An audit of surgical termination of pregnancy at a level 1 health facility in South Africa

[a]**Devjee J**, MBChB
[a,b]**Khedun S**, MMedSci
[b]**Moodley J**, MBChB, FCOG, FRCOG, MD
[a]Department of Obstetrics and Gynaecology, Addington Hospital, Durban
[b]Women's Health and HIV Research Unit, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban
Correspondence to: Jagidesa Moodley, e-mail: jmog@ukzn.ac.za
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Abstract

Background: It was alleged that the termination of pregnancy (TOP) services in a certain district health facility were forgoing the opportunity to offer screening tests for human immunodeficiency virus (HIV) and syphilis for women seeking legal medical abortions. In addition, there were concerns regarding the lack of provision of contraceptive services, particularly in view of media reports of young women having repeated TOP procedures as a family planning method. It was therefore decided to perform an audit of the TOP services at this district health facility.

Method: A semi-structured questionnaire was used to obtain information from all women undergoing a TOP during a six-month period at a district hospital in KwaZulu-Natal. Demographic information, clinical details and attitudes towards TOP were obtained. All women were interviewed in private prior to discharge from the clinic.

Results: A total of 645 women were enrolled. Their mean age was 23 (range 15-44) years and 437 (67.8%) were primiparous. Of the 645 women, contraceptive failure (condom) occurred in 38 cases (6%). Two hundred and twenty-two (34.4%) had previously used a family planning method, the most common being depot preparations (35.1%), followed by condoms (28.9%) and oral contraception (15.8%). One hundred and nine (16.9%) women accepted the condoms offered while the remainder indicated that they would obtain contraceptives from the family planning clinic in their area of residence. Twenty-nine (5%) had at least one previous TOP while 25 (86%) and four (14%) had second and third requests for TOP respectively. None of the women had any serological screening tests performed or were given information about testing for sexually transmitted diseases, including HIV screening, prior to discharge from the clinic.

Conclusion: Women having TOP at this district hospital are not offered counselling and information on screening for sexually transmitted diseases. In addition, few women take up the offer of contraceptives. There is a need for health care providers to strengthen reproductive health services at TOP clinics.

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Introduction

The introduction of the Choice on Termination of Pregnancy (cTOP) Act in 1996 meant that South African women could make critical decisions regarding their pregnancies including the choice of termination in designated facilities in the public and private health sectors.[1,2]

Although the cTOP legislation resulted in a decrease in morbidity and mortality,[3] access to safe and legal termination of pregnancy (TOP) services is still not universal in South Africa. There are multiple barriers and some women are left with no recourse other than continuing with an unintended and unwanted pregnancy, or accessing termination services from an unsafe provider or method.[4,5] The recent Saving Mothers Report indicates an increase in the numbers of deaths associated with illegal miscarriages in South Africa.[6] In another study, 138 (19.1%) of the 721 women requesting TOP had at least one prior TOP, while 583 (80.1%) of the women stated it was their first visit; 547 (73.3%) women were not using any family planning at the time of request for TOP.[7]

Despite the obstacles to TOP, the authors' impression is that the number of requests for legal TOP in the public sector has increased particularly in KwaZulu-Natal and a number of women may be having repeated legal miscarriages thus raising the spectre of TOP as a form of contraception. In addition, little is known about the views and attitudes of women who have undergone TOP and the quality of

TOP services in the public sector. The present study was undertaken to perform an audit of TOP services at a specific level 1 health facility.

Method

This was a questionnaire-based audit of women who requested and underwent first trimester surgical TOP at a level 1 health facility in KwaZulu-Natal, South Africa.

At the study site, first trimester (up to 12 weeks' gestation) TOPs are performed by professional nurses trained to perform manual vacuum aspiration (MVA) on an outpatient basis. Prior to acceptance for TOP all women have a sonar examination to ensure the appropriate gestational age and to exclude an extrauterine pregnancy and any other pelvic organ abnormalities. The MVA is done following "cervical ripening" with misoprostol, following standard guidelines, and the women are usually discharged home on the same day, after a period of rest for two to four hours.

All women were interviewed by a nurse and/or medical officer in a private room, in order to maintain confidentiality. The questionnaire was completed prior to discharge to avoid any biases related to the women's request for TOP and the service they received.

