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Datum
Date
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07 September 2000

Departement van Gesondheid
Department of Health
iSebe lezeMpilo

TO All: Directors (Head Office)
Regional Heads
Heads of Associated Academic Hospitals and Satellites
Heads of Institutions
Provincial Aided Hospitals
District Surgeons
Health Local Authorities (Regions please circulate)

CIRCULAR NUMBER: H97/2000

PROVINCIAL ADMINISTRATION: WESTERN CAPE: TERMINATION OF PREGNANCY (TOP): POLICY, GUIDELINES AND PROTOCOLS

The Choice on Termination of Pregnancy (CTOP) Act, (Act No. 92 of 1996) has reference.

This circular replaces all previous Provincial circulars regarding termination of pregnancy.

Attached for your information, attention and further action please find the following documents:

1) Policy and Guidelines (Part 1);
2) Protocols for Termination of Pregnancy (TOP) (Part 2):
   - Management Protocols;
   - Counselling Protocols;
   - Infection Control and Manual Vacuum Aspiration Instrument Reuse;
3) Examples of Referral Letters and Client Information Leaflets (Part 3);
4) Notification Forms and Guidelines (are included again for your convenience) (Part 4);
5) A List of Designated Facilities for Termination of Pregnancy (Part 5)

The Afrikaans version of these documents will be circulated in the near future.

Please ensure that the Policy, Guidelines and Protocols are brought to the attention of all concerned and are implemented.

Your co-operation and support is highly appreciated.

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PART 1

POLICY ON THE MANAGEMENT OF TERMINATION OF PREGNANCY SERVICES DEPARTMENT OF HEALTH: WESTERN CAPE:

1. PREAMBLE

The aim of this policy is to provide equitable, accessible, cost-efficient and user-friendly services for women with unwanted pregnancies as part of the Reproductive Health Programme, integrated into the comprehensive health services.

1.1 The policy in the Western Cape Province is to provide Termination of Pregnancy (TOP) services at tertiary, regional and district hospitals initially and then to decentralise these services to community health centres and primary care clinics as soon as possible.

1.2 Clients requesting the service should enter the Provincial Health System at the primary care level.

PRIMARY CARE LEVEL

1.3 Personnel at clinics and community health centres as well as general practitioners therefore need to adhere to the attached Management Protocols (Part2) in respect of clients requesting termination of pregnancy in the first trimester (< 12 weeks):

1.4 In the case of clients requesting termination of pregnancy in the second trimester (> 12 weeks), the above steps must be followed, and the doctor at the clinic/community health centre/hospital must also satisfy him/herself that the specific requirements of the Act would be met by the termination.

REFERRALS

1.5 If the service is not available at primary care facilities, clients wishing to proceed with the termination of pregnancy must then be referred to the appropriate designated district or regional facility.

1.6 The following referral principles are applicable:

- A referral letter from the health worker must accompany the client. All the relevant information must be included in the letter;
- A telephonic booking must be made in all cases;
- A record must be kept of the numbers of clients referred so that the demand for the service can be monitored.

1.7 The provisions of the Act differentiate between first and second trimester terminations. It is therefore important that clients who present in the first trimester are booked for the procedure at the relevant designated facility, prior to the end of the twelfth week of gestation.
Terminations in the first trimester will usually not be performed before the sixth week of pregnancy. The referring practitioner at the primary care service should therefore indicate to the booking clerk the dates between which the client should be booked.
In the case of a second trimester termination, the client must be given an appointment at the relevant designated facility as urgently as possible.

Note: Circular No. H135/1997: Referral and Support Zones of the Public Sector Health Institutions in the Western Cape Province applies to termination of pregnancy referrals.

RECORD KEEPING

1.8 Except for the Annexure A, Anonymous Copy of the Notification form, the records are kept in the usual manner in the client's file.

NOTIFICATION

1.9 The requirements for the notification of termination of pregnancy in terms of Regulation R 168 must be noted.
Attached, for your convenience, are copies of the amended Western Cape Notification Forms and Guidelines (Part 4 - Annexures A and C).

MANUAL VACUUM ASPIRATION (MVA) EQUIPMENT

1.10 Facilities should order their own Manual Vacuum Aspiration instruments from SA Biomedical (PTY) LTD. Tel: (021) 696 5202 Fax: (021) 696 9320
The cost of a double valve syringe with six cannulae is presently R300.00 (Dec. '99).

TRAINING

1.11 Training courses are available as follows:

- 1 day Values Clarification Workshops (including the Act & Regulations);
- 1 day Pre- and Post Termination of Pregnancy Counselling Workshops;
- 160 Hour Abortion Care Course for Registered Midwives (including the Manual Vacuum Aspiration technique) and
- Training for physicians in Abortion Care.

All medical, nursing and social work personnel are strongly urged to attend the relevant training.

