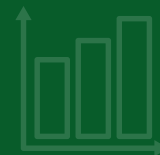




health

Department:
Health
REPUBLIC OF SOUTH AFRICA



NATIONAL CLINICAL GUIDELINE FOR IMPLEMENTATION OF THE CHOICE ON TERMINATION OF PREGNANCY ACT ED. 1



1 FORWARD

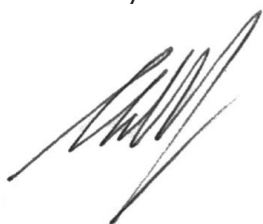
South Africa remains committed to providing comprehensive sexual and reproductive services with an equitable and rights-based approach. Unsafe termination of pregnancy remains one of the major causes of maternal morbidity and mortality and needs to be addressed to further reduce South Africa's maternal mortality rate to the Sustainable Development Goal of 70 maternal deaths per 100,000 live births by 2030.

Following the enactment of the Choice on Termination of Pregnancy (CTOP) Act 92 of 1996, expanded access to the legal termination of pregnancy has directly contributed to reducing South Africa's maternal morbidity and mortality. However, barriers to high-quality legal services remain; these include poor general provider knowledge on termination of pregnancy, lack of training and mentorship, and the inadequate availability of relevant medicines and equipment.

In response to these challenges, this *National Clinical Guideline for Implementation of the Choice on Termination of Pregnancy Act* is being introduced with the purpose of standardizing and expanding service delivery and reaffirming all citizens' right to comprehensive reproductive health care, as per the Constitution. South Africa's laws and policies support a rights-based framework for its sexual and reproductive health programme that is aligned with the United Nations Sustainable Development Goals and the global Family Planning 2020 framework. Additionally, the South African government has ratified regional and international agreements regarding reproductive health and rights, including at the International Conference on Population and Development (1994) and the Maputo Plan of Action (2006).

This guideline is primarily intended for registered medical practitioners, nurses, and midwives who continue to work tirelessly to advance the sexual and reproductive health of South Africans and are positioned to help improve access, quality, and equity of termination of pregnancy services. It is also of interest to public health researchers, professional associations, and civil -society organizations.

It is our sincere hope that through this expression of the government's commitment to the health and well-being of women and girls of South Africa that we will be able to accelerate the already downward trend of maternal mortality, advance women's agency, and ultimately contribute to the development of the South African citizen with regards to their reproductive autonomy.



DR A PILLAY

ACTING DIRECTOR GENERAL: HEALTH

NOVEMBER 2019

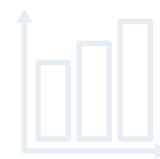


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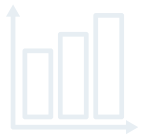
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ACRONYMS

β-hCG	Beta-human chorionic gonadotrophin
CBO	Community-based organization
CTOP	Choice on Termination of Pregnancy
D&E	Dilatation and evacuation
D&C	Dilatation and sharp curettage
DBE	Department of Basic Education
DHE	Department of Higher Education
DHIS	District health information system
DoH	Department of Health
DSD	Department of Social Development
EVA	Electric vacuum aspiration
FBO	Faith-based organisations
Hb	Haemoglobin
hCG	Human chorionic gonadotrophin
HIV	Human Immunodeficiency Virus
ICD	International statistical classification of diseases
ICPD	International Conference on Population and Development
IM	Intramuscular
IUD	Intrauterine device
IV	Intravenous
LMP	Last menstrual period
MNCWH	Maternal, neonatal, child, and women health
MVA	Manual vacuum aspiration
M&E	Monitoring and evaluation
NGO	Non-governmental organization
NDoH	National Department of Health
NSAIDs	Non-steroidal anti-inflammatory drugs
PHC	Primary Health Care Facility
POC	Products of conception
PPH	Postpartum haemorrhage
Rh	Rhesus
SGBV	Sexual and gender-based violence
SRH&R	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TOP	Termination of pregnancy
WHO	World Health Organization



DEFINITION OF TERMS

TERM	DEFINITION
Age of consent	16 years of age for heterosexual and homosexual acts Note: There is no age of consent (no minimum age) for access to termination of pregnancy services.
Autonomy	The right to self-governance over one's own life decisions and body without external influence or coercion. In this guideline, mentally competent individuals, including those under 18, do not require the consent (authorization) of any third party, such as husband or partner, to access termination of pregnancy health services.
CTOP Acts	<i>Choice on Termination of Pregnancy Act 92 of 1996¹</i> <i>Choice on Termination of Pregnancy Amendment Act 38 of 2004²</i> <i>Choice on Termination of Pregnancy Amendment Act 1 of 2008³</i>
Duration or gestational age of a pregnancy	The number of days or weeks since the first day of the individual's last menstrual period (LMP) in those with regular cycles. For individuals with irregular cycles, the gestational age may need to be determined by physical or ultrasound examination. Throughout this document gestational age is defined in both weeks and days, reflecting its definition in the international statistical classification of diseases (ICD).
First trimester	Refers to the gestational period of the first day of the last menstrual period through to the 12 weeks, 0 days of the pregnancy.
Incomplete termination of pregnancy	The clinical presentation of open cervical os and bleeding, whereby all products of conception have not been expelled from the uterus.
Live birth	Delivery of a foetus that shows evidence of life.
Medical termination of pregnancy	Use of pharmacological drugs to terminate the pregnancy. Sometimes, the terms 'non-surgical TOP' or 'medication TOP' are also used.
Minor	The South African Constitution defines a child, and perforce a minor, as a person under the age of 18 years. Similarly, international human rights instruments applying specifically to minors, such as the <i>Convention on the Rights of the Child</i> , define a child as a person under the age of 18 years.
Osmotic dilators	Short, thin rods made of treated seaweed (laminaria) or synthetic material. After placement in the cervical os, the dilators absorb moisture and expand, gradually dilating the cervix.
Post-termination of pregnancy care	Life-saving services that meet the needs of individuals suffering complications from termination of pregnancy.

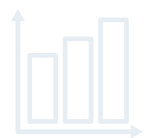
TERM	DEFINITION
Registered Medical Practitioners	A practitioner who is registered with the Health Professions Council of South Africa or the South African Nursing Council to provide any services related to the termination of pregnancy services.
Routes of misoprostol administration	Oral. Pills are swallowed immediately Buccal. Pills are placed between the cheek and gums and swallowed after 30 minutes Sublingual. Pills are placed under the tongue and after 30 minutes. Vaginal. Pills are placed in the vaginal fornices (or as deep as possible) and the individual is instructed to lie down for 30 minutes.
Second trimester	Refers to the gestation period between 12 weeks, 1 day through to 27 weeks, 6 days of the pregnancy.
Sexual Offences and Related Matters Amendment Act, 2007 (Act No. 32 of 2007)	This is an Act of the Parliament of South Africa that reformed and codified the law relating to sex offences. This law imposes a duty to provide various services to the victims of sexual offences, including free post-exposure prophylaxis for HIV, emergency contraception, and the ability to obtain a court order to compel HIV testing of the alleged offender, as well as report sexual offences against children. In all cases, individuals who are a victim of sexual offence and in need of termination of pregnancy services must be provided with these services promptly. ⁴
Statutory rape	Non-forcible sexual activity in which one of the individuals is below the age of consent (the age required to legally consent to the behaviour and often referred to as sexual assault in South Africa). In the context of termination of pregnancy, it is important that the pursuit of legal recourse in such cases does not detract the provider from offering the termination of pregnancy services that the individual needs.
Surgical termination of pregnancy	Use of transcervical procedures for terminating a pregnancy, including vacuum aspiration and dilatation and evacuation (D&E).
Termination of pregnancy	As per the CTOP Act, the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman.
Trained providers	The registered practitioners and counsellors who have completed the prescribed termination of pregnancy services training.
Unsafe termination of pregnancy	A procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both.

PREAMBLE

The National Guideline for Implementation of the Choice on Termination of Pregnancy Act provides additional context based on information that may not be available in the Choice on Termination of Pregnancy Act 92 of 1996, the CTOP Amendment Act 38 of 2004, the CTOP Amendment Act 1 of 2008, Regulations under the Choice of the Termination of Pregnancy Act, 1996, or the Integrated Sexual and Reproductive Health and Rights Policy (2018).

Additionally, this guideline is a critical piece of the broader effort to take a comprehensive approach to reproductive health in South Africa, which not only improves population health, but follows human rights principles to enhance access, choice, and dignity for individuals who seek care. This guideline should be read in tandem with the South Africa National Integrated Sexual and Reproductive Health and Rights (SRH&R) Policy (2019) and used together with other related guidelines on contraception, fertility and safe conception, and the comprehensive management of sexually transmitted infections, among others.

To note, termination of pregnancy (TOP) is used in this guideline to ensure a clear alignment with South Africa's CTOP Act and refers to the conditions of legal termination during the whole of pregnancy. It is recognized that globally, the terms "abortion" and "induced abortion" are considered terminology for voluntary termination of pregnancy.



1 INTRODUCTION

1.1 Background

South Africa's landmark CTOP Act of 1996 was enacted in December 1996 and came into effect in February 1997. The CTOP Act was a ground-breaking and progressive policy change that continues to enable strengthened sexual and reproductive health rights (SRH&R) and serves as a global model for the reform of termination of pregnancy law. Following this Act, TOP-related deaths and complications in South Africa decreased by over 90% between 1997 and 2002.⁵

Yet, more than a decade later, the Department of Health estimated that unsafe TOPs directly resulted in 23% of maternal deaths from septic miscarriages in public health facilities between 2008 and 2010.⁶ Additionally, the 2014-2016 Saving Mothers Report indicated unsafe TOP as an avoidable factor in 25% of maternal deaths due to miscarriage.⁷ Maternal mortality due to TOP-related complications in South Africa is likely underreported due to an overlap in how causes of maternal death are classified. For example, HIV accounts for 32% of maternal deaths⁸ and HIV-positive women who die from septic abortions are likely to be recorded as HIV deaths, rather than TOP-related deaths.

In 2004 and 2008, amendments to the CTOP Act^{2,3} were introduced with the aim of expanding access to TOP services and expanding provider cadres to include trained nurses. However, improved access and equity are required to enhance quality TOP service provision. Individuals continue to seek unsafe termination of pregnancies and risky adverse health outcomes or death, with an estimated minimum of 50% of terminations provided by informal, illegal and unsafe providers in South Africa. Furthermore, there is significant variability in access and quality of TOP service delivery across South Africa. Many studies have identified barriers to safe TOP in South Africa, including provider bias and opposition, stigma, lack of infrastructure, equipment and/or trained providers at the facility, general limited knowledge of TOP legislation, and unmet contraceptive needs.⁹⁻¹²

The National Department of Health (NDoH) 2014 Midterm Review of the Maternal Child and Women's Health Strategy developed recommendations to address implementation challenges for TOP services, which are enabled in full by this guideline, as well as the National Integrated Sexual and Reproductive Health and Rights (SRH&R) Policy (2019).

These recommendations are summarized below:

- Develop a training strategy for all levels of health care providers, including management. This includes introducing TOP into the medical and nursing school curricula, training doctors in second-trimester management, and developing an SRH&R course that covers a continuum of services (SRH&R rights, contraception, TOP, etc.).
- Develop an integrated strategic and operational plan targeted at strengthening TOP services.
- Expand access to medical TOP in all nine provinces and monitor acceptability and impact. This may include facility audits to determine reasons why designated TOP sites are not operational, the effect that medical TOP may have on provider willingness to offer services and acceptability of medical TOP by clients.
- Conduct additional research and develop guidelines for the provision of TOPs for HIV-positive individuals and those with unknown HIV status.
- Strengthen public-private partnerships in areas where the public sector is unable to address the unmet need for safe and legal TOP services or where there are delays.
- Ensure TOP services are able to provide on-site post-TOP contraception. If this is not possible for any reason, ensure that individuals are referred and encouraged to take up a contraceptive method that they choose or prefer to prevent further unwanted pregnancy.

1.2 Objectives of the Guidelines

This TOP guideline provides a clinical and operational framework for the provision of **equitable, accessible, cost-efficient, and user-friendly** TOP services. It aims to advance individuals' rights to access the highest quality of safe TOP services while ensuring integration into the comprehensive SRH&R health care service package.

