THE STATE OF ABORTION SERVICES IN THE EASTERN CAPE: 2022 REPORT

+SECTION27
catalysts for social justice

CENTRE FOR CHILD LAW

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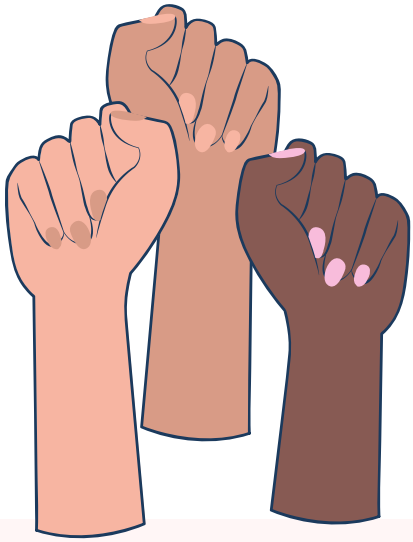
RESEARCH TEAM

This report has been prepared in a partnership between SECTION27 and the Treatment Action Campaign (TAC).



SECTION27

SECTION27 is a public interest law centre that seeks to achieve substantive equality and social justice in South Africa. Guided by the principles and values in the Constitution, SECTION27 uses law, advocacy, legal literacy, research, and community mobilisation to achieve access to healthcare services and basic education.

SECTION27 aims to achieve structural change and accountability to ensure the dignity and equality of everyone.

Treatment Action Campaign

Treatment Action Campaign (TAC) is a membership-based organisation that, through its branches and members, monitors thousands of clinics and hospitals throughout South Africa.

By organising locally, TAC is able to demand accountability and quality healthcare services at public health institutions. In addition to monitoring, TAC campaigns, litigates, and advocates on critical issues related to the quality of and access to healthcare.

EXECUTIVE SUMMARY

Over the past 4 years, SECTION27 and TAC have monitored and assessed access to abortion services in the Eastern Cape. Monitoring has been achieved by way of telephonic hot-spotting, physical visits to designated facilities and interviews with patients and providers. Through various engagements with the Eastern Cape Department of Health (ECDoH), we have brought to their attention several issues that we have identified as barriers to access to abortion services. These issues include, but are not limited to, the insufficient designation of second trimester abortion facilities; insufficient number of abortion providers to meet the demand for the service; inadequately trained abortion providers; lack of equipment for timely provision of the service; and shortages in abortion medicines.

According to information provided to us by the ECDoH, there are five designated second trimester abortion facilities in the Eastern Cape. However, only two are operational. Reasons given for lack of services include refusal of care by medical professionals; insufficient equipment, such as second trimester abortion beds; and too few abortion providers. 10 of the 13 facilities that we visited during May 2022 have only one abortion provider. These 13 facilities are approached by an average of 1 200 women per month seeking abortion services. The shortage in staff often means that these facilities are unable to assist all the women who approach them in a day. For example, approximately 320 women approach Frere Hospital per month for an abortion, however, due to capacity constraints, the hospital is only able to assist approximately 200 of those women. Worse still, the provision of abortion services is often completely halted if that abortion provider is on leave or otherwise unavailable.

Through our research we have found that the shortage of designated second trimester facilities, coupled with the shortages in staff and equipment has resulted in a disproportionate demand on the few facilities which do provide second trimester abortions. In the instances where women cannot afford, or are otherwise unable to travel to the only other operational second trimester facility, they turn to illegal abortion providers.

INTRODUCTION

Between 17 May 2022 and 27 May 2022, Khanyisa Mapipa and Thokozile Mtsolongo of SECTION27 travelled to 13 (thirteen) healthcare facilities within the Eastern Cape, accompanied in parts by Nomangesi Mafanya and Thembisile Nogamphula of TAC.[1]

The purpose of their visit was to conduct field research on the state of abortion services at public health facilities and in so doing establish the state of abortion services at designated facilities in the Eastern Cape. Sexual reproductive health rights are provided for under section 27(1)(a) of the Constitution. Abortion rights are specifically provided for in terms of the Choice on Termination of Pregnancy Act[2] (the Act) and the Guidelines on the Implementation of the Choice on Termination of Pregnancy Act[3] (the Guidelines).