1.11.1 Refer to the annual Regional HRD&T circulars for dates of planned courses.

1.11.2 Arrangements to attend training courses can be made via the relevant supervisors / co-ordinators and the Regional Human Resource Development and Training (HRD&T) Components.

1.11.3 Applications for the Abortion Care Course for midwives can be made to:
The Metropole HRD&T Component Tel: (021) 918 1672 Fax: 021) 946 1271;

1.11.4 The contact persons for medical training and practica arrangements for midwives are as follows:

- Groote Schuur Hospital: Dr. J Cole at Tel: (021) 404 4488 Fax**:** (021).448 6921
- Tygerberg Hospital: Ms Joan Bannister at Tel: (021) 938 4661 Fax**:** (021) 931 6595.

CONTRACEPTION

1.12 It is intended that termination of pregnancy should be done as an emergency measure only and must not become an alternative contraceptive method. Unwanted pregnancies must be prevented before women has to resort to terminations To this end, every opportunity must be used to persuade sexually active individuals to make regular use of contraceptive methods to avoid unwanted pregnancies. All efforts must be made to promote and provide emergency contraception in cases of method failure or unprotected sexual intercourse.

Dual protection against infection and unwanted pregnancy must be promoted at every opportunity.

CONSCIENTIOUS OBJECTIONS

1.13 The Department respects the right of health care workers to conscientious objections in participating in the termination of pregnancy. According to section 15 (1) of The Constitution of the Republic of South Africa, 1996 (Act 108 of 1996), "everyone has the right to freedom of conscience, religion, thought, belief and opinion".
However, the clients' right to information and access to health care services, including termination of pregnancy, must also be respected. Therefore, if a health care provider feels uncomfortable in dealing with a client who request a termination of pregnancy, the client must be respectfully referred to a colleague who is willing to assist the client in obtaining the service.
It must be emphasised that public health facilities are public domain. The management therefore must ensure that women have access to the services, which they are legally entitled to.

1.14 It is essential that equitable, accessible and user-friendly comprehensive Reproductive Health Services be provided

1.15 To ensure the availability of sufficient personnel for rendering termination of pregnancy services, it may be necessary when posts are advertised to indicate that the duties of the incumbent will include termination of pregnancy services and it should then be reflected in the appointment letter.

1.15.1 Conscientious objection should only be dealt with when expressed by individual staff members, not as a group action.

1.15.2 Employees could be encouraged to discuss possible conscientious objections electively. Refusal to discharge obligations when faced with a particular task could lead to breach of contract.

STAFF SUPPORT

1.16 The Management of the services concerned must ensure that adequate support is provided for staff involved in termination of pregnancy. Confidential access to professional counselling should be made available to personnel in need of it.

2 STANDARDIZED GUIDELINES

2.1 Use and Ordering of Manual Vacuum Aspiration (MVA) Equipment

Facilities should order their own MVA equipment from:
SA Biomedical (PTY) LTD. Tel: (021) 696 5202 Fax: (021) 696 9320

Syringes:
For 1st trimester termination of pregnancy, single or double valve syringes may be used. However, double valve syringes are more appropriate for use in 10 – 12 week gestation terminations of pregnancy.

Cannulae sizes:
A variety of cannulae from 4-12mm must be available for each procedure.

2.2 Re-use of MVA equipment

Syringes and cannulae may be re-used until no adequate suction can be produced.
The life expectancy of syringes is extended by proper cleaning after the procedure and applying silicon gel on a regular basis to the top of the plunger.

2.3 Processing of MVA Equipment for Re-use

See attached protocols for infection control and Manual Vacuum Aspiration instrument re-use.

2.4 Incomplete Abortions

Note: The Manual Vacuum Aspiration method should also be used for incomplete abortion procedures, since it involves huge cost savings.

Kindly ensure that these set policy and guidelines are brought to the attention of all concerned and is carried out.

Your co-operation and support is highly appreciated.

HEAD: DEPARTMENT OF HEALTH

PART 2

PROTOCOL FOR TERMINATION OF PREGNANCY SERVICES
DEPARTMENT OF HEALTH: WESTERN CAPE:

PREAMBLE

The changes in the protocols are based on evidence gathered since the implementation (February 1997) of the Choice on Termination of Pregnancy Act (1996). It may be necessary to revise these protocols in the future, as new evidence become available.

1. OUTLINE OF MANAGEMENT PROTOCOL:

- A client presenting at a primary care provider (clinic, community health centre, general practitioner), requesting termination of pregnancy, should have a full standard work-up (see 2).
- The client should be referred to facilities providing the TOP procedure (see referral flow chart).
- The procedure is Manual Vacuum Aspiration (MVA) under local anaesthesia/sedation.
- The client should have a follow-up appointment to ensure appropriate future contraceptive use.

