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ABORTION COUNSELLING IN SOUTH AFRICA: A STEP-BY-STEP GUIDE FOR PROVIDERS

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These guidelines were developed by the Critical Studies in Sexualities and Reproduction (CSSR) research unit of Rhodes University and the Sexual and Reproductive Justice Coalition (SRJC). This step-by-step guide is based on research conducted by the CSSR on current abortion counselling practices in South Africa as well as the academic literature on abortion counselling. The research included recording of sessions, and interviewing healthcare providers and patients about the counselling sessions. A policy brief based on this research may be obtained at the following website. An electronic form of these guidelines may also be downloaded from this site.

https://www.ru.ac.za/criticalstudies/policybriefsfeedbackreports/

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ABORTION COUNSELLING IN SOUTH AFRICA:

A STEP-BY-STEP GUIDE FOR PROVIDERS[1]

The Choice on Termination of Pregnancy Act (Act No. 92 of 1996) (henceforth CTOP Act) makes provision for non-mandatory counselling to be offered to clients seeking abortion prior to and after the procedure. In these guidelines, we provide a step-by-step guide to healthcare providers for conducting abortion counselling. While these guidelines are written mainly for healthcare providers located in Termination of Pregnancy Clinics, they may also be useful for others working outside of this context.

These guidelines are premised on taking a ***client-centred approach*** to counselling. Research shows that such an approach is appreciated by clients and leads to a high level of satisfaction with the counselling session. The steps outlined in this guide include: in the case of minors; establishing the client's wishes; establishing the type of counselling to be provided to the client; basic information to establish consent; conducting particular types of counselling.

[1] NOTES ON TERMINOLOGY

i) In this document, we refer to abortion and termination of pregnancy interchangeably. The South African law refers to termination of pregnancy, but many people prefer abortion. Of course, all pregnancies terminate, but not all women have abortions. It is good to attempt to destigmatise language. Importantly, the healthcare provider should use the terminology used by the client.
ii) We use the pronouns 'they', 'their' and 'them' to refer to clients. Although most clients will be cisgender women (i.e. women who identify with the female gender assigned to them at birth), it is also possible for transmen, queer- or gender diverse- identifying people to become pregnant. Healthcare providers need to be alert to these possibilities and to alter their language to suit the client's gender.

DEVELOPING A CLIENT-CENTRED APPROACH

At all steps in the counselling process, the needs of the client are central. Developing client-centred counselling skills takes some practice, and counsellors are encouraged to develop these skills through training, mentoring, role-play, and self-reflection. Features of client-centred counselling include:

- Clients' concerns are listened to carefully and without judgement;
- Other than providing basic information, counsellors respond to the concerns raised by the client, rather than introducing their own views;
- Counsellors show 'positive regard' (unconditional support) for clients;
- Counsellors demonstrate that they understand the circumstances within which clients may request a termination of pregnancy;
- Counsellors encourage the clients to express themselves by providing various signs, such as good eye contact, head nodding, verbal affirmation (mmm; yes; I understand), and phrases such as "tell me more".

A client-centred approach should be adopted throughout the steps listed below.

In addition, counsellors need to be aware that they are bound by professional **confidentiality**. Confidentiality means that the client must feel safe to share personal information, should they wish to, and that this information will not be shared with people outside of the counselling setting. If counsellors wish to discuss cases with colleagues in order to get guidance about the case from these colleagues, this must be done in such a way as to make it impossible for the colleague to identify the particular person (e.g. through the use of a pseudonym and disguising personal details that may make them identifiable). Counsellors should never discuss clients (even anonymously) with family, friends or work colleagues who are not directly involved in providing guidance. Counsellors must be aware, however, that there are limits to confidentiality: a court of law is allowed to subpoena the case file and to require a counsellor to give evidence. While this is likely to be extremely rare in the case of abortion counselling, counsellors do need to be aware of this. . The counsellor also has an obligation to alert others (in particular social services) if they feel that the client is at risk of harming themselves (e.g. suicide) or harming others (e.g. suspected or possible child abuse, old-age abuse, or homicide).

FIRST VERSUS SECOND TRIMESTER COUNSELLING

The CTOP Act allows clients to request an abortion up to 12 weeks of gestation. Second trimester abortion may only be performed under certain conditions (see below). This means that the client's reasons for wanting an abortion need to be ascertained for second trimester abortion.

The steps outlined below should be followed in both first and second trimester counselling, with the *exception* of asking for reasons for the abortion in the second trimester. The steps needed in ascertaining the client's reasons for requesting an abortion are contained in a separate section at the end of these guidelines.

