

**STRATEGIC PRIORITY 3: A WORKFORCE FOR NEW SERVICE STRATEGIES  
ENSURING VALUE FOR MONEY**

*Strategic objective 3: To meet workforce requirements of new and emerging service strategies and thereby ensure a health service which promotes health and provides value for money*

<b>Objective 3.1</b>	<b>Implement the re-engineered PHC model through creating the new structures and ensuring the health cadres are skilled and employed as required (Community Outreach teams, District Clinical Specialist teams, school health nurse teams)</b>
Activity 3.1.1.	Implement the District Clinical Specialist Team model – develop job descriptions, advertise posts, facilitate appointments and financing, detail scope of practice and competency requirements, training requirements, monitor placement and progress.
Activity 3.1.2.	Implement the School Health programme – detail the job description, detail skills, competencies and training requirements, train nurses, appoint nurses and implement the programme, monitor progress.
Activity 3.1.3.	Implement the Community Outreach Team model – enable implementation of the Provincial Guidelines for training and appointment of Community Health Workers, train the first 5,000 CHWs by December 2011, enable appointment of nurses for leading the Community Outreach teams, ensure appointment of Outreach teams and monitor progress.
Activity 3.1.4.	<p>Remodel provincial district health staffing structures to fit the re-engineered PHC model:</p> <ul style="list-style-type: none"> <li>• Develop policies and interventions on task-shifting and task sharing</li> <li>• Develop policies and interventions on multi disciplinary working and a referral system for the re-engineered PHC system health cadres</li> <li>• Identify up skilling/broadening of skills training required for health cadres in employment who will become part of the re-engineered PHC system and commission the training</li> <li>• Establish a process for all health professional associations and councils to review their scopes of work to promote task-shifting for re-engineered PHC system</li> <li>• Develop and institutionalise job profiles, person specifications, competence frameworks, terms and conditions and registration requirements for new and realigned jobs/cadres</li> <li>• Based on policy directives, quantify the numerical (competent people) and financial (remuneration, goods and support services) need for district outreach teams, school health nurses, CHWs, specialist teams, and other district staff and oversee the plan for securing finance and implementation.</li> </ul>

<b>Objective 3.2</b>	<b>Establish and sustain Public Health units at district and provincial levels</b>
Activity 3.2.1.	Define the job description and career path for Public Health specialists and public health professionals in an NHI service delivery framework.
Activity 3.2.2	Establish an NDoH Public Health Unit and Public Health Units in provinces, and facilitate appointments of public health specialists.
Activity 3.2.3.	The provincial Public Health Unit leaders will develop public health strategies for each province and work with district health managers to develop district health strategies.
Activity 3.2.4.	The provincial Public Health Unit leaders will develop a monitoring and evaluation framework evaluating the outcomes of the three stream re-engineered PHC model.
<b>Objective 3.3</b>	<b>Develop staffing norms for tertiary hospitals, regional and district hospitals to ensure a balanced health system</b>
Activity 3.3.1.	Develop the service model for hospital services and the staffing norms (informed by the Modernisation of Tertiary Services Model and other work on staffing norms for hospital services).
Activity 3.3.2.	Develop adjusted norms for service sites which serve as a training platform for health professionals.
Activity 3.3.3.	Collaborate with relevant role players in the development of staffing norms for hospital services (Five Flagship Hospitals Project, provincial departments of health etc.).
Activity 3.3.4.	Detail the HRH requirement implications of the proposed staffing norms for hospitals and evaluate the financial affordability of staffing model options.
<b>Objective 3.4</b>	<b>Formulate public/ private sector contracting arrangements for primary care</b>
Activity 3.4.1	Develop policies and interventions on private sector role and engagement in the public health system at primary care level starting with pilot projects for General Practitioner, rehabilitative, mental and dental services.
<b>Objective 3.5</b>	<b>Detail the HRH requirements for the NHI service delivery model</b>
Activity 3.5.1.	Work with the NHI Ministerial Advisory Committee to determine HRH requirements for the NHI service delivery model as the model is formulated.
<b>Objective 3.6</b>	<b>Develop health workforce plans to staff health services which align to HR and Service Transformation Plans and provide a basis for MTEF budgeting for 2012/13 – 2016/17</b>
Activity 3.6.1.	Develop detailed staffing requirements for minimum staffing in all services, and submit MTEF requirements for strengthened staffing establishments.
Activity 3.6.2.	Ensure planned funded posts for health professional graduates within affordability parameters.

## **STRATEGIC PRIORITY 4 : Upscale and Revitalise Education Training & Research**

### **Planned expansion of the health workforce to be accompanied by retention**

The health workforce in many facilities is overworked due to service demand and staff shortages. The NDoH is committed to expansion of the numbers of doctors, nurses and other health professionals. Alongside expansion, review of existing practice is proposed, where appropriate, to change the ways staff work and productivity, to enhance skills and ensure retention of health professionals. The strategy is to realise the potential of the existing workforce, and expand where it is necessary. Expansion and recruitment must be carefully planned to avoid the 'boom and bust' scenario. A concurrent activity to expansion is to ensure a meaningful working environment and the funds for employing professionals on graduation.

### **Recruitment of foreign trained health professionals**

In the short term to medium term, the next five years, it will be necessary to selectively recruit health professionals, especially doctors from abroad, especially South African doctors. The strategy must be carefully targeted and ensure transfer of skills and benefit to the South Africa health system and South Africa health professionals. Priority will be given to recruiting academic health professionals who will train, transfer skills, and develop innovative service and health care interventions; and health professionals willing to work in rural areas. This process will need to be undertaken in consultation with the Higher Education Institutions involved in training health professionals and provincial departments of health.

### **Expansion projections and improved career pathways**

Expansion of most categories of the health professions and health cadres is required. Initial modelling on expansion has been undertaken as part of the HRH Strategy development process. Proposals on expansion for each profession on a 14-year time frame are reported in Section 6 on 'Forecasting and Modelling the Health Professions'. Higher Education Institutions and the professions will be encouraged to review these initial proposals and be part of a process of more refined forecast modelling based on information informed by service plans and current status of the professions. Improved career pathways for the professions will need to accompany the expansion and development process.



### **The transformative role of education and development of 'change agents'**

To have a positive influence on the functioning of health systems and effect a transformative role on the health outcomes of patients and populations, educational institutions have to be 'designed to generate an optimal instructional process' which the Lancet special edition on 'Education of Health Professionals for the 21<sup>st</sup> Century'<sup>35</sup> defines as the four C's. The four C's are:

- i. *Criteria for admission* which include both achievement variables, such as previous academic performance, and admission variables such as social origin, race or ethnic origin, sex and nationality;
- ii. *Competencies* as they are defined in the curriculum, which must meet future health and service needs;
- iii. *Channels of instruction* by which is meant the teaching and training technologies, methodologies, modalities and communication media;
- iv. *And career pathways*, which are options graduates have on completion of their professional studies, as a result of the knowledge and skills they have attained, the process of professional socialization to which they have been exposed as students, and their perceptions of opportunities in local and global labour markets.

Different configurations of how the educational institutions are led, governed and financed, and 'instructional design' will lead to varying education outcomes. Making the desired results explicit is necessary in order to ensure the desired outcomes. Necessary to ensuring a desired outcome is the interdependence of the education system and the health system, the recognized transformative role of the education system, and 'the harnessing of the power of global pools and flows on knowledge and other resources'. The transformative role of health professional education in the 21<sup>st</sup> Century is about developing leadership attributes and producing enlightened and professionally capable change agents.<sup>36</sup> In this way education becomes a crucial component of the building of the future health system.

### **The requirements of health professional education for the future are challenging**

Health professional education needs to address primary health care priorities, ageing, changing patient populations, cultural diversity, chronic diseases, care-seeking behavior and heightened public expectations. In addition to professional specific education and training, the competencies developed by

<sup>35</sup> The Lancet, Health Professionals for a New Century, Transforming Education to Strengthen Health Systems in an Interdependent World, A Global Independent Commission, December 2010, p13.

<sup>36</sup> The Lancet, Health Professionals for a New Century, Transforming Education to Strengthen Health Systems in an Interdependent World, A Global Independent Commission, December 2010, p53.

all professionals need to include patient-centered care, interdisciplinary teams, evidenced-based practice, continuous quality improvement, use of new informatics, and integration of public health. Research skills should be taught and a culture of critical inquiry developed. Competencies in policy, law, health economics, management and leadership should also be part of health professional education as it affects the particular professions. Undergraduate education should prepare graduates for lifelong learning. This is the vision of the Lancet on health professional education and it poses challenges to HEIs to ensure the development of graduates who are change agents and can meet health challenges of the future.

### **The training environment**

Professional education is deeply affected by the available environment for clinical training. Academic systems must not only expose trainees to specialized professional care in tertiary centres but also to have a broader exposure to the range of practice environments at community level and in areas of health care need. This has been policy of the NDoH and Faculties of Health Sciences in the past fifteen years. However implementation of this approach requires resources and the appropriate funding streams have not been available for implementing new training sites. Primary health care training should be seamlessly integrated into the academic system. Academic systems must provide a balanced environment for the education of health professionals through engagement with local communities, to proactively address population based prevention, anticipate future health threats, and to lead in the design and management of the health system.

### **Teamwork, inter-professional education and task shifting**

Teamwork has grown in importance with the transformation of health systems. New disease patterns and care patterns require new ways of working together as teams. Patient care is a series of transitions from home to hospital and rehabilitative facilities engaging with a host of multidisciplinary professionals in the process. Team based learning can prepare students for effective and collaborative working relationships.

Inter-professional education can involve the students of two or more professions working together. This approach is now being proposed internationally as an instructional tool for health professional education. Although a simple concept, inter-professional education is difficult to implement and requires resources in the form of educators with new skills and an appropriate training environment.

Task sharing and task shifting, definition of new scopes of practice and competencies, new professional categories and new training programmes all need to be defined in a dynamic process to ensure health professionals which meet the needs of the future.



**STRATEGIC PRIORITY 4: UPSCALE AND REVITALISE EDUCATION, TRAINING AND RESEARCH**

*Strategic objective 4: To ensure the revitalisation of the production of a health workforce with the skills mix and competencies, education and training, to meet health service demand*

<b>Objective 4.1</b>	<b>Review HRH SA strategy scenarios and develop proposals for scaling up graduate output in line with projected service requirements and based on review of the professions and new categories</b>
Activity 4.1.1	<p>NDoH, in consultation with the Forum on Health Professional Education and Development, to develop reports for future growth on each professional category within the following broad professional groups. The reports should detail the burden of disease, service requirements, and training requirements for:</p> <ul style="list-style-type: none"> <li>• Medical practitioners, dental practitioners and specialists</li> <li>• Nurses including priority new categories and specialist nurses</li> <li>• Allied health professionals</li> <li>• Public Health professionals</li> <li>• Clinical support professionals/ Mid Level Workers</li> <li>• Management, IT, scientific and finance/economics professionals</li> <li>• Scarce skills</li> <li>• The technical, logistic and procurement support workforce.</li> </ul>
<b>Objective 4.2</b>	<b>NDoH with HEIs and DHET to plan faculty and campus growth for 2030</b>
Activity 4.2.1.	HEIs to implement the plan for the Minister of Health on the expansion of MBChB students.
Activity 4.2.2.	HEIs to engage with the proposals for expansion of the health professions (produced in Objective 4.1) and to develop planned expansion in education and training for the medium term (next 5 years).
Activity 4.2.3.	HEIs to detail plans for rural campuses and peri-urban training sites in areas of health need.
Activity 4.2.4.	HEIs to detail education and research bursary strategies for the development of specific health sector professions (clinical and non-clinical) and certain student groups (rural and disadvantaged).
<b>Objective 4.3</b>	<b>Implement an integrated strategy to strengthen the nursing profession</b>
Activity 4.3.1.	A Task Team appointed by the DG will ensure the elaboration and implementation of the outcome of the Nursing Summit.
Activity 4.3.2.	<p>The Forum on the Nursing Profession will develop a strategy for the nursing profession. The strategy will include the following:</p> <ul style="list-style-type: none"> <li>• Ensure that the scope of practice and level of competence of nurses is</li> </ul>

<p>Activity 4.3.3.</p> <p>Activity 4.3.4.</p>	<p>adequate for the delivery of quality and effective PHC &amp; hospital services</p> <ul style="list-style-type: none"> <li>• Develop a strategy to promote and maintain professionalism in nursing</li> <li>• Develop national and sector-specific plans (private and public) for requirements for all key categories nurses to meet the health service needs</li> <li>• Finalise the location of nursing education in the higher education training framework</li> <li>• Strengthen the capacity of nursing education institutions to increase production and improve the quality of graduates in accordance with the human resource plan for nursing</li> <li>• Ensure implementation of recommendations of the Nursing Summit 2011.</li> </ul> <p>NDoH will implement an effective regulatory framework for nursing practice and education and training in accordance with the requirements of the Nursing Act, 2005.</p> <p>NDoH in consultation with HEIs and provincial departments of health, will expand the training of nurses, especially the development of the new staff nurse and specialist nurses as a matter of urgency.</p>
<p><b>Objective 4.4</b></p>	<p><b>Plan the development and institutionalised training of Mid Level Workers</b></p>
<p>Activity 4.4.1.</p> <p>Activity 4.4.2.</p> <p>Activity 4.4.3.</p> <p>Activity 4.4.4.</p> <p>Activity 4.4.5.</p> <p>Activity 4.4.6.</p>	<p>Undertake an audit of MLW's.</p> <p>In consultation with provincial departments of health and HEIs develop a plan for growth of specified categories and their competencies and scope.</p> <p>Develop the service plan needs for MLWs.</p> <p>Identify the training platform for planned MLW's and ensure funding of training.</p> <p>Ensure Clinical Associate training is funded, expands to meet district hospital needs, and that posts are opened in the public sector for new CA graduates.</p> <p>Assess national capacity to increase Advanced Pharmaceutical Assistant training and facilitate additional student intake according to modelled demand for re-engineered PHC.</p>
<p><b>Objective 4.5</b></p>	<p><b>Revitalise clinical research and innovation capacity in HEI's</b></p>
<p>Activity 4.4.1.</p> <p>Activity 4.4.2.</p> <p>Activity 4.4.3.</p>	<p>Collaborate with the HEIs, Academy of Science and the NDoH Committee on Clinical Research to implement nationally prioritised clinical research programmes to improve research skills and develop service and clinical interventions.</p> <p>Support the National Clinical Scholars Programme to produce 10 PhDs and appoint 30 research 'Chairs' in 10 years.</p> <p>Enable funding for clinical research.</p>

<b>Objective 4.6</b>	<b>Ensure the effective public sector financing of health professional training and development</b>
Activity 4.6.1.	Review and make recommendations of the financing of health professional development, taking into consideration proposals in Strategic Priority 5 on the financing of Academic Health Complexes.
Activity 4.6.2.	In cooperation with DHET to ensure the planned expansion of the Clinical training Grant and for inclusion of all relevant professional programmes which have a clinical training requirement.
Activity 4.6.3.	Develop a reporting framework for 'ring fenced' funding of registrars posts in consultation with the Project Team responsible for Strategic Priority 5.
Activity 4.6.4.	Effectively implement revised/new professional education and training funding mechanisms.
<b>Objective 4.7</b>	<b>Planned training of health professionals outside of South Africa</b>
Activity 4.7.1.	Evaluate existing training programmes outside of South Africa.
Activity 4.7.2.	Identify appropriate postgraduate training outside of South Africa for medical and other health professionals and develop the appropriate bursaries.
<b>Objective 4.8</b>	<b>Planned growth of academic clinicians in HEI's</b>
Activity 4.8.1.	HEIs to develop proposals and plans for requirements and posts for academic clinicians linked to scaling up of output of health professionals.
Activity 4.8.2	HEIs to be encouraged to develop collaborative initiatives between South African HEI's, and institutions recognised for excellence internationally, to strengthen South Africa academic training capacity in the health professions for implementation of the NDoH HRH Strategy: HRH SA.
<b>Objective 4.9</b>	<b>To identify and elaborate additional sources for financing and for resources for the education and development of health professionals</b>
Activity 4.8.1.	To identify additional sources of finance for the education and training of professionals locally and internationally.
Activity 4.8.2.	To identify relevant clinical training sites to enhance exposure and resource clinical training of health professionals.



## STRATEGIC PRIORITY 5 : Academic Training and Service Platform Interfaces

### The role of Academic Health Complexes and training colleges

Academic Health Complexes (AHCs) and academic medicine have a critical role to play in the health system. The development of strong AHCs is central to the development of the health system financed through National Health Insurance. Other training platforms such as Nursing Colleges, Ambulance Colleges and provincial training colleges also are also critical to the development of health professionals and the health system. Strengthening the health service training platforms is a priority for the HRH SA Strategy.

### The legislation on Academic Health Complexes

The Health Act 2003 provides the legal framework for the development of AHCs:

#### ***“Establishment of academic health complexes***

- 51.** *The Minister may, in consultation with the Minister of Education, establish*
- (a) Academic health complexes, which may consist of one or more health establishments at all levels of the national health system, including peripheral facilities, and one or more educational institutions working together to educate and train health care personnel and to conduct research in health services; and*
  - (b) any co-ordinating committees that may be necessary in order to perform such functions as may be prescribed.”* Page 58.

Consultation with the national Minister of Education is required as according Schedule 4 (Part A) of the Constitution higher education is specified as being an exclusive national competence. An organisational arrangement is therefore required which integrates the education, service and research functions of the mission of Academic Health Complexes.

### Academic medicine

Academic medicine is a complex endeavour at the heart of the health system. Academic Health Complexes are the organisational home of academic medicine and need to provide the appropriate governance, financing mechanisms and work environment to ensure the objectives of academic medicine can be achieved. A definition of academic medicine is as follows:

*“Academic medicine encompasses looking for better ways of promoting health, preventing disease, understanding health and disease processes, making a diagnosis, and improving patient care by basic and applied research and by using evidence based medicine and rational policies. It also includes conducting research into psychosocial and societal aspects of health and disease,*

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*looking for a better understanding of patient and community needs; studying bioethics and ensuring that the fruits of all of these studies are translated into policy and practice. Academic medicine demands that the efficacy of all new processes is carefully assessed and that all knowledge gained through the preceding processes is widely disseminated via teaching, refresher courses, publication and presenting work at congresses".<sup>37</sup>*

### **A process to strengthen Academic Health Complexes**

To enable the up scaling of the development of health professionals, a strengthening of the environment in which they are trained is necessary, specifically Academic Health Complexes. The 2010 Report of the Colleges of Medicine of South Africa, which reflected work done over two years by the CMSA Governance Task Team,<sup>38</sup> proposed elements of a process for strengthening Academic Health Complexes. This included refining the definition of AHCs, accreditation, organisational arrangements and financing arrangements.

### **Definition of an Academic Health Complex**

The CMSA proposed a draft definition of the South African concept of an Academic Health Complex which could be considered by stakeholders:

#### **Academic Health Complexes:**

- may consist of one or more health establishments at all levels of the national health system, including peripheral facilities;
- may take different organisational forms;
- may include one or more educational institutions working together to educate and train health care professionals at under- and postgraduate level in health promotion, disease prevention, and curative and rehabilitative medicine at primary, secondary and tertiary levels;
- have integrated governance and leadership structures that have assumed the role of strategically and operationally managing both healthcare and relevant academic resources;
- undertake educational and research activities which increase knowledge and understanding of health and disease;
- use knowledge and evidenced based research as the basis for treating illness and improving health;
- design and test new models for improved clinical care, service delivery and improvement of population health;
- advise government on population health and health care.

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<sup>37</sup> The late Kirsch R.E., A New Vision for Academic Medicine, page 2, Presentation to the CMSA Project on The Strengthening of Academic Medicine and Specialist Training: Governance Group Meeting 21<sup>st</sup> February 2009

<sup>38</sup> The Colleges of Medicine of South Africa Report: Project on Strengthening Academic Medicine and Specialist Training, Section 2.2: Strengthening Academic Health Complexes: An Issue of for the Future of Academic Medicine, 2010.



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### **Criteria for being accredited with Academic Health Complex Status**

In order to ensure standards for the training environment, an accreditation process is proposed for Academic Health Complexes. Criteria for the 'accreditation' of Academic Health Complexes in South Africa could include strategic and operational criteria. Strategic and operational criteria are proposed below.

#### Possible criteria for Academic Health Complex status in South Africa:

##### *Strategic Criteria:*

- Integrated governance for the clinical and academic missions (this could range from delegated authority, to affiliations and through to full mergers);
- National recognised excellence in research and clinical practice;
- International recognised excellence in research and clinical practice;
- External research funds comprise 30% or more of the academic budget;
- Integrated leadership and career paths in clinical and academic medicine;
- Joint programmes which combine research and clinical work;
- Benefits to the South African economy and health sector.

##### *Operational Criteria:*

- Board (s) reflecting required Academic Health Complex governance structure;
- Information system, data collection and analysis which conforms to agreed national standard for Central Hospitals and has the capacity for case mix analysis and integration of clinical and financial information;
- Conformance to hospital quality accreditation standards by national accrediting authority ;
- Growth and development in the output of health professionals;
- Growth in research output.

#### **Organisational structure**

There can be various organisational options for achieving strengthened governance and management of a joint mission of education, training, research and patient care. Two options are detailed: the status quo and a new scenario which can have variations.

##### i. University Affiliation Model (The SA Status Quo)

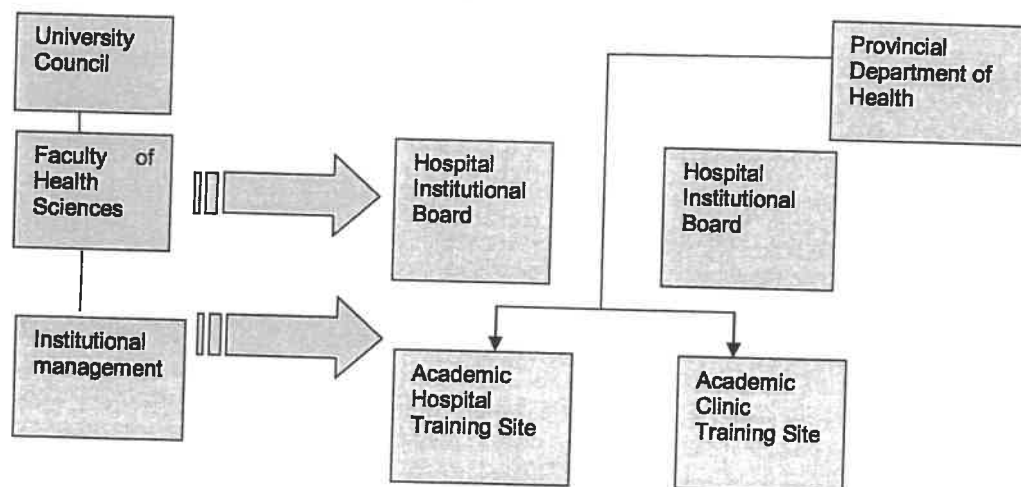
This is probably closest to what exists in South Africa at present in the relationships between Faculties of Health Sciences, Academic (Central) Hospitals, and other academic training service sites. In this model affiliation agreements between a university, a hospital and other members potentially create an Academic Health Complex as a voluntary association where members agree on purposes

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in common. This model depends on good will, mutual respect and a desire to collaborate. This attitude is also required for model ii below but it is more structured.

The disadvantage of this model is that there is not a necessary alignment in the clinical and academic missions of affiliated parties, and therefore related resources and organisational performance outcomes. The Board does not play an influential role, and the Provincial Department of Health is the main authority overseeing the financing, planning and staffing of the institutions which serve as accredited academic training sites. 'Joint agreements' exist for some of the provinces between the provincial department of health and the Faculties of Health Sciences. For some provinces the 'Joint Agreements' are not finalised and a source of dispute. There is no national policy which provides a guideline for 'Joint Agreements' on the relationship between provincial departments of health, Academic (Central) hospitals, other training service sites, and the Faculties of Health Sciences.

**Figure 11: University affiliation model (The SA Status Quo)**



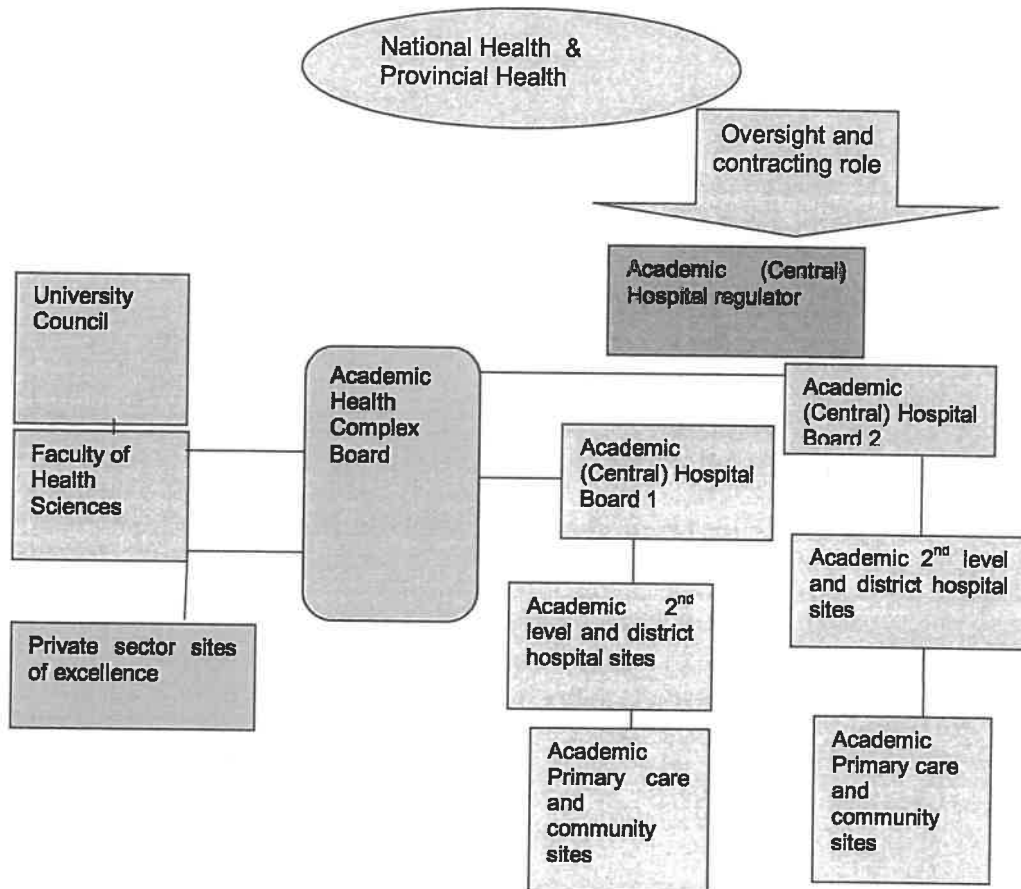
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ii. Consortium, Network or Joint Partnership Board Model

In this model the institutions of the Academic Health Complex form a board as a vehicle for strengthening collaboration between partners while maintaining separate funding and accountability mechanisms for the academic and clinical missions. Some autonomy is ceded to the common body, in which the participants share in decision-making, but authority remains with the individual institution's board of governors.