In line with the National Integrated SRH&R Policy (2019), the **objectives of these guidelines are to:**

- ensure that every individual who seeks a TOP can access the service without undue delay and should not have to wait more than seven days from the first request to access services
- enable all TOP seeking individuals to make informed decisions and ensure their human rights are respected, protected, and fulfilled
- provide a standardised approach to TOP services across South Africa
- increase access to and uptake of TOP services
- deliver integrated TOP services at the lowest appropriate level of care
- promote multi-sectoral collaboration and shared accountability related to the provision of TOP within the context of SRH&R services

1.3 Audience

These guidelines provide strategic and operational guidance to all public and private health care providers. This includes, but is not limited to: national, provincial, and district health officials, health facility managers, health care workers, counsellors, community health care workers, community-based organisations (CBOs), non-governmental organisations (NGOs), faith-based organisations (FBOs), and any other service provider in the private sector and educational institutions.

1.4 Guiding Principles of Implementation

These guidelines are in accordance with global standards of TOP care¹³ and in line with the National Integrated SRH&R Policy (2019). It prescribes that all norms, standards, and clinical practice relating to TOP should promote:

- health, well-being, and human rights
- rights-based approaches characterised by equality and non-discrimination
- strong and visible stewardship
- informed and voluntary decision-making
- autonomy in decision-making
- non-discrimination
- confidentiality and privacy

2.1 Who can terminate a pregnancy and when can a pregnancy be terminated?

The CTOP Act prescribes that only those persons who have the following qualifications and have undergone the prescribed training, as detailed in Chapter 5, can provide TOP services:



REGISTERED MEDICAL PRACTITIONER

A person registered with the Health Professions Council of South Africa, as required under the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974)



REGISTERED NURSE

A person registered with the South African Nursing Council, as required under the Nursing Act (Act No. 33 of 2005)



REGISTERED MIDWIFE

A person registered with the South African Nursing Council, as required under the Nursing Act (Act No. 33 of 2005)

As per Table 1 below, the CTOP Act further prescribes the following:

Table 1 / When, who, and under what condition a pregnancy can be terminated

IN WHAT GESTATION PERIOD?	WHO CAN TERMINATE THE PREGNANCY?	UNDER WHAT CONDITIONS?
UP TO 12 WEEKS + 6 DAYS (1ST TRIMESTER)	- a registered and trained medical practitioner - a registered and trained nurse - a registered and trained midwife	upon request from the woman (no reason required)
BETWEEN 13 WEEKS + 0 DAYS TO 20 WEEKS + 6 DAYS	a registered and trained medical practitioner	- the continued pregnancy would pose a risk of injury to the woman's physical or mental health - there is a substantial risk that the foetus would suffer from a physical or mental abnormality - the pregnancy resulted from rape or incest - the continued pregnancy would significantly affect the social or economic circumstances of the woman
AFTER 20 WEEKS + 6 DAYS	a registered and trained medical practitioner	The providing medical practitioner must consult with another registered medical practitioner, registered nurse, or registered midwife to be of the opinion that continuing the pregnancy would: - endanger the woman's life - result in severe malformation of the foetus - pose a risk of injury to the foetus

2.2 Where can a pregnancy be terminated?

Pregnancy can be terminated at most health care facilities, and as such, all health facilities **should** seek to fulfil the criteria in Table 2 to enable site designation and provision of TOP services.

Table 2 / Site criteria at which a pregnancy can be terminated

CRITERIA (AS PER C TOP ACT)	MINIMUM OPERATIONAL DEFINITION
A / Gives access to medical and nursing staff	≤12 weeks: Availability of at least one registered and TOP trained medical practitioner, nurse, or midwife (as per Chapter 2.1) >12 weeks: Availability of at least one registered and TOP trained medical practitioner (as per Chapter 2.1)
B / Gives access to an operating theatre	A list of facilities with an operating theatre that patients can be referred to
C / Has appropriate surgical equipment	Manual and/or electric vacuum aspirator device, cannulae, dilator, tenaculum, speculum and ring, or sponge forceps available
D / Supplies drugs for intravenous and intramuscular injection	Drugs to manage TOP complications (i.e. haemorrhage) and pain management
E / Has emergency resuscitation equipment and access to an emergency referral centre or facility	As per the Ideal Clinic Framework and Manual
F / Gives access to appropriate transport should the need arise for emergency transfer	As per the Ideal Clinic Framework and Manual
G / Has facilities and equipment for clinical observation and access to in-patient facilities	Recovery room for observation and blood pressure monitor, heart rate monitor, temperature monitor.
h / Has appropriate infection control measures	As per the Ideal Clinic Framework and Manual
I / Gives access to safe waste disposal infrastructure	As per the Ideal Clinic Framework and Manual
J / Has telephonic means of communication	As per the Ideal Clinic Framework and Manual
K / Has been approved by the member of the Executive Council by notice in the Gazette	The approval letter and/or certificate

Any facility that has a **24-hour maternity service and complies with the above (a) to (j) requirements** may terminate pregnancies up to and including 12 weeks without having to obtain the approval of the Member of the Executive Council (MEC).

See Annex 1 for detailed minimum operational facility requirements for each type of TOP procedure (medical, surgical manual, or electric vacuum aspiration, surgical dilatation & evacuation).

2.3 Obstruction to Access

OBSTRUCTION TO ACCESS

Obstruction to access refers to **any person or act which prevents an individual from accessing any part of a quality and lawful TOP service, in a timely manner.** This includes any person in or around a health facility, clinical or non-clinical, ranging from facility support personnel to illegal providers.

In line with the CTOP Act (Section 10, Offences and penalties), obstruction to access refers to all of the following:

1. Any provider who is not a registered medical practitioner, registered midwife, or registered nurse and has completed the prescribed training course and who performs the termination of a pregnancy (as per Chapter 5)
2. Any person or act preventing a lawful termination of pregnancy or obstructing access to a facility for the lawful termination of pregnancy (see “Refusal to care” below)
3. When the TOP takes place at a facility not approved to provide TOP services (as per Chapter 2.2)

As per the CTOP Act (Section 10, Offences and penalties), any person who obstructs access to TOP, as outlined above, shall be found guilty of an offence and liable on conviction to a fine or imprisonment for a period not exceeding 10 years.

REFUSAL TO CARE

Refusal to care includes **any person or act preventing a lawful termination of pregnancy or obstructing access to a facility for the lawful termination of a pregnancy.**

This refers to individuals who prevent a lawful termination of pregnancy or obstruct access to a facility for a lawful termination of pregnancy based on personal beliefs, usually religious or spiritual in nature.

According to Section 15 (1) of The Constitution of the Republic of South Africa, 1996, *“everyone has the right to freedom of conscience, religion, thought, belief, and opinion.”* Access to TOP under the CTOP Act is, similarly, regarded as a constitutional right. Although Section 15 of the Constitution implicitly accommodates provider refusal to provide TOP services, this creates harm and additional barriers for patients who are entitled to receive comprehensive SRH&R care.

A provider that refuses to provide TOP services, and thus exercises Section 15 of the Constitution, should not be a detriment to the individual seeking a TOP. Given stewardship obligations within the public service, public servants must acknowledge their fiduciary duties.



SECTION 15 OF THE CONSTITUTION:

“FIDUCIARY DUTY MEANS THAT A CLINICIAN SHOULD NEVER GIVE HIGHER PRIORITY TO HER OR HIS OWN CONSCIENCE THAN TO THE PATIENT’S NEEDS.”

Only the direct TOP provider can refuse care (no other health care or support staff member can refuse care). As such, a direct TOP provider who refuses care based on personal beliefs must refer the individual to a colleague or facility that is able to offer such services. The individual's right to information and access to health care services, including TOP, should always be provided for.

In the case of a direct provider's refusal to care, the following standard protocol should be exercised:

1. *Section 36 of the Constitution imposes a duty to, at a minimum, provide the individual with information about where the individual can obtain a TOP and refer the individual accordingly.*
2. *A register of TOP services refused should be kept in each facility, noting:*
 - the clinical details of the individual
 - the referral process
 - the name of the clinician who refused services
3. *A health care professional's refusal to care cannot violate the right of other health care professionals who are willing to provide TOP services:*
 - Health care professionals who are not willing to provide TOP services must inform their Facility Manager in writing when applying for a position in the facility.
 - Facility Managers must confirm whether a staff member is fit to provide TOP services when appointing staff.
 - Each staff member who exercises a refusal to treat must be handled individually. TOP service provision should never be handled in a group, or as a group action.
 - Refusal to treat only applies to individual trained health care professionals and not to groups, institutions, support personnel, or complementary services.
4. *In non-emergency cases, health care professionals who refuse to provide a TOP service must still:*
 - Explain their refusal to the individual in a manner that is non-judgemental and does not stigmatise.
 - Explain to the individual their right to request a safe TOP.
 - Refer the individual to a facility/provider who will conduct the TOP.
 - Update the facility register to note the refusal to treat.

REFUSAL TO CARE FOR OTHER HEALTH CARE PROFESSIONALS

Ancillary staff (e.g. reception, ward clerks, janitorial, catering, etc.) and other health care professionals involved in the general care of a patient (e.g. pharmacist) **may not** refuse to provide general or standard care to an individual under any circumstances.

Thus, conditions of unlawful violation of the CTOP Act includes the following and would be found chargeable of offence:

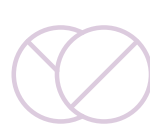
- If a direct provider is found to be denying an individual access to safe TOP services by failing to provide the TOP service and failing to provide referral to a colleague or facility that will provide the TOP service and/or obscuring other health care workers to provide safe TOP services, the health care professional has unlawfully violated the CTOP Act.
- If a health care professional refuses to assist and is not directly involved in performing the TOP, the health care professional has unlawfully violated the CTOP Act.

OBLIGATIONS IN EMERGENCY SETTINGS

All health care professionals must provide emergency care when continuation of a pregnancy poses a serious danger to the life or health of the individual or the fetus, regardless of gestational age.

Section 36 of the Constitution limits the right to refuse treatment or care to when there is a medical emergency and maternal life or health is in danger. A health care professional can therefore not legally or ethically object to the rendering of care in cases of life- or health-endangering emergencies associated with TOP procedures.

According to the law, health care professionals, regardless of their religious or moral objections, have a duty to perform a TOP procedure if the individual will suffer *adverse health consequences* if the TOP is not promptly carried out. When an individual faces a risk to their health because a health care professional refuses to provide a TOP, the individual's right to health is jeopardised.



3.1 Information

RIGHT TO INFORMATION

As per the CTOP Act, any individual requesting TOP services has the right to information concerning the TOP. It is mandatory for the health care professional with whom the individual first requested the TOP service to inform the individual of the following:

- They are entitled to the TOP upon request during the first 12 weeks of the gestation period.
- Their pregnancy may be terminated from the 13th week up to and including the twentieth week of the gestation period under the circumstances outlined in Table 1.
- Only their consent is required for the TOP.
- The provision of non-mandatory and non-directive counselling, **before and after the TOP, shall be available.**
- If the facility first visited by the individual does not provide TOP, the individual will be referred to a list of facilities providing TOPs and their locations.

3.2 Counselling

The provision of informative and supportive counselling forms an essential part of high-quality TOP services. Every pregnant individual who is contemplating TOP should be offered pre- and post-counselling from a trained health care professional, although it is up to the individual whether or not to access the service. As per Section 4 of the CTOP Act, counselling shall, at minimum, include sufficient information to assist an individual to make an informed choice regarding the TOP. This information should be in a form that the individual can understand and recall. A trained health care professional (midwife, nurse, medical doctor, or a community-based health care worker) can provide counselling.

COUNSELLING STANDARDS

The following standards should be adhered to regardless of the type of counselling provided.

COUNSELLING

- Should be non-directive and non-mandatory, and conducted in a manner that allows the individual to make autonomous and informed decisions.
- Should be confidential at all times and individuals should be informed of their right to confidentiality.
- Should be patient-centred and based on human rights, which emphasises the following:
 - an interactive, two-way discussion during which the stories and narratives told by the individual are important and respected
 - an attitude and style of communication, security, and trust that ensures the individual's positive experience
 - a respect for the individual by being responsive to their stories and experiences



SECTION 4 OF CTOP ACT:

"THE STATE SHALL PROMOTE THE PROVISION OF NON-MANDATORY AND NON-DIRECTIVE COUNSELLING, BEFORE AND AFTER THE TERMINATION OF A PREGNANCY."

- an understanding of the social context within which an individual requests the TOP
 - » counsellors should, under no circumstances, demand information from the individual and should show understanding for the individual's situation if the individual does not share information
- a normalisation of TOP and the experience of having a TOP as a reproductive health right
 - » negative discussions about TOP should be avoided (for example, if individuals bring up their own religious beliefs, counsellors should dispel fears without judgement)
- a focus on content and topics which individuals wish to discuss
 - » this does not apply to accurate medical information about the procedure as this is required for informed consent to proceed with the TOP

COUNSELLING TOPICS

Table 3 outlines the most important counselling topics that should be offered to all pregnant individuals contemplating TOP.