Our visit was preceded by engagement with the Eastern Cape Department of Health (ECDoH) in November 2019, in which we requested a list of public health facilities designated by the MEC for Health in the province to provide abortions. In January 2020, the ECDoH responded with a list in which it indicated that there are 54 public health facilities in the province which are designated to perform abortions but that only 44 of those are marked as operational.[4] Pursuant to our receipt of the list, we conducted a hot-spotting exercise, during which SECTION27 contacted 29 public health facilities to confirm whether they indeed perform abortions. This exercise was conducted in November 2021. The results of this exercise, together with the results of fieldwork conducted in Mthatha around the same time, were relayed to the ECDoH in a letter dated 19 January 2022.[5] The letter indicated that the provision of abortion services in the province was lacking significantly, with major deficits in certain areas, including Mthatha, Cofimvaba and Queenstown.

1. A list of the facilities visited is attached as Annexure "A"
2. Act 92 of 1996
3. Guidelines on the Implementation of the Choice of Termination of Pregnancy Act. Accessed at: https://www.knowledgehub.org.za/system/files/elibdownloads/2021-03/Termination%20of%20Pregnancy%20Guideline_Final_2021.pdf.
4. A copy of the list is annexed here as Annexure "B"
5. A copy of the letter is annexed here as Annexure "C"

In order to gain a better understanding of the effect of the deficit in the provision of abortion services specifically in Cofimvaba and Queenstown, during our visit, SECTION27 and TAC held two dialogues with an audience of 38 women in total, on access to abortion in Cofimvaba and Ezibeleni. In keeping with our respective mandates, which include assisting members of our communities to gain access to healthcare, SECTION27 and TAC consider the views and experiences of these women to be a critical component of the research conducted into the effects of a lack of abortion services in remote areas such as Cofimvaba and Ezibeleni.

In this report, we provide a summary of our findings as extracted from the information provided to us by facility managers, abortion providers, patients at the various facilities and members of the community. Further, we provide recommendations for the improvement of service delivery based on our findings.

Approach and Methodology

Prior to our visit to the public abortion facilities in the Buffalo City Municipal area and the Nelson Mandela Metropolitan Municipal area, we wrote letters to the relevant ECDoH District Managers requesting that they provide authorisation to the facility managers and abortion providers at their facilities to engage us during the course of our visits. This authorisation was communicated to the relevant public health facilities. With respect to our visit to Chris Hani District Municipality and the Amatole District, and upon the advice of the CEO at Butterworth Hospital, we addressed an email to Dr Rolene Wagner, Superintendent General of the ECDoH, and Ms Sindiswa Gede, ECDoH District Manager of the Amatole district, in which we similarly requested that they provide authorisation to the facility managers and abortion providers at the public health facilities designated to provide abortions within the Chris Hani District. We received no response in this regard. Nonetheless, we proceeded with our research, and only engaged with those facility managers, abortion providers and patients who were willing to speak to us.

Bearing in mind the often acrimonious and combative experiences that women report facing at abortion facilities, and in anticipation of a defensive and adversarial response from the personnel at the facilities we visited, we initially observed the treatment that women receive when they approach public health facilities to request an abortion before introducing ourselves. This was done to ensure that the information provided to us by the abortion providers and facility managers we approached during our research accurately represented the realities women face when they attend these facilities.