Any new governance model requires the alignment of the academic and clinical missions of the university and academic hospitals and other training sites. This idea must have the support of the political leaders, specifically support of the Ministers of Higher Education and Training, and Health.

Figure 12: Consortium, network or joint partnership board model



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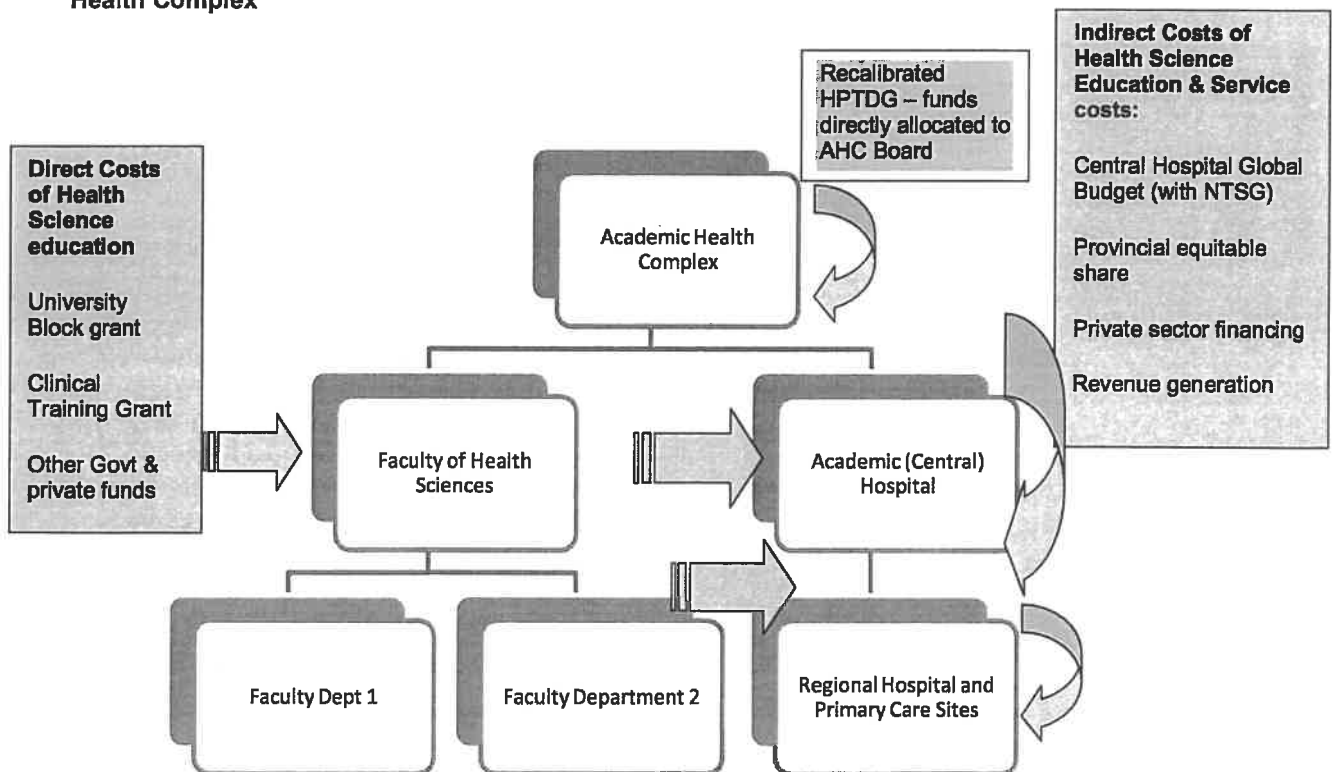
## Financing Flows

The financing of Academic (Central) Hospitals, Academic Health Complexes and health professional education and development needs to be improved for effectiveness and efficiency. Current financing for health professional development occurs through a number of funding streams, primarily:

- The Clinical Training Grant and the Block Grant from DHET
- The Health Science Programme of provincial health budgets
- The Health Professions Teaching and Development Grant (HPTDG) and the National Tertiary Services Grant (NTSG), which are allocated to provinces from the NDoH budget.

The model in the Figure below identifies existing funding flows for Academic Health Complexes. Grants which are currently under review are the HPTDG and the NTSG. Figure 13 shows a possible suggestion for consideration where the HPTDG could be allocated to AHC boards for the funding of specific aspects of the extra service costs of health professional development and training. The extra service cost of training are significant and have to be separately budgeted for.

**Figure 13: Model for financing of academic medicine, the Health Sciences and the Academic Health Complex**



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## STRATEGIC PRIORITY 5: ACADEMIC TRAINING AND SERVICE PLATFORM INTERFACES

*Strategic objective 5: To strengthen Academic Health Complexes and other training platforms to strategically manage both health care and academic resources and provide an integrated platform for service, clinical, research and education functions*

<b>Objective 5.1</b>	<b>Elaborate activities for strengthening of AHCs based on an organisational model which integrates governance and leadership structures to strategically and operationally manage both health care and relevant academic resources</b>
Activity 5.1.1.	The Minister of Health will appoint a Project Team to lead the development of proposals on the organisational strengthening of Academic Health Complexes. The Academy of Science is proposed as a key organisation in the Project Team.
Activity 5.1.2.	The Project Team will elaborate proposals in line with the Health Act Para 51, on the definition of Academic Health Complexes, and define the organisation and financing flows and sources of funds for Academic Health Complexes.
Activity 5.1.3.	The Project Team will define and implement a stakeholder consultation process for the development of a process of strengthening Academic Health Complexes.
Activity 5.1.4.	The Project Team will collaborate with the Academic Advisory Panel appointed by the Minister of Health to provide advice on the development of the five Flagship Academic (Central) Hospitals.
<b>Objective 5.2.</b>	<b>Develop strategic activities on how to strengthen the management infrastructure of Academic Health Complexes</b>
Activity 5.2.1.	<p>The Project Team will develop activities to strengthen the management infrastructure of AHCs specifically on:</p> <ul style="list-style-type: none"> <li>• National conditions of service for academic clinicians employed in AHCs and Academic Central Hospitals;</li> <li>• Information technology to standardise ITC in Academic Central Hospitals to enable financing, case mix analysis, revenue generation, grant monitoring for education and specialist services, service and performance management, monitoring of training;</li> <li>• Development of the service planning model incorporating staffing guidelines and adjustment for the training and research environment;</li> <li>• Elaboration of national tertiary and highly specialised service needs and planned units/centres of excellence integrated with specialist and sub specialist training;</li> <li>• Identification of other issues on which action is required for the strengthening of management infrastructure.</li> </ul>

<b>Activity 5.3</b>	<b>Develop national structures for the oversight, planning and governance of Academic Health Complexes</b>
Activity 5.3.1.	Establish a National Advisory Committee for the Minister of Health on Academic Health Complexes.
Activity 5.3.2.	Establish a Secretariat to resource the National Advisory Committee of the Minister.
Activity 5.3.3.	Establish an Association of Academic Health Complexes to provide peer support for the growth of AHC's and a forum for consultation and capacity development.
Activity 5.3.4.	Establish a Finance Committee on Academic Health Complexes as a Sub Committee of the NDoH Financing Committee on HRH to develop and monitor costing, financing and budgeting of AHCs and Academic Central Hospitals.
Activity 5.3.5.	Develop an accreditation framework for Academic Central Hospitals and Academic Health Complexes and define the implementation process of accreditation.
<b>Objective 5.4.</b>	<b>Develop and commission the academic service platforms of the five flagship Academic Central Hospitals</b>
Activity 5.4.1.	Advertise and adjudicate bids, award and manage contracts for the five flagship Academic Central Hospitals in cooperation with DBSA (the contract and PPP managers).
Activity 5.4.2.	Define the financing requirements, plan and identify future sources of finance for the Five Flagship Academic Central Hospitals.
Activity 5.4.3.	Ensure the Project Team appointed by the Minister of Health to develop policy on organisation and financing of AHCs and Academic Central Hospitals (Objective 5.1) collaborates with the Academic Advisor panel appointed by the Minister to advise on the integrated academic training and service dimensions of the DBSA/NDoH Project on Five Flagship Academic Central Hospitals.
Activity 5.4.4.	Develop a phased plan for expansion of training on the Flagship Project academic service platforms in consultation with the Academic Advisor panel appointed by the Minister to advise on the academic training and service dimensions of the DBSA/NDoH Project on Five Flagship Academic Central Hospitals.
<b>Objective 5.5.</b>	<b>Review nursing college capacity, &amp; develop and commission nursing colleges</b>
Activity 5.5.1.	Agree the training model for nursing education and training, the standards and facility equipment for the nursing colleges.
Activity 5.5.2.	Ensure development of business plans on nursing college refurbishment are developed and submitted to National Treasury, and ensure the implementation of the nursing college projects.

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Activity 5.5.3.	Develop phasing-in plans for teaching and training in the new/ refurbished nursing colleges.
<b>Objective 5.6</b>	<b>Identify needs and develop plans for the training platforms required for MLWs and other categories of provincial health cadres</b>
Activity 5.6.1.	Detail requirements and implement plans for training platforms required for MLWs and other categories of provincial health cadres.

## **STRATEGIC PRIORITY 6 : Professional Human Resource Management**

### **Enhancing the professional role of the Human Resource Management function**

The working environment is key to the quality of care that health professionals can and are willing to offer. The Human Resource Management function has an important role to play in creating and enabling environment for health care delivery. Human Resource Management in health care facilities is often undertaken by the clinical line manager. A tricky relationship often exists between the Human Resource Management department and clinical and service line managers. To improve the working environment it is necessary to improve the professional capacity of the Human Resource Management to provide support and improve working conditions for line management and the health care professionals.

### **The role of the HR Departments in the context of the HRH Strategy**

The broader organisational strategy of any organisation predetermines the HR strategy. The HR strategy, in turn, predetermines the strategy of the HR department. These distinctions are important: the HR strategy cannot succeed if it is left to the HR department to implement. This is because, increasingly, in global Best Practice organisations, the central role in the management of the organisation's HR has to be played by line managers. The role of the HR department is to act as a professional, internal consultant and to support line management in their HR responsibilities. It is important to differentiate between the HRH strategy of the Health Sector and the strategy to be pursued by the HR department in its support. The Director-General is responsible for ensuring that the Human Resources Management function is integrated and supports the HRH Strategy and the overall NDoH Strategy for the Health Sector.

### **Developing strengthened and integrated Human Resource Management (HRM) strategies**

Provincial departments of health are responsible for the development of Human Resource Management strategies and the development of HR Plans, which also must comply with the Department of Public Service requirements. A process of strengthening HRM strategies is proposed as well as an alignment of the DPSA HR Plan format with health sector specific requirements. Provincial departments of health have undertaken extensive work in the development of HR Plans. Provinces are encouraged where appropriate to strengthen the HRM function in order to address work environment issues that affect the recruitment, retention and careers of health professionals.

The following methodologies can be used to gain a better understanding of the workforce and therefore contribute to HRM strategy development:

An audit of the workforce: An annual audit and analysis of the workforce can assist with identifying human resource issues, trends and gaps.

HR structures, policies and procedures: An audit of HR policies and procedures can assist with the identification of policies and practices that act as barriers to the appointment, development, promotion and retention of critical talent or that lead to direct or indirect discrimination.

An audit of attitudes and perceptions: Various audits of attitudes and perceptions can be undertaken. These provide insights into how various constituencies in the organisation perceive it as performing with respect to levels of engagement, productivity and the retention of staff.

The three types of audit commonly used in this context are:

- An audit of attitudes and perceptions of current employees towards the conduciveness of the current environment to retention and high performance. This audit also identifies barriers to the retention and engagement of talent;
- A Turn-over and Retention Survey. This audit involves interviews (often telephonic) with employees who have left the organisation in the last year to gain insight into the real reasons for their resignation; and
- Propensity to Stay. This audit generally involves on-line surveys of critical talent to assess their level of engagement with the organisation and their Propensity to Stay.

These audits can be supplemented by in-depth interviews with key personnel, document analysis and analysis of exit interview records.

#### Formulating an Integrated Human Resources Management Strategy

On the basis of the investigations recommended above, existing Human Resource Management strategies can then be strengthened. Key elements of such strategies would include the following:

- A practical workforce planning process
- A practical career and succession planning process
- Functional or departmental HRM action plans
- Training, coaching or leadership development processes to ensure the competence of all of those in leadership and Human Resource Management roles

- The integration of objectives for Human Resource Management into the performance contracts of managers
- The performance management of managers in terms of their Human Resource Management role
- Regular reviews of progress and adaptation of the Human Resource Management strategy to changing needs.

### Competitiveness in terms of people

A key factor contributing to the success of the health sector will be its ability to recruit, retain and develop critical talent, thereby becoming an Employer of Choice.

The HR department and Human Resource Management strategies need to ensure they will support line management in:-

- Recruiting the right people
- Ensuring performance is evaluated as objectively as possible
- Ensuring performance is rewarded appropriately
- Analysing reasons for resignation and reporting its findings to line management
- Ensuring fairness and equity
- Ensuring that training and development opportunities are matched with individual strengths and weaknesses
- Ensuring the organisation provides a total employment offering in line with employee expectations e.g. in terms of:
  - ✓ Financial and career achievement
  - ✓ Benefits; work-life balance; flexibility
  - ✓ Challenging work
  - ✓ Social environment (e.g. networking opportunities; two-way communication and consultation; employee recognition)
  - ✓ Stability (e.g. clear strategy; mature leadership; job security)
  - ✓ Inclusion and support (e.g. professional Human Resources Management; access to resources and equipment; training, mentoring and coaching; career development plans and supportive diversity culture)
  - ✓ Creating a sense of adding value (e.g. listening to employees suggestions; providing stretch goals and allowing accountability and appropriate decision-making opportunities.

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## STRATEGIC PRIORITY 6: PROFESSIONAL HUMAN RESOURCES MANAGEMENT

Strategic objective 6: *To effectively manage human resources in a manner that attracts, retains and motivates the health workforce to both the public and private sectors in an appropriate balance*

<b>Objective 6.1</b>	<b>Undertake an audit of the health workforce in each province</b>
Activity 6.1.1	Undertake an annual audit of the health workforce and identify relevant issues including health workforce requirements.
Activity 6.1.2	Undertake an audit of HR structures, policies and procedures to identify policies and practices that act as barriers to the appointment, development, promotion and retention of health professionals or that lead to direct or indirect discrimination.
Activity 6.1.3.	Undertake an audit to develop strategies for retention by auditing attitudes and perceptions using three methodologies: <ul style="list-style-type: none"> <li>• An audit of attitudes and perceptions of current employees towards the conduciveness of the current environment to retention and high performance</li> <li>• A turnover and retention survey which interviews employees who have left and asks why they have left</li> <li>• A propensity to stay survey which interviews existing employees on their propensity to stay.</li> </ul> Provincial departments of health could identify differing methodologies to achieve the same objective.
Activity 6.1.4.	Integrate the results of the audits into the HR Strategic plan for 2012/13 – 2016/17, proposed in Objective 6.2.
<b>Objective 6.2</b>	<b>Formulate integrated HR strategic plans with an emphasis on recruitment and retention of health professionals</b>
Activity 6.2.1	To formulate HR Strategic plans for 2012/13 – 2016/17. The HR Strategic Plans should meet DPSA requirements and use DPSA format, but also address issues of the health sector. The HRH Task Team should discuss the following in the process of developing the HR Strategic Plans: <ul style="list-style-type: none"> <li>• Agree guiding principles for an HRM strategy which integrate health sector transformation objectives</li> <li>• Agree appropriate governance structures and practices to ensure the HRM strategy is achieved and enhanced</li> <li>• Agree HRM delivery method in terms of strategic partnering; competitiveness in terms of attracting, recruiting, motivating and retaining critical talent; assistance in building a high performance culture and functional excellence.</li> <li>• Agree how the performance of the HR Department will be measured against key strategic objectives.</li> </ul>



Activity 6.2.2.	<p>The HR Strategic Plans should cover the following areas:</p> <ul style="list-style-type: none"> <li>• Strategic Partnering</li> <li>• Strategic alignment with NDoH goals</li> <li>• Scanning the environment to predict workforce challenges</li> <li>• Ensuring competitiveness in the war for talent and recruitment of health professionals</li> <li>• Managing people for high performance</li> <li>• Functional excellence</li> </ul> <p>Ensure that the information in the HR strategic plans links to Service Transformation Plans, annual plans and MTEF.</p>
<b>Objective 6.3</b>	<b>Clarify roles and responsibilities of HRM function and line managers</b>
Activity 6.3.1.	<p>To strengthen HRM function the roles and responsibilities of HR and line managers should be agreed or refined. This will involve undertaking the following:</p> <ul style="list-style-type: none"> <li>• Define roles, responsibilities and competences required of HRM function and line managers in relation to HR;</li> <li>• Decentralise more HRM functions to district and facility level;</li> <li>• Clarify job descriptions, job objectives and key performance indicators in relation to roles and responsibilities of HR managers;</li> <li>• Communicate roles and responsibilities and performance measures to line managers and the HRM function personnel;</li> <li>• Assess competence of HRM function personnel and line managers in relation to roles and responsibilities;</li> <li>• Provide training and coaching to up skill relevant personnel in their roles and responsibilities;</li> <li>• Engage with Persal unit of National Treasury to assess ways of improving functionality and objectivity of Persal;</li> <li>• Provide continuous Persal user training for all HRM practitioners.</li> </ul>
<b>Objective 6.4</b>	<b>Implement a performance management framework in the public health sector and stop abuse of RWOPS and moonlighting</b>
Activity 6.4.1.	Customise DPSA performance management tools and processes to the requirements of the health workforce and implement performance management through line management in health care facilities (where this is not already the case).
Activity 6.4.2.	Eliminate the abuse of RWOPS and moonlighting by the relevant executive authority applying the provisions of the PSA (Public Service Act).
<b>Objective 6.5</b>	<b>Review and implement the changes for the Occupation Specific Dispensation</b>
Activity 6.5.1.	Commission a review of the OSD and ensure the recommendations enhance retention and attraction of health professionals.
Activity 6.5.2.	Ensure the OSD addressed retention and attraction of health professionals in rural areas.
Activity 6.5.3.	Implement the revised OSD

116  


## STRATEGIC PRIORITY 7 : Quality Professional Care

Ensuring quality professional care is an ongoing process which requires:

- Strong Statutory Council oversight over professional training and practice;
- Ensuring quality of the clinical training environment for undergraduate and postgraduate health professions;
- Ensuring ongoing professional development linked to health priorities, the development of new technologies and new clinical interventions;
- Ensuring the working environment in which health professionals practice is conducive to quality health care;
- Oversight and firm action on professional malpractice;
- Guidance and protocols on clinical best practice and evaluation of new clinical interventions for National Health Insurance;
- High level ongoing interaction between NDoH and the Statutory Councils;
- Resourcing of the Statutory Councils for their functions.

### Statutory Council oversight

The Statutory Councils are required to define the regulations for scopes or practice and competency, oversee the clinical training environment, and protection of the public from malpractice, as well as register health professionals and meet member needs. It is recommended that the two primary roles are separated and separately financed.

Firstly, member registration and meeting member needs is an important role and should continue to be financed from membership fees. Secondly, the oversight role of ensuring professional quality care in practice and protection of the public should be separately financed, and defined resources made available for this purpose. Professionals who generate costs through oversight investigations should also cover the costs where appropriate.

### **Forum of Statutory Councils**

A Forum of Statutory Councils will be established in order to enable collaboration in areas of common interest which requires resources and cooperation. For example, information technology capacity for reporting on health professional numbers, defining and setting standards for staffing and infrastructure on the academic service platform, professional oversight of the re-engineered PHC health system etc.. Cooperation would enhance oversight rather than only engaging with the health system in professional silos.

### **NDoH interaction with the Statutory Councils**

The interaction and engagement between the National Department of Health and the Statutory Councils must be strengthened so that it is consistent and regular. The level of engagement will be at DDG level so that decisions can be taken at joint NDoH/ Statutory Council meetings.

### **Improving quality of clinical training**

The academic quality of higher education qualifications is overseen by the Council for Higher Education (CHE) and the Higher Education Quality Council. HPCSA has a history and responsibility for ensuring standards of professional practice. The HPCSA has the responsibility of accrediting clinical training sites where the clinical training of health professionals takes place, namely the environment of clinical training component of academic health professional qualifications.

Both the CHE and HPCSA are therefore responsible for overseeing the quality of professional development and training. Yet there are big differences in the outcome of health professionals from different Higher Education Institutions. There is variation in the quality of the clinical training environment, despite the HPCSA accreditation. No standards or requirements are set for academic clinicians/trainers. A recent review of one of the Faculties of Health Sciences noted with concern the lack of qualified senior academic clinical staff.

To improve the quality of clinical training the following activities will be undertaken:

- The criteria for HPCSA review of clinical training sites must be tightened and address the quality of the training environment and academic capacity
- Where an academic site is not in compliance, a firm course of corrective action must be taken
- All health professional programmes which have a requirement for clinical training must have site accreditation for all levels of the health system.

### **Continuing Professional Development**

Continuing Professional Development is necessary to ensure professional quality care. The system is reported to not be working effectively. Health professionals are reregistered annually without the relevant



Council checking that the required CPD courses have been undertaken. The Councils' information systems need to ensure up-to-date linked information on CPD and the professional member. Further CPD courses must be linked directly to professional development and updating of skills and knowledge relevant to the individual's professional practice. It is recommended that all Statutory Councils ensure information systems that can report on members and their CPD, and that members are not reregistered if they have not complied. An example of relevant generic CPD training is resuscitation and emergency life support. A minimum number of Ethics points are required for registration of medical professionals, yet a skill which is life saving is not taught and required across the professions. The requirements of CPD by profession and the implementation of CPD must be strengthened.

#### **Licensing of health professional practices**

Health professionals can set up a health care practice and see patients without a license. A practice number is required for medical aid purposes, but not for professional purposes. It is recommended that all health professionals must be licensed to practice, re-registration with the relevant Council being a relevant criterion. Health professionals should only be allowed to practice in the clinical area for which they are professionally qualified and no other areas of clinical practice. In addition the physical facility of the practice must be licensed for the professional and service functions to be performed. More licensing requirements exist for opening a restaurant than for opening a health care practice.

#### **Council oversight of malpractice and confidential peer reporting**

Council oversight on malpractice must ensure reported issues are speedily dealt with and responded to. The turn-around time for investigations should be publicly reported. Health care professionals have requested that a confidential reporting mechanism be set up to report on peers who are practicing in an unacceptable manner. One of the reasons health professionals tend not to report on a colleague is that no confidential channel is available, and yet they, more than the public see professional behavior that should not be allowed to continue.

#### **National Coordinating Centre for Clinical Excellence in Health and Health Care**

The development of a health system financed by National Health Insurance and setting the objective of providing universal coverage and access to care requires that a similar standard of care should be offered to all of the population. Currently national guidelines exist for priority programs such as HIV and Aids and TB for example. All the professional associations have guidelines and standards for care for their particular area of care or discipline. In an academic training setting protocols and standards will be locally set. But these approaches need to become part of national guidelines for best practice. For NHI national protocols and guidelines will be required for the NHI services and health care interventions. In many cases this will mean coordinating with existing associations and professional groups. But resources will

be required to develop guidelines, protocols, provide evidenced based recommendations, and standards for quality clinical care.

An NDoH *National Coordinating Centre for Clinical Excellence in Health and Health Care* will be established. The operations of the Centre will be located in various sites: academic sites of excellence, the MRC, and in the NDoH. However the central office would provide a coordinating function. It will bring together associations, professional groups, provincial departments of health and the academic community to define and oversee clinical quality professional health care. Associations and academic departments or disciplines would be able to access resources from the Centre in order to undertake relevant work on excellence and cost effectiveness in clinical care. A priority for the Centre in the short term would be to coordinate the development of the clinical and health care standards, guidelines and protocols for re-engineered primary health care.

The Centre will:

- Provide guidance on new and existing medicines, treatments and procedures; and treating and caring for people with specific diseases and conditions;
- Make recommendations to the NDoH, provincial departments of health, municipalities and other organisations in the public, private, voluntary and community sectors on how to improve people's health and prevent illness and disease;
- Advise on cost and effectiveness of medicines, procedures and interventions that will be offered in an NHI healthcare environment;
- Provide evidence for health care interventions and practice;
- Develop and define the clinical standards of health care that people can expect to receive from services which are part of the NHI package of health care delivery;
- Provide guidance on standards for clinical treatment (or set of clinical procedures) and indicate if they are considered highly effective, cost effective and safe, as well as being viewed as a positive experience by patients;
- Develop quality and outcomes framework for primary care practitioners and primary health care NHI practice.

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## STRATEGIC PRIORITY 7: QUALITY PROFESSIONAL CARE

Strategic objective 7: *To develop a health workforce that delivers an evidenced based quality service, with competence, care and compassion*

<b>Objective 7.1</b>	<b>Strengthen the role of the Statutory Councils and ensure the Statutory Councils are financed for their mandate and functions</b>
Activity 7.1.1.	Strengthen the NDoH relationship with Statutory Councils.
Activity 7.1.2.	Develop a Forum of Statutory Councils which meets annually and shares common issues and develops common capacities (for example in information technology) consistent with the provisions of the National Health Act.
Activity 7.1.3.	
Activity 7.1.4.	Review Statutory Council functions and define how to strengthen oversight of professional behavior and protection of the public.
Activity 7.1.5.	Review Statutory Council functions and activities for members and define how to strengthen their membership support function, for which members pay fees (this should include a survey of members of what they would require).
	Cost and ensure financing for Statutory Council mandates and functions which require additional financing and should not be paid from member fees.
<b>Objective 7.2</b>	<b>Improve oversight of clinical training for all professions</b>
Activity 7.2.1.	Review and refine standards for inspection for accreditation of clinical training sites for all professions.
Activity 7.2.2.	Strengthen compliance mechanism and corrective action where standards on clinical training sites are not met.
<b>Objective 7.3</b>	<b>Implement Continuing Professional Development</b>
Activity 7.3.1.	Develop the information technology capacity for linking members to their reported CPD and ensure up to date reporting on member's CPD status.
Activity 7.3.2.	Link professional re-registration to member CPD status (professionals should not be re-registered if their CPD status is not up to date).
<b>Objective 7.4</b>	<b>Implement licensing of professional health care practices</b>
Activity 7.4.1.	Develop the licensing requirements, framework and process for licensing professional health care practices.
Activity 7.4.2.	Detail the required organizational capacity and financial requirements to implement licensing of health care practices.
Activity 7.4.3.	Develop and implement a phased implementation plan to license professional health care practices.

