Department of Health
Republic of South Africa

An Evaluation of the Implementation of the *Choice on Termination of Pregnancy Act*

South Africa 2000

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Contents

Foreword 3

Acknowledgements 4

Definition of terms. 5

General introduction 7

Section 1 11

Executive summary – Section 1. 13
A survey of termination of pregnancy services

Section 1: A Survey of Termination of Pregnancy Services 17
- Aims and objectives 17
- Methodology 17
- Results 18
- Discussion. 34
- Conclusions. 37
- Key recommendations 37
- References 37

List of tables
- Table 1: Current status of functioning TOP services in South Africa 20
- Table 2: Access to facilities for first trimester TOPs 25
- Table 3: Access to facilities for second trimester TOPs 26

List of figures
- Figure 1: Number of TOP facilities designated and functioning by province 21
- Figure 2: Distribution of health facilities undertaking TOPs in the first trimester 22
- Figure 3: Distribution of health facilities undertaking TOPs in the second trimester 23
- Figure 4: Mean number of TOPs performed in each province per month 27
- Figure 5: TOPs performed per month per 100 000 women 28

Section 2. 39

Executive summary – Section 2 41
Epidemiology of incomplete abortions

Section 2: Epidemiology of Incomplete Abortions 45
- Aim and objectives 45
- Methodology. 45
- Discussion. 66
- Conclusion 69
- Key Recommendations 71
- References 72

List of Tables
- Table 1: Comparison of 1994 and 2000 incomplete abortion research methodologies. 49

Contents

Table 2: Rates of incomplete abortion: comparison of results from the 1994 and 2000 studies . . . 50
Table 3: Comparison of characteristics of women and clinical findings on admission between 1994 and 2000 studies . . . 52
Table 4: Characteristics of women and clinical findings on admission by province in 2000 . . . 54
Table 5: Characteristics of women and clinical findings on admission by hospital category in the 2000 study . . . 56
Table 6: Demographic characteristics and clinical findings on admission by age of women, 2000 study . . . 58
Table 7: Changes in hospital management of incomplete abortion between 1994 and 2000 . . . 59
Table 8: Relationship between blood transfusion and haemoglobin level, trimester status, and severity category, 2000 study . . . 60
Table 9: Relationship of antibiotic type and severity status and trimester status, 2000 study . . . 61
Table 10: Relationship of antibiotic usage and severity status and trimester status . . . 63
Table 11: Hospital management by province, 2000 study . . . 65

Section 3 . . . 73

Executive summary – Section 3 . . . 75

Why are women still having illegal abortions in Gauteng?

Section 3: Why are Women still having Illegal Abortions in Gauteng? . 79

Aim and objectives . . . 79
Methodology . . . 79
Results . . . 80
Discussion . . . 93
Conclusions . . . 96
Key Recommendations . . . 97
References . . . 97

List of tables

Table 1: Demographic and social characteristics of the women interviewed . . . 81
Table 2: Pregnancy history, contraceptive use and attitudes towards pregnancy . . . 82
Table 3: Incomplete abortion history and induction method . . . 84
Table 4: Induced abortions: source of help, methods and payment . . . 85
Table 5: Knowledge of CTOP law, facilities and main reasons for not using a legal facility . . . 87
Table 6: Partner support with pregnancy and pregnancy loss . . . 92

List of figures

Figure 1: Main reasons why women did not abort in a legal facility . . . 86

Appendix 1: List of Participating Hospitals . . . 98

Appendix 2: Data Collection Forms . . . 99

Foreword

The 1996 Choice on Termination of Pregnancy Act (Act 92 of 1996) is one of the most important pieces of legislation aimed at improving women's lives. By allowing all women the right to choose whether to terminate their pregnancies within certain specified parameters, South Africa has embarked on a journey to bring access to safe abortions to all women, in order to prevent morbidity and mortality associated with unsafe, illegal 'back street' abortions.

In 1999 the Department of Health commissioned the Reproductive Health Research Unit to conduct research into Incomplete Abortion in South Africa, following the implementation of the Choice on Termination Act in February 1997. A series of studies into the accessibility of termination of pregnancy facilities, the epidemiology of incomplete abortion and the reasons why some women were still resorting to unsafe, illegal abortions was conducted. The studies were conducted from September 1999 to June 2000 with a view of measuring the impact of the new policy around termination of pregnancy in South Africa.

The information collected in the studies will be instrumental in further informing strategies aimed at improving access to termination of pregnancy services for all South African women, and for instituting programmes aimed at reducing the incidence of unsafe, illegal abortions. In addition, an understanding of the reasons behind why some women resort to these illegal, unsafe abortions is critical in improving not only the access, but the quality of our service provision as well.

I am grateful to all those who contributed to the success of the evaluation of the implementation of the Choice on Termination of Pregnancy Act: 2000 and hereby place on record my gratitude for their efforts in making this important information available. I wish to express my thanks to the Reproductive Health Research Unit for conducting the study in partnership with the Medical Research Council. I would like to thank the Clusters Health Information, Evaluation and Research as well as Maternal, Child and Women's Health and Nutrition in the Department of Health for initiating and guiding this important study.The results come at a time when we enter the fifth year of the implementation of the Choice on Termination of Pregnancy Act, and will provide much needed information for future planning.

Special thanks go to the provincial Departments of Health for their contributions to the study, and the staff at the participating hospitals for contributing to the data collection and whose tireless efforts towards making abortions accessible and safe do not go unnoticed. Lastly, but not least, I would like to thank all the women who agreed to participate in the study, without whom the valuable lessons would not have been learnt.

Dr ME Tshabalala-Msimang
Minister of Health

February 2002

Acknowledgments

I wish to thank the Health Systems Research, Research Coordination and Epidemiology and Women's Health and Genetics Directorates for initiating and guiding this important study on the impact of the Choice on Termination of Pregnancy Act on incomplete abortions.

Many thanks go to the Reproductive Health Research Unit in partnership with the Medical Research Council for conducting this study. In particular I wish to thank all those involved for their dedicated efforts in the completion of this work.

Thanks also to the Henry J. Kaiser Family Foundation and the United Kingdom Department for International Development (DFID) for co-funding this study.

I am also grateful to all the provincial Maternal, Child and Women's Health coordinators and hospital staff, who willingly gave of their time to make this study a success.

Special thanks to all the women who agreed to participate in this study, without whom the study would not have been possible.

Dr A Ntsaluba
Director-General: Health

March 2002

Definition of Terms

Abortion

The WHO defines abortion as the induced or spontaneous loss of a pregnancy prior to the 22nd week of gestation or, if the gestation is not known, where the foetus weighs less than 500g.