Remember that counselling should only focus on each of these topics if and when the individual expresses a need to discuss it. The content of each topic is dependent on the length of pregnancy and type of counselling needed by TOP individuals.

Table 3 / Types of counselling for pregnant women considering a TOP

DECISION-MAKING COUNSELLING

This counselling is usually requested by individuals who have not made a final decision. It plays an important role in helping individuals consider all options and ensures a decision can be made without coercion.

Many individuals may have already decided to have a TOP before visiting the facility. This decision should be respected, and decision-making counselling should focus on ensuring the individual has made their decision based on accurate, non-directive information.

Should minors not want to consult an adult, services should proceed without delay, otherwise this would be legally understood as an enforced waiting period and is in violation of the CTOP Act.

The following should be provided during Decision-Making Counselling:

- the TOP method options, such as medication and manual vacuum aspiration (MVA)
 - » Counsellors can show the medication and MVA apparatus to familiarise the individual with the procedure and to allay any fears, concerns, or misinformation the individual might have
- what will be done during and after the procedure
- what is likely to be experienced (e.g. menstrual-like cramps, pain, and bleeding)
- how long the process is likely to take
- what pain management will be made available
- risks and complications associated with the TOP method
- when the individual will be able to resume their normal activities, including sexual intercourse
- any follow-up care

If the individual chooses to proceed with TOP, the health care professional should inform the individual of their rights. The individual should be given as much time as is needed to make a decision and given information on the advantages of a TOP at an earlier gestational age.

Table 3 / Types of counselling for pregnant women considering a TOP

PRE-TOP COUNSELLING

This type of counselling is for individuals who want to know more about the details of the TOP procedure and which options are available for their gestational age. This counselling helps individuals who need emotional support immediately before the procedure.

The following should be provided during pre-TOP counselling, (if not covered under Decision-Making Counselling):

- the TOP methods and pain management options available to the individual before, during, and after the TOP
- counsellors may show the medication and MVA to familiarise the individual with the procedure and to allay any fears, concerns, or misinformation the individual may have, provided the individual also consents to this
- initiate a discussion on future contraceptive needs and provide the necessary and accurate information on the availability of contraceptive options as per the National Clinical Guideline for Contraception (2019)
- inform the individual of available HIV counselling and testing services (knowledge of one's HIV status is strongly recommended but not a pre-requisite to receive TOP)

POST-TOP COUNSELLING

This counselling option outlines the available support and steps to follow after the TOP procedure.

- clear, simple, oral, and written instructions about follow-up care after leaving the facility
- instructions should include how to recognize complications that require medical attention and where to seek help if required
- offer a contraceptive method and prescription or referral for methods that require provider placement, if requested by the individual (this should be encouraged, but not imposed by the provider)
 - » fertility can return up to 10 days after a first-trimester TOP or miscarriage and within 4 weeks after a second-trimester TOP or miscarriage
- information on when the individual will be able to resume normal activities, including sexual intercourse
 - » to avoid infection, the individual should not have sexual intercourse or place anything in the vagina until bleeding stops (approximately 5 to 7 days post-TOP). If being treated for an infection or vaginal/cervical injury, the individual should wait until fully healed to resume sexual intercourse

POST-TOP COMPLICATIONS COUNSELLING

An individual who experiences post-TOP complications requires compassion and support. While this is especially true for an individual who has received an unsafe induced TOP, counselling for individuals who experience complications after a safe or unsafe TOP is key.

If post-TOP complications are experienced, the following should be provided:

- an effort to understand what the individual has been through
- treating the individual with respect and avoiding judgement and criticism
- an offer to include a trusted friend or family member present in counselling sessions, with the individual's consent
- consideration of other reproductive health services that should be provided, such as contraceptive advice and emphasis on the use of dual protection, which is key in the context of prevention of STIs

Topics to avoid when talking to TOP seeking individuals:



- Never require an individual to disclose how they conceived.
- Do not shame individuals for lack of contraceptive use or any other behaviour that could be interpreted as leading to the pregnancy.
- Do not require an individual to divulge their reasons for wanting a TOP or judge the individual for the pregnancy or their reason for wanting a TOP.
- Refrain from using the word 'baby' to refer to the embryo/foetus or unborn child, unless preferred by the individual.
- Refrain from using graphic descriptions of foetal development, showing pictures of foetuses, or requiring the individual to listen to the foetal heartbeat.
- Do not communicate unproven, disputed, or false claims about negative physical and mental consequences of TOP.
- Do not use religious references.

3.3 Informed consent

TOPs may only take place with the informed consent of the pregnant individual. No consent other than that of the pregnant individual is required, irrespective of age. Pregnant minors (any individual under 18 years of age) may benefit from consulting with an adult (parents, guardian, or other adult family or friends) before a TOP. However, consulting an adult is not required and a pregnant minor cannot be denied TOP services if they choose not to consult with an adult.¹

Written consent in the form of a signed consent form (Annexure B) should be obtained from the individual before the TOP procedure. The information outlined under 3.1 *Right to Information* should be provided to all individuals before obtaining their consent.



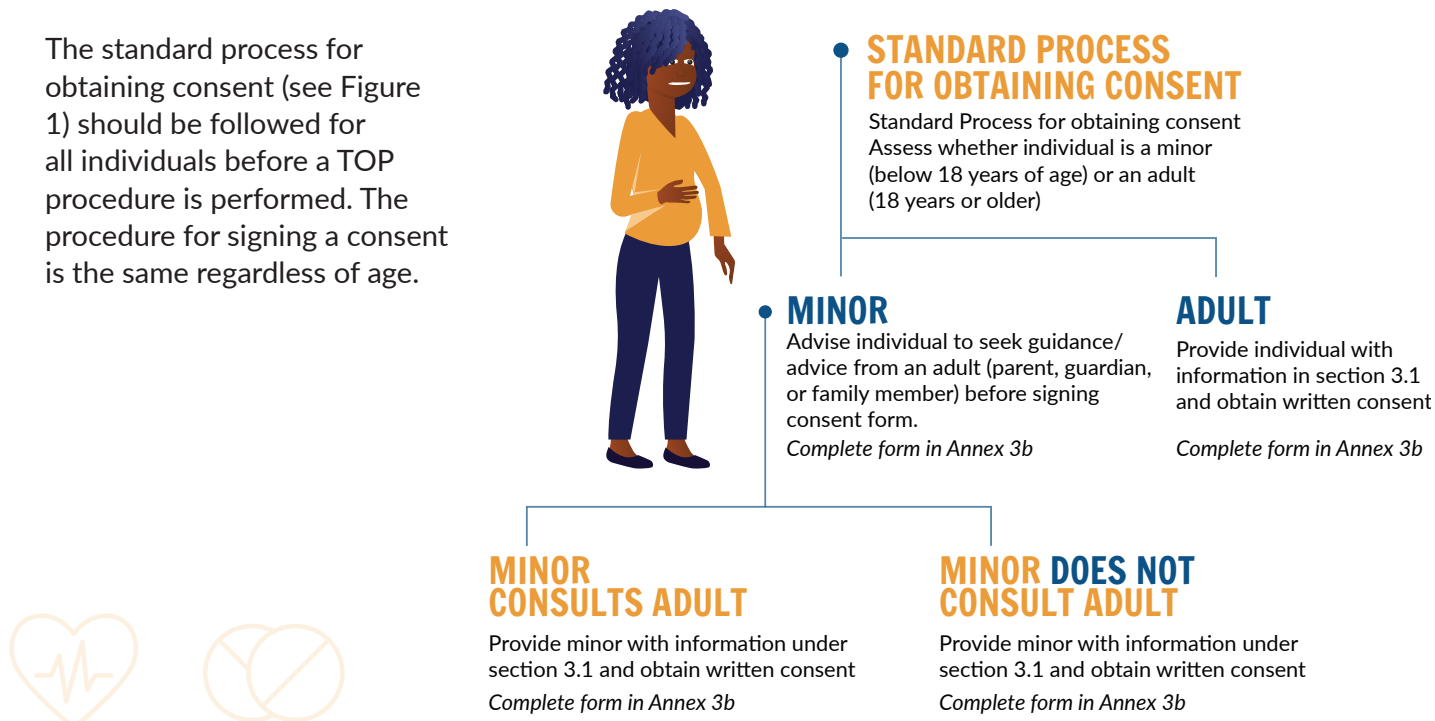
SECTION 5 OF CTOP ACT:

**"NO CONSENT OTHER
THAN THAT OF THE
PREGNANT WOMAN
SHALL BE REQUIRED
FOR THE TERMINATION
OF A PREGNANCY."**

THE STANDARD PROCESS FOR OBTAINING CONSENT

Figure 1 / The standard process for informed consent

The standard process for obtaining consent (see Figure 1) should be followed for all individuals before a TOP procedure is performed. The procedure for signing a consent is the same regardless of age.



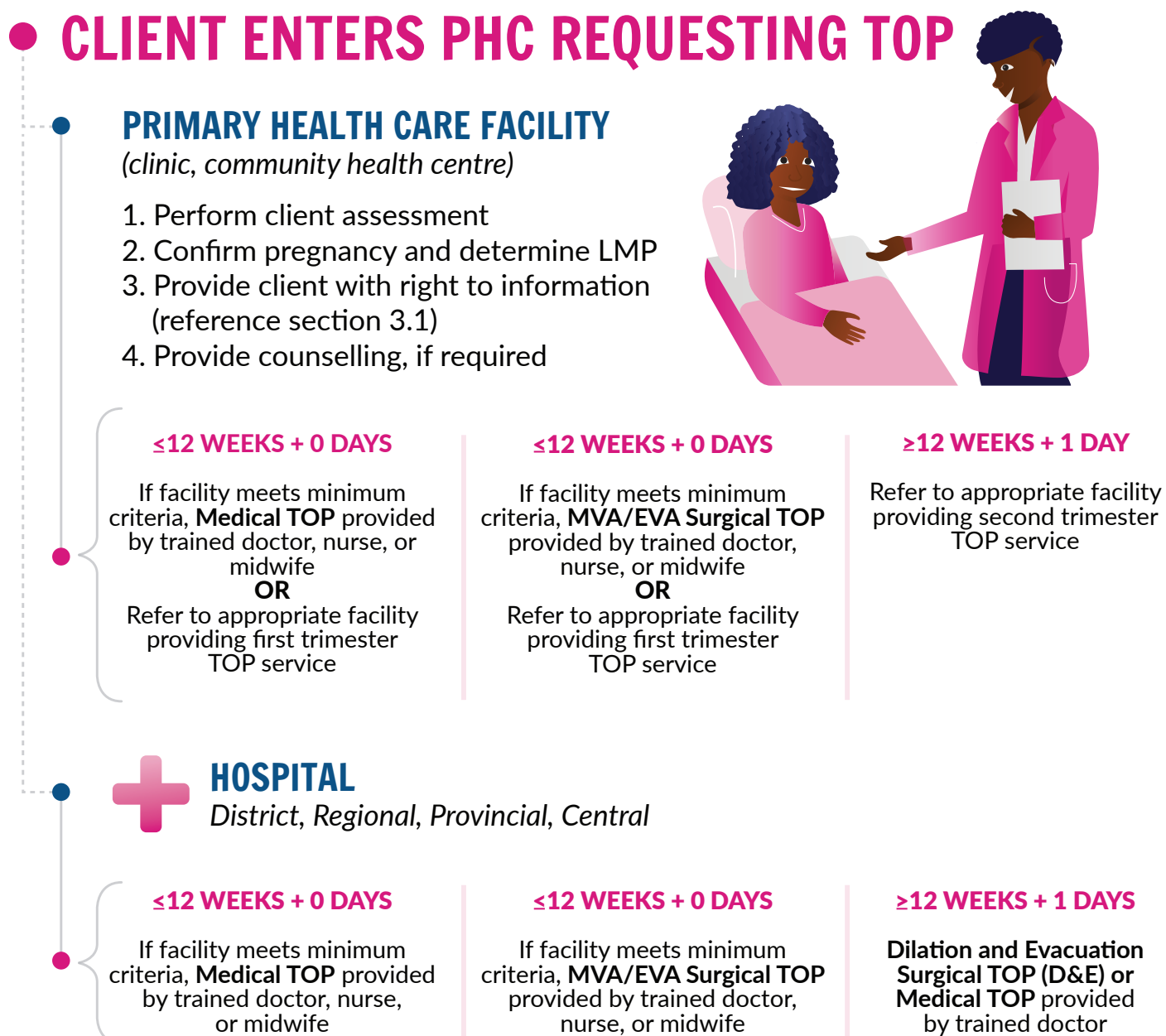
4 / CLINICAL CARE

This section addresses the clinical management of individuals who chose to terminate their pregnancy and outlines the essential components of providing clinical care before, during, and after the provision of TOP services. The following publications have been used as evidence-based references for the clinical care guidance in this section: *WHO Clinical Practice Handbook for Safe Abortion (2014)*, *WHO Medical management of abortion (2018)* and *the Royal College of Obstetricians & Gynaecologists, Best practice in comprehensive abortion care (2015)*.

