STUDENT PAPER

Characteristics of women booking for first and second trimester abortions at public sector clinics in Cape Town

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The liberalisation of the South African abortion legislation, via the 1996 Choice on Termination of Pregnancy (CTOP) Act, has directly resulted in a substantial decline in abortion-related morbidity and mortality across the country.[1] Under the Act, a pregnancy may be terminated upon a woman's request in the first trimester (during the first 12 weeks of gestation). In the second trimester of pregnancy (beyond 12 weeks and up to 20 weeks) termination may be done for reasons of adverse effects on the woman's mental or physical health or socio-ecomomic status, in cases of rape and incest, and when there is a risk that the fetus suffers from severe physical or mental abnormality. From 20 weeks' gestation onwards (late second trimester and beyond) terminations are available only under very limited circumstances. Across South Africa, well over 20% of TOPs performed are at a gestational age of more than 12 completed weeks,[2] which is considerably higher than in other countries with legalised abortion such as the USA, Russia and Vietnam, where 10% or less of abortions are in the second trimester and most occur before 8 completed weeks.[3-5] Reducing the proportion of second trimester TOPs by ensuring that more women have access to first trimester TOPs has several advantages, including decreased risk of procedure-related complication to patients, decreased cost to health services, and increased feasibility of TOP becoming a predominantly primary level, nurse-provided health service.[4,6]

Little is known about the characteristics of women booking for termination of pregnancy and whether or how the characteristics of women booking for second trimester terminations differ from those of women booking for first trimester terminations. As part of a broader study on timing and patterns of pregnancy confirmation in the greater Cape Town area, we investigated patient characteristics and health service factors associated with booking for a second trimester versus a first trimester TOP.

We conducted a descriptive, cross-sectional survey in two areas of Cape Town in the Western Cape Province. Women booking for a first trimester or second trimester TOP at a public sector health facility in the study areas were eligible for entry. We interviewed consecutive consenting women at all the facilities that provide these services in the study areas and asked questions on timing, method and location of pregnancy confirmation, and referral pathways to current point of service. Participants were interviewed in their home language using a standardised, pre-tested questionnaire. Data analysis was conducted in the statistical programme Stata 9.0 (Stata Corporation, College Station, Texas). Ethical approval was given by the Research Ethics Committee of the University of Cape Town.

A total of 164 women participated in the study, 82 of whom presented for first trimester and 82 for second trimester termination. The participants were young women (median age 24 years, range 15 - 39 years). Twenty per cent of first trimester TOP clients (N = 16) and 24% of second trimester clients (N = 20) were teenagers. Just over one-quarter (N = 44, 27%) supported themselves financially, 13% (N = 22) were supported by their partner, and about half were supported by a parent or other family member (N = 85, 52%). Forty-three per cent (N = 70) were employed, 34% were unemployed (N = 56), and 23% (N = 38) were still in school.

Most participants had had previous pregnancies (N = 111, 68%), were currently in a relationship (N = 104, 63%) and spoke Xhosa (N = 111, 68%) or Afrikaans (N = 32, 20%) as their main language. Only 5 women (3%) had ever previously had an abortion. For all participants, the current pregancy had been unplanned. Thirty-eight per cent of first trimester (N = 31) and 22% (N = 18) of second trimester clients had told someone about the pregnancy, most commonly their sexual partner or a family member. Twenty-one per cent (N = 34) considered themselves to be using a method of contraception when they fell pregnant, namely the condom (N = 18, 53%), the pill (N = 12, 35%) and the injection (N = 4, 12%). All the users of the injectable contraceptive reported missing a follow-up injection, and 9 of the 12 pill users reported forgetting to take more than 2 pills consecutively in a cycle; of the 18

condom users 15 reported condom breakage and 3 reported inconsistent use.

