“Advancing the Roles of Midlevel Providers in Menstrual Regulation and Elective Abortion Care”

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MIDWIFE’S ROLES
IN EXPANDING ACCESS TO
AND THE MANAGEMENT
OF SAFE ABORTION CARE

South African Country Report

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Significant portions of the text in this report are excerpted from:
1 INTRODUCTION

The passage of the Choice of Termination of Pregnancy (CTOP) Act was one of the great strides that has been made in the past ten years. The Choice on Termination of Pregnancy Act (CTOP) was introduced in South Africa on the 1st of February 1997 (Act No. 92 of 1996), permitting termination of pregnancy (TOP) upon the request of the woman up to and including 12 weeks of gestation, under certain defined circumstances from the 13th to the 20th week of gestation, and under very limited circumstances after the 20th week of pregnancy. For the first time all women in South Africa, irrespective of age, socio-economic status, race or location could have access to early, safe and legal termination of pregnancy according to her individual beliefs.

In passing the Act, the Government of South Africa committed itself to delivering accessible and available services to all women, in particular poor women and those who had been disadvantaged during apartheid and who were most likely to suffer complications and die from an unsafe abortion. Activists, policymakers and health care providers recognised that a liberal law alone would not guarantee the creation of high quality abortion services accessible to all women. As such, important steps have been taken since 1997 to implement the Act, including training and certifying registered midwives to provide abortion and post-abortion care services (Dickson-Tetteh & Billings 2002).

This report draws upon the work of researchers from the Women’s Health Project, the Reproductive Research Unit and Ipas, summarising the main activities undertaken in the Midwifery Abortion Care Training Programme (1998-2000), the first programme in South Africa to train midwives to provide abortion services as part of the National Abortion Care Programme. Their paper also outlines major findings of an evaluation of the quality of midwives’ practices and presents recommendations for continuing and strengthening training and supervision of midwives in abortion care throughout South Africa.

The focus of this report is on advancing the role of the registered midwife in the rendering of safe elective abortion care in South Africa.

SECTION 1: COUNTRY PROFILE

Reproductive health and abortion statistics

Expanding access to and the management of safe abortion care should be seen against the background of unique demographic features of South Africa. Our country is classified as an upper middle-income country with a per capita GNP in 1997 of

\[\text{Dickson-Tetteh K and Billings DL 2002: Abortion Care Services Provided by Registered Midwives in South Africa. Forthcoming, International Family Planning Perspectives}\]

\[\text{Varkey & Fonn 2000:30}\]
US$3400, with a huge gap existing between the rich and the poor (SAHR 1999; Mbewu & Mngomezulu 1999:1).  

According to the population figures given for 1999, South Africa has a population of 43 054 306 (the October 2001 census is presently done). Of the nine provinces, KwaZulu Natal has 20.7% of the population, followed by Gauteng with 18.1%. Gauteng has by far the greatest population density with 448.4 people per km$^2$ (1996).

For the period 1983-1999 the annual population growth rate was 2.4. The total fertility rate is currently given as 2.9 children per woman (1998, 1999) and the maternal mortality rate as 150 per 100,000 births (1998). The percentage adolescent mothers, also for 1998, are given as 13.2%. The average household size for 1996 was 4.4 and the literacy rate 65.5%.

Prior to the passing of the Act, national level research conducted in 1993 showed that approximately 425 women died each year in public hospitals as they were treated for complications resulting from unsafe abortions. This research also estimated that of the nearly 45,000 women admitted to public hospitals with incomplete abortions each year, at least one third arrived because of medical complications related to unsafe abortion.

From February 1997 to date, according to the latest figures, there has been concerted action to translate the Act into services and a steady increase in the numbers of abortions in public health facilities, rising from 29,326 abortions reported in the first year (February 1997 to January 1998) to 40,568 (February to January 1999) and to 44,558 (February 1999 to January 2000) (Varkey, Fonn & Kethlapile 2000:103). This increase was expected and served as an important indirect indicator that the incidence of unsafe abortion was being reduced.

However, women’s access to safe services remained restricted and unequal. In the first three months after the Act was passed, 60 percent of all legal abortions were performed in Gauteng Province. A year later only one-third of the hospitals and clinics that were designated by the Department of Health to provide abortions actually had the services in place. Of the 31,312 legal abortions performed in 1997, almost all were carried out in tertiary centers located in urban areas, given that services were not offered in primary level sites at that time.