4.1 TOP service delivery algorithm

All individuals who request or need TOP services should enter the health system at the primary health care level. However, TOP services can only be offered in a facility that fulfils the criteria outlined in Table 2. All facilities that do not fulfil these criteria should fully assess and refer individuals to the nearest facility that is known to provide TOP at the gestation the individual requires.

Figure 2 / TOP service delivery and referral algorithm



4.2 Clinical assessment

An individual who presents at a primary care provider (clinic, community health centre, or general practitioner) and requests TOP should be fully assessed.

MEDICAL HISTORY AND PHYSICAL EXAMINATION

Service providers should obtain a complete medical history of the individual, including contraindications to medical or surgical TOP methods, to identify risk factors for complications of treatment.

Medical history-taking should include:

- personal and family history of relevant diseases
- obstetric and gynaecological history, including previous ectopic pregnancy
- bleeding tendencies or disorders
- history or presence of STIs
- current medications used
- known allergies
- risk assessment for violence or coercion
 - service providers should be alert to the possibility of violence or coercion and offer counselling if violence or coercion is suspected

Conduct physical examination:

This consists of using abdominal and pelvic examinations (bimanual and speculum examinations) to help determine the last menstrual period (LMP) and rule out ectopic pregnancies. Examinations should be conducted in the following sequence:

- Confirm pregnancy by rapid pregnancy diagnostic test (urine or blood).
- Conduct an abdominal palpation and bimanual examination to exclude ectopic pregnancy and determine gestational age (see Annex 2). **Note that an ultrasound is not a prerequisite for TOP.** Where an ultrasound is not available, clinical assessment of gestational age that agrees with LMP is acceptable.
 - If an ectopic pregnancy is suspected, or if there is any other abnormality or concern about the gestational age, refer the individual to the appropriate level of care.
 - An irregular uterus on palpation could be suggestive of fibroids and should be treated as a fibrous uterus. If suspected, refer to the appropriate level of care.
- Conduct speculum examination to assess for bleeding, discharge, or lesions. Women with signs and symptoms of a reproductive tract infection should be treated immediately and the procedure can be performed without delay.

LABORATORY AND OTHER INVESTIGATIONS

Routine laboratory testing is not a prerequisite for TOP services and **should not delay the TOP procedure**. The following tests, when available, may be performed on the basis of individual risk factors, findings on physical examination, and available resources.

- Haemoglobin (Hb) or haematocrit for suspected anaemia
- Rhesus (Rh)-testing, where Rh-immunoglobulin is available for Rh-negative women
- HIV testing/counselling
- STI screening (usually performed during the pelvic examination)
- cervical cancer screening (performed during the pelvic examination)
- other laboratory tests as indicated by medical history (kidney or liver function tests, etc.)

4.3 Infection prevention and control

Since TOP procedures involve contact with blood and other bodily fluids, all clinical and support staff that provide these services should understand and apply standard precautions for infection prevention and control, for both their own protection and that of their patients. Requirements for infection prevention and control should be adhered to as per the *South Africa Ideal Clinic Framework and Manual*.

The following should be noted with care:

- Gloves should be worn and replaced between contact with different individuals and between vaginal and rectal examinations of the same individual.
- After completing care of one individual and removing gloves, the provider should always wash their hands, as gloves may contain undetected tears.
- Aseptic technique: Prior to any surgical TOP procedure, the individual's cervix should be cleaned with an antiseptic (e.g. betadine).
- Aspirators, cannulae, and adaptors are not safe to handle with bare hands until cleaned.

4.4 Pain management

All individuals must be offered pain medication before a medical or surgical TOP procedure.

Neglecting to offer pain medication to individuals undergoing a TOP procedure increases an individual's anxiety and discomfort, potentially lengthening the procedure and compromising care. The amount of pain an individual will experience with uterine evacuation or pregnancy expulsion and their response to that pain varies greatly. It is necessary to assess each individual's pain-management needs.

Pain related to both physiological and mechanical cervical dilatation and uterine contractions are common among individuals undergoing a TOP procedure. Both pharmacological and non-pharmacological methods may be helpful to reduce pain associated with TOP.

Table 4 / Pharmacological methods for pain management

PAIN MEDICATION	MEDICAL TOP	SURGICAL TOP
ANALGESIA	NSAIDs, e.g. Ibuprofen (400-800 mg)	NSAIDs, e.g. Ibuprofen (400-800 mg)
LOCAL ANAESTHETIC	N/A	Lidocaine (20 mL of 1%) for para-cervical or intra-cervical block
ANXIOLYTICS/ SEDATIVES	Diazepam (5-10 mg)	Fentanyl, midazolam, propofol Diazepam (5-10 mg)
ADJUVANT MEDICATIONS	Adjuvant medications may also be provided, if indicated, for side-effects of misoprostol (e.g. loperamide for diarrhoea, anti-emetic for nausea). ≥12 weeks + 1 day gestation: In addition to NSAIDs, offer at least one or more of the following: oral opioids, intramuscular (IM) or intravenous (IV) opioids, epidural anaesthesia.	General anaesthesia is not routinely recommended for vacuum aspiration or D&E. Medications used for general anaesthesia are one of the few potentially life-threatening aspects of TOP care. Any facility that offers general anaesthesia must have the specialized equipment and staff to administer such and handle associated complications.

Note: Paracetamol is **not** recommended to decrease pain during a TOP. Oral medication should be administered 30 to 45 minutes before a TOP procedure to ensure optimal effectiveness during the procedure.

MEDICAL TOP

- respectful, non-judgmental communication
- verbal support and reassurance
- thorough explanation of what to expect
- the presence of a support person who can remain with the individual during the process (if requested)
- hot water bottle or heating pad

SURGICAL TOP

- respectful, non-judgmental communication
- verbal support and reassurance
- gentle, smooth operative technique
- advanced notice of each step of the procedure (upon individual request)
- the presence of a support person who can remain with the individual during the process (if requested)
- encouraging deep, controlled breathing
- listening to music
- hot water bottle or heating pad

4.5 Other considerations

ECTOPIC PREGNANCY

Ectopic pregnancy is an uncommon, but potentially life-threatening event, occurring in 1.5 to 2% of pregnancies. Signs and symptoms that might indicate extrauterine pregnancy include:

- uterine size smaller than expected for the estimated length of pregnancy
- cervical motion tenderness
- lower abdominal pain, especially if accompanied by vaginal bleeding
- spotting, dizziness or fainting, pallor
- adnexal mass (in some individuals)

If an ectopic pregnancy is suspected, it is essential to:

1. Confirm the diagnosis immediately.
2. Initiate treatment or transfer the individual as soon as possible to a facility that has the capacity to confirm the diagnosis and provide treatment.

Note: The inspection of aspirated tissue following a surgical TOP procedure can nearly eliminate the risk of an ectopic pregnancy going undetected.

Neither mifepristone nor misoprostol drugs are treatments for ectopic pregnancy, which, if present, will continue to grow. Therefore, health care professionals must be particularly alert to clinical signs of ectopic pregnancy as listed above.

Where clinical features raise suspicion of an ectopic pregnancy, further investigations should be performed. These may include pelvic ultrasound and serial beta-human chorionic gonadotrophin (β -hCG) measurements. The individual should be transferred to an appropriate referral centre for treatment.

RH-ISOIMMUNIZATION

Rhesus (Rh)-testing is not a requirement for TOP services, especially where it is not available or if the prevalence of Rh-negative status is low. There is currently no conclusive evidence about the need for this measure after early induced TOP.

In settings where the prevalence of Rh-negative status is high and Rh-immunoglobulin is routinely provided in the facility to Rh-negative individuals, it should be administered at the time of the TOP procedure. The dose of Rh-immunoglobulin may be reduced from 300 μ g (the dose given after term delivery) to 50 μ g in

pregnancies of less than 12 weeks. However, in pregnancies up to 9 weeks, the theoretical risk of maternal Rh-sensitization with medical TOP is very low. Thus, determination of Rh status and the offer of anti-D prophylaxis are not considered prerequisites for early medical TOP.

If Rh-immunoglobulin is available, administration of the immunoglobulin to Rh-negative individuals having a medical TOP is recommended at the time of the prostaglandin administration. For individuals using misoprostol at home, Rh-immunoglobulin may be administered at the time mifepristone is taken.

4.6 Medical termination of pregnancy

Medical TOP is a multistep process involving two medications (mifepristone and misoprostol) and/or multiple doses of one medication (misoprostol alone).

CLINICAL CONSIDERATIONS

A combined regimen of mifepristone with misoprostol is the preferred regimen for medical TOP. It is more effective and safer, with success rates of over 95%, continuing pregnancy rates of less than 2% and complication rates of 3% up to 13 weeks + 0 days gestation. Compare that to the misoprostol-only regimen, which has a lower success rate at 85%, with continuing pregnancy rates of 3-10% and complication rates of 4% up to 13 weeks + 0 days gestation. The combined regimen of mifepristone and misoprostol also results in faster completion of TOP and is associated with fewer side effects than misoprostol only.

- Home-use of misoprostol (up to 10 weeks + 0 days gestation) following provision of mifepristone at a health care facility can improve the privacy, convenience, and acceptability of services, and has been shown to be safe and effective.
- Facility-based TOP care should be reserved for the management of medical TOP for pregnancies over 10 weeks + 0 days and management of severe TOP complications. Individuals must be able to access advice and emergency care in the event of complications, if necessary.
- Mifepristone and misoprostol do not terminate an ectopic pregnancy.
- Absence of bleeding is a possible indication that the pregnancy may be ectopic, but it may also signify that an intrauterine pregnancy did not terminate.
- Even if a pregnancy is ectopic, an individual can experience some bleeding after taking mifepristone and misoprostol because the decidua may respond to the medications.
- Evaluate the individual for ectopic pregnancy if they report signs or symptoms of ongoing pregnancy after medical TOP.

FIRST TRIMESTER (≤12 WEEKS + 0 DAYS)

Table 6 / Combined Mifepristone and Misoprostol and Misoprostol-only protocol ≤12 weeks + 0 days gestation

GESTATIONAL AGE	MIFEPRISTONE DAY 1	MISOPROSTOL			
	ROUTE	DOSE	ROUTE	TIMING	DURATION
Combined regimen: ≤12 weeks + 0 days	200 mg Oral Single-dose X	800 µg	Sublingual, vaginal, or buccal	1-2 days (after taking mifepristone) <i>The minimum recommended interval between mifepristone and misoprostol is at least 24 hours. Note: There is limited evidence to suggest that simultaneous dosing of mifepristone and misoprostol is efficacious.</i>	Single-dose (Repeat doses can be considered when needed to achieve the success of the medical TOP)
Misoprostol only regimen: ≤12 weeks + 0 days	N/A	Same as outlined above			

Administer the medication to initiate medical TOP

- Mifepristone is always administered orally.
- Misoprostol can be administered by different routes including oral, vaginal, buccal, and sublingual. Evidence suggests that the vaginal route is the most effective. Consideration to patient and provider preference suggests the inclusion of all routes, including buccal administration.
- Antibiotic prophylaxis is not necessary for medical TOP.
- Health care professionals should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with a prior uterine incision. Uterine rupture is a rare complication; preparedness for emergency management of uterine rupture must be considered with advanced gestational age.

Offer supportive care prior to and during pregnancy expulsion

It is essential that the individual knows to seek medical attention for:

- prolonged or heavy bleeding (soaking more than two large pads per hour for two consecutive hours)
- fever lasting more than 24 hours after using misoprostol
- feeling generally unwell for more than 24 hours after misoprostol administration

Follow-up care

- A routine follow-up visit should be encouraged, especially if a misoprostol-only regimen was used as it has a lower success rate, although it is not necessary for medical reasons. If a follow-up visit is scheduled, it should be between 7 and 14 days.
- Assess for complete TOP: The use of clinical signs and symptoms with the bimanual examination is typically adequate to determine if the TOP has been successful. Human chorionic gonadotrophin (hCG) levels or ultrasonography (if available) can be used to confirm TOP success if there is doubt.