2. CLIENT ASSESSMENT AND PREPARATION (see Referral letter):

- History- Complete medical history.
- Examination- Do physical examination, including abdominal palpitation, speculum and bimanual examinations.
- Pregnancy Test- Confirm pregnancy by urine pregnancy test.
- Indications to refer for ultrasonoghrapy:
    - Uncertain duration of pregnancy,
    - Signs and symptoms of ectopic pregnancy.
- Treat symptomatic STIs, using Syndromic approach.
- Do a Pap smear if necessary (refer to the policy, Circular H84/1995).
- Do the relevant investigations (Blood Grouping, Hb, RPR and Rh).
- Counselling should coverall aspects including the options open to client (see attached counselling guidelines).
- If TOP is accepted, the procedure should be fully explained the to the client (see attached patient letter).
- Complete the standard referral letter and hand it to the patient.
- Arrange a follow-up appointment to ensure continuity of contraceptive use and to do further post TOP counselling if necessary.

3. MANAGEMENT PLAN

Level of Care:

Primary Care: (if service is on-line)

- **<u>Arrange TOP Procedure</u>** if pregnancy gestation is <12 weeks and uncomplicated;
  - Give date for the procedure.

- **<u>Refer to hospital care if</u>:**
  - Pregnancy gestation assessed to be > 12 weeks;
  - Early pregnancy complications suspected (e.g. p.v. bleeding & abdominal pain);
  - The client has an acute or chronic medical condition, such as:
- Heart disease, Asthma, Diabetes, Anaemia, Blood clotting disorders, Seizure disorder, Alcohol or Drug abuse, suspected Ectopic pregnancy;
- Cervical stenosis or "juvenile cervix";
- Large fibroids (hampering determination of gestation age and/or MVA).

4. <u>APPLIED PHARMACOLOGY – Manual Vacuum Aspiration (MVA)</u>

The following are recommended but other alternatives may be used:

a) <u>Pain Control</u>:

<u>1st Level of Care:</u>

1. Pre-Operatively: **give one of the following:**
   - Paracetamol 1000 mg orally
   - Ibuprofen 400 mg orally
   - Diclofenac 75 mg orally

   Anxiolytics are indicated for very anxious patients:
   - Lorazepam 1mg orally
   - Diazepam 5 mg orally

2. **Intra Operatively:**
   - Paracervical Block, if needed (15-20cc Lignocaine 1%).
   - Good client-provider interaction "Verbocaine" (Reassuring communication).

3. **Post-Operatively:**
   - As Pre-Operatively

<u>2nd and 3rd Level of Care</u>

As 1st level.

Other possibilities:

<u>Systemic Analgesia</u>: * Fentanyl 100 micrograms IVI; } Use pulse oximeter
* Dormicum 5 mg IVI
(if available, <u>is expensive</u>).

N.B. In case of Respiratory Depression:

- Assist respiration with Ambu bag and oxygen;
- Reverse Fentanyl with Naloxone 0.4 mg IVI;
- Reverse Dormicum with Flumazenil 0.2 mg IVI.

b) Pre-Treatment (TOP Preparation):

Note: It is recommended that Misoprostol be used on-site only, if possible.

i) On-Site Regimen:

First Trimester TOP

- Misoprostol 2 tablets (400 micrograms) orally or vaginally on admission.
- The procedure can be done 2-3 hours later.
- Repeat Misoprostol 200 micrograms once only 4-6 hours later if the cervix is unfavourable;

Second Trimester TOP

1. **13-16 weeks gestation:**
   - Misoprostol 400 micrograms orally on admission.
   - Repeat 400 micrograms 6 hours later if needed (depending on status of cervix).
2. **17-20 weeks gestation:**
   - Misoprostol 400 micrograms orally on admission.
   - Repeat Misoprostol 200 micrograms 6 hours later if cervix is unfavourable.

   Further management according to circumstances.

ii) Off-Site Regimen:

Misoprostol 1 tablet (200 micrograms) at 16:00 and 1 tablets at 22:00 on the day before the planned procedure.

N.B. Provide instruction leaflet to the client about Misoprostol with details of nearest emergency gynaecological unit that she must go to in the event of excessive pain or bleeding (see attached).

c) Rhesugam IM Protocol

Anti D (Rh o) immunoglobulin prevents active immunisation of Rh-negative individuals exposed to Rh positive blood. It should be given to all Rh-negative women after a 2nd trimester TOP.

- Give 100 micrograms (500 international units) of Rhesugam intramuscularly within 72 hours of the termination of pregnancy

d) **Contraceptive:** - should be given on-site before discharge.

5. SURGICAL PROCEDURE-MANUAL VACUUM ASPIRATION (MVA)

08:00 Admit the client on the planned day;

- Inquire about Misoprostol use, occurrence of pain and bleeding;
- Ensure results of investigations are available (see 2. Assessment);
- Affirm gestation of pregnancy;
- Examine per vagina. The cervix should be favourable;
- Do MVA under light sedation/analgesia (see protocol);

(Procedure takes about 10 minutes and requires private room and 2 people, practitioner to do the procedure and an attendant to provide emotional support to the client).