ABORTION COUNSELLING STEPS

The steps involved in abortion counselling are outlined below.

STEP 1: IN THE CASE OF MINORS, ESTABLISHING THE CLIENT'S WISHES

The CTOP Act states that minors do not need the consent of their parents or guardians to undergo a termination of pregnancy. There are good reasons for this, including that: research shows that minors are, in general, competent to make such decisions; minors may live in circumstances of emotional, physical or sexual abuse which may have contributed to the pregnancy or may exacerbate problems in the pregnancy. The challenge brought to overturn this stipulation of the CTOP Act failed (see details below)[2].

If the client is a minor, counsellors should ascertain their needs in terms of support from family and/or other adults in their lives.

- Assure the minor that parental/guardian consent is not required and that this discussion is merely to ascertain whether the minor has received and/or wants some support from a trusted person with decision-making.
- Ask the client if they have discussed their decision with anybody else:
  - If yes, ask whether they would like to discuss any conversations they have had about their decision. If they do not, then leave the matter there. If they do, then listen carefully, making no judgement and asking only clarifying questions.
  - If no, suggest that discussing this experience with someone they trust might be helpful. Do not insist that they speak to somebody.

[2] The Christian Lawyers' Association (CLA) brought an application to have this subclause taken out of the CTOP Act (Christian Lawyers Association v Minister of Health and Others, 2005). The CLA failed in its application. In his judgement, the judge stated that:

> Any distinction between women on the ground of age would accordingly invade [the young woman's constitutional] rights. ... [T]he Act served the best interest of the pregnant girl because it was flexible in recognising and accommodating her individual position based on her intellectual, psychological and emotional make-up. ... (Christian Lawyers Association v Minister of Health and Others, 2005, p. 509).

STEP 2: ESTABLISHING THE TYPE OF COUNSELLING TO BE PROVIDED TO THE CLIENT

It is important to note that not all clients want 'counselling' before or after an abortion procedure. The CTOP Act indicates that counselling should be offered but that it is NOT mandatory. In addition, those who do want counselling may not have the same needs.

In order to provide a service that is client-centred, the first step is to determine *whether* the client does in fact want or need counselling, and what kind of counselling would best serve their wants and needs. After receiving the client, inform them that:

a) counselling is available at the clinic;
b) receiving counselling is voluntary; and
c) they may choose different kinds of counselling.

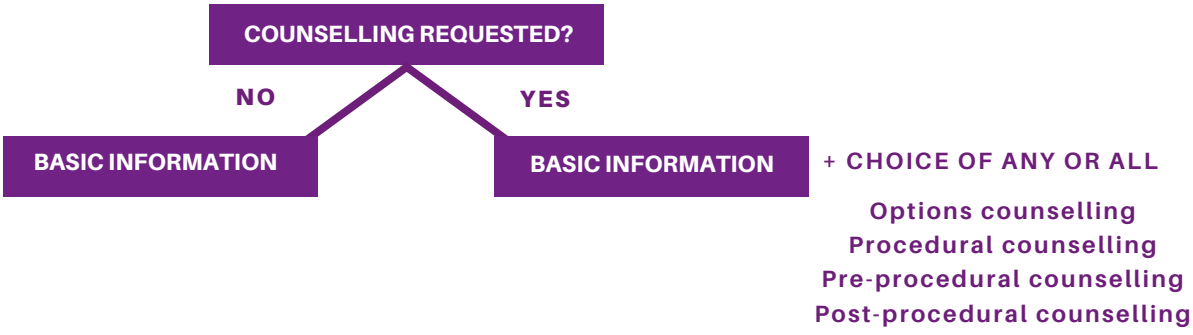
Inform the client that should they not wish to receive counselling, basic information will be explained to them to establish consent for the procedure (see below).

If the client wishes to receive information about the different kinds of counselling offered, proceed to outline the options below. If not, proceed straight to providing the basic information to establish consent (see later section).

The different kinds of counselling are (see further explanation of each later):

- **Options/decision-making counselling:** the purpose of this type of counselling is to provide support to clients who may be undecided about having an abortion and/or may want to explore their options;
- **Procedural counselling:** the purpose is to provide additional information over and above the basic information about the procedure;
- **Pre-procedural counselling:** the purpose is to provide emotional support before the procedure;
- **Post-procedure counselling:** the purpose is to provide support after the procedure.

If the client elects one or a combination of the above types of counselling, start off with the basic information required to establish consent and then proceed to the type of counselling requested by the client. The following flow-chart explains the possible avenues that may be followed as outlined in this step.