Further evaluation for completed TOP

- If an individual reports ongoing symptoms of pregnancy and/or has only minimal bleeding after taking the TOP medications as directed:
 - » Ongoing pregnancy should be suspected. Further evaluation could include pelvic examination, demonstrating a growing uterus, or an ultrasound scan, demonstrating an ongoing pregnancy.
 - » Offer vacuum aspiration or repeat administration of misoprostol to complete their TOP. A client should be advised that in the case of an ongoing pregnancy, a repeat dose of misoprostol is only approximately 30% effective and vacuum aspiration will likely be necessary.
- If an individual reports prolonged or excessive bleeding and cramping and ongoing intrauterine pregnancy (see above) are not suspected:
 - » Consider a diagnosis of ectopic pregnancy and manage appropriately.
 - » Offer repeat misoprostol or a vacuum aspiration to complete the TOP.
- If individual reports lighter than expected bleeding or no bleeding and ongoing intrauterine pregnancy is not suspected:
 - » Consider a diagnosis of ectopic pregnancy and manage appropriately.

SECOND TRIMESTER (≥12 WEEKS + 1 DAY)

After 10 weeks + 0 days of gestation, medical TOP should be undertaken in a health facility only. Individuals should remain in-facility until the expulsion of pregnancy is complete.

Table 7 / Combined Mifepristone and Misoprostol and Misoprostol-only protocol ≥12 weeks + 1-day gestation

GESTATIONAL AGE	MIFEPRISTONE DAY 1	MISOPROSTOL			
	ROUTE	DOSE	ROUTE	TIMING	DURATION
≥12 weeks + 1 day	200 mg Oral Single-dose X	400 µg	Sublingual, vaginal, or buccal	1-2 days (after taking mifepristone) <i>The minimum recommended interval between mifepristone and misoprostol is at least 24 hours.</i>	Every 3 hours until foetal and placental expulsion. <i>Note: There is no maximum number of doses.</i>
Misoprostol only regimen: ≥12 weeks + 1 day	N/A	Same as outlined above			

Administer the medication to initiate medical TOP

- Mifepristone is always administered orally.
- Misoprostol can be administered by different routes including oral, vaginal, buccal, and sublingual. Evidence suggests that the vaginal route is the most effective. Consideration to patient and provider preference suggests the inclusion of all routes, including buccal administration.
- The use of a loading dose of misoprostol is not necessary. There is no advantage to the use of moistened over dry misoprostol.
- Antibiotic prophylaxis is not necessary for medical TOP.
- Health care providers should use caution and clinical judgment to decide the maximum number of doses of misoprostol in individuals with a prior uterine incision. Uterine rupture is a rare complication; clinical judgement and health system preparedness for emergency management of uterine rupture must be considered with advanced gestational age.

Ensure prompt administration of repeat misoprostol as necessary and offer supportive care prior to and during pregnancy expulsion

- Cramping will often begin before the second dose of misoprostol is administered, however, timing is variable. From the timing of the first dose of misoprostol, the individual should be monitored regularly, particularly in relation to their need for pain management.
- If the foetus/products of conception (POC) have not passed after 8 to 10 hours of receiving misoprostol, perform a vaginal examination, and remove the POC if present in the vagina or cervical os.
- **Routine uterine curettage is unwarranted.** Use of modern methods of medical TOP (misoprostol with or without mifepristone) result in low rates (<10%) of retained placenta. Uterine evacuation by vacuum aspiration to remove the placenta should only be performed in individuals who have heavy bleeding, fever, or a retained placenta beyond 3 to 4 hours.

Recovery and discharge from the facility

- Reassure the individual that the procedure is finished and that the individual is no longer pregnant.
- Monitor the individual for any complications and provide management as needed. The individual may leave the facility when they are stable and meet the criteria for discharge.
- Ensure that the individual has all the necessary information and/or medications prior to leaving the facility.
- Document all outcomes of the treatment, including any adverse events.

Note

- Fever or chills can be a frequent side-effect of repeated doses of misoprostol. Administration of paracetamol or ibuprofen will decrease an individual's discomfort. Fever that persists for hours after the last dose of misoprostol should be evaluated.
- Severe pain that persists should be evaluated to rule out uterine rupture, a rare complication.

4.7 Surgical termination of pregnancy

Surgical TOP makes use of transcervical procedures for terminating a pregnancy, including vacuum aspiration and D&E.

CLINICAL CONSIDERATIONS

Surgical TOP is a quick procedure that allows for verification of a complete TOP by evacuation of aspirated products of conception. The inspection of aspirated tissue following a surgical TOP procedure can nearly eliminate the risk of an ectopic pregnancy going undetected.

- A surgical TOP may be necessary in the following cases: there are contraindications to medical TOP, there are constraints for the timing of the TOP, or the individual prefers it.
- All individuals having surgical TOP, regardless of their risk of pelvic inflammatory infection, should receive appropriate prophylactic antibiotics pre- or peri-operatively. Women with signs and symptoms of reproductive tract infections should receive treatment doses of antibiotics and the procedure can be performed without delay.
- For surgical TOP, an individual can leave the health care facility as soon as they feel able and their vital signs are normal.

VACUUM ASPIRATION (≤14 WEEKS + 0 DAYS)

Vacuum aspiration is the recommended technique of surgical TOP for pregnancies of up to 14 weeks + 0 days of gestation. The procedure should not be completed by sharp curettage. Dilatation and sharp curettage (D&C) is not recommended and, if still practised, should be replaced by vacuum aspiration.

- **Manual vacuum aspiration (MVA)** uses a hand-held aspirator to generate a vacuum. The aspirator is attached to cannulae ranging from 4 to 14 mm in diameter and can be used in multiple settings, including those without electricity.
- **Electric vacuum aspiration (EVA)** uses an electric pump to generate a vacuum and can accommodate a cannula up to 14–16 mm in diameter, with larger-diameter tubing (for cannulae >12 mm).

The TOP procedure is performed similarly, regardless of the type of vacuum used. Table 8 details the protocol for a vacuum aspiration.

Table 8 / Vacuum aspiration protocol, recommended for ≤ 14 weeks + 0 days gestation

Prior to the start of the procedure	• Refer the individual to an appropriate facility if conditions are detected that may cause or exacerbate complications. • Perform cervical preparation, if needed. • Provide antibiotic prophylaxis to reduce post-procedure infection. • Confirm that the individual has received pain medications. • Ensure all necessary equipment is gathered and available for use. • If using MVA, make sure that the aspirator holds a vacuum before starting the procedure and that back-up aspirators are readily available, in case the first aspirator is faulty.
Cervical preparation	• Cervical preparation is recommended for all women with pregnancy over 12 weeks + 0 days of gestation. However, its use should be considered for women before 12 weeks + 0 days of gestation if there is a high risk for cervical injury or uterine perforation. • For cervical preparation before surgical TOP in the first trimester, any ONE of the following methods is recommended: » oral mifepristone 200 mg (24 to 48 hours in advance) » misoprostol 400 µg administered sublingually, 1 to 3 hours prior to the procedure » misoprostol 400 µg administered vaginally or buccally 3 hours prior to the procedure » osmotic dilators placed intracervical 6 to 24 hours prior to the procedure
Prophylactic antibiotics	• To reduce the risk of post-procedure infection, prophylactic antibiotics initiated pre- or peri-operatively are recommended. Facilities offering surgical TOP should make efforts to secure adequate antibiotic supplies. • Antibiotics are not a prerequisite for TOP.

DILATATION AND EVACUATION (≥ 14 WEEKS + 1 DAY)

D&E is the recommended surgical method for TOP for gestation over or equal to 14 weeks + 1 day.

Table 9 / Dilatation and evacuation protocol, recommended for ≥ 14 weeks + 1-day gestation

Prior to the start of the procedure	• Perform cervical preparation. • Provide antibiotic prophylaxis. • Confirm that the individual has received pain medications at the appropriate time. • Ensure all necessary equipment is gathered and available for use.
Cervical preparation	• All individuals undergoing D&E with pregnancy ≥ 14 weeks + 1 day of gestation should receive cervical preparation prior to the procedure. • Adequate cervical preparation decreases the morbidity associated with second-trimester surgical TOP, including the risk of cervical injury, uterine perforation, and incomplete TOP. • The recommended methods of cervical preparation, prior to D&E with pregnancy ≥ 14 weeks + 1 day of gestation, are osmotic dilators or misoprostol. Suitable preparations include any ONE of the following: » osmotic dilators 6 to 24 hours before the procedure (if the pregnancy is at less than 18 weeks + 0 days of gestation, osmotic dilators will be effective at just 3 to 4 hours before the procedure) » mifepristone 200 mg 24 to 48 hours before the procedure » misoprostol 400 µg vaginally or buccally 3 hours or sublingually 2 hours before the procedure

4.8 Post-TOP care

Health care professionals involved in post-TOP care should ensure that the individual leaves the TOP service knowing what to expect following the procedure and where to get help, if necessary. One of the most effective ways to reduce TOP-related mortality and morbidity is to provide high-quality post-TOP care.

Before leaving the facility, the individual should receive instructions and information about how to care for themselves. This should include:

- how much bleeding and pain to expect in the following days and weeks
- how to recognize potential complications, including signs of ongoing pregnancy
- when normal activities can be resumed (including sexual intercourse)
- how and where to seek help if required
- knowledge that a urine pregnancy test can remain positive for several weeks after a TOP
- the possible return to fertility within 2 weeks following TOP

The woman should return to the hospital or clinic if she experiences:

- increased intensity of cramping or abdominal pain
- heavy vaginal bleeding
- fever

CONTRACEPTION

Before leaving the health care facility, and as per the *National Clinical Guideline for Contraception (2019)*, all individuals should receive contraceptive information and, if desired, the contraceptive method of their choice. If the chosen method is not available, they should be referred to a service where the method can be provided.

Almost all methods of contraception can be initiated immediately following a surgical or medical TOP.

Table 10 / Contraceptive methods and medical eligibility after TOP

METHOD	WHEN TO STOP AFTER TOP
Hormonal methods <i>Hormonal methods (including pills, injections, implants, the patch, and vaginal ring)</i>	May be started immediately after any TOP, including septic TOP. Hormonal contraception methods can be started immediately after the first pill of the medical TOP.
IUDs	Cervical preparation is recommended for all women with pregnancy over 12 weeks + 0 days of gestation. However, its use should be considered for women before 12 weeks + 0 days of gestation if there is a high risk for cervical injury or uterine perforation. For cervical preparation before surgical TOP in the first trimester, any ONE of the following methods is recommended: » oral mifepristone 200 mg (24 to 48 hours in advance) » misoprostol 400 µg administered sublingually, 1 to 3 hours prior to the procedure » omisoprostol 400 µg administered vaginally or buccally 3 hours prior to the procedure » osmotic dilators placed intracervical 6 to 24 hours prior to the procedure
Condoms	Use may start with the first act of sexual intercourse after TOP, including septic TOP.

Diaphragm or cervical cap

Use may start with the first act of sexual intercourse after TOP, including septic TOP. Use should be postponed for 6 weeks following TOP >14 weeks + 0 days gestation.

Fertility-awareness-based methods

Should be delayed until regular menstrual cycles return.

Surgical sterilization

Can be performed immediately after uncomplicated TOP. However, it should be delayed if TOP is complicated with infection, severe haemorrhage, trauma, or acute hematometra. Vasectomy can be performed on male partners at any time.

Emergency contraception

May use emergency contraceptive pills or a copper IUD within 5 days (120 hours) of an act of unprotected sexual intercourse to decrease pregnancy risk.

Withdrawal

Use may start with the first act of sexual intercourse after TOP, including septic TOP.

MANAGEMENT OF POST-TOP COMPLICATIONS

Although complications from TOP are rare when performed by skilled personnel, they still may occur even when taking all the necessary precautions. When TOP is obtained from unsafe providers or locations, complications are much more common and individuals may need immediate emergency attention for life-threatening conditions.

It is important that every service delivery site at every level of the health system is equipped and has trained personnel able to recognize TOP complications and to provide or refer individuals for prompt care.

In providing post-TOP care, it is important to:

- Demonstrate empathy, understanding, compassion, and counselling throughout an individual's care.
- Manage the immediate situation first. For example, deal with bleeding and shock first, and then provide or refer an individual for required care.