There is a trend nationally towards accessing services earlier in pregnancy with a shift moving from 65% under 12 weeks pregnancy over the first year of implementation to 71% over the second year of implementation to 75% over the third year of implementation to date (Barometer December 1999:1). Unfortunately the national statistics also indicates that access to safe legal termination of pregnancy continues to be uneven in respective provinces.

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Laws and Policies

The Choice on Termination of Pregnancy Act (CTOP)\(^7\) permits termination of pregnancy (TOP) upon the request of the woman up to and including 12 weeks of gestation, under certain defined circumstances from the 13\(^{th}\) to the 20\(^{th}\) week of gestation, and under very limited circumstances after the 20\(^{th}\) week of pregnancy.

The Abortion and Sterilisation Act of 1975 was heavily criticised for being unduly restrictive of legal abortion, by not permitting abortion on request. The impact of this previous legislation on creating inaccessible services has been documented by the “Abortion study” of Rees et al (1997). This included high numbers of women (44,686 women per year) treated for complications from incomplete abortions; high rates of mortality (57/1000 000 live births) and morbidity rates (385 per 100 000 live births) amongst those treated for incomplete abortions; and inaccessible services for young, black, single women.

The underpinning objectives of the Act, as reflected in the preamble, can be summarised as follows:

- To provide for legal TOP in a context that recognises the value of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the achievement of human values and freedoms, which underlie a democratic South Africa.
- To recognise that both women and men have a right to be informed of, and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and that women have the right to appropriate health care services to ensure future safe pregnancy and child birth.

The grounds for abortion, especially during the first 12 weeks of pregnancy, have been substantially liberalised. Abortion on request is now available during the first 12 weeks of pregnancy. During this period the woman is not required to give any reasons for her wanting to have an abortion. A medical practitioner as well as a midwife, who has undergone prescribed training, may perform the abortion during this gestation period.

From the 13\(^{th}\) to the 20\(^{th}\) week, however, abortion requires more than the mere request and the consent of the woman and midwives are not allowed to perform the procedure, although their function with regard to referral and counselling is of utmost importance. Abortion is available: (i) if the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or (ii) there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality; or (iii) the pregnancy resulted from rape or incest; or (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman.

Abortion is also available from the 20\(^{th}\) week up to term, providing a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy-(i) would endanger the woman's life; or (ii) would result in a severe malformation of the foetus; or (iii) would pose a risk of injury to the foetus.

It is clear that the Government of National Unity is committed to working towards making TOP services accessible to all women. The basic components of sexual and reproductive health were policy in South Africa before they were articulated as international policy at the International Conference on Population and Development (ICPD) in Cairo (1994) and the Fourth World Conference on Women (FWCW) in Beijing (1995). The government is committed to the implementation of these international policy agreements (SAHR 2000).

Although the Act reflects the intention of the legislature to make legal TOP equally accessible to all SA women, in itself the Act cannot ensure or guarantee equitable and unrestrained access to TOP.

### Organisation of abortion care

Service provision at primary health care level is a key challenge in ensuring access to services whilst training of registered midwives is a critical component of this process (Barometer 1999:14). Furthermore, the rendering of abortion services at the lowest appropriate level of care and preferably in the first trimester is cost-effective.

The decentralisation of abortion services to PHC level was expected to be slow initially, as midwives needed to be trained in abortion provision. To date, a national training programme has trained some 92 registered midwives from all nine provinces in MVA (Varkey, Fonn & Kethlapile 2000:104).

All registered nurses and midwives working in the community, irrespective of the setting, play an important role in helping women to avoid unwanted pregnancy through giving information and contraceptives. They also need to inform women about their rights according to the Act and how to obtain safe abortion and treatment for unsafe abortion without delay (South Africa 1996). Health education includes information on family planning and abortion services, contraceptive information and distribution of appropriate methods of contraception. All registered nurses and midwives should be trained to recognise abortion complications and promptly refer women for services. Transportation to services for abortion and complications of unsafe abortion should also be in place and functioning.

Together with the abovementioned aspects, the following services should be available at primary health care level: manual vacuum aspiration (MVA) up to 12 weeks of pregnancy, medical methods of early abortion, stabilisation of patients with complications of unsafe abortion, vacuum aspiration for incomplete abortion and prompt referral and transport for women needing abortion services that cannot be provided on site.

At secondary level of health care (district or first referral hospital level) hospitals should offer all essential abortion services. This level of facility should be staffed and equipped to treat abortion complications and be prepared to accept referrals from health care facilities throughout the catchment area. Furthermore, it should provide all elements of abortion care mentioned for the primary health care level, abortion
services for all circumstances and stages of pregnancy in which it is permitted, management of complications of unsafe abortion, information and outreach programmes covering the full catchment area.

