

Accessibility and Acceptability of women receiving Medical Terminations of Pregnancy at Kalafong Provincial Tertiary Hospital

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Abstract

Background: The South African Choice on Termination of Pregnancy Act was passed in 1996, legalizing a women's right to request a termination of pregnancy.¹ Despite this legislation, there are still a large number of women who seek out unsafe abortions, with estimates as high as 50% of all abortions.² Barriers to accessing safe and legal abortions at designated healthcare facilities is an important public health issue. In a study by Frederico et al during the period of 2014-2016, unsafe abortions were an avoidable factor in 24,8% of deaths due to miscarriage.³

Objectives: The aim of the study is to describe the population making use of the TOP service at Kalafong Provincial Tertiary Hospital (KPTH), to determine the accessibility and evaluate the experiences of the services provided and to evaluate the Mifepristone – misoprostol outpatient medical TOP regimen.

Methods: A prospective descriptive study was conducted at the KPTH Women's Health Clinic (KWHC), in Atteridgeville, Pretoria between February and April 2020. A self-administered questionnaire and the interviewer-administered follow-up questionnaire were anonymously completed.

Results: 245 participants completed the initial questionnaire, and 102 participants completed the follow-up questionnaire. Most of the study population were between the ages of 19 to 35 78.4% (n=193) and 9.8% (n=24) were between the ages of 16 and 18. 18.4% (n=45) of participants had a previous TOP. 9.8% (n=24) of participants said that they do not feel safe attending the KWHC for various reasons. Prior to falling pregnant, 65.3% (n=160) of participants were not making use of any contraceptive methods.

Conclusion: TOP remains a highly stigmatized topic. Comprehensive sexual health and contraceptive training, at KPTH and its feeder healthcare facilities is required to ensure a decentralization of TOP services. Youth-focused, community-based public health campaigns on safe sexual practices; appropriate timing of TOP and accessible and free contraceptive services are essential in addressing the age old need for TOP and associated maternal morbidity and mortality.

Keywords: Medical termination of pregnancy, medical abortion, termination of pregnancy, safe termination of pregnancy, abortion clinic, abortion services, TOP, Mifepristone, Misoprostol

Introduction

Since the introduction of the South African Choice on Termination of Pregnancy Act (CTOP) in 1996, there has been a substantial decrease in maternal death due to unsafe Termination of pregnancies (TOPs).^{1,2} Mbele et al demonstrated a drop in mortality index for women in Pretoria West from 21.7% to 2.0% (p = 0.02, RR 0.1, 95% CI 0.01-0.89) between the timeframes of 1997-1998 and 2003-2005. Unsafe abortions were an avoidable factor in 24,8% of deaths due to miscarriage between 2014-2016, highlighting the inaccessibility and lack of acceptable and safe

options for TOP for the majority of South African women.³

Almost two thirds of women in South Africa decide to go to a traditional healer or carry out self-induced abortions for reasons including: experiencing barriers to legal service use such as financial; not being aware of the CTOP Act and their options; not knowing of a legal facility in order to get a legal abortion early enough; and fearing maltreatment by healthcare professionals at legal facilities.⁴ Stigma from one's community and healthcare providers, as well as privacy concerns are two other factors forcing women outside of the legal system of abortion services.⁵

The most common reason for one's being denied a TOP is due to gestational age over 12 weeks.⁵ These women actively seek out other options - often illegal and "quick solutions" found through internet searches.⁵ Approximately 25% of TOPs performed in South Africa

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occur after 12 weeks gestation and as such, the denial of TOP services due to advanced gestational age demonstrates the need for more trained second trimester TOP providers. The Kalafong Women's Health Clinic (KWHC) provides both medical and surgical TOPs as per WHO guidelines for women with a gestational age of less than 12 weeks.⁸ Medical TOP using a combination of mifepristone 200mg per os followed by 800 micrograms of misoprostol 24 to 48 hours later either buccally, sublingually or per vagina is offered to all women <63 days pregnant. This regimen has been validated by the WHO and has an efficacy of up to 97% particularly in women <63 days pregnant.^{7,8} In contrast to surgical TOP which is labour intensive and time-consuming, women undergoing medical TOP can be managed as outpatients provided they meet the correct criteria.