Incomplete Abortion

Incomplete abortion refers to the clinical situation when only part of the products of conception have been expelled, the remainder being retained in the uterine cavity.

Unsafe Abortion

Termination of pregnancy (induced or spontaneous) either by persons lacking the necessary skills or in an environment lacking the minimum medical standards or both (WHO 1992).

Illegal Abortion

An abortion induced or performed outside the provisions of the Choice on Termination of Pregnancy Act (Act No 92 of 1996), outside of designated health service facilities, or by persons who are not registered to perform abortions.

General Introduction

The 1996 Choice on Termination of Pregnancy Act[1] of South Africa is one of the most liberal examples of abortion legislation in the world. The Act reflects both a desire to empower women in the country generally, and a recognition that illegal abortion has been widespread and caused significant mortality and morbidity. The passage of the legislation through parliament and the shape of debates in the popular media were significantly influenced by the findings of research on the epidemiology and hospital management of incomplete abortions, costs to the health sector of incomplete abortion management and research into women's experiences of illegal abortions which was undertaken in 1994.

In the first three years after the legislation was enacted services were established in the private and public sectors and approximately 40 000 legal terminations have been performed annually.[3] The ability of provinces to establish abortion services so quickly in a resource constrained environment has been substantially influenced by the promotion of low-cost technology: manual vacuum aspiration following cervical ripening with misoprostol under local anaesthesia.[4] There has been a national clinical training programme[5] and a values clarification programme aimed chiefly at securing participation of nursing staff in service.[6]

In 1999 the Department of Health commissioned an evaluation of progress in implementation of the Choice on Termination of Pregnancy Act and its health impact. Three studies were undertaken:

- The first was a national survey of TOP services to describe the distribution and accessibility of services for first and second trimester terminations of pregnancy.
- The second was a study of the epidemiology of incomplete abortion cases presenting to the public sector. This study reviewed the profile and medical condition of women admitted to hospitals with incomplete abortions. This report presented findings and drew comparisons where possible with the data from the 1994 National Incomplete Abortion Study.
- The third was a study of why women continue to resort to illegal abortions in a province such as Gauteng which has considerable public sector service provision.

Choice on Termination of Pregnancy Act

The Choice on Termination of Pregnancy Act (CTOP Act), implemented from February 1997, permits termination of pregnancy (TOP) upon the request of a woman up to and including 12 weeks' gestation, under certain defined circumstances from the 13th to the 20th week of gestation, and in very limited circumstances after the 20th week of pregnancy.[6] Previously termination of pregnancy in South Africa was available for a small group of indicators and required a lengthy process of application to the relevant authorities. Access to legal termination was therefore limited. Between 800 – 1 000 legal terminations were granted each year[7], representing about 40% of applications. The majority of women did not even attempt to access legal termination, resorting instead to illegal and often dangerous methods of abortion.

Survey of TOP services

The National Department of Health has the legal responsibility to designate services to perform terminations of pregnancy, but provincial and local health departments must apply for designation of hospitals. The approach to designation has varied among provinces. In some instances only facilities which had definite plans to offer services were designated, as was the case in the Northern Cape. Other provinces, such as KwaZulu-Natal, applied for the designation of all services that have the potential to render TOP services, and therefore requested designation for a large number of facilities. Services are designated in public and private sector hospitals and clinics to perform first and second trimester TOPs according to those institutions' capacity and level of care.

Despite the increase in the numbers of terminations performed under the 1996 Choice on Termination of Pregnancy Act, there has been concern that women's access to safe services remains restricted and unequal. In the first three months after the Act was passed, 60% of all legal abortions were performed in Gauteng province. A year later only one-third of the hospitals and clinics which were designated to provide abortions actually had the services in place. Of the 31 312 legal abortions performed in 1997, almost all were carried out in tertiary centres

located in urban areas. The survey of termination of pregnancy facilities was commissioned in order to identify where services were functioning in 1999, describe their activities and identify problems in access nationally.

Illegal abortion research

A further measure of the effectiveness of the legislation and service provision is provided by examination of the impact of the legislation on illegal abortion activity and associated morbidity. Unfortunately, the study of illegal abortions is extremely difficult because legal, social and cultural factors provide powerful incentives for women to conceal them. In order to research this sensitive problem the World Health Organisation (WHO) has recommended that the focus move from 'illegal' or 'induced' abortions to 'unsafe' abortions. This definition emphasises the effect of health services on women as the reasons for unsafe abortions include barriers to access to health services after miscarriage or induced abortion, as well as unsafe induction practices. One way of measuring the incidence of unsafe abortions is through looking at incomplete abortions. Incomplete abortions, whether induced or spontaneous, are common reasons for admission to gynaecological wards. It is expected that a 'normal' spontaneous incomplete abortion causes very little morbidity or medical complications. By identifying women with incomplete abortions who experience serious medical complications it is therefore possible to gain further insight into the numbers of illegal abortions. The 1994 study of incomplete abortions followed the methodology developed for a WHO multi-country study of unsafe abortions[8] (with certain modifications[9]). Comparison of the current study's findings with that of the 1994 study provides a measure of the impact of the legislation on unsafe abortion. Both studies also examine hospital management of cases. The 1994 study highlighted areas of unsatisfactory practice (both over and under treatment) and this study provided an opportunity to re-examine these areas.

Why are women still illegally aborting?

Even in Gauteng province there has been evidence that abortions are still being induced outside registered facilities.[10] In Kalafong Hospital, despite a busy first trimester abortion unit in the hospital, monitoring of the early impact of the new

legislation revealed that there was a decrease in the number of patients with complicated abortions, but no decrease in incomplete abortions.[10] This suggested that patients who previously induced illegally but now had legal treatment available to them were being replaced in numbers by patients inducing using safer methods, most probably misoprostol.

Review of the literature suggests several reasons why women should still be seeking illegal abortions. With limited public health facilities providing TOPs in urban areas, access and cost become major barriers to choice. Other barriers include lack of knowledge about the Act, lack of awareness concerning early pregnancy signs, fear of the procedure itself and its consequences, denial of the pregnancy, the stigma of openly seeking assistance, and preferences for traditional medicines.[11] Initial reluctance to implement the Act has now given way to acceptance and even enthusiasm by some staff involved in TOP procedures, while the judgemental attitude of other staff has been reported to continue to hamper implementation progress. The study of illegal abortions was undertaken to understand the relative importance of different barriers to using legal services and to gain an understanding of how women make decisions to induce in this way.

