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**CHARACTERISTICS OF WOMEN HAVING FIRST TRIMESTER  
TERMINATION OF PREGNANCY IN A DISTRICT/REGIONAL HOSPITAL IN  
KWAZULU-NATAL**

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Master of Family Medicine**

**BY**

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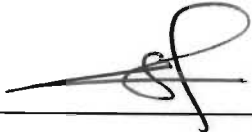
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**MARCH 2011  
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## DECLARATION

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Dr Andrew Ross (Supervisor)

## **DEDICATION**

This study is dedicated to my family for their impressive supportive role during the period of this study.

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## **ACRONYMS AND ABBREVIATIONS**

|     |                                  |
|-----|----------------------------------|
| HIV | Human immunodeficiency virus     |
| TOP | Termination of pregnancy         |
| SA  | South Africa                     |
| USA | United States of America         |
| UK  | United Kingdom                   |
| NAF | The National Abortion Federation |



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## ABSTRACT

**Introduction:** Despite the availability of contraceptives, some women still seek an induced abortion. If these women are known, they can be targeted for intensive contraceptive counseling. An accessible termination of pregnancy health facility can also be provided to those who still wish to have an abortion.

**Aim:** To determine the characteristics of women having first trimester induced termination of pregnancy in Newcastle Provincial Hospital in Amajuba district.

**Methods:** Quantitative retrospective chart review. Seven hundred and fifty eight women had an induced first trimester abortion between 1<sup>st</sup> January and 31<sup>st</sup> December 2008 at Newcastle Provincial Hospital. The medical records of 254 were systematically sampled and the data obtained from these medical records were analyzed descriptively.

**Results:** Most women (75%) were aged between 20 and 34 years. The commonest age was 23 years while the mean age was 25.27 years. Two percent were less than 16 years of age. Ninety seven percent of the sample were of African race, 75.6% reported having at least one child alive, 93.3% were single, 70.1% of the women reside in Newcastle sub-district while 19.7% reside outside Amajuba district. Eighty nine percent of the women were not using any contraception before the pregnancy that was terminated. Four (1.6%) women had previously had a termination of pregnancy. Fifty eight percent of the women requested abortion between 9 and 12 weeks of gestation (commonest gestational age was 8 weeks). Seventy four percent of the women were self-referred. Ninety six percent of the women reported having an abortion because of socio-economic reasons. Only 69.7% disclosed their intention to procure abortion to a second person. Every woman was counseled before her pregnancy was terminated.

**Conclusions:** In our patient population, women who are more likely to have an induced first trimester abortion are: in their twenties; African; single; parous; sexually active and not using any contraceptive; residing in Newcastle sub-district and of poor socio-economic status. These groups of women should be targeted for intensive contraceptive counseling. The proportion of women who are less than 16 years of age shows that statutory rape is still a challenge in South Africa and deserves more attention. Further study is needed to establish if the location of Newcastle Provincial Hospital is denying women living in other sub-districts in Amajuba (apart from Newcastle sub-district) the

opportunity to procure an induced abortion. Such a study will thus guide the place where future termination of pregnancy services may be established in Amajuba.

# 1 CHAPTER I: INTRODUCTION

## 1.1 Background

Termination of pregnancy (TOP) has been a subject of much debate. Those who are pro TOP base their argument mainly on the right a woman has to private life<sup>1</sup> and the right she has to decide whether her pregnancy continues beyond the second trimester.<sup>2</sup> On the other hand, those who are opposed to a TOP commonly present their argument from a religious point of view (favouring the personhood of a human embryo).<sup>2</sup> Interestingly, the legal status of abortion in a country does not influence the rate of abortion but when TOP is illegal it is associated with increased maternal morbidity and mortality.<sup>3,4</sup>

### 1.1.1 What is known so far?

The Choice on Termination of Pregnancy Act was enacted in South Africa (SA) in 1996.<sup>5</sup> The implementation of this act began in February 1997.<sup>6</sup> Since then it has been possible for women to access a TOP at approved health institutions across the country. Between the year 1997 and 2008, approximately 731 193 induced abortions were reported to the National Department of Health, Epidemiology and Surveillance Directorate.<sup>6</sup> In the United Kingdom, one in five pregnancies ends in a TOP.<sup>7</sup> In the USA, about half of the pregnancies among American women are unintended and four in ten of these pregnancies are terminated. About one-third of American women have had an abortion by age of 45.<sup>8</sup>

There are certain features that are peculiar to women who seek a TOP. These women engage in inconsistent and incorrect use of contraception.<sup>7</sup> Among these women, knowledge of contraception does not equate to consistent contraceptive usage.<sup>9</sup> The inconsistent or incorrect use of contraception by these women who are sexually active may result in unplanned and unwanted pregnancies. A descriptive, cross-sectional survey of the characteristics of clients seeking first and second-trimester TOPs in public health facilities in Cape Town revealed that all participants regarded their current pregnancy as unplanned.<sup>10</sup> Education, age, marriage duration and residence have all been shown to influence the likelihood of a women to abort an unplanned pregnancy.<sup>11</sup> In Durban for instance, women in their twenties are more likely to have a TOP than women in other age

categories.<sup>12</sup> However, women seeking TOPs are found in all socioeconomic and demographic groups.<sup>7</sup>

Following unintended pregnancies and the subsequent desire to have an abortion, health-seeking behaviour is exhibited. Seeking help involves making contact with a helping agency.<sup>13</sup> These women who seek an abortion may confide in their spouse or partner, sister, and/or a friend about their choice to have a TOP.<sup>12, 14</sup> Despite having a confidant, women seeking a TOP usually present to the health facility unaccompanied.<sup>15</sup> On arrival at the abortion facilities, the commonest reasons for requesting a TOP are poor financial status and short birth interval.<sup>9, 12</sup> Women who present for a TOP usually seek help early in their pregnancies<sup>12, 15</sup> Occasionally they present repeatedly for a TOP.<sup>10, 16, 17</sup>

Despite the establishment of TOP services in public health institutions in SA, access to these services has been constrained by inadequate information about availability of TOP clinics, limited capacity and long waiting lists. Poor knowledge of the availability of TOP clinics in SA is a worrying issue. For instance in Cape Town, women who seek a first trimester TOP attend a median of two other health facilities before presenting to an appropriate clinic to initiate abortion.<sup>10</sup> These delays may account for the high proportion of second trimester TOPs performed in SA. In SA 72% of TOPs are done during the first trimester, 22% are performed during the second trimester while 6% are unspecified.<sup>6</sup> The proportion of second trimester terminations is considerably higher than what is obtainable in other countries with legalized abortions.<sup>10</sup> For instance, in Vietnam, Russia and USA second trimester TOPs constitute less than 10% of all the TOPs.<sup>10</sup>

TOP clinics are available only in designated health facilities that have the capacity to offer this service. This limits the number of TOP clinics available to the public and results in long waiting lists before the TOP can be performed. However, most SA women in their reproductive age live within 50km to 100km radius of a health facility offering first trimester TOP.<sup>18</sup>

### **1.1.2 What needs to be known?**

Patients commute from within and outside Amajuba district to access healthcare in Newcastle Provincial Hospital. This applies to TOP services that are also provided at this hospital. The aim of this study is to determine the characteristics of women who have a TOP in Newcastle Provincial Hospital (an urban district/regional hospital in Amajuba district) in KwaZulu-Natal. To date, there is no study on the characteristics of women utilizing the TOP services at Newcastle Provincial Hospital.

### **1.1.3 What is the importance of this study?**

This study is important because the characteristics of the women utilizing the TOP services in Amajuba district will be described. Studies of women undergoing TOP are useful in making health policies as they may highlight problem areas especially in the use of contraception.<sup>19</sup> The information obtained from this study will help policy makers in planning where future TOP services should be established in Amajuba district. Over and above this, women prone to seek TOP can be targeted for more intensive contraceptive counseling in every healthcare facility. This is important given the evidence which shows that there is a disparity between contraceptive knowledge and contraceptive usage.<sup>9</sup>

## **1.2 Statement of the problem**

Patients commute from within and outside Amajuba district to access TOP services in the Newcastle Provincial Hospital. The characteristics of these patients have never been studied. Such information is important for planning and service provision in the health sector. The characteristics of the women having induced first trimester TOP in Newcastle Provincial Hospital will be described. The findings of this study may be peculiar to the Amajuba district because Newcastle Provincial Hospital attends to patients from remote areas outside Amajuba district in addition to those within the district.

## **1.3 Purpose of the research**

The purpose of this study is to determine the characteristics of women having a first trimester induced TOP in Newcastle Provincial Hospital in 2008.

## **1.4 Specific objectives of the research**

### Major objective

To determine the demographic profile, contraceptive usage, frequency of TOP and help-seeking behaviour of women that have a first trimester induced TOP at Newcastle Provincial Hospital.

### Minor objectives

- i) To determine the indications for having a first trimester TOP
- ii) To determine to whom patients disclose their intention to procure a TOP.
- iii) To determine the support given to patients having a TOP.

## **1.5 Scope of the study**

This is a descriptive study conducted at Newcastle provincial Hospital. A retrospective chart review was done of patients who had an induced first trimester TOP between 1 January 2008 and 31 December 2008.



## **2 CHAPTER II: LITERATURE REVIEW**

### **2.1 History of termination of pregnancy**

Unwanted pregnancies have been recorded throughout history and all such pregnancies are at risk of voluntary termination. The Egyptians were the first people to write on induced abortion in 1550 BC.<sup>20</sup> The use of mercury to induce abortion by the Chinese was practiced almost 5000 years ago.<sup>20</sup>

Over the ages many techniques have been employed for TOP. These include abdominal compression, strenuous physical activity including diving, Lacedaemonian leap (touching the buttocks with the heels during a jump) and weight lifting.<sup>20</sup> Other methods to induce an abortion include the insertion of traditional herbs into the vagina by herbalists.

The debate on the ethics of abortion dates back many decades. In the ancient times, the Romans held the view that the man who fathered the pregnancy owns the foetus, while the Greeks regarded a TOP as an acceptable procedure because they considered the foetus to be plant-like until it breathes air.<sup>20</sup> This debate has been affected by religious viewpoints, medical paternalism, and medicalization of obstetrics (including better understanding of foetal development and maternal mortality). In England a TOP was considered an offence by the Act of Habeas Corpus (offence against the person) promulgated in 1861. Prior to this, English common law allowed a TOP before quickening occurred.<sup>20</sup>

Over the years, many countries including SA promulgated new abortion laws or amended existing abortion laws. In more than sixty percent of countries around the world, a TOP is permitted if the health of a pregnant woman is endangered by the pregnancy.<sup>21</sup> Approximately 40 percent of the countries allow TOPs in cases of rape, fetal impairment, or incest; about thirty-three percent of countries permit a TOP because of socio-economic reasons; and about twenty five percent of countries allow abortion on maternal request.<sup>21</sup>

## **2.2 Maternal morbidity and mortality from abortion**

Globally, the maternal mortality ratio was 251 (221–289) per 100 000 live births in 2008.<sup>22</sup> More than 50% of these maternal deaths occurred in six countries including India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of the Congo.<sup>22</sup> In the same year, the maternal mortality ratio in SA was 237 (146–372) per 100 000 live births.<sup>22</sup>

Worldwide, one in eight maternal deaths (an estimated 67 000 deaths), occur annually as a result of an unsafe TOP.<sup>23</sup> The majority of these deaths occur in Africa.<sup>4</sup> In 2008, approximately 41 million induced abortions were performed worldwide.<sup>4</sup> Almost half (48%) of the abortions performed annually are unsafe.<sup>4, 23</sup> Fifty five percent of abortions in developing countries are unsafe while 92% of abortions in developed countries are safe.<sup>4</sup> About 10% to 50% of women who procure an unsafe abortion develop medical complications. The common complications are sepsis, incomplete abortion, haemorrhage and uterine perforation. Common long-term complications are chronic pelvic pain, pelvic inflammatory disease, ectopic pregnancy, spontaneous pregnancy loss, and secondary infertility. Occasionally, these women suffer criminal prosecution and social isolation.<sup>23</sup> In comparison with adults, adolescents are more likely to present late, delay having the abortion, resort to using unskilled persons to perform the TOP, and use dangerous methods. These behaviours are more likely to lead to complications.<sup>24</sup>