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<b>Objective 7.5</b>	<b>Ensure timely response to malpractice and a develop confidential reporting process</b>
Activity 7.5.1.	Ensure timely response to patients who report malpractice and timely processing of the cases.
Activity 7.5.2.	Define and implement an approach for confidential reporting on professional malpractice.
<b>Objective 7.6</b>	<b>Develop a National Coordinating Centre for Clinical Excellence in Health and Health Care</b>
Activity 7.6.1.	Appoint a short-term project team with a chairperson appointed by the Minister to develop the concept of a National Coordinating Centre for Clinical Excellence in Health and Health Care in order to deliver excellent professional clinical care for National Health Insurance.
Activity 7.6.2.	The project team will develop and implement a stakeholder consultation process for the development of the Coordinating Centre (stakeholders include professional associations, the private sector administrators and managed care companies, the Council for Medical Schemes, the MRC, the academic community, Faculties of Health Sciences, the Academy of Science, provincial departments of health, the Colleges of Medicine, NDoH health programme heads etc)
Activity 7.6.3.	The project team will develop the concept of the Coordinating Centre and a draft Strategic Plan.
Activity 7.6.4.	The project team will propose the location, staffing and financing sources and requirements for the Coordinating Centre.
Activity 7.6.5.	The project team, in consultation with the Minister, will appoint the CEO of the Coordinating and Centre and the staff and ensure that the Coordinating Centre is operational by the end of 2012.

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## STRATEGIC PRIORITY 8 : Access in Rural and Remote areas

### A special strategy for HRH for rural and remote areas

Specific issues that indicate the need for a special strategy on access to health professionals in rural and remote areas are;

- There has not been a substantial change in access to health professionals in rural and remote areas in the past fifteen years, and health outcomes in rural areas have become worse;
- There is no history or culture in South Africa of incorporating rural areas into mainstream health professional training, which is essential in making these sites attractive to future professionals;
- Most health services do not consider the provision of facilities for students and there are no faculties which are yet running mainstream, longer-term rural health placements for students;
- There is little understanding on the part of administrative staff of the approaches required to recruit and retain health professionals, and even sometimes of their value to the health service, as a scarce skill;
- About 34% of deliveries in urban areas are attended by a doctor compared to 13% in non-urban areas, one of the primary reasons for high maternal mortality in rural areas.

### Special financing mechanisms, staffing norms and other adjustments are required

The environment for rural health care is very different to the environment for urban health care. This impacts on strategies and interventions to improve access to HRH in rural areas. Some of the factors which need to be taken into account are:

- Access to health care is generally more difficult;
- Rural communities face additional economic cost in accessing the health care system;
- Indirect costs, including transport, are higher for the rural poor;
- The consequences for individuals of a failing in the poorly resourced health system are more costly to rectify in the rural areas than amongst the urban poor;
- How the human resources (inputs) are used to achieve desired outcomes (improved health outcomes) are different due to the different circumstances and may require higher staffing ratios with special skills;

- People living in rural areas are often poor and the health status of rural communities in South Africa is generally poorer than communities in urban areas.

Strategies to overcome these inequities in rural health care need to be customised and resourced appropriately. This may include a disproportionately high allocation of budget to attract, recruit and retain human resources in the health care sector. The development of facilities and staffing will also be more costly due to adjustments for lack of infrastructure and a general under resourced environment.

**Rural Health Advocacy Project proposed critical performance indicators to impact on access to health professional in rural areas:**

- i. Appoint a rural HRH strategy task team (working group) under the National Health Council, to develop the details of the Rural HRH Strategy and to support the NDoH in implementing them;
- ii. Adopt a national Human Resources for Rural Health strategy, as part of a broader rural health services strategy;
- iii. Agree on a definition of 'rurality and remoteness' which can inform policies on OSD, rural allowances and related issues, as well as assist in 'rural proofing' other health policies;
- iv. Negotiate with HEI's on curriculum and admission policies;
- v. Increase the proportion of rural students in health professional courses in South Africa;
- vi. Increase proportion of training of health professionals that occurs in rural areas;
- vii. Increase uptake of suitably qualified foreign health workers;
- viii. Provide support and incentives for professionals in rural areas.

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## STRATEGIC PRIORITY 8: ACCESS IN RURAL AND REMOTE AREAS

Strategic objective 8: *To promote access to health professionals in rural and remote areas*

<b>Objective 8.1</b>	<b>Implement short-term strategies on access to professionals in rural and remote areas</b>
Activity 8.1.1	Appoint a Rural HRH Strategy task team under the National Health Council, to develop the details of the Rural HRH Strategy and to support the Department in implementing them.
Activity 8.1.2	Ensure that allocation of Community Service health professionals is focussed on underserved and rural areas, with limited placement in central hospitals, and that these professionals are supported and nurtured, and incentivised to stay on in rural sites.
Activity 8.1.3.	Ensure that provinces do not freeze critical health professional posts in underserved and rural areas as part of hiring moratoria resulting from overspending, through the development of norms for minimum numbers of health professionals for district facilities.
Activity 8.1.4	Revise foreign and local recruitment and retention policies and processes and ensure that appropriately skilled persons are tasked with the implementation of the policy and doing the recruitment.
<b>Objective 8.2</b>	<b>Design and Implement an educational strategy based on WHO guidelines for rural and remote areas (in consultation with Faculties of Health Sciences)</b>
Activity 8.2.1.	Consult with Faculties of Health Sciences on the development of targeted admission policies, with Faculties being required to admit a minimum number of students from rural areas, and provision of funding for rural student cohorts.
Activity 8.2.2.	Provide funding for each Faculty of Health Sciences faculty to have at least one rural campus and to locate clinical training opportunities outside of major urban centres.
Activity 8.2.3.	Regulate clinical training, at both undergraduate and postgraduate level, to ensure that rural clinical exposure is included in all training.
Activity 8.2.4.	Develop funding formulae to reward faculties that produce health professionals for public service and rural areas.
Activity 8.2.5.	Ensure that health sciences curricula address priority health needs in the country, including rural health needs.
Activity 8.2.6.	Establish a system to support continuing professional development programmes in each rural district.

<b>Objective 8.3</b>	<b>Develop regulatory strategies to improve access to health professionals in rural and remote areas and quality of care</b>
Activity 8.3.1.	Determine the optimum range of skills required for rural hospitals.
Activity 8.3.2.	Develop Mid-level Workers (MLWs) with specific scope of practice to meet these skills needs.
Activity 8.3.3.	Enhance the development and placement of Clinical Associates, including establishing posts in all district hospitals and development of training positions in rural districts.
Activity 8.3.4.	Allow for enhanced scopes of practice for health professionals in rural areas in district hospitals, ensuring flexibility in these scopes, to address the skills needed.
Activity 8.3.5.	Provide rural-bonded scholarship schemes managed at a district level in partnership with Faculties of Health Sciences and local communities, in order to encourage return of service.
<b>Objective 8.4</b>	<b>Develop financial incentives to attract health professionals to work in rural areas</b>
Activity 8.4.1	Develop, use and evaluate financial incentives to attract rural health care professionals, including: <ul style="list-style-type: none"> <li>- revision of the OSD;</li> <li>- a more focused and targeted rural allowance;</li> <li>- sabbatical leave for rural health professionals;</li> <li>- opportunities for postgraduate training.</li> </ul>
<b>Objective 8.5</b>	<b>Provide personal and professional support to health professionals working and training health professionals in rural areas</b>
Activity 8.5.1.	Provide personal and professional support to health professionals working in rural areas, specifically: outreach support from referral hospitals, improved living conditions including accommodation (where that is not easily available locally) , a safe and supportive working environment, opportunities for career development and CPD programmes.
Activity 8.5.2.	Provide training to health service managers to enable them to provide appropriate support for and discipline of health professionals in rural areas.



# HRH SA

## 6 PROFESSIONS FORECAST MODELLING

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### 6.1 MODELLING ASSUMPTIONS

The NDoH Workforce Model developed in 2008 was used for developing initial indicative modelled requirements for the health professions. The figures and scenarios produced are a start and further work is required in the future and has been identified for action in the Strategic Priorities in Section 5. Further work is also required on the model to make sure it is useful as a tool for planning for National Health Insurance staffing requirements. This work is underway.

Models are intended to provide a clearer picture from a wide range of interrelated and interactive data. Of necessity they use assumptions and variables to drive formulae and calculate numerical outputs. Forecast modelling does not substitute for critical analysis and detailed planning.

The accuracy and predictability of the model is dependent on the validity of the baseline data, the assumptions made and the mathematics of the model. Various scenarios were modelled and Scenario 3 which plans over a 14 year time frame was selected as an indicative departure point.

The model that has been used to generate numerical expectations for health care professionals is built on previous work done in 2008 by NDoH. The model does generate financial implications, specifically costs for training and employing professional numbers detailed in the model. The costings have not been included in the results provided in this HRH Strategy as they require further work.

#### 6.1.1 Baselines used for modelling

Baseline data used is detailed below. Baseline data will need verification with professional groups for future modelling. The baseline on the professions was calculated by taking the public sector numbers of health professionals and adding 17% for the private sector to produce a ratio for the whole population. Further work is required on the model to visibly separate public and private sector data and integrated projections. This work is underway and will be incorporated in the unabridged HRH SA Strategy finalised in October.

  
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Modelling assumptions re:

- **Population** data is adjusted mid-year estimates, and the last census was 5 years ago
- The source of data on existing **professionals** varies in accuracy and a best estimate was used, based on various data sources.
- **Retention, retirement, death, etc** figures are averages based on research

### 6.1.2 Benchmarking

For setting targets for the professions a range of benchmarks can be used:

- International Benchmarks
- Official and unofficial service planning benchmarks
- Professionals associations – for example mental health

Ideally the targets should be set from a South African model that determines HRH requirements based on well researched and assessed service staffing needs for a National Health Insurance service delivery model. This type of refined SA model to guide HRH requirements does not exist as yet. As a proxy guide various local norms were used. Service Transformation Plans (STP) norms were reviewed as one source based on the Integrated Health Planning Framework,<sup>39</sup> Work done by a MRC/W Cape/NDoH team was reviewed and is described in the table below as the *SA Service Model ratio*.<sup>40</sup> In this latter model, staffing requirements are indicated for both PHC as well as acute hospital services. The staffing requirements for the *SA Service Model* are below the SA current staffing ratios, and the IHPF which is only for public sector staffing norms. A summary of staffing benchmarks for some of the categories of health professionals is given in the table below, for the six peer countries, STPs and the 'SA Service Model'. The current figures for South Africa are also shown.

Finally, these requirements are placed within the context of the budget constraint, which may mean that some key health personnel categories are prioritised, in order to deliver the maximum impact on health outcomes possible. For the development of Scenario 3, international and all SA benchmark data was taken into account, but no one benchmark was used for all HRH categories. Target decisions were made for each profession based on a variety of data sources. These target decisions need to be refined in consultation with provincial departments of health, academics, the professions and care groups and

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<sup>39</sup> Sourced from the IHPF v108.

<sup>40</sup> *SA Service Model* developed by C Hongoro, W Van Rooyen & Moremi Nkosi

128  
  
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associations. The targets and output numbers will change as data is refined and the NDoH Workforce Model developed. However, the broad direction will be consistent.

**Table 18: Summary of staffing benchmarks, ratios per 10,000 population**

Staff category	Brazil	Chile	Costa Rica	Colombia	Thailand	Argentina	STPs*/ IHPF	Service Model	SA current
Medical practitioners		5.91	8.59	11.74	2.43		3.21	2.60	3.63
Medical specialists		4.90 <sup>41</sup>	4.65 <sup>42</sup>	2.57	2.93 <sup>43</sup>		0.52	2.53	1.96
Physicians	17.31	10.81	13.24	14.30	5.36	31.96		5.13	
Medical assistants			2.53		0.43		0.7		
Professional nurse							13.93	10.49	18.61
Staff nurse							5.63	5.44	6.28
Nursing assistant							9.62	9.01	11.21
Nursing personnel	65.42	6.27	9.24	5.83	27.16	3.77			36.10
Midwifery personnel	0.17	4.18	0.06		0.25	1.10			
Personal care			12.90		5.80				
Dentists	11.56	4.23	3.73	8.26	1.17	9.28	0.26		1.07
Dental tech/ assts	2.13	3.21	1.11		0.56				
Dental specialist							0.05		
Pharmacists	5.48	1.62	2.91		2.10	5.08	1.52	0.78	2.29
Pharmaceutical technicians/ assts	0.33	2.10	2.43		0.82			0.98	
Other health workers	1.98	29.44	16.24		1.84	20.73			
Environment and public health workers	9.59	0.26	3.22		0.35				0.63
Laboratory scientists	0.80					5.12			
Laboratory tech assts	4.35								
Health management & support workers	48.19		46.82		18.83				
Allied health prof & technical staff							4.54		
Managers, admin, logistics							29.48		

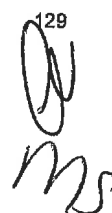
*\*Public sector only*

Sources: World Health Organisation and other sources, Northern Cape STP IHPF V108, Hongoro et.al, Econex calculations

<sup>41</sup> <http://www.ncbi.nlm.nih.gov/pubmed/17130996>

<sup>42</sup> <http://www.nacion.com/2010-11-15/EIPais/NotasSecundarias/EIPais2577856.aspx>

<sup>43</sup> <http://www.thaivisa.com/forum/topic/416153-severe-shortage-of-medical-specialists-in-thailand/>

129  


### 6.1.3 Targets

The important consideration is that the target number, skills set mix and range of competencies must be based on service demands and epidemiological priorities and not on other countries exclusively.

The targets chosen from modelling against these priorities and the economic and other environmental realities discussed in this document all present significant challenges. The interventions need deliberate sequencing across and within professional categories. The lead times for some interventions are long and they need immediate intervention to produce desired outcomes in the long term. Others have the potential to be implemented immediately but may have political (labour, professional or macro-political) constraints, etc.

It is critical that long-term output/impact decisions are not forgotten after implementation and that the capacity to absorb the professionals in training product is properly planned to coincide with the end of the training process. For instance increase in production of specialist paediatricians, or clinical associates will take several years to yield graduates and it is necessary in the intervening period to create posts, create career paths and to fund the vacancies into which to employ them.

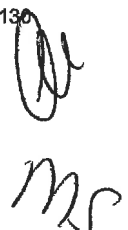
### 6.1.4 Realistic scenarios

It is proposed that the SA HRH design to improve health outcomes will have seven key foundations:

- CHW at community level;
- Enhanced nurse capacity;
- Planning of mid-level workers;
- Expansion of general health professionals;
- Expansion selected specialist health professionals;
- Planning of public health specialists;
- Development of academic clinicians.

Based on this expected high-level policy, and a mass of variables, a set of prioritised realistic scenarios are presented. They contain timelines for action, short, medium and long term outcome and impact expectations and sequencing proposals to address financial constraints. It must be noted that only Scenario 3 is presented in this HRH Strategy document for further consultation. The NDoH Workforce Planning Model with the other scenarios is available for review.

The model provides projections for over 100 registered health professions and is designed to be interactive, with the option to adjust baseline data and several assumptions for each profession. What is presented in this document is a suggested preferred scenario based on the following assumptions.

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## 6.2 MODEL OUTPUTS

The scenario assumptions show that at a constant GDP growth rate, with concerted investment for the next five years (3% to 5% annual growth rate in personnel spending), it is possible to close the gap in the realistic numbers in a fifteen- to twenty-five year time frame. Operational implications of the targets need to be examined and evaluated.

### 6.2.1 Model refinements

Because the models are large and are fed by a large data set it has not been possible to examine every possible detail in the HRH arena. The start has been at a single consolidated macro (national) level. However there is room to improve the model to split the results into levels of care, professional group, and to look separately at regions of the country or provinces. In particular adjustments need to be made for staffing ratios for rural areas. The new categories proposed so far as part of the HRH Strategy have been incorporated (CHWs, new Staff Nurse, Clinical Associate) and old categories phased out e.g. enrolled nurse. These details can be built into subsequent versions of the model and used to refine decisions in the future. Non-clinical professionals essential to the health sector, such as health economists, medical physicists, clinical engineers, clinical data analysts – have not yet been able to be incorporated into the NDoH Workforce model, but will be in the future.

### 6.2.2 Routine data from source

The modelling tool is intended to have skilled personnel trained to improve data sets, to examine the outputs very cautiously and to follow up on implementation with monitoring and evaluation of impact. On line data on professional in the public and private sector is necessary for future use of the NDOH Health Workforce model. Developing a reliable data base on the health workforce for the public and private sectors is short term urgent priority. The modelling scenarios proposed are only as good as the data on which they are based.

## 6.3 RECOMMENDATIONS

The targets that have been estimated are based on a range of peer countries, South Africa ratios, and on a set of identified priority professionals for fast-tracking.

The costs of the proposed model have been estimated and a scenario set in the model that appears to be reasonably economically viable.

It is recommended that:

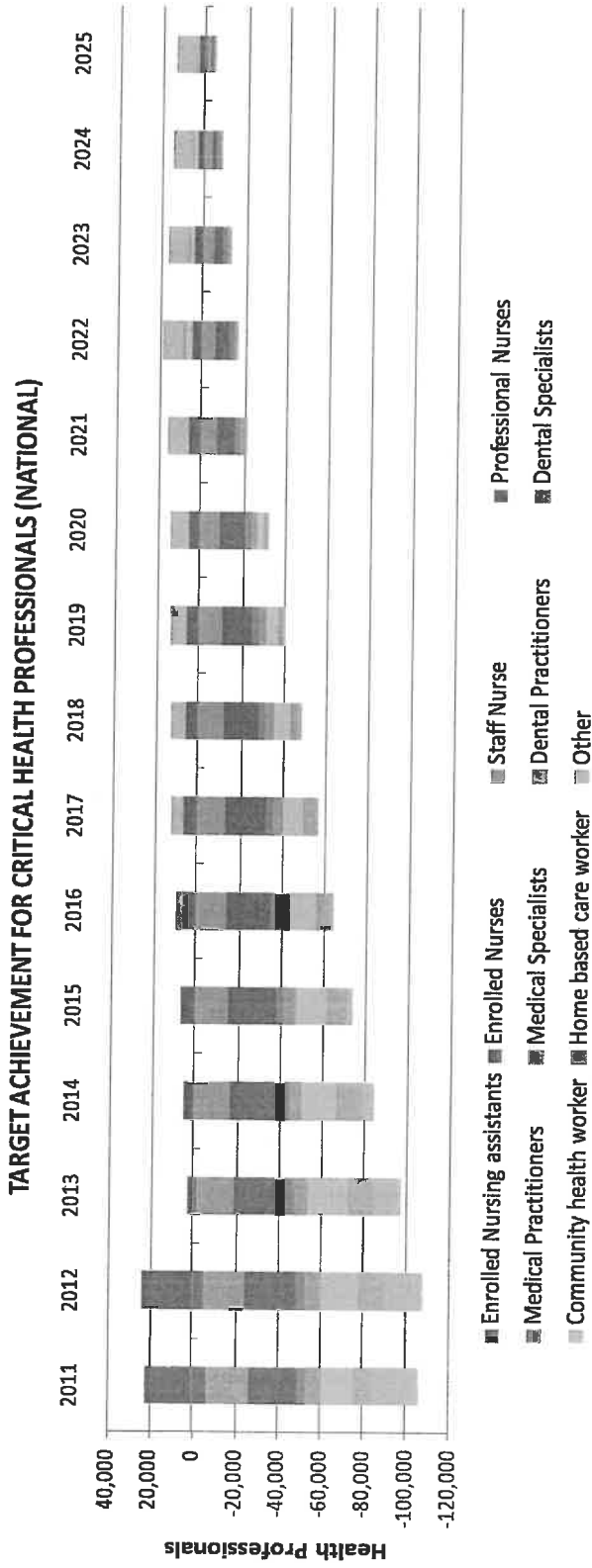
- i. Stakeholders engage with the methodology, assumptions and targets within the context and challenges and issues outlined (NDoH to facilitate consultation with stakeholder groups);
- ii. Once the assumptions are agreed in principle the modelling can be adjusted to establish the impact on numbers and cost;
- iii. The targets generated by the STP's should be interpreted with caution and used mainly to provide another, 'distributive', target between provinces, which each have different service environments;
- iv. Staffing norms should be used with caution as they undermine productivity, new decisions and staffing options as well as local variability;
- v. Vacancies in the public sector should be ignored for targeting and planning purposes and only used to establish whether the posts exists on the personnel administration system (a requirement for filling a post);
- vi. Improving existing establishment at all levels of the system is a separate management exercise which should be correlated with the short, medium long-term strategic plan.

The numbers are indicative of the size of the challenge but are only a part of the challenge. The rest of the challenge is implementing the myriad of challenges, most importantly changes in roles, categories and scopes of practice, to achieve the staffing levels calculated to be feasible.

The following tables summarise the results of Scenario 3 developed to date on the NDoH Health Workforce Model.

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Figure 14: Scenario 3 resultant narrowing of identified 'gap'



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Table 19: Scenario 3 Summary of gap for all health professionals, 2011-2025

GAP IN CRITICAL HEALTH PROFESSIONALS								
StaffName	base year	2011	2012	2015	2020	2025		
Audiologists	-142	-21	89	221	79	112		
Bioknefticists	-33	-41	-48	-26	7	4		
Environmental assistants	-88	-108	-127	-62	56	58		
Environmental health practitioners	-900	137	1,076	1,299	219	720		
EMS practitioners	-3,753	-4,914	-5,986	-3,650	583	254		
Nutritionists/Dieticians	-181	-33	101	268	98	139		
Occupational Therapists	-297	-95	89	349	127	179		
Optometrists	-142	8	142	280	76	114		
Medical Orthotist/Prosthetist	-47	-36	-25	12	13	16		
Pharmacists	-778	-557	-360	254	307	378		
Physiotherapists	-345	-58	201	515	160	231		
Podiatrists	-7	8	21	5	23	23		
Psychologists	-71	239	519	99	631	625		
Clinical Psychologists	-21	-39	-55	6	-27	-29		
Radiographers	-270	-137	-19	135	329	328		
Social Workers	-1,777	-407	832	2,426	801	1,145		
Speech Therapists	-23	-40	-54	12	-2	-0		
Dental assistants	-59	76	199	-67	55	104		
Oral Hygienists	-23	5	30	9	44	52		
Dental practitioners	0	168	320	480	603	519		
Dental Technicians	0	3	5	17	73	103		
Dental therapists	0	8	15	24	45	52		
Medical practitioners	-4,145	-4,294	-4,447	-3,800	-2,109	-525		
Enrolled Nursing assistants	-8,381	-6,434	-4,707	1,993	1,304	-723		
Enrolled Nurses	21,010	22,471	23,792	4,470	4,061	3,046		
Professional Nurses	-14,932	-16,675	-18,319	-17,131	-8,752	-913		
Professional Nurses: PHC	-4,146	-4,270	-4,392	-4,128	-2,404	-16		
Professional Nurses: Adv. midwife	-1,658	-1,407	-1,183	-863	-371	32		
Staff Nurse	-20,138	-19,605	-19,522	-15,380	-8,990	-1,357		
Medical Physicist	-9	-18	-25	-27	1	-5		
Anaesthesiology	-1,312	-1,299	-1,289	-1,006	-578	-99		
Cardiology	-68	-69	-70	-57	-36	-7		
Community Health	-122	-108	-95	-52	-20	-3		
Critical Care	-154	-158	-163	-137	-83	-15		
Dermatology	-139	-136	-133	-100	-57	-10		
Endocrinology	-31	-33	-36	-33	-21	-3		
Gastroenterology	-21	-22	-23	-20	-12	-3		
Genetics: Human	-10	-9	-8	-6	-4	-0		
Genetics: Medical	-17	-18	-19	-16	-10	-1		
Haematology: Clinical	-17	-13	-9	-1	1	-1		
Medicine	-488	-405	-331	-121	0	4		
Medicine: Emergency	-87	-80	-74	-49	-25	-3		
Medicine: Family	-888	-853	-822	-593	-314	-52		
Medicine: Geriatric	-87	-88	-90	-74	-44	-8		
Neonatology	-4	-5	-7	-8	-5	-2		
Nephrology	-3	-6	-8	-11	-9	-2		
Neurology	-16	-13	-10	-3	4	1		
Nuclear Medicine	-8	-3	3	14	13	3		
Obstetrics and Gynaecology	-409	-416	-424	-350	-199	-33		
Occupational Health	-107	-82	-59	-3	21	5		
Oncology: Medical	-33	-36	-39	-36	-20	-3		
Oncology: Radiation	-33	-27	-22	-7	2	1		
Ophthalmology	-86	-83	-82	-61	-29	-5		
Orthopaedics	-525	-528	-533	-432	-261	-54		
Otorhinolaryngology	-453	-456	-459	-372	-229	-47		
Paediatrics	-234	-284	-331	-351	-225	-48		

184  
  




Paediatrics: Cardiology	-5	-7	-8	-9	-6	-0
Paediatrics: Developmental	-5	-1	3	8	8	1
Paediatrics: Neurology	-5	-6	-7	-7	-4	-1
Paediatrics: Surgery	-2	-1	-1	1	3	2
Pathology: Anatomical	-98	-96	-93	-69	-35	-6
Pathology: Chemical	-50	-48	-47	-34	-18	-2
Pathology: Clinical	-13	-13	-13	-10	-5	-2
Pathology: Forensic	-136	-147	-158	-144	-88	-15
Pathology: Haematology	-84	-62	-60	-44	-22	-4
Pathology: Microbiology	-64	-59	-54	-35	-15	-3
Pathology: Virological	-19	-18	-16	-11	-6	-2
Psychiatry	-168	-164	-162	-122	-58	-8
Psychiatry: Child	-10	-8	-6	-3	0	1
Pulmonology	-10	-6	-2	6	9	3
Radiology: Diagnostic	-502	-496	-490	-377	-214	-38
Rheumatology	-1	-0	0	2	2	1
Surgery	-718	-730	-743	-615	-372	-77
Surgery: Cardiothoracic	-31	-36	-41	-42	-25	-6
Surgery: Neurosurgery	-209	-212	-215	-177	-109	-23
Surgery: Plastic	-93	-94	-94	-76	-47	-10
Surgery: Vascular	-6	-5	-5	-2	-0	-1
Urology	-28	-31	-33	-31	-17	-4
Surgery: Maxillo Facial	-10	-11	-12	-11	-2	2
Orthodontics	-3	-3	-2	-0	2	3
Oral Pathology	-3	-4	-5	-5	-0	3
Periodontics	-3	-3	-3	-2	1	3
Prosthodontics	-3	-3	-3	-2	1	3
Clinical associates	-188	-184	-181	-45	55	61
Medical technicians	-236	-245	-254	-90	54	57
Medical technologists	-4,738	-3,984	-3,306	83	1,026	1,274
Optical dispensers	-131	-97	-65	30	28	37
Orthopaedic footwear technicians	-46	-26	-7	22	5	12
Medical Orthotist assistant	-131	-121	-111	-20	36	41
Occupational Therapy assistants	-140	-130	-122	-23	37	44
Pharmacy assistants	-1,254	-1,365	-1,468	-552	429	443
Physiotherapy assistants	-117	-105	-94	-12	30	35
Psychology assistant	-131	-121	-111	-20	36	41
Radiography assistants	-206	-203	-200	-53	60	67
Speech Therapy assistants	-118	-106	-96	-12	30	36
Pharmacy assistants: post basic	-7,503	-8,288	-9,017	-3,513	2,609	2,666
Community health worker	-11,689	-14,651	-17,392	-14,279	-3,006	152
Home based care worker	-7,360	-9,655	-11,772	-8,874	-2,079	197
<b>TOTAL</b>	<b>-82,962</b>	<b>-83,043</b>	<b>-83,439</b>	<b>-66,305</b>	<b>-16,764</b>	<b>9,258</b>
Enrolled Nursing assistants	-8,381	-6,434	-4,707	1,993	1,304	-723
Enrolled Nurses	21,010	22,471	23,792	4,470	4,061	3,046
Staff Nurse	-20,138	-19,805	-19,522	-15,380	-8,990	-1,357
Professional Nurses	-20,736	-22,352	-23,894	-22,121	-11,527	-898
Medical Practitioners	-4,145	-4,294	-4,447	-3,800	-2,109	-525
Medical Specialists	-7,590	-7,471	-7,379	-5,677	-3,158	-583
Dental Practitioners	0	168	320	480	603	519
Dental Specialists	-22	-24	-26	-21	2	13
Community health worker	-11,689	-14,651	-17,392	-14,279	-3,006	152
Home based care worker	-7,360	-9,655	-11,772	-8,874	-2,079	197
Other	-23,911	-20,995	-18,413	-2,096	8,135	9,414
<b>Total</b>	<b>-82,962</b>	<b>-83,043</b>	<b>-83,439</b>	<b>-66,305</b>	<b>-16,764</b>	<b>9,258</b>
<b>% of total</b>	<b>n/a</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