According to unit statistics since the introduction of outpatient based medical TOP at KWHC the number of TOPS performed monthly has gone from 40 to 120 on average per month. There is currently only one other government facility in the Tshwane area, Laudium Clinic which also provides TOP services.

Data is lacking on the demographics, barriers to accessing the services and the experiences of the services provided to the population served by the KWHC. Information on this is essential to evaluate the inadequacies in the system and identify area of improvement.

The aim of this study was to describe the population making use of the TOP service at KPTH, determine the accessibility to the service and to evaluate their experiences of the services provided at KPTH.

Methods

The study is a prospective descriptive study conducted at the KPTH Women's Health Clinic, in Atteridgeville, Pretoria. All healthy pregnant women who attended the KWHC for TOP between February 2020 to April 2020, who were willing and able to provide consent to take part in the study were included. Exclusion criteria included women under the age of 16 years and women unwilling or unable to provide consent to take part in the study. The study was performed over a period of three months from February 2020 to April 2020. During this time 245 patients who attended the KWHC took part in the study.

Participants were requested to complete two different questionnaires with a combination of closed-ended and open-ended questions. The Initial Questionnaire and the Follow-up Questionnaire were developed with the aim of answering the objectives of the proposed study. Questionnaires were available in both English and Setswana. The self-administered initial questionnaire took approximately 10-15 minutes to complete. The follow up questionnaire was interviewer-administered and was completed at the two-week follow-up date for those who underwent a medical TOP. All data was collected anonymously. Completed questionnaires were placed in sealed envelopes and placed in a closed container, in a locked cupboard situated in the KWHC.

All data was captured on a password protected Microsoft Excel Spreadsheet with access limited to the principal investigator, statistician, and supervisor. Data was analysed using Microsoft Excel. Ethics approval was obtained from the Human Research Ethics Committee, University of Pretoria; number 630/2019.

Results

The KWHC reviewed 2406 women for possible termination of pregnancy (TOP) from November 2019 to November 2020, during which time 1205 TOPs were performed. The study was conducted in 2020 after ethics approval was attained and 245 women voluntarily enrolled and completed the questionnaire. Of the 245 women enrolled, 102 went on to complete the follow up questionnaire. This number was lower as only 44.5% (n=109) of the women were eligible for medical TOP after assessment at the clinic and others chose not to continue with follow interview.

Demographics

The majority of the study population were between the ages of 19 to 35 (78.4% (n=193)), and 9.8% (n=24) were between 16 to 18 years old. Results of demographics are depicted in table 1. We had data from 242 women about their highest level of education, of which 35.1% (n=86) have a tertiary level of education, while 61.6% (n=151) have only a secondary or high school level education. Alarming, 48.8% (n=119) of participants were unemployed.