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Section 1

A survey of termination of pregnancy services

A survey of termination of pregnancy services

Introduction

This report presents the findings of a survey that was undertaken in 1999 with the objective of describing the availability and accessibility of services for termination of pregnancy two years after the enactment of the Choice on Termination of Pregnancy Act.

Methods

This was a cross-sectional study of services conducted between September and December 1999. Lists of services were provided by the departments of health in each province and each service was contacted telephonically to determine where they had performed TOP in the four weeks prior to the call (ie were functional), how many TOPs they had performed between June and August 1999, where they did second trimester terminations and what their waiting time was.

Results

Two hundred and ninety-two services were designated in the country and only 32% were functioning. In five provinces the private sector performed more than 20% of terminations, but in Mpumalanga, the Northern Cape and Northern Province there were no functioning private facilities. Overall 27% of facilities were in the private sector.

Mapping services available for TOP indicate that there are substantial parts of the country with no services at all. These include the major rural areas of the Karoo and most of the Northern Cape, most of the Northern Province, the Drakensberg in the Eastern Cape and KwaZulu-Natal, and northern and central KwaZulu-Natal.

Analysis of the proportion of the population of women in their reproductive years living within 0 – 50km (as the crow flies) of a TOP service indicates that only one province (Gauteng) has managed to achieve service provision where 90% or more of the population is within this distance of a first or second trimester service. Access to second trimester services is much poorer than that for first trimester TOPs. Only four provinces have succeeded in having 90% of their population within

100km of a second trimester service. In the Northern Cape over a third of the population is not within 100km of a first trimester TOP service and two-thirds are not within 100km of a second trimester service.

A measure of service activity is the number of terminations per month per 100 000 women in their reproductive years. This indicates considerable inequality in TOP service activity in the provinces. When compared to population, activity in Gauteng appears to be well above average (92.5 per 100 000 women) and that in the Northern Province by a long way the lowest (6.6 per 100 000 women). The other provinces cluster in two groups of very similar activity level: Mpumalanga (39.5 per 100 000 women), Western Cape (36.5 per 100 000 women) and the Free State (36.3 per 100 000 women) performing relatively better and KwaZulu-Natal (23.8 per 100 000 women), the Northern Cape (22.3 per 100 000 women), North West (19.4 per 100 000 women) and the Eastern Cape (18.7 per 100 000 women) performing far less well.

Almost half (48.5%) of the country's terminations are being performed in Gauteng province despite only 19.4% of women in their reproductive years living there. This also indicates considerable problems with service provision in other provinces. Waiting times were short for most services, but this may have been an artefact as many services do not have a waiting lists system. If women cannot be fitted into the available TOP slots they are being turned away. This is not a good indicator of unmet need for services.

Conclusions

Although in the first two years after the new legislation considerable efforts have been made to establish services, this study shows that there is gross inequality. There is very little service provision for women in rural areas and in certain provinces. Norms are needed for service provision with careful monitoring of service indicators. Considerable efforts need to be made to expand private sector service provision, especially at a primary care level with the involvement of general practitioners in legal TOP services.

Key recommendations

From the findings of this study it is recommended that:

1. Norms for service provision for first and second trimester termination of pregnancy should be set for all provinces. These should include the number of services, norms for the proportion of the female population of reproductive age who live within a certain distance of a service, and the capacity of services (measured by the average number of TOPs performed per month per 100 000 women).
2. There should be annual monitoring of the progress of each province in reaching the norms for TOP service provision.
3. Plans should be developed to enhance provision for TOPs at primary care level in both private and public sector facilities. This should include training midwives and general practitioners.
4. Provinces should develop plans for improving services based on an understanding of local circumstances and barriers to more widespread service provision.

A survey of termination of pregnancy services

Aims and objectives

The Survey of Termination of Pregnancy (TOP) services investigates the availability of TOP services within the country. This report outlines the survey's findings.

The main objectives of the survey were:

1. To determine the number of designated TOP facilities in each province
2. To determine the proportion that are functioning and the throughput (average number of TOPs per month based on the three months before the telephone contact).
3. To determine the waiting time for TOPs in each facility (time from first contact with facility to procedure).
4. To determine impact of trimester status on the above.
5. To make recommendations for improvements to the TOP service provision throughout the country.

Methodology

The study was a cross-sectional survey of TOP services in South Africa. Between September and December 1999, all the reproductive health coordinators in the nine provincial departments of health were contacted telephonically and asked to provide a list of designated termination of pregnancy services in their provinces. This included termination of pregnancy services in both the public and private sectors. The provincial coordinators were asked to indicate which of the designated services were functional, ie which ones is had performed a termination of pregnancy in the four weeks prior to the inquiry. This information was then verified telephonically by interviewing a member of staff in charge of the TOP service in each facility. The staff member was asked to provide statistics of TOPs performed for the three months prior to the inquiry, ie for June, July and August of 1999. They were asked to subdivide this into first trimester and second trimester terminations. The staff also provided information on the waiting time to obtain an appointment for termination of pregnancy and waiting time for the procedure to be performed at each service. The data was all collected on a standard data capture sheet. The data was analysed using Epi Info.[6]

Definition of terms

Certain definitions were used during the data collection to standardise the information collated:

1. **First trimester** – termination of pregnancy up to and including the 13th week of gestation.
2. **Second trimester** – termination of pregnancy from the 13th up to and including the 20th week of gestation.
3. **Designated TOP facility** – a facility that has been given permission by the Minister of Health to provide TOP services.
4. **Functional TOP facility** – a facility that actually provides TOP services. A service was deemed functional if it had performed at least one termination of pregnancy in the four weeks preceding the inquiry.
5. **Waiting time** – the time a woman has to wait from the date of first contact with the facility to the day arranged for the operative procedure. This is divided into two parts: from the time of the first contact until the first appointment and the time from first appointment to the operative procedure. The time recorded is the actual time pertaining on the day of the inquiry. Where TOPs were only performed or clinics held on certain days of the week an average waiting time is presented.

Results

Distribution of TOP Services

Table 1 and figure 1 illustrate the current status of TOP services in the country. In total there were 292 designated TOP services throughout the country. Table 1 shows that only about a third (32%) of these facilities were providing TOP services. The greatest number of facilities for TOP lay in the public sector (73%) while the private sector contributed just over a quarter (27%) of TOP provision. Gauteng had the most designated facilities (75), followed by KwaZulu-Natal (66), the Western Cape (59) and the Northern Province (36). The number of facilities designated in a province varied from 2 – 75, the mean number was 32.4 and median 22.

In the process of data collection it was reported that TOP service provision was largely dependent on a core of committed providers. Even the facilities that were functional at the time of the study were vulnerable to be rendered 'non functional' at certain periods, depending on the presence of the committed providers. A few of the facilities denoted as not functioning in this study had been previously providing TOP services but may not have provided services in the month prior to the survey because a particular provider was on leave or absent for other reasons (illness, transfer to other duties).