Once we had assessed the conditions of the facility and the treatment received by women requiring abortions, we introduced ourselves and conducted interviews with abortion providers and management of the various healthcare facilities. Further, we interviewed women who had approached the facilities to obtain an abortion. During our discussions with these women, we asked questions regarding their experience when seeking abortions at the respective public health facilities. In some instances, the women we interviewed gave accounts of arbitrary refusal of care and requested that we intervene and advocate for access to abortion services on their behalf. Where we were requested to do so, we approached the relevant facility's management and requested that arrangements be made to ensure access to abortion services for our clients. On each occasion, they adhered to our request.

In addition to the interviews conducted with abortion providers, facility managers and women seeking abortion services, SECTION27 and TAC also hosted two community dialogues, in Cofimvaba and Ezibeleni. The purpose of these sessions was to determine the information available to the greater Queenstown and Cofimvaba communities and their experience with access to abortion services in these areas. The community dialogues were attended by 35 people, collectively. The information shared in these sessions was informative and provided insight into the availability of abortion services in the area. The accounts of the women interviewed during these sessions were used to inform some of our findings below.

KEY FINDINGS

We have grouped our findings thematically as some are common throughout the healthcare facilities we visited, while others are only common among a few facilities. In each instance, we have named each of the affected healthcare facilities under the relevant themes.

1. Delays in care

The provision of both first and second trimester abortions is significantly delayed in two of the healthcare facilities, namely, Frere Hospital and Cecilia Makiwane Hospital. For example, at Frere Hospital, we were advised that there is an approximate, three week wait for first trimester abortions and a six week wait for second trimester abortions. In real terms this means that a woman who approached the facility for an abortion on the day of our visit, being 17 May 2022, would only be assisted with a first trimester abortion on or about 6 June 2022, while a woman requiring a second trimester abortion would only receive care on or about 27 June 2022. While Cecilia Makiwane Hospital services first trimester abortion patients on a first come, first serve basis, there is a three week waiting period for second trimester abortions. Meaning that a woman who approached the facility for an abortion on the date of our visit, being 18 May 2022, would have had to wait to be assisted until almost a month later, on 13 June 2022.

The abortion unit at Frere Hospital operates on a booking system. While this practice in itself is not a cause for concern, the manner in which the bookings are arranged is disquieting. When a woman approaches the hospital, she is provided with a date for when she must return for an ultrasound scan which will then confirm her gestational age. This initial date, is, as stated above, three weeks into the future. It is only at this point that a woman is either provided with a first trimester abortion or booked for a second trimester abortion a further three weeks into the future. This type of booking system has the potential of effectively denying abortions to women who are already nearing the legal gestational age limit for an abortion as stipulated in section 2(1)(b) of the Act[6] and necessitating second trimester abortions, a more arduous and complex procedure, for women who would have otherwise qualified for first trimester abortions had they been assisted with an ultrasound scan upon their initial visit to Frere Hospital

Similarly, the delays at Cecilia Makiwane with respect to the performance of second trimester abortions risk resulting in a denial of timely second trimester abortions. These delays, at both hospitals are directly attributable to a lack of resources.

On our visit to Cecilia Makiwane, we encountered a number of women who had approached the facility seeking abortion services and who had been turned away. One woman's story stood out as being particularly egregious. In the interest of preserving her privacy, we will refer to her as ZM.

ZM is a resident of a village on the outskirts of King Williams Town. On or about 25 April 2022, she approached Bhisho Provincial Hospital to obtain an abortion, there she was advised that the nurse providing the service was on sick leave. She was advised to return on a later date. ZM returned to the hospital on the date she was given but was again turned away for the same reason. On or about 17 May 2022, ZM returned to the Bhisho Provincial Hospital for the third time to seek abortion services. On this occasion a scan was performed, and she was advised that she was, at the time, 15 weeks pregnant and no longer qualified to access abortion services there, given that it is designated to perform abortion services only in the first trimester. She was provided with a referral letter to Frere Hospital.