MANAGEMENT OF INCOMPLETE TOP

Post-TOP care can reduce the morbidity and mortality associated with complications of either a miscarriage or incomplete TOP (including TOP that was performed unsafely). Incomplete TOP is defined by the clinical presentation of open cervical os and bleeding, whereby all products of conception have not been expelled from the uterus. Options for management of incomplete TOP include expectant management or surgical and medical methods of uterine evacuation. The mode of management should be selected based on the individual's clinical condition and preference for treatment.

Assessment: Incomplete TOP should be suspected when an individual of reproductive age presents with vaginal bleeding and/or abdominal pain after one or more missed menstrual periods. The woman may have an open cervical os with products of conception visible and/or heavy bleeding. The uterus may be enlarged, with or without tenderness. It should also be suspected if, upon visual examination, the expelled tissue during surgical TOP is not consistent with the estimated duration of the pregnancy. Ectopic pregnancy should be suspected if the uterus is small, the cervix closed, and/or there is an adnexal mass. Incomplete TOP, following spontaneous or induced TOP, may be managed similarly.

Unsafe TOP: It is important to distinguish between safe and unsafe TOP since the latter is much more likely to be associated with infection.

Indications that a TOP has been attempted by unsafe methods include the presence of:

- vaginal laceration
- cervical injury
- uterine enlargement equivalent to a pregnancy of >12 weeks + 0 days of gestation
- products of conception visible at the cervix (although this is true of a spontaneous TOP as well)
- presence of foreign body in the vagina
- signs of abdominal injury or uterine perforation
- signs or symptoms of sepsis or shock

Infection: It is vital to identify an individual who may have an infection and to manage this urgently. Infection is much more likely to be severe if the TOP has been performed unsafely. Clinical features suggestive of infection include:

- temperature above 37.5 C and/or chills
- localised or general abdominal tenderness, guarding, and rebound
- foul-smelling vaginal or cervical discharge or pus visible in the cervical os
- uterine, lower abdominal, or cervical motion tenderness

Clinical features suggestive of sepsis and indicating the need for urgent intervention include:

- hypotension
- tachycardia
- increased respiratory rate

Table 11 / Management of incomplete TOP

STAGE	METHOD	CLINICAL GUIDANCE
If no suspicion of infection and uterine size is <13 weeks + 0 days	Uterine evacuation with vacuum aspiration	200 mg doxycycline or a single dose of 500 mg azithromycin within 2 hours before the procedure Antibiotic prophylaxis should be given before surgical evaluation. Note: If antibiotics are not available, the procedure should not be delayed.
	Misoprostol	600 µg orally or 400 µg sublingually Repeat doses can be considered when needed to achieve the success of the TOP process. There is no maximum number of doses of misoprostol.
Misoprostol only regimen: >13 weeks + 1 days	Uterine evacuation using vacuum aspiration and blunt forceps if necessary	200 mg doxycycline or a single dose of 500 mg azithromycin within 2 hours before the procedure Antibiotic prophylaxis should be given before surgical evaluation. Note: If antibiotics are not available, the procedure should not be delayed.
	Misoprostol	400 µg misoprostol administered vaginally, sublingually, or buccally every 3 hours Repeat doses can be considered when needed to achieve the success of the TOP process. There is no maximum number of doses of misoprostol.
If an infection is present, the uterus should be evacuated urgently	Surgical uterine evacuation	Start broad-based antibiotics immediately (intravenously if the infection is severe and/or the individual is in septic shock) If the procedure cannot be performed in the facility where the individual presents, transfer the individual to a facility that can perform surgical uterine evacuation.
	If the skills necessary for urgent surgical uterine evacuation are not available, misoprostol can be used	400 µg misoprostol administered vaginally, sublingually, or buccally every 3 hours Repeat doses can be considered when needed to achieve the success of the TOP process. There is no maximum number of doses of misoprostol.

Clinically stable patients have the following three options. The decision should be based on the clinical condition of the individual and their preferences for treatment (see Table 11):

- expectant management
- vacuum aspiration (for the uterine size of up to 14 weeks + 0 days of gestation)
- management with misoprostol (for the uterine size of up to 13 weeks + 0 days gestation, see Table 12)

Table 12 / Comparison of management options for missed and incomplete TOP

METHOD	POTENTIAL ADVANTAGES	POTENTIAL DISADVANTAGES	EFFICACY	
			Missed	Incomplete
Expectant management	• may minimize visits • avoids side effects and complications of other methods • avoids intrauterine instrumentation	• unpredictable time frame • may still require follow-up aspiration if not successful	16 to 75%	82 to 100%
Misoprostol alone	• avoids intrauterine instrumentation	• may cause more bleeding and need for a follow-up than aspiration • short-term effects of misoprostol	77 to 89%	61 to 100%
Aspiration	• quick resolution	• surgical procedure	96 to 100%	96 to 100%

Source: WHO Clinical Practical Handbook for Safe Abortion, table adapted from Goodman S, Wolfe M and the TEACH Trainers Collaborative Working Group. Early abortion training workbook, 3rd ed. San Francisco: UCSF Bixby Center for Reproductive Health Research and Policy; 2007, with permission.

MANAGEMENT OF INTRAUTERINE FOETAL DEMISE AT ≥ 14 WEEKS + 0 DAYS TO ≤ 28 WEEKS + 0 DAYS OF GESTATION

Foetal demise refers to situations in which the foetus is no longer alive, but the uterus has not yet started to expel its contents and the cervical os remains closed. The diagnosis is made by ultrasound scan following the clinical findings, which can include vaginal bleeding, absent foetal heart sounds on electronic auscultation, a failure to feel foetal movements, or a uterus that is significantly smaller than the expected size.

Table 13 / Management of intrauterine foetal demise at ≥ 14 weeks + 0 days to ≤ 28 weeks + 0 days of gestation

METHOD	POTENTIAL ADVANTAGES	CLINICAL GUIDANCE
Uterine size is ≥ 14 weeks + 0 days to ≤ 28 weeks + 0 days	Uterine evacuation with vacuum aspiration	200 mg doxycycline or a single dose of 500 mg azithromycin within 2 hours before the procedure Antibiotic prophylaxis should be given before surgical evaluation. Note: If antibiotics are not available, the procedure should not be delayed.
	Combined mifepristone and misoprostol	Mifepristone: 200 mg, orally, single-dose, a minimum of 24 hours before misoprostol is administered Misoprostol: 400 μg administered vaginally or sublingually every 4 to 6 hours. Repeat doses can be considered when needed to achieve the success of the TOP process. There is no maximum number of doses of misoprostol. » For misoprostol only regimen, repeat doses of 400 μg, administered sublingually (preferred) or vaginally every 4 to 6 hours.

POST-TOP HAEMORRHAGE

Haemorrhage can result from retained products of conception, trauma or damage to the cervix, coagulopathy, or rarely, uterine perforation or uterine rupture. This should be managed in the same way as post-partum haemorrhage (PPH), following the PPH algorithm. Episodes of heavy bleeding are common during medical TOP and bleeding complaints will likely constitute the greatest proportion of triage and management tasks for health care professionals involved in these services.

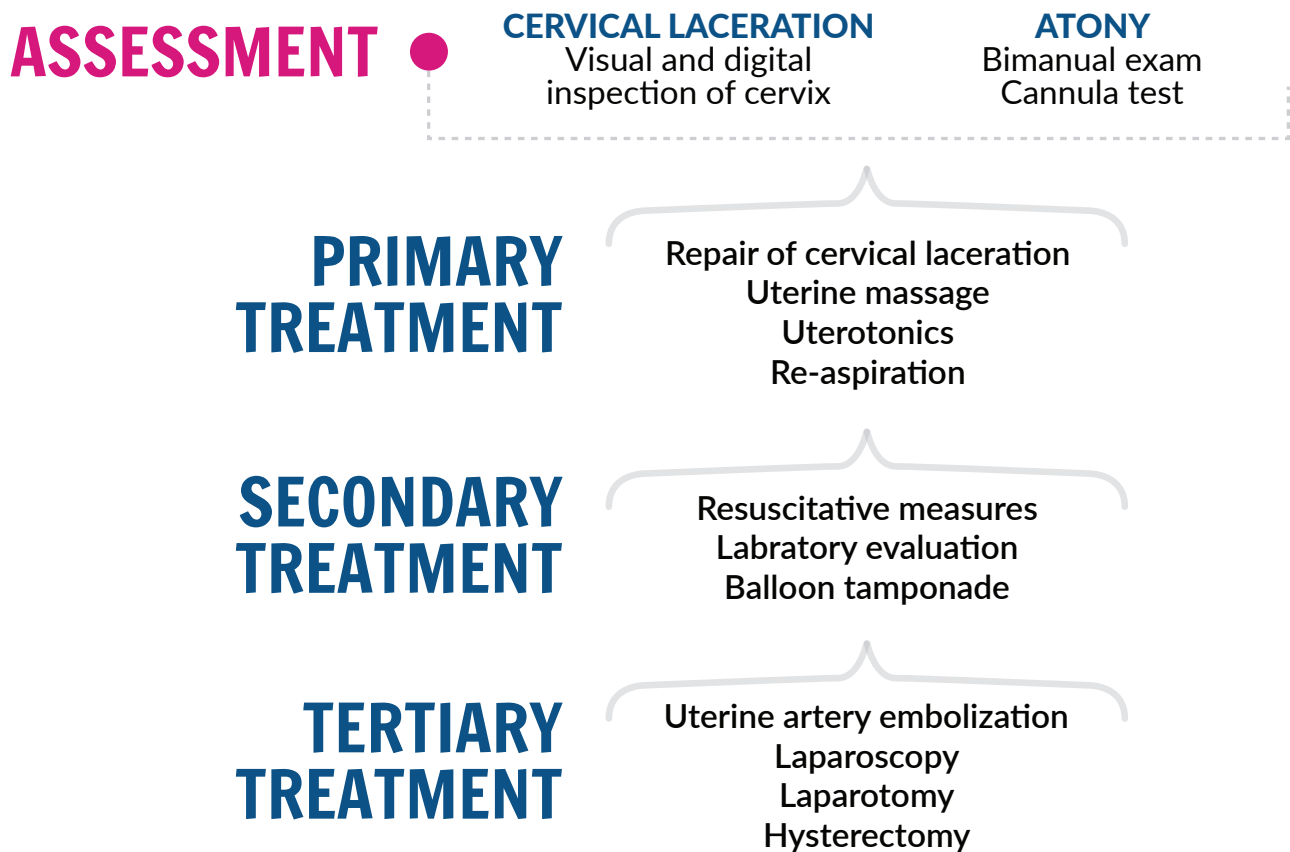
- Although medical TOP is associated with more bleeding than surgical TOP, overall bleeding for the two methods is minimal and not clinically different.
- All service-delivery sites must possess the capacity to stabilize a haemorrhage as quickly as possible. Appropriate treatment for a haemorrhage depends on its cause and severity and includes re-evacuation of the uterus, administration of uterotonic drugs, intravenous fluid replacement, blood transfusion, replacement of clotting factors, laparoscopy, exploratory laparotomy, or referral of the individuals. All facilities should have clear referral plans for emergent cases.
- Identifying patients who may be at increased risk of haemorrhage can help reduce blood loss with TOP. Specifically, women with a uterine scar and complete placenta previa seeking TOP at gestations >16 weeks + 0 days should be evaluated for placenta accreta. For those at high risk, referral to a high acuity centre is recommended.

For active management of haemorrhage, established clinical policies which guide the decision-making process may be a helpful adjunct to risk management:

- ☐ Assessment and exam are needed to treat the patient without delay and identify and manage shock as an emergency
- ☐ Identify the sources of bleeding
- ☐ Many individuals experience some bleeding after taking mifepristone but before using misoprostol. However, even if individuals have been bleeding, they will need to use misoprostol as scheduled to complete the TOP
- ☐ Bleeding usually starts 2 to 4 hours after administration of misoprostol, however timing can vary, with some individuals experience bleeding before 2 hours and after 4 hours. In most studies, individuals bleed for a median duration of 10 to 18 days after mifepristone.
- ☐ If there is any possibility of ectopic pregnancy (for instance, if a gestational sac is not identified on pre-treatment ultrasound and β -hCGs are inconclusive), the individual should be promptly evaluated by a health care professional.



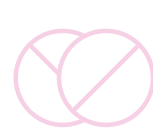
Figure 3 / Algorithm for managing post TOP haemorrhage



SEPTIC TOPs

A septic TOP should be managed the same way as post-partum sepsis, following the algorithm for post-partum sepsis.