Table 1: Showing participant demographics by age group

	AGE GROUP			
	16 – 18 years of age (n=24)	19-35 years of age (n=193)	>35 years of age (n=27)	Total n=244
PARITY				
Nulliparous	21 (8.6%)	59 (24.1%)	1 (0.4%)	81 (33.1%)
1	2 (0.8%)	72 (29.4%)	4 (1.6%)	78 (31.8%)
2	1 (0.4%)	41 (16.7%)	9 (3.7%)	51 (20.8%)
≥3	0	21 (8.6%)	13 (5.3%)	34 (13.9%)
HIV STATUS				
Positive	0	28 (11.4%)	7 (2.9%)	35 (14.3%)
Negative	22 (9.0%)	150 (61.2%)	16 (6.5%)	188 (76.7%)
Unknown	3 (1.2%)	14 (5.7%)	4 (1.6%)	21 (8.6%)
HIGHEST LEVEL OF EDUCATION				
Primary	1 (0.4%)	2 (0.8%)	2 (0.8%)	5 (2.0%)
Secondary	23 (9.4%)	111 (45.3%)	17 (6.9%)	151 (61.6%)
Tertiary	0	79 (32.2%)	7 (2.9%)	86 (35.1%)
Unknown	1 (0.4%)	0	1 (0.4%)	2 (0.8%)
RELATIONSHIP STATUS				
Single	23 (9.4%)	131 (53.5%)	17 (6.9%)	171 (69.8%)
In a Relationship	1 (0.4%)	58 (23.7%)	10 (4.1%)	69 (28.2%)
Unknown	1 (0.4%)	3 (1.2%)	0	4 (1.6%)
EMPLOYMENT STATUS				
Unemployed	7 (2.9%)	99 (40.4%)	13 (5.3%)	119 (48.6%)
Study/school	17 (6.9%)	59 (24.1%)	2 (0.8%)	78 (31.8%)
Employed	1 (0.4%)	31 (12.7%)	11 (4.5%)	43 (17.6%)
Unknown	0	3 (1.2%)	1 (0.4%)	4 (1.6%)

Current Pregnancy and Support

The majority of the study population presented within a gestational age appropriate for TOP (<12 weeks) and 18.4% (n=45) reported having a previous TOP. 44.5% (n =109) had a gestational age less than 9 weeks; 35.1% (n=86) had a gestational age between 9- and 12-weeks and only 2.9% (n=7) presented between 12 and 20 weeks. No one presented after 20 weeks gestation and 17.6% (n=43) of the study population were uncertain of their gestational age at the time of presentation.

Table 2 shows that over three quarters of the study population stated that the father is aware of the pregnancy 76.3% (n=187) while 22.9% (n=56) stated that the father was unaware of the pregnancy. Reasons for not informing the father about the planned TOP was documented in only 58 participants, 48.3% (n=28) of participants were no longer with the father and 36.2% (n=21) did not want to tell the father. The father was unknown in 3.4% (n=2) of cases and 12% (n=7) had other reasons for not informing the father, not specified.

Majority of women (88.6%) had informed at least one person that they were attending the KWHC on that day, 11% had not informed anyone. The decision for TOP was more likely to be discussed with friends 46.9% (n=115) than parents or other family members in 23.2% (n=57) versus the father 10.2% (n=25).

Table 2: Showing comparison between level of support amongst different age groups (n=59).