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Table 20: Summary Plans for Major Categories

Staff category:	Medical practitioners					
Year	Default	2011	2012	2013	2014	2025
Professionals: start of year	13,817	13,829	13,840	14,156	14,502	19,894
Professionals: end of year	13,829	13,840	14,156	14,502	14,855	21,508
<i>annual growth: start of year</i>	n/a	n/a	<b>0.1%</b>	<b>2.3%</b>	<b>2.4%</b>	<b>4.9%</b>
Gap in relation to the target	-4,145	-4,294	<b>-4,447</b>	<b>-4,295</b>	<b>-4,115</b>	<b>-1,213</b>
Positions at start of year: target	17,962	18,124	18,287	18,451	18,617	21,107
Pop per professional: actual (per 10,000)	2.82	2.82	2.93	2.97	3.01	3.74
Pop per professional: target (per 10,000)	3.66	3.66	3.66	3.66	3.66	3.66
Intake from training	1,394	1,394	1,394	1,419	1,445	1,843
Intake - other (full period)	0	0	8,289			
<b>TOTAL ENTRANTS</b>	1,394	1,394	<b>1,701</b>	<b>1,761</b>	<b>1,803</b>	<b>3,603</b>
Exit - other (require plan)	553	553	554	566	580	796
Exit - Retire at 65 (expected)	553	553	554	566	580	796
Exit - death/invalidity/etc (expected)	276	277	277	283	290	398
<b>TOTAL EXITS</b>	1,382	1,383	<b>1,385</b>	<b>1,415</b>	<b>1,450</b>	<b>1,990</b>
<b>TOTAL ENTRANTS LESS EXITS</b>	12	11	<b>316</b>	<b>346</b>	<b>353</b>	<b>1,613</b>
New student intake	1,394	1,394	1,557	1,594	1,630	2,199
Continuing students	6,970	6,970	6,956	7,079	7,211	9,193
Total enrolment at start of year	8,364	8,364	8,513	8,672	8,841	11,392
<i>Required annual increase in enrolments</i>	n/a	n/a	11.7%	2.3%	2.3%	4.6%
Graduates	1,394	1,394	1,419	1,445	1,474	1,899
Pre-service training loss	14	14	16	16	16	22
Continuing students	6,956	6,956	7,079	7,211	7,351	9,471
Population (000)	49,029	49,470	49,916	50,365	50,818	57,615

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Staff category:	Medical Specialists					
Year	Default	2011	2012	2013	2014	2025
Professionals: start of year	6,361	6,597	6,809	7,537	8,237	15,818
Professionals: end of year	6,597	6,809	7,537	8,237	8,896	17,069
<i>annual growth: start of year</i>	n/a	n/a	<b>3.2%</b>	<b>10.7%</b>	<b>9.3%</b>	<b>6.1%</b>
Gap in relation to the target	-7,599	-7,489	<b>-7,404</b>	<b>-6,804</b>	<b>-6,233</b>	<b>-588</b>
Positions at start of year: target	13,961	14,086	14,213	14,341	14,470	16,405
Pop per professional: actual (per 10,000)	1.30	1.30	1.44	1.58	1.71	2.98
Pop per professional: target (per 10,000)	2.85	2.85	2.85	2.85	2.85	2.85
Intake from training	872	872	872	881	912	1,642
Intake - other (full period)	0	0	9,202			
<b>TOTAL ENTRANTS</b>	872	872	<b>1,408</b>	<b>1,453</b>	<b>1,482</b>	<b>2,838</b>
Exit - other (require plan)	254	264	272	301	329	633
Exit - Retire at 65 (expected)	257	267	273	302	331	636
Exit - death/invalidity/etc (expected)	124	129	135	149	163	318
<b>TOTAL EXITS</b>	635	660	<b>680</b>	<b>752</b>	<b>823</b>	<b>1,587</b>
<b>TOTAL ENTRANTS LESS EXITS</b>	236	212	<b>727</b>	<b>701</b>	<b>659</b>	<b>1,251</b>
New student intake	872	872	954	1,048	1,133	2,063
Continuing students	2,776	2,776	2,759	2,813	2,928	5,387
Total enrolment at start of year	3,648	3,648	3,713	3,861	4,061	7,449
<i>Required annual increase in enrolments</i>	n/a	n/a	9.5%	9.8%	8.1%	5.7%
Graduates	872	872	881	912	956	1,729
Pre-service training loss	17	17	19	21	23	41
Continuing students	2,759	2,759	2,813	2,928	3,083	5,679
<b>Population (000)</b>	<b>49,029</b>	<b>49,470</b>	<b>49,916</b>	<b>50,365</b>	<b>50,818</b>	<b>57,615</b>

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Staff category:	<b>Dental practitioners</b>
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Year	Default	2011	2012	2013	2014	2015
Professionals: start of year	981	1,158	1,319	1,297	1,418	1,672
Professionals: end of year	1,158	1,319	1,297	1,418	1,506	1,669
<i>annual growth: start of year</i>	n/a	n/a	<b>13.9%</b>	<b>-1.6%</b>	<b>9.3%</b>	<b>-0.3%</b>
Gap in relation to the target	0	168	<b>320</b>	<b>289</b>	<b>401</b>	<b>519</b>
Positions at start of year: target	981	990	999	1,008	1,017	1,153
Pop per professional: actual (per 10,000)	0.20	0.20	0.28	0.27	0.29	0.31
Pop per professional: target (per 10,000)	0.20	0.20	0.20	0.20	0.20	0.20
Intake from training	265	265	265	238	216	147
Intake - other (full period)	0	0	-168			
<b>TOTAL ENTRANTS</b>	265	265	<b>97</b>	<b>238</b>	<b>216</b>	<b>147</b>
Exit - other (require plan)	39	46	53	52	57	67
Exit - Retire at 65 (expected)	29	35	40	39	43	50
Exit - death/invalidity/etc (expected)	20	23	26	26	28	33
<b>TOTAL EXITS</b>	88	104	<b>119</b>	<b>117</b>	<b>128</b>	<b>150</b>
<b>TOTAL ENTRANTS LESS EXITS</b>	177	161	<b>-22</b>	<b>121</b>	<b>88</b>	<b>-3</b>
New student intake	265	265	130	131	132	150
Continuing students	1,061	1,061	1,058	949	863	585
Total enrolment at start of year	1,326	1,326	1,188	1,080	995	735
<i>Required annual increase in enrolments</i>	n/a	n/a	-51.1%	0.9%	0.9%	1.8%
Graduates	265	265	238	216	199	147
Pre-service training loss	3	3	1	1	1	1
Continuing students	1,058	1,058	949	863	795	586
Population (000)	49,029	49,470	49,916	50,365	50,818	57,615

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Staff category:	Dental specialists					
Year	Default	2011	2012	2013	2014	2015
Professionals: start of year	160	160	159	162	165	227
Professionals: end of year	160	159	162	165	170	233
<i>annual growth: start of year</i>	n/a	n/a	-0.1%	1.4%	2.3%	2.3%
Gap in relation to the target	-22	-24	-26	-26	-24	13
Positions at start of year: target	182	184	186	187	189	214
Pop per professional: actual (per 10,000)	0.03	0.03	0.03	0.03	0.03	0.04
Pop per professional: target (per 10,000)	0.04	0.04	0.04	0.04	0.04	0.04
Intake from training	16	16	16	17	18	26
Intake - other (full period)	0	0	23			
<b>TOTAL ENTRANTS</b>	16	16	19	20	21	26
Exit - other (require plan)	6	6	6	6	7	9
Exit - Retire at 65 (expected)	5	5	5	5	5	6
Exit - death/invalidity/etc (expected)	5	5	5	5	5	5
<b>TOTAL EXITS</b>	16	16	16	16	17	20
<b>TOTAL ENTRANTS LESS EXITS</b>	-0	-0	2	4	5	5
New student intake	16	16	21	21	22	28
Continuing students	51	51	51	54	57	82
Total enrolment at start of year	67	67	72	76	79	110
<i>Required annual increase in enrolments</i>	n/a	n/a	28.4%	0.9%	0.9%	1.8%
Graduates	16	16	17	18	19	26
Pre-service training loss	0	0	0	0	0	0
Continuing students	51	51	54	57	60	83
Population (000)	49,029	49,470	49,916	50,365	50,818	57,615


Staff category:	<b>Dental other</b>					
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Year	Default	2011	2012	2013	2014	2025
<b>Professionals: start of year</b>	1,795	1,985	2,160	2,279	2,218	2,516
<b>Professionals: end of year</b>	1,985	2,160	2,279	2,218	1,945	2,564
<b>annual growth: start of year</b>	n/a	n/a	<b>8.8%</b>	<b>5.5%</b>	<b>-2.7%</b>	<b>1.9%</b>
<b>Gap in relation to the target</b>	-82	92	<b>249</b>	<b>351</b>	<b>273</b>	<b>310</b>
<b>Positions at start of year: target</b>	1,877	1,894	1,911	1,928	1,945	2,206
<b>Pop per professional: actual (per 10,000)</b>	0.37	0.37	0.46	0.48	0.46	0.47
<b>Pop per professional: target (per 10,000)</b>	0.38	0.38	0.38	0.38	0.38	0.38
<b>Intake from training</b>	353	353	353	259	262	274
<b>Intake - other (full period)</b>	0	0	-488			
<b>TOTAL ENTRANTS</b>	353	353	<b>315</b>	<b>144</b>	<b>-74</b>	<b>274</b>
<b>Exit - other (require plan)</b>	72	79	86	91	89	101
<b>Exit - Retire at 65 (expected)</b>	54	60	65	68	66	75
<b>Exit - death/invalidity/etc (expected)</b>	36	39	44	46	44	50
<b>TOTAL EXITS</b>	162	178	<b>195</b>	<b>205</b>	<b>199</b>	<b>226</b>
<b>TOTAL ENTRANTS LESS EXITS</b>	191	174	<b>119</b>	<b>-61</b>	<b>-273</b>	<b>48</b>
<b>New student intake</b>	353	353	268	272	269	287
<b>Continuing students</b>	337	337	336	344	353	414
<b>Total enrolment at start of year</b>	690	690	604	616	622	701
<b>Required annual increase in enrolments</b>	n/a	n/a	3.9%	0.9%	0.9%	1.8%
<b>Graduates</b>	353	353	259	262	259	278
<b>Pre-service training loss</b>	4	4	3	3	3	3
<b>Continuing students</b>	336	336	344	353	361	421
<b>Population (000)</b>	<b>49,029</b>	<b>49,470</b>	<b>49,916</b>	<b>50,365</b>	<b>50,818</b>	<b>57,615</b>

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Staff category:	Nurses					
Year	Default	2011	2012	2013	2014	2025
Professionals: start of year	139,808	144,709	149,167	136,308	143,063	203,700
Professionals: end of year	144,709	149,167	136,308	143,063	148,360	211,196
<i>annual growth: start of year</i>	n/a	n/a	<b>3.1%</b>	<b>-8.6%</b>	<b>5.0%</b>	<b>3.0%</b>
Gap in relation to the target	-33,462	-30,120	<b>-27,236</b>	<b>-41,682</b>	<b>-36,529</b>	<b>89</b>
Positions at start of year: target	173,270	174,829	176,403	177,990	179,592	203,612
Pop per professional: actual (per 10,000)	28.52	28.52	31.53	28.56	29.71	38.33
Pop per professional: target (per 10,000)	35.34	35.34	35.34	35.34	35.34	35.34
Intake from training	17,482	17,482	17,482	12,989	13,430	20,174
Intake - other (full period)	0	0	43,943			
<b>TOTAL ENTRANTS</b>	17,482	17,482	<b>567</b>	<b>19,024</b>	<b>18,173</b>	<b>25,828</b>
Exit - other (require plan)	5,592	5,788	5,967	5,452	5,723	8,148
Exit - Retire at 65 (expected)	4,194	4,341	4,477	4,091	4,293	6,111
Exit - death/invalidity/etc (expected)	2,794	2,894	2,982	2,726	2,861	4,073
<b>TOTAL EXITS</b>	12,580	13,023	<b>13,426</b>	<b>12,269</b>	<b>12,877</b>	<b>18,332</b>
<b>TOTAL ENTRANTS LESS EXITS</b>	4,901	4,458	<b>-12,859</b>	<b>6,755</b>	<b>5,297</b>	<b>7,496</b>
New student intake	17,482	17,482	15,504	16,370	16,865	24,424
Continuing students	18,447	18,447	17,542	19,201	21,240	41,833
Total enrolment at start of year	35,928	35,928	33,046	35,571	38,105	66,257
<i>Required annual increase in enrolments</i>	n/a	n/a	70.4%	1.3%	2.5%	1.8%
Graduates	17,482	17,482	12,989	13,430	13,951	20,932
Pre-service training loss	1,399	1,399	1,240	1,310	1,349	1,954
Continuing students	17,542	17,542	19,201	21,240	23,227	43,843
<b>Population (000)</b>	<b>49,029</b>	<b>49,470</b>	<b>49,916</b>	<b>50,365</b>	<b>50,818</b>	<b>57,615</b>

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Staff category:	<b>Allied</b>
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Year	Default	2011	2012	2013	2014	2015
Professionals: start of year	35,753	38,939	41,833	45,687	47,960	56,741
Professionals: end of year	38,939	41,833	45,687	47,960	48,829	57,581
<i>annual growth: start of year</i>	n/a	n/a	<b>7.4%</b>	<b>9.2%</b>	<b>5.0%</b>	<b>1.5%</b>
Gap in relation to the target	-8,878	-6,093	<b>-3,604</b>	<b>-160</b>	<b>1,701</b>	<b>4,295</b>
Positions at start of year: target	44,631	45,032	45,438	45,847	46,259	52,446
Pop per professional: actual (per 10,000)	7.29	7.29	8.84	9.57	9.96	10.68
Pop per professional: target (per 10,000)	9.10	9.10	9.10	9.10	9.10	9.10
Intake from training	6,401	6,401	6,401	5,584	5,628	5,944
Intake - other (full period)	0	0	-782			
<b>TOTAL ENTRANTS</b>	6,401	6,401	<b>7,615</b>	<b>6,383</b>	<b>5,184</b>	<b>5,944</b>
Exit - other (require plan)	1,430	1,558	1,673	1,827	1,918	2,270
Exit - Retire at 65 (expected)	1,071	1,170	1,254	1,369	1,437	1,701
Exit - death/invalidity/etc (expected)	713	779	834	913	959	1,134
<b>TOTAL EXITS</b>	3,214	3,507	<b>3,761</b>	<b>4,109</b>	<b>4,314</b>	<b>5,105</b>
<b>TOTAL ENTRANTS LESS EXITS</b>	3,186	2,894	<b>3,854</b>	<b>2,273</b>	<b>869</b>	<b>839</b>
New student intake	6,401	6,401	5,525	5,920	6,154	6,818
Continuing students	15,043	15,043	14,552	14,022	13,813	14,592
Total enrolment at start of year	21,443	21,443	20,076	19,942	19,967	21,410
<i>Required annual increase in enrolments</i>	n/a	n/a	9.3%	2.7%	2.6%	1.8%
Graduates	6,401	6,401	5,584	5,628	5,642	6,030
Pre-service training loss	640	640	552	592	615	682
Continuing students	14,552	14,552	14,022	13,813	13,800	14,781
Population (000)	49,029	49,470	49,916	50,365	50,818	57,615



Staff category:		Clinical support				
Year	Default	2011	2012	2013	2014	2025
Professionals: start of year	78,437	74,157	70,265	72,147	80,449	137,278
Professionals: end of year	74,157	70,265	72,147	80,449	89,220	138,631
<i>annual growth: start of year</i>	n/a	n/a	-5.2%	2.7%	11.5%	0.9%
Gap in relation to the target	-33,991	-39,282	-44,196	-43,343	-36,081	5,163
Positions at start of year: target	112,428	113,439	114,460	115,491	116,530	132,115
Pop per professional: actual (per 10,000)	16.00	16.00	14.85	15.12	16.71	25.83
Pop per professional: target (per 10,000)	22.93	22.93	22.93	22.93	22.93	22.93
Intake from training	2,782	2,782	2,782	7,797	8,071	13,703
Intake - other (full period)	0	0	58,932			
<b>TOTAL ENTRANTS</b>	2,782	2,782	<b>8,208</b>	<b>14,795</b>	<b>16,013</b>	<b>13,703</b>
Exit - other (require plan)	3,137	2,966	2,811	2,886	3,218	5,491
Exit - Retire at 65 (expected)	2,354	2,225	2,109	2,164	2,414	4,116
Exit - death/invalidity/etc (expected)	1,570	1,483	1,405	1,444	1,610	2,743
<b>TOTAL EXITS</b>	7,061	6,674	<b>6,325</b>	<b>6,494</b>	<b>7,242</b>	<b>12,350</b>
<b>TOTAL ENTRANTS LESS EXITS</b>	-4,280	-3,893	<b>1,883</b>	<b>8,301</b>	<b>8,771</b>	<b>1,353</b>
New student intake	2,782	2,782	5,281	5,661	6,261	9,415
Continuing students	2,313	2,313	2,834	3,089	3,390	5,367
Total enrolment at start of year	5,095	5,095	8,116	8,750	9,651	14,782
<i>Required annual increase in enrolments</i>	n/a	n/a	48.6%	0.1%	1.2%	1.8%
Graduates	2,782	2,782	7,797	8,071	8,796	13,947
Pre-service training loss	139	139	264	283	313	471
Continuing students	2,834	2,834	3,089	3,390	3,736	5,457
Population (000)	49,029	49,470	49,916	50,365	50,818	57,615

# ANNEXURE A:

## Data on HRH

### List of Tables

Table 1: Summary of 27 clinical professions in SA, total (public & private) and ratio per 10,000 population, by province, 2010 .....	2
Table 2: Public sector vacancies and cost of filling for 14 clinical professions, per province, 2010 .....	6
Table 3: All foreign medical practitioners registered with the HPCSA by nationality, June 2011 .....	8
Table 4: All specialists by specialty per province, public and private, 2008 .....	9
Table 5: All nurses by province, gender and qualification, 2010 .....	13
Table 6: Graduate output of higher education institutions by programme, 2008 .....	14
Table 7: Headcount enrolments by clinical programme and province, 2008.....	15
Table 8: Headcounts and full time equivalent (FTE) of students in clinical training.....	16

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**Table 1: Summary of 27 clinical professions in SA, total (public & private) and ratio per 10,000 population, by province, 2010**

	Eastern Cape		Free State		Gauteng		KwaZulu-Natal		Limpopo	
	Total	Total per 10 000 population	Total	Total per 10 000 population	Total	Total per 10 000 population	Total	Total per 10 000 population	Total	Total per 10 000 population
Medical Practitioners	1846	2.53	904	3.04	5147	5.23	4076	4.05	1170	2.06
Medical specialists	533	0.73	612	2.06	3781	3.85	1456	1.45	182	0.32
Pharmacologists, pathologists and related professionals*	3	0.00	3	0.01	2	0.00	0	0.00	1	0.00
Nursing Assistants	7522	10.30	2937	9.88	12730	12.94	9538	9.47	7698	13.52
Professional Nurses	13069	17.89	4578	15.40	20504	20.85	21274	21.11	10353	18.18
Staff nurses and pupil nurses	3142	4.30	683	2.30	7645	7.77	11198	11.11	3535	6.21
Dental practitioners	337	0.46	210	0.70	2075	2.11	702	0.70	228	0.40
Dental specialists*	0	0.00	0	0.00	58	0.06	7	0.01	1	0.00
Dental technicians*	0	0.00	0	0.00	21	0.02	0	0.00	0	0.00
Dental therapists	59	0.08	17	0.06	163	0.17	181	0.18	92	0.16
Emergency medical services*	2004	2.74	1220	4.10	1117	1.14	2771	2.75	1957	3.44
Pharmaceutical assistants*	27	0.04	2	0.01	5	0.01	699	0.69	186	0.33
Pharmacists	1054	1.44	535	1.80	3660	3.72	1913	1.90	624	1.10
Radiographers	785	1.07	531	1.79	2360	2.40	1429	1.42	244	0.43
Supplementary diagnostic radiographers*	49	0.07	29	0.10	13	0.01	14	0.01	33	0.06
Community development workers*	4	0.01	29	0.10	26	0.03	1	0.00	18	0.03
Dieticians and nutritionists*	81	0.11	58	0.20	164	0.17	107	0.11	136	0.24
Environmental health practitioners	327	0.45	186	0.63	698	0.71	662	0.66	337	0.59
Health science professionals*	881	1.21	1994	6.71	1189	1.21	876	0.87	218	0.38
Medical researchers and related professionals*	0	0.00	7	0.02	16	0.02	11	0.01	3	0.01
Medical technicians/technologists*	21	0.03	29	0.10	92	0.09	69	0.07	8	0.01
Occupational therapists	209	0.29	288	0.97	1227	1.25	458	0.45	211	0.37
Optometrists and opticians*	2	0.00	5	0.02	19	0.02	19	0.02	74	0.13

Oral hygienists*	22	0.03	5	0.02	38	0.04	27	0.03	52	0.09
Physiotherapists	330	0.45	327	1.10	1969	2.00	940	0.93	236	0.41
Psychologists and vocational counsellors	411	0.56	262	0.88	3240	3.29	757	0.75	154	0.27
Speech therapy and audiology*	33	0.05	15	0.05	112	0.11	88	0.09	49	0.09
<b>TOTAL</b>	<b>32751</b>	<b>44.83</b>	<b>15467</b>	<b>52.01</b>	<b>68069</b>	<b>69.21</b>	<b>59274</b>	<b>58.83</b>	<b>27801</b>	<b>48.83</b>

*\*Public sector data only*

**Table 1 (continued)**

	Mpumalanga		North-West		Northern Cape		Western Cape		South Africa	
	Total	Total per 10 000 population	Total	Total per 10 000 population	Total	Total per 10 000 population	Total	Total per 10 000 population	Total	Total per 10 000 population
Medical Practitioners	972	2.77	906	2.32	387	4.13	2739	5.67	18147	3.70
Medical specialists	167	0.48	217	0.56	61	0.65	2626	5.44	9637	1.96
Pharmacologists, pathologists and related professionals*	37	0.11	0	0.00	0	0.00	1	0.00	47	0.01
Nursing Assistants	3203	9.14	4305	11.04	1336	14.29	6769	14.01	56039	11.42
Professional Nurses	5856	16.70	4179	10.71	1700	18.18	9323	19.30	93049	18.97
Staff nurses and pupil nurses	1641	4.68	746	1.91	213	2.27	2593	5.37	31395	6.40
Dental practitioners	416	1.19	130	0.33	90	0.96	1157	2.40	5345	1.09
Dental specialists*	31	0.09	0	0.00	0	0.00	30	0.06	127	0.03
Dental technicians*	0	0.00	0	0.00	0	0.00	12	0.02	33	0.01
Dental therapists	82	0.23	33	0.08	17	0.18	6	0.01	648	0.13
Emergency medical services*	787	2.24	838	2.15	568	6.07	1527	3.16	12789	2.61
Pharmaceutical assistants*	4	0.01	109	0.28	26	0.28	1	0.00	1059	0.22
Pharmacists	723	2.06	564	1.44	226	2.42	2126	4.40	11425	2.33
Radiographers	400	1.14	173	0.44	141	1.51	1437	2.98	7500	1.53
Supplementary diagnostic radiographers*	11	0.03	19	0.05	3	0.03	0	0.00	170	0.03
Community development workers*	13	0.04	7	0.02	2	0.02	1	0.00	101	0.02
Dieticians and nutritionists*	65	0.19	41	0.11	30	0.32	81	0.17	763	0.16
Environmental health practitioners	365	1.04	90	0.23	88	0.94	419	0.87	3172	0.65
Health science professionals*	153	0.44	118	0.30	19	0.20	882	1.83	6330	1.29
Medical researchers and related professionals*	1	0.00	1	0.00	1	0.01	35	0.07	75	0.02
Medical technicians/technologists*	19	0.05	30	0.08	5	0.05	124	0.26	397	0.08
Occupational therapists	265	0.76	82	0.21	83	0.89	957	1.98	3779	0.77

Optometrists and opticians*	4	0.01	0	0.00	3	0.03	0	0.00	126	0.03
Oral hygienists*	14	0.04	5	0.01	4	0.04	27	0.06	194	0.04
Physiotherapists	361	1.03	119	0.30	123	1.31	1447	3.00	5850	1.19
Psychologists and vocational counsellors	246	0.70	172	0.44	50	0.53	1426	2.95	6718	1.37
Speech therapy and audiology*	27	0.08	14	0.04	18	0.19	40	0.08	396	0.08
<b>TOTAL</b>	<b>15863</b>	<b>45.24</b>	<b>12896</b>	<b>33.06</b>	<b>5193</b>	<b>55.53</b>	<b>35786</b>	<b>74.08</b>	<b>273098</b>	<b>55.67</b>

