The Profile of The First Women Presenting for Elective Termination of Pregnancy at the Pretoria Academic Hospital

Kirkby, RE
MB, ChB, DA,
BSc (Hons)(Pharm), MFGP (SA),
MPraxMed, MSc (Sports Med)

Blitz, JJ
B Sc, MB, BCh, MPraxMed
(Medunsa)

Kluÿts, T McD
B Sc, MB, ChB, MPraxMed
(Pret)

Department of Family Medicine,
University of Pretoria and
Pretoria Academic Hospital,
South Africa

Address for correspondence
Dr. Russel Kirkby
King Faisal Specialist Hospital &
Research Centre
Riyadh, Saudi Arabia.

Keywords:
abortion, survey, elective, South Africa, Pretoria

Abstract

Introduction: At the time of the study (1998), a termination of pregnancy (TOP) service had never been provided at Pretoria Academic Hospital or elsewhere in South Africa before and this elicited much speculation about the women who would present for this service. It was decided to study the first group of women who came to Pretoria Academic Hospital for this service and explore some of the issues surrounding their decision.

Methods: A prospective descriptive study was performed on the first 122 women presenting for termination of pregnancy at the Pretoria Academic Hospital.

Results: The "average" woman requesting TOP was a 25-year-old single woman busy with tertiary education. She was a P_1G_2 and had been in a stable relationship of more than 1 year's duration. She and her partner had used a condom that had been unsuccessful in preventing conception. The duration of her pregnancy was 10 weeks. She had informed her partner who provided her with positive emotional support at the time. There was an equal chance that she informed her family or did not inform them of her pregnancy and her decision to seek elective termination. If informed they also positively supported her.

Her decision to request elective termination was usually a joint decision with either her partner and/or her family and would be for more than one reason - the most common being financial and study reasons.

Discussion: Our overwhelming impression is that of a group of patients faced with a very difficult decision. The decisions never seem to be made lightly, easily or without some deep soul-searching. They need more involvement from their doctors, not less, and these doctors might do well to understand the patients before summarily dismissing them and refusing to become involved.

S A Fam Pract 2001;23(3): 11-16

Introduction

Recent estimates indicate that as many as 53 million pregnancies are terminated by induced abortion each year [1]. The new laws [2] have changed the legal implications of medically induced termination of pregnancy (TOP), but ethical and moral dilemmas remain.

It is an understatement to say that the issues surrounding medically assisted termination of pregnancy arouse strong feelings and opinions. Strong opposition accompanied the introduction of the service for termination of pregnancy at Pretoria Academic Hospital with most health care professionals refusing to partake in the provision of services for this purpose.

There was also much commentary and speculation from them about the women who would present for this service. Many of these were reflections of the speakers' own perceptions and beliefs. The most common perception was that it would be irresponsible, promiscuous single teenagers who would make use of this service.

Perusing the world literature did not help much in either confirming or dispelling these beliefs. More is written about the medical issues surrounding the request for termination

of pregnancy than about those who present for this request, why they do and what some of the emotions and conflicts are that accompany this decision. Studies performed in Ethiopia[3], Norway[4,5], India[6] and Italy[7] address some of the issues but it is uncertain whether their findings are applicable to the South African situation. Skjeldestad[4,5] probably sums it up best by commenting on the heterogeneity of women seeking elective termination of pregnancy.

As this service had never been provided at Pretoria Academic Hospital or elsewhere in South Africa before, it was decided to study those who came for these services and explore some of the issues surrounding their decision.

Method

A prospective descriptive study was performed on a convenience sample of 122 consecutive women presenting for termination of pregnancy at the Pretoria Academic Hospital from the start of the TOP service in 1998.

Due to the lack of medical personnel willing to become involved in the process, the clinical load of history taking, physical examination and ultrasound plus blood tests were all performed by one doctor and one nurse. The doctor also recorded the answers to the questions at the same time. Hence some of the research forms were not completed comprehensively. No patients declined to partake in the study but some declined to answer certain questions.

The data reflects that which was recorded at the time – no data collection subsequent to the initial consultation was possible. All data is presented in percentages with the number of satisfactory replies stated for each variable studied. "Satisfactory replies" refers to the adequacy of the recorded information for evaluation i.e. the number of adequately recorded answers to a specific question. Although 122 questionnaires were scrutinised for the study, not all answers in each questionnaire were necessarily adequately recorded. Thus the number of replies noted for each question may vary.

The very first women who presented for termination (approximately 10-12) were not included in this study, for logistical reasons. Excluding these women, the profiled 122 were the first women that presented to Pretoria Academic Hospital requesting termination of pregnancy when this service was introduced in 1998.