The morbidity and mortality resulting from an unsafe abortion are preventable by addressing the determinants of an unsafe abortion. These determinants include restrictive abortion legislation, lack of female empowerment, poor social support, inadequate contraceptive services and poor health-service infrastructure.<sup>25</sup>

In South Africa, the introduction of the Choice on Termination of Pregnancy Act has been associated with a reduction in maternal deaths due to abortion,<sup>26</sup> and a decrease in the number of women presenting with incomplete abortions.<sup>27</sup> In 2001, there was 91.1% reduction in the mortality resulting from unsafe abortions in SA.<sup>28</sup> In 2009, the World

Health Organization and Guttmacher Institute reported that infection resulting from a TOP in South Africa had decreased by 52% due to the legalization of induced abortion.<sup>4</sup> Despite these findings, the fourth confidential enquiry into maternal deaths in SA (2005 to 2007) showed that the number of deaths due to abortion increased slightly in that triennium after a significant decrease in the previous triennium. This was attributed to poor access to TOP services as the number of health institutions performing TOPs has decreased. Among the ten recommendations emanating from this confidential enquiry was that “the number of deaths from unsafe abortions must be reduced.”<sup>29</sup>

### **2.3 Choice on Termination of Pregnancy Act in South Africa**

The current regulations on TOP in South Africa are provided by the Choice on Termination of Pregnancy Act No 92 of 1996.<sup>5</sup> This act was amended in the Choice on Termination of Pregnancy Amendment Act of 2008<sup>30</sup> These acts guide TOP services in all health facilities in SA including Newcastle Provincial Hospital.

The Choice on Termination of Pregnancy Act No 92 of 1996 states that:

A pregnancy may be terminated under the following circumstances:

- a) In the first 12 weeks of gestation (first trimester) following the request of the pregnant mother.
- b) From 13 weeks to 20 weeks gestation (second trimester) following consultation of the pregnant woman by the medical practitioner, if the pregnancy is detrimental to the woman’s health, or pose severe mental or physical impairment on the fetus, or if the pregnancy was as a result of rape, or if the pregnancy will cause major socio-economic problems to the woman.
- c) Beyond 20 weeks gestation, after a medical officer must have consulted with a registered midwife or another medical practitioner and still holds the opinion that the continuation of the pregnancy will be detrimental to the woman’s health, or that the fetus will be severely malformed or that the pregnancy will be injurious to the fetus.

A medical practitioner may carry out a first or second trimester TOP. A registered midwife who has completed the prescribed training course may also carry out a first trimester TOP.

The act also specifies the need to provide non-directive counseling to pregnant women seeking a TOP before and after the procedure. Informed consent is mandatory prior to TOP. With respect to consent of a minor, a pregnant minor shall be advised by a medical practitioner or a registered midwife to consult their parents, guardian, family members or friends before her pregnancy is terminated. However, a TOP cannot be denied to a minor if she chooses not to consult with them prior to the procedure.

Pregnant women who are mentally disabled or who are unconscious with no prospect of regaining consciousness in time to request and consent to a TOP, can have a TOP if such pregnancy is not more than 20 week gestation provided that:

- i) Her natural guardian, spouse or legal guardian requests and gives consent to the TOP;
- or
- ii) Her curator personae (where her spouse or guardian cannot be found) requests and gives consent to the TOP; and
- iii) Two medical practitioners or a medical practitioner and a trained registered midwife consent thereto.<sup>5</sup>

The Choice on Termination of Pregnancy Amendment Act, 2008 provides that TOP may only take place at an accredited facility which:

- gives access to medical and nursing staff
- gives access to an operating theatre
- has appropriate surgical equipment
- supplies drugs for intravenous and intramuscular injection
- has emergency resuscitation equipment and access to an emergency referral to a health facility
- has facilities for emergency transportation, has capacity for in-patient management and clinical observations
- has telephone for communication
- has appropriate methods of waste disposal and infection control.

However, health facilities with 24-hour maternity services may terminate pregnancies that are not more than 20 weeks gestation without getting the approval of a Member of

the Executive Council. In addition, annual statistics of the number of TOPs performed must be submitted from every approved facility to the Minister of Health.

The Act also makes it illegal for anyone who is not a registered nurse or a medical practitioner to perform a TOP. The Act also imposes a fine or imprisonment for any person who obstructs a TOP, or any person who allows or terminates a pregnancy in a facility not legally meant for a TOP.<sup>30</sup>

#### **2.4 Incidence of induced termination of pregnancy**

About 46 million induced abortions were performed worldwide in 1995. This declined to 42 million in 2003.<sup>4,31,32</sup> This reduction in the incidence of abortion was more pronounced in Eastern Europe (where abortion is legalized and also safe). The decrease in TOP occurred when there was an increased contraceptive usage in Eastern Europe.<sup>31,32</sup> The induced abortion rate per 1000 women of childbearing age (15 - 44 years of age) in 1995 and 2003 were 35 and 29 respectively.<sup>4,31,32</sup> Worldwide, one out of every five pregnancies ends as an abortion.<sup>4,31</sup>

About 35 million and 7 million abortions occur yearly in developing and developed countries respectively.<sup>4</sup> The larger human population in the developing countries accounts for the greater number of abortions that occur in the developing countries. Most abortions occur in Asia because Asia is more densely populated than any other part of the world. Each year about 26 million abortions occur in Asia with approximately 9 million occurring in China alone.<sup>4,31</sup>

In the UK, almost 200 000 pregnancies are terminated every year.<sup>33</sup> However, the likelihood of a woman having an abortion is similar whether she lives in a developed or developing country. In 2003, there were 26 abortions per 1000 women aged 15-44 in developed countries compared with 29 per 1000 in the developing countries.<sup>4</sup> The number of induced abortions in Africa has increased since 1995, but the abortion rate has declined due to an increase in the number of reproductive-age women. The lowest

abortion rate in the world is in Western Europe (12 per 1000 women aged 15 - 44) while the highest is in Latin America (31 per 1000 women aged 15 - 44).<sup>4</sup>

In SA, there is both under reporting and delayed reporting of TOP statistics.<sup>6</sup> Between 2006 and 2008, the provinces with the highest incidence of under reporting were Mpumalanga, Eastern Cape and KwaZulu-Natal.<sup>6</sup> From 1997 till date, Gauteng province reports or performs the majority of TOPs in SA followed by the Western Cape.<sup>6</sup> Northern Cape province performs the least number of TOPs.<sup>6, 34</sup>

In 2009, a total of 77 201 TOPs were performed in SA.<sup>35</sup> See Table 1 below

Table 1: The number of TOPs performed in SA in 2009

| Province      | Number of TOP | Percentage of TOPs |
|---------------|---------------|--------------------|
| Gauteng       | 22 354        | 28                 |
| Western Cape  | 13 772        | 17.84              |
| Eastern Cape  | 10 841        | 11.05              |
| Limpopo       | 9 035         | 11.70              |
| Free State    | 6 581         | 8.52               |
| KwaZulu-Natal | 5 933         | 7.69               |
| North West    | 4 939         | 6.39               |
| Mpumalanga    | 2 676         | 3.34               |
| Northern Cape | 1 067         | 1.38               |
| Total         | 77 201        |                    |

Table 1 shows that the number of TOPs performed in each province in 2009 were: Gauteng 22 354(28%), Western Cape 13 772(17.84%), Eastern Cape 10 844(11.05%), Limpopo 9 035(11.70%), Free State 6 581(8.52%), KwaZulu-Natal 5 933(7.69%), North West 4 939(6.397%), Mpumalanga 2 676(3.47%) and Northern Cape 1 067(1.38%).<sup>35</sup>

## **2.5 Incidence of unintended pregnancies**

In 2008, approximately 208 million pregnancies occurred worldwide.<sup>4</sup> Among these pregnancies, 33 million were unintended while 41 million ended in TOPs.<sup>4</sup> In the developed countries 23 million pregnancies occur yearly, but more than 40% of these pregnancies are unintended, while 28% end in a TOP.<sup>4</sup> On the other hand, of the 182 million pregnancies that occur in developing countries, 40% are unintended, and 19% end in TOPs.<sup>4</sup> Unfortunately, 48% of all TOPs performed worldwide are unsafe. In the developing countries 55% are unsafe but in the developed countries only 8% are unsafe.<sup>4</sup> Every year about 2.0 to 4.4 million adolescents procure abortions worldwide.<sup>24</sup> The UK has the highest teenage pregnancy rate in the developed world and one in five pregnancies ends in a TOP.<sup>7</sup> As at 2002, fifty-two out of every 1000 girls aged between 15 and 19 in the United States gave birth while in the UK it was just over 30 births in 1000 teenagers. Korea, Japan, Switzerland, the Netherlands, and Sweden had a rate of less than seven births per 1000 teenagers.<sup>36</sup>

In South Africa, early sexual activity and teenage pregnancy is extremely common.<sup>37</sup> With the high incidence of HIV in Southern Africa, studies have shown that one in five pregnant teenagers is infected with HIV.<sup>37</sup> Among women under the age of 20 years in SA, only 3% are married or live with a partner while 35% have been pregnant or have a child.<sup>37</sup> The study on characteristics of women booking for first and second trimester abortions at public sector clinics in Cape Town showed that the current pregnancies in all the 164 research participants had been unplanned.<sup>10</sup>

## **2.6 Demography**

Induced abortion affects women in all socioeconomic and demographic groups.<sup>7</sup> However, education, age, marriage duration and residence have been shown to have an influence on the rate of abortion.<sup>11</sup> In 1998, Barrett and his colleagues showed that there are significant differences in terms of marital status, parity, lifetime number of sexual partners, ethnicity, and attitude to TOP between women who do not have abortions and women who do procure an abortion.<sup>19</sup> From 1997 to 2008 in SA, about 76% and 10% of

all the TOPs were performed on women older than 18 years and younger than 18 years respectively. The ages of the women were not specified in the remaining 14.4% of cases of TOP.<sup>6</sup> In Durban, women in their twenties are more likely to have a TOP than women in any other age category. The largest single age group of these Durban women was 21 years while their mean age was 25 years.<sup>12</sup> In Cape Town women booking for first and second trimester termination were aged 15 - 39 (median age 24 years); 20% of first and 24% of second trimester clients were teenagers.<sup>10</sup> In Singapore, the mean age of 1370 women who presented for induced abortion between 1 January 1996 and 31 December 2000 was 29.6 years; teenagers constituting 8.5% of the sample.<sup>38</sup> In the US 50% of women obtaining abortions are younger than 25 years; women aged 20-24 obtain 33% of all abortions while teenagers obtain 17%.<sup>8</sup> Most clients that present for a TOP in South Africa have had previous pregnancies.<sup>10, 12</sup> In a prospective, population-based study in Durban involving 400 women requesting a TOP, 26% were primigravida, 70% were Para 1 to Para 4 while 4% were  $\geq$  Para 4. The study also showed that 2.6% were divorced/separated, 13.1% were married/engaged and 84.3% were single.<sup>12</sup> Interestingly, in Cape Town, 63% of clients booking for induced abortions were currently in a relationship.<sup>10</sup> The likelihood of a woman having an abortion is the same whether she lives in an advanced or developing country. In 2003, the number of abortions performed per 1000 women aged 15 - 44 in developing and developed countries were 29 and 26 respectively.<sup>31</sup> Other demographic features found among women requesting termination of pregnancy in Durban were that only 3% had no formal education while 82% had either secondary (60%) or tertiary education (22%), 71% were unemployed and 41% of this group were students, and of the employed group 4% had white collar jobs while 17.8% had blue collar jobs.<sup>12</sup> Interestingly, in the United States, 43% of women obtaining abortions identify themselves as Protestant, and 27% as Catholic.<sup>8</sup>

## **2.7 Contraception**

In the last three decades, newer contraceptive methods have been introduced. Disappointingly, this innovation has not changed the compliance to contraceptives or the incidence of unwanted pregnancy.<sup>39</sup> However, it has been suggested that the lack of information about contraception is one of the main preventable causes of TOP in Italy



and that 10-50% of induced abortion may have been prevented through education and counselling.<sup>40</sup>

In the developing countries, two third of unintended pregnancies arise from women who are not using contraception. In these countries, unmet needs for contraception occur in more than one million females who are married. This means that “they are sexually active; are able to become pregnant; do not want to have a child soon or at all; and are not using any method of contraception, either modern or traditional.”<sup>31</sup> In the US nearly half of pregnancies are unintended and four in 10 of these are terminated. Studies in the United States have shown that about half of unintended pregnancies occur among the 11% of women who are at risk of unintended pregnancy but are not using contraceptives.<sup>8</sup> Worldwide only 18% of unintended pregnancies occur in women who are using modern contraceptives.<sup>4</sup>

In SA, 65% of sexually active women are using some method of contraception.<sup>41</sup> However, a nationally representative cross-sectional survey of women aged 15 to 24 showed that the contraceptive usage was 52.2% among sexually active women.<sup>42</sup> In another study, a larger number of young sexually active South African women living in an urban area were using a method of contraception compared to their counterparts in the rural areas (76% versus 53%).<sup>43</sup> A community-based survey of unwanted pregnancies involving 3743 women in southwestern Nigeria revealed that 91.3% of women were aware of some form of contraception but the “ever used rate” was only 36.6% while the current use rate at the time of the study was only 23.4%.<sup>9</sup> This disparity between contraceptive knowledge and usage calls for the strengthening of contraceptive counseling.

