Safe abortion in South Africa: “We have wonderful laws but we don’t have people to implement those laws”

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Abstract

In South Africa, abortion was legalized in 1996, during the nation’s transition from apartheid to independence and democracy, under the Choice on Termination of Pregnancy Act (CTOPA). The law drew from both a public health and rights-based framework. A coalition of advocates played a key role in passage. In the years after the CTOPA was passed, abortion services were expanded—in part through a 2008 amendment that allowed trained registered nurses to provide abortions—and deaths from unsafe abortions decreased. However, there have been hurdles to implementation, including competing health priorities such as HIV/AIDS, and a high number of conscientious objectors. There is a geographic disparity in accessibility of abortion services between provinces as well as between urban and rural areas. Women seeking legal abortions face a lack of accessible information on where to obtain an abortion, often experience stigma at facilities, and many obtain illegal procedures.

Keywords

Conscientious objection; Human rights; Implementation; Legalization; Public health; Safe abortion; South Africa

METHODOLOGY FOR ALL CASE STUDIES

This case study is one of six comprising a comparative examination of varied countries’ approaches to the implementation of national abortion service programs, after changes in laws or policy guidelines that established or expanded access to services. In addition to South Africa, case studies were conducted in Colombia, Ethiopia, Ghana, Portugal, and Uruguay, as they had all either implemented new abortion laws or policies, or changed interpretations of existing laws or policies, within the past 15 years. Each study used the Integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) framework to organize the analyses. i-PARIHS posits successful implementation to be a function of the innovation to be implemented and its intended recipients in their specific context, with facilitation as the “active ingredient” aligning innovation and recipients.\(^{1}\) For each country case, two types of data sources were used: an in-depth desk review and 8–13 semistructured, in-depth interviews with key stakeholders and experts in each country, selected in collaboration with in-country partners. Respondents provided written informed consent and were guaranteed confidentiality. Several respondents from each country served as in-country coauthors, in doing so giving up their anonymity as participants of the study, although no quotations provided as respondents are directly attributed to them. Respondents included healthcare providers, public health and government officials who had been involved in establishing or expanding the service, academics, and members of nongovernmental organizations (NGOs) and legal and feminist advocacy groups; in some countries interviewees came from the full range listed, in others from a subset (Table 1). Interviews were conducted in English by a physician member of the team. Quotes presented are from interviews without attribution as we promised confidentiality.
Data analysis comprised a multistep iterative thematic analysis, with coding structured to follow the i-PARIHS framework. In South Africa, the proposal was submitted to the ethics committee of the University of Cape Town’s School of African and Gender Studies, Anthropology and Linguistics, who reviewed and cleared the study. A full discussion of methodology can be found in Chavkin et al.²

1 | CONTEXT

South Africa’s abortion law arose against the backdrop of the transition from apartheid to independence and democracy, when equality, women’s rights, and reproductive rights were enshrined in the new constitution. The Choice on Termination of Pregnancy Act (CTOPA) of 1996 drew on a rights-based framework and addressed the pressing need to lower inequitable maternal mortality. The Act established abortion as a legally codified and constitutionally underpinned right, available on request during the first trimester, and available under exceptional circumstances after 20 weeks of gestation.³–⁵

The law that preceded this, the 1975 Abortion and Sterilization Act, legalized abortion under a narrow range of circumstances. It represented a compromise to reconcile concerns about high levels of illegal and unsafe abortion—approximately 120 000 in 1990—with the apartheid-era government’s interest in preferentially increasing birth rates among white women while lowering them among black women.³⁶–⁸ This law required approval by two physicians, and for the procedure to be performed by a third physician.⁷ Thus, access to the procedure was dependent on access to and support from physicians, and the ability to bear the associated financial costs.³⁶–⁸ White women, comparatively socially and financially advantaged, were far better able to obtain legal abortions, an unintended consequence for a government hoping to boost white birth rates.⁴ Furthermore, for white women with the financial means, a trip to England or the Netherlands served as an alternative option for procuring a safe abortion.⁶,⁷ Thus, black women continued to bear the worst consequences of illegal, unsafe, and legal abortions even after this law had been passed.⁶,⁹