Results

122 interviews were conducted. In each of the following categories the number of replies that were satisfactory for assessment are indicated:

Age:
(N = 117, see Figure 1)
The mean age was 25.1 years, with the youngest 14 years old, the oldest 45 years old and the mode 20 years old.

Educational status:
(N =111, see Table I)
67.6% of applicants had a matriculation or better educational status.

Occupation:
(N = 120, see Table II)
Only 20% of applicants were unemployed, whilst 34% was still engaged in studies either as a scholar or as a student.

Marital status:
(N =114, see Table III)
More than 85% of applicants was single, of which the vast majority (83%) was never married.

Figure 1: ***Frequency distribution of age of applicants (n=117)***

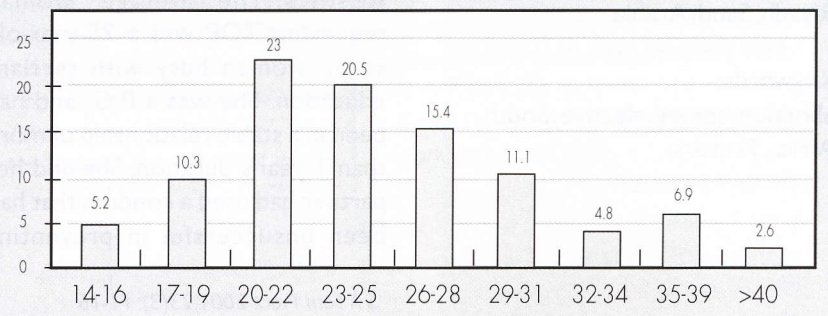

Table I: ***Educational Status of Applicants***

Educational Status (n=111)	%
Illiterate	0.9%
Below Std. 5	0.9%
Std. 5	4.5%
Std. 6	2.7%
Std. 7	8.1%
Std. 8	9.9%
Std. 9	5.4%
Std. 10 / Matriculation	25.2%
Tertiary Education*	42.4%

*Tertiary Education = either completed tertiary education or currently engaged in tertiary education.

Parity:
(N =103, see Figure 2)
About 69.9% of applicants had already had at least one child and only 30.1% did not have any children.

Gravidity:
(N =103, see Figure 3)
70% of applicants had at least one pregnancy before.

Duration of relationship with sexual partner:
(N =116, see Table IV)
3 applicants (2.6%) reported that they were raped and in these the length of relationship was not relevant as the rapes were committed by someone other than the person with whom they were having a relationship.

Stability of the relationship with sexual partner:
(N = 95, excluding the three reported rapes)
47.4% of applicants described their relationships as stable i.e.mutually desirable by both partners with a commitment to an ongoing relationship 52.6% of applicants described their relationships as unstable i.e. one where there was no commitment by at least one of the partners to continue in the relationship, or a desire on the part of one of the partners to end the relationship.

Duration of pregnancy:
(N = 84, see Figure 4)
1.2% of applicants were not pregnant. 77.4% of the applicants were under 12 weeks of pregnancy.16.6% were between 12 and 20 weeks duration of pregnancy at the time of application. Thus 94% of applicants were pregnant with duration of less than 20 weeks. 4.8% were beyond 20 weeks of pregnancy when assessed.

Contraception usage:
(N = 120)
65.8% reported that they were using some form of contraception. 3.3% of applicants used more than one form of contraception concomitantly. 34.2% of applicants did not use contraception.

Table II:* *Occupational Status of Applicants

Occupation (n=120)	%
Housewife	3.3
Professional	10.0%
Scholar	10.8%
Clerical	10.8%
Unemployed	20.0%
Operator	21.7%
Student	23.4%

Student = Busy with tertiary education
Scholar = At school
Operator = Cleaner, Cashier, Waitress etc.

Table III:* *Marital Status of Applicants

Marital Status (n=114)	%		
Married	14.9%		
Single	85,1%	Never Married	83.5%
		Widowed	2.1%
		Divorced	14.4%

Figure 2:* *Parity of Applicants (n=103)

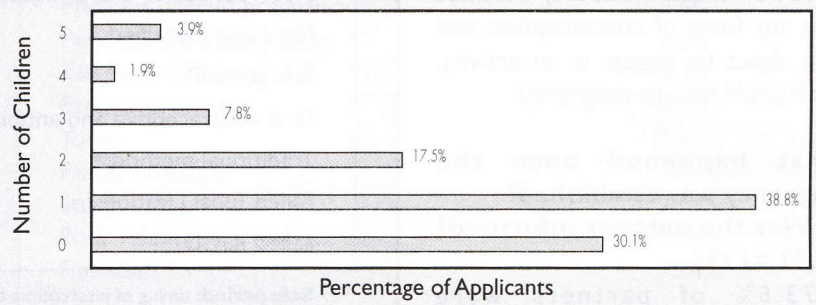

Figure 3:* *Gravidity of Applicants (n=103)