All secondary and tertiary hospitals should have staff and facility capacity to perform abortions in all circumstances and to manage all complications of unsafe abortion. The provision of abortion care at teaching hospitals is particularly important to ensure that all cadres of health professionals develop technical competence in abortion during medical training rotations. Furthermore, it should provide all elements of abortion care mentioned for the previous levels, and manage all complications of abortion.

Management protocols for the first trimester TOPs are the same irrespective of whether the procedure is performed in a primary, secondary or tertiary institution (Barometer 2000:39). First trimester abortions are performed as a side ward (day) procedure. The abortion is induced with Misoprostol; products of conception are evacuated using MVA under local anaesthetics. This is made possible by the use of Misoprostol, which ripens and dilates the services, usually culminating in the spontaneous expulsion of the products of conception. This serves to decrease the number of staff required for the procedure, decrease the amount of time required to prepare the patient for the procedure and increases the number of patients who can be managed.

The use of MVA is the method of choice to remove the products of conception rather than sharp curettage. International studies have shown that there is evidence that the use of MVA over sharp curettage has resulted in a decreased duration of the procedure and a reported 40% decrease in hospital stay.

For a second trimester abortion, the woman is accessed in the out-patients department. If she meets the criteria as stipulated in the legislation, she will be given a return date for admission. Total in-patient stay ranges from 24-112 hours (median 36 hours). For both first and second trimester abortions emphasis is placed on the importance of ensuring that the women receives contraceptive counselling before leaving the health service after her abortion.

Choosing cheap but effective drugs to induce abortion and using MVA as a method to evacuate the uterus, the average costs of an abortion is minimised without compromising the safety of the woman undergoing the procedure. Most patients have to wait 1-7 days (52%) or 8-15 days (22%) between first seeking an abortion and actually having the procedure done (Barometer 2000:28).

The counselling role of the midwife cannot be overemphasised. Feedback on the quality of service shows that an overwhelming majority of clients received information about the procedure itself, possible post-op bleeding, and immediate risk if pregnancy as well as the recommendation to avoid sexual intercourse until bleeding stopped (Barometer 2000:28). In 93% of all facilities registered midwives offered post-abortion contraceptive services. No women are referred off-site for post-abortion contraceptive services, indicating a positive step towards linkage of TOP and other reproductive health services.
Records

Notification of TOP is legally required in terms of section 7 of the Act (Act no 92 of 1996). Present management mechanisms to monitor TOP service provision includes monthly data to the Health Information and Epidemiology Directorate; quarterly reports on TOP service provision; and provincial visits by the National Directorate to support provincial work. Provincial management differs from province to province (e.g. a Reproductive Health Committee in the Western Cape and a TOP Committee in Mpumalanga).

Results from the evaluation study of Dickson-Tetteh & Billings (2001) indicate that record-keeping needs to be strengthened in all of the sites. In most facilities, patient registers included the date of the TOP procedure (100%), the patient ID number (90%), and the age of the client (100%). However, critical information was not being recorded in patient registers, such as the name and category of provider performing the TOP. Less than one-half (30%) of patient registers reviewed contained a place to record information about procedural complications, names of antibiotics and pain medications administered (33%), whether misoprostol was used as a cervical ripening agent (37%), and which contraceptive method was accepted (41%).

Clearly, record keeping is one of the aspects needing attention. Challenges in relation to gathering data on TOP services provision has been a lack of information technology readily available at a clinic level and retaining staff that has been trained to manage this process. In addition, private facility provision is not being adequately monitored. Against this backdrop, government asserts the need to ensure standardised management information systems on TOP service provision, focusing on both quantitative and qualitative aspects (Barometer 2000:28).

Referral plans and practice at different levels of service provision

Abortion clients who experience complications beyond the skill of the midwife and/or the capacity of the facility in which she is working are referred to other facilities where they can receive the range of services needed, such as gynaecology outpatient department (OPD), gynaecology wards, or general OPD, or from clinics to a secondary or tertiary level hospital (Dickson-Tetteh & Billings 2002).