STEP 3: BASIC INFORMATION TO ESTABLISH CONSENT

This information is required to establish consent for the procedure. It involves providing information on:

- The client's rights under the CTOP Act;
- The method of termination (what to expect from a clinical perspective);
- The potential short-term physical side effects and complications of the procedure;
- Any symptoms to look out for in case treatment is needed;
- The duration of the procedure;
- Any pain management that is available at the facility and/or what pain medication clients may take on their own;
- If the client is to be given a separate date for the abortion procedure, any items that the client needs to bring with them (i.e., blanket, food, change of clothes etc.);
- If the client's pregnancy is advanced beyond 12 weeks, the grounds for the abortion need to be established through discussion and clinical examination. Sensitive questions concerning the client's physical and mental health, the circumstances of conception (e.g. rape or incest), and the client's social or economic circumstances may be asked.

Do not:

- Provide graphic information about the procedure or the products of termination;
- Describe medical abortion as "like birth";
- Discuss infertility, cancer or psychological trauma as 'risks' of abortion (this is misinformation as research **has not established** a causal link between abortion and infertility, cancer or psychological trauma);
- Provide information about the foetus' development or its features;
- Use models of the foetus or show any pictures of foetuses;
- Ask for the client's reason for abortion if the pregnancy is in the first trimester (if the client volunteers this information, simply accept it without commenting in any way);
- Ask if the client was using contraception when they conceived (this simply serves to place blame on the client).

When referring to the foetus, use whatever word is used by the client themselves. If the client does not refer to the foetus in any way, then use the word "foetus" and not "baby". If clients are required to sign a consent form, the form **should not** contain any misinformation about the 'risks' of abortion.

STEP 4: IF THE CLIENT HAS REQUESTED TO RECEIVE COUNSELLING

If the client does not wish to receive counselling, then proceed to the next steps in offering the abortion service. If they do wish to receive counselling, offer the kind of counselling that they have indicated they would like to receive.

Options/decision-making counselling

Although options/decision-making counselling may involve providing information about adoption and any government/social assistance that the client may access in terms of parenting, it should **still be led by the client**. Do not assume that the client *can*, is willing or *should* be willing to go the route of adoption or to parent.

Steps for options/decision-making counselling:

- Ask the client if they would like to receive information about adoption and/or government social assistance support that they can access;

IF YES:

- Supply the information (see appendix for full information);
- Ask if they have any questions or if there is anything else they would like to know about the information you have just provided (adoption or social assistance for parenting).

IF NO:

- Do not supply the information but proceed to the general section below.

IN BOTH CASES (YES AND NO), PROCEED WITH THE FOLLOWING:

- Ask the client what they would like to talk about in relation to the decision on the outcome of the pregnancy. Follow the lead of the client in terms of what they bring up. Ask them to elaborate on issues they present. Do not bring in issues not raised by the client.
- The client may have questions about the so-called risks of abortion (cancer, infertility and psychological trauma). **IF** the client raises questions around any of these, reassure the client that the research evidence does not support abortion performed in safe conditions **causing** such problems. Reassure the client that there are support services available post-procedure if needed. Provide them with the details of affordable and accessible support services should they feel that this may be necessary.
- Determine if the client is still unsure at this point or has made a decision. Keep in mind that some of the uncertainty around doing a TOP may be due to abortion stigma and *false* information about the risks of abortion. It is therefore important to normalise abortion: emphasise that while all medical procedures have some risks, abortion is a very common and generally safe medical procedure and that the CTOP Act stipulates that it is the client's reproductive right to have an abortion should they wish.

Do not:

- Ask the client to give you a reason or reasons for the abortion; **if** this information is volunteered, simply accept it;
- Make negative statements about abortion (e.g. "abortion is not a nice thing to go through";
- Introduce religion into the counselling;

- **If** the client's religion is itself a source of conflict and doubt, mention that there are religious organisations that recognise the reproductive right to abortion (e.g. Catholics for Choice). Give the client space to talk through their concerns, listening carefully and asking clarifying questions. Do not give advice on how to solve the dilemma – this must come from the client: you can only facilitate their movement towards a solution.
- Give information about the foetus, unless *requested* by the client themselves.
- Make any statements about psychological trauma or mental ill-health post-abortion as studies have shown that people may have very different emotional experiences of abortion, including relief, happiness, a sense of empowerment, and sadness, doubt, grief.

If the client is still unsure or doubtful, discuss the possibility of the client having some time to think about it, keeping in mind the gestation of the pregnancy and the conditions under which a TOP may be performed according to the CTOP Act. This must also be discussed with the client if they do want more time to think about it.