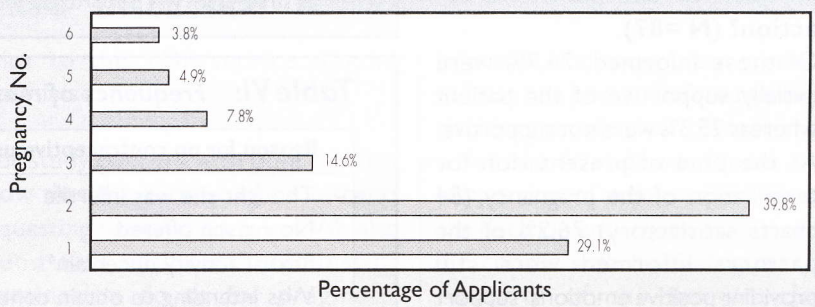

Table IV:* *Duration of relationship with partner

Duration of Relationship (n=116)	%
Short term relationship i.e. less than 3 months	13.7%
Relationship of between 3-12 months	25.9%
Relationship of longer than 12 months	56.8%

Contraception failure:
(N =75, see Table V)
79 applicants (65.8%) were using contraception. An attempt was made to ascertain why the particular contraceptive method failed. In 63 instances the cause was identified and in 12 it was not.

No contraception:
(N = 39, see Table VI)
41 applicants (34.2%) did not use contraception.

Why did people not on contraception engage in sexual activities with the possibility of becoming pregnant?
(N = 41, see Table VII)
This question is slightly different when compared to the question of "Why did they not use contraception if sexually active?". This attempts to explain what happened at the "moment critique". These women knew that they were not using any form of contraception and were about to engage in an activity, which could lead to pregnancy.

What happened once the pregnancy was established?

(a) Was the partner informed? (N =121)
73.6% of partners were informed and 26.4% were not informed.

(b) What was the partner's reaction? (N =87)
Of those informed, 74.7% were initially supportive of the patient whereas 25.3% were not supportive. At the time of presentation for termination of the pregnancy (84 charts satisfactory) 76.2% of the partners informed were still providing positive emotional support for the applicant and 23.8% were not. 7.8% of the partners informed would have preferred the pregnancy to continue if the decision had been theirs alone.

(c) Was the family informed? (N= 103)
This refers to family other than the partner. 50.5% of the applicants

Figure 4:* *Duration of current pregnancy in weeks (n=84)

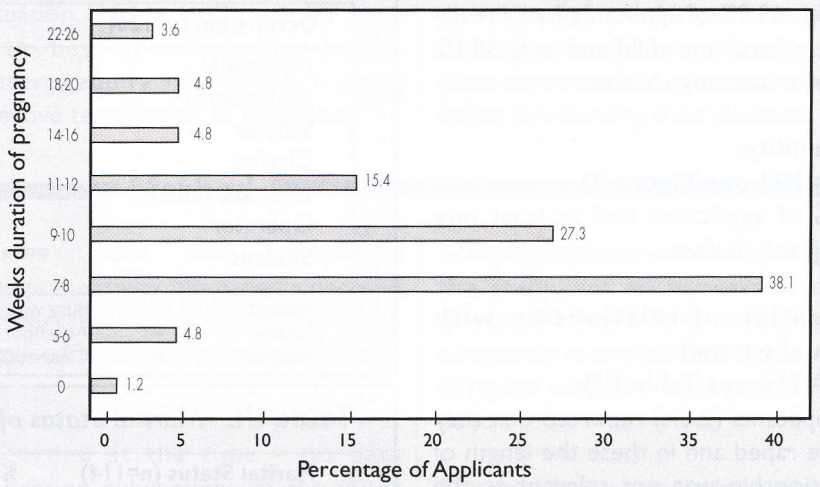

Table V:* *Frequency of reasons for contraceptive failure

Causes of contraceptive failure (n=75)	%
Condom failure	32.0%
Incorrect use of OC or injection	21.3%
No cause identified	16.0%
Safe period*	14.7%
Oral contraceptive and antibiotic	8.0%
Traditional method**	4.0%
Failed Tubal Ligation	2.6%
Failed IUCD	1.3%

* **Safe period:** timing of intercourse to fall outside the estimated ovulation date
** **Traditional method:** these were methods prescribed by traditional healers and not recognised. In two instances it was the installation of a herbal remedy of unknown ingredients "prescribed" by a traditional healer and in a third instance the wearing of a coloured piece of string which was purported to protect the wearer from pregnancy.

