

Characteristics of patients seeking termination of pregnancy at a private provider in South Africa

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Background. There is a great need for safe and supportive facilities that provide termination of pregnancy services in South Africa (SA), owing to the passing of the Choice on Termination of Pregnancy Act. Since the Act's implementation, most research and statistical publications and analyses have focused on abortion in the public health sector, with minimal information pertaining to abortion in the private health setting. Private facilities are essential to abortion provision. It is also vital to understand the characteristics of termination-of-pregnancy (TOP)-seeking patients, so that a more concise and effective strategy may be developed to prevent unintended pregnancies. Understanding the patients' socioeconomic position, demographics, contraceptive use, pregnancy outcomes, etc. allows departments of health at national and provincial levels to make more informed choices about TOP strategies.

Objective. To understand the characteristics of TOP-seeking patients at a private clinic in Sandton, Johannesburg, SA.

Method. The study was conducted between June 2016 and July 2017 at DISA Clinic in Sandton, in Johannesburg, SA. DISA Clinic has been a reproductive health service provider for the past 30 years. DISA keeps various written records about TOP-seeking patients, procedures and outcomes, in the form of a register. A convenience sampling strategy made use of the register, which contained the non-identifiable data of 241 women who came to the clinic for TOP during the study period. All 241 women were included in this study, and all had opted for TOP.

Results. The provision of continued care services for TOP-seeking women in private clinics has enabled service users to access the service. Many of the women in this study are employed, but they remain without easy access to TOP services as their income is insufficient to cover medical aid enrolment, and ultimately they resorted to using cash, which they do not readily have.

Conclusion. Age and income for women who access abortion facilities in this private clinic seem to be consistent with findings in the public sector, leading to the conclusion that women of all ages and financial backgrounds require TOP services.

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The World Health Organization estimates that 211 million pregnancies occur each year worldwide, of which 87 million are unplanned, with an estimated 30% (26.5 million) of these a result of contraceptive method failure, or inappropriate use of contraception.^[1]

Contraceptive failure is a problem particularly in lower middle-income countries. A Demographic and Health Surveys (DHSs) study conducted in 20 low- to middle-income countries across the world, including three southern African countries, from various time periods between 2002 and 2010, found that approximately one in every three unplanned pregnancies was due to contraceptive failure, and in four countries, more than half of the unintended births resulted from conception while women were using contraception.^[1]

An analysis of DHSs from 43 countries from 1990 to 2013 assessed contraceptive failure according to demographic and socioeconomic factors. It found that in women <25 years of age, never-married women, women with lower parity (0 - 2 children), women from lower wealth quintiles, women living in urban dwellings and women using injectable methods, contraceptive

failure rates were generally similar by educational attainment for most methods, with the exception of injectables and withdrawal, for which women who had at least some secondary education had slightly higher failure rates.^[2]

Another common reason for unwanted pregnancies was found to be medical risks associated with advanced maternal age, which is a term used to describe pregnant females ≥35 years old. This is associated with increased risk of abnormal intrauterine fetal development, including chromosomal abnormalities such as Down syndrome.^[3] Advanced maternal age (>35) poses increased risks of obstetric complications, gestational diabetes, pre-eclampsia and adverse perinatal outcomes, including preterm birth, low birth weight, and poor Apgar scores at 5 minutes, when compared with pregnancies within the maternal age group of 20 - 24 years.^[3] Therefore termination of such a pregnancy may be suggested, to ensure the mother's survival or sustained good health.

Premarital fertility (birth of offspring before first marriage) is perceived as socially undesirable, and is still highly stigmatised in South Africa (SA).^[4] When pregnancy occurs out of or before

marriage, potential fathers often leave the woman, for social, economic or geographical reasons, which can cause pregnant mothers to feel isolated and unsupported. Furthermore, owing to potential fathers' refusal to acknowledge the pregnancy, the pregnant women can often face family sanctions and punishment for irresponsibility, and future economic burdens.^[4]

Therefore there is a great need for safe and supportive facilities that provide TOP services. Prior to the 1997 implementation of the Choice on Termination of Pregnancy Act No. 92 of 1996, the previous Abortion and Sterilization Act No. 2 of 1975 was highly restrictive for SA women, as an abortion could only be performed under specific procedural requirements, and approval was needed from at least three physicians.^[5] This had an immense impact on the illegal abortion industry, as more than 99.5% of abortions performed in southern Africa in 1995 took place under unsafe conditions,^[5] with an estimated 1 500 to 3 000 maternal deaths from unsafe abortion annually in SA, before the implementation of the Choice on Termination of Pregnancy (CTOP) Act No. 92 of 1996.^[6] With the dawn of democracy, the CTOP Act succeeded the earlier law, and now stipulates that any woman of any age can terminate her pregnancy upon request at a registered facility during the first 12 weeks of gestation, and thereafter under specific circumstances.^[7] The Act has had a positive impact on maternal health in the country, where the annual number of abortion-related deaths decreased by 91% between 1994 and 1998 - 2001.^[8]