Amid the struggle for democratization prior to 1994, feminist arguments for abortion services tended to focus on public health needs rather than a choice- or rights-based framework. During this time, many of those opposing apartheid believed that gender equality needed to take a backseat to racial equality.⁸ Eventually, advocates’ public health rhetoric addressed the racial inequity in South Africa’s maternal mortality rate, tying these issues of equality together.³ In 1994, South Africa’s maternal mortality ratio was 69 deaths per 100 000 live births, compared with a regional maternal mortality ratio of 944 deaths.¹⁰ However, a study conducted the same year found that over 90% of the estimated 45 000 women admitted to hospital for incomplete abortion were black by apartheid-era classification, and all 425 women who died from illegal abortion were black.⁹,¹¹

During the negotiations for a democratic constitution, reproductive rights, including for abortion, began to move into the forefront. The issue was framed in terms of human rights and equality, and bolstered by the support of the African National Congress (ANC) Women’s League.¹¹ These advocates drew a line linking gender-based violence, unwanted pregnancies, and apartheid policies providing inadequate health care to black South Africans, with the positive health and economic consequences that comprehensive, equitable reproductive health care and reproductive rights could generate. Activism within the ANC was mirrored in civil society by a coalition of civil society activists from health, legal, and human rights backgrounds, known as the Reproductive Rights Alliance.³,¹¹ These advocates connected reproductive rights with improved maternal health, and, in an iterative process, both contributed toward and tapped into an international consensus on these issues developed at the 1994 International Conference on Population and Development (ICPD), held in Cairo.³

2 | INNOVATION

In December 1994, at the Women’s Health Conference, delegates from trade unions, women’s groups, health professional associations, and government finalized a proposal for a new abortion law after a year of research and national consultations.¹² In 1996, the ANC, with the support of then President Nelson Mandela, passed the CTOPA by a wide margin—albeit derived from a mandated ANC party-line vote, and marked by significant absenteeism.⁷ Nonetheless, ANC rhetoric behind the CTOPA, positioned abortion services as necessary for comprehensive, acceptable reproductive health services within a constitutional framework of equality, dignity, and privacy.³,⁶ Interviewees identified support for reproductive rights as stemming from a unique groundswell of support for a human rights agenda, originating with the Women’s League of the ANC, civil society groups, providers, professional organizations, and NGOs.³ One respondent explained:

It was part of the democratization of society [...] from a feminist point of view as well as a race point of view.

Advocates were successful in including clauses in the new constitution ensuring both the “right to bodily and psychological integrity” and “right to make decisions concerning reproduction”.³ The CTOPA included the key provisions from the Women’s Health Conference proposal on abortion, that a woman can terminate her

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**TABLE 1** Professional domains of interviewees in South Africa.

| Professional domain       | Number of interviewees |
|---------------------------|-------------------------|
| Medical practitioners     | 4                       |
| Government officials      | 1                       |
| NGO staff                 | 2                       |
| Other¹                    | 2                       |

Abbreviation: NGO, nongovernmental organization.

¹“Other” comprises academics, or individuals from feminist or legal advocacy groups, or UN agencies.
pregnancy on request during the first 12 weeks of pregnancy (hereafter first trimester). During weeks 13–20 of gestation, she can obtain an abortion if a practitioner determines that the pregnancy risks injury to her physical or mental health, if there is a fetal anomaly, if the pregnancy is the result of rape or incest, or if the continued pregnancy would negatively impact her social or economic situation. After 20 weeks of gestation a woman can only terminate her pregnancy if two practitioners determine it poses a serious danger to the woman’s health or life, or if the fetus will be severely malformed.\textsuperscript{4,5,7} Consent from a woman’s spouse, or her parents if she is a minor, is not required. Midwives with the required training can provide abortion services through the first trimester; only doctors can initiate an abortion after 12 weeks, although nurses can administer medication and lead patient management for these procedures.\textsuperscript{3} In 2008, in response to still-patchy implementation, the legislation was amended to expand the types of facilities able to provide safe abortion services, and to allow registered nurses (RNs) to provide the service after training and certification (there are three categories of nurse in South Africa; only registered or professional nurses, who have 4 years of training, can provide abortions).\textsuperscript{13,4} Physicians do not require accreditation, whereas midwives and RNs must undergo a training and be found competent to provide abortion services.\textsuperscript{5,14,15}