- If the cervix is still unfavourable the MVA can be done with a paracervical block and cervical dilatation provided the practitioner has the necessary skill, if not,
- repeat Misoprostol (see regimen), review and perform MVA.
- In the rare case of persistent unfavourable cervix the client should be referred to a 2nd level hospital.
- Intravenous fluids for resuscitation and a referral route via ambulance must be available in case of complications.

Note: Physicians should continue with methods of TOP that have been used in the past, based on their clinical knowledge and competence.

6. POST PROCEDURE

- Check vital signs, bleeding and contraction of the uterus.
- Inspect the tissue removed from the uterus to ensure completeness (follow standard infection control protocols).
- Fill in appropriate notification forms (see notification guidelines).
- Monitor client recovery:

- Allow her to rest comfortably and observe for 1-2 hours;
- Check that bleeding and cramping have diminished and uterus is well contracted;
- If the client is Rh negative, administer Anti-D if necessary (see protocol).

Discharge if clinically stable, after ensuring the following have been done:

- Post-operative counselling and information on: signs of normal recovery; taking any prescribed medication; about routine personal hygiene, resumption of sexual activity and resumption of normal menses (within 4-8 weeks); signs and symptoms requiring immediate emergency attention,(including: prolonged cramping (more than a few days); prolonged bleeding (more than a few weeks); bleeding more than normal menstrual bleeding; severe or increased pain; fever, chills, or malaise; syncope (fainting); What to do and sources of emergency care if complications occur;
- Contraceptive counselling and provision;
- Arrange for further counselling with a social worker if required and/or requested;
- Arranged follow-up in 2-3 week, where it is convenient for the client.

7. Manual Vacuum Aspiration (MVA) instruments

7.1 Syringes

- For 1st trimester TOPs single or double valve syringes may be used;
- Double valve syringes are more appropriate for use in 10-12 week gestation TOPs.

7.2 Cannulae Sizes

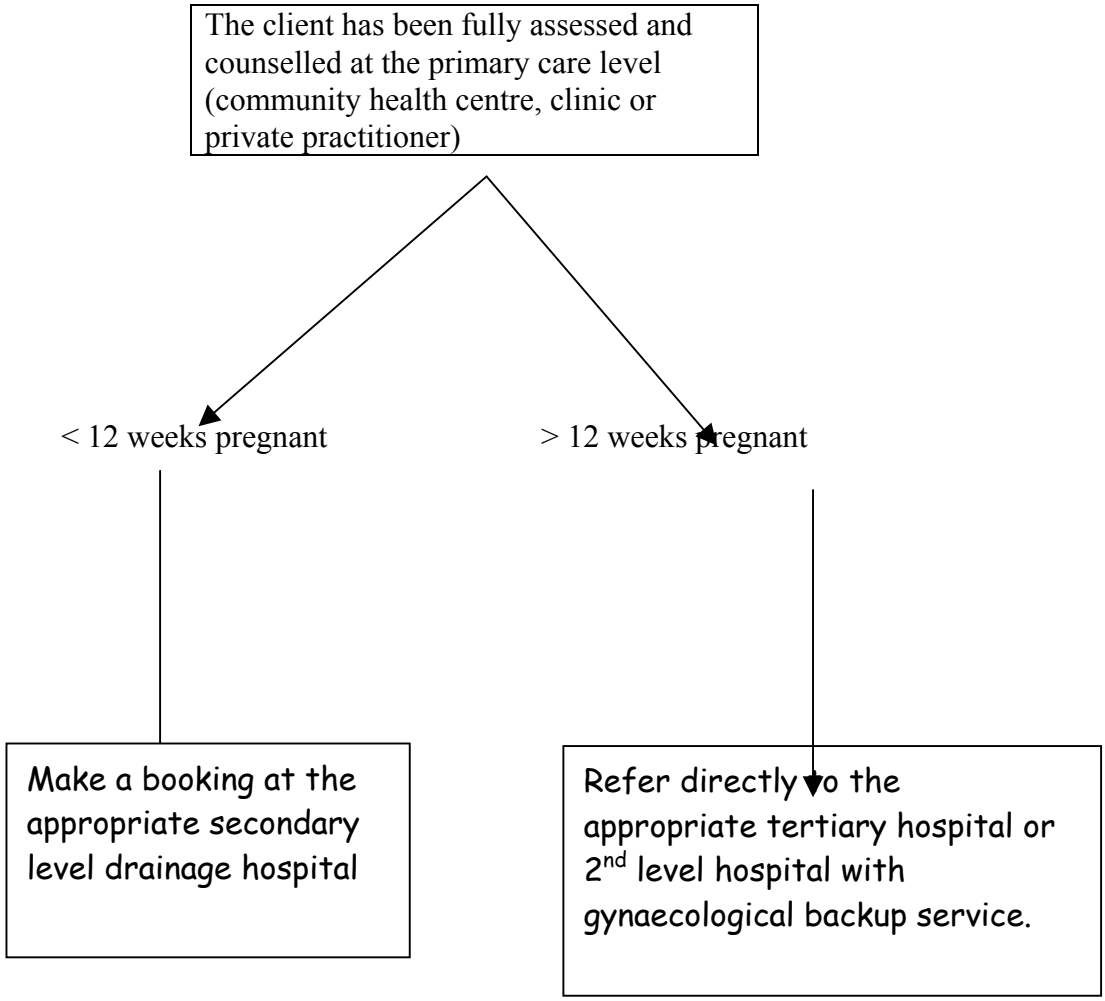
The size of the cannula used depends on the duration of the pregnancy, e.g. a 6mm cannula for 6-8 weeks gestation age.