Contraceptive usage among women seeking a TOP is generally sub-optimal. Uncertainty about the desire for future pregnancy is associated with less likelihood to use contraception.<sup>44</sup> In Durban, only 75% of those seeking abortion had previously used some form of contraception while only about 5% had some knowledge of emergency contraception.<sup>12</sup> In Cape Town, only 21% of those seeking abortion reported using

contraception when they became pregnant, most commonly the condom (53%) or pill (35%).<sup>10</sup> Studies have shown that women who undergo a TOP do not use any contraceptive, are using condom or oral contraceptives at the time they become pregnant.<sup>39</sup> These studies have shown that there is poor compliance to oral contraceptives and barrier contraceptives. On the other hand, the non-daily dosing of long acting contraceptive improve their compliance and minimizes their failure rate.<sup>39</sup> Among South African women attending primary care facilities in Cape Town, the knowledge and the use of long acting contraceptives, such as an intrauterine contraceptive device, was low.<sup>45</sup> A study involving 2908 women in Scotland, using a self-administered questionnaire, showed that the use of emergency contraception is low in women who do not want to become pregnant, meaning that this method of contraception may not reduce unplanned pregnancies.<sup>33</sup> However, emergency contraceptives are available in most pharmacies in Europe therefore readily accessible to individuals. Trussell and colleagues have concluded that the use of emergency contraception in the USA could prevent 1.7 million unplanned pregnancies and consequently prevent termination of half of these pregnancies.<sup>33</sup> Unfortunately, three randomized studies only showed an increased use of emergency contraception but not a decrease in unintended pregnancy when emergency contraceptives are given to individuals prior to their sexual encounters.<sup>39</sup>

In SA, there is evidence of an association between contraceptive use and being employed or being a student (versus unemployed); having fewer sex partners; having talked to the last partner about condom use and having ever been pregnant.<sup>42</sup>

The commonest reasons why women (married and unmarried) do not use contraceptives include worrying about possible side effects of contraceptives, and the belief that they are not at risk of getting pregnant.<sup>31</sup> Concerns about weight gain and cost are other reasons reported by some women.<sup>46</sup> Kozinszky reported from Hungary in 2004 that financial means were a non-significant determinant in the choice of contraceptive.<sup>47</sup>

Effective contraceptive counseling can reduce sexual ill health and consequently reduce the incidence of unintended pregnancy.<sup>39</sup> However, to change human behaviour is a

challenging process. This is made worse by the fact that many factors influencing sexual behaviour changes with time. There is no effective counseling for the changing behaviour or changing knowledge of humans. So counseling is unlikely to result in a marked reduction of unintended pregnancy.<sup>39</sup> However, counseling may improve the situation in places where there is poor service delivery and poor knowledge of contraception.<sup>39</sup> In an area where contraceptive prevalence is high, the focus arguably should be on how to improve correct and consistent use of contraception.<sup>39</sup>

## **2.8 Repeat termination of pregnancy**

Worldwide, one in five women will have more than one abortion in her lifetime.<sup>48</sup> In Cape Town, a study of 164 women booking for abortions showed that 3% had previously had an abortion.<sup>10</sup> In Northern Europe, the rate of repeat induced abortion varies from 30% to 38%.<sup>49</sup> In the UK, a study at Luton in 2007 showed that out of 159 women referred for a TOP, 26.4% were repeat procedures.<sup>16</sup> At the Royal Infirmary in Edinburgh, 26% of those presenting for a TOP were for repeat procedures.<sup>48</sup> Repeat TOPs constitutes 35.5% and 48% of all induced abortions in Canada and USA respectively.<sup>17</sup> A study evaluating request for a repeat TOP within 24 months of the first TOP showed that: financial difficulty was the main reason why women requested a repeat TOP (75%); the most commonly used contraceptives prior to the first TOP were combined oral contraceptive pill (35%) and condom (38%); only 8% of the women were using a long acting reversible contraceptive before their TOP; fifty-eight percent agreed to use long-acting reversible contraception following the first TOP, but the percentage of women who continued its use and those who were not using contraception during the repeat termination were 2% and 50% respectively.<sup>50</sup> In Edinburgh, women who are parous and deprived have more than a 50% risk of having more than one TOP.<sup>48</sup> In Finland, a history of prior abortion, being parous, young age, smoking and failure to attend a follow-up clinic were all associated with repeat TOPs.<sup>49</sup> In the US, postpartum teens who receive Depot Medroxyprogesterone Acetate have significantly lower repeat pregnancy rates within one year of delivery when compared to teens who choose oral contraceptive pills or the patch; the contraceptive patch offering no advantage over oral contraceptive pills in terms of compliance or repeat adolescent pregnancy rates.<sup>51</sup>

## 2.9 Help-seeking behaviour

Individuals seek help for their emotional problems in three stages. Kessler proposed these three stages to include: recognition that there is a problem; belief that outside help is needed; and eventual contact with a helper or helping agency.<sup>13</sup> Patients who seek a TOP recognize that there is a problem and there is a need for help. Their contact with a TOP clinic may be early or late. In a government hospital in the Eastern Cape of SA, most patients requesting a TOP presented to the clinic in the first trimester, and there was no correlation between their ages and the gestational ages at which they presented.<sup>15</sup> In Durban, it was found that most patients also presented in the first trimester.<sup>12</sup> In Cape Town, the median gestational age at presentation for a TOP was 9 and 15 weeks for first and second trimester clients respectively. In the same study there was a one-week delay after pregnancy confirmation before the clients presented at the TOP clinic. The second trimester clients were more likely than first trimester clients:

- to be Xhosa-speaking (versus Afrikaans/English speaking) ( $p < 0.01$ )
- to think they must wait until at least 3 months of pregnancy before presenting for care ( $p = 0.04$ )
- to recognize pregnancy later in gestation ( $p = 0.001$ )
- to wait longer between thinking that they might be pregnant and pregnancy confirmation ( $p = 0.05$ )
- were less likely to obtain a urine pregnancy test from a pharmacy during this pregnancy ( $p = 0.01$ )
- to know about TOP time restrictions ( $p < 0.001$ ).<sup>10</sup>

In comparison with adults, adolescents are more likely to delay the abortion, resort to unskilled persons to perform it, use dangerous methods and present late when complications arise.<sup>24</sup> A structured survey in 2004 showed that minors did not suspect that they were pregnant as early as adults did.<sup>52</sup> The most common reasons given by clients for delays in obtaining abortion are obstacles in financing the abortion, traveling long distances for a TOP, fear,<sup>53</sup> the length of time it takes to make appropriate arrangements, the long time it takes to decide on having a TOP, and the long time it

takes to find out about the pregnancy.<sup>52</sup> In SA, personal circumstances, the delay in detecting pregnancy and health service related barriers are the reasons why women delay in seeking abortion.<sup>54</sup> These reasons may explain why second trimester induced TOP, an inherently more risky procedure, constitute 22% of all abortions in SA.<sup>6</sup> Ideally with better help seeking behavior, women requesting abortion will present in the first trimester. The advantages of first trimester induced abortions include decreased risk of complications, decreased cost to health services, and increased feasibility of TOP becoming a predominantly primary-level, nurse provided service.<sup>10</sup>

In India, about 40% of adolescent girls are married before the age of 18, at a median age of 16, contravening the minimum legal age of 18 years. In addition, there is evidence to show that some husbands of these women made the decision whether their wives could seek reproductive health-care and their mother-in-law sometimes influenced these decisions.<sup>55</sup> These girls had neither decision-making power nor influence.<sup>55</sup> This shows that early marriage influences the help-seeking behaviour of teenagers.

## **2.10 Indications for termination of pregnancy**

The reasons why women request a TOP could be an interplay of circumstances including logical arguments, social, emotional, psychological, moral, and economic factors.<sup>56</sup> In 1999, Adanlawo and Moodley reported from Durban that 72% of women requested a TOP for socio-economic reasons.<sup>12</sup> These reasons include interruption of schooling, unemployment, or merely having had enough children to cope with. In the same study, about 14% requested a TOP because of problems with partners, viz fear that the male partner would leave the relationship as the male partner was not supportive of the pregnancy.<sup>12</sup> In Southwestern Nigeria the commonest reason given for a TOP was short birth interval.<sup>9</sup> Other specific reasons for TOPs are a dislike of single parenthood, young maternal age, fear of lifestyle modifications, bad timing of pregnancy, insistence from male partner for the woman to have an abortion, and feelings of tiredness.<sup>56</sup>

## **2.11 Disclosure of intention to terminate pregnancy**

Disclosing an intention to have an abortion may be a method of demonstrating intimacy with the confidant, or a method of seeking support. Disclosure of intention to have a TOP was made by 32% of patients in Durban in 1998. Among these patients, 51.8% confided in their spouse or boyfriend, while others confided in a friend or sister.<sup>12</sup> A retrospective study at the Centre Hospitalier Universitaire (CHU) of Nice involving minors has shown that in more than 56% of cases parents were not informed about requests for a TOP.<sup>14</sup> In the US, 6 in 10 minors who have had an abortion reported that at least one parent knew about the TOP.<sup>8</sup>

## **2.12 Support for patients having an induced termination of pregnancy**

Universal access to reproductive health care services includes access to family planning and contraception, TOP, sexuality education and counseling services. In SA, the State has a responsibility to provide reproductive health to its citizens.<sup>5</sup> Women who decide to have an abortion deserve support at all times. This support ranges from good legislation on abortion, facilitation of access to a TOP clinic, provision of counseling services (before and after abortion), provision of safe abortion, and provision of follow-up care after the TOP. In SA, counseling by health care providers is a mandatory form of support that must be provided to patients seeking termination of pregnancy.<sup>5,57</sup>

A retrospective descriptive study by Delotte et al, showed that with regards to minors, in the majority of cases the entourage (sexual partner or parents who were informed about the request for TOP) supported the patient in her choice. However the same study showed that in more than 56% of cases, the parents were not informed of the request for a TOP.<sup>14</sup> In the Eastern Cape province of SA, most patients requesting a TOP were not accompanied to the clinic, with older women being significantly less likely to be accompanied than younger women. While partners hardly ever accompanied the women, they were most likely to be told about the TOP.<sup>15</sup> Mdleleni-Bookholane, who studied support for women undergoing a TOP in the Eastern Cape province, showed that expected parental support and perceived support from friends were associated with a more favourable reaction to undertaking a TOP.<sup>58</sup> In KwaZulu-Natal, support for the

Choice on TOP Act was found to be low (11%) among both community members and nurses. In the same study only 18% of community members and 6% of nurses supported abortion on request.<sup>59</sup> A European study has shown that even obstetricians in eight European countries expressed opposing views about late TOPs, although active euthanasia of a live-born infant was practiced in France and the Netherlands.<sup>60</sup> These views about TOPs may impact on the assistance given to women seeking abortion.