Procedural counselling

In addition to the basic information provided in order to obtain consent, clients may want more information about the procedure.

- Ask the client if there is any aspect of the procedure they would like to discuss or if they have any questions or concerns regarding the procedure. Address these.
- Stick to factual information about the procedure. If the client wants to know what to compare abortion to, you may say that people's experiences differ greatly.
- It is important to normalise the abortion process: regardless of the procedure that will be used, emphasise its relative safety as a medical procedure.

Pre-procedural counselling

This is to provide emotional support before the procedure.

- Ask the client what their thoughts and/or feelings are about the abortion procedure and if they have any questions.
- Listen carefully to the client's responses; provide affirmation that you have heard and understand their feelings (e.g. head nodding; good eye contact; using affirming "Hmm" sounds).
- Allow the client to express their emotions, whatever these may be. For example, the client may cry or may simply need to be silent for a while.
- If necessary, ask the client to elaborate on anything that they bring up (e.g. "tell me more about ...").
- The client may simply require reassurance that they are doing the right thing for them. It is therefore important to normalise abortion: emphasise that abortion is a very common and safe medical procedure and that the CTOP Act stipulates that it is a client's reproductive right to have an abortion.

The 'do not' list supplied under 'options/decision-making' counselling applies in this form of counselling as well.

Post-procedural counselling

This takes place after the procedure, if requested by the client, and is designed to help them adjust to their non-pregnant status.

- Ask the client what they would like to discuss.
- If emotional support is required, ask the client what their thoughts and feelings are now that the procedure is over. If the client discusses feelings of relief, happiness, empowerment etc., normalise this experience by stating that many other people have felt this way too. If the client discusses feelings of regret, grief, loss, sadness or doubt, try to normalise abortion: other people have also felt this way, many people all over the world have abortions and in South Africa it is a client's right to do so.
- Reassure the client that they made the best decision for themselves.
- Mention that it may be helpful to talk about their experience with someone, like a friend or even a professional counsellor.
- Refer the client to any further counselling services available at the facility or elsewhere, **if** the client requests this.
- If, in your clinical judgement (e.g. signs of clinical depression), the client needs referral, you may mention the possibility of referral, but you must still gain permission from the client to do so. The only circumstances in which referral is mandatory is when a client is clearly threatening harm to self or others. In this case, ask the client to wait, and seek the urgent assistance of the social worker if available. If no social worker is available, refer the matter to your facility supervisor.
- If the client expresses concern about infertility or cancer, reassure the client that it is unlikely that abortion performed under safe conditions will cause infertility or cancer.
- The client may request information about contraception. You may also ask **if** the client would like to talk about contraception. Only provide this information **if** requested by the client.
- If contraception information is requested, outline the options available at that facility. Once you have provided this information, ask the client if they would like contraception and if so, whether they want the contraception to be administered now or later. If later, let the client know where they may access contraception at a later date. **Do not** coerce or force the client to accept a form of contraception post-abortion.

WHAT TO DO IF THERE ARE THIRD PARTIES PRESENT

Some clients may present at the clinic with a partner, family member or friend. Generally, these people are there to provide support. This must be acknowledged and encouraged. However, it is not always the case that the third party is there to provide support (e.g. a parent coercing a minor to terminate a pregnancy).

It is very important to focus on the client from the very first encounter. In the waiting room, ask if the client would like the third party to be present in the counselling session. Do not ask the third party.

When conducting the counselling with a third party present, maintain eye contact with the client, and ensure that the third party does not answer on behalf of the client. If the third party does answer for the client, repeat the question looking at the client. Ensure that the third party understands that the decision regarding the outcome of a pregnancy is the client's alone. If the third party dominates and is unwilling to let the client speak for themselves, you can gently ask them to leave the room so that you are able to speak to the client directly, as the law requires that only the client can give permission for an abortion.

Direct engagement with the third party should be restricted to the kinds of support they are able to provide the client, and if they would like any information on how to provide that support.