Almost 82% of facilities rendering TOP service have written abortion care protocols available for staff to review, although content of such protocols differ from site to site (Barometer 2000:28; Dickson-Tetteh & Billings 2002). The majority of these protocols includes written information on infection prevention procedures and the administration of misoprostol, as well as the use of analgesics and antibiotics. Of the 27 staff interviewed in the facilities visited during the evaluation of Dickson-Tetteh and Billings (2002), 74 percent stated that a mechanism for the review of maternal deaths either did not exist or they did not know of such a mechanism.
The importance of public and private partnerships and collaboration is emphasised by Hlatshwayo (2000:34). Over a 30-month period a total of 25,731 terminations were provided nationally by Marie Stopes (Barometer 1999:16). Marie Stopes is currently running ten clinics in six provinces, primarily in urban areas. Future planning includes the establishment of clinics in rural areas.

SECTION 2.
THE ROLE OF MIDWIVES IN ABORTION SERVICES IN SOUTH AFRICA

The Choice on Termination of Pregnancy Act stipulates that registered midwives who have completed the prescribed training course may carry out the termination of pregnancy for women with pregnancies of 12 weeks or less gestation. This is a significant legislative victory to increase access to abortion care (Varkey & Fonn 2000:30), if compared with the previous legislation (the Abortion and Sterilisation Act, Act No. 2 of 1975). Training midwives throughout South Africa is, therefore, a critical step toward full implementation of the law.

The South African Nursing Council (SANC) regulates training of professional nurses and midwives in South Africa. Because of the unique health needs of the South African population, the majority of registered nurses are trained by means of an integrated four-year nursing programme, including nursing science (general nursing, psychiatric nursing and community nursing) and midwifery. This means that all registered midwives in South Africa do not practice midwifery, but that they are all trained to provide reproductive health care. Therefore, in this report “midwife” refers to all registered nurses who are also qualified midwives but who may be working in any health care setting.

Although midwives practice at all levels of health in South Africa, they have a crucial role to play in effecting accessible TOP service delivery. In the first place, midwives work in areas where physicians are not available, especially in rural areas. They are the point of first contact and are usually members of the local community, therefore understanding the local cultural and religious values. In the absence of the physician the midwife has a professional-ethical responsibility to provide the service (Muller 1998:123).

The most cost effective way of rendering abortion services is to provide it at the lowest possible level of care and preferably in the first trimester. Although cost of first trimester terminations performed by a midwife is only eight percent lower than that performed by a physician, it is essential that midwives are trained to provide these services. If these services are not provided, women may resort to back street, which places a considerable cost burden on the health sector (Barometer 2000:39).

There is currently approximately 180 000 nurses/midwives in the registers and rolls of the four nursing councils (Boputhatswana, Ciskei, South Africa and Transkei), of

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whom approximately 50% falls within the registered category. The nurse: population ratio is 43:10 000, which compares favourably with the recommendation of the WHO for developing countries. This implies that the nurses/midwives constitute more than 60% of the health human resources in South Africa. When the distribution of nurses/midwives is analysed, urban distribution is more favourable that that of rural areas. The nurses/midwives are, however, more available in the “underserved” areas the doctors (Muller 1998:122).

**THE NATIONAL ABORTION CARE PROGRAMME**

During the first year of implementation of the Act, authorities in all of the provinces reported difficulty in implementing the new Act due to the lack of health care providers trained to provide abortion care. The National Abortion Care Programme was officially initiated in April 1998, which set out to provide a co-ordinated approach to the implementation of the Choice on Termination of Pregnancy Act, and to ensure that providers would be trained in all provinces, and at all levels of care. The programme was carried out through a partnership among the Maternal, Child and Women’s Health (MCWH) Directorate of the Department of Health, the Reproductive Health Research Unit (RHRU), which coordinated the National Abortion Care Programme, and provincial health departments and academic institutions. Ipas, an international non-governmental organization with extensive experience in training and research on abortion care, collaborated in the design of the training content and process as well as in the evaluation of midwives’ skills.

The main purpose of the National Abortion Care Programme was to develop the capacity to provide safe, high quality and accessible abortion care services in public sector hospitals and clinics. The Programme aimed to include abortion services as part of the array of services offered at primary and secondary level health care facilities, therefore bringing services closer to the communities where women live, particularly poor women and women living in rural areas whose access to services is often limited.

The key elements of the National Abortion Care Programme were: training physicians in the use of manual vacuum aspiration (MVA) for termination of pregnancy and treatment of incomplete abortions; and the Midwifery Abortion Care Training Programme, which focused on training midwives to provide comprehensive abortion care services. This included the use of manual vacuum aspiration for first trimester abortion and in the treatment of incomplete abortion, as well as training other midwives in post abortion contraceptive counselling.