Support offered to women having an abortion has far reaching effects. Studies have shown that after an abortion, a woman makes a better adjustment to the TOP if her male partner supported her decision to undergo termination. Two years after an abortion, a woman has a higher chance of experiencing psychological problems if her male partner coerced her to procure the TOP.<sup>56</sup> Support in the form of post-abortion family planning is an integral part of comprehensive abortion care that helps prevent another unintended pregnancy and also prevents the attitude of over-reliance on abortion for preventing unwanted pregnancies.<sup>61</sup> Pre-abortion counseling combined with the provision of contraceptive intervention immediately post-abortion has been shown to significantly increase contraceptive use at 6 months post-procedure.<sup>62</sup> A counseling session during an abortion creates room for health care givers to be patient-centred; thus exploring subjective (woman's feeling, beliefs, wishes, expectations) issues related to contraception, etc.<sup>40</sup> During this counseling session contextual issues can equally be explored and addressed. By not asking a woman about her abortion experiences, healthcare providers risk perpetuating a women's guilt, shame, and silence.<sup>63</sup> In 2008, Charles et al. conducted a systematic review of long-term mental health outcomes of induced abortion. The finding of this high quality study was mostly neutral, suggesting few, if any, differences between women who had abortions and their respective comparison group in terms of mental health sequels. Charles et al. concluded that studies with flawed methodologies have found negative mental health sequels associated with TOPs.<sup>64</sup>

## **2.13 Factors encouraging a request for abortion and those encouraging the development of complications of abortion**

Request for a TOP and development of complications of abortion are enhanced by a number of factors. These factors have been categorized by the World Health Organization to operate at individual, community and health service levels.<sup>23</sup> These include:

### **Individual factors**

- Engaging in sexual encounters at a very young age
- Poor knowledge of family planning
- Limited knowledge about where to access family planning
- Refusal to utilize family planning services due to emotional and socio-economic reasons
- Poor compliance to contraceptive usage
- Failure of contraception
- Poor knowledge of the morbidity and mortality associated with an unsafe TOP
- Poor knowledge of the complications of severe vaginal bleeding
- Low level of education which also leads to lack of knowledge
- Poor financial status with subsequent inability to afford health services
- Unsatisfactory health condition with very **high** chance of developing post-abortal complications
- Past TOP that resulted from unintended **pregnancy**

### **Community factors**

- Poor knowledge of the morbidity and **mortality** associated with unsafe abortion
- Poor knowledge of the complications of **severe** vaginal bleeding especially when the amount of blood loss is more than that of normal menstruation
- Living far away from a health facility such that emergency access to health facility is problematic
- Lack of transportation to a health institution
- Unavailability of family planning and TOP services
- Poor social and economic status



- Tradition and environment that oppose TOP
- Illegalization of TOP
- Poor participation of males in reproductive and contraceptive matters
- Power imbalance in favour of men denying women the opportunity to seek health care without the permission of a significant member of her family

**Health services factors**

- Time wastage before initiation of resuscitative treatment for complication of TOP
- Wrong assessment of severity of haemorrhage
- Inability to supply blood and blood products
- Inappropriate management of complications arising from TOP
- Late referral to a higher level of care or refusal to seek the assistance of other healthcare workers
- Lack of empathy (from healthcare personnel) towards adolescents and unmarried women who develop complications from TOP
- Medical personnel who are not exposed to the management of complications of TOP
- Health workers lacking the necessary skills involved in family planning services, counseling of women seeking TOP and management of complications of TOP.<sup>23</sup>

## **2.14 Method of first trimester termination of pregnancy in Newcastle Provincial Hospital**

Professional nurse(s) working in a TOP clinic in Newcastle Provincial Hospital assess any patient that requests a TOP. During this time, gestational age is determined with an ultrasound. Information about the patient is then documented in her case notes/file. A nurse then counsels the patient. Any patient who accepts termination of pregnancy gives an informed consent. A specific hospital form (questionnaire) is used to record data of any patient who is to undergo TOP. Trained nurses at the TOP clinic terminate pregnancies that are up to 12 weeks. These patients are usually given an appointment for TOP. The scheduled appointment is due to the waiting list of patients wanting a TOP. On the appointment day, the patient is given 400mcg of vaginal or oral misoprostol 2 hours before manual vacuum aspiration is performed. This regimen is according to South African standard treatment guidelines and essential drug list.<sup>65</sup>

Any patient with a pregnancy that is more than 12 weeks is admitted to the gynaecology ward where a doctor may terminate the pregnancy. Any pregnancy that is up to 12 weeks or those complicated with gross fetal anomaly is also terminated by the doctor after the patient is admitted into the gynaecology ward.

Counseling (including contraceptive counseling) is offered to all patients post-TOP.

## **3 CHAPTER III: METHODS**

### **3.1 Introduction**

Patients commute from within and outside Amajuba district to access TOP services at Newcastle Provincial Hospital. The characteristics of these patients have never been studied. Such information is important for the planning and service provision in the health sector. We wanted to describe the characteristics of the women having first trimester TOP in Newcastle Provincial Hospital

### **3.2 Study setting**

This study was carried out in the TOP clinic and gynaecology ward of Newcastle Provincial Hospital.

Newcastle Provincial Hospital is an urban hospital (with 252 beds) that renders both district and regional health services. This hospital is situated in the town of Newcastle in the Amajuba district. In the year 2008, there were a total of 7406 deliveries in Amajuba district.<sup>66</sup>

Newcastle Provincial Hospital is an approved public hospital in Amajuba district where TOP services are provided. Each patient that requests a TOP is assessed (including an ultrasound assessment of gestational age) and counseled by a professional nurse and biographical and clinical data is recorded in the medical record. Any patient who accepts TOP gives an informed consent. A specific hospital form (questionnaire) is used to record data of any patient who is to undergo a TOP. Professional nurses who have had the appropriate training complete this hospital questionnaire (see appendix E) and also terminate pregnancies that are up to 12 weeks. Any patient with a pregnancy that has developed more than 12 weeks is admitted to the gynaecology ward where a doctor may terminate the pregnancy. Any pregnancy that is up to 12 weeks or complicated with gross fetal anomaly is also terminated by the doctor after the patient is admitted to the gynaecology ward. The medical records of patients who have undergone a TOP at the TOP clinic are kept at this clinic while the medical records of patients who were admitted to the gynaecology ward for a TOP are kept in the records department of the hospital.

The information about these patients is not computerized. For the purpose of this research we had to access patients' records from the TOP clinic and the hospital records department.

### **3.3 Type of research**

This is a health system research.

### **3.4 Study design**

This study is a retrospective chart review. The medical records of women that had first trimester TOP were reviewed in this study.

### **3.5 Target population**

The target population is women having first trimester TOP in Amajuba district in Kwazulu-Natal.

### **3.6 Inclusion criteria**

Pregnant women who had first trimester TOP initiated in Newcastle Provincial Hospital between 1<sup>st</sup> January 2008 and 31<sup>st</sup> December 2008.

### **3.7 Exclusion criteria**

All pregnant women who were more than 12 weeks pregnant, but had TOP in Newcastle provincial hospital were excluded.

Also excluded were women who presented with an incomplete abortion where such TOP was not initiated in Newcastle Provincial hospital.

### **3.8 Study population**

We studied the women who had a first trimester TOP in the year 2008. During this period, a total of 758 first trimester TOPs were done between 1<sup>st</sup> January 2008 and 31<sup>st</sup> December 2008 at Newcastle hospital.

### **3.9 Sample size**

This is an exploratory study. For the sake of convenience, we randomly selected 30% of the study population as our sample.

### **3.10 Selection of study sample**

Hospital records of women who had a first trimester TOP in Newcastle Provincial Hospital in the year 2008 were systematically sampled. The hospital identity numbers of these women were retrieved from TOP records in the TOP clinic and from admission/discharge records from the gynaecology ward. The medical records of the women in the sample were traced using their hospital identity numbers. A total of 758 first trimester TOPs were done between 1<sup>st</sup> January 2008 and 31<sup>st</sup> December 2008. From this pool of 758 hospital charts, every third chart was systematically selected. This led to the selection of 254 medical records that represents the sample used in this study.

### **3.11 Data sources**

Two hundred and fifty three systematically sampled medical records of women who had a first trimester TOP between January 2008 and December 2008 were reviewed. Data were extracted from each medical record using a data extraction sheet (see Appendix A).

### **3.12 Variables**

The following variables were extracted from the medical records of each patient.

- Demographic profile: Age, race, parity, marital status, area of residence
- Contraceptive usage: Type of contraceptive, if any, being used by patient
- Frequency of TOP: Number of previous TOPs
- Help seeking behaviour: Gestational age at presentation, and the healthcare provider that referred patient for TOP
- Indications for TOP: Indications for requesting TOP
- Disclosure of intention to seek TOP; the person that the patient told of her intention to seek a TOP

- Support given to TOP patient: whether or not the patient was accompanied to the hospital for TOP; if so who accompanied the patient? Secondly, whether the patient was counseled before the TOP.

### **3.13 Statistical analysis**

In this study, data is presented using descriptive statistics. Categorical data is presented as frequency counts and percentages in tables, or bar charts, while quantitative data has been summarized using mean and median. Every analysis was done using SPSS 15.0 for Windows.

### **3.14 Ethics**

The ethical approval to conduct this study was obtained from the Biomedical Research Ethics Committee of the Nelson R Mandela School of Medicine, University of KwaZulu Natal, South Africa (Reference number BE057/09). See appendix D.

## 4 CHAPTER 1V: RESULTS

A total of 254 women who had a first trimester induced TOP in Newcastle Provincial Hospital from January 2008 to December 2008 were reviewed.

The hospital identity numbers of these women were extracted from TOP records in the TOP clinic and from admissions/discharges records in the gynaecology ward. The medical records of these women were then traced using these hospital identity numbers. Systematic sampling of 254 medical records was then conducted. There were no missing folders. Unless otherwise stated N = 254.

### 4.1 Demographic profile

Table 2: Age groups

| Age category   | Frequency | Percent |
|----------------|-----------|---------|
| < 16 years     | 5         | 2.0     |
| 16 to 19 years | 39        | 15.4    |
| 20 to 34 years | 192       | 75.6    |
| > 35 years     | 18        | 7.1     |
| Total          | 254       | 100.0   |

One hundred and ninety two women (75.6%) were aged between 20 and 34 years representing the age group with the highest number of abortions.

Table 3: Age

| Age   | Frequency | Percent |
|-------|-----------|---------|
| 14    | 4         | 1.6     |
| 15    | 1         | 0.4     |
| 16    | 2         | 0.8     |
| 17    | 14        | 5.5     |
| 18    | 8         | 3.1     |
| 19    | 15        | 5.9     |
| 20    | 14        | 5.5     |
| 21    | 15        | 5.9     |
| 22    | 15        | 5.9     |
| 23    | 24        | 9.4     |
| 24    | 20        | 7.9     |
| 25    | 5         | 2.0     |
| 26    | 15        | 5.9     |
| 27    | 12        | 4.7     |
| 28    | 19        | 7.5     |
| 29    | 14        | 5.5     |
| 30    | 13        | 5.1     |
| 31    | 5         | 2.0     |
| 32    | 11        | 4.3     |
| 33    | 4         | 1.6     |
| 34    | 6         | 2.4     |
| 35    | 4         | 1.6     |
| 36    | 3         | 1.2     |
| 37    | 2         | 0.8     |
| 38    | 4         | 1.6     |
| 39    | 1         | 0.4     |
| 40    | 1         | 0.4     |
| 42    | 1         | 0.4     |
| 43    | 1         | 0.4     |
| 45    | 1         | 0.4     |
| Total | 254       | 100.0   |

The mean age of the sample was 25.27 years while the single most common age of these women was 23 years. Forty-four (17.3%) women were aged less than 20 years (teenagers). Five (2%) women were less than 16 years.