However, since the Act's implementation, research and statistical publications and analyses have mainly focused on abortion in the public health sector, with minimal information pertaining to abortion in the private healthcare setting. Private facilities are essential in abortion provision. Before the implementation of the amendment of the CTOP Act in 2008, private facilities accounted for almost a third of functioning abortion facilities nationally, while in Gauteng Province, private facilities accounted for almost half (45%) of all functioning abortion facilities.^[9]

It is also vital to understand the characteristics of TOP-seeking patients, so that a more concise and effective strategy may be developed to prevent unintended pregnancy. Understanding their socioeconomic position, demographics, contraceptive use, pregnancy outcomes, etc., would allow departments of health at both national and provincial levels to make more informed choices about TOP strategy. The aim of this study is therefore to understand the characteristics of TOP-seeking patients at a private clinic in Sandton, Johannesburg, SA.

Methods

The study was conducted at DISA Clinic in Sandton in Johannesburg, SA. DISA Clinic has been a reproductive health service provider for the past 30 years. It has gained a reputation for TOP service provision via its broad clientele, which includes women from working professionals to domestic workers, and even students. Situated in Hurlingham in Sandton, the clinic's location provides both privacy and an affordable service.

Having been at the forefront of providing TOP services in Johannesburg, DISA has become one of the legally registered providers amidst many illegal providers. It was therefore necessary

to ask questions about the service from users, to gather data on the challenges they face, and locate these challenges within the broader discourse, and identify them as possible explanations for the surge in illegal services. A team of researchers therefore convened to ask patients pertinent questions, as captured in the following characteristics of the TOP register (Table 1).

Data collection

DISA keeps various written records about TOP patients, procedures and outcomes. Anonymous data in the form of a register were systematically collected. A convenience sampling strategy was used. The register contained non-identifiable data for 241 women who had come to the clinic for TOP. All 241 women were included in this study, and all had opted for TOP. The demographic characteristics considered for this study included all those women who could pay for TOP, and in exceptional circumstances, those who could not pay for themselves: this category included domestic workers, whose employers had negotiated a lower fee on their behalf.

All patients included in the study were paying clients: ZAR2 750 for a medical TOP, and ZAR3 500 for a medical vacuum aspiration. All patients referred to another service provider were excluded from the study.

Data analysis

Conventional thematic analysis was used and where appropriate, descriptive statistics.^[10] The initial categories used for data analysis were drawn from the intake form, and themes and patterns were then identified after reviewing the data.^[11] The themes were linked to the research question on the characteristics of women seeking TOP services at a private facility. Coding was done following analysis of the intake forms at admission. The codes included demographic details, contraception use, TOP outcomes, pregnancy outcomes and, lastly, psychosocial support outcomes.

Data processing was accomplished through intensive analysis of paper-based reports. The categories of data collected, subcategories and data types are shown in Table 2.

Results

Demographic characteristics of TOP-seeking patients

Of the 241 women, 136 were black, 65 were white, 11 were coloured and 29 were Asian. Most of the women came from Gauteng Province, apart from 5 from other parts of SA, and 1 from Zimbabwe. All the patients considered were day patients who came to the clinic in the morning and left by day's end.

Two percent of the patients were 41 - 45 years old, 4% were between 16 and 20 years old, 17% were between 21 and 25 years old, 23% were between 31 and 35 years old, 25% were between 36 and 40 years old and the largest group of 29% were between 26 and 30 years old. A total of 27% of all unwanted pregnancies were advanced maternal age pregnancies, with the average advanced age patient being 38 years old.

Seventeen percent ($n=41$) of all the women were unemployed, 13% ($n=35$) were students, 57% ($n=139$) were professionally employed and the remainder ($n=26$) 13% were classified

Table 1. Patient characteristics captured in TOP register

Variable name	Operational definition/question	Coding
Age	Age of woman, gestational age	Woman's age = 1 Gestational age in weeks = 2
Employment	Are you employed?	Employed = 1 Unemployed = 2 Entrepreneur = 3 Unknown = 4
Race	What is your race?	Black = 1 White = 2 Coloured = 3 Asian = 4
Medical aid	Do you have medical aid?	With medical aid = 1 Without medical aid = 2 Unknown = 3
Marital status	What is your relationship status?	Single = 1 Married = 2 Living with partner = 3 Divorced = 4
Pregnancy	What have been your previous pregnancy outcomes?	Still birth = 1 Live birth = 2 Miscarriage = 3 TOP = 4
Contraception	Do you use any contraception?	No contraceptive use = 1 Contraceptive use = 2 Unknown = 3

TOP = termination of pregnancy.