On or about 18 May 2022, ZM attended at Frere Hospital to obtain abortion services. Upon her arrival she was advised that Frere Hospital's abortion services work on a booking system and that the next available date for an ultrasound scan was 6 June 2022. She was then referred to Cecilia Makiwane Hospital in Mdantsane.

On the same day, ZM attended at Cecilia Makiwane Hospital to obtain abortion services. Upon her arrival, she was advised that Cecilia Makiwane Hospital's abortion services are limited to 10 patients a day, that the hospital works on a booking system, and that the next available date for her to obtain an abortion was 13 June 2022.

6 SECTION 2(1)(B) OF THE ACT LIMITS THE TERMINATION OF A PREGNANCY IN THE SECOND TRIMESTER TO 20 WEEKS AND 6 DAYS.

When ZM first approached the Eastern Cape public healthcare system to obtain abortion services she was approximately 11 weeks pregnant and still within the gestational period permissible for her to obtain an abortion at Bhisho Provincial Hospital. Due to the unavailability and shortage of trained service providers at Bhisho Provincial Hospital, ZM was delayed in accessing abortion services and her right to reproductive health was effectively denied.

The earliest date that ZM could access any type of abortion service was 6 June 2022 at Frere Hospital in East London. By that time ZM would have been approximately 17 weeks pregnant and in need of a second trimester abortion – which we were advised was only available from 27 June 2022 at Frere Hospital. A Second trimester abortion is more complicated medically than a first trimester abortion, more time intensive as it requires the patient to be admitted at the hospital and has higher health risks. A second trimester abortion would have been unnecessary had ZM been assisted when she first approached Bhisho Provincial Hospital.

ZM travelled to three major hospitals without receiving assistance. The earliest date that she would be able to receive services placed her dangerously close to the gestational age limit for a legal abortion.

Unfortunately, ZM's story is not unique. Her story reflects the depth of the abortion crisis in Eastern Cape. It demonstrates the lengths to which women in the Eastern Cape, who are often destitute and who rely solely on the ECDoH to provide them with health services, must go to in order to obtain safe abortion services. The delay in care, attributable mainly to a lack of resources, poses a major barrier to access and is one of the key reasons that women turn to illegal abortion providers.

2. Equipment constraints

The abortion unit at Frere Hospital services approximately 300 to 350 women per month. It relies on a single ultrasound machine, shared between the abortion unit, maternity unit and the high-risk maternity unit. These three units also share a single sonographer who operates the ultrasound machine and confirms the gestational age of each woman. Due to the demand on this single machine, the sonographer only has time to assist abortion patients early in the morning. As a result, they can only attend to approximately 10 women per day before they must turn their attention to patients from the maternity unit and the high-risk maternity unit.

Similarly, the abortion unit at Uitenhage Hospital shares an ultrasound machine with the gynaecology unit, the gynae-oncology unit, the labour unit and the high-risk pregnancy unit. Given the high demand on the ultrasound machine, the sonographer dedicates a limited time to abortion patients per day, which ultimately limits the number of patients who can be assisted with an abortion per day. Likewise, at Dora Nginza Hospital, the ultrasound machine is shared between labour unit and the abortion unit, which limits the number of women who can be assisted per day. It is worth noting that Dora Nginza Hospital is approached by approximately 30 women per day for abortions. It is limited to a maximum of 12 patients it can assist as a result of the shared ultrasound machine.

Alarmingly, Nqamakwe CHC does not have an ultrasound machine. Women seeking abortions are therefore required to bring their own ultrasound scan from a private facility or another public facility – the closest one being Butterworth Hospital, approximately 35 kilometres away. The costs associated with obtaining an ultrasound scan, whether it is the costs of private care or the traveling costs to Butterworth Hospital, in these circumstances create a barrier to access to abortionsat Nqamakwe CHC, particularly given that the average woman in Nqamakwe is poor and may not afford these costs.