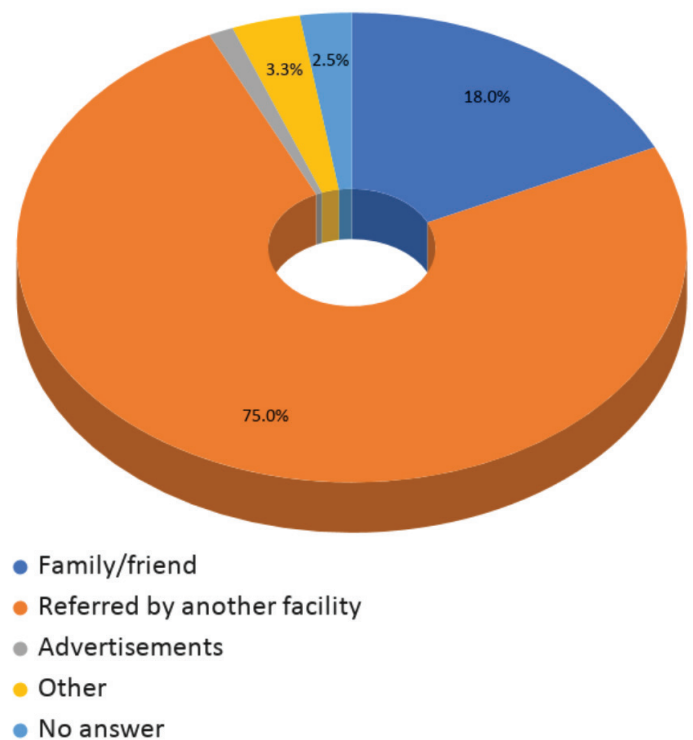
AGE GROUP				
	16 – 18 years of age (n=24)	19-35 years of age (n=193)	>35 years of age (n=27)	Total n=244
Does anyone know that you are here today?				
Yes	23 (10.9%)	173 (70.6%)	20 (8.2%)	217 (88.6%)
No	1 (0.4%)	19 (7.8%)	6 (2.4%)	27 (11%)
No answer	0	0	1 (0.4%)	1 (0.4%)
Is father aware of pregnancy?				
Yes	18 (7.3%)	151 (61.6%)	18 (7.3%)	187 (76.3%)
No	7 (2.9%)	41 (16.7%)	8 (3.3%)	56 (22.9%)
No answer	0	0	1 (0.4%)	1 (0.4%)
Reason why father doesn't know				
Primary	1 (0.4%)	2 (0.8%)	2 (0.8%)	5 (2.0%)
Secondary	23 (9.4%)	111 (45.3%)	17 (6.9%)	151 (61.6%)
Tertiary	0	79 (32.2%)	7 (2.9%)	86 (35.1%)
Unknown	1 (0.4%)	0	1 (0.4%)	2 (0.8%)
RELATIONSHIP STATUS				
Single	23 (9.4%)	131 (53.5%)	17 (6.9%)	171 (69.8%)
In a Relationship	1 (0.4%)	58 (23.7%)	10 (4.1%)	69 (28.2%)
Unknown	1 (0.4%)	3 (1.2%)	0	4 (1.6%)

EMPLOYMENT STATUS				
Unemployed	7 (2.9%)	99 (40.4%)	13 (5.3%)	119 (48.6%)
Study/school	17 (6.9%)	59 (24.1%)	2 (0.8%)	78 (31.8%)
Employed	1 (0.4%)	31 (12.7%)	11 (4.5%)	43 (17.6%)
Unknown	0	3 (1.2%)	1 (0.4%)	4 (1.6%)

Access to the TOP service

Before attending KWHC, 24.5% (n=60) had either initially visited another clinic and later been referred. 73.1% (n=179) had not visited any other facility prior to coming to KWHC. The study population had come to hear about the KWHC via a multitude of means, depicted in the pie chart below.

Pie Chart to show methods by which participants came to hear of WHC



Almost 10% (n=24) of the study population said that they do not feel safe attending the KWHC. The most common reason given was 'other' at 42%, followed by 38.7% who stated they were 'afraid someone will see them'. 'Unfriendly staff' was the reason that 19.4% of the study population felt unsafe at the clinic.

Family Planning

As seen in table 3, prior to falling pregnant, 65.3% (n=160) of study participants were not making use of family planning or contraception methods, 30.6% (n=75) used some form of contraception and 4.1% (n=10) gave no answer to the question. Only 69 study participants specify which primary method of contraception they were using prior to falling pregnant, namely - pills or oral contraceptives 50.7% (n=35); injectable contraceptives 39.1% (n=27); implants 5.8% (n=4); intrauterine devices (2.9%); and condoms 1.5% (n=1). 43.3% (n=106) of the study participants reported that they had previously

experienced side effects from family planning, depicted in the chart below.

In future, 90.6% (n=222) of study participants plan on making use of family planning. Injectable contraceptives 56.2% (n=114) were the most popular method of family planning, followed by pills (oral contraceptives) at 20.2% (n=41); implants (13.8% (n=28)); intrauterine devices 5.4% (n=11); sterilization 3.9% (n=8) and lastly, 0.5% (n=1) who stated the use of dual protection.