The numbers of functioning services ranged from 2 – 33, the mean number was 10.2 and median 9. The picture here was different from that given by consideration of numbers of designated services alone. Gauteng province had the largest number of functioning TOP services (33), with the Western Cape in second place (14), followed by the Eastern Cape (10), North West Province (9), KwaZulu-Natal (8), Mpumalanga (6), Northern Province (5), Free State (5) and Northern Cape (2). Table 1 indicates that the proportion of designated TOP services which are functioning varied from 12% – 100%. The Northern Cape with the lowest total number of TOP services (2) had the highest proportion of services functioning. This indicates that proportion of designated services which are functioning is not a very useful indicator of TOP service provision.

Figure 1 shows the numbers of designated facilities, and of those that were actually functioning (ie providing TOP services) by province. Figures 2 and 3 show the geographical distribution of functioning first and second trimester TOP services around the country. These maps indicate that there were large parts of the country with no access to services, most notably the interior and northern part of the Western Cape, southern part of the Northern Province and north-west part of the Eastern Cape. This pattern is even more pronounced when facilities providing second trimester terminations are considered. The northern and mountainous parts of the Eastern Cape and KwaZulu-Natal are also without TOP services.

Table 1 indicates considerable inequality in provision of TOP facilities in the private sector from province to province. Mpumalanga, Northern Cape and the Northern Province did not have any private sector facilities performing TOPs and

the Eastern Cape and Free State only had one for the whole province. Gauteng province had the largest number (15), and proportion (45%) of private sector facilities providing TOP services. Apart from in the Western Cape, private sector facilities offer both early and late terminations.

Table 1: Current status of funtioning TOP services in South Africa

Province	No. of designated facilities	No. of functioning facilities (% of designated)	No. of functioning public facilities (% of total functioning)	No. of functioning private facilities (% of total functioning)
Eastern Cape	11	10 (91)	9 (90)	1 (10)
Free State	9	5 (56)	4 (80)	1 (20)
KwaZulu-Natal	66	8 (12)	6 (75)	2 (25)
Gauteng	75	33 (44)	18 (55)	15 (45)
Mpumalanga	22	6 (27)	6 (100)	0 (0)
Northern Cape	2	2 (100)	2 (100)	0 (0)
Northern Province	36	5 (14)	5 (100)	0 (0)
North West	12	9 (75)	7 (78)	2 (22)
Western Cape	59	14 (24)	10 (71)	4 (29)
TOTAL	**292**	**92 (32)**	**67 (73)**	**25 (27)**

Figure 1: Number of TOP facilities designated and functioning by province

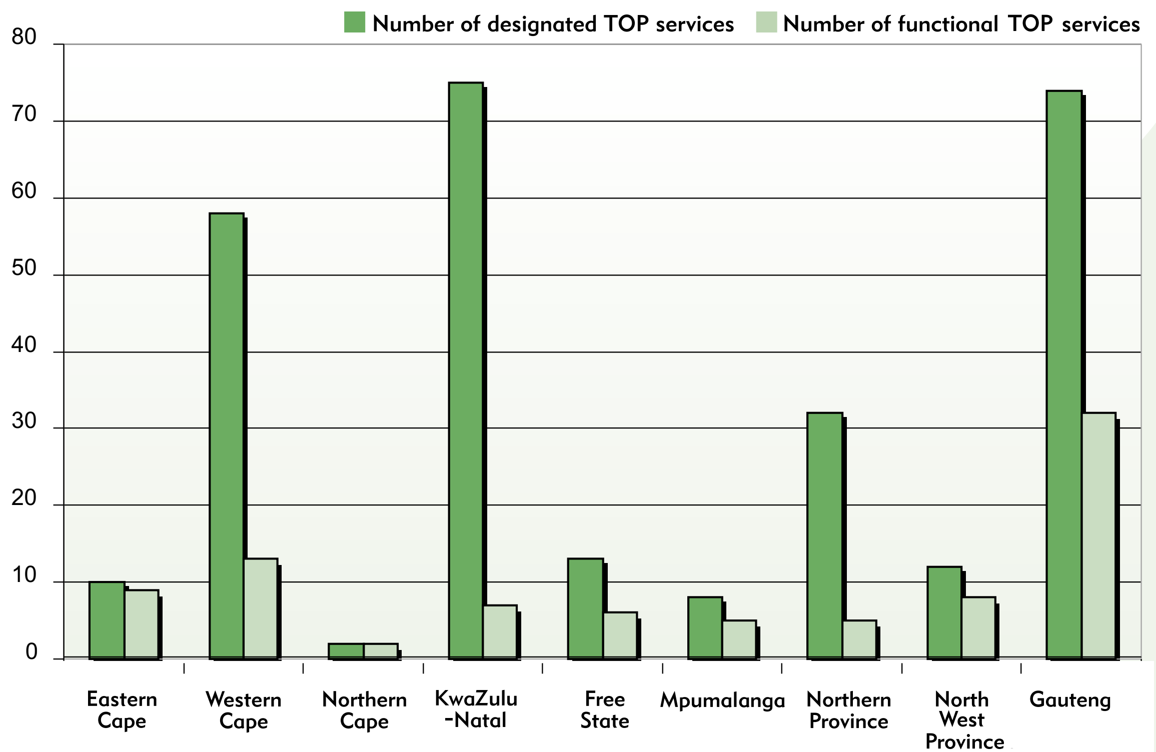


Figure 2: Distribution of health facilities undertaking Termination of Pregnancies (TOPs) in South Africa for the first trimester