The average gestational age at booking visit was 9 weeks (range 8 - 11.5 weeks) and 15 weeks (range 14 - 17 weeks) for first and second trimester clients, respectively. For the majority of participants (first trimester TOP 58%, second trimester TOP 52%) confirmation of pregnancy and first pregnancy-related health care visit occurred outside the public sector health services; first trimester clients had attended a median of 2 (interquartile range (IQR) 2 - 3) other health facilities before presenting at the current public sector clinic to initiate abortion care, while second trimester clients had attended a median of 2.5 (IQR 2 - 3) other facilities.

On average, first and second trimester abortion clients first thought they were pregnant 35 (IQR 30 - 47) and 50 (IQR 33 - 71) days after their last menstrual period (LMP). After this, first trimester clients waited a median of 12 days (IQR 5 - 28) and second trimester clients 24 days (IQR 11 - 40) before actually confirming the pregnancy. For all abortion clients, after pregnancy confirmation there was further 1-week delay (7 days for first trimester and 8 days for second trimester clients) before presenting at the current point of service.

Women presenting for second trimester abortion were more likely than women presenting for first trimester abortion to be Xhosa speaking (as opposed to Afrikaans/ English speaking) (74% of second v. 60% of first trimester clients spoke Xhosa, $p < 0.01$); to think that they should wait until they were 3 months pregnant or more before presenting for pregnancy care (56% of second v. 40% of first trimester clients, $p = 0.04$); and to have confirmed their pregnancy at a public sector clinic (54% of second v. 37% of first trimester clients, $p = 0.03$). Second trimester termination clients were also more likely than first trimester clients to first recognise their pregnancy later in gestation ($p = 0.001$) and to wait for a longer period of time between thinking that they might be pregnant and confirming the pregnancy ($p = 0.05$). Second trimester abortion clients were less likely than first trimester clients to have obtained, of their own accord, a urine pregnancy test from a pharmacy during this pregnancy (24% for second trimester v. 43% for first trimester clients, $p = 0.01$), and to know about the time restrictions on abortion services (22% for second trimester v. 55% for first trimester clients, $p < 0.001$).

To our knowledge, this is the first study focusing on identifying characteristics of women booking for second versus first trimester TOPs in South Africa. In recent years, the number of abortions performed nationally and in each of the provinces, including the Western Cape, has increased substantially, indicating increasing availability and accessibility of TOP services.[2] However, there has not been a decline in the proportion of second trimester TOPs performed. The proportion of TOPs that are performed in the second trimester in South Africa is higher than that in other countries and has ranged between 20% in 1997 and 26% in 2003.[2] The high proportion of second trimester abortions has substantial staffing, resource and clinical implications.[4,6]

In addition to expanding TOP services generally, our findings suggest that in order to decrease the proportion of second trimester TOPs in South Africa women need education about the importance of early pregnancy recognition, correct knowledge about when to present for abortion-related care, correct information about the time limitations of the abortion service, and greater access to urine pregnancy testing, ideally at public sector clinics, as a means of early pregnancy confirmation. Also, given that half of second trimester TOP clients attended more than 2.5 health facilities before reaching the current point of service, and that for many clients these visits were to both public and private sector facilities, abortion referral pathways require examination. Importantly, we found that very few women were having a repeat abortion.

Our study has several limitations. First, this was a relatively small survey conducted in one part of South Africa. The results require further investigation in other geographical settings. Second, our calculation of delays between various pregnancy-related events (e.g. LMP, suspecting pregnancy, pregnancy confirmation, etc.) was based on client recall and may therefore be somewhat unreliable. However, to minimise recall error we used calendars and key event prompts. While these results may incorporate a degree of inaccuracy, they nonetheless provide a good indication of where in the process delays occur. Finally, this quantitative survey is unable to shed light on the complex patient-related factors resulting in later presentation or the role of provider-client interactions – for this qualitative methodologies will be more informative.

This study provides insights into the characteristics of women presenting for second versus first trimester TOPs in public sector clinics in the Cape Town area, and identifies some potential strategies for interventions to decrease the gestational age at presentation among TOP clients.

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