WHAT TO DO IF A CLIENT REVEALS THAT THEY WERE RAPED OR A VICTIM OF SEXUAL OR DOMESTIC VIOLENCE

There are a range of reasons for people to seek abortions, including rape, sexual violence, and domestic violence. As indicated, unless the client offers reasons for wanting an abortion, do not press them to provide one. **IF**, however, the client does indicate that they were the victim of rape, sexual violence, or domestic violence, address the issue as follows:

- It is essential that the client feels that their story is believed; it is only in this way that they will feel sufficiently supported to possibly take further steps;
- Ask whether they would like to talk more about the incident(s); ensure that this is an open-ended question; do not ask for specific details (e.g. 'When did it take place? Where did it take place?);
- If the client chooses to relate the details, maintain an empathic stance; gently counter any gendered myths regarding rape, sexual or domestic violence. These myths are beliefs about sexual and domestic violence that lead us to blame the victim-survivor instead of the perpetrator. Some of these myths include the belief that women who walk by themselves, wear clothes that are revealing, go out drinking and/or dance in a certain way, walk by themselves at night, reject a man's sexual advances, or are interested in/attracted to women invite rape. These myths also include the belief that women lie about rape to get revenge on a man, that boyfriends or husbands cannot rape their girlfriends or wives, or that men have the right to use physical violence to punish their girlfriends or wives if they don't listen to them. All of these are not true and are harmful because they do not support the victim-survivor. If the client blames themselves for the rape, sexual or domestic violence, it is important to stress that it is rapists and abusers who are at fault. It is NOT the client's fault.
- If the client says that they do not wish to talk more about the incident, respect this and go on to the more concrete questions listed below.
- Ask the client if they have consulted with anybody about the rape/sexual violence/domestic violence:
  - If they have, ascertain whether they are satisfied with the responses. If they are not, explore alternative possibilities;
  - If they have not consulted with anybody, ask if they feel ready to do so; speak through the possibilities of resources in their area.

- Ensure that you have information on resources in your area – telephone numbers, addresses, people to talk to. If a client indicates that they are not yet ready to talk with somebody, ask if you can provide them with the details anyway (preferably in written form) so that they may access them later should they wish to. If they say no, respect their decision. The following local resources would be useful information to have on hand: South African Police Services; Social Welfare Services; Counselling Services.
- Remember that a client-centred approach means that the wishes of the client are paramount. Whatever your thoughts on the client's circumstances, you cannot insist that they take action, whatever that may be, unless the client wants to, feels ready and supported to do so.
- If the clinic automatically sends the products of pregnancy resulting from rape for forensic testing, you need to inform the client of this. You should assure them that this is standard procedure and that action will only be taken against the alleged perpetrator if they lay a complaint with the South African Police Services.

ASCERTAINING REASONS FOR SECOND TRIMESTER ABORTIONS

The CTOP Act makes provisions for abortions in the second trimester under the following conditions:

> [F]rom the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that-
>
> (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
> (ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
> (iii) the pregnancy resulted from rape or incest; or
> the continued pregnancy would significantly affect the social or economic
> (iv) circumstances of the woman (CTOP Act, 1996, p. 5)

In these guidelines we focus on second trimester abortion, not abortion performed after 20 weeks. If the client is in the second trimester of the pregnancy, at Step 3 above when explaining the client's rights under the CTOP Act, mention that there are conditions under which abortion may be performed from 13 weeks gestation. Outline the conditions as provided above. Indicate that in order to ascertain the condition pertinent to the client, you will need to ask the client for the reasons that they would like to have the abortion.

Whatever reason is provided by the client, do not question it. The following processes should be followed in relation to (i) to (iv) above, depending on the response of the client:

(i) Ask the client if they have consulted with anybody about the rape/sexual violence/ domestic violence:If health, emotional or psychological factors are mentioned, probe about additional symptoms that will allow for a tentative diagnosis (e.g. depression);

(ii) If scans or tests show that there is a risk of foetal abnormality, and this is the only reason that the client is obtaining an abortion, it is possible that they will need additional counselling, especially if the pregnancy was planned and wanted; gently ask the client about the support that they have and what additional support they may need; refer them for psychological counselling, if needed;

(iii) The steps in the case of rape are outlined above; in the case of incest, it is imperative the social services are involved if the client is a minor; let the client know that they will be referred to social services for additional assistance;

(iv) Clients may refer to a range of social and/or economic circumstances, including: not having sufficient finance for a (or another) child; needing to complete school; insufficient support at home or from the partner; extreme stigma associated with the pregnancy (and many others). The counsellor's task is not to judge whether these are suitable reasons or not. Instead, clients can be asked if they would like to talk more about these difficult circumstances. If not, the counsellor should simply record the reasons provided.

SELF-CARE AND SUPPORT

Providing abortion counselling can be a rewarding experience. It may also be taxing for the counsellor. It is important that counsellors engage in self-care in whatever way suits them. Support from colleagues and friends (without breaking confidentiality) is vital. Ongoing training and supervision can help to sustain a counsellor's interest and capacity to engage in this very important process.