8. Referral Letter and Client Information Letter/leaflet

Attached are examples of the above-mentioned documents that can be used by the relevant services (see Part 3).

9. Designated Facilities

Attached is a list of designated facilities for termination of pregnancy.
On-line means the facility is providing a service (see Part 5).



NOTE: The Marie Stopes Clinic (Tel 021- 418 0560) will terminate up to 16 weeks pregnancy at a cost of between R700 and R900 to the client. The waiting list is usually very short.

PAWC: DOH: TOP Protocol for Health Workers – January 2000
Western Cape TOP Protocol/ma

GUIDELINES FOR PRE-TERMINATION OF PREGNANCY COUNSELLING
DEPARTMENT OF HEALTH: WESTERN CAPE:

1. **What information should be given to a woman who requests a TOP?**

The health professional should inform the woman of her rights under the **CTOP Act, 1996** (Act No. 92 of 1996):

- She is entitled to a TOP on request within the first 12 weeks of gestation of her pregnancy (under certain circumstances her pregnancy may be terminated between the 13th and 20th weeks of gestation of her pregnancy).
- Only the woman's consent is required for the procedure. A minor should be advised to consult her parents, guardian, family member or friend. However, the TOP can not be denied, if she chooses not to consult them.
- Pre- and post- TOP counselling will be available.
- The locality of TOP service.

2. **What counselling should be given Pre-TOP?**

Counselling should provide sufficient information to assist the client to make an informed choice regarding the TOP.

The counselling should include the following aspects:

- Assuring the client of confidentiality;
- Listening to the reasons for the TOP request;
- Discussing the available alternatives to TOP (i.e. adoption or keeping the baby);
- Allowing the client to express her views, feelings, and concerns;
- Giving details of the termination of pregnancy;
- Ensuring that the client understands that once the Misoprostol has been taken, there is no turning back. The procedure must be completed;
- The available and suitable contraceptive methods for her use post- TOP;
- Respect and support the client's decision, without being judgmental.

GUIDELINES FOR INFECTION CONTROL AND MANUAL VACUUM ASPIRATION (MVA) INSTRUMENT REUSE

MVA instruments may be reused until there is no longer adequate suction.

Standard infection control practices and universal blood precautions, including hand washing, using barriers (masks, gowns, aprons, & gloves), safe waste disposal and protection from needle-sticks should be strictly followed.

Sterilization versus High-Level Disinfection (HLD)
Sterilization kills all micro-organisms, including bacterial endospores. When sterilization is not available, high-level disinfection is the only acceptable alternative method for processing the MVA cannulae. HLD destroys all micro-organisms including Hepatitis B virus (HBV) and HIV, but does not readily kill bacterial endospores.

The four basic steps for processing MVA instruments for reuse are as follows:

1. **Decontaminate** all instruments immediately after use, and before washing, to make them safe for staff to handle.

- Fill a plastic bucket with room temperature Biocide solution and place it next to the treatment table. Immediately after the MVA procedure, draw the solution through the cannula into the syringe and drop the instruments and into the bucket. Soak for *10 minutes only*. Using gloves, a pair of forceps or a strainer, remove instruments from the solution.
- Change the solution daily or more frequently if grossly contaminated.

2. **Clean** cannulae and syringe after decontamination by washing all the parts thoroughly in lukewarm with detergent (not soap, which may leave a residue).
- If tissue is trapped in the tip of the cannula, flush water through the cannula repeatedly or flick the tip of the cannula with fingertip.

DO NOT INSERT ANYTHING INSIDE THE CANNULA.
- Disassemble the syringe completely and open the valve(s). Clean all parts thoroughly, using a soft brush if necessary.
- Rinse syringe and cannulae thoroughly with clean water. Dry instruments with a clean towel or by air (do not place wet instruments into chemical disinfectant).

3. **Sterilize or HLD** cannulae and **disinfect** syringe after cleaning,
- Soak cannulae in Cidex for 20 minutes at room temperature (25 C) or boil for 20 minutes in clean water.
- Cannulae may also be gas sterilized.
- Soak syringe in Cidex or Hibitane in 70%Alcohol for 20 minutes.