\*Public sector data only

**Table 2: Public sector vacancies and cost of filling for 14 clinical professions, per province, 2010**

	Average cost per worker	Eastern Cape		Free State		Gauteng		KwaZulu-Natal		Limpopo	
		Public sector vacancies	Cost of filling vacancies	Public sector vacancies	Cost of filling vacancies	Public sector vacancies	Cost of filling vacancies	Public sector vacancies	Cost of filling vacancies	Public sector vacancies	Cost of filling vacancies
Medical Practitioners	R 796,922	806	R 642,238,532	427	R 340,242,994	1118	R 890,846,996	1811	R 1,443,044,642	5053	R 4,026,341,566
Medical specialists	R 1,052,236	418	R 439,834,648	287	R 301,991,732	533	R 560,841,788	1078	R 1,134,310,408	656	R 690,266,816
Nursing Assistants	R 127,939	4585	R 586,600,315	2679	R 342,748,581	582	R 74,460,498	1875	R 239,885,625	8022	R 1,026,326,658
Professional Nurses	R 393,591	16683	R 6,566,278,653	1684	R 662,807,244	1720	R 676,976,520	4381	R 1,724,322,171	15605	R 6,141,987,555
Staff nurses and pupil nurses	R 166,925	3480	R 580,899,000	301	R 50,244,425	575	R 95,981,875	2648	R 442,017,400	6776	R 1,131,083,800
Dental practitioners	R 538,904	162	R 87,302,448	31	R 16,706,024	59	R 31,795,336	46	R 24,789,584	507	R 273,224,328
Dental specialists	R 1,052,236	27	R 28,410,372		R 0	37	R 38,932,732	2	R 2,104,472	57	R 59,977,452
Dental therapists	R 284,592	85	R 24,190,320	6	R 1,707,552	6	R 1,707,552	55	R 15,652,560	72	R 20,490,624
Pharmacists	R 411,516	373	R 153,495,468	115	R 47,324,340	263	R 108,228,708	1312	R 539,908,992	1191	R 490,115,556
Radiographers	R 126,316	293	R 37,010,588	84	R 10,610,544	145	R 18,315,820	437	R 55,200,092	378	R 47,747,448
Environmental health practitioners	R 284,592	24	R 6,830,208	23	R 6,545,616	31	R 8,822,352	93	R 26,467,056	160	R 45,534,720
Occupational therapists	R 284,592	123	R 35,004,816	41	R 11,668,272	101	R 28,743,792	184	R 52,364,928	612	R 174,170,304
Physio-therapists	R 284,592	102	R 29,028,384	63	R 17,929,296	86	R 24,474,912	325	R 92,492,400	295	R 83,954,640
Psychologists and vocational counsellors	R 284,592	106	R 30,166,752	20	R 5,691,840	77	R 21,913,584	109	R 31,020,528	258	R 73,424,736
<b>TOTAL</b>		<b>27267</b>	<b>R 9,247,290,504</b>	<b>5763</b>	<b>R 1,816,218,460</b>	<b>5340</b>	<b>R 2,582,042,465</b>	<b>14359</b>	<b>R 5,823,560,858</b>	<b>39653</b>	<b>R 14,284,646,203</b>

Source: Econex calculations from PERSAL and National Treasury data

**Table 2 (continued)**

	Average cost per worker	Mpumalanga		North-West		Northern Cape		Western Cape		South Africa	
		Public sector vacancies	Cost of filling vacancies	Public sector vacancies	Cost of filling vacancies	Public sector vacancies	Cost of filling vacancies	Public sector vacancies	Cost of filling vacancies	Public sector vacancies	Cost of filling vacancies
Medical Practitioners	R 796,822	535	R 426,299,770	157	R 125,101,054	408	R 925,103,376	545	R 434,267,990	10860	R 8,653,486,920
Medical specialists	R 1,052,236	88	R 92,596,768	16	R 16,835,776	18	R 18,940,248	397	R 417,737,692	3491	R 3,673,355,876
Nursing Assistants	R 127,939	1381	R 176,683,759	173	R 22,133,447	393	R 50,280,027	1253	R 160,307,567	20943	R 2,679,426,477
Professional Nurses	R 393,591	1354	R 532,922,214	443	R 174,360,813	638	R 251,111,058	2272	R 894,238,752	44780	R 17,625,004,980
Staff nurses and pupil nurses	R 166,925	1141	R 190,461,425	131	R 21,867,175	223	R 37,224,275	927	R 154,739,475	16202	R 2,704,518,850
Dental practitioners	R 538,904	30	R 16,167,120	11	R 5,927,944	42	R 22,633,968	33	R 17,783,832	921	R 496,330,584
Dental specialists	R 1,052,236	2	R 2,104,472		R 0	30	R 31,567,080		R 163,096,580	155	R 163,096,580
Dental therapists	R 284,592	27	R 7,683,984	4	R 1,138,368	10	R 2,845,920	22	R 6,261,024	287	R 81,677,904
Pharmacists	R 411,516	109	R 44,855,244	48	R 19,752,768	105	R 43,209,180	229	R 94,237,164	3745	R 1,541,127,420
Radiographers	R 126,316	121	R 15,284,236	17	R 2,147,372	50	R 6,315,800	96	R 12,126,336	1621	R 204,758,236
Environmental health practitioners	R 284,592	50	R 14,229,600	9	R 2,561,328	52	R 14,798,784	1	R 284,592	443	R 126,074,256
Occupational therapists	R 284,592	53	R 15,083,376	13	R 3,699,696	25	R 7,114,800	108	R 30,735,936	1260	R 358,585,920
Physio-therapists	R 284,592	63	R 17,929,296	10	R 2,845,920	47	R 13,375,824	83	R 23,621,136	1074	R 305,651,808
Psychologists and vocational counsellors	R 284,592	17	R 4,838,064	11	R 3,130,512	11	R 3,130,512	90	R 25,613,280	699	R 198,929,808
<b>TOTAL</b>		<b>4972</b>	<b>R 1,557,139,328</b>	<b>1043</b>	<b>R 401,502,173</b>	<b>2024</b>	<b>R 796,083,772</b>	<b>6097</b>	<b>R 2,303,521,856</b>	<b>106518</b>	<b>R 38,812,025,619</b>

Source: Econex calculations from PERSAL and National Treasury data



**Table 3: All foreign medical practitioners registered with the HPCSA by nationality, June 2011**

Nationality	Total	Nationality	Total	Nationality	Total
American	23	Egyptian	18	Pakistani	82
Angolan	4	Eritrean	1	Palestinian	1
Arabian	19	Ethiopian	15	Polish	57
Argentina	4	French	4	Portuguese	4
Australian	15	German	73	Republic Of Congo	13
Austrian	10	Ghana	31	Romanian	7
Bangladeshi	66	Greek	4	Russian	20
Belarussian	1	Hungarian	1	Rwandese	32
Belgian	59	Indian	124	Sierra Leona	1
Botswana	16	Iranian	32	Spanish	2
British	265	Irish	26	Sri Lankan	3
Bulgarian	18	Israeli	4	Sudan	16
Burmanese	8	Italian	13	Swaziland	12
Burundi	1	Japanese	2	Swedish	12
Cameronian	17	Kenyan	65	Swiss	8
Canadian	25	Lesotho	20	Tanzanian	32
Chinese	7	Liberian	32	Tunisian	83
Congolese	11	Malawian	45	Ugandan	83
Cuban	194	Mauritius	20	Uruguayan	1
Czechoslovakian	2	Namibian	21	Zaire	199
Democratic Republic Of The Congo	264	Netherlands	36	Zambian	35
Denmark	3	Nigerian	551	Zimbabwean	84
Dutch	39	Norwegian	8		
<b>GRAND TOTAL</b>					<b>3,004</b>

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Table 4: All specialists by specialty per province, public and private, 2008

	EC	FS	GA	KZ	LI	MP	NC	NW	WC	TOTALS
<b>Anesthetists</b>	<b>56</b>	<b>66</b>	<b>499</b>	<b>177</b>	<b>13</b>	<b>22</b>	<b>8</b>	<b>28</b>	<b>330</b>	<b>1199</b>
Public	23	39	132	60	6	3	1	3	138	405
Private	33	27	367	117	7	19	7	25	192	794
<b>Cardio Thoracic Surgeons</b>	<b>7</b>	<b>9</b>	<b>55</b>	<b>18</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>28</b>	<b>120</b>
Public	2	6	21	12	0	0	1	1	13	56
Private	5	3	34	6	0	1	0	0	15	64
<b>Dermatologists</b>	<b>10</b>	<b>8</b>	<b>73</b>	<b>24</b>	<b>1</b>	<b>3</b>	<b>2</b>	<b>3</b>	<b>39</b>	<b>186</b>
Public	2	4	17	6	0	0	0	0	6	55
Private	8	4	56	18	0	2	2	2	39	131
<b>Emergency Medicine</b>	<b>0</b>	<b>0</b>	<b>15</b>	<b>5</b>	<b>1</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>11</b>	<b>34</b>
Public	0	0	4	2	1	3	0	0	7	17
Private	0	0	11	3	0	0	0	0	4	18
<b>Family Physicians</b>	<b>82</b>	<b>56</b>	<b>246</b>	<b>123</b>	<b>30</b>	<b>51</b>	<b>16</b>	<b>32</b>	<b>154</b>	<b>790</b>
Public	68	40	150	78	26	30	12	21	96	521
Private	14	16	96	45	4	21	4	11	58	269
<b>Forensic Pathologists</b>	<b>3</b>	<b>6</b>	<b>14</b>	<b>5</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>13</b>	<b>45</b>
Public	3	5	14	4	2	0	1	1	12	42
Private	0	1	0	1	0	0	0	0	1	3
<b>Maxillo Facial &amp; Oral Surgeons</b>	<b>4</b>	<b>3</b>	<b>57</b>	<b>14</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>27</b>	<b>111</b>
Public	0	2	21	0	1	0	0	1	8	33
Private	5	2	40	14	0	1	1	1	21	85
<b>Neurologists</b>	<b>4</b>	<b>8</b>	<b>61</b>	<b>17</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>32</b>	<b>123</b>
Public	1	4	22	7	0	0	0	0	13	47
Private	3	4	39	10	1	0	0	0	19	76
<b>Neurosurgeons</b>	<b>7</b>	<b>8</b>	<b>63</b>	<b>17</b>	<b>1</b>	<b>3</b>	<b>1</b>	<b>4</b>	<b>31</b>	<b>135</b>

HRH STRATEGY FOR THE HEALTH SECTOR 2012/13 – 1016/17: ANNEXURE A

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Public	3	1	11	3	1	1	0	1	10	31
Private	4	8	52	14	0	2	1	3	21	105
<b>Nuclear Physicians</b>	<b>2</b>	<b>3</b>	<b>26</b>	<b>1</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11</b>	<b>45</b>
Public	1	1	10	1	2	0	0	0	6	21
Private	1	2	16	0	0	0	0	0	5	24
<b>Obstetricians and Gynaecologists</b>	<b>56</b>	<b>38</b>	<b>350</b>	<b>170</b>	<b>21</b>	<b>23</b>	<b>5</b>	<b>24</b>	<b>201</b>	<b>888</b>
Public	23	14	75	75	5	5	1	0	65	263
Private	33	24	275	95	16	18	4	24	136	625
<b>Ophthalmologists</b>	<b>22</b>	<b>12</b>	<b>110</b>	<b>33</b>	<b>4</b>	<b>7</b>	<b>6</b>	<b>10</b>	<b>69</b>	<b>273</b>
Public	8	5	22	9	3	5	1	4	12	69
Private	14	7	88	24	1	2	5	6	57	204
<b>Oral Pathologists</b>	<b>0</b>	<b>0</b>	<b>6</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>6</b>	<b>14</b>
Public	0	0	5	0	0	0	0	2	6	13
Private	0	0	1	0	0	0	0	0	0	1
<b>Orthodontists</b>	<b>6</b>	<b>4</b>	<b>69</b>	<b>13</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>3</b>	<b>30</b>	<b>128</b>
Public	0	0	35	0	0	0	0	2	8	45
Private	6	4	34	13	0	3	0	1	22	83
<b>Orthopaedics</b>	<b>33</b>	<b>33</b>	<b>261</b>	<b>83</b>	<b>10</b>	<b>13</b>	<b>5</b>	<b>13</b>	<b>154</b>	<b>605</b>
Public	12	18	80	13	4	2	0	1	54	184
Private	21	15	181	70	6	11	5	12	100	421
<b>ENT</b>	<b>14</b>	<b>14</b>	<b>121</b>	<b>51</b>	<b>5</b>	<b>6</b>	<b>2</b>	<b>6</b>	<b>73</b>	<b>292</b>
Public	3	8	30	18	2	1	1	1	27	91
Private	11	6	91	33	3	5	1	5	46	201
<b>Paediatricians</b>	<b>41</b>	<b>32</b>	<b>274</b>	<b>106</b>	<b>14</b>	<b>13</b>	<b>4</b>	<b>15</b>	<b>181</b>	<b>680</b>
Public	21	17	119	49	8	1	1	0	106	322
Private	20	15	155	57	6	12	3	15	75	358
<b>Pathologists</b>	Data not available									

HRH STRATEGY FOR THE HEALTH SECTOR 2012/13 -- 1016/17: ANNEXURE A



Private	25	13	190	57	4	10	1	11	82	393
<b>Surgeons</b>	<b>45</b>	<b>29</b>	<b>221</b>	<b>132</b>	<b>12</b>	<b>18</b>	<b>3</b>	<b>15</b>	<b>160</b>	<b>635</b>
Public	24	14	88	76	7	6	0	1	87	303
Private	21	15	133	56	5	12	3	14	73	332
<b>Urologists</b>	<b>11</b>	<b>11</b>	<b>95</b>	<b>40</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>8</b>	<b>51</b>	<b>222</b>
Public	5	6	46	14	0	0	0	2	19	92
Private	6	5	49	26	2	2	2	6	32	130
<b>GRAND TOTAL</b>	<b>546</b>	<b>475</b>	<b>3,699</b>	<b>1,393</b>	<b>153</b>	<b>206</b>	<b>74</b>	<b>228</b>	<b>2,284</b>	<b>9,081</b>

Source: Results of the Survey of the Presidents of the Constituent Colleges of the CMSA, 31st August 2009

**Table 5: All nurses by province, gender and qualification, 2010**

Province	Gender / Total	Population	Nursing Manpower as at 2010/12/31			
			Registered	Enrolled	Auxiliaries	Total
Limpopo	- Females	2827900	8074	3736	7423	19233
	- Males	2611700	951	434	908	2293
	- Total	5439600	9025	4170	8331	21526
North West	- Females	1635500	6936	2305	4152	13393
	- Males	1565400	839	244	580	1663
	- Total	3200900	7775	2549	4732	15056
Mpumalanga	- Females	1853300	5211	2099	3403	10713
	- Males	1764300	503	177	329	1009
	- Total	3617600	5714	2276	3732	11722
Gauteng	- Females	5597000	28494	12112	15571	56177
	- Males	5594700	1569	894	1096	3559
	- Total	11191700	30063	13006	16667	59736
Free State	- Females	1464300	6711	1586	2606	10903
	- Males	1360200	839	260	345	1444
	- Total	2824500	7550	1846	2951	12347
KwaZulu Natal	- Females	5512600	22754	17053	10433	50240
	- Males	5132800	1606	1842	1056	4504
	- Total	10645400	24360	18895	11489	54744
Northern Cape	- Females	561200	1971	422	1192	3585
	- Males	542700	175	39	119	333
	- Total	1103900	2146	461	1311	3918
Western Cape	- Females	2709000	13909	5299	7616	26824
	- Males	2514900	717	302	519	1538
	- Total	5223900	14626	5601	8135	28362
Eastern Cape	- Females	3501500	12969	3218	5317	21504
	- Males	3242300	1016	348	807	2171
	- Total	6743800	13985	3566	6124	23675
<b>TOTAL</b>	<b>- Females</b>	<b>25662300</b>	<b>107029</b>	<b>47830</b>	<b>57713</b>	<b>212572</b>
	<b>- Males</b>	<b>24329000</b>	<b>8215</b>	<b>4540</b>	<b>5759</b>	<b>18514</b>
	<b>- Total</b>	<b>49991300</b>	<b>115244</b>	<b>52370</b>	<b>63472</b>	<b>231086</b>

Source: SANC, 2010

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Table 6: Graduate output of higher education institutions by programme, 2008

Institution	MBChB	Dentistry	Pharmacy	Physiotherapy	Occup. Therapy	SLP & Audiol.	Dietetics	EMS	Biomedical Tech.	Clinical Tech.	Radiography	Optometry	All Professions
UP	200	49		38	27	28					25		367
WSU	103												103
UCT	164			54	46	28							292
US	157			38		19	16						230
UFS	109			37	31		24					25	226
UKZN	223		61	33	25	25						28	395
Wits	189	35	40	38	35	30							367
Limpopo	153	39	94	40	18	27	24				26		421
UNWC		91	60	48	21		9						229
Rhodes			74										74
NW			76								32		108
CPUT								5	22		11		38
CUOT								10	21	16	20		67
DUOT								11	12	26	34		83
UJ								11	5			60	76
Mangosuthu									25				25
NMMU									7		26		33
TUT									18	15	6		39
All Institutions	1298	214	405	326	203	157	73	37	110	57	180	113	3173

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**Table 7: Headcount enrolments by clinical programme and province, 2008**

Qualification	Academic year of study	Eastern	Cape		KwaZ.	lu-Natal	Mpumalanga	Northern	Cape	Western Cape	NHLS	Total
			Free State	Gauteng		Limpopo		North	West			
MBChB	4 or 3	89	131	583	191	0	0	0	0	360	0	1354
	5 or 4	93	111	546	214	8	0	0	0	350	0	1322
	6 or 5	107	116	594	263	27	6	0	5	351	0	1469
BDS	3	0	0	151	0	0	0	0	0	87	0	238
	4	0	0	132	0	0	0	0	0	108	0	240
	5	0	0	119	0	0	0	0	0	97	0	216
Physiotherapy	3	0	39	142	39	0	0	0	0	137	0	357
	4	0	36	107	35	6	0	0	7	143	0	334
Occupational therapy	3	0	35	126	16	0	0	0	2	107	0	286
	4	0	30	81	21	8	0	0	1	106	0	247
Speech & hearing	3	0	0	86	23	0	1	0	0	51	0	161
	4	0	0	86	24	3	0	0	0	53	0	166
Pharmacy	4	131	0	80	59	84	0	0	100	95	0	549
Dental therapy	2	0	0	2	21	0	0	0	0	0	0	23
	3	0	0	14	20	0	0	0	0	0	0	34
Dietetics	4	0	24	42	32	6	0	0	19	36	0	159
MMed	1-4	64	169	1037	591	0	14	18	15	794	180	2882
MMed (Fam Med)	1-4	9	45	0	0	0	0	0	16	0	0	70
MDent	1-4	0	0	81	0	0	0	0	0	15	1	97
M Fam Med	1-4	0	0	27	52	0	0	0	0	5	0	84
Nursing	1	255	60	236	181	136	0	0	76	364	0	1308
	2	208	61	192	87	88	0	0	58	303	0	997
	3	186	52	194	85	80	0	0	52	195	0	844
	4/BTech	154	48	138	118	92	0	0	88	222	0	860
Biomedical Technology	1	39	40	105	73	0	0	0	0	178	0	435
	2	29	31	171	113	0	0	0	0	128	0	472
	3	18	28	229	67	0	0	0	0	144	0	486
	BTech	0	16	74	27	0	0	0	0	0	0	117
Clinical Technology	1	0	30	18	43	0	0	0	0	0	0	91
	2	0	21	26	50	0	0	0	0	0	0	97
	3	0	34	25	31	0	0	0	0	0	0	90
	BTech	0	24	39	49	0	0	0	0	0	0	112
Emergency Medical Care	1	0	22	37	40	0	0	0	0	51	0	150
	2	0	23	17	34	0	0	0	0	37	0	111
	3	0	13	19	48	0	0	0	0	45	0	125
	BTech	0	0	21	35	0	0	0	0	28	0	84
Radiography	1	39	48	179	61	4	0	0	0	98	0	429
	2	21	44	151	56	5	0	0	0	78	0	355
	3	23	34	140	49	5	0	0	0	54	0	305
	4/BTech	0	44	69	57	0	0	0	0	101	0	271
<b>TOTAL</b>		<b>1465</b>	<b>1409</b>	<b>6116</b>	<b>2905</b>	<b>552</b>	<b>21</b>	<b>18</b>	<b>439</b>	<b>4921</b>	<b>181</b>	<b>18027</b>



**Table 8: Headcounts and full time equivalent (FTE) of students in clinical training**

Provinces	FTEs Clinical Training 2010/2011		
	Institution	Headcounts 2008	FTE's
W Cape	UCT	1,216	241
	UWC	1,658	289
	CPUT	942	60
	SU	1,105	223
	<b>Sub Total</b>	<b>4,921</b>	<b>813</b>
E Cape	NMMU	520	73
	UFH	226	46
	WSU	649	129
	Rhodes	70	9
	UCT	-	-
	SU	-	-
<b>Sub Total</b>	<b>1,465</b>	<b>256</b>	
N West	NWU	393	71
	UL	15	2
	Wits	31	10
	<b>Sub Total</b>	<b>439</b>	<b>82</b>
Free State	UFS	993	189
	CUT	416	29
	<b>Sub Total</b>	<b>1,409</b>	<b>218</b>
N Cape	UFS	18	6
	<b>Sub Total</b>	<b>18</b>	<b>6</b>
Gauteng	UP	1,569	290
	UJ	670	74
	Wits	1,656	345
	VUT	278	16
	TUT	551	60
	UL	1,392	250
	<b>Sub Total</b>	<b>6,116</b>	<b>1,035</b>
UKZN	UKZN	1,874	400
	DUT	707	53
	Zululand	198	41
	MUT	126	5
	<b>Sub Total</b>	<b>2,905</b>	<b>499</b>
Limpopo	UL	352	62
	Venda	200	38
	<b>Sub Total</b>	<b>552</b>	<b>101</b>
Mpumalanga	UP	14	4
	UL	7	2
	<b>Sub Total</b>	<b>21</b>	<b>6</b>
NHLS	NHLS	181	56
	<b>Sub Total</b>	<b>181</b>	<b>56</b>
<b>TOTAL</b>		<b>18,027</b>	<b>3,072</b>

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Country  
Factsheet

# South Africa

# Unsafe Abortion



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## Globally

The annual number of abortions worldwide is estimated at 56.3 million, with 25% of pregnancies ending in abortion (2010-2014).<sup>1</sup> 6.9 million women in the developing world were treated for complications from unsafe abortion in 2012,<sup>2</sup> and as many as 40% of women who need care do not obtain it.<sup>3</sup> Globally, unsafe abortion procedures account for an estimated 13% of maternal deaths, or 47,000 women.<sup>4</sup> The Sustainable Development Goals aim to reduce the global maternal mortality ratio from 216 (2015) to 70 (2030) maternal deaths per 100 000 live births.<sup>5</sup> The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both.<sup>6</sup>

## Key Issues

- South Africa has one of the most progressive abortion laws in the world with abortion on demand. However, it estimated that 50% of abortions in South Africa occur outside of designated health facilities.
- Reportedly, many women who opt for illegal abortion services experience complications and seek care in the formal health sector, adding strain to an already resource-constrained health system.
- Health care provider objections to providing abortion procedures results in fewer than half of government designated facilities providing abortion services.
- Limited access to second trimester terminations in public health facilities results in women exceeding the legal gestation period for obtaining abortions and seeking abortions outside of designated health facilities.
- The majority of women are unaware of their legally recognised abortion rights under South African law, meaning many women believe illegal and unsafe abortion providers are their only option.
- Religious and cultural stigmatization of abortion also results in women seeking discrete, clandestine abortions outside of designated health facilities.
- Legal authorities take minimal preventative measures to control street and cyber marketing for illegal abortion services in South Africa.
- Restrictive abortion laws in countries in southern and east Africa drive women who can afford it to access legal abortions in South Africa. However, many of the cross-border clients unwittingly access abortions from illegal and unsafe abortion providers.

## South Africa

### Unsafe abortion

The legality of abortion in South Africa affords women reproductive autonomy and the right to access safe abortion procedures on demand. As a result of this 1996 liberalisation of abortion law, studies have shown that abortion-related mortality decreased by 91% in South Africa between 1994 and 1998–2001.<sup>7</sup> However, an estimated 50% of abortions in South Africa continue to occur outside of designated health facilities.<sup>8</sup>

The 1998 Demographic and Health Survey (DHS), which formed the baseline indicator for the Millennium Development Goal (MDG) maternal mortality target in South Africa, approximated the maternal mortality rate at 150 per 100,000 live births,<sup>9</sup> though many maternal deaths are not registered. The 2015 MDG target was set at 38 per 100,000 live births. However, by 2015, the World Bank estimated South Africa's maternal mortality rate had fallen only marginally, to 138 deaths per 100,000 live births.<sup>10</sup>

The percentage of maternal deaths attributable to abortion complications is unknown. The Department of Health's (DoH) 2011-2013 'Confidential enquiries into maternal deaths in South Africa' did not provide a separate category to account for abortion-related mortality. However, the DoH estimated that between 2008 and 2010, 23% of maternal deaths resulting from septic miscarriages in public health facilities, were as a direct result of unsafe abortions.<sup>11</sup>

### Law & policy

Reproductive health rights are protected under the South African constitution including the right for men and women to exercise control over their bodies. The South African Choice on Termination of Pregnancy Act (CTOP) No.92 of 1996 replaced the restrictive Abortion and Sterilization Act, 1975. The CTOP Act stipulates that women have the right to access safe and effective methods of fertility control and this extends to termination of pregnancy rights.

The COTP Act came into effect on 1 February 1997. The new law intended to make abortion services accessible for all women in South Africa, particularly those who were disadvantaged and lacked access to adequate health care facilities during apartheid. Under the COTP Act, every woman has the right to access early termination of pregnancy in accordance with her beliefs. The minor-consent provision in the Act also ensures that minors have access to safe abortion services without the need for parental consent. In the first 12 weeks of gestation, a termination may be performed on request. Between the 13<sup>th</sup> and 20<sup>th</sup> week gestation period, pregnancy may be terminated if the pregnancy endangers the woman's physical or mental health, in case

of foetal physical and mental abnormalities, or if the pregnancy resulted from rape or incest. The act also takes into account a woman's social and economic circumstances and a woman can request a pregnancy termination on socio-economic grounds up until the 20<sup>th</sup> gestational week.<sup>12</sup>

The COTP Act was amended in 2004 to increase accessibility to abortion services by allowing registered nurses and midwives to perform first trimester abortions, and local governments and executive councils to approve new facilities and the maintenance standards of abortion facilities. Under the 2004 amendment, facilities with 24-hour maternity services no longer required executive-council approval to perform first trimester abortions. While the amendment was ruled as invalid by the Constitutional Court in 2006, the amendment was re-enacted by parliament as the Choice on Termination of Pregnancy Amendment Act of 2008.