Table VI:* *Frequency of reasons for failure to use contraception

Reason for no contraceptive use (n=39)	%
Thought she was infertile	20.5%
No reason offered	15.4%
Sexual activity uncertain*	12.8%
Was intending to obtain contraception	12.8%
Hoped would not fall pregnant	7.7%
Rape	7.7%
Side effects	7.7%
Partner opposed to contraceptive use	5.1%
Family opposed to contraceptive use	5.1%
Wanted to fall pregnant	2.6%
Ignorance	2.%

* **Sexual activity uncertain:** the person was not regularly sexually active

informed and involved their families and 49.5% did not.

(d) What was their reaction if involved? (N = 47)

91.6% of the families provided positive emotional support, 6.3% were unsupportive with 2.1% equivocal in their support. At the time of presentation for termination of the pregnancy, 93.9% of the families involved provided positive emotional support to the applicant and 6.1% were antagonistic or negative in their support.

(e) Who made the decision to apply for elective termination of pregnancy? (N = 122)

28.7% of applicants made this decision entirely on their own. 71.3% made the decision jointly i.e. either with their partner (54%) or with their family (25.3%) or with more than one instance (Family, friend, partner) - 20.7%.

(f) Why did they request an elective termination of pregnancy? What were the reasons that they chose this course of action over continuing the pregnancy? (N = 114, see Table VIII)

These generated 208 reasons for requesting termination of pregnancy, which could be divided into 15 categories. 60.5% of applicants cited more than one reason for requesting the termination

Table VII: ***Frequency of reasons why women not on contraception still indulged in intercourse.***

"Le moment critique" (n=41)	%
Took a chance	39.1%
Declined to answer	29.3%
Believed they were infertile	19.5%
Rape	7.3%
Resuming a relationship	2.4%
Wanted to fall pregnant	2.4%

Table VIII: ***Frequency of reasons for requesting TOP.***

Reasons for requesting Termination (n=114)	%
Previous congenital defect	0.9%
Failed IUCD	0.9%
Failed T/L	1.8%
Work opportunities affected	2.6%
Too old	2.6%
Rape	2.6%
Previous difficult pregnancy	2.6%
Pervious child too young	3.5%
Too many children	6.1%
Partner pressure	6.1%
Youth	7.9%
Family pressure	11.4%
Study	28.1%
Poor relationship with partner	29.8%
Financial	75.4%

Discussion

The data obtained from these 122 women may not reflect the experience in other clinics or countries. It may not even reflect the current population of people presenting at Pretoria Academic Hospital for elective termination of pregnancy. It did bring home to us that much of the speculation and most preconceptions that were aired prior to this TOP service starting were false.

Our study concurs with others [6,7] that show that the number of adolescents requesting termination is low. We also found that applicants requesting termination do so for pragmatic reasons [8]. In contrast to Ytterstad et al [9] who found that all women had informed, and most often consulted, at least one person before making the decision, usually their partner and/or a female friend, we found a fair proportion of women (28.7%) made the decision entirely on their own. We did concur with his finding that "the majority of the persons [she] consulted supported her, whatever her decision."

Conclusion

Our overwhelming impression is that of a group of patients faced with a very difficult decision. The decisions never seem to be made lightly, easily or without some deep soul-searching. They need more involvement from their doctors, not less, and these doctors might do well to understand the patients before summarily dismissing them and refusing to become involved.

We would like to thank Dr Zola Njongwe, the Chief Medical Superintendent of Pretoria Academic Hospital for permission to perform the study and Miss Elmarie de Beer for data processing

References

1. Medical methods for termination of pregnancy. Report of a WHO Scientific Group. World Health Organisation Technical Report Series 1997;871:i-vii, 1-110
2. Choice on Termination of Pregnancy Bill. Government Gazette W 80B – 96
3. Abdella A. Demographic characteristics, socio-economic profile and contraceptive behaviour in patients with abortion at Jima Hospital, Ethiopia. East African Medical Journal 1996;73:660-4
4. Skjeldestad FE When pregnant-why induced abortion? Scandinavian Journal of Social Medicine 1994;22:68-73
5. Skjeldestad FE. Borgan JK, Daltveit AK, Nymoen EH. Induced abortion. Effects of marital status, age and parity on choice of pregnancy termination. Acta Obstetrica et Gyecologica Scandinavica 1994;3:255-260
6. Ganguly G, Biswas A, Sharma GD . Profile of women undergoing medical termination of pregnancy in hospital. Journal of the Indian Medical Association 1993;91:286-7
7. Bettarini SS. D'Andrea SS. Induced abortion in Italy: levels, trends, characteristics. Family Planning Perspectives 1996;28:267-71, 277
8. Allanson S, Astbury J. The abortion decision: reasons and ambivalence. Journal of Psychosomatic Obstetrics & Gynecology 1995;16:123-36
9. Ytterstad TS; Tollan A. The decision process in induced abortion. Tidsskr Nor Laegeforen 1990;110:2096-7