The syringe need not be sterile. Low to mid-level disinfection is acceptable since it does not come into direct contact with the patient.
Note: Do not boil or autoclave the syringe (heat will crack the valve assembly).

4. **Store** HLD cannulae in a dry, covered sterile or LDH containers with tight-fitting lids.

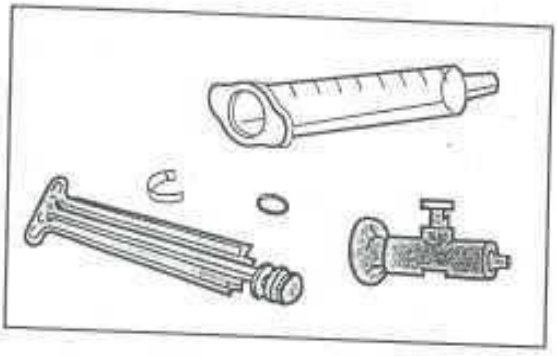
- Store only a few cannulae per container.
- To remove cannulae from the container, grasp the non-aperture end with sterile/HLD forceps.
- Re-clean and re-sterilize weekly if not used.
- Store disinfected syringes in covered containers/closed spaces, protected from dust and other contaminants. (Unnecessary to re-clean/re-disinfect unless contaminated).

Cleaning, Disinfecting and Maintaining Instruments

Drawing Biocide Solution into syringe

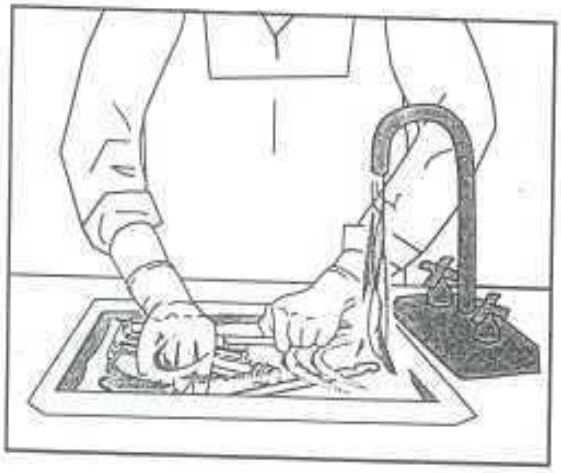
Placing Instruments in Biocide Solution

Removing Instruments from Solution

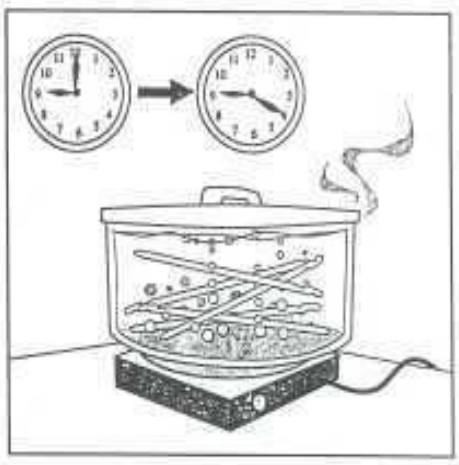


Disassembled Syringe

Removing the Plunger

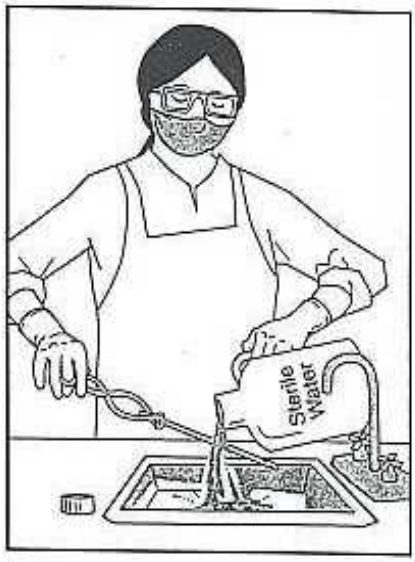


Washing Instruments

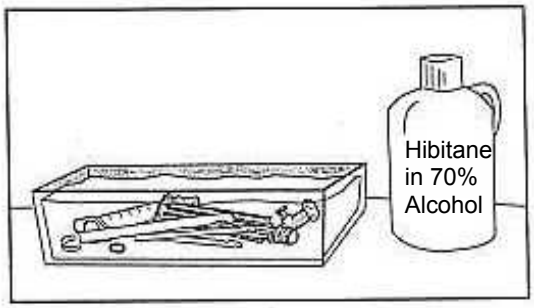


Boiling Cannulae for High-Level Disinfection

Sterilizing Cannulae

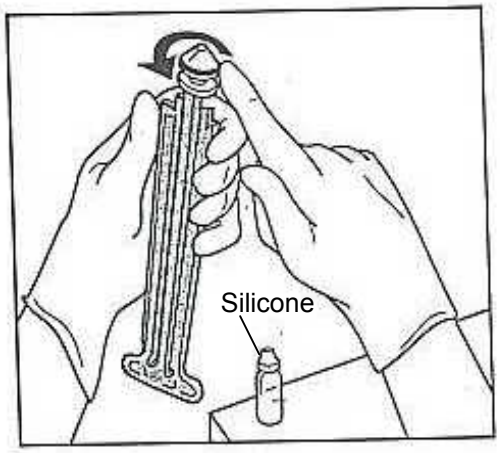


Rinsing Cannulae

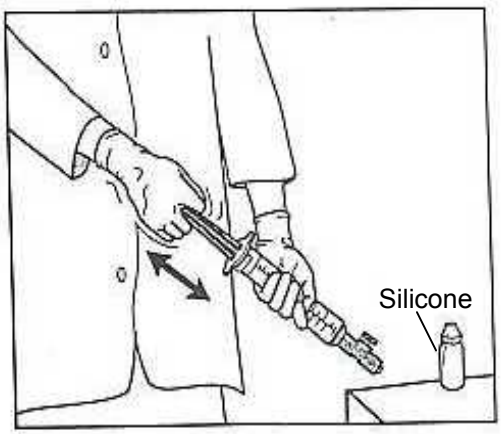


High-Level Disinfecting

Storing Cannulae



Lubricating Plunger O-Ring



Lubricating the Syringe

REFERRAL OF PATIENTS FOR TERMINATION OF PREGNANCY FROM PRIMARY LEVEL

Name of Patient: ……..

Date Seen: ……

Patient has been fully counselled, discussing the reasons for TOP, other options, patient's feelings, futurecontraception, Y N

Pregnancy confirmed (urine test or ßHCG) Y N

Date of last menstrual period ……..

Gestational age by dates ……..

Gestational age clinically (Pelvic examination) …….

STD or other co-existing disease treated Y N

Fully counselled about manual vacuum aspiration procedur (and patient letter given) Y N

Haemoglobin ……..

RPR ……..

Rh factor if > 12 weeks pregnant …….

Date of TOP booking …….

Post TOP family planning choice ……..

Patient to be referred back to primary health care worker Y N

Place of referral ……

Name of referring practitioner: …….…….

Signature of referring practitioner: ……..…

04/01/2000

Dear Patient,

You have an appointment for a termination of pregnancy (TOP) at ……hospital. This is the process that will occur:

Day of 1st appointment

When you arrive at the hospital at 8:00 with your letter from the CHC (Day Hospital), clinic or private doctor, a folder will be opened for you. A doctor will examine you. You must sign a form giving them permission to do the termination of pregnancy. You will then be given a date to come back to hospital for the termination of pregnancy procedure.