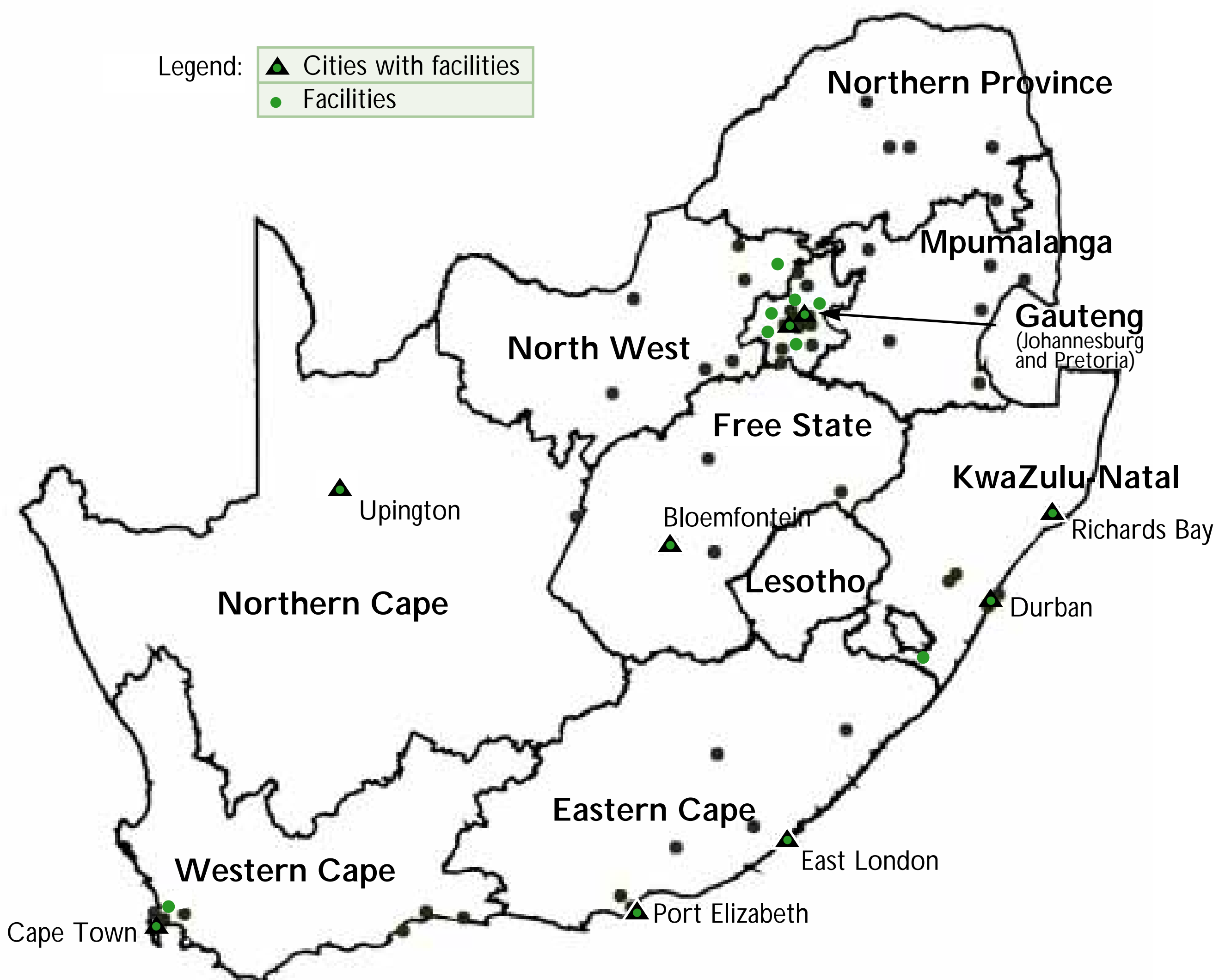


Figure 3: Distribution of health facilities undertaking Termination of Pregnancies (TOPs) in South Africa for the second trimester

Access to TOP services

A further indicator of access to TOP services is the number of women in a reproductive age group living near a TOP service facility. This is based on the assumption that if you live near to a health facility you have access to the services offered and does not take into account transport routes. There is no convention for the maximum distance from a TOP service which is necessary to ensure access, so the proportion of the population living within 50km and 100km was considered. Tables 2 and 3 show, by province, the number of women of reproductive age who lived within 0 – 50km and 50 – 100km of TOP services providing first and second trimester TOPs. The tables also show the percentages of women of reproductive age who did not live within at least 50km and 100 km of a TOP service.

Access to first trimester TOP services was generally much better than access to second trimester TOP services. More women in all provinces lived within at least 50 and 100km of a facility offering first trimester TOP services than those offering second trimester TOP services.

Gauteng province clearly offered the best access to first trimester TOP services, with only 0.3% of women not living with 50 km distance of a first trimester facility. The Western Cape also offered reasonably good access with only 16.8% of women not living within 50km of a first trimester TOP service. In some provinces over a quarter of the women of the reproductive age group did not live within 50km of a TOP service, North West (27.2%), Mpumalanga (28.4%), and the Free State (28.5%). In KwaZulu-Natal and the Eastern Cape, over 40% of women did not live within 50km of a service (40.6% and 41.1% respectively). More than half of the women of reproductive age in the Northern Cape and Northern Province did not live within 50km of a TOP service (56.8% and 62.8% respectively).

Most women in all the provinces lived within at least 100km of a facility offering first trimester TOP services. All women in Gauteng province lived within at least 100 km of a first trimester TOP service. In the other provinces, except Northern Cape (38.5%), Northern Province (17.8%), and Kwa Zulu-Natal (16.0%), less than 10% of women lived further than 100km from a first trimester TOP service.

Access to second trimester TOP services was more limited than access to first trimester services. Gauteng province again offered the best access to services with only 1.6% of women not living within 50km of a second trimester TOP service. In the Western Cape 17.3% of women did not live within 50km of a second trimester service. In the other provinces between 29.2% and 71.1% of women in their reproductive years did not live within 50km of a second trimester service. In provinces such as the North West (61.9%) and the Northern Cape (71.1%) two thirds of women lived more than 50km from a second trimester TOP service.

Even though more women in all the provinces lived within 100km of a facility offering second trimester TOP services, access was still very restricted. Four provinces had a high proportion of their population living within 100km of a functioning second trimester TOP service. These were Gauteng (all women), Mpumalanga (98.9%), Free State (95.1%), and Western Cape (91.4%). In the other provinces, between 16.5 and 63.1% did not live within 100km of a second trimester TOP service.