- Health care professionals must be equipped and trained to provide treatment for infections that may result from unsafe TOPs. Such treatment includes the administration of antibiotics and evacuation of the uterus where the infection is caused by retained products of conception. Health care professionals must be alert to the warning signs and symptoms of this rare post-obstetrical complication.
- Individuals must be counselled that the late appearance (e.g. >24 hrs after the use of misoprostol) of abdominal pain, discomfort, and/or “flu-like” symptoms (including nausea, diarrhoea, vomiting, and weakness, but not typically fever) should be reported to their provider immediately.
- Health care professionals should consider these symptoms when combined with characteristic clinical findings (tachycardia, hemoconcentration and leucocytosis with a marked left shift) as indicators for immediate hospital admission.



5 SERVICE DELIVERY PLATFORM

5.1 Training

Adequate training, as well as supervised mentorship, is required to ensure all levels of health care professionals have the skills and knowledge to deliver integrated TOP services. All TOP providers need to be assessed for basic competency in medical TOP and MVA clinical assessments prior to professional registration.

This clinical guideline along with the standardized and comprehensive TOP Training Manual will form the essential training materials for managers and health care professionals at provincial, district, and sub-district levels. Additionally, integrated TOP training should be incorporated into pre-service curricular (medical and nursing school) as a component of SRH&R course that covers a continuum of services (SRH&R rights, contraception, TOP, etc.).

5.2 Monitoring and evaluation

REPORTING

In order to improve data collection and reporting, facilities providing TOP services will keep complete records of the notification of TOPs as follows, as per Regulations under the CTOP Act 1996, R168:

- The medical practitioner, registered nurse, or registered midwife who is performing the TOP will complete Annexure A in cases where the individual is 18 years of age or above and Annexure B where the individual is a minor or where the individual is severely mentally disabled or in a state of continuous unconsciousness. A third form, Annexure C, is a monthly summary of Annexures A and B, which the facility manager will forward to the District/Sub-District office for data recording on the District Health Information System (DHIS).
- THREE COPIES of each form shall be printed:
 - The first copy shall be filed and remain at the facility
 - The second copy shall be filed at a provincial level
 - The third copy excludes the name of the individual and shall be forwarded by the facility manager to the District/Sub-structure office for filing

INDICATORS

Additional indicators and strategies are recommended to improve data quality, availability, and completeness. These are made available at the national and provincial level:

INDICATORS

number of medical TOPs performed

number of surgical TOPs performed

list of facilities at district level that offer first trimester TOP

list of facilities at district level that offers second trimester TOP

number of individuals who present for services at public facilities in the second trimester that are referred to as ANC or not provided services at a facility that offers TOP services

documentation of individuals who receive a method of contraception when they leave post-TOP procedure

documentation of serious adverse TOP-related complications, where possible (as a measure of service quality)

number of individuals who present for services at public facilities in the first trimester but who ultimately have their procedure in the second trimester, as a result of structural or other barriers

list of facilities at provincial and district level with public-private partnerships for TOP provision

DATA PRACTICES SHOULD BE IMPROVED IN THE FOLLOWING WAYS:

- All public and private facilities should keep records of all referred and performed TOPs.
- Complications referred to another facility must be managed and documented as *a new TOP case*.
- Detailed notes of the individual must be kept in their file, including the contraceptive method offered, if applicable.
- Deaths of HIV-positive individuals who had a TOP or who had additional medical conditions should be recorded according to the maternal mortality recording process. For example, in cases where an individual is HIV-positive and dies from septic TOP, the death should be recorded as a TOP death and not an HIV death.

DATA AVAILABILITY, QUALITY, AND COMPLETENESS SHOULD BE INCREASED THROUGH THE FOLLOWING:

- routine calculation and publication of the per cent of pregnancies ending in induced TOP, by province and with age disaggregation
- routine calculation and publication of the rate of unsafe TOP per 1,000 women aged 15-44
- improved data capturing and availability of Annexure A data including individual's age, gestational age, and procedure type (medical or surgical)
- collaboration with the private sector to combine public and private sector data on the TOP provision
- undertaking of research to assess the magnitude of unsafe TOP and the proportion of hospital admissions resulting from unsafe TOP in the country

5.3 Multi-sectoral collaboration and stewardship

COLLABORATION WITH COMMUNITIES

Partnership and cooperation between the government, private sector, civil society, and development partners are critical to strengthen the integration of multi-sectoral efforts to increase overall access to safe TOP services.

Establish and strengthen multi-sectoral coordination mechanisms and structures at all levels, to integrate TOP services and other communicable and non-communicable disease services, as part of overall sexual and reproductive health and rights service delivery.

- Establish, strengthen, and coordinate effective and seamless referral systems between government facilities at all levels, private sector facilities, and non-governmental organisations offering safe TOP.
- Engage civil society groups and others committed to advancing safe TOP in dialogue and decision making.
- Develop strategies, including supportive supervision and mentorship for health workers and other service providers, to ensure quality assurance in the provision of integrated TOP services.

- Train community health workers to provide information on safe and local TOP services during community outreach and home-based visits.
- Engage with community leaders, faith-based and religious organisations, clinic committees, and other community-based implementers to promote safe TOP services in communities and to identify illegal providers, encouraging them to refer individuals for safe TOP.
- Use media to address stigma and minimize sensational reporting.

COLLABORATION WITHIN GOVERNMENT

Partner with the Department of Social Development (DSD) and Department of Basic Education (DBE) for the provision of psychosocial services.

- Implement collaborative interventions with the justice system, including working with the police to address issues of SGBV.
- Engage with the DBE to include safe TOP in comprehensive sexuality education consistent with the curriculum.
- Engage with the Department of Higher Education to continue and ensure competency in the delivery of safe TOP services in pre-service curricula for nurses, pharmacists, and doctor.

5.4 Summary of best practices in service delivery

ACCESS TO SERVICES

- ☐ TOP services must be available to the fullest extent that the CTOA Act of 1996 and the CTOA Amendment Acts of 2004 and 2008 enable, as detailed in section 2 (Circumstances and place where termination of pregnancy may take place). Health care professionals should know what the law does allow in South Africa and be clear about the circumstances for which TOP is legal.
- ☐ If an individual requesting a TOP fulfils the legal criteria, there should be no further restriction of access on grounds such as age, marital status, or the number of previous TOPs.
- ☐ TOP is safer the earlier it is performed. Services should be able to meet the local demand for TOP so that the individual can have their TOP at the earliest possible gestation and as close to home as possible.
- ☐ As the equipment needed for routine early medical TOP is not sophisticated, this service can be provided in basic facilities, as per section 2, thereby increasing access to safe TOP care and enhancing convenience to individuals.
- ☐ As the equipment and space required for a safe TOP service are similar to those needed for routine health care and family planning services, efforts should be made to provide safe TOP services in a wide range of health facilities and in an integrated manner.
- ☐ All health care providers should be trained to provide comprehensive TOP care in line with their skills and licenses, as per section 2. This can help distribute the workload across various women's health care providers, improving their skills, enhancing access to TOP, and increasing the safety of TOP care. TOP services should be integrated within the overall maternal/women's health care system in order to minimize the stigma associated with TOP care for both women and providers.
- ☐ Robust and timely referral pathways must be developed in facilities that offer TOP services but do not have emergency or specialist care.

INFORMATION PROVISION

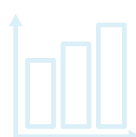
- ☐ Local arrangements should be in place for providing information to women and health care professionals on routes of access to safe TOP care.
- ☐ Services should ensure that written, objective, evidence-guided, and understandable information is available to individuals considering TOP. Information should be made available in a variety of languages and formats, as relevant.
- ☐ Individuals should have access to objective information and, if required, counselling and decision-making support about their pregnancy options.
- ☐ Information for individuals and providers should emphasize the need for confidentiality.

INITIAL ASSESSMENT

- ☐ A pathway to appropriate medical care should be in place for individuals with known significant medical conditions requiring specialist TOP care (e.g. heart disease).
- ☐ Individuals presenting for induced TOP who are found to have a non-viable pregnancy will also require contraception and sexual health care.
- ☐ Individuals requesting TOP but who subsequently decide to continue the pregnancy should be referred for antenatal care.
- ☐ Services should identify issues/characteristics that make individuals particularly vulnerable (e.g. adolescents, victims of domestic abuse, or gender-based violence) and refer them to appropriate support services.

ARRANGEMENTS FOR THE PROCEDURE

- ☐ To minimize delay, service arrangements should be in place to ensure that the TOP is provided as soon as possible, ideally on the same day as the assessment.
- ☐ A system should be in place to ensure that the required legal documentation is completed accurately and in a timely manner.
- ☐ The setting for the TOP service (the consultation room, the procedure room, and the recovery room) should respect the need for the individual's privacy and dignity.



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NDoH leads

Dr Yogan Pillay and Dr M Makua

Clinical experts

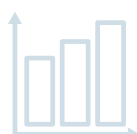
WRHI under the leadership of Prof Helen Rees and Melanie Pleaner
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Eastern Cape clinical team under the leadership of DR Justus Hofmeyer
University of Witwatersrand under the leadership of Dr Saiqa Mullick
University of Pretoria under the leadership of Dr Zozo Nene
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North West under the leadership of Dr Florence Legabe
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National Department of Health contributors

Provincial Department of Health Contributors

Partners and CSOs

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ANNEX 1

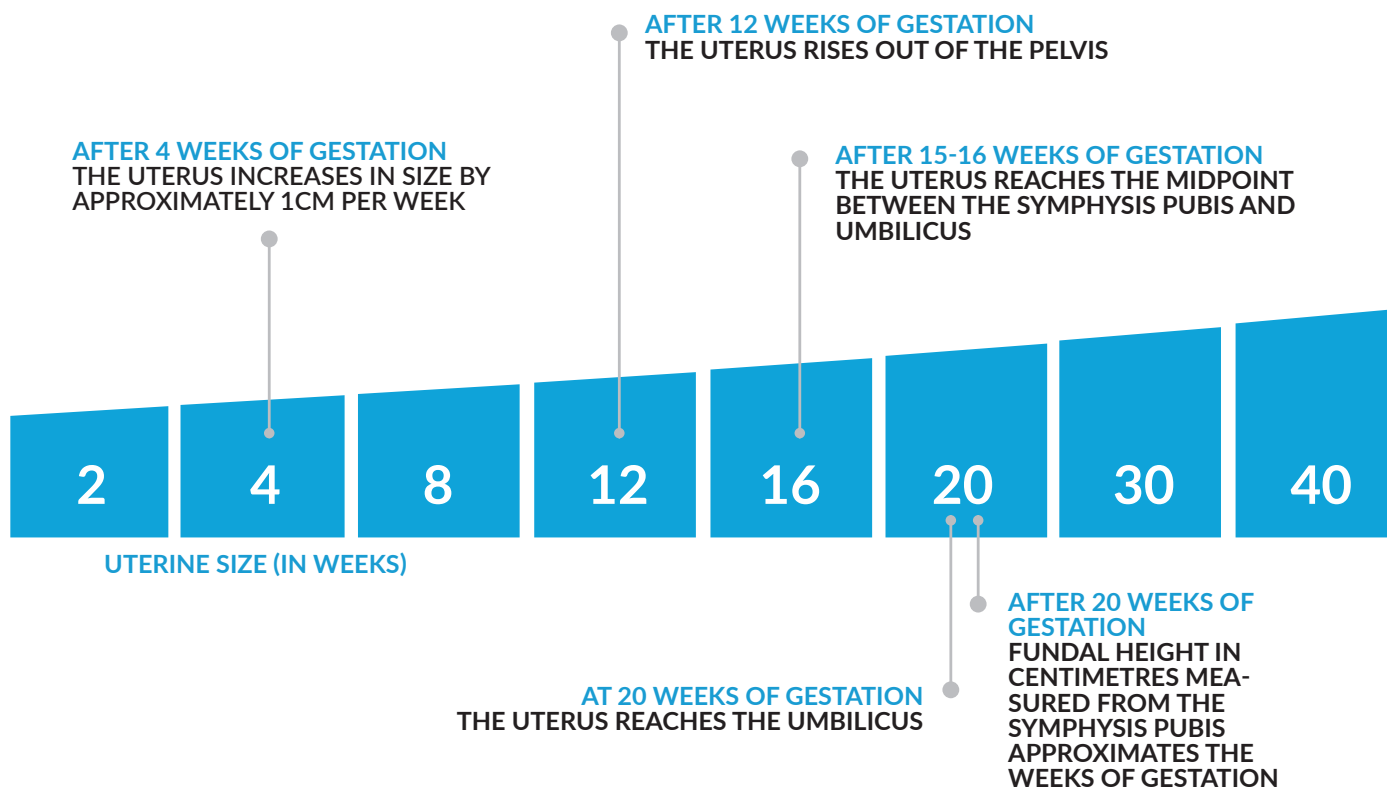
Definition of minimum operational requirements for each TOP procedure, as per the CTOP Act of 1996 and Amendments of 2004 and 2008