## Knowledge & attitudes

A combination of widespread anti-abortion religious and cultural beliefs in South Africa fuels a strong stigma around abortion, affecting abortion-seeking behaviours and service provider attitudes. Service providers are known to chastise clients, particularly minors, for early sexual debut and irresponsibility for choosing to terminate the pregnancy. Abortion is associated with social ills such as drug abuse, moral deterioration and promiscuity. The stigma associated with providing abortions can result in service provider resistance to be trained in providing termination of pregnancies, thereby limiting service provider capacity to meet the growing demand for abortions in the country. The absence of ongoing values clarification for health care workers also leads to insensitivity, isolation and stigmatisation of abortion service providers in the work place. Conscientious objections, stigma and the lack of extra remuneration for performing abortions results in short abortion staff turnover periods, with serious implications for the sustainability of abortion services. Limited understanding of how to interpret the COPT Act grounds for legal abortion also results in service providers setting unnecessary barriers to women seeking abortions.

The lack of information dissemination and media coverage on safe abortions resulted in a 2006 study concluding that 30% of South Africans were unaware of the liberalised status of induced abortion and the gestation limits permitted by law to access abortion services.<sup>13</sup> Consequently, many women fail to seek early pregnancy terminations resulting in an unnecessarily high number of second trimester abortions. Abortion stigma means abortion is treated by most as a deeply private matter and confidentiality of service providers is paramount. Public health facilities document abortion procedures and many clients fear breach of confidentiality; the shame associated with terminating a pregnancy means many women access illegal abortion services which they believe to be more discrete.

## Abortion & post abortion care services

Women can obtain a state funded abortion in public health facilities at no cost to themselves. Yet, fewer than half of the public health facilities designated by government to carry out abortion procedures are offering the service. The negative perceptions surrounding abortion result in abortion services not being prioritised, and some public facilities set daily quotas for the number of abortions they are willing to perform. Consequently, women are turned away when the daily quota has been reached, resulting in missed opportunities for first trimester terminations. Only a limited number of healthcare facilities offer second trimester abortions. Women often have to travel long distances to access these facilities, with waiting periods in most public hospitals exceeding four weeks. This leads to women seeking second trimester abortions exceeding the 20-week gestation legal limit for terminating pregnancy and being referred for antenatal care services.

The cost associated with seeking abortions in designated private facilities results in the poor being unable to access these services. While the government is making efforts to subsidise these costs through public-private partnerships with private clinics such as Marie Stopes, such clinics remain inaccessible both financially and geographically to most, poor women. Illegal service providers thrive by offering affordable, same day procedures. The liberalisation of medical (i.e. non-surgical) abortions results in unregistered (and therefore illegal) service providers having easy access to Misoprostol for medical abortion. Illegal service providers do not necessarily adhere to the gestational limits for performing abortions set by the COTP Act and may provide termination at advanced pregnancy stage, often with large doses of Misoprostol. This increases risk of incomplete abortions, pelvic infections, uterine rupture and haemorrhaging. Limited access to abortion services also results in self-induced terminations, often with the ingestion of toxic cleansers, herbal concoctions, castor oil and Magnesium sulphate. These can cause severe organ damage, and death.

Due to the highly restrictive abortion laws in most southern African countries, South Africa also receives a large number of cross-border clients who present for abortion services. Many of these women, in ignorance, respond to street advertisements for abortion services placed by illegal service providers in the false belief that they are accessing safe abortion services.

The confidentiality of postabortion care is a concern for women who seek postabortion care in public health facilities. However, in most public hospitals women are referred back to their primary health facility for postabortion care. Fear of recognition and consequent exposure at the local health facility means many women only seek postabortion care when they believe they are facing life threatening complications.

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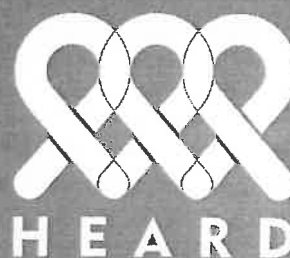
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## Knowledge of the abortion legislation among South African women: a cross-sectional study

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### Abstract

**Background:** In order to ensure that legalized abortion in South Africa improves reproductive health, women must know that abortion is a legal option in the case of unwanted pregnancy. This study investigated knowledge of abortion legislation eight years after the introduction of legal abortion services in one province of South Africa.

**Methods:** In 2004/2005, we conducted a cross-sectional study among 831 sexually-active women attending 26 public health clinics in one urban and one rural health region of the Western Cape Province.

**Results:** Thirty-two percent of women did not know that abortion is currently legal. Among those who knew of legal abortion, few had knowledge of the time restrictions involved.

**Conclusion:** In South Africa there is an unmet need among women for information on abortion. Strategies should be developed to address this gap so that women are fully informed of their rights to a safe and legal termination of pregnancy.

### Background

Experiences from around the world show that restrictive abortion laws lead women to have unsafe abortions, in turn contributing to over one-tenth of maternal deaths in developing countries [1]. Before liberalization of the South African law in 1996, about 1000 legal abortions were granted annually in South Africa, mostly to middle- and upper-class white women [2]. At the same time, roughly 200,000 unsafe abortions were performed annually, the vast majority among poor black women, resulting in an estimated 45,000 hospital admissions and over 400 deaths from septic abortions each year [2]. The 1996

Choice on Termination of Pregnancy (CTOP) Act gives women in South Africa the right to choose whether or not to have a safe abortion [3]. As a direct result of this legislation, abortion-related morbidity and mortality have plummeted across the country [4]. However, abortion services still remain inaccessible to many women because of stigma, provider resistance, and lack of trained providers and facilities certified by the national or provincial department of health to provide abortions, especially in rural areas [5]; as a result, illegal abortions still occur [6,7].

Abortion is a time-restricted health service: the Act states that a pregnancy may be terminated upon a woman's request during the first 12 weeks of gestation, beyond 12 weeks and up to 20 weeks for reasons of adverse effects on the woman's mental or physical health or socio-economic status, in cases of rape and incest, and in cases where the fetus would suffer from severe physical or mental abnormality. From 20 weeks onwards terminations are available under very limited circumstances. Because of these time restrictions, for this law to fully achieve its goal of improving reproductive health by allowing a woman to decide whether and when to reproduce, women must know that abortion is a legal and accessible option in the case of unwanted pregnancy, ideally *before* they become pregnant. Moreover, women need to be aware of the time constraints involved, as well as how and where to access abortion services. This study investigated knowledge of the abortion legislation eight years after the introduction of legal abortion services in South Africa among women attending primary care public health clinics in the Western Cape Province, South Africa.

### Methods

To assess women's knowledge of key reproductive health services, including abortion, emergency contraception (EC) and voluntary testing and counselling for HIV, in 2004/2005 we undertook a cross-sectional study in 26 community health clinics in one urban and one rural health region in the Western Cape Province, South Africa. The Western Cape is among South Africa's better-resourced provinces, with the largest number of positive reproductive health indicators, and is considered to have the best-developed reproductive health infrastructure in the country. The study was requested by the Western Cape provincial health department. Here we report on women's knowledge about abortion legislation.

In each region, we selected a random sample of primary health care clinics with the probability of selection weighted by patient load based on the clinics' usage statistics obtained from the provincial health department. Over a two-day data collection period at each clinic, interviewers approached consecutive women as they signed into the clinic to participate, regardless of their reason for attending the clinic. Women were eligible if they had ever had sexual intercourse and were between the ages of 15 and 49. The number of women interviewed at each facility was proportional to clinic size (based on total patient load) and varied from 11 to 52. We interviewed consecutive women until the target sample size was reached. Refusals were minimal (<2%). Semi-structured interviews were conducted in participants' home languages and lasted approximately 15 minutes. To assess knowledge of the abortion law, we asked the following key questions: 1) "Does the present law on abortion in South Africa allow

for a woman to have an abortion?" 2) "Up to how many weeks of pregnancy is a woman allowed by this law to have a legal abortion?", and 3) "Has a health care worker ever discussed abortion with you?". After responding to these questions, a description of legal abortion was then read to all participants and they were asked open ended questions about their attitudes towards legal abortion and their perceptions of its safety.


In the analysis, responses to open-ended questions were coded and collapsed into categories to facilitate quantitative assessment. Bivariate analyses employed  $\chi$ -square tests. A multiple logistic regression model was developed to examine how demographic and behavioral factors were associated with abortion knowledge. Variables that demonstrated significant bivariate associations with abortion knowledge (defined as  $p < 0.05$ ) were entered into the model. Variables were retained in the final model if they demonstrated a significant independent association with the outcome of interest, or if their removal altered the association between other covariates and the outcome of interest [8].

All participants provided written informed consent and ethical approval to conduct the survey was granted by the Provincial Department of Health, the City of Cape Town Health Department, each participating clinic and the Research Ethics Committee of the University of Cape Town.

### Results

Of the 831 women who participated (628 urban participants and 203 rural participants), most were attending the clinic on the day of the interview for medical complaints (37%,  $n = 307$ ), antenatal or postnatal care (32%,  $n = 266$ ), or family planning services (21%,  $n = 175$ ). The median age was 28 years and the median level of education was grade 10 (Table 1). Most participants spoke either Afrikaans or Xhosa as their main language (47%,  $n = 391$  and 44%,  $n = 366$ , respectively). Of the 688 participants who had ever been pregnant, 61% ( $n = 420$ ) reported that their last pregnancy was unintended.

Overall, thirty-two percent of women ( $n = 264$ ) did not know that the law in South Africa allows for legal abortion, and this proportion was substantially higher in the rural region (40%,  $n = 82$ ) compared to the urban region (29%,  $n = 182$ ) ( $p < 0.01$ ). Furthermore, from clinic to clinic, the proportion who knew abortion was legal ranged from less than 6% to more than 64%. Among the 567 respondents who were aware of legal abortion, almost half (48%,  $n = 272$ ) did not know there was a time restriction for a legal termination of pregnancy on request (without restriction). Of the 295 participants who knew that there was a time restriction, 20% ( $n = 59$ ) thought

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**Table 1: Socio-demographic characteristics of participants**

Characteristic	Urban Region N = 628	Rural Region N = 203	Total N = 831
Mean age in years (standard deviation)	28.4 (9.0)	27.3 (8.2)	28.2 (8.9)
Age categories, %			
15-19	18.2	17.9	17.8
20-29	42.6	45.3	43.1
30-39	24.4	28.3	25.2
40-49	14.8	8.5	13.8
Marital status, %			
Married	35.8	31.7	35.4
Single, current relationship	50.8	57.4	53.1
Single, no current relationship	13.3	10.7	11.4
Level of education, %			
No formal schooling	3.1	0.9	2.8
Grade 1-Grade 7 (primary)	15.8	20.8	17.1
Grade 8-Grade 12 (secondary)	77.6	78.3	77.4
Tertiary	3.4	0	2.7
Employment status, %			
Employed	25.5	32.7	27.6
Scholar/student	13.6	9.4	12.3
Unemployed	46.7	44.9	45.7
Houseminder/disabled/pensioner	14.3	13.1	13.8
Main language spoken, %			
Afrikaans	46.0	48.6	46.7
Xhosa	42.7	50.9	44.2
English	10.8	0	8.6
Other	0.5	0.5	0.5

that it was 12 weeks or less, 4% (n = 12) thought that it was more than 12 weeks, and 76% (n = 224) did not know what the time restriction was. Of those who were aware of legal abortion, only 9% (n = 51) had ever discussed abortion with a health care worker.

Of the total sample, most women perceived legal abortion in the first trimester by manual vacuum aspiration as medically safe (62%, n = 515) and believed that women should be allowed to have a legal abortion upon request (63%, n = 524). A substantial minority of women (38%, n = 316), however, considered legal abortion to be an unsafe procedure, and most commonly mentioned concerns about a reduction in future fertility as the reason.

Age, level of education and employment were not associated with knowledge of legal abortion in the bivariate analysis. In the multivariate analysis, characteristics independently associated with knowledge of legal abortion were: living in the urban vs. rural region (OR 1.5; 95% confidence interval (CI) 1.0-2.0), having heard of emergency contraception vs. having not heard of EC (OR 2.8; 95% CI 1.9-4.2) and having used an effective method of contraception at last sexual intercourse vs. not using contraception (OR 2.0; 95% CI; 1.2-3.3) (Table 3).

## Discussion

This is one of the few studies focusing on South African women's knowledge of the abortion law. These findings show that one-third of women surveyed do not know that abortion is legal in South Africa. Knowledge of the legality of abortion in other similar settings where abortion is legal in some form ranges from 45% in Mexico to 57% in Latvia to 78% in the Gauteng Province of South Africa [7,9,10]. In one qualitative study of South African women who had abortions outside of the legal abortion services, 54% reported having done so because they did not know about the law [7]. The 1998 South African Demographic and Health Survey (DHS), which was conducted less than two years after the implementation of the CTOP Act, found that nationally 53% of women knew of legal abortion; the Western Cape provincial figure was 51% [11]. In this study, 68% of women knew that abortion is a legal health service. Although this study used the same questions as the DHS, the DHS figures are not directly comparable to these findings due to different sampling methodologies: the DHS was a community-based sample of women and this study sampled women attending health services. A comparison of these two sets of data suggests that more women know about legal abortion now than did in 1998. However, another explanation for

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**Table 2: Associations between participant characteristics and knowledge of legal abortion. A bivariate analysis**

Characteristic	Know that abortion is legal	Do not know that abortion is legal	P-value
Total	68.7	31.3	
Region			
Urban	71.5	28.5	<0.01
Rural	60.3	39.7	
Age (years)			
15-19	68.3	31.7	0.5
20-29	68.7	31.3	
30-39	67.0	33.0	
40+	75.2	24.8	
Education			
Less than school	62.6	37.4	0.1
Secondary or above	69.4	30.6	
Marital status			
Married	67.0	33.0	0.4
Unmarried	70.0	30.0	
Main language spoken			
IsiXhosa	69.2	30.8	0.6
African	67.4	32.6	
English	75.8	24.2	
Other	75.0	25.0	
Last pregnancy intended			
Yes	69.4	30.6	0.8
No	68.4	31.6	
Method of sexual intercourse			
No	65.0	35.0	<0.01
Oral	80.0	20.0	
Male condom	79.5	20.5	
Health status			
Yes	82.4	17.6	<0.001
No	62.9	37.1	

This difference in levels of knowledge is that this was surveyed among individuals attending public health facilities with greater access to health education. These 2005 results may simply reflect greater knowledge in this sample compared to the general population in the Western Cape, as opposed to an increase in knowledge among all women through time. In general, it is a lack of awareness of abortion legislation in this clinic in the Western Cape Province, which

has a better reproductive health infrastructure than most other areas of the country, is higher than in the general population of South Africa.

These data suggest that approximately one-third of the women we surveyed in 2004/2005 do not know that abortion is legal in South Africa. This finding, coupled with the findings that 61% of last pregnancies in this sample were unintended and 25% of women who did not

**Table 3: Factors independently associated with knowledge of legal abortion (n = 831). A multivariate analysis.**

Characteristic	Odds ratio	95% CI
Region		
Urban	1.4	1.0-1.9
Rural	1 (Ref)	
Health status		
Yes	2.8	1.9-4.2
No	1 (Ref)	
Contraception at last sexual intercourse		
Yes	2.0	1.2-3.3
No	1 (Ref)	

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want to fall pregnant did not use contraception during last intercourse [12], is worrisome. Not only are an appreciable proportion of these women uninformed about the option of abortion in the case of unwanted pregnancy, they are also unable to protect themselves from unintended pregnancy in the first place. This study shows that lack of knowledge of legal abortion is associated with lack of other reproductive health knowledge, such as awareness of EC and contraceptive use. Thus, the 32% of women who do not know that abortion is a legal option may be the women at greatest risk for unwanted pregnancy.

Furthermore, this study reveals tremendous variability from clinic to clinic in terms of women's knowledge of the abortion legislation. Reasons for this inter-clinic variability are poorly understood. This is a key finding that requires further research so that the health services are able to appropriately target certain clinics and areas for intervention.

Given that only 9% of those aware of the law had ever discussed abortion with a healthcare worker, there is clearly a need for greater client-provider dialogue regarding abortion, particularly the time restrictions and safety of the legal procedure. Regardless of individual provider beliefs, relaying basic information on the legality of abortion may need to become part of routine reproductive health counseling.

In addition, community-based health information campaigns and school-based sex education and life skills programs should incorporate information on abortion services. Expanding access to information about abortion beyond the clinic setting is essential in that women who are at highest risk for unintended pregnancy and therefore for abortion – women who cannot or do not access family planning services – are unlikely to visit a healthcare provider who could discuss the law with them.

### Conclusion

Overall, these findings indicate that there is a substantial unmet need among women for information on abortion. Strategies should be developed to address this gap so that women are fully informed of their rights to a safe and legal termination of pregnancy. For the abortion legislation to fully contribute to improve health in South Africa, all South African women must know that abortion is a legal and accessible option in the case of unwanted pregnancy.

### Competing interests

The author(s) declare that they have no competing interests.

### Authors' contributions

CM conceptualised and designed the study, oversaw data collection and data analysis, was primarily responsible for the interpretation of results and drafting the manuscript.

LM participated in designing the study, conducted the data analysis and participated in the interpretation of results and drafting and critically reviewing the manuscript.

KT assisted in data analysis, interpretation of results and critically reviewed the manuscript.

All authors read and approved the final manuscript.

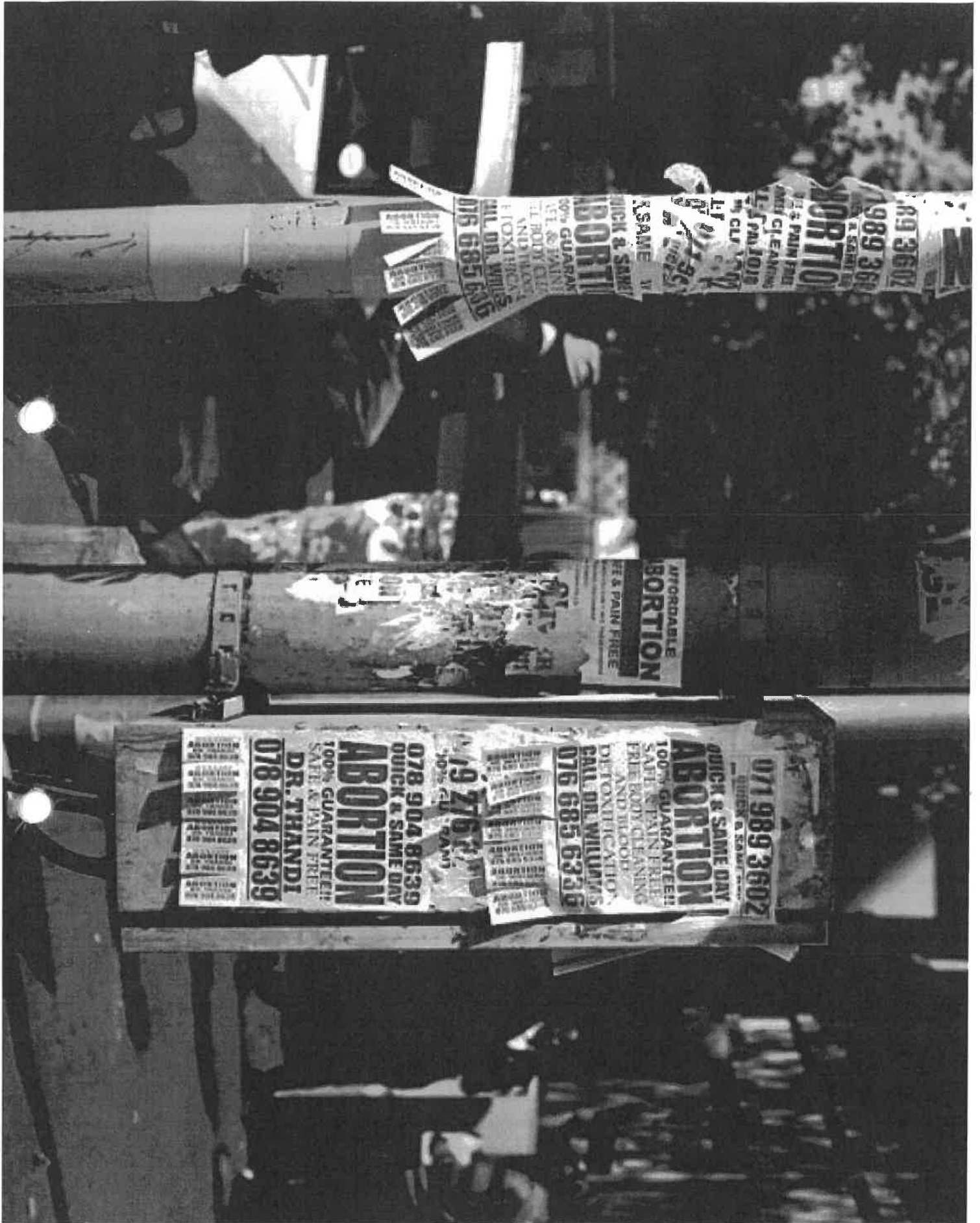
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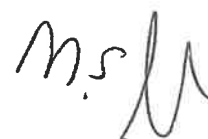
**PROVINCIAL STANDARDISED GUIDELINES AND PROTOCOLS ON THE CHOICE OF  
TERMINATION OF PREGNANCY (CTOP)**

1. **This circular replaces circular H157/2010.**
2. Attached are the revised Provincial policy, standardized guidelines and protocols to guide the Choice of Termination of Pregnancy services in the Western Cape.
3. It replaces all existing CTOP guidelines.
4. The contents of this circular must be brought to the attention of all relevant staff.
5. Your cooperation in this regard is appreciated.

  
.....  
DR B ENGELBRECHT

WCG: HEAD OF HEALTH

DATE: 2016-03-15





Western Cape  
Government

Health

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Policy Guidelines &  
Protocols for Choice on  
Termination of  
Pregnancy Service

February  
2016

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Western Cape Department of Health

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TABLE OF CONTENTS

		Page No
1.	Purpose	5
2.	Referral guidelines for clients requesting Termination of Pregnancy	6
3.	Outline of management protocol	7
4.	Client assessment and preparation	8
5.	Referral routes for non-designated sites	9
6.	Standard procedure for performing TOPs and referrals	11
7.	Combined mifepristone and misoprostol protocol	12
8.	Notification, Keeping of records & Submission of data	12
9.	Confidentiality	13
10.	Ethical and legal obligations	13
11.	Staff support	14
<b>Annexures/Addendums</b>		
Annexure A:	Notification of Termination of Pregnancy in terms of Section 7 of the CTOP Act (Act No 92 of 1996)	
Annexure C:	Monthly data collection form	
Annexure D:	Royal College of Obstetricians & Gynaecologists: Best practice in abortion care (Best Practice Paper No 2 June 2015)	
Annexure E:	Referral form for second trimester TOP	

ACRONYMS & ABBREVIATIONS	
ACOG	American Congress of Obstetricians and Gynaecologists
BANC	Basic Antenatal Care
CTOP	Choice of Termination of Pregnancy
D&E	Dilatation and Evacuation
EML	Essential Medical List
IUD	Inter Uterine Device
MTOP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
PACK	Practical Approach to Care Kit
RCOG	Royal College of Obstetricians and Gynaecologists
STG	Standard Treatment Guidelines
TOP	Termination of Pregnancy
WCG	Western Cape Government
WHO	World Health Organisation

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## 1. PURPOSE

The purpose of this document is to provide a policy framework to guide the provision of equitable, accessible, cost-efficient and user-friendly services for women with unwanted pregnancies as part of the Sexual and Reproductive Health and Rights Programme, integrated into the comprehensive health care services.

This document does not include criteria & protocols for Termination of Pregnancy (TOP) after 20weeks in terms of the Choice on Termination of Pregnancy (CTOP) Act of 1996.

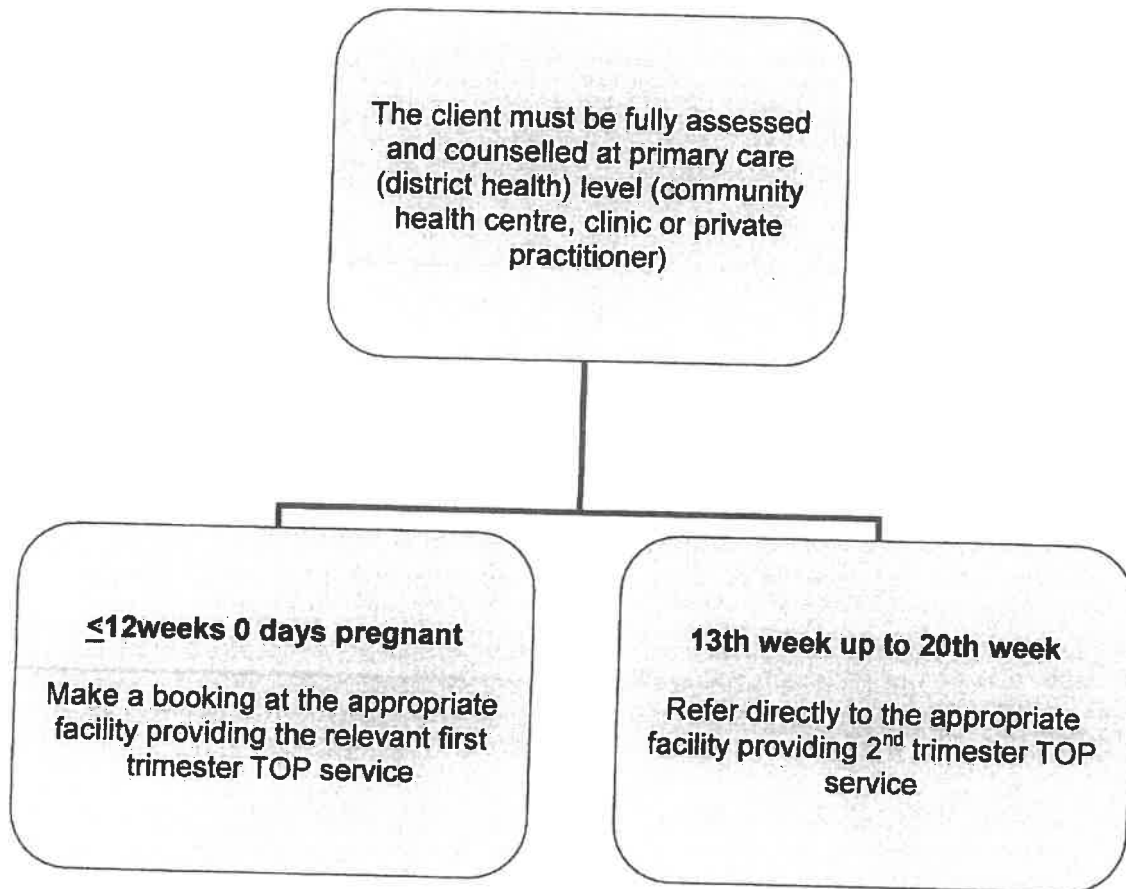
Included in this policy are guidelines for the provision of Medical and Surgical TOPs:

- Referral guidelines for clients requesting Termination of Pregnancy
- Outline of Management protocols
- Client assessment and preparation
- Referral routes for non-designated sites
- Standard procedure for performing TOPs and referrals
- Combined mifepristone and misoprostol protocol
- Keeping of records and Submission of data (H55/2013)
- Confidentiality
- Ethical and legal obligations
- Staff support

Also consult the Annexure D: Royal College of Obstetricians and Gynaecologists: Best practice in abortion care (Best Practice Paper No 2 June 2015)



## 2. REFERRAL GUIDELINES FOR CLIENTS REQUESTING A TERMINATION OF PREGNANCY



According to the WCG "Levels of Care" policy document, a first trimester TOP should take place in the district health service and second trimester TOP at specialist level (secondary hospital or appropriate service with specialist backup). Clients requesting the service should enter the Provincial Health System at the primary care level.