Table 2: Access to facilities for the first trimester TOPs
(number of women living in each province within 0 – 50km and 50 – 100km of a facility providing first trimester TOPs and proportion who do not)

Province	Total 16-50 yr old females	Within 0-50km	% Not within 0-50km	Within 50-100km	% Not within 0-100km
Eastern Cape	1 541 476	906 878	41.1	514 866	7.6
Free State	702 486	502 283	28.5	167 717	4.6
KwaZulu-Natal	2 237 265	1 329 378	40.6	550 566	16.0
Gauteng	2 097 147	2 090 263	0.3	7 121	0
Mpumalanga	718 689	515 032	28.4	203 046	0.1
Northern Cape	215 261	92 982	56.8	39 422	38.5
Northern Province	1 182 998	440628	62.8	531 889	17.8
North West	866 619	631 209	27.2	207 729	3.2
Western Cape	1 102 618	917 714	16.8	91 566	8.5

Table 3: Access to facilities for the second trimester TOPs
(number of women living in each province within 0 – 50km and 50 – 100km of a facility providing second trimester TOPs and proportion who do not)

Province	Total 16-50 yr old females	Within 0-50km	% Not within 0-50km	Within 50-100km	% Not within 0-100km
Eastern Cape	1 541 476	800 435	48.1	486 905	16.5
Free State	702 486	489 090	30.4	179 241	4.9
KwaZulu-Natal	2 237 265	1 253 111	44.0	545 829	19.6
Gauteng	2 097 147	2 064 309	1.6	33 075	0
Mpumalanga	718 689	508 503	29.2	209575	1.1
Northern Cape	215 261	62 306	71.1	17 332	63.1
Northern Province	1 182 998	435 933	43.2	526 183	18.7
North West	866 619	330 304	61.9	244 066	33.2
Western Cape	1 102 618	911 991	17.3	96 354	8.6

Figure 4 shows the mean number of all terminations. early and late, per month in each province. The average number of terminations of pregnancy per month for the three-month study period nationwide was calculated to be 3 997; the majority (77.8%) were early terminations.

The results show that Gauteng was performing the majority (48.5%) of terminations in the country. Gauteng province performed an average of 1 939 terminations per month. Northern Cape province was performing the least number of terminations, contributing to only 1.2% of the number of monthly terminations. Northern Cape province only performed an average of 48 terminations per month. First trimester terminations constituted at least 75% of the terminations done in most provinces. The main exceptions were the Northern Province (48.1%), and the Northern Cape (50%).

Figure 4: Mean number of TOPs performed in each province per month

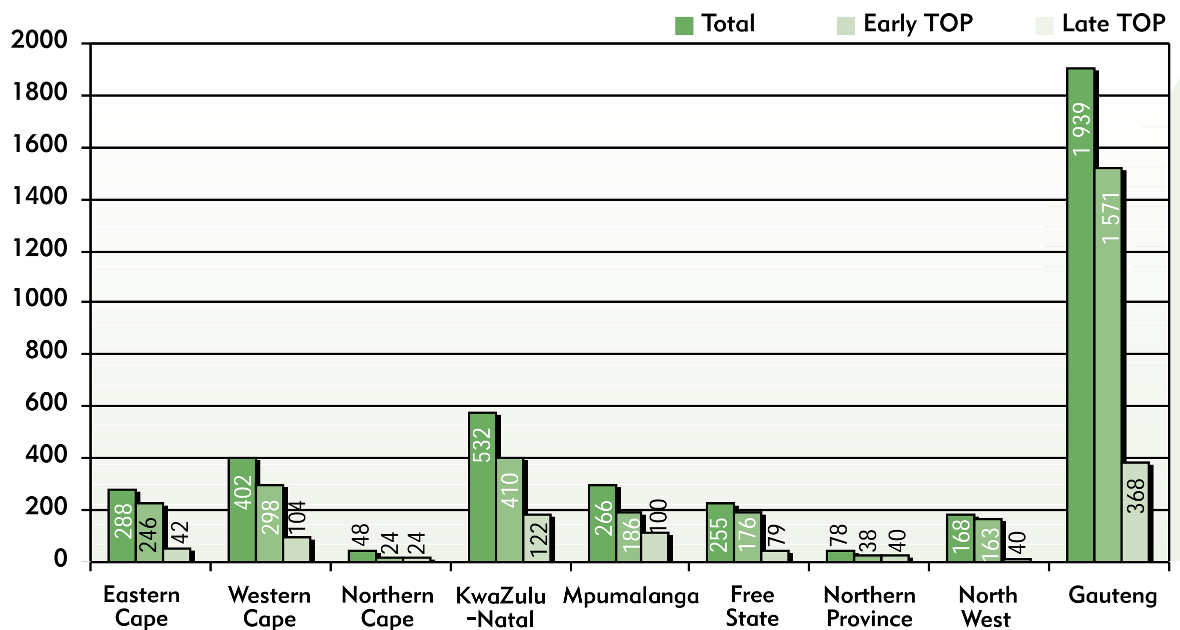
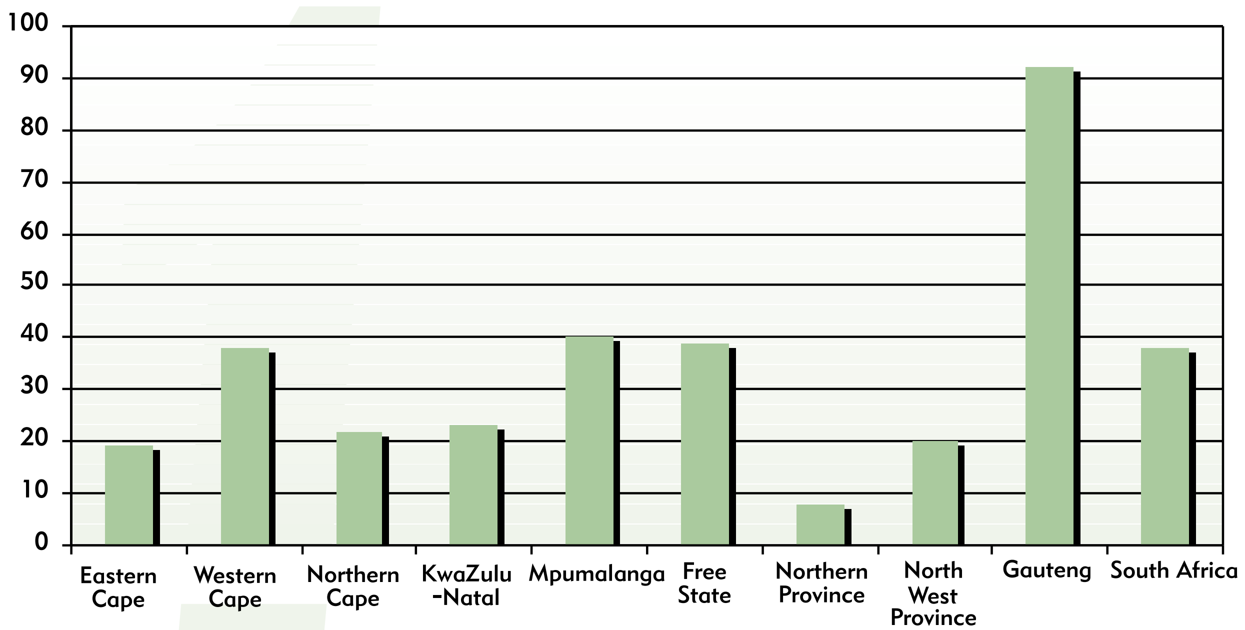


Figure 5 shows the number of terminations of pregnancy performed on average in a month per 100 000 women aged 16 – 50 years in each province. When compared to population, activity in Gauteng is seen to be well above average (92.5 per 100 000 women) and that in the Northern Province to be by a long way the lowest (6.6 per 100 000 women). The other provinces cluster in two groups of very similar activity level, Mpumalanga (39.5 per 100 000 women), Western Cape (36.5 per 100 000 women) and the Free State (36.3 per 100 000 women) performing relatively better and KwaZulu-Natal (23.8 per 100 000 women), the Northern Cape (22.3 per 100 000 women), North West (19.1 per 100 000 women) and the Eastern Cape (18.7 per 100 000 women) performing much less well.