While the National Clinical Guideline for the Implementation of the Choice on Termination of Pregnancy Act, provides that "where an ultrasound is not available, clinical assessment of gestational age that agrees with LMP [last menstrual period] is acceptable"[7], we note that medical professionals are reluctant to perform abortions without an ultrasound. The reasons offered by the medical professionals we interviewed during our research allegedly relate to the requirements of their own professional bodies. For example, the nurses interviewed confirmed that they were trained in abdominal palpation and bimanual examination as a method of determining the gestational age, but that the South African Nursing Council requires nurses to confirm gestational age using an ultrasound before performing abortions.

On the face of it, there appears to be a conflict between the requirements of the professional body to which abortion providers belong and the expectations of the ECDoH to supplement the use of an ultrasound machine with abdominal palpation and bimanual examination. To the extent that this conflict exists, we recommend that the ECDoH address the discrepancy in the rules with the relevant professional body. It is not enough for the state to provide an option for treatment that does not require machines if medical professionals are barred from performing the said option.

Frere Hospital has dedicated only two hospital beds for second trimester abortions. As a result, at most, the hospital can only assist six to eight second trimester abortion patients a week. Cecilia Makiwane experiences similar issues. While there is no limit on the number of beds that is allocated to second trimester abortion patients, the hospital's gynaecology and obstetrics ward faces a high demand on resources. According to hospital management, there are 24 beds in the ward (there were previously 32 beds, 8 were reallocated at the instance of the ECDoH).

These 24 beds accommodate women with varying gynaecological needs, including labour patients, high-risk pregnancies, women showing symptoms of septic abortions, women who have suffered spontaneous miscarriages, women who require operations on their reproductive organs, and oncology patients suffering from cancer of the reproductive system.

7 NATIONAL CLINICAL GUIDELINE FOR THE IMPLEMENTATION OF THE CHOICE ON TERMINATION OF PREGNANCY ACT, ED 1 PG 22

The ward admits approximately 8 women per day and the average stay is anywhere from three to seven days. There is therefore very little space available for second trimester abortion patients, which contributes to the long waiting periods.

3. Staff shortages

With the exception of Uitenhage Hospital, Dora Nginza Hospital and Butterworth Hospital all the healthcare facilities we visited have only one abortion provider assigned to the abortion unit. It may be noted that the unit manager at Frere Hospital is also a trained abortion provider and assists when the assigned abortion provider is away on leave, however, given that her responsibilities include managing the gynaecology and maternity unit, as well as the abortion unit, her operational responsibilities make it difficult for her to ensure the uninterrupted provision of abortion services when the assigned abortion provider is unavailable.

The account relayed above of the experience endured by a patient who approached Cecilia Makiwane Hospital (referred to as ZM) for abortion services was a result of the unavailability of the abortion provider at her designated facility. ZM's experience is not unique to her. In SECTION27's letter dated 19 January 2022, addressed to the ECDoH,[8] we described how scores of women were travelling to Mthatha Gateway Clinic to access abortion services, despite residing in areas close to designated abortion facilities. When we inquired regarding the reason for this, most advised that the abortion facilities in their area were not operational. Furthermore, when we conducted the hot-spotting exercise in November 2021, several facilities, including Butterworth Hospital, confirmed that they were referring patients to the nearest designated facility because the nurse responsible for abortion services was on leave. The shortage of staff is a critical issue which impacts on the availability of the service.

All the abortion providers that we interviewed, with the exception of the abortion provider at Nqamakwe CHC, expressed that they desperately require more staff in order to effectively meet the demand for the service.

According to ECDoH, Dora Nginza Hospital is designated to provide second trimester abortion services. This notwithstanding, abortion providers within the Nelson Mandela Metropolitan Municipal area advise that they are unable to refer women in need of a second trimester abortion to Dora Nginza Hospital. Women referred to the hospital are advised that it does not perform second trimester abortions unless the woman claims rape, incest, or the life of the foetus or the woman's life is in danger. Medical practitioners at Dora Nginza Hospital object to performing abortions in any other circumstances. As a result, abortion providers in the Nelson Mandela Metropolitan Municipal area, including those who perform first trimester abortions at Dora Ngniza Hospital are forced to refer women to private facilities such a Marie Stopes. It is safe to assume that some of those who cannot afford the high costs of private abortions turn to illegal abortion service providers.