The CTOP Act is quite specific in its definition of first and second trimester termination:

**First trimester:** "during the first 12 weeks of the gestation period of a woman who so requests". The first 12 completed weeks of pregnancy is up to 12 weeks and 0 days.

**Second trimester:** "from the 13th up to and including the 20th week of the gestation period..." The thirteenth week of pregnancy starts after the 12th week (from 12 weeks and 1 day) and the 20th week ends at 20 weeks and 0 days.

### 3. OUTLINE OF MANAGEMENT PROTOCOL:

- A client presenting at a primary care provider setting (clinic, community day centre, community health centre, general practitioner) requesting termination of pregnancy, should have full assessment and preparation before referral.
- 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.
- The procedure will depend on the eligibility criteria. For the first trimester it will either be a medical TOP (if gestation 63 days or less), or a combination of medical priming followed by surgical evacuation of products using Manual Vacuum Aspiration (MVA) under local anesthesia/sedation/analgesia. For second trimester the procedure will either be medical termination in a facility providing 2<sup>nd</sup> Trimester abortion; followed by evacuation of products if the abortion was not complete; or a Dilatation and Evacuation (D&E) procedure done by specially trained staff as an outpatient procedure in specially designated sites.

The preferred evidence based management of TOP according to gestation is:

- Up to 63 days (9 weeks) - Medical TOP with Mifepristone and Misoprostol as outpatient.
- 9 weeks +1 day to 12 weeks 0 days – Surgical TOP with Manual Vacuum Aspiration (MVA). As an alternative to MVA from 9 weeks +1 day to 12 weeks 0 days MTOP may be administered with the following provisions:
  - That the procedure be conducted by a medical practitioner.
  - That the facility has beds for observation and administration of drugs.

- 12 weeks + 1 day to 17 weeks 0 days – Surgical TOP by D&E.
- 17 weeks 1 day to 20 weeks 0 days – Medical TOP with Mifepristone and Misoprostol in hospital.
- The client should be counselled and commenced on a contraceptive method of choice before leaving the facility. The only exception is the client who chooses an IUD following medical TOP. This client must preferably use an interim method.
- The client must also have a follow-up appointment at her local clinic to ensure appropriate future contraceptive use.
- The normal referral routes between levels of care in the Western Cape Province apply to termination of pregnancy referrals.

#### 4. CLIENT ASSESSMENT AND PREPARATION:

- **History:** Complete medical history.
- **Examination:** General health assessment; physical examination, including abdominal palpation, bimanual examination, and speculum examination where indicated.
- **Pregnancy Test:** Confirm pregnancy by urine pregnancy test.
- **Indications to refer for ultrasonography:**
  - Ultrasound is the preferred method of determining gestational age.
  - Where ultrasound is not available clinical assessment of gestational age that agrees with the menstrual dates is acceptable.
  - Signs and symptoms of ectopic pregnancy or other early pregnancy complications.

- Treat symptomatic vaginal discharge or any sexually transmitted infections using Essential Medicines List (EML); Standard Treatment Guidelines (STG's) and in accordance with the Practical Approach to Care Kit (PACK) guidelines **but do not delay the TOP procedure.**  
Do a cervical cytology if necessary and available.  
Do laboratory and other investigations if necessary and available.
- **Special investigations** should be done by the referring facility and should not delay the procedure.
- **Counselling** should cover all aspects.
- **Complete the standard referral letter** and hand it to the patient.
- A **booking** must be made in all cases.
- As a **minimum standard**, women should be assessed and referred within 2 weeks of requesting a TOP procedure.
- Arrange a **follow-up appointment** at the local clinic to ensure continuity of contraceptive use and further post TOP counseling.

It must be stated that referral of a client is an important consideration and applies throughout the management of a client undergoing TOP. Facilities not designated to provide TOP services must refer clients to designated facilities. All facilities must provide counselling before referral.

##### 5. REFERRAL ROUTES (FOR NON-DESIGNATED SITES)

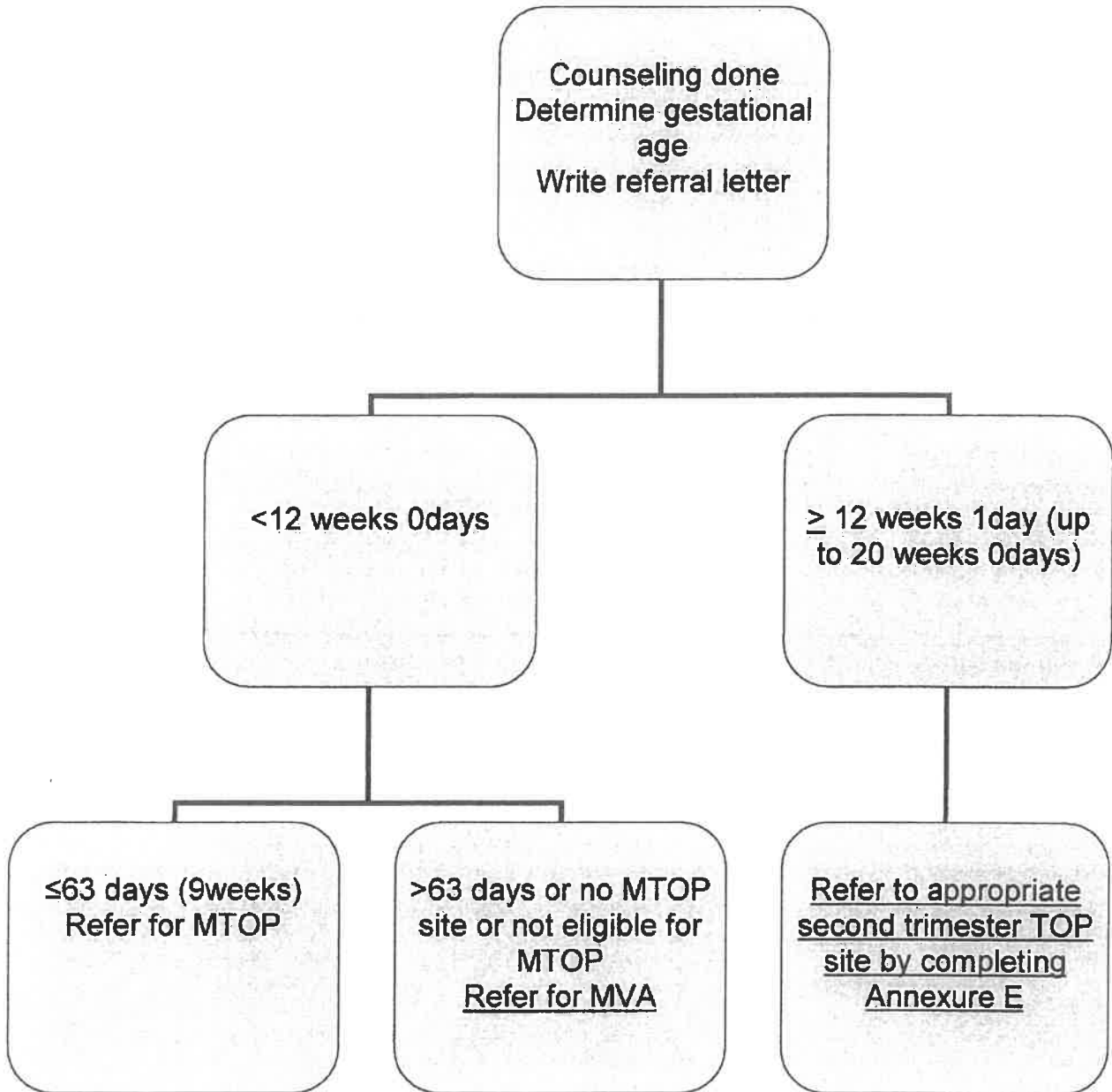
- If gestation is <9 weeks (63 days), make an urgent appointment at the nearest site dedicated to MTOP. If gestation is 9 weeks -12 weeks 0 days, refer to the nearest site offering first trimester TOP.
- For sites where MTOP is not available, if pregnancy gestation is <12 weeks 0 days and uncomplicated, give a date for the procedure at the nearest site offering first trimester TOP.
- If the pregnancy gestation is assessed to be in the 13<sup>th</sup> week or more (12 weeks 1 day up to 20 weeks 0 days), refer to the appropriate facility for a second trimester TOP service.

- If the pregnancy gestation assessed to be more than 20 weeks, book the patient for pregnancy (using the BANC approach or refer to the closest BANC site) and refer to a social worker to discuss options on adoption.

Refer any client, regardless of gestation, to a district or secondary hospital service in any of the following cases:

- Early pregnancy complications suspected (e.g. vaginal bleeding & abdominal pain);
- Suspected ectopic pregnancy;
- Acute or chronic medical conditions such as:
  - Heart disease
  - Asthma
  - Diabetes
  - Anaemia
  - Blood clotting disorders
  - Seizure disorder
  - Alcohol or Drug abuse
  - Hypertension.
  - Large fibroids (hampering determination of gestation age and/or MVA)

## 6. STANDARD PROCEDURE FOR PERFORMING TOPS AND REFERRALS



Clients that are close to a cut-off gestational age e.g. 11 weeks and 2 days or 19weeks and 2 days should be referred urgently on the same day.

## 7. Combined Mifepristone and Misoprostol Protocol

Gestational age	Mifepristone Day 1	Misoprostol			
	Route	Dose	Route	Timing	Duration
<b>Up to 9 weeks (63 days)</b>	<ul style="list-style-type: none"> <li>• 200 mg</li> <li>• Oral</li> <li>• Single dose</li> </ul>	800 ug	<ul style="list-style-type: none"> <li>• sublingual</li> <li>• Single dose</li> </ul>	24 hrs-48 hrs after taking mifepristone	
<b>9-12 weeks (63-84 days)</b>	<ul style="list-style-type: none"> <li>• 200 mg</li> <li>• Oral</li> <li>• Single dose</li> </ul>	800 ug, then 400ug	<ul style="list-style-type: none"> <li>• 1<sup>st</sup> dose vaginal or sublingual;</li> <li>• Additional doses sublingual</li> </ul>	36-48 hrs after taking mifepristone	Every 3 hours up to 5 doses
<b>Above 12 weeks (84 days)<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• 200 mg</li> <li>• Oral</li> <li>• Single dose</li> </ul>	800 ug, then 400ug	<ul style="list-style-type: none"> <li>• 1<sup>st</sup> dose vaginal or sublingual;</li> <li>• Additional doses sublingual</li> </ul>	36-48 hours after taking mifepristone	Every 3 hours up to 5 doses

### References

1. Clinical practice handbook for Safe abortion Geneva World Health Organization 2014

## 8. NOTIFICATION KEEPING OF RECORDS AND SUBMISSION OF DATA IN THE PUBLIC AND PRIVATE SECTOR

- The requirements for the notification of termination of pregnancy in terms of Regulation R168 must be noted.
- All healthcare facilities, public and private, must keep record of **all** TOP's performed.
- Complications referred to another facility must be managed and documented as a NEW case of TOP.

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- **Annexure A** must be completed for every procedure performed. The original copy (one with client's name) should be filed in the client's folder. Forward the anonymous copy via the Facility Manager to the District / Sub-structure Offices for filing.
- Detailed client notes must be kept in the client folder.
- **Annexure C** must be completed on a monthly basis to provide statistics and should be forwarded via the Facility Manager to the District / Sub-structure Office where the data will be entered onto Sinjani.

## 9. CONFIDENTIALITY

All clients seeking abortion have the right to confidentiality from all the staff involved in the care of the client. Women should be informed that all procedures are notified at the district office, but that an anonymous copy of the form (Annexure A) is used.

Clients have a right to auditory and visual privacy.

## 10. ETHICAL and LEGAL OBLIGATION

### CONSCIENTIOUS OBJECTIONS

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. Should a health care provider wish to exercise his/her right to conscientious objection, he/she may do so providing the client is offered all the necessary information that will allow her access to services. The client must be respectfully referred to a colleague who is willing to assist the client in obtaining the service. Protection of the health care worker's spiritual interest should not be at the cost of the patient's health or other interests, nor should a health care worker subordinate a patient's religious convictions to his/her own.



It must be emphasized 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.

There are some important circumstances when conscientious objections are no longer applicable:

- When continuation of a pregnancy poses a serious danger to the life or health of women, regardless of gestational age.
- A health care worker may not legally or ethically object to the rendering of care in cases of life-or health-endangering emergencies associated with TOP procedures, in the same way that they have to deal with the emergency consequences arising from unlawful procedures.
- Objection is limited to the staff directly involved in the TOP procedure. Ancillary staff (e.g. ward clerks, catering etc) and staff involved in the general care of a patient may not refuse to provide general or standard care to a TOP client.

Health professionals who have conscientious objection must inform their Facility Manager in writing. The manager needs to place this in the staff members' personnel file. The Facility Manager must also inform the staff member of the client's right to access to CTOP and information.

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

Employees could be encouraged to discuss possible conscientious objections electively. Refusal to discharge obligations as it appears in the employee's job description when faced with a particular task could lead to breach of contract.

## **11. STAFF SUPPORT**

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.

**ANNEXURES:**

- Annexure A: Notification of Termination of Pregnancy in terms of Section 7 of the CTOP Act (Act No 92 of 1996)
- Annexure C: Monthly data collection form
- Annexure D: Royal College of Obstetricians and Gynecologists Best practice in abortion care (Best Practice Paper No 2 June 2015)
- Annexure E: Referral form for Second trimester TOP

**Supporting literature to Termination of Pregnancy (TOP) Service**

1. ACOG Practice Bulletin: CLINICAL MANAGEMENT GUIDELINES FOR OBSTETRICIAN–GYNECOLOGISTS NUMBER 67, OCTOBER 2005  
*Medical Management of Abortion*
2. ACOG Practice Bulletin: CLINICAL MANAGEMENT GUIDELINES FOR OBSTETRICIAN–GYNECOLOGISTS NUMBER 135, JUNE 2013  
*Second Trimester Abortion*
3. WHO Safe Abortion: Technical and Policy Guidelines for health systems 2<sup>nd</sup> edition 2012
4. WHO Clinical practice handbook for safe abortion. 2014
5. RCOG Leading Safe Choices: Best practice in comprehensive abortion care. Best Practice Paper No. 2 June 2015

## ANNEXURE A

### NOTIFICATION OF TERMINATION OF PREGNANCY IN TERMS OF SECTION 7 OF THE ACT

CHOICE ON TERMINATION OF PREGNANCY ACT, 1996 (Act No. 92 of 1996)  
TO BE COMPLETED BY A MEDICAL PRACTITIONER OR A REGISTERED MIDWIFE  
(To be completed in duplicate).

**This copy remains in the client folder.**

**1. PATIENT DETAILS**

Surname   
First Names   
Hospital No.

**RACE**

Asian/Indian  
 Black  
 Coloured  
 White  
 Other

**PRESENT MARITAL STATUS**

Married/Including Traditional  
 Living together  
 Single  
 Divorced  
 Widow

Age  Gravida  Parity  Miscarriages  Date LMP

**2. INSTITUTION**

Name   Public  Private  Hospital  Clinic

Time from 1<sup>st</sup> consultation to TOP procedure (total working days).

<10	10 - 15	>15

**3. ABORTION DETAILS**

*Indication for termination of pregnancy (tick the appropriate block)*

<input type="checkbox"/> < 13 weeks: On demand	<input type="checkbox"/> >20 weeks: Maternal physical/mental
<input type="checkbox"/> 13-20 weeks: Maternal physical/mental health	<input type="checkbox"/> >20 weeks: Fetus malformation
<input type="checkbox"/> 13-20 weeks: Fetal physical/mental	<input type="checkbox"/> >20 weeks: Risk of injury to fetus
<input type="checkbox"/> 13-20 weeks: Rape or incest	<input type="checkbox"/> *Mental disability
<input type="checkbox"/> 13-20 weeks: Social/economic	<input type="checkbox"/> *Continuous unconsciousness

Gestation (weeks):

*\*Requires the consent of an additional medical/nurse practitioner - sign below*

**4. COUNSELLING**

**5. CONSENT**

<input type="checkbox"/> Pre-abortion counselling
<input type="checkbox"/> Contraception counselling
<input type="checkbox"/> Booking for post abortion counselling
<input type="checkbox"/> Counselling refused

*I have been informed about termination of pregnancy (including the possible adverse effects of drugs used) and give consent for terminating this pregnancy and/or removal of pregnancy products.  
(Delete where appropriate)*

*I also understand that this consent includes management of any complication that may arise from the termination. (This may include anaesthesia or hysterectomy)*

**CONTRACEPTION AFTER TOP**

<input type="checkbox"/> Sterilisation
<input type="checkbox"/> Oral contraception
<input type="checkbox"/> Long acting progesterone
<input type="checkbox"/> IUCD
<input type="checkbox"/> Condoms

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

**6. MANAGEMENT AND COMPLICATIONS**

Drugs used	Method(s)	Complications
<input type="checkbox"/> Analgesia pre-TOP	<input type="checkbox"/> Manual vacuum aspiration	<input type="checkbox"/> No complications
<input type="checkbox"/> Analgesia intra-operatively	<input type="checkbox"/> MTOP	<input type="checkbox"/> Perforation of uterus
<input type="checkbox"/> Analgesia post-TOP	<input type="checkbox"/> D&E	<input type="checkbox"/> Laparotomy for complications
<input type="checkbox"/> Misoprostol	<input type="checkbox"/> Sharp curettage (D&C)	<input type="checkbox"/> Method failure
<input type="checkbox"/> Mifepristone	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Excessive bleeding
<input type="checkbox"/> Prostaglandin E2	<input type="checkbox"/> Hysterotomy	
<input type="checkbox"/> Prostaglandin F2alpha		
<input type="checkbox"/> Prophylactic Antibiotics		
<input type="checkbox"/> Rhesus anti-D		

**7. DETAIL OF PRACTITIONER(S) for COUNSELLING AND CONSENT**

I declare the above information as correct.

Name  Qualification  Signature \_\_\_\_\_  
Date  ( Nurse practitioner  Medical practitioner) Reg. No

\*Name  Qualification  Signature \_\_\_\_\_  
Date  ( Nurse practitioner  Medical practitioner) Reg. No

**8. DETAIL OF PRACTITIONER PERFORMING THE PROCEDURE**

Name  Qualification  Signature \_\_\_\_\_  
Date  ( Nurse practitioner  Medical practitioner) Reg. No

Date Admitted  Date of Procedure  Date of Discharge

msk

## ANNEXURE A

### NOTIFICATION OF TERMINATION OF PREGNANCY IN TERMS OF SECTION 7 OF THE ACT

CHOICE ON TERMINATION OF PREGNANCY ACT, 1996 (Act No. 92 of 1996)  
TO BE COMPLETED BY A MEDICAL PRACTITIONER OR A REGISTERED MIDWIFE

(To be completed in duplicate).

**Anonymous copy**

#### 1. PATIENT DETAILS

Surname

First Names

Hospital No.

#### RACE

- Asian/Indian
- Black
- Coloured
- White
- Other

#### PRESENT MARITAL STATUS

- Married/Including Traditional
- Living together
- Single
- Divorced
- Widow

Age  Gravida  Parity  Miscarriages  Date LMP

#### 4. INSTITUTION

Name   Public  Private  Hospital  Clinic

Time from 1<sup>st</sup> consultation to TOP procedure (total working days).

<10	10 - 15	>15
<input type="text"/>	<input type="text"/>	<input type="text"/>

#### 5. ABORTION DETAILS

**Indication for termination of pregnancy (tick the appropriate block)**

<input type="checkbox"/> < 13 weeks: On demand	<input type="checkbox"/> *>20 weeks: Maternal physical/mental
<input type="checkbox"/> 13-20 weeks: Maternal physical/mental health	<input type="checkbox"/> *>20 weeks: Fetus malformation
<input type="checkbox"/> 13-20 weeks: Fetal physical/mental	<input type="checkbox"/> *>20 weeks: Risk of injury to fetus
<input type="checkbox"/> 13-20 weeks: Rape or incest	<input type="checkbox"/> *Mental disability
<input type="checkbox"/> 13-20 weeks: Social/economic	<input type="checkbox"/> *Continuous unconsciousness
Gestation (weeks): <input type="text"/>	<b>*Requires the consent of an additional medical/nurse practitioner - sign below</b>

#### 4. COUNSELLING

<input type="checkbox"/> Pre-abortion counselling
<input type="checkbox"/> Contraception counselling
<input type="checkbox"/> Booking for post abortion counselling
<input type="checkbox"/> Counselling refused
<b>CONTRACEPTION AFTER TOP</b>
<input type="checkbox"/> Sterilisation
<input type="checkbox"/> Oral contraception
<input type="checkbox"/> Long acting progesterone
<input type="checkbox"/> IUCD
<input type="checkbox"/> Condoms

#### 5. CONSENT

I have been informed about termination of pregnancy (including the possible adverse effects of drugs used) and give consent for terminating this pregnancy and/or removal of pregnancy products.  
(Delete where appropriate)

I also understand that this consent includes management of any complication that may arise from the termination. (This may include anaesthesia or hysterectomy)

Signature

Witness

Date

#### 9. MANAGEMENT AND COMPLICATIONS

Drugs used	Method(s)	Complications	
<input type="checkbox"/> Analgesia pre-TOP	<input type="checkbox"/> Manual vacuum aspiration	<input type="checkbox"/> Date / /	<input type="checkbox"/> No complications
<input type="checkbox"/> Analgesia intra-operatively	<input type="checkbox"/> MTOP	<input type="checkbox"/> Date / /	<input type="checkbox"/> Perforation of uterus
<input type="checkbox"/> Analgesia post-TOP	<input type="checkbox"/> D&E	<input type="checkbox"/> Date / /	<input type="checkbox"/> Laparotomy for complications
<input type="checkbox"/> Misoprostol	<input type="checkbox"/> Sharp curettage (D&C)	<input type="checkbox"/> Date / /	<input type="checkbox"/> Method failure
<input type="checkbox"/> Mifepristone	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Date / /	<input type="checkbox"/> Excessive bleeding
<input type="checkbox"/> Prostaglandin E2	<input type="checkbox"/> Hysterotomy	<input type="checkbox"/> Date / /	
<input type="checkbox"/> Prostaglandin F2alpha			
<input type="checkbox"/> Prophylactic Antibiotics			
<input type="checkbox"/> Rhesus anti-D			

#### 10. DETAIL OF PRACTITIONER(S) for COUNSELLING AND CONSENT

I declare the above information as correct.

Name  Qualification  Signature   
Date  ( Nurse practitioner  Medical practitioner) Reg. No

\*Name  Qualification  Signature   
Date  ( Nurse practitioner  Medical practitioner) Reg. No

#### 11. DETAIL OF PRACTITIONER PERFORMING THE PROCEDURE

Name  Qualification  Signature   
Date  ( Nurse practitioner  Medical practitioner) Reg. No

Date Admitted  Date of Procedure  Date of Discharge

*msk*

## ANNEXURE C

(CONFIDENTIAL)

<b>CHOICE ON TERMINATION OF PREGNANCY ACT, 1996 (Act No. 92 of 1996)</b> <b>Monthly notification of TOP's and other abortions</b>
--

### 1. FACILITY DETAILS

SUB-DISTRICT:	
FACILITY:	
PERIOD (Month / Year):	
COMPLETED BY:	
NAME OF PERSON IN CHARGE OF FACILITY:	

### 2. DETAILS OF TERMINATIONS PERFORMED

Total number of terminations performed	< 10	10 - 15	>15
Waiting time from first consultation to TOP procedure (total in working days) – put total number of patients per month in applicable block			

### 3. AGE & ETHNIC GROUP OF WOMEN

Age	African TOP	White TOP	Coloured TOP	Asian TOP	Unknown TOP	TOTAL TOP
<18						
≥18						

### 4. GESTATION PERIOD

Gestation Period	NUMBER	
	Med TOP	Surgical TOP
< 9 weeks		
9 - 13 weeks		
13 - 20 weeks		
21 - 24 weeks		
<b>TOTAL</b>		

### 5. MANAGEMENT

#### 5.1 Drugs

Number of TOP's done aided by Misoprostol	
Number of TOP's done aided by Mifepristone & Misoprostol	

#### 5.2 Surgical (Number of procedures done using the following methods)

Manual Vacuum Aspiration	
Suction Curettage	
Sharp Curettage	

Signature (Head of Institution): .....

Date: .....

Form to be completed by the person in charge of the designated facility in terms of Section 7(2) at the end of each month.  
Send to your District Office by the 8<sup>th</sup> of the following month.

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leading  
**SAFE**  
choices



Royal College of  
Obstetricians &  
Gynaecologists

# Best practice in comprehensive abortion care

Best Practice Paper No. 2  
June 2015

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Copy-editing and typesetting: Andrew Welsh ([www.andrew-welsh.com](http://www.andrew-welsh.com))

A handwritten signature in black ink, located in the bottom right corner of the page. The signature is stylized and appears to consist of several overlapping loops and lines, possibly representing the initials of the publisher or a related party.

## Contents

Introduction to the <i>Best Practice Papers</i>	ii
Introduction	1
Information for women requesting abortion	1
Information for staff assessing women prior to induced abortion	3
Taking the medical history	3
Blood tests	3
Determining gestational age	4
STI screening	4
Prevention of infective complications	4
Contraception	4
Information for staff providing the abortion	5
For pregnancies of less than 14 weeks of gestation	5
For pregnancies of 14 weeks of gestation or more	6
Cervical preparation before surgical abortion	6
Medication for pain management	6
Contraceptive provision	7
Information for staff concerned with care after induced abortion	7
Information to provide	7
Contraception	7
Anti-D IgG	8
Management of incomplete abortion	8
Assessment	8
Management	9
Service delivery	10
Access to services	10
Information provision	11
Initial assessment	11
Arrangements for the procedure	11
Evidence sources	12
Additional literature reviewed	12
Appendix: Post-abortion contraception	13



## Introduction to the *Best Practice Papers*

Professionals providing reproductive health care have a responsibility to ensure that the women and men they treat benefit from the latest evidence-based clinical practices. In support of these, and in line with the Royal College of Obstetricians and Gynaecologists' mandate of improving health care for women everywhere, by setting standards for clinical practice, this Best Practice Paper sets out the essential elements of a high-quality abortion care service including comprehensive post-abortion care and contraception.