Figure 5: Number of TOPs performed on average in a month per 100 000 women aged 16 – 50 years in each province



Client waiting times for TOP services

Most facilities (80%) had waiting times of less than seven days for early TOPs. Even for late TOPs, most services (75.9%) had a waiting time of less than seven days. Even though most facilities had standard waiting times, many facilities said that the waiting time was even shorter if the woman was nearer the end of the first trimester, and several would do the same day or next day procedures for women who had traveled long distances. Two hospitals indicated that a notion of 'merit' was used in determining whether women were eligible for second trimester terminations. The system of 'merit' was not based on the stipulations of the act and was applied subjectively by the providers. This is contrary to the stipulations of the Act.

The facilities with the longer waiting times were all in Gauteng, the Western Cape, and KwaZulu-Natal. The longest waiting times were found in Gauteng for women in the second trimester, where 50% of facilities providing second trimester TOPs had waiting times of over seven days for late TOPs, and 20% had waiting times of over 14 days. In KwaZulu-Natal 17% of facilities had waiting times of longer than seven days for second trimester TOPs. In thirty per cent of facilities in Gauteng and Western Cape, and 14% in KwaZulu-Natal facilities the waiting time was over 14 days. The functioning private sector facilities in all provinces offered the same day service.

Provincial picture

Eastern Cape

The Eastern Cape had 11 designated services of which 10 (91%) were functional. There was one private designated service, which was functional. On average 288 terminations were performed per month, of which the majority (85.4%) were early terminations and the remainder were late. The private hospital provided a same day service for both early and late terminations. The public sector had an average waiting time of one to seven days, regardless of the gestation of the pregnancy. The province was among the bottom three provinces based on the number of designated services, but had the third largest number of functioning services. Unfortunately, this was insufficient to provide reasonable access to care and it again ranked among the bottom three provinces when judged on the proportion of the population not living within 50km of a service and the number of TOPs performed per 100 000 women.

Free State

The province had nine designated services of which five (56%) were functional. There was one private designated service, which was functional. On average 255 terminations were performed each month. The majority (69%) of these were early terminations. The private sector hospital performed early terminations only. In the public sector waiting times ranged from one to seven days due to early terminations being performed once weekly in four of the five services. Late terminations were usually done almost immediately. The private sector hospital offered a same day service. The province ranked among the bottom three based on numbers of designated and of functioning facilities. However, geographical access was somewhat better, and it ranked five and four respectively for the proportion of women living within 50km of a first and second trimester service. Overall it ranked fourth on the number of TOPs performed per 100 000 women.

KwaZulu-Natal

There were 66 designated services of which only eight (12%) were functional. Fourteen private facilities had been designated of which two were functional. On average 532 terminations were performed per month, the majority (77.1%) of these being early terminations. The private sector performed both early and late terminations. The waiting times in the public sector ranged from one to seven days for early terminations, and one to 15 days for late terminations. The private sector offered a same day service for both early and late terminations. The province ranked second on the number of designated facilities, but only fifth on the number functioning. The proportion of designated facilities which were functioning was the smallest of any province. It ranked sixth on distance from facilities and fifth on the number of TOPs per 100 000 women. It was part of the group of more poorly performing provinces when judged against this indicator of activity per population.

Gauteng

Gauteng had 75 designated services, 33 (44%) of which were functional. Gauteng had 15 designated private sector facilities and all of these provided TOP services. An average of 1 939 terminations were performed per month in Gauteng. The majority (81%) of the total number of terminations were early terminations. The private sector performed both early and late terminations, and contributed 21% of the early terminations and 58% of the late terminations performed. The private sector offered a same day service for TOPs. The waiting times in the public sector ranged from one to seven days for early terminations, and one to four weeks for late terminations. In performance Gauteng was top of the league of provinces for all important indicators of termination of pregnancy services. However, waiting times were a persisting concern.

Mpumalanga

There were 22 designated services of which six (27%) were functional. No private sector facilities had been designated or provided TOP services in this province. On average 286 terminations were performed per month, of which 65% were early

terminations and 35% late terminations. The waiting times ranged from a same day service to two weeks, depending on staff availability. Mpumalanga ranked fifth when judged on the number of designated services and sixth on the number functioning. It was fourth when judged against the proportion of women living between 0-50km of a first trimester facility and third for second trimester access. It had the second highest number of terminations performed per month per 100 000 women.

Northern Cape

This province had only two designated services, both of which were functional. There was no designated private facility in this province. On average there were only 48 terminations of pregnancy performed per month, of which half (50%) were early, and the other half were late terminations. At one service there was a same day service for early terminations, and a four-day waiting time for late terminations. At the other service there was a three to four day waiting time for both early and late terminations. The Northern Cape had the fewest designated and functioning facilities of any province. Geographical access for first trimester TOPs was the second worst of any province and for second trimester Northern Cape was the worst. However, when compared to the province's population, its TOP activity was not the lowest – in fact it ranked sixth.

Northern Province

There were 36 designated services of which five (14%) were functional. There was no designated private sector facility in this province. On average 78 terminations were performed per month, of which 48.7% were early terminations. The waiting times ranged from one to four days for early, and one to seven days for late terminations. This province ranked fourth based on the number of designated services, but was second to bottom on the number functioning. It had the poorest geographical access of any province to first trimester terminations but ranked fifth on access to second trimester ones. When comparing activity to the province's fairly large population, this province had by far the lowest level of termination of pregnancy activity.

North West

There were twelve designated services, of which nine (75%) were functional. The province had designated three private facilities and two of these were functional. On average 168 terminations were performed per month, and the majority of these (97%) were early terminations. The private sector only performed early terminations. The waiting times ranged from one to seven days in the public sector. All the facilities had set days for terminations to be done. The private sector offered a same day service. This province ranked sixth on the number of designated facilities and fifth on the number functioning. Geographical access to first trimester facilities was relatively good with a rank of three, but second trimester access was much poorer and the province was the second worst in this regard. Overall its position was seventh on activity per 100 000 women.