Post-TOP follow up group

One of the 102 (<1%) participants that underwent medical TOP and presented for follow up questionnaire had a positive pregnancy test at the two-week follow up post TOP using the mifepristone/misoprostol medical regimen.

There were no side effects reported from the medical TOP regimen in 23.5% (n=24) of the study population. Of those that experienced side effects, 52% (n=53) experienced heavy bleeding; 15.7% (n=16) had a vaginal discharge; 5.9% (n=6) had pain; 2% (n=2) had a fever; lastly 1% (n=1) developed an infection. Only 18.8% (n=15) used further medical treatment for side effects experienced. Bleeding post TOP mostly lasted either 0-3 days and 38.2% (n=39) experienced bleeding up to 7 days.

Family planning options were discussed with 91.2% (n=93) of the study participants who completed the follow-up questionnaire. Pills (oral contraceptives) were chosen by 16.7% (n=17), injectables by 54.9% (n=56), intrauterine device 14.7% (n=15), implants 2% (n=2), and no answer/none in 11.8% (n=12). Contraception use is documented in table 3.

The majority of the study population would recommend the TOP service to other people 88.2% (n=90).

Table 3: to compare family planning decisions between different age groups

	AGE GROUP		
	16 – 18 (n = 24)	≥ 19 (n= 220)	Total (n=244)
Were you making use of family planning prior to falling pregnant?			
Yes	2 (0.8%)	73 (29.8%)	75 (30.6%)
No	23 (9.4%)	137 (55.9%)	160 (65.3%)
No answer	0	9 (3.7%)	9 (3.7%)
What method were you making use of?			
No answer/not applicable	24 (9.8%)	151 (61.6%)	175 (71.4%)
Pills	1 (0.4%)	34 (13.9%)	35 (14.3%)
Implant	0	4 (1.6%)	4 (1.6%)
IUD	0	2 (0.8%)	2 (0.8%)
Injection	0	27 (11.2%)	27 (11.0%)
Condoms	0	1 (0.4%)	1 (0.4%)
If not using family planning, why not?			
Afraid of side effects	11 (4.5%)	82 (33.5%)	93 (38.0%)
Don't know about family planning	10 (4.1%)	6 (2.4%)	16 (6.5%)
Previous side effects	0	27 (11.2%)	27 (11.0%)
Don't believe in family planning	0	4 (1.6%)	4 (1.6%)
No answer	0	4 (1.6%)	4 (1.6%)

Side effects experienced from family planning			
Heavy bleeding	1 (0.4%)	24 (9.8%)	25.2 (10.2%)
Headaches	0	20 (8.2%)	20 (8.2%)
Weight gain	1 (0.4%)	19 (7.8%)	20 (8.2%)
Amenorrhoea	1 (0.4%)	34 (13.9%)	35 (14.3%)

Discussion

South Africa's laws surrounding sexual and reproductive health are both progressive and comprehensive and yet the accessibility for safe terminations of pregnancy is still low within our communities.⁶

In 2015, The Sustainable Development Goals were set out, one such goal was the attainment of universal access to sexual and reproductive health.⁷

Globally, between the year 2015 – 2019 there was an annual average of 73.3 million abortions - both safe and unsafe – with most induced abortions in women between the ages of 15-49 years. Unwanted pregnancies have a huge financial, social and psychological burden on women as well as their families and the community at large.⁸

In our setting we are yet to combat issues such as: poor access to reproductive healthcare and contraception; a lack of education around safe sexual practices; gender-based violence, sexual coercion and transactional sex; teenage pregnancy, unsafe and illegal abortions and the disempowerment of women resulting in the lack of control over their own reproductive health.^{9,12}