**Midwifery Abortion Care Training Programme**

The Midwifery Abortion Care Training Programme consisted of three major activities:

1) Development of abortion care curriculum and manual;
2) Training of registered midwives in abortion care; and
3) Post-training evaluation of the quality of midwives’ practices.

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10 Abortion care refers to services that meet the needs of women seeking a TOP (or treatment for complications of unsafe abortion), which include: high quality abortion services and/or treatment of abortion complications, contraceptive services and counselling, and other reproductive health services needed by the woman.
The Midwifery Abortion Care Training Curriculum and Manual was developed (October 1997) and the curriculum approved by the South African Nursing Council (SANC) by July 1998. Based on the approved curriculum a training manual was compiled by RHRU and Ipas and sent out to all the major stakeholders for review, including representatives from SANC, midwifery training institutions, medical schools, national and provincial reproductive health departments, practicing midwives, academic institutions involved in reproductive health programs, and reproductive health and reproductive rights organisations.11

The objectives of the abortion care curriculum are to teach midwives to provide comprehensive services to women seeking abortion care (TOPs to women with a normal pregnancy of 12 weeks gestational age and under; treatment of incomplete abortion for women with uterine size equivalent to 12 weeks gestational age and under); stabilise and refer women with abortion complications and uterine size over 12 weeks gestation; refer women for TOP who are over 12 weeks pregnant; link abortion services with post-TOP contraceptive services and follow-up care; and link abortion services and other reproductive health services, as needed by women.

Overall, the approach that has been emphasized is that abortion care services should not be provided in isolation but rather as an integral component of comprehensive reproductive health care. Therefore, a midwife who is trained to perform a TOP should also be able to adequately attend to a woman with an incomplete abortion, and with other related reproductive health problems, such as the identification and treatment of sexually transmitted diseases and reproductive tract infections. Midwives also should be able to provide contraceptive services to women after the TOP, according to each woman’s reproductive needs and desires.

The total duration of the training course was 160 hours, with 80 hours of theoretical training and 80 hours of clinical training under supervision by experienced practicing physicians in accredited hospitals in the provinces. The course duration of 160 hours is a requirement of SANC for any short course that is to be formally certified. Certification of midwives was considered after the successful completion of both the theoretical and clinical training.

Training of registered midwives took place from November 1998 through May 1999. The RHRU and Ipas conducted the first training course in November 1998. The group was comprised of 22 midwives who were trained as provincial trainers. The two-week course emphasised both clinical and psychosocial skills and included: a didactic introduction to clinical issues and abortion techniques, classroom instruction in counselling and interpersonal communication skills, and training in clinical techniques using pelvic models. After completion of the theoretical training, midwives were given a period of three months within which to complete their two-week clinical training with women seeking abortion care services. Similar national-level workshops were conducted in March and May 1999 by RHRU. Participants of these workshops were not trained to be trainers but were to set up services and practice soon after their training.

Of the 92 midwives who entered the programme and participated in the two-week theoretical training, 81 (88%) completed their clinical practice and were certified by the SANC to provide abortion care services to women. After the training all the midwives were given start-up kits, including MVA, for their clinical practicals and to set up initial services. As part of the programme the provincial authorities were responsible for ensuring that clinics provided a physical space and equipment for the midwives to set up their practices. By the end of 1999 at the time of the evaluation described below, 69 (85%) of the certified midwives were providing services in a total of 39 public sector health care facilities as well as five Marie Stopes Clinics in the nine provinces of South Africa.

In the evaluation of the clinical competency of these midwives, it was found that MVA was used as the clinical technique in 85 of 96 TOP procedures observed; 11 TOPs were performed using EVA. Midwives did not use dilation and curettage (D&C) for first trimester abortions in any of the facilities. Good clinical practice was observed in at least 75 percent of the procedures. Good clinical practice is defined by the following skills: listening to and informing the client about the procedure, infection prevention activities, use of MVA (including no-touch technique), examination and management of aspirated tissue, monitoring for post-procedural complications, discussion with the client about questions she had, warning signs of possible health problems, and the risk of pregnancy if contraceptives were not used. Only the practice of administering antibiotics when necessary was identified as an area of clinical practice that needed to be improved significantly (Dickson-Tetteh & Billings 2002).

Professional Organizations for Midlevel Providers
Registered midwives providing abortion care services receive full support from the Democratic Nursing Association of South Africa (DENOSA) and South African Society of Obstetricians and Gynaecologists. Both of these organisations advocate the role of the midwife with regard to abortion care services.