The data obtained from the questionnaire were entered in a structured format and included demographic and clinical characteristics. The questionnaire also included questions on gestation at the first visit and the day of procedure, all aspects of family planning, pre- and post-abortion counselling, any complications, and views and attitudes of patients towards abortion. Descriptive statistics were utilised and all results were presented as frequencies, means, range and percentages.

Institutional ethical approval (BF 162/08) and hospital permission was obtained to conduct this study.

Results

Seven hundred and sixty-nine women attended the TOP clinic between February 2009 and September 2009 requesting termination of their pregnancy. Six hundred and forty-five women were eligible to participate in the study. Of the 645 women requesting TOP, 616 were seeking a TOP for the first time, while the remaining 29 had at least one TOP in the past. Six hundred and twenty-three women needed a single misoprostol regimen while 22 women required a second misoprostol regimen after consultation with the medical officer. One hundred and twenty-four women were excluded: nine did not return for the MVA procedure and 115 presented at a gestational age exceeding 12 weeks (Figure 1).

Four hundred and thirty-seven (68%) women were primiparous [mean age 20 (15-26) years]. Two hundred and twenty-three (51%) of the 437 primiparae were teenagers (aged up to 19 years). The repeat termination group were older; only two (7%) were under 20 years. The socio-demographic data of the 645 participants are listed in Table I. The majority of the women had attained secondary (75.8%), tertiary (12.2%) or primary (11.6%) level of education and only 0.3% had no formal education. None of the women had any serological screening tests prior to the procedure. However, 506 (78%) of the women indicated that they would have undergone voluntary counselling and human immunodeficiency virus (HIV) testing.

Contraceptive failure occurred in 38 cases (6%): in all of these cases male condoms were used. Six hundred and seven of the women did not use any family planning method at the time of request for TOP. Two hundred and twenty-two (34.4%) of the 645 women had previously used a family planning method, the most common being the injection (35.1%), followed by condoms (28.9%) and pills (15.8%).

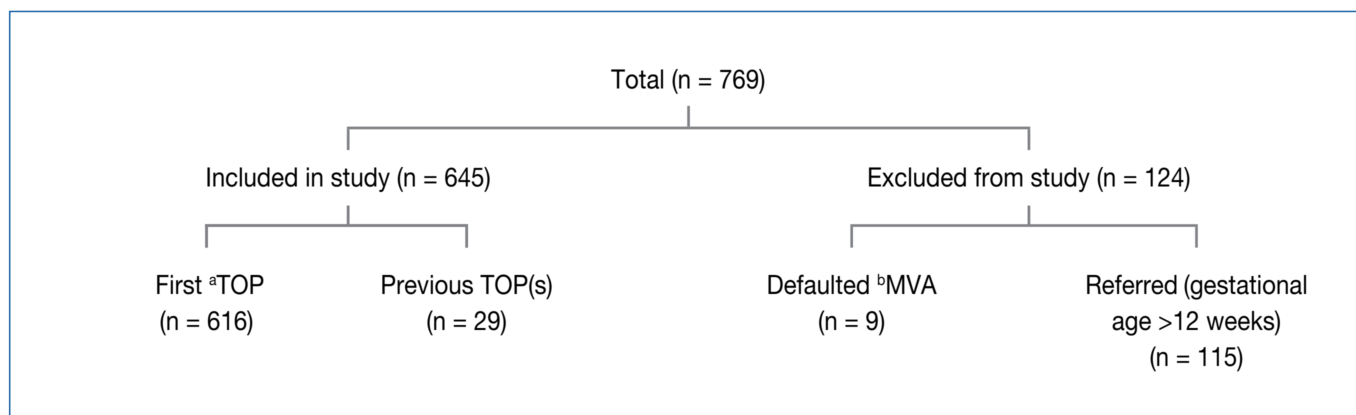

Figure 1: Flow chart of the distribution of patients enrolled in the study
a = termination of pregnancy, b = manual vacuum aspiration

Table I: Demographic data of the 645 women entered in the study

Age	23 (15-44) years
Parity	1 (0-5)
Primiparous	437 (67.8%)
Multiparous	208 (32.2%)
Race	
Black	637 (98.7%)
Caucasian	5 (0.78%)
Foreign	3 (0.47%)
Education	
Primary	75 (11.6%)
Secondary	489 (75.8%)
Tertiary	79 (12.20%)
No education	2 (0.30%)
Marital status	
Single	450 (69.8%)
Married	195 (30.2%)
Gestational age (weeks)	
1st visit	8 (6–11)
MVA	10 (7–12)
Previous [a]TOP	
Yes	29 (5.0%)
No	616 (95.0%)
Previous contraception use	
Yes	222 (34%)
No	423 (66%)
Contraception use at TOP request	
Yes	38 (6%)
No	607 (94%)

a = termination of pregnancy

Table II: Indications for 1st trimester (up to 12 weeks' gestation) termination of pregnancy