Table 4: Race

| Race      | Frequency | Percent |
|-----------|-----------|---------|
| African   | 247       | 97.2    |
| Coloured  | 2         | 0.8     |
| Asian     | 2         | 0.8     |
| Caucasian | 3         | 1.2     |
| Total     | 254       | 100.0   |

Ninety seven percent of the women who had a TOP were of African race.

Table 5: Live children

| Live children | Frequency | Percent |
|---------------|-----------|---------|
| 0             | 62        | 24.4    |
| 1             | 91        | 35.8    |
| 2             | 63        | 24.8    |
| 3             | 23        | 9.1     |
| 4             | 7         | 2.8     |
| 5             | 6         | 2.4     |
| 6             | 1         | 0.4     |
| 8             | 1         | 0.4     |
| Total         | 254       | 100.0   |

Of the 254 women, 192 (75.6%) have at least one child alive.

Table 6: Stillbirths

| Stillbirths | Frequency | Percent |
|-------------|-----------|---------|
| 0           | 251       | 98.8    |
| 1           | 1         | 0.4     |
| 2           | 2         | 0.8     |
| Total       | 254       | 100.0   |

Ninety eight percent of the women (251) have never had a stillbirth. Only 3 (1.2%) have had stillbirth.

Table 7: Number of previous spontaneous abortions

| Abortions | Frequency | Percent |
|-----------|-----------|---------|
| 0         | 247       | 97.2    |
| 1         | 7         | 2.8     |
| Total     | 254       | 100.0   |

Seven women (2.8%) in the sample have had previous spontaneous abortions.

Table 8: Marital status

| Marital status                      | Frequency | Percent |
|-------------------------------------|-----------|---------|
| Unspecified                         | 1         | 0.4     |
| Single                              | 237       | 93.3    |
| Married                             | 13        | 5.1     |
| Not married but living with partner | 3         | 1.2     |
| Total                               | 254       | 100.0   |

Of the 254 women, 237(93.3%) were single, 13(5.1%) were married, 3(1.2%) were not married but living with their partner. The marital status of one of the women was not specified in her medical record.

Table 9: Area of residence

| Area of residence  | Frequency | Percent |
|--|-----------|---------|
| Newcastle sub-district                                     | 178       | 70.1    |
| Dannhauser sub-district                                    | 17        | 6.7     |
| Utrecht sub-district                                       | 5         | 2.0     |
| Outside Amajuba district but within Kwazulu-Natal province | 46        | 18.1    |
| Outside Kwazulu_Natal province                             | 4         | 1.6     |
| Unspecified  | 4         | 1.6     |
| Total  | 254       | 100.0   |

Of the 254 women, 178 (70.1%) reside in the Newcastle sub-district while 50 (19.7%) of the women reside outside Amajuba district. The area of residence was not specified in the medical records of four women.

## 4.2 Contraceptive usage

Table 10: Methods of contraception

| Methods of contraception | Frequency | Percent |
|--------------------------|-----------|---------|
| No method                | 227       | 89.4    |
| Injectable               | 2         | 0.8     |
| Oral contraceptive pill  | 7         | 2.8     |
| Condom                   | 14        | 5.5     |
| Unspecified              | 4         | 1.6     |
| Total                    | 254       | 100.0   |

Among these women, 227(89.4%) were not using any contraception before the pregnancy that was terminated. The most commonly used contraceptive was male condom (5.5%). Only 2.8% and 1.6% of the women were using an oral contraceptive pill and injectable contraceptives respectively. The method of contraceptive usage was not specified in 4 women.

Table 11: Methods of contraception versus previous TOP

|                          |                         | Previous TOP |     | Total |
|--------------------------|-------------------------|--------------|-----|-------|
|                          |                         | 0            | 1   | Total |
| Methods of Contraception | No method               | 225          | 2   | 227   |
|                          | Injectable              | 2            | 0   | 2     |
|                          | Oral contraceptive pill | 5            | 2   | 7     |
|                          | Condom                  | 14           | 0   | 14    |
|                          | Unspecified             | 4            | 0   | 4     |
| Total                    | 250                     | 4            | 254 |       |

Fifty percent of the women who had a previous TOP were not using a contraceptive at the time they had a repeat TOP. The other 50% were using oral contraceptive pills.

### 4.3 Frequency of termination of pregnancy

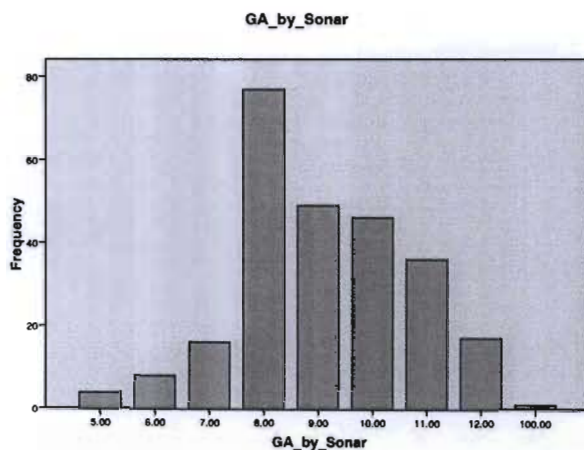
Table 12: Previous TOP

| Previous TOP | Frequency | Percent |
|--------------|-----------|---------|
| 0            | 250       | 98.4    |
| 1            | 4         | 1.6     |
| Total        | 254       | 100.0   |

Only four (1.6%) women had previously terminated a pregnancy.

### 4.4 Help-seeking behaviour

Figure 1: Gestational age (by ultrasound) at presentation



The commonest gestational age (mode) at first presentation for induced abortion was 8 weeks. The median and mean gestational ages during this time of presentation were 9 weeks and 9.437 weeks respectively.

Table 13: Gestational age group (by ultrasound) at presentation

| Gestational age | Frequency | Percent |
|-----------------|-----------|---------|
| ≤ 4 weeks       | 2         | 0.8     |
| 5 to 8 weeks    | 103       | 40.6    |
| 9 to 12 weeks   | 149       | 58.7    |
| Total           | 254       | 100.0   |

One hundred and forty-nine (58%) women (representing a majority of the participants) requested TOP between the gestational age of 9 and 12 weeks.

Table 14: Age groups versus gestational age groups

|            |                | Gestational group |              |               | Total |
|------------|----------------|-------------------|--------------|---------------|-------|
|            |                | ≤ 4 weeks         | 5 to 8 weeks | 9 to 12 weeks |       |
| Age groups | < 16 years     | 0                 | 1            | 4             | 5     |
|            | 16 to 19 years | 1                 | 18           | 19            | 39    |
|            | 20 to 34 years | 1                 | 77           | 114           | 192   |
|            | > 35 years     | 0                 | 7            | 11            | 18    |
| Total      |                | 2                 | 103          | 149           | 254   |

The most common time of presentation for abortion in every age group was between 9 and 12 weeks of gestation.

Table 15: Referral of patients to the TOP clinic

| Referred by          | Frequency | Percent |
|----------------------|-----------|---------|
| General practitioner | 14        | 5.5     |
| Hospital             | 32        | 12.6    |
| Primary health care  | 18        | 7.1     |
| Self-referral        | 189       | 74.4    |
| Friend               | 1         | 0.4     |
| Total                | 254       | 100.0   |

Of the 254 women, 189 (74.4%) were self-referral. A friend referred one woman. General practitioners referred 14 (5.5%) women and the remaining 50 (19.7%) women were referred from a health facility.

#### 4.5 Indications for having a termination of pregnancy

Table 16: Indications for TOP

| Indications           | Frequency | Percent |
|-----------------------|-----------|---------|
| Social/Economic       | 244       | 96.1    |
| Contraceptive failure | 1         | 0.4     |
| Current medication    | 2         | 0.8     |
| No reason             | 7         | 2.8     |
| Total                 | 254       | 100.0   |

Of the 254 women, 244 (96.1%) had a TOP because of socio-economic reasons. Other reasons for having a TOP were contraceptive failure 1 (0.4%), current medication 2 (0.8%) and no reason 7 (2.8%).

Table 17: Indications for having a TOP versus methods of contraception

| Indication for TOP |                       | Methods of Contraception |            |                         |        |               | Total |
|--------------------|-----------------------|--------------------------|------------|-------------------------|--------|---------------|-------|
|                    |                       | No method                | Injectable | Oral contraceptive pill | Condom | Not specified |       |
| Social/Economic    |                       | 222                      | 2          | 6                       | 14     | 0             | 244   |
|                    | Contraceptive failure | 0                        | 0          | 1                       | 0      | 0             | 1     |
|                    | Current medication    | 2                        | 0          | 0                       | 0      | 0             | 2     |
|                    | No reason             | 3                        | 0          | 0                       | 0      | 4             | 7     |
| Total              |                       | 227                      | 2          | 7                       | 14     | 4             | 254   |

Of the 244 women who requested a TOP due to socio-economic reasons, 90.98% of them were not using any method of contraception.

#### 4.6 Disclosure of intention to procure termination of pregnancy

Table 18: Disclosure to whom prior to the TOP

| Disclosure to whom   | Frequency | Percent |
|----------------------|-----------|---------|
| Nobody & unspecified | 77        | 30.3    |
| Mother               | 21        | 8.3     |
| Father               | 1         | 0.4     |
| Brother              | 2         | 0.8     |
| Sister               | 48        | 18.9    |
| Sexual partner       | 59        | 23.2    |
| Friend               | 33        | 13.0    |
| Other relative       | 13        | 5.1     |
| Total                | 254       | 100.0   |

Sixty-six (26%) women did not disclose their intention to anybody. Eleven (4.3%) medical records did not specify if the women had disclosed their intention to anybody prior to the TOP. These two groups constituted 30.3% (77) of the women.

Of the 177 (69.7%) women who disclosed their intention, 59 (23.2%) disclosed to their sexual partner, 48 (18.9%) disclosed to their sister, 33 (13%) disclosed to a friend, 21 (8.3%) disclosed to their mother, 1 (0.4%) to her father, 2 (0.8%) to a brother, and 13 (5.1%) to other relatives.

Table 19: Age groups versus disclosure

| Age Group      |  | Disclosure |     |             | Total |
|----------------|--|------------|-----|-------------|-------|
|                |  | No         | Yes | Unspecified | Total |
| < 16 years     |  | 1          | 3   | 1           | 5     |
| 16 to 19 years |  | 6          | 31  | 2           | 39    |
| 20 to 34 years |  | 52         | 133 | 7           | 192   |
| > 35 years     |  | 7          | 10  | 1           | 18    |
| Total          |  | 66         | 177 | 11          | 254   |

About 79.4% of women aged 16 and 19 years disclosed their intention for a TOP. Only 55.5% of those older than 35 years disclosed their TOP intention. Women most likely to disclose their intention for TOP are those between the ages of 16 and 19 years. Those who are least likely to disclose their intention are those older than 35 years.

#### 4.7 Support given to women having termination of pregnancy

Table 20: Women counseled before TOP

| Counseled | Frequency | Percent |
|-----------|-----------|---------|
| Yes       | 254       | 100.0   |

Every woman was counseled before her pregnancy was terminated.

Table 21: Was patient accompanied to the TOP clinic?

|             | Frequency | Percent |
|-------------|-----------|---------|
| Unspecified | 254       | 100.0   |

In all the medical records sampled, it was not stated if patients were accompanied by anybody to the health facility for the TOP. Consequently, who accompanied the patient was not specified. However, this information was documented in the medical records sampled when a pilot study was carried out prior to the resumption of this main study.