SECTION 3 LESSONS LEARNED

Passing the Choice on Termination of Pregnancy Act was an important milestone in South Africa, marking a significant commitment by the government to improve women’s health. As with any new and progressive law, implementation has posed challenges to national and provincial authorities. All these challenges can be translated into lessons to be learned and used to improve our health care service to the community.

The evaluation study of Dickson-Tetteh and Billings (2002) provides valuable information and important insights for the continuation of the Midwife Abortion Training Programme. The study includes data from almost all of the sites where midwives are providing abortion care services in all nine provinces of South Africa.

12 Denosa is a voluntary, independent, professional organisation for all South African nurses/midwives with both professional and union responsibilities.
Various other studies have been done on exploring the extent of policy implementation from both a supply and demand side in analysing the delivery of abortion services (Varkey et al 1999; Engelbrecht et al: 2000; RRA 2000).

Problem areas that came forward are in short the following:
- The large number of women requesting abortion services at health facilities throughout the country;
- Resistance on the part of some health care personnel to provide abortion care services;
- Opposition expressed toward those who do offer such services;
- Lack of trained health care personnel to provide women with comprehensive abortion care services;
- Victimisation of health care providers by their colleagues; congestion in functional facilities impacting on quality of services rendered;
- Work overload, particularly by nurses who are involved in a range of other services as well
- Services are largely urban based with distance serving as a major obstacle to women accessing services;
- Lack of community knowledge on the Act and on how women’s bodies function, e.g., detecting early signs of pregnancy (Barometer Dec 2000:49).

Service organisation factors such as the availability of abortion services, increase access to training personnel, improvement in quality care; and community factors such as information barriers, women’s status in society and socio-economic factors, have an impact on women’s access to abortion.

In 1997 when the Act was passed, there was a significant increase in the number of legal abortions requested and performed. This was expected and served as an important indirect indicator that the incidence of unsafe abortion was being reduced. However, women’s access to safe services remained restricted and unequal. In the first three months after the Act was passed, 60 percent of all legal abortions were performed in Gauteng Province. A year later only one-third of the hospitals and clinics that were designated by the Department of Health to provide abortions actually had the services in place. Of the 31,312 legal abortions performed in 1997, almost all were carried out in tertiary centres located in urban areas, given that services were not offered in primary level sites at that time. During the year 2000, 48% of TOPs were performed at secondary level (Barometer 2000:28).15

There is an uneven distribution between provinces: Nearly half of the TOPs are being carried out in the two richest provinces (Gauteng and Western Cape (Public Hearings 2000:6). Women are on average 100km away from a facility providing abortion, while SA guidelines call for a distance of 10-16 km from PHC services. Although passing of the Act increased the availability of TOP services, the increase is uneven which mean that it is not available to all women. Gauteng provides 49% of national TOPs compared to the under-resourced North West Province (1%). Furthermore, all

designated facilities are not providing services. Only 28% of the 248 designated facilities nationally (Varkey & Fonn 2000:30). (Varkey, Fonn & Kethlapile 2000:104).

The know well-known “Public Hearings on the Implementation of the CTOP Act”, convened by the National Assembly Portfolio Committee on Health, supported by the RRA, in June 2000, aimed at establishing to what degree the stated objectives of the Act had been achieved.\(^{16}\) The main finding of the Public Hearings was that, although progress had been made, with over 100,000 women accessing safe and legal termination of pregnancy, much more need to be done to improve service delivery and access to TOPs to women in South Africa. Problems identified by staff are the lack of time during the process of care, disinterest of patients, methods not being available, lack of privacy, lack of staff commitment, lack of training in post-abortion counselling methods.

Possible explanations for the lack of TOP services as published by the “Public Hearings on the Implementation of the CTOP Act”, convened by the National Assembly Portfolio Committee on Health, supported by the RRA, in June 2000), are a shortage of trained staff, resources and beds; a lack of support for the process by hospital and district management personnel.; unwillingness of certain staff to participate in TOP services; fear of victimisation from other members of staff with members of the community; lack of political commitment to the process from provinces; and difficulties in introducing a new service at a time of major reorganisation of the health care system. Other explanations could be women’s lack of knowledge about their rights under the Act, problems with family planning/contraceptive services; need to make women aware of the early signs of pregnancy in order for them to make informed choices about management and to have access to safe, affordable and legal TOP services should they choose termination.