There are no national abortion guidelines that would provide guidance on standards of care or methods, although some aspects of abortion services provision are covered by standard clinical guidelines. The public health sector is responsible for providing abortion services in “designated” facilities accredited by the National Department of Health. Private health facilities can provide abortion services after receiving accreditation. The availability and thus designation of facilities for provision of medication abortion does not exist nationwide,\textsuperscript{6,14} but some provincial health services have ensured that the appropriate medicines are on their essential drug list and use them accordingly.

Conscientious objection is not regulated under the CTOPA, but the Act does set forth guidelines for providers that stipulate that only a direct service provider can invoke conscientious objection; that a service provider cannot deny a woman medical care unrelated to abortion services; and that all clinical staff are required to treat patients with abortion complications and to perform abortion services in an emergency. Service provider objections must be stated in writing for their employer.\textsuperscript{4,7}

### 3 RECIPIENTS

South African women, of course, are the ultimate and most important recipient group of the CTOPA and their access to safe, legal abortion is far from universal. While it was beyond the scope of this study to recruit and interview a representative sample of South African women, their experiences accessing abortion care have been studied elsewhere.\textsuperscript{16–20} Within our study, respondents felt that knowledge of rights under CTOPA was low among women, and those who were aware often didn’t know how to gain access to services. Urban women were reported to have better knowledge of both rights and how to find services, including illegal medical abortions, as well as having closer proximity to abortion services.\textsuperscript{18} In addition, respondents felt women faced community, provider, and internalized stigma for seeking abortion services.

Reflecting the diverse coalition that supported the passage of the CTOPA, the other “recipients” of the law were a wide-ranging group, including the national and provincial Departments of Health (DOH), clinicians, professional associations, local and international NGOs, and activists.\textsuperscript{3}

The DOH was a key recipient, charged as it was with implementing the publicly available, safe abortion services guaranteed under the CTOPA. Immediately after the CTOPA was passed, the DOH made comprehensive maternal, children’s, and women’s health a priority, requiring a system-wide overhaul. During this time, access to abortion services expanded quickly.\textsuperscript{3,22} However, 20 years after its passage, study respondents felt DOH attitudes to the CTOPA were mixed. Some respondents indicated that the DOH leadership did not want to be associated too closely with abortion, and others felt amid competing health concerns, “termination of pregnancy has not been identified as priority by the Department.” With the 2008 amendment, the nine provincial DOHs received increased control over implementation of the CTOPA, and abortion access became more dependent on the differential resources and political will of these Departments. For example, many interviewees cited the Western Cape as an exception, reporting a workable relationship with relevant health officials in this state. This contrasted to their experiences with other provinces working with apathetic or actively obstructionist health officials: “the Western Cape is not fantastic but it is the province that shows an upward change in terms of providing [abortion] whereas most don’t...”

Clinicians, as the group responsible for delivering abortion services, hold an important role within the i-PARHIS framework as “individuals in supporting or resisting change”.\textsuperscript{3} While interviewees reported that some public sector doctors were early supporters of the CTOPA “because they saw the problems, women coming in with all these backstreet abortions who were dying,” the proportion of clinicians willing to perform safe abortions has always been lower than those eligible to do so. Under the CTOPA and its subsequent 2008 amendment extending eligibility for provision of first-trimester abortion services to RNs, physicians, midwives, and RNs can all perform first-trimester abortion services.\textsuperscript{19} Interviewees noted that the 2008 move to task shifting with RNs was met with a mix of support and resistance from both physicians and RNs. Some physicians felt that appropriately trained RNs would expand access to safe abortion, while others felt abortion services should stay restricted to physicians and midwives. Among RNs, one interviewee reported initial resistance from already “overloaded nurses [RNs],” while another noted that “it’s easier, the nurses [RNs] do it too... we’re finding less resistance to it.”