As a designated second trimester abortion provider, Dora Nginza Hospital is required to perform second trimester abortion services within the ambit of section 2(1)(b) of the Act. According to section 2(1)(b) a second trimester abortion is permissible if the medical practitioner is of the opinion that:

"(i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or

(ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or

(iii) the pregnancy resulted from rape or incest; or

(iv) **the continued pregnancy would significantly affect the social or economic circumstances of the woman."** (our emphasis)

As it appears, the medical practitioners at Dora Nginza Hospital believe that they can consider some and not all of the circumstances listed in the aforementioned section. As Dora Nginza is a designated second trimester abortion facility, it is incumbent on the medical practitioners to consider all the circumstances listed in section 2(1)(b), including whether "the continued pregnancy would significantly affect the social or economic circumstances of the woman." It is the belief of the first trimester abortion providers in that Nelson Mandela Metropolitan Municipal area that this consideration is not made.

8 A COPY OF THE LETTER IS ATTACHED AS ANNEXURE "C"

4. Shortages in abortion medicines

Two hospitals, namely Cecilia Makiwane and Dora Nginza reported an occasional shortage of mifepristone. The shortages in mifepristone result in services not being offered to women seeking an abortion. This is despite the possibility of offering a misoprostol-only regimen (which has 85% effectiveness in terms of the Guidelines), which though not the preferred regimen under the Guidelines, is nonetheless an effective option. The preferred method, (the combined mifepristone-misoprostol regimen) has 95% effectiveness in terms of the Guidelines. This 10% difference in effectiveness can be ameliorated by reinforcing the availability of post-abortion care to women.

5. Inefficient referral systems and designation of second trimester abortion facilities

Frere Hospital receives referrals for second trimester abortions from Mthatha, Queenstown, Cofimvaba, King Williams Town and Butterworth. Undoubtedly, the scores of patients travelling from these cities to access second trimester abortions at Frere Hospital place a higher strain on the hospital. The same can be said for Cecilia Makiwane Hospital, which receives referrals for second trimester abortions from King Williams Town and Frere Hospital.

In our view, much of the strain would be alleviated, if the ECDoH designated and equipped more hospitals to provide second trimester abortions and ensured that those already designated to do so, provide the service. Dora Nginza Hospital and Mthatha Regional Hospital are designated to provide second trimester abortions, however, both hospitals do not provide second trimester abortions in accordance with the Act.

Dora Nginza Hospital only provides second trimester abortions if a woman meets certain criteria, which exclude some of the criteria which must be considered according to the Act. This practice deprives women who are otherwise entitled to second trimester abortions of their rights. Mthatha Regional Hospital does not provide second trimester abortions at all, despite being designated to do so. On our visit to Mthatha Regional Hospital in November 2021, we encountered several women seeking second trimester abortions but who had been turned away by the hospital. We intervened on behalf of two of these women. It was only after our intervention that they received assistance from the hospital. It is unacceptable that a designated second trimester abortion facility will only provide safe second trimester abortions under threat of legal action.

RECOMMENDATIONS

1. Delays in care

1.1. The considerable delay experienced by women seeking abortions at Frere Hospital and Cecilia Makiwane is unacceptable and, in some instances, it is tantamount to a denial of service. The primary cause of delays, as noted by abortion providers and hospital administration at both hospitals, is the lack of resources.