Day of termination of pregnancy

7:30 Be at hospital.
On admission you will be given two tablets to take. The tablets might give some stomach cramps, like "period pains" and you might have some bleeding. So take sanitary towels ("pads") with you. The termination will be done during the course of the morning. You should be discharged later the same day.

The termination

From start to finish takes less than ½ hour. You will also be given an injection or tablets for pain, which may make you drowsy, and you won't remember the procedure afterwards. The first tablets you took opens the mouth of the womb for the doctor so that he can clean out the womb. A plastic tube with a plastic syringe at the end of it sucks out any blood clots and material from the pregnancy. This part of the operation takes about 5 minutes. From the operating room you are taken back to the ward for observations, before you are discharged.

Things to remember:
- Letter for the hospital
- Sanitary towels (pads)

Most important

1. Family Planning
You are not "safe". You can fall pregnant quickly again so it is essential that you get a Family Planning method immediately.

2. Infection
Do not use tampons or have penetrating sexual intercourse for 2 weeks after the operation.
If you develop a discharge, temperature or cramps that won't go away, contact the hospital immediately.

3. Menstruation
This differs from person to person. There will be some bleeding similar to a period straight after the operation. This should not go on for more than 10 days. If there is a problem, contact the doctor at hospital.

Wishing you all of the best. 10/01/2000

PART 4

GUIDELINES FOR NOTIFICATION OF TERMINATION OF PREGNANCY / REMOVAL OF PREGNANCY PRODUCTS
DEPARTMENT OF HEALTH: WESTERN CAPE:

1. A form MUST be completed for every pregnancy ending prior to 24 weeks gestation period where there had been either:
   1. Termination of Pregnancy induced by medical methods
   2. Products of Conception removed by surgical procedure as managed by your institution.

2. The form includes the type of abortion, indication for Termination of Pregnancy and the consent of the patient.

3. In case of Termination of Pregnancy in terms of the Choice on Termination of Pregnancy Act, the signed consent form includes consent for management of any complications arising from the termination and may include a laparotomy or hysterectomy
   This consent is also valid for the treatment of removal of products of conception (other / spontaneous abortions).