The best practices described are drawn from current evidence-based guidance produced by organisations such as the World Health Organization (WHO), the Royal College of Obstetricians and Gynaecologists, and Ipas. So as to be readable and useful to people providing healthcare on a daily basis, the paper has been deliberately kept short and succinct. Therefore the primary evidence for the recommendations and the strength of that evidence have been omitted but can be found in the original source documents. Very recently published evidence has been assessed to determine whether any of the recommendations from current guidelines should be amended.

Recognising that different healthcare providers may be involved at different stages of the management of induced abortion, the paper has been divided into sections specific to these stages where appropriate.

The use of the clinical recommendations should be individualised to each woman, with emphasis on her clinical needs.

The recommendations may also be used as a tool to assist policy makers in moving their services forward.

While the paper may be used for reference in any country, varying legal, regulatory, policy and service-delivery contexts may require some recommendations to be adapted to the local context; however, it is important to ensure that best practice is maintained.

For support on adapting the document while still maintaining good practice, please write to [leadingsafechoices@rcog.org.uk](mailto:leadingsafechoices@rcog.org.uk).

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## The Leading Safe Choices initiative

Globally, 222 million women would like to prevent or delay pregnancy but have no access to contraception. Meeting this need would allow women to control their own fertility and reduce maternal deaths by one-third, with lasting benefits for their families and communities.

Thanks to a three year, multi-million pound grant, an important new initiative called Leading Safe Choices offers the RCOG a unique opportunity to address this unmet need. Leading Safe Choices will initially pilot in Tanzania and South Africa and focus on postpartum family planning (PPFP) in both countries, and on comprehensive abortion care in South Africa and comprehensive post-abortion care in Tanzania.

The initiative will take an integrated systems approach, working within existing health structures and with professionals currently working in women's health in these two countries. The pilot phase will focus on selected high-volume maternity hospitals and midwifery units, increasing skills and improving quality in PPFP and comprehensive abortion care.

The programme has three broad objectives:

- 1 developing RCOG *Best Practice Papers* on PPFP and comprehensive abortion care in South Africa and on comprehensive post-abortion care in Tanzania
- 2 training healthcare providers and supporting the delivery of high-quality PPFP and comprehensive abortion care in South Africa and comprehensive post-abortion care in Tanzania
- 3 establishing a formal accreditation and certification process to:
  - recognise competence
  - raise standing within professions
  - increase the uptake and quality of service provision.

The long-term vision is to expand the Initiative across South Africa and Tanzania and to other countries, following on from this pilot phase.

## Introduction

Each year, 22 million unsafe abortions are estimated to take place, resulting in the death of approximately 47 000 women. Some 5 million women suffer injury as a result of complications due to unsafe abortion, often leading to chronic disability. Abortion need **not** be unsafe. Safe abortion should be and can be available and accessible for all women, to the full extent that the law allows. Even in countries where legal abortion is severely restricted, in circumstances where it is permitted, such as to save the life of the woman, it should always be done safely.

Abortion is not a complex procedure. A range of providers, including nurses and midwives, have been shown to be competent to deliver abortion services safely in a number of settings. As with many other medical procedures, adherence to best practice standards will ensure that the most effective and the safest services are delivered. This *Best Practice Paper* is designed to be used on a daily basis by healthcare workers who are responsible for delivering pre-abortion counselling and assessment, and abortion and post-abortion care services including post-abortion contraception.

All aspects of abortion care should be delivered in a respectful and sensitive manner that recognises women as decision makers.

## Information for women requesting abortion

Women should be informed about their pregnancy options so that they can make an informed choice about their preferred course of action.

All women who require more support in deciding whether to continue the pregnancy or have an abortion should be identified and offered further opportunities to discuss their decision.

If performed in line with best practice, abortion is safer than childbirth.

The following information should be provided to women requesting abortion, with an emphasis on the overall safety of the procedure and in a way that women can understand:

- the choice of abortion method available (if appropriate) and the characteristics of each (see Table 1)
- the side effects, risks and complications associated with each available abortion method
- what will be done during and after the abortion
- symptoms likely to be experienced both during and after the abortion (e.g. menstrual-like cramps, pain and bleeding)
- how long it will take for the abortion to be completed
- what pain management will be made available
- follow-up care, including contraceptive advice and provision
- the range of emotions commonly experienced after having an abortion
- other services that are available, such as sexually transmitted infection (STI) testing and support for women experiencing sexual coercion or domestic violence.

**Table 1** Characteristics of abortion procedures; adapted from WHO (2014) *Clinical Practice Handbook for Safe Abortion*

Medical abortion	Surgical abortion
<ul style="list-style-type: none"> <li>• avoids surgery</li> <li>• mimics miscarriage</li> <li>• controlled by the woman and may take place at home (at less than 9 weeks of pregnancy)</li> <li>• takes time (hours to days) to complete abortion, and the timing may not be predictable</li> <li>• women experience bleeding and cramping, and potentially some other side effects (nausea, vomiting)</li> <li>• may require more clinic visits than surgical abortion</li> </ul> <p><i>May be necessary in the following situations:</i></p> <ul style="list-style-type: none"> <li>• for severely obese women</li> <li>• if the woman has uterine malformations or fibroids, or has had previous cervical surgery</li> <li>• if the woman wants to avoid surgical intervention</li> <li>• if a pelvic examination is not feasible or is unwanted</li> </ul>	<ul style="list-style-type: none"> <li>• quick procedure</li> <li>• complete abortion is easily verified by evaluation of aspirated products of conception</li> <li>• takes place in a healthcare facility</li> <li>• sterilisation of the woman or placement of an intrauterine device (IUD) may be performed at the same time as the procedure</li> <li>• requires instrumentation of the uterus</li> <li>• small risk of uterine or cervical injury</li> <li>• timing of abortion is controlled by the facility and provider</li> </ul> <p><i>May be necessary in the following situations:</i></p> <ul style="list-style-type: none"> <li>• if there are contraindications to medical abortion</li> <li>• if there are constraints for the timing of the abortion</li> </ul>

The information should be given in a non-judgemental and supportive way.

This is particularly important for adolescent girls who may be visiting a reproductive health facility for the first time. If the law requires an adult to consent to her procedure, this should be clearly explained at the start of the consultation. While all young people should be encouraged to involve a trusted adult in their decision if possible, do **not** insist on parents' authorisation unless it is a legal requirement.

The **pre-abortion consultation** should confirm the woman's decision and should include the following information:

- 1 Abortion is a safe procedure for which major complications and mortality are rare at all gestations. If performed in line with best practice, abortion is safer than childbirth.
- 2 The earlier in pregnancy an abortion is undertaken, the safer it is likely to be.
- 3 Surgical and medical methods of abortion carry a small risk of failure to end the pregnancy (1 or 2 per 100 procedures).
- 4 There is a small risk (less than 2 in 100 for surgical and 5 in 100 for medical) of the need for further intervention to complete the procedure, i.e. surgical intervention following medical abortion or re-evacuation following surgical abortion.
- 5 The following complications may occur:
  - severe bleeding requiring transfusion – the risk is lower for first-trimester abortions (less than 1 in 1000), rising to around 4 in 1000 at gestations beyond 20 weeks
  - uterine rupture in association with second-trimester medical abortion – the risk is less than 1 in 1000.

*For surgical abortions only:*

- cervical trauma – the risk of damage is no more than 1 in 100 and is lower for first-trimester abortions; trauma is less likely if cervical preparation is undertaken in line with best practice
  - uterine perforation – the risk is in the order of 1–4 in 1000 and is lower for first-trimester abortions.
- 6 Further treatment (e.g. blood transfusion, laparoscopy, laparotomy or hysterectomy) may be required, should one of these complications occur.
- 7 Upper genital tract infection of varying degrees of severity is unlikely, but may occur after medical or surgical abortion and is usually associated with pre-existing infection.

There are a number of myths about the consequences of abortion. If the woman expresses concern, she can be reassured that there are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia, infertility, breast cancer or psychological problems.

It is best practice to discuss contraception at the initial consultation.

The benefits of the most effective methods (IUDs and implants) should be explained.

If a contraceptive method is chosen, that choice should be documented so that it can be provided when the abortion is undertaken.

## **Information for staff assessing women prior to induced abortion**

It should be confirmed that the woman is seeking abortion voluntarily. Those responsible for assessing women in respect of medical eligibility for abortion should be able to ensure that women who need specialist care (e.g. women with serious chronic medical conditions such as heart disease) are referred as soon as possible to an appropriate service.

It is important at this stage to make sure that abortion eligibility by gestation is correctly assessed and that any ongoing genital tract infection is excluded or properly managed.

## **Taking the medical history**

It should be determined whether the woman is eligible to undergo abortion safely in the service concerned by taking a general medical history to exclude serious or relevant acute or chronic medical conditions.

### **Blood tests**

Pre-abortion assessment should include determination of Rhesus blood status if testing is available.

Where clinically indicated, pre-abortion assessment may also include measurement of haemoglobin concentration.



### Determining gestational age

It is not necessary to determine the exact gestational age but rather to make sure that the gestation falls within the range of eligibility for a particular method of inducing abortion. The date of onset of the last menstrual period, bimanual pelvic examination, abdominal examination and recognition of symptoms of pregnancy are usually adequate after a positive pregnancy test. Table 2 shows gestation in both weeks and days of amenorrhoea.

**Table 2** Weeks of gestation in terms of days since the last menstrual period (LMP); reproduced from RCOG (2011) *The Care of Women Requesting Induced Abortion*, Evidence-based Clinical Guideline Number 7

Completed weeks	0	1	2	3	4	5	6	7	8	9	10	11	12
Days since LMP	0-6	7-13	14-20	21-27	28-34	35-41	42-48	49-55	56-62	63-69	70-76	77-83	84-90
Completed weeks	13	14	15	16	17	18	19	20	21	22	23	24	
Days since LMP	91-97	98-104	105-111	112-118	119-125	126-132	133-139	140-146	147-153	154-160	161-167	168-174	

Routine pre-abortion ultrasound scanning is unnecessary but, if available, may be useful if there are concerns about complications such as ectopic pregnancy.

### STI screening

It is best practice to undertake a risk assessment for STIs for all women (e.g. HIV, chlamydia, gonorrhoea, syphilis), and then to screen for them if appropriate and available. This should be done without delaying the abortion. The partners of women who test positive for STIs should be informed and advised about treatment, provided that the woman gives her consent to this.

Ideally, a system for partner notification and follow-up or referral should be in place.

Services should make available information about the prevention of STIs, and offer condoms for STI prevention to all women undergoing abortion.

### Prevention of infective complications

Routine use of antibiotics at the time of surgical abortion is best practice as it reduces the risk of infection after the abortion. However, abortion should not be delayed if antibiotics are not available.

The following regimens are recommended for perisurgical abortion antibiotic **prophylaxis**:

- 200 mg doxycycline within 2 hours before the procedure

**OR**

- 500 mg azithromycin within 2 hours before the procedure.

### Contraception

Effective methods of contraception should be discussed with women at the initial assessment and a plan agreed, and documented, for contraception after the abortion. Women should be advised of the greater effectiveness of long-acting reversible methods of contraception (LARC: implants and

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MS

IUDs) and encouraged (but not coerced) to choose them. Immediately after surgical abortion is an optimal time for insertion of an IUD (and is safe after both first- and second-trimester surgical abortions). Contraceptive implants can be provided at any time once the abortion procedure has started.

## Information for staff providing the abortion

The most appropriate abortion methods/regimens (surgical or medical) should be determined and discussed with the woman (see Table 1).

Dilatation and sharp curettage (D&C) is an obsolete method of surgical abortion, for which the current recommended method is vacuum aspiration.

### *For pregnancies of less than 14 weeks of gestation*

#### **Surgical abortion**

Either manual or electric vacuum aspiration:

- There is no lower limit of gestation for surgical abortion.
- It is best practice to inspect aspirated tissue at all gestations to confirm complete evacuation; this is essential following vacuum aspiration at under 7 weeks of gestation.
- During vacuum aspiration, the uterus should be emptied using the suction cannula and forceps (if required) only. The procedure should **not** be routinely completed by sharp curettage.
- Use of medications containing either oxytocin or ergometrine are **not** recommended for prophylaxis to prevent excessive bleeding either at the time of vacuum aspiration or afterwards.
- Sharp curettage should not be performed.

**OR**

#### **Medical abortion**

If mifepristone is available, it is best practice to use it in combination with misoprostol as it shortens the induction-abortion interval, reduces side effects and decreases the rate of ongoing pregnancy.

Effective regimens for medical abortion include:

- at up to 63 days of gestation, mifepristone 200 mg orally, followed 24–48 hours later by misoprostol 800 micrograms given by the vaginal, buccal or sublingual route; if misoprostol is provided for a woman to use at home, a single dose of 800 micrograms should be provided
- from 64 days to 13 weeks and 6 days, mifepristone 200 mg orally, followed 24–48 hours later by misoprostol 800 micrograms given by the vaginal, buccal or sublingual route, followed by misoprostol 400 micrograms every 3 hours until abortion occurs

**OR**

- If mifepristone is not available, and for all gestations up to 13 weeks and 6 days, misoprostol 800 micrograms given by the vaginal, buccal or sublingual route, followed by misoprostol 400 micrograms every 3 hours until abortion occurs.

### *For pregnancies of 14 weeks of gestation or more*

#### **Surgical abortion**

Surgical abortion can be performed by trained providers using:

- vacuum aspiration using large bore cannulae
- dilatation and evacuation (D&E).

**OR**

#### **Medical abortion**

At 14 weeks of gestation or more, medical abortion should be undertaken in a medical facility. If mifepristone is available, it should be used in combination with misoprostol as it shortens the induction-abortion interval, reduces side effects and decreases the rate of ongoing pregnancy. The regimens are as follows:

- mifepristone 200 mg orally, followed 12–48 hours later by misoprostol 800 micrograms vaginally, followed by misoprostol 400 micrograms orally or vaginally every 3 hours until abortion occurs; if after 24 hours abortion does not occur, mifepristone can be repeated 3 hours after the last dose of misoprostol, and 12 hours later misoprostol may be recommenced

**OR**

- where mifepristone is not available, misoprostol 800 micrograms followed by misoprostol 400 micrograms every 3 hours until abortion occurs.

#### *Cervical preparation before surgical abortion*

Cervical preparation should be used for all women with a pregnancy of gestational age over 14 weeks. Suitable preparations include:

- osmotic dilators 12–24 hours before the procedure; if the pregnancy is at less than 18 weeks of gestation, osmotic dilators will be effective at just 3–4 hours before the procedure

**OR**

- mifepristone 200 mg 12–24 hours before the procedure

**OR**

- misoprostol 400 micrograms vaginally 3 hours or sublingually 2 hours before the procedure.

Cervical preparation may be considered for women before 14 weeks if there is a high risk for cervical injury or uterine perforation. The following regimen is recommended:

- Misoprostol 400 micrograms administered vaginally 3 hours before the procedure or sublingually 2 hours before the procedure.

#### *Medication for pain management*

For both medical and surgical abortions, analgesia (pain relief) should **always** be offered and provided without delay, if requested.

- In most cases, analgesics (e.g. nonsteroidal anti-inflammatory drugs (NSAIDs)), local anaesthesia and/or conscious sedation supplemented by verbal reassurance are sufficient.

- The need for pain management increases with gestational age and narcotic analgesia may be required.
- Prophylactic NSAIDs at the time of initiation of misoprostol for second-trimester medical abortion may reduce the need for narcotic analgesia.
- Prophylactic paracetamol (oral or rectal) is ineffective in reducing pain after surgical abortion.

**Local anaesthesia**, such as lidocaine, can be used to alleviate discomfort from mechanical cervical dilatation and uterine evacuation during surgical abortion.

General anaesthesia is not recommended for routine abortion procedures, as it has been associated with higher rates of complications than analgesia and local anaesthesia.

### *Contraceptive provision*

If a woman has chosen a contraceptive method that can be provided as part of or during the abortion procedure (e.g. IUD insertion once manual vacuum aspiration is completed), it should be ensured that this is done. IUDs can be inserted at the time of the abortion in both the first and second trimesters. Contraceptive implants can be inserted at any time during the abortion procedure.

## **Information for staff concerned with care after induced abortion**

Healthcare staff involved in post-abortion care should ensure that the woman leaves the abortion service knowing what to expect following the procedure and where to get help if necessary. They should also ensure that every woman is able to leave with a method of contraception that she can start immediately. Women should be informed of the superior effectiveness of IUDs and implants in preventing unintended pregnancy.

### *Information to provide*

Before leaving the facility, women should receive instructions about how to care for themselves after they go home, including:

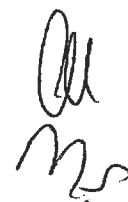
- how much bleeding to expect in the next few days and weeks
- how to recognise potential complications, including signs of ongoing pregnancy
- when they can resume normal activities (including sexual intercourse)
- how and where to seek help if required.

### *Contraception*

Before they leave the healthcare facility, all women should receive contraceptive information and, if desired, the contraceptive method of their choice. If the chosen method is not available, they should be referred to a service where the method can be provided.

Women should be advised of the greater effectiveness and duration of LARC methods (implants and IUDs) and of their safety, and healthcare staff should dispel any myths there may be about these methods.

Sterilisation can be safely performed at the time of induced abortion although it can be more likely than interval sterilisation to be associated with regret.





### **Anti-D IgG**

If available, anti-D IgG should be given intramuscularly to all non-sensitised RhD-negative women within 72 hours following abortion.

## **Management of incomplete abortion**

Post-abortion care can reduce the morbidity and mortality associated with complications of either miscarriage or incomplete abortion (including abortion that was performed unsafely). Options for management for incomplete abortion include surgical and medical methods of uterine evacuation.

For women who wish to avoid another pregnancy, contraception should be discussed and a method provided. Women experiencing a miscarriage who wish to get pregnant again should be advised to wait until after having at least one normal menstrual period, longer if chronic health problems (e.g. anaemia) require treatment.

### **Assessment**

Incomplete abortion should be suspected when any woman of reproductive age presents with vaginal bleeding and/or abdominal pain after one or more missed menstrual periods. Ectopic pregnancy should be suspected if the uterus is small, the cervix closed and/or there is an adnexal mass.

### **Unsafe abortion**

In many settings it is important to distinguish between safe and unsafe abortion since the latter is much more likely to be associated with infection. Indications that an abortion has been attempted by unsafe methods include the presence of:

- vaginal laceration
- cervical injury
- uterine enlargement equivalent to a pregnancy of more than 12 weeks of gestation
- products of conception visible at the cervix.

### **Infection**

It is vital to identify women who may have an infection and to manage this urgently. Infection is much more likely, and much more likely to be severe, if the abortion has been performed unsafely. Clinical features suggestive of infection include:

- temperature above 37.5°C
- localised or general abdominal tenderness, guarding and rebound
- foul odour or pus visible in the cervical os
- uterine tenderness.

Features suggestive of sepsis and indicating the need for urgent intervention include:

- hypotension
- tachycardia
- increased respiratory rate.



## Management

### If there is no suspicion of infection and uterine size is less than 14 weeks

- uterine evacuation with vacuum aspiration:
  - antibiotic prophylaxis should be given before surgical evacuation – 200 mg doxycycline within 2 hours before the procedure or a single dose of 500 mg azithromycin within 2 hours before the procedure (NB. If antibiotics are not available, the procedure should not be delayed.)

#### OR

- misoprostol 600 micrograms orally or 400 micrograms sublingually.

### If there is no suspicion of infection and uterine size is 14 weeks or larger

- evacuation using vacuum aspiration and blunt forceps if necessary:
  - antibiotic prophylaxis should be given before surgical evacuation – 200 mg doxycycline within 2 hours before the procedure (with or without 200 mg doxycycline after the abortion) or a single dose of 500 mg azithromycin within 2 hours before the procedure (NB. If antibiotics are not available, the procedure should not be delayed.)

#### OR

- misoprostol:
  - 14–28 weeks: at least 200 micrograms administered vaginally, sublingually or buccally at least 6-hourly:
    - If available and time permitting, mifepristone 200 mg orally should be administered 12–48 hours before misoprostol
    - In order to align protocols, services may use the same dosing and intervals as recommended in regimens for induced abortion
  - 28+ weeks: 25 micrograms vaginally 6-hourly or 25 micrograms orally 2-hourly.

### If infection is present the uterus should be evacuated urgently

- start broad-spectrum antibiotics immediately – intravenously if infection is severe
- transfer to a unit with the facilities for undertaking surgical evacuation if it cannot be done in the facility to which the woman presents
- if the woman is in septic shock, she should be transferred immediately to a specialist unit for surgical uterine evacuation – broad-spectrum antibiotics (such as a combination of ampicillin 0.5–1 g 6-hourly, metronidazole 500 mg 8-hourly and gentamicin 120 mg daily) should be administered intravenously prior to transfer if available
- if the skills necessary for urgent surgical uterine evacuation are not available, misoprostol can be used:
  - 14–28 weeks: At least 200 micrograms administered vaginally, sublingually or buccally at least 6-hourly
  - 28+ weeks: 25 micrograms vaginally 6-hourly or 25 micrograms orally 2-hourly.



### Information to provide after the abortion

Before leaving the facility, women should receive instructions about how to care for themselves after they go home, including:

- how much bleeding to expect in the next few days and weeks
- how to recognise potential complications, including signs of ongoing pregnancy
- when they can resume normal activities (including sexual intercourse)
- how and where to seek help if required
- women who want to try again to conceive should be advised to wait until after having at least one normal menstrual period, longer if chronic health problems (e.g. anaemia) require treatment.

### Contraception

Before they leave the healthcare facility, all women should receive contraceptive information and, if desired, the contraceptive method of their choice. If the chosen method is not available, they should be referred to a service where the method can be provided.

Women should be advised of the greater effectiveness and duration of LARC methods (implants and IUDs) and of their safety, and healthcare staff should dispel any myths that exist about these methods.

IUD insertion or female sterilisation should be delayed until the woman's health is restored and any infection is resolved. Interim contraception should be provided using the most effective acceptable method until an IUD can be inserted or sterilisation performed.

### Anti-D IgG

If available, anti-D IgG should be given intramuscularly to all non-sensitised RhD-negative women within 72 hours following abortion.

## Service delivery

The provision of a safe and effective comprehensive abortion care service depends on everyone involved in the service ensuring that everything can be done to meet the essential standards for safe abortion care. It is not enough for doctors, nurses and midwives to perform effectively if the facilities and tools that they need are not reliably available and if the service is not organised in a way that ensures safe and effective comprehensive abortion care. **Best practices for service delivery** are listed below.

### Access to services

- 1 Abortion services must be available to the fullest extent that the law allows. Healthcare providers should know what the law *does* allow in their country and be clear about the circumstances for which abortion is legal.
- 2 If a woman requesting abortion fulfils the legal criteria, there should be no further restriction of access on grounds such as age, marital status or the number of previous abortions.
- 3 Abortion is safer the sooner it is done. Services should be able to meet the local demand for abortion so that women can have their abortion at the earliest possible gestation and as close to home as possible.



- 4 As the equipment needed for routine early medical abortion is not sophisticated, this service can be provided in basic facilities, thereby increasing access to safe abortion care and enhancing convenience to women.
- 5 As the equipment and space required for a safe abortion service are similar to those needed for routine women's healthcare and family planning services, efforts should be made to provide safe abortion services in a wide range of health facilities and in an integrated manner.
- 6 All healthcare providers should be trained to provide comprehensive abortion care in line with their skills and licences. This can help spread the workload and improve the skills of *all* providers of women's health care, thereby enhancing access to and increasing the safety of abortion care.
- 7 Integrating abortion services within overall maternal/women's health care minimises the stigma associated with abortion care for both women and providers.
- 8 Where abortion services are provided but there is no provision for emergency or specialist care, there must be robust and timely pathways for referral.

### *Information provision*


- 1 There should be local arrangements in place for providing information to women and healthcare professionals on routes of access to safe abortion care.
- 2 Services should ensure that written, objective, evidence-guided information is available in a way that is understandable to women considering abortion. Information should be available in a variety of languages and formats.
- 3 Women should have access to objective information and, if required, counselling and decision-making support about their pregnancy options.
- 4 Information for women and providers should emphasise the need for confidentiality.

### *Initial assessment*

- 1 There should be a pathway to appropriate medical care for women with known significant medical conditions requiring specialist abortion care (e.g. heart disease).
- 2 Women presenting for induced abortion who are found to have a non-viable pregnancy also require contraception and sexual health care.
- 3 Women requesting abortion but who subsequently decide to continue the pregnancy should be referred for antenatal care (together with all their relevant information, such as ultrasound scan reports)
- 4 Services should identify issues/characteristics that make women particularly vulnerable (e.g. adolescents, victims of domestic abuse or gender-based violence) and refer/signpost them on to appropriate support services.

### *Arrangements for the procedure*

- 1 To minimise delay, service arrangements should be such that the abortion can be provided as soon as possible, ideally on the same day as the assessment.
- 2 A system should be in place to ensure that the required legal documentation is completed accurately and in a timely manner.
- 3 The setting for the abortion service (the consultation room, the procedure room and the recovery room) should respect the need for women's privacy and dignity.



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## Appendix: Post-abortion contraception

(Adapted from World Health Organization (2014) *Clinical Practice Handbook for Safe Abortion*)

Generally, almost all methods of contraception can be initiated immediately following a surgical or medical abortion. Immediate start of contraception after surgical abortion refers to the same day as the procedure, and for medical abortion refers to the day the first pill of a medical abortion regimen is taken. As with the initiation of any method of contraception, the woman's medical eligibility for a method should be verified.

### Post-abortion medical eligibility recommendations for hormonal contraceptives, intrauterine devices and barrier contraceptive methods

POST-ABORTION CONDITION	FIRST TRIMESTER	SECOND TRIMESTER	IMMEDIATE POST-SEPTIC ABORTION
COC	1	1	1
CIC	1	1	1
Patch & vaginal ring	1	1	1
POP	1	1	1
DMPA, NET-EN	1	1	1
LNG/ENG implants	1	1	1
Copper-bearing IUD	1	2	4
LNG-releasing IUD	1	2	4
Condom	1	1	1
Spermicide	1	1	1
Diaphragm	1	1	1

CIC, combined injectable contraceptive; COC, combined oral contraceptive; DMPA/NET-EN, progestogen-only injectables: depot medroxyprogesterone acetate/norethisterone enantate; IUD, intrauterine device; LNG/ENG, progestogen-only implants; levonorgestrel/etonorgestrel; POP, progestogen-only pill.

#### Definition of categories

- 1: a condition for which there is no restriction for the use of the contraceptive method.
- 2: a condition where the advantages of using the method generally outweigh the theoretical or proven risks.
- 3: a condition where the theoretical or proven risks usually outweigh the advantages of using the method.
- 4: a condition that represents an unacceptable health risk if the contraceptive method is used.

### Contraception for women on antiretroviral therapy for HIV

There are potential drug interactions between some antiretroviral drugs and hormonal contraception. However, WHO has reviewed the data and concluded that the benefits of using hormonal contraception outweigh the risks (2015 MEC, Category 2).