As per the CTOP Act Amendment, 2008 3.1 Termination of a pregnancy may take place only at a facility which...	MINIMUM OPERATIONAL REQUIREMENTS FOR EACH TOP PROCEDURE				
	MEDICAL TERMINATION OF PREGNANCY		SURGICAL TERMINATION OF PREGNANCY		
	FIRST TRIMESTER	SECOND TRIMESTER	MANUAL VACUUM ASPIRATION (MVA) / ELECTRIC VACUUM ASPIRATION – FIRST TRIMESTER	MANUAL VACUUM ASPIRATION (MVA) / ELECTRIC VACUUM ASPIRATION – SECOND TRIMESTER	DILATATION AND EVACUATION (D&E)
Gives access to medical and nursing staff	At least one registered and TOP trained medical practitioner (doctor), nurse or midwife, fully available during facility normal working hours.	At least one registered and TOP trained medical practitioner (doctor), upon appointment.	At least one registered and TOP trained medical practitioner (doctor), nurse or midwife, fully available during facility normal working hours.	At least one registered and TOP trained medical practitioner (doctor), upon appointment.	At least one registered and TOP trained medical practitioner (doctor) and at least one registered and TOP trained nurse or midwife to assist the medical practitioner (doctor), upon appointment.
Gives access to an operating theatre	A list of facilities with operating theatre for referral.	A list of facilities with operating theatre for referral.	A list of facilities with operating theatre for referral.	A list of facilities with operating theatre for referral.	A list of facilities with operating theatre for referral.
Has appropriate surgical equipment	Surgical equipment not required.	Equipped with manual and/or electric vacuum aspirator device, cannulae, dilator, tenaculum, speculum, sponge or ring forceps and relevant consumables.	Equipped with manual and/or electric vacuum aspirator device, cannulae, dilator, tenaculum, speculum, sponge or ring forceps and relevant consumables.	Equipped with manual and/or electric vacuum aspirator device, cannulae, dilator, tenaculum, speculum, sponge or ring forceps and relevant consumables.	Equipped with manual and/or electric vacuum aspirator device, cannulae, dilator, tenaculum, speculum, sponge or ring forceps and relevant consumables.
Supplies drugs for intravenous and intramuscular injection	IV and IM injections not required.	IV and IM injections not required.	IV and IM injections not required.	IV and IM injections not required.	Saline or anaesthetic (e.g. lidocaine) for paracervical or intra-cervical block. Uterotonic agent (misoprostol or IM/PO methergine or IV/IM oxytocin), IV fluids if needed.
Has emergency resuscitation equipment and access to an emergency referral centre or facility	As per Ideal Clinic Framework and Manual (Version 18, www.idealclinic.org.za/). A list of contacts and address of emergency referral centres or facilities available.	As per Ideal Clinic Framework and Manual (Version 18). A list of contacts and address of emergency referral centres or facilities available.	As per Ideal Clinic Framework and Manual (Version 18). A list of contacts and address of emergency referral centres or facilities available.	As per Ideal Clinic Framework and Manual (Version 18). A list of contacts and address of emergency referral centres or facilities available.	As per Ideal Clinic Framework and Manual (Version 18). A list of contacts and address of emergency referral centres or facilities available.
Gives access to appropriate transport should the need arise for emergency transfer	As per Ideal Clinic Framework and Manual (Version 18).	As per Ideal Clinic Framework and Manual (Version 18).	As per Ideal Clinic Framework and Manual (Version 18).	As per Ideal Clinic Framework and Manual (Version 18).	As per Ideal Clinic Framework and Manual (Version 18).

Has facilities and equipment for clinical observation and access to in-patient facilities	Oxygen saturation monitor, blood pressure monitor, heart rate monitor, temperature monitor. In-patient facilities not required.	In or out-patient ward with bed. Recovery room for patient observation. Oxygen saturation monitor, blood pressure monitor, heart rate monitor, temperature monitor.	Recovery room for patient observation. Oxygen saturation monitor, blood pressure monitor, heart rate monitor, temperature monitor. In-patient facilities not required.	Recovery room for patient observation. Oxygen saturation monitor, blood pressure monitor, heart rate monitor, temperature monitor. In-patient facilities not required.	Recovery room for patient observation. Oxygen saturation monitor, blood pressure monitor, heart rate monitor, temperature monitor. In-patient facilities not required.
Has appropriate infection control measures	As per Ideal Clinic Framework and Manual (Version 18).	As per Ideal Clinic Framework and Manual (Version 18).	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on availability of antiseptic (for cleaning of cervix).	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on availability of antiseptic (for cleaning of cervix).	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on availability of antiseptic (for cleaning of cervix).
Gives access to safe waste disposal infrastructure	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on safe waste disposal facility for products of conception.	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on safe waste disposal facility for products of conception.	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on safe waste disposal facility for products of conception.	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on safe waste disposal facility for products of conception.	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on safe waste disposal facility for products of conception.
Has telephonic means of communication	Availability of landline or mobile telephone.	Availability of landline or mobile telephone.	Availability of landline or mobile telephone.	Availability of landline or mobile telephone.	Availability of landline or mobile telephone.
Has been approved by the member of the Executive Council by notice in the Gazette	Documentation of approval, available upon request.	Documentation of approval, available upon request.	Documentation of approval, available upon request.	Documentation of approval, available upon request.	Documentation of approval, available upon request.

ANNEX 2

Pregnancy dating by physical examination (bimanual pelvic and abdominal examination)



LIMITATION TO DATING BY UTERINE SIZE ON PHYSICAL EXAMINATION

- uterine malformations/
- fibroids
- multiple gestation
- marked uterine retroversion
- obesity
- molar pregnancy

KEY CONSIDERATIONS

A UTERUS THAT IS SMALLER THAN EXPECTED MAY INDICATE:

- the woman is not pregnant
- inaccurate menstrual dating
- ectopic pregnancy or abnormal intrauterine
- pregnancy, e.g. spontaneous or missed abortion

A UTERUS THAT IS LARGER THAN EXPECTED MAY INDICATE:

- inaccurate menstrual dating
- multiple gestation
- uterine abnormalities, such as fibroids
- molar pregnancy

Source: Clinical practice handbook for safe abortion. Geneva: World Health Organization; 2014, p. 17 (http://www.who.int/reproductivehealth/publications/unsafe_abortion/clinical-practice-safe-abortion/en/); adapted from Goodman S, Wolfe M; TEACH Trainers Collaborative Working Group. Early abortion training workbook, third edition. San Francisco (CA): UCSF Bixby Center for Reproductive Health Research and Policy; 2007 (<http://www.teachtraining.org/trainingworkbook/earlyabortiontrainingworkbook.pdf>)

ANNEX 3: DATA COLLECTION TOOLS

ANNEXURE A

File no.: _____

CHOICE ON TERMINATION OF PREGNANCY ACT, 1996 (ACT No. 92 OF 1996)
NOTIFICATION OF TERMINATION OF PREGNANCY IN TERMS OF SECTION 7 OF THE ACT
FORM TO BE COMPLETED BY A MEDICAL PRACTITIONER OR A REGISTERED MIDWIFE
(To be completed in triplicate)

1. Name of facility: _____

2. Age of women requesting termination –
Consent form required

Yes	No
-----	----

3. Where appropriate (encircle appropriate number):
- 3.1 Termination in terms of section 2 (1) or (b) of the Act.
- 3.2 Severe mental disability [section 5 (4) (a) of the Act].
- 3.3 Continuous unconsciousness [section 5 (4) (b) of the Act].

4. Race (mark with a cross):

African	Coloured	Asian	White	Other
---------	----------	-------	-------	-------

If other, specify: _____

5. Marital status (mark with a cross):

Single	Living together	Married	Divorced	Widowed
--------	-----------------	---------	----------	---------

6. Date of last menstrual period (LMP) _____

7. How many weeks into pregnancy? _____

8. Number of previous pregnancies:

No. of live births	No. of stillbirths	No. of terminations	No. of miscarriages
--------------------	--------------------	---------------------	---------------------

9. Date of procedure _____

Type of procedure

Surgical	Medical	Combined
----------	---------	----------

Counselling on contraception

Yes	No
-----	----

Method offered

Pill	Injection	Implant	IUD	Condom	Other
------	-----------	---------	-----	--------	-------

10. Termination of pregnancy (mark with a cross):

(a) First 12 weeks	(b) 13-20 weeks
--------------------	-----------------

11. Indication for termination of pregnancy (applicable only to terminations performed from 13th up to and including 20th week of gestation period) (circle appropriate number):

- 11.1 Woman's physical or mental health [section 2 (1) (b) (i) of the Act].
- 11.2 Foetal physical or mental abnormality [section 2 (1) (b) (ii) of the Act].
- 11.3 Rape or incest [section 2 (1) (b) (iii) of the Act].
- 11.4 Social or economic circumstances [section 2 (1) (b) (iv) of the Act].

Name of medical practitioner or registered midwife _____

Signed _____ Date _____
Qualifications _____ Registration number _____

ANNEXURE B

CHOICE ON TERMINATION OF PREGNANCY ACT, 1996 (ACT No. 92 OF 1996)

I. STATEMENT BY MINOR WHO REQUESTS THE TERMINATION FOR HER PREGNANCY

I, the undersigned (surname and first names of minor) _____, hereby state that I have been advised by (surname and first name of medical practitioner/registered midwife*) _____ in terms of section 5 of the Act to consult with my parents, guardian, family members or friends before the termination of my pregnancy.

Signature _____

Date _____

**Delete what is not applicable*

II. CONSENT TO THE TERMINATION OF THE PREGNANCY OF A WOMAN WHO IS SEVERELY MENTALLY DISABLED OR IN A STATE OF CONTINUOUS UNCONSCIOUSNESS

Name of facility _____

1. Intended termination of the pregnancy of (surname and first names of minor/major woman) _____, born on _____ and having the identify number (where available) _____ and the facility/hospital/clinic number _____
2. I (surname and first names) _____ the undersigned, acting as the natural guardian/legal guardian/*curator personal/spouse** of the above-mentioned woman, hereby, in terms of section 5 (4) (i) or (ii) of the Act request and consent to the termination of the pregnancy of (surname and first names of the above-mentioned minor/major woman) _____, who is –
 - (a) so severely mentally disabled that she is completely incapable of understanding and appreciating the nature or consequences of the termination of her pregnancy; or
 - (b) in a state of continuous unconsciousness and has no reasonable prospect of regaining consciousness in time to request and to consent to the termination of her pregnancy in terms of section 2 of the Act.

Signature _____

Date _____

Natural guardian/legal guardian/curator personal/spouse refuses to consent.*

CONSENT OF TWO MEDICAL PRACTITIONERS OR A MEDICAL PRACTITIONER AND A REGISTERED MIDWIFE

3. I, _____, the undersigned, being a medical practitioner, and I, _____, the undersigned, being a medical practitioner/registered midwife who has completed the training course*, certify that we examined (surname and names of above-mentioned minor/major woman) _____ on _____ (date).
4. In our opinion her pregnancy is within the first 20 weeks of the gestation period and*–
 - (a) the continued pregnancy would pose a risk of injury to the woman's physical or mental health [section 2 (1) (i) of the Act];
 - (b) there is a substantial risk that the foetus would suffer from a severe physical or mental abnormality [section 2 (1) (b) (ii) of the Act];
 - (c) the pregnancy resulted from rape or incest [section 2 (1) (b) (iii) of the Act]; or
 - (d) the continued pregnancy would significantly affect the social or economic circumstances of the woman [section 2 (1) (b) (iv) of the Act].
5. We consent to the termination of her pregnancy.

(a) Signed _____

Date _____

Qualifications _____

Registration number _____

(b) Signed _____

Date _____

Qualifications _____

Registration number _____

**Circle what is applicable.*

ANNEXURE C

Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996) Choice on Termination of Pregnancy Monthly Summary Sheet

Choice on Termination of Pregnancy Tally

(Use Annexure A to tick the applicable block and submit to Information Manager at the end of the month)

Facility: _____

No	File no.	Age			Gestation		Method	
		10-14	15-19	20+	0-12	13-20	Medical	Surgical
1								
2								
3								
4								
5								
6								
7								
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50								
Running/Monthly Total								

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GUIDELINE
FOR IMPLEMENTATION OF THE
CHOICE ON
TERMINATION
OF PREGNANCY ACT
ED. 1**