Resistance on the part of health care providers to offer abortion services as well as negative attitudes toward service provision in general also posed major barriers to women’s access to high quality services. Midwives complain about the hospital management not being supportive; victimisation from other members of staff; the overwhelming demand and sever staff shortages (Public Hearings), as well as the inability to help women who are more than 12 weeks pregnant. There are no reliable, accessible second trimester services in many of the areas. Negative attitudes of management towards TOP service provision, intimidation of abortion care providers by both colleagues and communities, and service providers acting as gatekeepers, contribute to the non-functioning of designated facilities (Barometer, Dec 2000:49).

In order to translate the abortion law in SA into services that ensure equity of access and women’s right to control their bodies, interventions are needed to change judgemental views on abortion.

Based on the findings of their study, Varkey et al (2000:103-111)\(^{17}\) developed two interventions, that appeared to substantially influence personal views by getting

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\(^{16}\) RRA 2000: “Public Hearings on the Implementation of the CTOP Act”, convened by the National Assembly Portfolio Committee on Health, supported by the RRA, 6-9 June 2000.

people to make a connection between the need for abortion services and the circumstances in which unwanted pregnancies occur. These tools could be used in sexuality education on schools and in nursing and medical training, to complement current advocacy initiatives taking place at policy and programme levels in South Africa, to help to reduce the public health problem of unsafe abortion (Varkey & Fonn 2000:30).

Greater acceptance of abortion among health managers, providers and community members will help to ensure that equity of access and women’s right to control their bodies become a reality for all women in South Africa (Varkey et al 2000:104).

The Planned Parenthood Association of South Africa (PPASA), the Reproductive Health Research Unit (RHRU), and the Reproductive Rights Alliance (RRA) conducted values clarification workshops with a wide range of providers throughout the country during the first year of the implementation of the Act. The workshops aimed to give health care providers the time and space to reflect on their feelings and thoughts about abortion; educate health care providers about the provisions of the new Act; and encourage health care providers to approach termination of pregnancy in a non-judgmental way to be able to treat women seeking to have an abortion with dignity and respect, regardless of the provider’s own personal views (Dickson-Tetteh & Billings 2002).

Over 4,000 health care providers attended the values clarification workshops, which were successful as a first step in shifting the attitudes of many providers. A pilot study conducted by PPASA in Cape Town showed that nearly 70 per cent of workshop participants felt that the sessions had helped them to clarify their values such that they would be able to relate with patients having an abortion ‘quite a bit’ or ‘a lot’ better than before attending the workshop.\(^\text{18,19}\)

Midwives and other health care providers participating in abortion care services need to have a support system to which they can turn to have questions answered and concerns addressed. Monitoring and support is important after training so that specific problems and questions can be addressed immediately and on-site (Dickson-Tetteh & Billings 2002).

Lastly, an array of community education activities needs to be incorporated into the Programme such that information is disseminated about the provisions of the CTOP Act, as well as ways to prevent unwanted pregnancy, STIs and HIV. Information regarding early detection of pregnancy should be included so that women can seek TOP services as early as possible in primary level facilities (Dickson-Tetteh & Billings 2002).

\(\text{18 Marais, T 1997: Abortion Values Clarification Workshops for Doctors and Nurses, HST Update, 1997, Issue no. 21.}\)

\(\text{19 Barometer Dec 2000:49}\)
SECTION 4
STRATEGIES FOR THE FUTURE

The stance taken by the National DOH reflects an understanding of the complexity of health care provision in a resource constraint context and demonstrates a serious commitment to addressing challenges in an integrated way. Whilst this may not be translated into tackling all challenges immediately, it lends itself to sustainable management for the improvement and enhancement of access to TOP services in the medium to long term (Barometer 2000:50).

Attitudes
- There is still much to be done to improve registered nurses’ and midwives’ attitudes towards termination of pregnancy, to improve referral links between community and district levels of health care, ways to integrate abortion-related care into existing programmes and to support programmes that build capacity of community-level health professionals to offer abortion-related care.
- Furthermore, measures should be taken against health care providers and health facility managers who obstruct provision of TOP services. Such behaviour is unethical and disciplinary action should be taken against such professionals. Ensuring that members of the public know where to lodge complaints if they meet with obstruction.
- Psychological support should be provided to TOP providers and consideration should be given to providing incentives to retain staff and sustain the service.
- Value clarification workshops should target all individuals working in health care settings to contribute towards ensuring an enabling environment for quality care service provision.