Indication	Number	%
Unplanned/unintended	401	62.0
Insecure relationship	63	9.8
Fear or lack of family support	37	5.7
Too young	57	8.8
Financial problems	40	6.2
Rape (non-consensual sex)	23	3.4
HIV positive	24	3.7

The reasons for requesting TOP is set out in Table II. Unexpected pregnancy (unplanned/unintended) was the most common reason for termination (62%), followed by insecure relationship (9.8%), fear or lack of family support (9.8%), being too young (8.8%), financial problems (6.2%), rape (3.4%) and positive HIV status (3.7%).

Twenty-nine women (5%) had a history of a previous TOP; 25 (86%) had one previous TOP and for four women (14%) this was the third request. One hundred and ninety-five (30.2%) of the women requesting TOP were married.

Four hundred and forty women (68%) had no knowledge of postcoital contraception. Of the 205 (31.8%) who did, 62 (10%) had previously used this method.

The TOP clinic issued male condoms free of charge prior to discharge but only 109 women (16.9%) accepted them. The remainder indicated that they would obtain contraceptives from the family planning clinic in their area of residence. All the women were happy to receive information and were satisfied with the pre- and post-abortion contraception and family planning counselling. They also indicated that the counselling was very informative.

Three hundred and ninety-four women (61%) were against TOP. Two hundred and five (32%) of the 645 women complained of pain after the procedure but there were no immediate complications observed or reported.

When asked what they would do if their request for TOP was refused at the clinic, 81 (12.6%) stated that they would continue with their pregnancy, 442 (68.5%) said they would go to a private registered clinic for the procedure and the remaining 122 (18.9%) said they would resort to other measures.

Discussion

One hundred and fifteen women in our study requested TOP at a gestational age exceeding12 weeks and because this site did not provide second-trimester TOP, they were referred to private health facilities providing second-trimester TOP services. Women seeking TOP might not know that they need to access TOP services early in their pregnancy or it is possible that they had difficulties in accessing these services. There is circumstantial evidence that there are considerable delays in accessing TOP services. In South Africa, the majority of the surgical TOPs in the public sector are performed at specific hospitals and clinic facilities. These factors compromise women's access to TOP care. Often access is limited by the number of TOP that can be carried out per day and by the availability of staff. This results in excessive delays, which in turn result in pregnancies going into the second trimester and the necessity for referrals to health facilities performing second-trimester TOP.

At the study site, there was a two- to four-week delay for TOP services, probably largely related to a shortage of service providers. Dube reported a six-week delay for surgical abortion at a hospital centre in Ottawa, Canada.[8] According to the Medical Foundation for AIDS and Sexual Health, the earlier in pregnancy an abortion is performed, the lower the risk of complications and death. Therefore

women should be able to access an abortion within two weeks and within a maximum of three weeks of initial contact with health care providers.[9] The introduction of medication abortion services using a combination of misoprostol and mifepristone, in which women initiate the process themselves, may considerably decrease waiting times as it may overcome any objections raised by health workers as well as the shortage of health care professionals in South Africa. A recent qualitative study on health care providers' attitudes towards TOP services in the Western Cape found that there was a lack of understanding of the 1996 cTOP legislation, including conscientious objection, and suggested improving the knowledge of all health care workers, including health facility managers.[4]

In our study, 401 (62%) of the women seeking TOP had an unwanted pregnancy. Similar findings have been reported locally.[7] These figures are high when compared to an earlier study conducted in Peru, where 22% (91/410) of the pregnancies was unwanted.[10] The requests for TOP in our study were influenced by financial problems, being too young, being a student, positive HIV status and insecure relationships. Many of these unintended pregnancies can be prevented by strengthening family planning services and improving health information knowledge of the public.