Demographics

Our study shows similar results to global statistics. Notably, close to 10% of our respondents fall between the ages of 16-18 years illustrating the need for greater youth-directed education and contraceptive services in our setting. A parity of 1 or more children was recorded in 12.5% (n=3) participants aged 16-18. This is worrisome and further illustrates the need for adequate contraception and education. Gauteng Department of Health recorded 23226 teenage pregnancies (15 -19 years) in the province between March 2020 and April 2021 with 19316 deliveries in the public sector further illustrating the public health issues around teenage pregnancy.¹⁸

Multiparity, unintuitively, is not a drawing factor for TOPs with the largest proportion of respondents having had either one living child or were pregnant for the first time at the time of their visit to the clinic. Most participants were single at the time of their visit to the clinic, perhaps highlighting the necessity of both relational and social support to complete a pregnancy.

Despite South Africa's 20.4% HIV prevalence in the general population and 30% prevalence among pregnant women, most respondents 76.7% (n=188), were actively aware of their negative HIV status. This is contrary to previous findings where knowledge of one's HIV status prior to one's first antenatal visit was low.¹⁰ Highlighting the success of antenatal education surrounding HIV and the presumed destigmatization of HIV in South Africa.

In South Africa, the current unemployment rate sits at 31.3% for women; much lower than the findings of our study where 48.8% (n= 119) of participants were unemployed. A lack of financial stability, often associated with a lower level of education or the lack of completion of studies, remains a key factor in the choice to opt for a TOP.^{11,12}

Barriers

Barriers surrounding accessibility are largely rooted in cultural and stigma-related issues, as is seen globally.⁶ The lack of knowledge of legal and appropriate healthcare facilities; fear of being seen by a known community member and the fear of maltreatment by healthcare providers are factors that negatively affected the experiences of many of our respondents. At hospital level creating a safe discrete environment for women attending the KWHC is essential and thus the renaming of the clinic to the Kalafong Women's Health Clinic was a step in the right direction to reduce stigma associated with TOP / Womens choice clinic as before.

Further barriers include the lack of money for transport to the correct healthcare facility, as women's first interaction with the healthcare system was usually at a facility that did not provide TOP services and thus needed to be referred to another facility.¹²

There is a clear lack of known services by the community and most respondents knew only of the clinic through word-of-mouth or through referral from another known healthcare facility, after enquiry. A decentralization of the provision of safe medical TOPs by offering these services at healthcare facilities such as Maternal Obstetric Units (MOUs), will increase accessibility to those within this community.^{8,12} Medical TOP for pregnancies <63days have a success rate of 97% and require very little intervention and are done on an outpatient basis, this could be offered at primary health care clinic level rather than dedicated TOP clinics not only improving access to TOP but most likely reducing stigma by attending a dedicated TOP clinic.¹⁵ Lastly, in a bid to improve access and information of safe free TOP services advertisements and government website information should be made readily available to the public.

Services Received

The perceived notion of possible ill-treatment by hospital staff at legal healthcare facilities did not hinder the experiences of most respondents who reported positive experiences at every level of interaction at the hospital. Respondents recounted feeling safe; being well informed of the TOP process; receiving comprehensive information on their contraception choices; and positive attitudes of the healthcare providers at the facility. This demonstrates the dedication of the midwives who so passionately dedicated their time to the KWHC.

However, some patients' experiences were less positive, having experienced untoward comments from administrative workers surrounding the want to seek out TOP services; and xenophobic remarks directed at respondents by both healthcare providers and administrative staff. Training of all hospital staff on professional and non-judgementalism is important in the destigmatization of TOPs along with decentralization of services for early pregnancies of <63 days.

Contraception

The Contraceptive Prevalence Rate (CPR), a measure of women aged 15-49 who are currently using contraception, is currently 60% and has been at this level for almost 20 years.⁶ In the study only 30.6% of the participants reported using contraception and less than 8.5% of the teenager that present for TOP. This ultimately highlights the argument that without efficient sexual education and easy access to good quality contraception unwanted and unplanned pregnancies will continue to be a significant public health issue.