## 5 CHAPTER V: DISCUSSION

### 5.1 Findings

The characteristics of women having induced first trimester TOP in Newcastle Provincial Hospital were evaluated in this study. The characteristics of these women have been presented in the results section and will be discussed with reference to their demographic profile, contraceptive usage, frequency of TOP, health seeking behaviour, indications for having first trimester TOP, and their disclosure of their intention to procure an induced abortion.

This study showed that 75.6% (192) of women who had a TOP in Newcastle hospital were aged between 20 and 34 years. The single most common age of these women was 23 years. The mean age of the sample was 25.27 years. This suggests that women in their twenties are more likely to procure termination of pregnancy than older or younger women. This is comparable to findings from other studies<sup>10, 12, 38</sup> and is difficult to explain by any one single reason. This is because procurement of TOP can be influenced by factors operating at individual, community and health service levels.<sup>23</sup> Teenagers accounted for 17.3% (44) of all TOPs done at Newcastle hospital. This figure is higher than the 8.5% found in Singapore.<sup>38</sup> It is possible that societal permissiveness, cultural practices, peer pressure and the role models of older SA women may account for this figure. A study by Jewkes et al in 2001 showed that 35% of South African women have already been pregnant or already have a child before the age of 20 years.<sup>37</sup> This is the same group of women who become adults and role models for the younger generation. Jewkes and colleagues also showed that forced coital initiation of teenage females by older male partners and the reluctance of a female teenager to confront her unfaithful male partner were associated with teenage pregnancy in South Africa.<sup>37</sup> In our study, five women (2.0%) were aged 16 years or younger. Sex with a young woman under 16 years of age constitutes statutory rape, as the minimum legal age for consented coitus is 16 years.

Ninety seven percent of those presenting for a TOP were of African origin. This is not surprising as Newcastle hospital is a public sector hospital providing for the needs of the

indigent population around Newcastle. The low percentage of non-Africans presenting for a TOP may suggest either that unplanned pregnancy is not a problem in other race groups or, more likely, that most non-African patients requiring a TOP are able to access care in the private sector. This is an area that needs further research.

Of the 254 women who presented for a TOP, 192 (75.6%) have at least one child alive. This supports other studies that showed that most women who opt for a TOP in SA have had a previous pregnancy.<sup>10, 12</sup>

In this sample 251 (98.8%) of the women had not had a stillbirth while 7 (2.8%) of the sample had previously had a spontaneous abortion.

As indicated in Table 7, two hundred and thirty-seven (93.3%) of the women reviewed were single, 13(5.1%) were married, and 3(1.2%) were not married but were living with their partner. Previous research from Durban showed that 80% of women requesting a TOP were single.<sup>12</sup> These strongly suggest that a majority of the women having a TOP in Kwazulu-Natal are of single marital status.

One hundred and seventy-eight (70.1%) of the women who presented at Newcastle Provincial Hospital for a TOP reside in Newcastle sub-district. It is not clear from this study how big the need for TOP is within the Amajuba district and whether or not all women who need TOP services in Amajuba district have access to Newcastle Provincial Hospital. This is an area for further study. Fifty (19.7%) of the women who procured a TOP at Newcastle Provincial Hospital reside outside the Amajuba district. It is not clear why they chose to access the service at Newcastle Provincial Hospital. It may have to do with accessibility or the lack of TOP services in other districts or the quality of care provided at Newcastle hospital. Whatever the reason, women procuring a TOP at Newcastle Provincial hospital who live outside the district increase the cost of healthcare in the Amajuba district. The reasons these women access the services at Newcastle Provincial Hospital need to be investigated and the hospital must budget adequately for the TOP service, recognizing that women living outside the district use this service.

Table 9 highlights the poor contraceptive usage among the women studied. Two hundred and twenty-seven (89.4%) of those who presented for a TOP were not using any form of contraception before the pregnancy that was terminated. The most commonly contraceptive method used was the male condom (5.5%). Only 2.8% and 1.6% of the women were using an oral contraceptive pill and injectable contraceptives respectively. This finding is in keeping with other studies which have shown that the majority of women who have TOPs were either using no method of contraception before they became pregnant or were using unreliable methods of contraception such as condoms or oral contraceptive pills.<sup>10, 39</sup> Other studies have shown that condom use and oral contraceptive pills are prone to poor compliance.<sup>39</sup> Despite the challenges associated with condom use, the high prevalence of HIV in South African society calls for the continued promotion of condom use as a barrier form of contraceptive. This is because condom use is a preventive measure for HIV transmission. Table 10 shows that 50% of the women who had a previous TOP were not using a contraceptive at the time they had a repeat TOP. The other 50% were using an oral contraceptive pill. A study by Das and colleagues also showed that 50% of women who agreed to use a long acting reversible contraceptive during their first TOP were actually not using any contraceptive at the time of the repeat TOP.<sup>50</sup> This suggests that poor contraceptive usage is associated with unintended pregnancy and also a request for a repeat TOP.

Encouragingly only a few (1.6%) women had previously had a TOP. A study in Cape Town showed that 3% of women booking for a TOP had previously had an induced abortion.<sup>10</sup> The figure for previous TOPs varies widely from region to region. Repeat TOPs constitutes 35.5% and 48% of all induced abortions in Canada and USA respectively.<sup>17</sup> The figure in Northern Europe was 30% to 38%,<sup>49</sup> while in Luton in the UK 26.4% of all TOPs performed are repeat procedures.<sup>16</sup> In our study, the reason for the low percentage of women having a repeat abortion is not known and should be an area of further research.

The help-seeking behaviour was assessed using the gestational age at presentation for a TOP and by ascertaining who referred the patient to the TOP facility. The commonest

gestational age at first presentation for TOP was 8 weeks. The median gestational age was 9 weeks. This median age is similar to the finding of a study done in Cape Town.<sup>10</sup> One hundred and forty-nine (58%) women requested a TOP between the gestational age of 9 and 12 weeks. This was the most common time at presentation for every age group. This finding is contrary to the findings of Olukoya who showed that adults present earlier for abortion than adolescents.<sup>24</sup>

Of the 254 women reviewed, 189 (74.4%) were self-referred. A friend referred one woman. General practitioners referred fourteen women and the remaining 50 (19.7%) women were referred from a health facility. The high proportion of self-referrals indicates that women currently using the TOP facility are aware of the availability of the TOP service at Newcastle Provincial hospital.

This study showed that the vast majority (244 or 96.1%) of the women had a TOP for socio-economic reasons. This is higher than the figure reported from Durban where 72% of women requested a TOP for socio-economic reasons.<sup>12</sup> This may suggest that socio-economic factors are leading to an increase in the number of induced abortions performed in KwaZulu-Natal and may be related to the recent economic crisis and the large number of workers who lost their jobs following the crisis. Of the 244 women who requested TOP due to socio-economic reasons, 90.98% of them were not using any method of contraception. This review also showed that the other reasons for having a TOP were contraceptive failure 1 (0.4%), current medication 2 (0.8%) and no reason 7 (2.8%). This is an area that needs further study.

Of the 77 (69.7%) women who disclosed their intention to have a TOP, 59 (23.2%) disclosed to their sexual partner, 48 (18.9%) disclosed to their sister, 33 (13%) disclosed to a friend, 21 (8.3%) disclosed to their mother, 1 (0.4%) to her father, 2 (0.8%) to a brother, and 13 (5.1%) to other relatives. In Durban 51.8% of women who disclosed their intention to procure a TOP confided in their spouse or boyfriend while others confided in a friend or a sister.<sup>12</sup> According to Bower et al, in the Eastern Cape province in SA sexual partners are also more likely to be told about the TOP.<sup>15</sup> In France 44% of minors

disclose their intention to have a TOP to their parents,<sup>14</sup> while in the United States 60% of minors who had an abortion reported that at least one parent knew about the TOP.<sup>8</sup>

In this study we have evaluated support by assessing whether patients were counseled by healthcare worker(s) prior to a TOP, and by assessing whether patients were accompanied by anybody to TOP clinic. Data on whether patients were accompanied to the health facility during a TOP was not recorded in the medical records reviewed. However, every woman was counseled before her TOP. This effort to counsel everybody having a TOP is commendable. In SA, counseling by health care providers is a mandatory form of support that must be provided to patients seeking a TOP.<sup>5, 57</sup>

## **5.2 Bias and limitations**

The limitations of this study include the following.

- i) Only the information written on the medical records were collected and analyzed.
- ii) None of the medical records sampled contained information on whether or not patients were accompanied to the hospital for a TOP. This variable was therefore excluded in the analysis.
- iii) Other services that were rendered to the patients but not documented were not ascertained.

## **6 CHAPTER VI: CONCLUSIONS AND RECOMMENDATIONS**

### **6.1 Conclusion**

This study suggests that women in their twenties are more likely to access a TOP at Newcastle hospital than older women. Some women were found to be less than 16 years of age. This is of great concern as this constitutes statutory rape and should at least be reported to a social worker for further investigation. This study showed that socio-economic circumstances of Africans in this district are the most important reason why women have a TOP at Newcastle hospital. In keeping with this finding, women who are single are more likely to have an induced abortion – probably due to fewer financial resources and lack of partner support available to them.

The majority of women having a TOP in Newcastle provincial hospital reside in Newcastle sub-district. Further study is needed to determine if the location of Newcastle Provincial Hospital is preventing women living in other sub-districts (apart from Newcastle sub-district) the opportunity of accessing a TOP. Other issues that need to be studied include issues of access to a TOP facility at Newcastle Provincial Hospital from other parts of Amajuba district and to determine if there is a need to establish an additional TOP facility in the district. The proportion of women who reside outside Amajuba but have had a TOP in Newcastle Provincial Hospital may be increasing the cost of healthcare in Amajuba district.

Most women were not using any contraceptive before the pregnancy that led to an induced abortion. Contraceptive advice, their effective use, as well as the distribution of condoms must be improved. This is important in our society with a high HIV prevalence, as a condom functions as a contraceptive and a preventive measure against HIV transmission.

The high proportion of self-referrals shows that women currently having a TOP in Newcastle Provincial Hospital facility are aware of the availability of this service at the hospital. Further studies to determine how women have heard about this service would be important.

A professional nurse counseled every woman who had a TOP. This support is commendable.

## **6.2 Recommendations**

The following recommendations will help to reduce the number of women having a TOP and will guide the provision of TOP services in the Amajuba district and similar districts.

### **i) Education and contraceptive counseling**

Women in their twenties need intensive contraceptive counseling as a means of opportunistic health promotion. This is because this age group is more likely than other age groups to have an induced abortion. Other vulnerable women that should be targeted for intensive contraceptive counseling are Africans, those who have had a previous pregnancy, those who are single, women who do not intend to be pregnant but are sexually active without using any contraceptive, and those of poor socio-economic status. The distribution and correct use of condom must be strengthened since condoms function as a contraceptive and as a preventive measure for HIV transmission.

### **ii) Follow up of women under 16 years of age**

A careful follow-up of pregnant women below 16 years of age is necessary. This is to ascertain the circumstances that led to the pregnancy as in this study, 5 (2.0%) women were younger than 16 years of age. This contravenes the minimum legal age of 16 years for consented coitus.

### **iii) Further study**

Parous and pregnant women who live in other sub-districts in Amajuba (except Newcastle sub-district) should be evaluated to determine if lack of access to a TOP facility had previously prevented them from obtaining a TOP. This study will give an indication of whether or not additional TOP facilities should be established in the Amajuba district.

### **vii) Education on use of local health facilities**

There should be public education to emphasize the need for one to utilize (especially in non-emergency situation) the health facility serving one's area of residence. This will reduce the number of patients who live outside Amajuba district but utilize the health facility in Amajuba, thus increasing the cost of health care delivery in Amajuba.

viii) Economic empowerment

The SA government must continue to strengthen the economic empowerment of her citizens. This is because socio-economic reasons were the commonest reasons for requesting a TOP. A study done in Durban also showed similar finding.<sup>12</sup>

ix) Improve documentation

Documentation of data in patients' medical records should be improved. This is because there were some medical records with incomplete data documentation. As no hospital charts were missing, filing of medical records was considered good. This should be encouraged. However, storage of medical records should be computerized which will make patients' medical records more easily accessible.