The decision to seek TOP usually precedes any involvement of health care professionals.[11,12] In our study, over 70% of the women requesting TOP described receiving most support from their mothers and friends in the decision-making process regarding TOP, and least from their partners. Lang et al. reported that more than half of the participants in their study indicated that nobody had influenced their decision to undergo TOP but the partners represented the strongest influence (23.2%), followed by the parents (11.5%).[7] A USA study reported that women were more likely to confide in their female friends about their pregnancy and decision about TOP than family members or partners.[13]

In our study, despite positive attitudes of women towards abortion, 394 (61%) of the women were against having an abortion but were forced to undergo termination because of circumstances beyond their control. Similar findings were reported in a Swedish study.[14]

A low incidence (3.4%) of rape as an indication for TOP was observed in the current study. The general perception in South Africa is that the incidence of violence against women and rape is high. However, only a small proportion of women who have been raped report their cases to the police or attend specialised health services.[15] It is likely that many women in our study did not provide this information.

A small percentage of women (3.7%) requested termination based on their HIV status. It was surprising to note that these women knew about the Prevention of Mother-to-Child Transmission programme but opted for TOP because of their compromised health.

The possibility that some women were using abortion as a contraceptive method was one of the reasons of commissioning this audit. A small number of women returned for a second TOP and only four for a third TOP. It is difficult to ascertain the cause for this. According to Rowlands, a proportion of women having subsequent abortions tend to increase after legalisation of abortion.[16] In the United Kingdom, currently 32% of women having abortions have had an abortion in the past.[17] All types of contraception are freely available from public family planning clinics or commercial pharmacists. However, there is a need for promoting contraceptives and improving dissemination of reproductive health information to the community at large, particularly adolescents and young women.

Data from studies emanating from three low-income countries have shown that women are more likely to accept and use contraceptives when the service is offered as an integrated part of post-abortion care.[18-20] At the study site, condoms are offered freely as the only means of contraception. Only 109 (16.9%) of the 645 participants accepted the condoms offered by the clinic and the remainder indicated that they would obtain contraception from a family planning clinic in their district. There currently is no way of evaluating whether these women continue to access contraceptive services or whether they attend their local clinics to obtain contraceptives. More recently, various types of family planning methods together with voluntary counselling and HIV testing have been made available at our site.

It is important to note that 6% of the women in our study seeking TOP for the first time experienced contraception failure. Male condoms were used in all these cases as the family-planning method. The appropriate use of male condoms is questionable in these cases. In an earlier study on surgical TOP, Aktun et al. concluded from their questionnaire-based study that well-planned contraceptive counselling together with education can decrease unwanted pregnancies and subsequent requests for surgical TOP.[21]

In our study, 51% of the women (266 of 437) were teenagers. This, taken together with the fact there is an increasing number of teenage pregnancies in our area according to departmental statistics from 2010, strongly indicates that more attention should be given to improving family planning services and sexual education in school from an early age.

A disturbing finding in our study was the fact that besides sonography, the women were not offered any other screening tests. Given the continuing high incidence of HIV, the fact that this may be the first time many of these young women seeking medical care and the fact that HIV testing is being promoted by the Department of Health at the point of entry into the health sector, there should be guidelines for screening tests to be done at TOP clinics. Furthermore regular audits of these clinics should be done to ensure that they are providing comprehensive care. As a result of our audit this district health facility has now instituted screening tests for syphilis and HIV.

The demand for first-trimester abortion services at our centre exceeds its capacity primarily because of the shortage of TOP providers within the public sector for a variety of reasons. The lack of such services is impacting on the rate of mortality due to miscarriage. The latest Saving Mothers Report indicates that deaths from miscarriages have increased following the downward trend shown in the previous triennium.[6] Obstacles such as shortage of staff, reluctance of public sector health workers to take part in the process of TOP and stigmatisation of all who are involved in such procedures calls for public-private partnerships which seem to be successful in some institutions. Furthermore, as stated above, public education on assessing TOP services early, introduction of sexual education in schools, and improving family planning services is essential to provide comprehensive health care services for women. The high rate of unintended and unwanted pregnancies observed in our study highlights the necessity for accessible and timely abortion services.

Conclusion

It is universally accepted that effective contraception and the importance of education about contraception in general is vital in the prevention of unintended pregnancies, and although it will not prevent all conceptions, it will contribute significantly to a reduction in unintended pregnancies and decrease the incidence of requests for surgical abortion. Improving reproductive health services, particularly dissemination of information on the continued use of contraceptive methods, is an essential step in improving health care in a society. At the same time, women who have made a conscious decision to seek TOP should be provided with an acceptable standard of care.

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