those abortion clients receiving contraceptives also accepted male or female condoms and nearly 1,000 clients received HIV counseling and testing, and screening for STIs and GBV.

Recommendations

Since 2011, participating facilities in Amathole district have successfully launched CAC services, improved intra-facility referral systems, and contributed to larger district SRHR goals related to contraception, HIV prevention, and GBV. Facilities’ notable success reaching young people and ensuring uptake of dual method use since introduction of this holistic CAC approach suggests important lessons for future efforts in advancing access to safe abortion. Eastern Cape DOH support for Pathfinder interventions ensure adequate professional support for abortion providers, emphasize abortion as part of a spectrum of SRH services, and make YFS delivery models a core component of abortion care have generated value both for the health system and the communities it serves. In the future, donors and policymakers should invest in this broader approach to address safe abortion as part of larger SRHR improvement efforts.

v. Reflects all clients receiving one-on-one counseling, at which HIV counseling and testing and screening for STIs and GBV were conducted. Ultrasound conducted after counseling confirmed gestational age, at which point clients 13 weeks or more were referred to the district hospital. Thus, this figure exceeds the total number of clients who received abortion services at project-supported facilities.