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## 8 APPENDIX A: DATA EXTRACTION SHEET

### CHARACTERISTICS OF WOMEN HAVING FIRST TRIMESTER TERMINATION OF PREGNANCY IN A DISTRICT/REGIONAL HOSPITAL IN KWAZULU-NATAL

#### 1) Demographic profile

1.1) Age in years:

1.2) Race: African  Coloured  Asian  Caucasian

1.3) Parity:

|                     |  |                  |  |                    |  |                             |  |
|---------------------|--|------------------|--|--------------------|--|-----------------------------|--|
| No of live children |  | No of stillbirth |  | No of previous TOP |  | No of spontaneous abortions |  |
|---------------------|--|------------------|--|--------------------|--|-----------------------------|--|

1.4) Marital status: Single  Married  Separated  Divorced

Unmarried but living with her partner

1.5) Area of residence:

#### 2) Indications for requesting termination of pregnancy (TOP)

Social/Economic Yes  No

Foetal abnormality Yes  No

Contraceptive failure Yes  No

Rape Yes  No

Incest Yes  No

Mothers health Yes  No  If Yes Specify the illness

Current medication Yes  No  If Yes Specify the medication

#### 3) Type of contraceptive used by patient

No method

Injectables

Oral contraceptive pill

Intrauterine contraceptive device



Condom

4) Help seeking behaviour of clients regarding TOP services.

4.1) Last menstrual period:

4.2) Gestational age at presentation by ultrasound:

First 4 weeks  Greater than 4 weeks to 8 weeks  Greater than 8 weeks up to and including 12 weeks

4.3) Who referred patient to TOP clinic: General Private Practitioner  Hospital   
Primary health clinic  Self-referral  Friend  Relative

5) Disclosure of intention to seek TOP

5.1) Told someone about the TOP Yes  No

5.2) Told who? Mother  Father  Brother  Sister  Sexual partner  friend  Relative

6) Support given to patient requesting TOP

6.1) Patient counselled before the TOP in the TOP facility Yes  No

6.2) Patient accompanied to the clinic Yes  No

6.3) Who accompanied the patient? Mother  Father  Brother  Sister   
Sexual partner  friend  Relative

## **9 APPENDIX B: CHOICE ON TERMINATION OF PREGNANCY ACT, 1996**

(ASSENTED TO: 12 NOVEMBER 1996)

(COMMENCEMENT: 1 FEBRUARY 1997)

PRESIDENT'S OFFICE

No. 1891.

22 November 1996

NO. 92 OF 1996: CHOICE ON TERMINATION OF PREGNANCY ACT, 1996.

It is hereby notified that the President has assented to the following Act which is hereby published for general information:-

### **ACT**

To determine the circumstances in which and conditions under which the pregnancy of a woman may be terminated; and to provide for matters connected therewith.

Preamble.—Recognising the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms which underlie a democratic South Africa;

Recognising that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies;

Recognising that both women and men have the 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 of access to appropriate health care services to ensure safe pregnancy and childbirth;

Recognising that the decision to have children is fundamental to women's physical, psychological and social health and that universal access to reproductive health care services includes family planning and contraception, termination of pregnancy, as well as sexuality education and counselling programmes and services;

Recognising that the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm;

Believing that termination of pregnancy is not a form of contraception or population control;

This Act therefore repeals the restrictive and inaccessible provisions of the Abortion and Sterilization Act, 1975 (Act No. 2 of 1975), and promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs.

1. Definitions.—In this Act, unless the context otherwise indicates—

"Director-General" means the Director-General of Health;

"gestation period" means the period of pregnancy of a woman calculated from the first day of the menstrual period which in relation to the pregnancy is the last;

"incest" means sexual intercourse between two persons who are related to each other in a degree which precludes a lawful marriage between them;

"medical practitioner" means a person registered as such under the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974);

"Minister" means the Minister of Health;

"minor" means any female person under the age of 18 years;

"prescribe" means prescribe by regulation under section 9;

"rape" also includes statutory rape as referred to in sections 14 and 15 of the Sexual Offences Act, 1957 (Act No. 23 of 1957);

"registered midwife" means a person registered as such under the Nursing Act, 1978 (Act No. 50 of 1978);

"termination of a pregnancy" means the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman;

"woman" means any female person of any age.

2. Circumstances in which and conditions under which pregnancy may be terminated.—

(1) A pregnancy may be terminated—

(a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;

(b) from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that—

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

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

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

(iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or

(c) after the 20th week of the gestation period if 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;

(ii) would result in a severe malformation of the fetus; or

(iii) would pose a risk of injury to the fetus.

(2) The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1) (a), which may also be carried out by a registered midwife who has completed the prescribed training course.

3. Place where surgical termination of pregnancy may take place.—(1) The surgical termination of a pregnancy may take place only at a facility designated by the Minister by notice in the *Gazette* for that purpose under subsection (2).

(2) The Minister may designate any facility for the purpose contemplated in subsection (1), subject to such conditions and requirements as he or she may consider necessary or expedient for achieving the objects of this Act.

(3) The Minister may withdraw any designation under this section after giving 14 days' prior notice of such withdrawal in the *Gazette*.

4. Counselling.—The State shall promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy.

5. Consent.—(1) Subject to the provisions of subsections (4) and (5), the termination of a pregnancy may only take place with the informed consent of the pregnant woman.

(2) Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.

(3) In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family

members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

(4) Subject to the provisions of subsection (5), in the case where a woman is—

(a) severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of a termination of her pregnancy; or

(b) in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy in terms of section 2,

her pregnancy may be terminated during the first 12 weeks of the gestation period, or from the 13th up to and including the 20th week of the gestation period on the grounds set out in section 2 (1) (b)—

(i) upon the request of and with the consent of her natural guardian, spouse or legal guardian, as the case may be; or

(ii) if such persons cannot be found, upon the request and with the consent of her *curator personae*:

Provided that such pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course consent thereto.

(5) Where two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course, are of the opinion that—

(a) during the period up to and including the 20th week of the gestation period of a pregnant woman referred to in subsection (4) (a) or (b)—

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

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

(b) after the 20th week of the gestation period of a pregnant woman referred to in subsection (4) (a) or (b), the continued pregnancy—

(i) would endanger the woman's life;

(ii) would result in a severe malformation of the fetus; or

(iii) would pose a risk of injury to the fetus,

they may consent to the termination of the pregnancy of such woman after consulting her natural guardian, spouse, legal guardian or *curator personae*, as the case may be:

Provided that the termination of the pregnancy shall not be denied if the natural guardian, spouse, legal guardian or *curator personae*, as the case may be, refuses to consent thereto.

6. Information concerning termination of pregnancy.—A woman who in terms of section 2 (1) requests a termination of pregnancy from a medical practitioner or a registered midwife, as the case may be, shall be informed of her rights under this Act by the person concerned.

7. Notification and keeping of records.—(1) Any medical practitioner, or a registered midwife who has completed the prescribed training course, who terminates a pregnancy in terms of section 2 (1) (a) or (b), shall record the prescribed information in the prescribed manner and give notice thereof to the person referred to in subsection (2).

(2) The person in charge of a facility referred to in section 3 or a person designated for such purpose, shall be notified as prescribed of every termination of a pregnancy carried out in that facility.

(3) The person in charge of a facility referred to in section 3, shall, within one month of the termination of a pregnancy at such facility, collate the prescribed information and forward it by registered post confidentially to the Director-General: Provided that the name and address of a woman who has requested or obtained a termination of pregnancy, shall not be included in the prescribed information.

(4) The Director-General shall keep record of the prescribed information which he or she receives in terms of subsection (3).

(5) The identity of a woman who has requested or obtained a termination of pregnancy shall remain confidential at all times unless she herself chooses to disclose that information.

8. Delegation.—(1) The Minister may, on such conditions as he or she may determine, in writing delegate to the Director-General or any other officer in the service of the State, any power conferred upon the Minister by or under this Act, except the power referred to in section 9.

(2) The Director-General may, on such conditions as he or she may determine, in writing delegate to an officer in the service of the State, any power conferred upon the Director-General by or under this Act or delegated to him or her under subsection (1).

(3) The Minister or Director-General shall not be divested of any power delegated by him or her, and may amend or set aside any decision taken by a person in the exercise of any such power delegated to him or her.

9. Regulations.—The Minister may make regulations relating to any matter which he or she may consider necessary or expedient to prescribe for achieving the objects of this Act.

10. Offences and penalties.—(1) Any person who—

(a) is not a medical practitioner or a registered midwife who has completed the prescribed training course and who performs the termination of a pregnancy referred to in section 2 (1) (a);

(b) is not a medical practitioner and who performs the termination of a pregnancy referred to in section 2 (1) (b) or (c); or

(c) prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy,

shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years.

(2) Any person who contravenes or fails to comply with any provision of section 7 shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding six months.

11. Application of Act.—(1) This Act shall apply to the whole of the national territory of the Republic.

(2) This Act shall repeal—

(a) the Act mentioned in columns one and two of the Schedule to the extent set out in the third column of the Schedule; and

(b) any law relating to the termination of pregnancy which applied in the territory of any entity which prior to the commencement of the Constitution of the Republic of South Africa, 1993 (Act No. 200 of 1993), possessed legislative authority with regard to the termination of a pregnancy.

12. Short title and commencement.—This Act shall be called the Choice on Termination of Pregnancy Act, 1996, and shall come into operation on a date fixed by the President by proclamation in the *Gazette*.

Schedule

| No. and year of law | Short title                          | Extent of repeal                     |
|---------------------|--------------------------------------|--------------------------------------|
| Act No. 2 of 1975   | Abortion and Sterilization Act, 1975 | In so far as it relates to abortion. |



**10 APPENDIX C: CHOICE ON TERMINATION OF PREGNANCY AMENDMENT ACT, 2008**

Government Gazette  
Republic of South Africa

Vol. 512 Cape Town 18 February 2008 No. 30790

**THE PRESIDENCY**

No. 213 18 February 2008

It is hereby notified that the President has assented to the following Act, which is hereby published for general information:—

No. 1 of 2008: Choice on Termination of Pregnancy Amendment Act, 2008.

**GENERAL EXPLANATORY NOTE:**

[ ] Words in bold type in square brackets indicate omissions from existing enactments.

Words underlined with a solid line indicate insertions in existing enactments.

**ACT**

To amend the Choice on Termination of Pregnancy Act, 1996, so as to amend a definition and to insert others; to empower a Member of the Executive Council to approve facilities where a termination of pregnancy may take place; to exempt a facility offering a 24-hour maternity service from having to obtain approval for termination of pregnancy services under certain circumstances; to provide for the recording of information and the submission of statistics; to enable a Member of the Executive Council to make regulations; and to provide for matters connected therewith.

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:—

Amendment of section 1 of Act 92 of 1996

1. Section 1 of the Choice on Termination of Pregnancy Act, 1996 (hereinafter referred to as the principal Act), is hereby amended—

(a) by the insertion after the definition of “gestation period” of the following definition:

“‘Head of Department’ means the head of a provincial health department;”;

(b) by the insertion after the definition of “medical practitioner” of the following definition:

“‘Member of the Executive Council’ means the member of the Executive Council of a province who is responsible for health in that province;”;

(c) by the substitution for the definition of “registered midwife” of the following definition:

“ ‘registered midwife’ means a person registered as such under the Nursing Act, [1978 (Act No. 50 of 1978)] 2005 (Act No. 33 of 2005), and who has in addition undergone prescribed training in terms of this Act;”  
and

(d) by the insertion after the definition of “registered midwife” of the following definition:

“ ‘registered nurse’ means a person registered as such under the Nursing Act, 2005 (Act No. 33 of 2005), and who has in addition undergone prescribed training in terms of this Act;”.