Unlike their constituents, professional associations were reported to be broadly supportive of safe abortion services, and involved with trainings and accreditations. The South African Society of Obstetricians and Gynaecologists was also reported to be supportive of task shifting with midwives initially, and RNs in 2008, with an
Interviewee explaining “they saw the great impact that the RNs’ role has had in reducing maternal mortality and improving access to termination of pregnancy.”

International NGOs were involved with abortion implementation from the start, particularly Ipas and Marie Stopes South Africa (MSSA). Ipas was involved with training providers in the public health system, and medication and device procurement. MSSA, which provides services, was reported by interviewees to provide a substantial number of abortions in South Africa, particularly procedures after the first trimester. Not all NGOs were able to establish a foothold, reflecting an at-times contentious relationship with the DOH. One respondent reported that:

Planned Parenthood collapsed in this country...the reason [...] is that all the EU money went to government, [...] they throttled the NGOs, who had capacity, who understood what was happening on the ground.

From the start, women who could afford private health care have been able to access safe abortions from doctors and RNs in the private sector, whether at legally designated facilities or not.

Local implementation organizations, including Women Care Global (now defunct), Anova Health, and the Wits Reproductive Health and HIV Institute were also mentioned by interviewees as having played roles in training and values clarification work, as well as advocacy. Notably, the latter two are currently not active on abortion activities, with an interviewee explaining that in their opinion, they had been "gagged" under the USA's global gag rule. Several interviewees mentioned the Royal College of Obstetricians and Gynaecologists’ “Leading Safe Choices” initiative, which aims to strengthen family planning and comprehensive abortion care in South Africa and Tanzania, as an implementation and training actor.22

Activists within civil society as well as the ANC played a role from inception through implementation of the CTOPA: “it was the women’s movement and they were really fighting for it.” Organizations mentioned by interviewees included the ANC Women’s League and the Reproductive Rights Alliance; interviewees credited them with keeping attention on the law in the early days of implementation. Many interviewees reported that burnout had ensued after passing the law and working for over a decade for implementation, contributing to what one interviewee described as "a lot of struggle fatigue" among advocates. However, organizations such as the Sexual and Reproductive Justice Coalition (founded in 2015 in response to Ipas’s departure) and the Sex Workers Education and Advocacy Task Force were mentioned as continuing to do advocacy work around safe abortion.

4 | FACILITATION

Transforming the innovation represented by the CTOPA into easily accessible, respectful services to South African women has been a bumpier road than most interviewees originally imagined. However, they did mention elements of the law that had aided implementation.

One of the key facilitators mentioned was task shifting, whereby RNs became eligible abortion service providers under the 2008 amendment. Most agreed that “when the law changed and said a registered nurse can offer this service... it became much better.” Another interviewee expanded on this:

We knew all along that they [RNs] are the backbone of the health services, but in terms of termination of pregnancy... that’s where you really come to appreciate the importance of nurses, the lower-level or the mid-level worker.

In the Western Cape, interviewees reported workarounds in place to provide abortions at designated public facilities that had become de facto institutional objectors, including sending mobile teams of abortion providers. Alternatively, provincial DOHs have contracted out to private providers such as MSSA. The scarcity of clinicians willing to provide abortions after the first trimester is exacerbated by high need: an estimated 25% of abortion services are provided to women who are more than 12 weeks pregnant.23 One interviewee explained: “the problem is that a second trimester person may well have come early, and could have had an MVA [manual vacuum aspiration], or a medical TOP [termination of pregnancy]...” but either could not access one or faced long wait times, and passed 12 weeks of gestation in the interim. Thus, private provision is a critical supplement to publicly provided services, although rural, less affluent women remain at a disadvantage.

5 | REMAINING CONCERNS

The CTOPA guidelines for conscientious objection restrict it to clinical providers, and to the actual abortion procedure. However, interviewees reported that both clinical and administrative staff invoke conscientious objection broadly both to avoid and to obstruct all stages of abortion services. In rural and conservative areas, interviewees reported that entire facilities can become de facto conscientious objectors if enough practitioners or administrators refuse to provide the service. Interviewees described gaps between regulation and service delivery, with one interviewee reporting that certain facilities give all new hires a conscientious objection “form letter” to sign, an approach at odds with the ostensible purpose of permitting an individual choice with a deeply-felt rationale specific to each objector. While facilities can specify that performing safe abortion services is a job requirement, and screen for this during job interviews, a respondent noted that this is not helpful if no-one applying for a post is willing to perform abortion procedures in the first place.