1.2. While we do not object to the booking system established by some health facilities, it is unacceptable that women must travel to multiple health facilities before they are assisted due to long waiting periods. An ultrasound administered on the first visit to determine gestational age and accordingly the procedure necessary, would contribute significantly towards eliminating the long waiting periods and ultimately the delay in care. Therefore, we recommend that the ECDoH adopt a policy that necessitates the determination of the gestational age of a pregnancy when a woman first approaches a health facility for an abortion.

2. Equipment constraints

2.1. It is apparent that there exist severe equipment constraints, particularly a shortage of ultrasound machines and beds to be used for abortions. Worse yet, the existing beds available for abortions are diminishing in the case of Cecilia Makiwane Hospital. Moreover, facilities such as Uitenhage Hospital and Dora Nginza Hospital lack recovery beds for patients who have undergone vacuum aspirations. The shortage in equipment contributes significantly to the delay in care. We recommend that the ECDoH dedicate an ultrasound machine to each designated facility. To the extent that the ECDoH believes that alternative means of gestational age determination should be used, we recommend that it engage with the professional bodies of the medical professionals who work under it and establish a way forward.

2.2. We further recommend that the ECDoH conduct an audit of its abortion facilities to determine the number of beds available to each facility. Once this is done, we recommend that the ECDoH furnish each facility with enough beds to cater to the average number of abortion requests they receive, including beds for second trimester abortions and recovery beds.

3. Staff shortages

3.1. In addition to a lack of equipment, staff shortages are also a major contributing factor to the delays in care. Ten of the 13 facilities visited only had one abortion provider. In the event of these providers' absence, women are unable to access abortion services. In the circumstances we recommend that the ECDoH conduct an audit of the facilities to determine the demand on each facility and the staffing requirements. Further we recommend that the ECDoH recruit and train abortion providers to add to the currently very thin staff complement.

3.2. Given that Dora Nginza Hospital is a designated second trimester abortion facility, it is obliged to assist women who meet the criteria listed under section 2(1)(b) of the Act, including women who could be significantly affected socially or economically if they continued their pregnancy. We recommend that the ECDoH engage with the hospital with a view to ensuring its full compliance with its designation as a second trimester abortion facility.

4. Shortages in abortion medicines

4.1. As it appears, despite shortages in mifepristone, abortion providers are reluctant to offer a misoprostol-only regime. It is not immediately clear why this reluctance exists, however, be that as it may, we recommend that ECDoH communicate to its abortion providers that a misoprostol-only regime is also acceptable as a standard of practice. We believe that this will alleviate some of the waiting times caused by medical stock-outs of mifepristone.

5. Inefficient referral systems and designation of second trimester abortion facilities

5.1. We recommend that ECDoH designate and equip more second trimester abortion facility and ensure that those that are already designated, provide the service. We further recommend that ECDoH investigate the practices of medical practitioners at Dora Nginza Hospital and where necessary educate or train its medical practitioners on the requirements for a second trimester abortion as stipulated under section 2(1)(b) of the Act.

5.2. Furthermore, we recommend that ECDoH establish referral pathways for second trimester abortions. It is important that the facility to which a woman is referred for a second trimester abortion is accessible to her. This means that consideration must be given to the distance a woman must travel to arrive at the referred facility and the travel costs involved.

CONCLUSION

The state of abortion services in the Eastern Cape falls far below the standard set out in the Act and the Guidelines and is a violation of the constitutional rights of women to reproductive healthcare. The issues crippling abortion care in the province revolve specifically around lack of equipment, a shortage in staff, and the paucity of designated and operational second trimester abortion facilities. The limit on these resources contributes significantly (if not entirely) to the delay in access to abortion services.

A delay of approximately 3 weeks for access to first trimester abortion services may be the difference between a need for a first and second trimester abortion, which carries greater health risks, among other things. A delay of approximately 6 weeks for second trimester abortions could mean the difference between obtaining a safe and legal abortion or falling outside the gestational age limit as provided in the Act. These delays are avoidable and require the ECDoH to invest resources towards abortion care.

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CENTRE FOR CHILD LAW

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