Table 2. Demographic characteristics

Field	Subfield
Age (integer)	(integer)
Race (categorical)	Black, white, coloured, Asian
Marital status (categorical)	Single, married, living together, divorced
Medical aid (categorical)	Yes, no, unknown
Type of contraception used (categorical)	Barrier contraception, combined oral contraception, progestogen-only pill, emergency contraception, implant, injectable, IUCD, patch, natural method
Number of previous TOPs (integer)	(integer)
Post-abortion contraception used (categorical)	Yes, no
Parapsychological counselling attended (categorical)	Yes, no

TOP = termination of pregnancy; IUCD = intra-uterine contraceptive device.

as labourers. Nineteen percent ($n=46$) of all the women held managerial positions, 22% held administrator-type positions e.g. personal assistant, administrative clerk, sales clerk and receptionist, and 42% ($n=102$) of the TOP-seeking patients held jobs that required them to have at least an undergraduate degree or diploma. Thirty-three percent ($n=85$) used medical aid to pay for the TOP service, while 62% ($n=150$) stated they did not have medical aid, and paid cash. A total of 79% ($n=190$) of all TOP patients reported that they were not married, and of these, 73% ($n=241$) of the women who came to the clinic were single, 5% ($n=12$) were living with a partner and 2% ($n=5$) were divorced.

Contraceptive use and pregnancy history

The majority of the women (73%, $n=175$) used no contraception at all, whether they had intended to fall pregnant or not. Some of

the women (4%, $n=9$) attempted to use barrier contraception such as condoms, and inconsistent use of the barrier method had led to the pregnancy. Others (0.4%, $n=1$) used the withdrawal method, and consequently had fallen pregnant. After TOP, the patterns of who opted for contraception, such as long acting reversible contraception (LARC), for instance, did not change, and the women continued being inconsistent with contraception. Only 33.2% ($n=241$) of the women took up contraception post TOP. A total of 30% ($n=67$) of all TOP-seeking patients had had previous TOP services.

Of the 241 women in this study, 47.7% had given birth previously. Of these 115 women who had had children before, 50% of them had had at least 2 children ($n=57$). During the intake process, we also asked if the women who had previously given birth had had a previous termination, and 24.9% ($n=60$) had previously

terminated a pregnancy. Of those who had previously terminated a pregnancy, 8.3% ($n=5$) had had 2 previous terminations, and 1.7% ($n=1$) had had 3 previous terminations. Of those who had had previous terminations, all were within a period of 5 years prior to this consultation. Of the women who had had children before, 35% ($n=40$) had terminated at least once. A total of 93% of these women had the TOP in the first trimester. The price for a TOP in the first v. second trimester differs significantly, ranging from ZAR2 750 for a first trimester TOP, to ZAR8 250 in the second trimester for those who could afford it, and for one patient, ZAR1 000 (second trimester). The reason given for this patient's fee was that she was only charged for the LARC post TOP, and not for the procedure itself. The ZAR1 000 was paid in instalments over the entire period of the study (6 months).

Discussion

The results of the study showed many interesting characteristics of the TOP patients included. Many findings were counterintuitive, and analysis of the results shows many important aspects that need to be considered when creating a strategy for TOP, and understanding the characteristics of patients using the services of private TOP clinics. Private TOP clinics are profit-based service providers whose services are paid for before the service is dispensed. The service fees range from ZAR2 750 to ZAR8 250, depending on gestational period and the preferred service (manual vacuum aspiration v. surgery). Patients who use the services are required to pay beforehand, or through a medical aid scheme.

In terms of patient age, this study shows that there is no specific age group that is not represented, for as long as women are of a reproductive age. Although there are not as many teenagers as older women seeking TOP services, it is within the ambit of a private clinic to provide them with these services.^[12] In order to understand whether a statically significant difference exists between age groups, a proportionally based multivariable χ^2 test was performed. A p -value of 0.134 was obtained when comparing the 21 - 25, 26 - 30, 31 - 35 and 36 - 40-year age groups with one another. The results showed that there was no statistically significant difference in the number of TOPs per woman performed for each of the groups. However, when comparing these groups with the 16 - 20-year-old group, a p -value of 0.008 was obtained. There is therefore a statistically significantly lower number of TOP patients who are under 21 years old, compared with those over 21.