Several interviewees believe that a proportion of “objection” stems from clinicians’ workload: “they default on work overload, and all of them become conscientious objectors.” Performing abortions involves extra work with few concrete benefits and a host of costs, including professional and community stigma. Hence much “objection” has less to do with conscience and more to do with stigmatization and workload. One interviewee reported clinicians saying “we’ve had our cars stoned, we’ve
had people following us to our cars, abusing us as baby killers." Several interviewees said that many facilities had become de facto institutional "objectors," and that the DOH "should actually go to the facility and reprimand the facility manager." However, one interviewee expressed doubt that the DOH had disciplinary purview over these recalcitrant facilities, and others described little enforcement of measures that did exist. Indeed, in 2015, it was estimated that less than 40% of designated facilities actually provided abortion services, although the breakdown between facilities that refused to provide services and those that could not is unclear.3

The high number of conscientious objectors in South Africa has contributed to what respondents agree is a high number of illegal abortions (although illegal, these informal abortions were felt by respondents to be increasingly safe—many "backstreet" providers give women black market misoprostol, and are savvy enough to direct them to health facilities in the case of complications), despite the progressive and inclusive CTOPA.18 Explanations include stigma for women seeking abortions, lack of knowledge of rights under the law, lack of accessible services, and not qualifying for legal services. Respondents reported that "there hasn’t been a concerted effort in educating the public about the legality of providing abortion," nor do public facilities advertise abortion services. Moreover, "there are complaints about health workers being unsympathetic, disrespectful, rude," whereas in the illegal market, one interviewee explained, women are treated simply as clients seeking a service:

When they walk in [to a public sector facility], they are already judging themselves, stigmatizing themselves because of the way abortions are looked at...when they go to the backstreet abortionist, they don’t ask you questions. You come and you say ‘I want this,’ they sell you the drug...

Privacy was also cited as a concern driving women to seek illegal abortions, with one interviewee explaining that "very often there’s a family member working in the service and they don’t want to go there." Finally, it was reported that women who have passed their first trimester, and face more restrictions on abortion provision, are driven to seek illegal services. Interviewees reported that "there hasn’t been a concerted effort in educating the public about the legality of providing abortion," nor do public facilities advertise abortion services. Moreover, "there are complaints about health workers being unsympathetic, disrespectful, rude," whereas in the illegal market, one interviewee explained, women are treated simply as clients seeking a service:

...not reformers, they’re not pushing things along... they are definitely pro-choice and they say the right things and attend the right meetings... but then how do you translate that into actual service provision change?

Interviewees said that the particular interests and priorities of the Health Ministers affected implementation of the CTOPA, which suffered when Health Ministers did not "own" it.

There was a consensus among interviewees that health services in general were a low priority on the political landscape, and then "at the very bottom of that pile...is abortion." Interviewees cited HIV and prevention of maternal-to-child transmission as having superseded the provision of abortion services, with one interviewee citing, "they put emphasis more on [...] HIV, almost to the exclusion of women’s health and rights," and others describing contraception services as a higher—and less controversial—governmental priority than abortion.

This lack of political will has led to NGOs’, especially international NGOs, assumption of roles that interviewees thought ought to fall under the purview of the DOH. Several interviewees mentioned the loss that followed the departure of Ipas in 2014 (as of 2017, Ipas reopened their South Africa office), which had played an important role since the passage of the CTOPA in training and in facilitating procurement. An interviewee explained "they left because the DOH wouldn’t engage with them, they didn’t want anything to do with them." Others felt that NGOs had been too involved in South Africa, contributing to "state capture," or the determination of South Africa’s direction by supranational interests.30 The respondent who posited that Ipas left South Africa because of a lack of engagement from the DOH felt that it was “very problematic” and unsustainable that the government subcontracted this level of responsibility to a US NGO.