Organisation of services
- TOP services should be integrated with other reproductive health services to remove the stigma associated with the stand-alone service and be part of the broader reproductive health care service provision and decentralised to make them available at PHC level.
- Guidelines for TOP management should be updated and disseminated.
- Bringing private practitioners (especially midwives) on board for TOP service provision and encouraging them to apply for designation.
- Non-functional designated facilities should be made operational as soon as possible. Plans are currently being put in place for roll out of the service.
- Special mobile units should be used in poorly serviced areas and special centres with good referral systems should be developed.
- Budget allocation for TOP services provision should be adequate to ensure adequate staff and equipment for institutions providing the service.
- A human resource strategy must be developed to explore ways in which to deal with the present overload.
- A one-stop reproductive health service, which includes TOP, services provision; treatment for STDs and contraceptive services should be explored.

Education and Training
- Incorporating TOP training into the basic training curriculum for both nurses/midwives and physicians.
Advanced midwives and trained midwives should be retained in the relevant service area where their specialised skills are required and not moved to other units where their specialised skills are not fully utilised.

Consideration should be given to integrating TOP skills into the basic training of midwives.

Consideration should be given to creative distance learning programmes with limited contact hours and supervisors to monitor clinical skills developments.

Further research

- Quality of care studies focused primarily on the choice of methods to induce abortion and the competency of providers. Little is known about the personal relationships and provider-client information exchange process (Varkey & Fonn 2000:30).

- Denosa highlights the importance of counselling and support for all personnel working in a unit where TOP is being provided. Adequate staff: patient ratios should be developed and adhered to in order to minimise burn out. Training for midwives should be accelerated and should be extended to include midwives from the private sector.

- Much work is still required to ensure that all women, including young women who are particularly vulnerable to sexual violence and HIV infection, receive accurate information on their rights under the Act (Barometer 1999:2). The statistics show that there has been a drop of 5% from year 1 to year 3 in relation to the percentage of less than 18 years relative to the overall figure for each year. This may indicate a problem that young women are not accessing TOP services as readily as older women (Barometer 1999:2).

- Violence may contribute, both directly and indirectly, to unwanted pregnancies and abortion-related mortality and morbidity. Hlatshwaya (2000:26) is of the opinion that there is a direct link between violence, unwanted pregnancy and the need to terminate the pregnancy. South Africa has one of the world’s highest rates of male violence against women. Institutional violence may also be related to inadequate post-abortion care for the treatment of incomplete spontaneous and induced abortions. The role of violence has been neglected (De Bruyn 2001).

- A survey should be conducted spanning the public and private sector to determine best practice for analgesia and pain control. National policies and protocols should be developed on the use of analgesia during TOP.

Communication

- The provision of the Medical Control Council on Misoprostol as the drug used in TOP service provision must be communicated to all those involved in TOP service provision. The legal prescribing ability of midwives must be addressed to fully equip them to provide first trimester TOP services, particularly in rural areas.

- Clear guidelines on referral for TOP and location of services should be made available to all health care services.

- An information campaign should be launched on the Choice of Termination of Pregnancy Act to ensure that both clients and health care providers are aware of their rights and responsibilities.

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20 De Bruyn M 2001: Violence, unwanted pregnancy and abortion. IPAS: Chapel Hill, Clifornia, USA.
Incentives for midwives providing abortion services

- Employees working in rural and under-served areas should receive an incentive to attract and retain them in these areas. Facilities, trained staff and services should be made more readily available at primary health care level. Transport opportunities and possibilities to enable access to services should be created and/or negotiated with both the health services and the community. TOP teams should be established to visit clinics on a regular, rotational basis to perform TOPs.

CONCLUSION

Although moral and political views differ, at this point in time we would like to assume that South Africans are united in a desire to reduce the number of women who are forced to seek backstreet abortions (RRA 2001: http://www.healthlink.org.za/rra, 2001-09-18). Women continue to occupy a vulnerable position in society, which is reflected in their health status and in their ability to access relevant health services” (SAHR 2000). The adequacy of the health care system in offering women easy access to services such as TOP services exacerbates the plight of women in society.

Among the most significant results of the evaluation of the Midwifery Abortion Care Training Programme is that midwives can provide high quality abortion services independent of physicians. In general, the Programme has been successful in reaching its objective of training midwives to provide high quality abortion care services. The Programme breaks new ground for midwives in South Africa and around the world, providing an innovative model for expanding midwives’ scope of practice to include elective abortion care services. During the coming years, nationwide training in TOP and treatment of incomplete abortion needs to continue to expand service delivery at the primary care level. Special emphasis and resources need to be dedicated towards this so that TOP services can be made accessible to women throughout the country. The abortion care curriculum and training need to be integrated into pre-service midwifery training, and comprehensive documentation of midwives’ practice is needed to show the impact of the programme on women’s health and lives.