APPENDIX A:

SUMMARY OF BASIC INFORMATION TO ESTABLISH CONSENT FOR TOP PROCEDURE

CLIENT RIGHTS UNDER THE CTOP ACT

The Choice on Termination of Pregnancy Act (No.92 of 1996) and its amendments state that clients may obtain a termination of pregnancy, on demand (that is, without needing to fulfil any criteria) during the first 12 weeks of pregnancy. For this period, the TOP may be performed by a midwife, nurse or doctor with the required TOP training. Nurses or midwives performing the procedure do not need to consult with a doctor or other qualified person for first trimester TOPs.

From 13-20 weeks, clients may obtain a TOP if they meet the following criteria: the continued pregnancy would pose a risk of injury to the client's physical or mental health; or there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality; or the pregnancy resulted from rape or incest; or the continued pregnancy would significantly affect the social or economic circumstances of the client.

After the 20th week a TOP may be obtained if: a medical practitioner, after consultation with another medical practitioner or a registered midwife or nurse, is of the opinion that the continued pregnancy would endanger the client's life; or would result in a severe malformation of the foetus; or would pose a risk of injury to the foetus.

Furthermore, the CTOP Act stipulates that **only the client's consent for the procedure is required** and that clients may consent to having a TOP whether they are over the age of 18 or a minor. Therefore, the law **does not require** parental/guardian consent in the case of a minor requesting a TOP. In the case of a client below the age of 18, the CTOP Act states that the healthcare worker conducting the procedure and/or counselling can only suggest that the minor inform their parent or guardian but the **healthcare worker cannot insist on this and cannot refuse to perform the TOP** if the minor chooses not to inform their parent(s)/guardian(s). The law also **does not require** partner consent in the case of a client who is married or is not married but is in a relationship.

According to the law, it is a punishable offence to prevent a client from obtaining a TOP. Health workers CANNOT refuse to assist a client to get an abortion for any reason. If a healthcare worker has undergone TOP training but does not want to perform the procedure themselves (as per their right to object on the grounds of religion and belief), they must refer the client to another health worker and/or to an appropriate facility closest to the client. In the event of a referral to another colleague or appropriate facility, the client must be provided with a referral letter and a booking for the procedure. Administrative staff, pharmacists, security, or other clinic staff have no right to refuse to assist in providing information about where TOPs are legally and safely performed.

In terms of abortion counselling, the CTOP Act states that abortion counselling must be made available but must be voluntary. Therefore, it is the client's right to choose whether to receive abortion counselling or not, and which type of counselling they would like to receive. If a client chooses not to receive counselling, they still have the right to proceed with the abortion.

METHOD OF TERMINATION

There are two main kinds of abortion procedure. They are described below.

Medical abortion procedure

Medical abortion requires the use of two drugs: Mifepristone and Misoprostol. One tablet of Mifepristone is swallowed first, causing the embryo to stop growing. Two days later the client must take Misoprostol which causes contractions and uterine products to be expelled. Because Mifepristone and Misoprostol may cause foetal anomalies if the pregnancy has not been successfully terminated via medical abortion, a surgical abortion must follow the medical abortion procedure if the termination is not successful. A follow-up exam must be done one to two weeks after the abortion is performed to ensure that the uterine contents have been completely expelled.

Although medical abortion is generally a very safe procedure, there are some situations where a client cannot have a medical abortion and should have a surgical abortion instead. These are listed below:

- They have an Ectopic pregnancy (the pregnancy is outside of the uterus)
- Their adrenal glands do not function properly
- They are on long-term asthma medication (such as corticosteroids), are on blood-thinning medication or have a history of a bleeding disorder
- They are allergic to any components of the medication
- They have severe uncontrolled asthma
- They have an intra-uterine contraceptive device
- They have serious cardiovascular or high-blood pressure problems
- They cannot return to the clinic for a follow-up visit (one or two weeks post TOP)
- They cannot get to an emergency medical clinic in the event of an emergency

Sometimes surgical abortion is also indicated for those who do not have access to water and sanitation, and do not have a sanitary space to dispose of waste at home, and for queer-identified people or those who have experienced sexual assault who may need conscious sedation and a surgical procedure.

Surgical abortion procedure

A surgical abortion may be done via vacuum aspiration or dilation and evacuation.

Vacuum aspiration may be done manually or electrically, depending on the facility. A manual vacuum aspiration (MVA) removes the contents of the uterus using a hand-held plastic aspirator which has a vacuum source attached to a canula (thin tube). This removes the contents of the uterus through suction. An electric vacuum aspiration (EVA) uses an electric pump or suction machine to remove the uterine products.