Western Cape

The province had 59 designated services, 14 (24%) of which were functional. There were 25 designated private facilities and four of these were functional. An average of 402 terminations were performed each month, of which 74.1% were early terminations. The private sector performed on average 135 early terminations per month; this contributed to 46% of all the early terminations done in the province. The private sector in this province did not perform late terminations. The waiting times in the public sector ranged from one to 14 days. The majority of the services had waiting times of one to seven days, and only two services had longer waiting times. All of the services had set days of the week on which terminations were performed, with the proviso that any urgent requests for termination were performed almost immediately. There was no waiting time for terminations in the private sector in this province. It ranked third on number of designated facilities, but second on number functioning. It had the second best access for first and second trimester terminations and ranked third on termination activity per 100 000 women.

Discussion

This study shows that considerable progress was made in the first couple of years after the enactment of the new Choice on Termination of Pregnancy Act in establishing services. However geographical distribution of services was still very unequal and for people living outside the largest urban centres, access was still very restricted. Women in Gauteng and the Western Cape had far greater access to TOP services than any of the other provinces.

The fact that only 32% of designated facilities were actually providing services indicates that there are many facilities with the potential for providing termination of pregnancy that do not do so. Furthermore, the very substantial inter-provincial differences in the number of designated services points to different approaches to the designation of services. This raises the likelihood that the number of facilities with the potential for providing TOP services nationwide that are not doing so is very much higher than suggested by the current figure for designated services. Having said this, this study has shown that the proportion of designated facilities that are functioning is not a very helpful indicator of TOP service provision in provinces and attention should rather be focused on geographical access and the ratio of terminations to women in the reproductive years.

The report highlights the important role of the private sector in TOP service provision but also the substantial geographical limitations on this service. In Gauteng (the province that performs the majority of TOPs) nearly half (45%) of functioning services are private facilities. In a few other provinces, such as the Western Cape (29%), KwaZulu-Natal (25%) and North West (22%), the private sector provides over one fifth of all TOP services. However, most provinces only have one or two facilities actually providing private sector services. The private sector also plays an important role in increasing access to second trimester termination – apart from in the Western Cape.

It is a problem and also surprising that there is no private service provision in many provinces and that where private provision is found it is mostly restricted to so few facilities. This may reflect conservatism in designating private hospitals, but also a failure to engage GPs in providing abortion care. All the designated facilities

in 1999 were hospitals; in no province were GPs in the private sector contributing formally to TOP service provision. This is an important weakness of services in view of the broad geographical distribution of GPs and the evidence from the study of illegal abortion in Gauteng (and anecdotes from elsewhere) that there is considerable willingness among GPs to be involved with TOPs – as they are currently assisting TOPs through prescription of misoprostol. It suggests that developing a legal, safe and meaningful role for GPs in abortion services should be a priority as part of extending access.

Mapping TOP services using geographical information system (GIS) technology very clearly illustrates the large parts of the country with no TOP service provision. This is also shown by the calculations of the proportion of the population who do not live within 50 or 100km of a service. This latter approach serves to highlight problems in access and inequality between provinces, but in the process of doing this it provides a conservative estimate of access problems. This is because it does not take into account actual travel routes to facilities or available modes of travel, both of which mean that actual travelling times and difficulties can be much more substantial than indicated merely by distance. Nonetheless the proportion of the population living within a certain distance of a facility is an indicator of service provision, which can be monitored. The Department of Health should consider agreeing targets for this with provinces and monitoring achievement of these targets annually using GIS technology.

Gauteng is the only province that performs a number of terminations which is quite disproportional to the percentage of women living in the province. Nineteen per cent of women aged 15 to 49 live in Gauteng, and yet Gauteng is performing 49% of all terminations nationwide. However, the data on waiting times suggests that the population of Gauteng is still receiving a sub-optimal service, undoubtedly because people are travelling from underserved neighbouring provinces for TOPs. This places strain on Gauteng services as well as being expensive and difficult for the women involved, and points to the need to improve services in neighbouring provinces. The chart of TOP activity per 100 000 women indicates that there are four provinces with activity commensurate with their female populations. These are Gauteng, Mpumalanga, the Western Cape and the Free State. The services in

the other provinces need to be improved and this indicator of TOP service provision needs to be monitored on a regular basis.

Each province should consider what the main local barriers are to provision of equitable TOP services. In some provinces the priority may be to increase the absolute number of services functioning, whereas in others it may be more important to increase the number of terminations performed by each service. In some services the barriers to provision may be staff and resources, whereas in others it may be the will of staff – either from frontline workers or management. In this case, provision of in-service training in the form of values clarification sessions and directives from the department may be necessary interventions. Each province needs to investigate the problems with its own services and develop appropriate solutions.

The findings on service waiting time, when taken at face value, suggest that in most provinces there is little unmet need for TOP services – otherwise this would be reflected in long waiting periods. This conclusion would be false. The unmet need for services is reflected in the significant proportion of women who are continuing to use illegal or self-induced methods (as shown in the survey of why women are illegally aborting). It is also clearly indicated by the fact that women in Gauteng are either having a lot of terminations or that many users of their services are not from this province. There is anecdotal information that waiting lists are only operated by most services over a period of 1 or 2 weeks. If the service spaces are all full then women are turned away rather than placed on a waiting list. This means that waiting lists are a poor indicator of unmet needs for terminations and should be interpreted with caution. Demand for services should be expected to increase if new services can be provided in underserved areas and if information campaigns around abortion rights are conducted, providing sufficiently high quality of care can be provided so that women are not put off from using the services for fear of the staff.

Conclusions

This survey has shown that passing the Choice on Termination of Pregnancy Act has resulted in considerable activity in establishing TOP services, but that access after two years remains highly unequal. More efforts need to be made to provide services to women in rural areas. Training of midwifes and GPs to provide TOP services needs to be intensified and more services need to be opened up at the primary care level.

Key recommendations:

From the findings of this study it is recommended that:

1. Norms for service provision for first and second trimester termination of pregnancy should be set for each province. These should include the number of services according to the proportion of the female population of reproductive age who live within a certain distance of a service, and the capacity of services (measured by the average number of TOPs performed per month per 100 000 women).
2. There should be annual monitoring of the progress of each province in reaching the norms for TOP service provision.
3. Plans should be developed to enhance provision for TOPs at primary care level in both private and public sector facilities. This should include training midwives and GPs.
4. Provinces should develop plans for improving services based on an understanding of local circumstances and barriers to more widespread service provision.

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