4. The Annexure A form must be completed in duplicate. The top copy should remain in the patient's institution folder. The second copy, Annexure A : Anonymous Copy, without the patient identification, must be forwarded to the institution head.

5. The institution head is required to do the following:

   5.1 Collate the information from all the Annexure A: Anonymous Copies

   5.2 Transfer this information onto the Annexure C form (Monthly Notification of TOPs and Other Abortions)

   5.3 If TOPs as well as treatment for removal of products of conception (other / spontaneous abortions) were done that month – fax the Annexure C to the Regional Office as soon as possible after the month end.

   5.4 Arrange for the ORIGINAL Annexure C form, along with all the Annexure A: Anonymous Copies to be sent to the Regional Office. The National Office in Pretoria has indicated that they want the original Annexure C copy. The due date for receiving the original copy is the 8th of the following month. Please do not fax all the Annexure A: Anonymous Copies to the Regional Office.

   5.5 If no TOPs were performed, but treatment for other / spontaneous abortions was performed, forward the Original Annexure C to the Regional Office, plus the Annexure A: Anonymous Copies.

   5.6 A Nil return for TOPs is also required.

6. The Annexure A: Anonymous Copy arising from removal of products of conception (other / spontaneous abortion) are sent as is to National Office by the Provincial Office. This replaces the previous form GW 8/86

7. The copies that arise from TOPs will, in the interim, be sent as such to National Office. Plans for a computer programme for inputting the data are under discussion.

8. The Annexure A : Anonymous Copy replaces all other forms used to notify termination of pregnancy or removal of products of conception (other / spontaneous abortion)

9. In case of minors giving consent in terms of the Act, consent for management of the complications as outlined in Paragraph 3 also applies.

10. Institutions admitting women with complications of pregnancy termination initiated at other institutions, should manage the women appropriately. The institution head should notify the original institution of the complication. A new form should be completed and forwarded as in Paragraph 5.

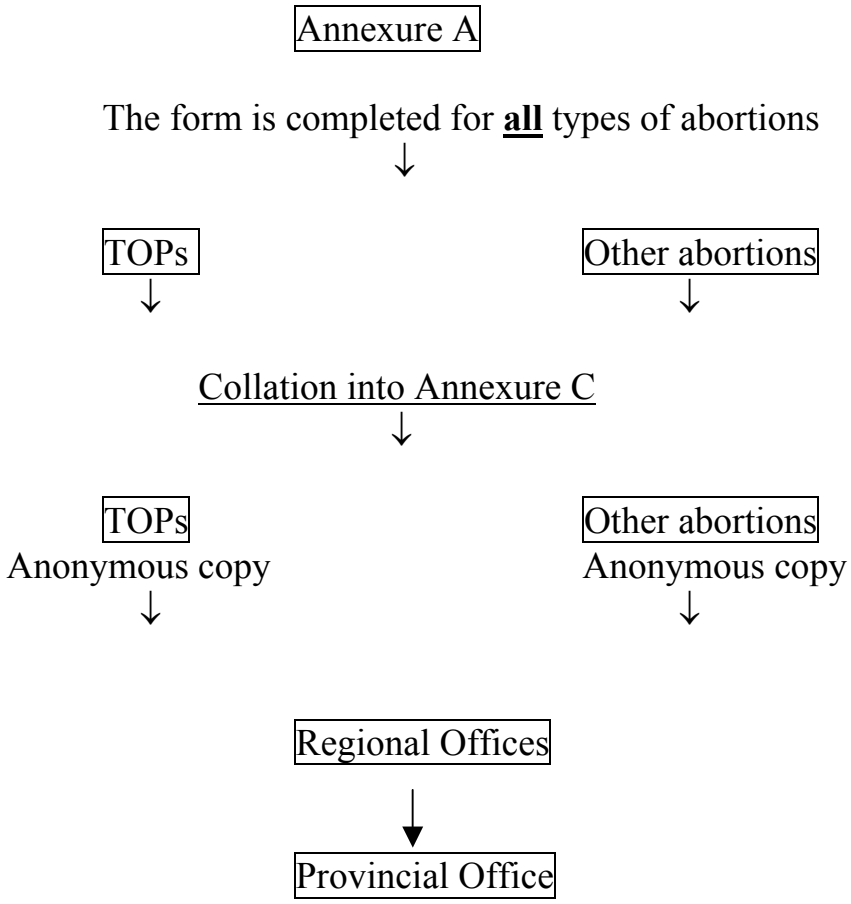
11. Maternal deaths arising from the complications of termination of Pregnancy.
The appropriate Maternal Death notification form needs to be completed and submitted for forwarding to the relevant health authority.

The aim of notification of abortions is to:

- Document the numbers of pregnancies terminated in terms of the Choice on Termination of Pregnancy Act.

- Document the procedure and complications related to abortions, either spontaneous or induced.

TOP NOTIFICATION FLOW CHART



MA,JtwN,NS