Dilation and Evacuation (D&E) is used for pregnancies that are 15 weeks or more gestation. This is usually if an earlier MVA has been unsuccessful and some uterine products have been retained or if a late pregnancy is being terminated.

SIDE EFFECTS AND POTENTIAL COMPLICATIONS

For surgical abortion, MVA has a success rate of 98% with only a 2% rate of complications. Severe complications for MVA include haemorrhaging requiring blood transfusion, or perforation of the uterus which requires surgical repair. Other complications include fever and infection and uterine tenderness which are signs of an incomplete abortion.

Because medical abortion uses medication, it has known side effects related to the medication. Bleeding (heavier at first and then lighter) and cramps are expected to follow once a medical abortion has been initiated and are signs that the medication is working. Clients may also, however, experience vomiting, nausea, diarrhoea, dizziness and headaches as a result of the medication. Minor allergic reactions to Misoprostol and/or Mifepristone may occur and include swelling of the hands or feet, wheezing or rashes. These may be treated with an antihistamine. Clients may, however, experience severe allergic reactions, such as shortness of breath, or swelling of the airway, which require emergency treatment. Complications due to medical abortion may include major complications which are defined as requiring hospitalization, surgery or blood transfusion. Other complications include incomplete abortion, failed abortion, haemorrhage, and infection.

PAIN MANAGEMENT

Surgical abortion: clients undergoing vacuum aspiration before 13 weeks gestation can receive pain medications, paracervical block (where a local injection is inserted into the cervix) or non-pharmacologic approaches (such as a heating pad or hot water bottle in the recovery room) to treat pain. Brufen may be used. Paracetamol is not routinely recommended for vacuum aspiration pain management. General anaesthesia is also not routinely recommended for vacuum aspiration pain management before 13 weeks. Intravenous conscious sedation may be used but this is usually done in a higher level health facility so the client can be closely monitored.

Medical abortion: pain medication can be administered/taken 2hrs after the second dose (Misoprostol) has been taken. Non-steroidal anti-inflammatory drugs (NSAIDs) such as brufen or diclofenac are more effective than paracetamol or acetaminophen. Narcotic analgesics and non-pharmacologic pain management measures may also be used.

DURATION OF TOP PROCEDURES

Medical abortion: During a medical abortion, the medications taken induce heavy bleeding which expels the pregnancy. Heavy bleeding may take place 3-5 hours after both medications have been taken or may take some days to occur. Individual clients may have different experiences.

Surgical abortion: a surgical procedure using aspiration (such as MVA or EVA) takes about 10-15 minutes. A D&E or D&C procedure takes approximately 15-30 minutes.

This information was accessed from the following sites and documents:

- https://srjc.org.za
- Ipas. (2010). *Medical abortion counselling resource for providers*. Chapel Hill, NC: Ipas
- Ipas. (2014). *Woman-centered, comprehensive abortion care: Trainer's manual* (second ed.) K. L. Turner & A. Huber (Eds.), Chapel Hill, NC: Ipas.
- Ipas. (2017). *Clinical Updates in Reproductive Health.* D. Brahmi (Ed.). Chapel Hill, NC: Ipas.

APPENDIX B:

INFORMATION ON ADOPTION AND GOVERNMENTAL SOCIAL ASSISTANCE/WELFARE FOR PARENTING

If clients have chosen to receive options counselling and would therefore like to receive information about adoption or social/welfare assistance for parenting, the information below might be useful. When giving the information provided below, it is important to be neutral.

ADOPTION

Types of adoption

There are different types of adoption. A disclosed adoption is where the birth parent(s) and the adoptive parent(s) know each other's identities. With this type of adoption, the birth parent(s) may decide upon an agreement with the adoptive parent(s) where the birth parent(s) may remain in contact with the child(ren) and/or receive progress reports on the child's development. This option makes information relating to the child's/ children's family and health history available to the parent(s) who are wishing to adopt the child(ren). Furthermore, because the identities of the potential adoptive parent(s) will be known to the birth parent(s), the social worker may take into consideration the views of the birth parent(s) concerning who the adoptive parent(s) will be.

A closed adoption is where the birth parent(s) has no knowledge of, or information about, the adoptive parent(s). The adoptive parent(s) also do not have access to the identity of the birth parent(s). This means that there will be no contact between the birth and adoptive parent(s) and that the birth parent(s) will not be able to have a relationship with the child(ren) once they are adopted.

Alternatively, birth parent(s) may choose to have a combination of a disclosed and closed adoption.

The adoption process

Once a client has received information about adoption and has decided that this is the route they want to and/or need to take, it is important for them to be referred to a social worker who will take them through the entire process. Social workers who work for the government provide their services free of charge. Below, the adoption process is outlined briefly.