Substitution of section 3 of Act 92 of 1996

2. The following section is hereby substituted for section 3 of the principal Act:

“Place where termination of pregnancy may take place

3. (1) Termination of a pregnancy may take place **only at a facility**  
which—

(a) gives access to medical and nursing staff;

(b) gives access to an operating theatre;

- (c) has appropriate surgical equipment;
- (d) supplies drugs for intravenous and intramuscular injection;
- (e) has emergency resuscitation equipment and access to an emergency referral centre or facility;
- (f) gives access to appropriate transport should the need arise for emergency transfer;
- (g) has facilities and equipment for clinical observation and access to in-patient facilities;
- (h) has appropriate infection control measures;
- (i) gives access to safe waste disposal infrastructure;
- (j) has telephonic means of communication; and
- (k) has been approved by the Member of the Executive Council by notice in the *Gazette*.
- (2) The Member of the Executive Council may withdraw any approval granted in terms of subsection (1)(k).
- (3) (a) Any health facility that has a 24-hour maternity service, and which complies with the requirements referred to in subsection (1)(a) to (j), may terminate pregnancies of up to and including 12 weeks without having to obtain the approval of the Member of the Executive Council.
- (b) The person in charge of a health facility contemplated in paragraph (a) must notify the relevant Member of the Executive Council that the health facility has a 24-hour maternity service which complies with the requirements referred to in subsection (1)(a) to (j).
- (4) The Member of the Executive Council shall once a year submit statistics of any approved facilities for that year to the Minister.
- (5) Notwithstanding anything to the contrary in this Act, the Minister may perform any of the functions that the Member of the Executive Council may or must perform, if it is necessary to perform such function in order to achieve any of the objects of this Act.”.

Amendment of section 7 of Act 92 of 1996

3. Section 7 of the principal Act is hereby amended—

(a) by the substitution in subsection (3) for the words preceding the proviso of the following words:

“The person in charge of a facility referred to in section 3 shall, within one month of the termination of a pregnancy at such facility, collate the prescribed information and forward it by registered post confidentially to the [Director-General] relevant Head of Department”; and

(b) by the substitution for subsection (4) of the following subsection:

“(4) The [Director-General] Head of Department shall—

(a) keep record of the prescribed information which he or she receives in terms of subsection (3); and

(b) submit to the Director-General the information contemplated in paragraph (a) every six months.”

Substitution of section 8 of Act 92 of 1996

4. The following section is hereby substituted for section 8 of the principal Act:

“Delegation

8. (1) The [Minister] Member of the Executive Council may, on such conditions as he or she may determine, in writing delegate to the [Director-General] Head of Department or any other officer in the service of the State, any power conferred upon the [Minister] Member of the Executive Council by or under this Act, except the power referred to in section 9.

(2) The [Director-General] Head of Department may, on such conditions as he or she may determine, in writing delegate to an officer in the service of the State, any power conferred upon the [Director-General] Head of Department by or under this Act [or delegated to him or her under subsection (1)].

(3) The [Minister or Director-General] Member of the Executive Council or Head of Department shall not be divested of any power delegated by him or her, and may amend or set aside any decision taken by

a person in the exercise of any such power delegated to [him or her] that person.”.

#### Substitution of section 9 of Act 92 of 1996

5. The following section is hereby substituted for section 9 of the principal Act:

“Regulations

9. The [Minister] Member of the Executive Council may, in consultation with the Minister, make regulations relating to any matter which [he or she may consider] it is necessary or expedient to prescribe for [achieving the objects] the proper implementation or administration of this Act.”.

#### Amendment of section 10 of Act 92 of 1996

6. Section 10 of the principal Act is hereby amended by the substitution for subsection (1) of the following subsection:

“(1) Any person who—

(a) is not a medical practitioner, or a registered midwife or registered nurse who has completed the prescribed training course, and who performs the termination of a pregnancy referred to in section 2(1)(a);

(b) is not a medical practitioner and who performs the termination of a pregnancy referred to in section 2(1)(b) or (c); [or]

(c) prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy; or

(d) terminates a pregnancy or allows the termination of a pregnancy at a facility not approved in terms of section 3(1) or not contemplated in section 3(3)(a),

shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years.”.

#### Substitution of certain expression in Act 92 of 1996

7. The principal Act is hereby amended by the substitution for the expression

“registered midwife”, wherever it appears, of the expression “registered midwife or registered nurse”, except in the circumstances contemplated in section 2(1)(c).

Transitional provision

8. Any facility designated in terms of section 3(1) of the principal Act prior to the commencement of this Act must be regarded as having been approved by the Member of the Executive Council in terms of section 3(1)(k) of the principal Act as amended by this Act.

Short title

9. This Act is called the Choice on Termination of Pregnancy Amendment Act, 2008.



UNIVERSITY OF  
KWAZULU-NATAL

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25 September 2009

Dr N C Ngene  
Department of Family Medicine  
Medical School

Dear Dr NC Ngene

**PROTOCOL:** Characteristics of women having first trimester termination of pregnancy in a district/regional hospital in Kwa Zulu-Natal. Dr Ngene, REF: BE057/09

### EXPEDITED APPLICATION

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application received on 16 March 2009.

The study was approved pending appropriate responses to queries raised. Your responses dated 17 September 2009 to queries raised on 28 August 2009 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given full ethics approval and may begin as from today; 25 September 2009.

This approval is valid for one year from 25 September 2009. To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2004), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at <http://research.ukzn.ac.za/ResearchEthics11415.aspx>.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

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The sub-committee's decision will be **RATIFIED** at a full sitting of the Biomedical Research Ethics Committee meeting to be held on **13 October 2009**.

We wish you well with this study. We would appreciate receiving copies of all publications arising out of this study.

Yours sincerely



Professor D.R Wassenaar  
Chair: Biomedical Research Ethics Committee





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20 September 2010

Dr N C Ngene  
Department of Family Medicine  
Medical School

Dear Dr NC Ngene

**PROTOCOL:** Characteristics of women having first trimester termination of pregnancy in a district/regional hospital in Kwa Zulu-Natal. Dr Ngene, REF: BE057/09

### PROTOCOL RECERTIFICATION RATIFICATION

Further to our letter to you dated 25 August 2010, this letter serves to notify you that at a full sitting of the Biomedical Research Ethics Committee Meeting held on 14 September 2010 the Committee RATIFIED the sub-committee's decision to approve the Recertification of the above protocol.

Yours sincerely

Mrs A Marimuthu  
Senior Administrator: Biomedical Research Ethics



13 October 2009

Dr A Ross  
Department of Family Medicine  
Howard College Campus  
UKZN

Dear Dr Ross

**PROTOCOL: "Characteristics of women having first trimester termination of pregnancy in a district/regional hospital in KwaZulu Natal": M-FAMD, Ngene NC Family Medicine (Ref: M-FAM INT 001/09) Student number 206523850**

The Postgraduate Education Committee ratified the approval of the abovementioned study on 06 October 2009.

Please note:

- The Postgraduate Education Committee must review any changes made to this study.
- The study may not begin without the approval of the Biomedical Research Ethics Committee.

May I take this opportunity to wish the student every success with the study.

Yours sincerely

Dr A Voce  
**Deans Assistant: Coursework Programmes  
Postgraduate Education Committee**

CC. Dr N Ngene  
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# 12 APPENDIX E: QUESTIONNAIRE USED IN THE TERMINATION OF PREGNANCY CLINIC IN NEWCASTLE PROVINCIAL HOSPITAL

## PATIENT CONSENT FORM

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

### CONSENT TO TERMINATION OF PREGNANCY PROCEDURES

I, the undersigned, ..... hereby consent to the termination of pregnancy and to such further or alternative procedures as may be found necessary during the course of the above-mentioned procedure. I agree that I accept the risks and complications related to the medication and procedures administered for the purpose of the termination of pregnancy.

I understand that I will be given medication to cause my womb to contract and to partially or completely expel the pregnancy. This process may be accompanied by pain and, or bleeding. Once I have taken the medication, I am committed to continuing with the procedure. I understand that I will require a further surgical procedure to empty the womb. This may entail general or local anaesthesia.

The process may result in physical damage, and it might become necessary that I undergo further treatment, perhaps even surgical treatment, to repair or treat such damage. I understand that on rare occasions, my health or future fertility may be compromised, and I accept this possibility. I further understand that it does sometimes happen that the termination of pregnancy fails, and if the pregnancy continues, the procedure may need to be repeated.

Signed: ..... Date: .....

Witness:

1. Name: ..... Signature: ..... Date: .....

2. Name: ..... Signature: ..... Date: .....

**PATIENT ASSESSMENT RECORD  
CHOICE ON THE TERMINATION OF PREGNANCY ACT, 1996.**

Name of Patient: *Theresa M. O'Sullivan*

Age: *32* Clinic No. *12345678*

LMP: *12/12/03*

Race (mark with a cross)

|                                  |                                   |                                |                                |                                |
|----------------------------------|-----------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> African | <input type="checkbox"/> Coloured | <input type="checkbox"/> Asian | <input type="checkbox"/> White | <input type="checkbox"/> Other |
|----------------------------------|-----------------------------------|--------------------------------|--------------------------------|--------------------------------|

Marital Status (mark with a cross)

|                                 |  |                                  |                                   |                                  |
|---------------------------------|--|----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Living Together | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |
|---------------------------------|--|----------------------------------|-----------------------------------|----------------------------------|

Number of Previous Pregnancies

|                    |                    |                  |                     |
|--------------------|--------------------|------------------|---------------------|
| No. Of Live Births | No. Of Stillbirths | No. Of Abortions | No. Of Miscarriages |
| <i>0</i>           | <i>0</i>           | <i>0</i>         | <i>0</i>            |

Method of contraception used before the current pregnancy

|                            |                          |
|----------------------------|--------------------------|
| No method used             | <input type="checkbox"/> |
| Injectables                | <input type="checkbox"/> |
| Oral contraceptives (pill) | <input type="checkbox"/> |
| IUD                        | <input type="checkbox"/> |
| Condom                     | <input type="checkbox"/> |
| Natural methods            | <input type="checkbox"/> |

Reason for Request

- Medical? Yes / No *.....*
- Social/Economic? Yes / No *.....*
- Contraceptive failure? Yes / No *.....*
- Other? Yes / No *.....*

Medical History

| History   | Please tick              | Please specify |
|---|--------------------------|----------------|
| Drug allergies                                    | <input type="checkbox"/> |                |
| Chronic diseases (specify disease and medication) | <input type="checkbox"/> |                |
| Other   | <input type="checkbox"/> |                |

Other Symptoms

- Lower abdominal pain? Yes / No *.....*
- PV bleeding? Yes / No *.....*
- Termination of pregnancy discussed with: *.....*

**Annexure A**

**CHOICES 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 duplicate)

1. Name of Facility \_\_\_\_\_
2. Age of woman requesting termination \_\_\_\_\_
3. Where appropriate (circle/s appropriate number)
  - 3.1 Termination in terms of section 2 (1) (a) or (b) of the Act
  - 3.2 Severe Mental disability (section 5 (4) (a) of the Act
  - 3.3 Conscious 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 Normal menstrual Period \_\_\_\_\_

7. How many weeks into pregnancy \_\_\_\_\_

8. Number of previous Pregnancies \_\_\_\_\_

|                 |                     |                     |                     |
|-----------------|---------------------|---------------------|---------------------|
| No. Live Births | No. of Still Births | No. of Terminations | No. of Miscarriages |
|-----------------|---------------------|---------------------|---------------------|

9. Date of Admission \_\_\_\_\_

Date of Procedure \_\_\_\_\_

Date of Discharge \_\_\_\_\_

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 13<sup>th</sup> week up to and including 20<sup>th</sup> gestation) (circle appropriate number)

11.1 Woman's physical or mental health (section 2 (1) (b) (i) of the Act

11.2 Fetal 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 \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Qualification \_\_\_\_\_ Registration number \_\_\_\_\_