These results are particularly interesting. Intuitively, it was assumed that there would have been a majority of younger TOP-seeking patients, since raising children may have interfered with their career plans. However, there were no statistically significant

differences in the number of women in all four age groups between 21 and 40 years old, which also includes the advanced maternal age group. All groups had an equal spread of the types of employment listed above. This is counter to the results in most literature from developed countries, where there are marked differences in the prevalence of TOPs in different age groups.^[4,13,14] The USA reports up to a 32% difference between the proportions of women in different age groups. However, these results are promising in a developing country, as they show how the change in judicial law, i.e. the CTOP Act of 1996, has positively influenced choices around TOP.^[15] With the advent of laws protecting TOP-seeking patients, such women can now make informed decisions about their lives.^[15,16]

In order to understand whether cultural differences played a role in contraceptive use, Table 3 was created to separate data by race, and to show whether patients had used contraceptives, or whether they had had previous TOPs. An analysis of variance test was performed to determine whether there was a difference in contraceptive use between races. A p -value of 0.199 was obtained, showing that there was no statistically significant difference between races in using v. not using contraceptives in the study population, and all were more likely to not use rather than use contraception.

Table 3 also demonstrates that black TOP-seeking patients had a statistically lower chance of having had a previous TOP ($p<0.05$), while there were no statistically significant differences among the other races. Since there is also a lower chance of black TOP-seeking patients using post-TOP contraceptives, this may indicate that such patients would either abstain from sexual acts that can result in pregnancy. This result is in keeping with the socioeconomic constraints of the country.

Each of the women received contraceptive counselling, but even so, only 33.2% adopted LARC as an option. Significant to contraceptive use is the nature of the relationships that women have. Despite a significant majority indicating that they were single, 'single' in this instance did not necessarily mean 'not in a relationship'. Rather, it meant simply unmarried. Previous studies^[17-20] on the use of contraception in relationships have suggested that not only does this present a challenge, but it is also usually not discussed, and it is the man who insists on the non-use of contraception. Because contraception use in relationships remains a challenge, it is important that data capturing establishes relationship status, and not merely marital status.

An interesting observation from the analysis of the data is that there is no statistically significant difference between the numbers of professional and non-professional people who make use of TOP services at this private clinic ($p=0.1238$). The issue of income v.

Table 3. Contraceptive use and previous pregnancy history (N=214)

Race	No contraceptive use, n (%)	Contraceptive use, n (%)	Withdrawal, n (%)	Previous TOP, n (%)	Post-TOP non-contraceptive use, n (%)
Asian, $n=29$	23 (79)	6 (21)	0 (0)	8 (28)	21 (72)
Black, $n=136$	102 (75)	33 (24)	1 (0.1)	41 (12)	87 (64)
Coloured, $n=11$	9 (82)	2 (18)	0 (0)	3 (27)	11 (82)
White, $n=65$	48 (74)	17 (24)	0 (0)	15 (24)	50 (77)

TOP = termination of pregnancy.

access is of major complexity in this study. On the one hand, most of the women were employed, yet a significant majority of them had no access to medical aid services. Their consultations at the clinic were on a cash basis. Overall, 72% of the women who came to the clinic within this 6-month period were employed. However, only about 45% of the employed women had access to medical aid, and the rest did not. The nature of employment in this country seems to suggest that medical aid cover is specific to a particular income quintile, and therefore the 55% who did not have medical aid fell below that income quintile. That these women accessed the clinic on a cash basis suggests that it may not have been an easy choice to terminate the pregnancy, but the benefits of not having a child outweighed the cost of paying cash at the private clinic.

Regarding pregnancy outcomes, all women in this study knew what they wanted to do. All of them wanted to terminate their pregnancy. Some of the women were terminating for the first time, others for the second or third time. The categories include married women, single, living together and divorced. For married women, TOPs are usually discouraged, based on the notion of family values. However, for the unmarried, single, divorced or those living together with a partner, there is a lot of societal stigma towards these women becoming pregnant and/or having a child. Society frowns upon unmarried women who fall pregnant, and it is considered worse for divorced women to fall pregnant than unmarried women.^[20,21]

The presence of psychosocial services in the private clinic in this study offers an extended contact period for the patients. The extended contact between staff members and patients has created a situation in which patients trust the TOP service provider well enough to recommend it to those in need, and to keep it in business, as it has been for the past 30 years.

Conclusion

The complexities in the provision of care for TOP services are diverse. The challenges of disparities in income and access remain a stumbling block for many women, particularly those who may not be able to afford private clinic fees. The data presented in this article demonstrate that the dynamics of patient services in TOP provision require a multifaceted approach in order to provide solutions on a day-to-day basis for women who need these services.

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