6 | LESSONS LEARNED

Interviewees were reflective about the shortfalls of implementation in South Africa, and made generalized recommendations for countries liberalizing or legalizing abortion services in the future. When asked about the state of abortion services in South Africa, one respondent replied, “you want me to be completely honest? I would suggest we’re bordering on pre-Act." As stated by interviewees, many women are unable to get abortions owing to issues of access, either proximity to a functional facility, or being denied an abortion by so-called objectors, negatively impacting their lives and economic circumstances. The overarching lesson drawn was that advocacy cannot stop when the law is passed, that “changing or modifying the act and so on is not an end in itself.” The collapse of all but one of the women’s health advocacy groups that had built national support for the development, passing, and implementation of the CTOPA is indicative of the overarching reproductive health landscape.31 Respondents felt that activism and advocacy lost momentum after the passage of the law, and that it is necessary to keep the conversation on safe abortion, and maintain pressure on the DOH to keep implementation moving. This lack of political will in the DOH manifested in an overreliance on
international NGOs for some regions and services, a state of affairs interviewees felt to be unsustainable: “there have to be national competencies to ensure provincial and local implementation.”

Another key lesson learned according to many interviewees was the need to push for population-wide education of women about their rights under the CTOPA, and how and where to gain access to services—a role originally carried by various NGOs. The fact that HIV-related NGOs across the country have been conducting HIV prevention work in communities throughout this period and have chosen not to ensure public knowledge of the right to a safe abortion under the CTOPA is evidence of the negative consequences of separating HIV from sexual and reproductive health and rights programming, and of the consequences of the gag rule. Lack of basic knowledge of the CTOPA extended to some providers, with interviewees reporting that some providers turned away women who came back for a second abortion, believing them to be ineligible.

Conscientious objection, or claims thereof, was cited as a critical obstacle to broad access, and multiple interviewees posited enhanced regulation of conscientious objection as a potential solution. One interviewee saying “I would put that in the law right from the start. There is an option for it... but it has to be according to certain rules.” As suggested by respondents, stricter guidelines for conscientious objection could include barring objectors from qualifying as obstetricians/gynecologists, and better enforcement of consequences for obstructionist providers and facilities. Another lesson learned around conscientious objection was to provide better support and supervision to abortion providers, who often face stigma both from colleagues and communities. Interviewees also suggested increased soft incentives—one interviewee proposed holiday parties—that help normalize this work. Almost all interviewees agreed about the utility of values clarification, with some specifying the Health Workers for Change qualification, with some specifying the Health Workers for Change qualification.

Several interviewees warned against “exceptionalizing” abortion services. Respondents recommended South Africa’s model of integrating abortion services into existing sexual and reproductive health and primary services, avoiding stand-alone clinics. This would improve service delivery, as “you can’t speak about abortion without talking about access to family planning,” and would decrease stigma. It was felt clinicians and units providing safe abortion services should be better integrated with their colleagues. Respondents also advised that abortion training should be integrated into medical, midwifery, and nursing school curricula nationally to increase provider familiarity and decrease stigma associated with it from the beginning of their training.

While the CTOPA was passed at a historic moment for equality and democracy, its inadequate implementation reflects ongoing cultural ambivalence toward the status of women and safe abortion.3,29 The ANC maintains its decades-long backing of the law, despite social and legal challenges, but has not ensured wide, equitable availability of services.3 One respondent, reflecting on the passage of the law, stated:

I think we were just lucky that all of this happened soon after the democracy, you know when people wanted to have as few restrictions on personal choices and personal life. I daresay if such a law went back to our Parliament now it might struggle to get passed.

Study participants and many advocates agree that gains made immediately following the passage of the law have stagnated and, in some cases, even receded.3

AUTHOR CONTRIBUTIONS
MF: Developed initial proposal and interview instrument, conducted South Africa interviews, collaborated on drafting manuscript, and provided edits and corrections to all versions of the manuscript. JMSG: Transcribed and coded South Africa transcripts, wrote first draft of paper, and collated edits and reviews. MS: Interviewee, served as in-country point person, provided information and details while writing, and reviewed, corrected, and edited all versions of the manuscript.

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CONFLICTS OF INTEREST
MS functioned as key informant, was interviewed, and served as a coauthor of this case study. The authors have no conflicts of interest to declare.

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