The involvement of the social worker ensures the well-being of the birth mother and that of their child(ren). This includes the social worker's assistance in gaining access to medical and ante-natal treatment if desired by the birth mother. It also means that the

social worker may arrange accommodation for the birth mother during their last trimester and also during the recovery period following the birth of their child(ren), should the birth mother wish to receive this care and accommodation. Depending on the type of adoption chosen, the social worker will make sure that due process take place and that all parties are held to any agreements made between the birth and adoptive parent(s).

Importantly, regardless of which type of adoption is chosen, both birth parents need to provide consent for placing the child up for adoption. If required, the social worker will assist in the process of contacting the birth father and obtaining his consent. The social worker will also assist in the steps to take if the birth father is deceased or is unreachable, in which case his consent is not required. If the birth mother is a minor, the consent of their parent(s)/guardian(s) is required. This will also be facilitated by the social worker who will ensure that the correct procedure is adhered to, including any exceptions to this requirement (such as in the event that the minor has been abused or assaulted by their parent(s)/guardian(s), or the minor's pregnancy is the result of rape).

Once everything is in order, the adoption process is finalised with the signing of consent forms which is an official process that takes place in front of a magistrate in the family court. From the day that the consent forms are signed, the birth parent(s) have 60 days in which they may change their minds about placing their child up for adoption. If the 60-day period elapses and the birth parent(s) has not notified the social worker that they have changed their mind about the adoption, the adoption process is considered to be complete. From that point, the birth parent(s) has relinquished their rights concerning the child(ren). Depending on the type of adoption that was chosen, the birth parent(s) may or may not be allowed to be in contact with the child(ren) once the process if finalised or to receive information on the progress and development of the child(ren).

SOCIAL/WELFARE ASSISTANCE FOR PARENTING

There are social grants that a client may access in the event that they wants to continue the pregnancy and parent the child(ren) but needs some financial assistance to do so. The South African Social Security Agency (SASSA) provides a Child Support Grant and a Care Dependency Grant that may be applicable to a client wanting to parent but who is in need of assistance. These are briefly described below. (SASSA provides other social grants which, depending on the client's circumstances, may be applicable as well. Information about these grants may be accessed from SASSA's website: http://www.sassa.gov.za)

To apply for a grant, the applicant needs to go their nearest SASSA office. If the applicant cannot go to a SASSA office themselves, someone may apply on their behalf provided that the applicant writes a letter giving permission for the individual to apply on their behalf.

Alternatively, the applicant can call the SASSA office and request a home visit. At the SASSA office, an application form must be filled out. This will take place in the presence

of a SASSA officer. There is no charge for the application. Once the application has been processed, the applicant will receive a receipt which must be kept as proof of the application. The applicant will receive a SASSA smart ID card which they will need to access the grants described below.

Child Support Grant

This grant is provided to a care-giver for assistance in caring for a child. The conditions of the grant are as follows:

- The primary care-giver (whether birth parent or guardian) must be a South African citizen, permanent resident or refugee;
- Both the person applying for the grant and the child(ren) must reside in South Africa
- The person applying for the grant must also be the primary care-giver of the child(ren)
- The grant applies to any child born after 31 December 1993
- The person applying for the grant (the primary care-giver) and the spouse (if the primary care-giver is married) must meet the requirements of a means test which will determine whether government financial assistance is required
- The "child" to be provided for using the grant cannot refer to more than six **non-biological** children
- This grant does not apply to a child/children who is/are already being cared for in a government institution

Care Dependency Grant

This grant is provided to the care-giver of a child with a severe disability. The conditions of the grant are as follows:

- The primary care-giver (whether birth parent or guardian) must be a South African citizen, permanent resident or refugee;
- Both the person applying for the grant and the child(ren) must reside in South Africa;
- The child(ren) being provided for using the grant must be below the age of 18 years;
- The care-giver must submit a medical/assessment report that confirms permanent, severe disability;
- The applicant (and spouse where relevant) must meet requirements of the means test which will determine whether governmental financial assistance is needed (foster parents are not required to meet the requirements of the test);
- This grant does not apply to a care-dependent child/children who is/are permanently cared for in a government institution.

This information was accessed from the following sources:

- https://www.adoption.org.za
- http://giftovlife.com/adoption/adoption-in-south-africa/
- http://www.sassa.gov.za/index.php/social-grants/
- South Coast Herald. (2017, November 19). Sassa grants: Who qualifies and how do you apply? Retrieved from https://southcoastherald.co.za/248250/sassa-grants-qualifies-apply/