The poor use of contraception prior to a respondents visit-

including the majority of teenagers - can be largely attributed to misinformation; a lack of information regarding one's contraception methods; concerns of side effects despite most respondents having never personally experienced these side effects; and biased counselling from healthcare providers - either intentionally or unintentionally.^{6,12}

Post TOP, the majority of respondents left with some form of contraception, mostly short-acting methods such as injectables or oral contraception. This can be attributed to contraceptive health counselling as respondents confirmed that they felt they were well and adequately informed of their contraceptive method options from the healthcare workers at the facility. There is room for improvement on counselling regarding contraception as this should be at 100% however there are challenges in this resource restricted setting. Educational contraceptive videos in the waiting area and hand outs are a consideration to improve counselling on contraceptives.

Safety

The medical TOPs were performed as per the WHO Guidelines of Medical Termination of Pregnancy, under the guidance of 3 trained professional sisters and a rotating doctor to perform sonography to confirm a gestational age of less than 12 weeks.¹⁰

The most common side effects experienced included bleeding; discharge and pain, the majority of which were self-limiting. No major complications such as haemorrhage and infections were noted and there was no need to seek further medical care by any of the respondents. One patient, <1% reported having a positive pregnancy test at 2 weeks post medical TOP thus indicating that the success of the TOP was higher than the documented 97% in the literature.^{17,18} TOP was acceptable and safe as an outpatient-based regimen in this community.

Weaknesses & Limitations

The topic of sexual health and reproduction is a sensitive one, with TOPs being one of the most taboo subjects of discussion. Many questions were left unanswered or only partially answered which could be attributed to the sensitivity of the topic broached in these questions. It is understandable that many questions may have left respondents feeling uncomfortable. Less than 50 % of women who answered the initial questionnaire qualified for medical TOP and thus did not present for the follow up questionnaire. Even then there was also some loss to follow up that could introduce bias as 7 women underwent medical TOP and did not return for 2 week review possibly impacting assessment of safety and efficacy of this out patient regimen.

Poorly answered questions were mostly questions that followed-on from a previous question asked. Poor phrasing or a lack of clarity of the questions posed may also have played a role in the poor response to some questions.

A lack of follow up, as seen by our decreased population of respondents that completed the follow-up questionnaire further demonstrates the sensitive nature of the topic and the stigma it holds.

Conclusion

TOP remains a highly stigmatized topic within communities and with health care service providers.^{12,18} Appropriate and comprehensive training on sexual health and contraceptive counselling, specifically on LARCs, at Kalafong Provincial Tertiary

Hospital and its feeder healthcare facilities is necessary. Teenage pregnancy remains a huge public health issue particularly in Gauteng and improved adolescent contraceptive services would limit the number of TOPS required and furthermore prevent teenage pregnancy which comes with its own implications.¹⁴

The decentralization of TOP services is dependent on the increased training of healthcare providers at primary and secondary level healthcare facilities in the provision of TOPs – both medical and surgical however medical outpatient-based TOP regimen using mifepristone is safe and effective and could easily be administered at MOU level with minimal need for increased financial input or training.^{10,18} This would reduce stigma as women would be managed in MOUs and would allow the overburdened KPTH clinic to focus on more complicated TOPs and consider opening services to those women that are >12 weeks gestation. The medical TOP outpatient-based regimen using Mifepristone 200mg and Misoprostil 800 micrograms 24 – 48 hours later is safe and effective with similar efficacies and safety seen in other studies.^{16,18}

There is a clear lack of known TOP services in the community and community-wide public health campaigns to educate communities on the facility; services offered; the working hours of the clinic; appropriate timing of TOPs; and health and safe sexual practices are required with specific engagement with the youth – both male and female.

Further research into this topic at other facilities within South Africa is important to be able to compare techniques and programmes of sexual health and reproductive services. This information will be able to better inform national responses and programmes.

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