

Original research article

Accessing medical and surgical first-trimester abortion services: women's experiences and costs from an operations research study in KwaZulu-Natal Province, South Africa[☆]

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Abstract

Objective(s): To explore women's experiences accessing services and estimate costs incurred for first-trimester abortion at four public hospitals in KwaZulu-Natal Province, South Africa.

Study design: Subanalysis from a prospective cohort study (2009–2011) of women aged 18–49 years accessing abortion services through 12 weeks' gestation. Trained study personnel conducted structured interviews with women about their reason for having an abortion, experiences accessing services and costs incurred. Women who were 9 weeks' gestation or less were eligible to choose medication abortion or manual vacuum aspiration (MVA); women 10–12 weeks' gestation all had MVA.

Results: We enrolled 1167 women; 923 (79.1%) were eligible to choose their procedure. The median age was 25 years; most were black African, single and unemployed. Many women reported concerns about the affordability of raising a(nother) child (58.9%) or not being ready for (more) children (43.4%) as their reason for having an abortion. In total, women incurred a median cost of US\$9.99 (interquartile range 6.46–14.85) for their procedure which usually required two facility visits. Many had to pay for transportation, a pregnancy test, sanitary pads or pain medication.

Conclusions: Despite the availability of government assistance for children through South Africa's "child grant," the affordability of raising a child was a major concern for women. Although theoretically available free of charge in the public sector, women experienced challenges accessing abortion services and incurred costs which may have been burdensome given average local earnings. These potential barriers could be addressed by reducing the number of required visits and improving availability of pregnancy tests and supplies in public facilities.

Implications: Many women cited concerns about the affordability of having a(nother) child when requesting an abortion. Although public services are technically free or low-cost in South Africa, women incurred costs for first-trimester abortions. Women's costs could be lowered by reducing facility visits and improving availability of pregnancy tests and supplies.

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1. Introduction

In South Africa, abortion up to 12 weeks of gestation is available on request, and termination up to 20 weeks is legal in

cases of socioeconomic hardship, rape, incest and for reasons related to the health of the pregnant woman or fetus [1]. The methods available vary by location and gestational age, but manual vacuum aspiration (MVA) is most commonly offered in the public sector for women in their first trimester. In 2013, medication abortion became available in the public sector, where most South Africans receive their health care [2], but today, the service is available in just six of the country's nine provinces. Access remains limited, and given that roughly a third of women presenting for abortion services present in the

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second trimester [3], questions remain about whether women will present early enough for early medication-based services.

Women's reasons for having an abortion have been documented in several settings [4,5]; problems related to the affordability of raising a(nother) child are often noted. There is less information available on the costs – both financial (or out-of-pocket expenditure) and other economic costs – of accessing a safe abortion and the affordability of those costs. In South Africa, safe abortion in the public sector should be offered freely to all women who do not have private health insurance [6]. In practice, however, some women, including foreign nationals, may be asked to pay according to published guidelines [7]. Irrespective of whether fees are charged at public facilities, women accessing services incur costs. A study focusing on second-trimester safe abortion in South Africa showed that women accessing second-trimester services in the public sector incurred costs for multiple visits to health facilities, doctor's fees and the supplies needed for the abortion [8]. No published studies exist showing the costs of accessing first-trimester abortion in South Africa. Abortion-related costs may exacerbate other existing barriers to accessing safe, legal services [9–13], and may prevent access altogether in some cases. Two recent studies from South Africa indicate that not being able to afford the fee for accessing abortion services at an NGO provider was a reason for being turned away from the service [14,15].

In this study, we aimed to better understand women's abortion-seeking experiences and to estimate women's costs associated with accessing first-trimester MVA and medication abortion services at public hospitals. We also aimed to shed light on current practices which may be contributing to unnecessary costs and to make suggestions for service improvements which could impact on women's access and acceptability.

2. Materials and methods

The data presented here were collected as part of an operations research study conducted from 2009 to 2011 in public-sector facilities offering first-trimester abortion services in KwaZulu-Natal. We have described the methodology and clinical outcomes of the operations research study separately [16]. In summary, the study employed an observational, cohort design and aimed to assess and compare clinical and acceptability outcomes among women undergoing medical and surgical first-trimester abortion. At four intervention sites, we introduced medication abortion services alongside existing MVA services. At all sites, women were eligible if they were 18–49 years old, reporting 12 weeks' gestation or less based on their last menstrual period, and presenting at the facility to request an abortion. The study nurse assessed each woman's gestational age; if the woman was ≤ 9 weeks' gestation and clinically eligible for medication abortion, she was able to choose MVA or medication abortion. If the woman chose medication abortion, the nurse provided mifepristone to take at

the facility and misoprostol to take at home 48 h later. If the woman chose MVA, in accordance with the local standard of care, she was given an appointment for the procedure, typically within 1 week. All women who were ≤ 9 weeks' gestation were also scheduled for a follow-up visit 10–21 days after the initial visit as part of the study protocol. (Follow-up visits are standard of care for medication abortion, but not for MVA in South Africa.) A trained study interviewer conducted a semistructured interview on the day of presentation at the facility after the woman chose her procedure and at the follow-up visit if the woman returned. If the woman did not present for her study follow-up visit in person, we attempted to conduct the interview by telephone.

The focus of the original cohort study was outcomes among women who were ≤ 9 weeks' gestation; however, women who were between 10 and 12 weeks' gestation were also enrolled. They were not eligible to choose their abortion procedure because medication abortion eligibility is limited to women ≤ 9 weeks' gestation. These women had a semistructured interview at their first visit, underwent the MVA a few days later, and were not called back for a follow-up visit.

We captured data using CS Pro (v4.1) (U.S. Census Bureau, Washington, DC, USA, 2011) and conducted the analysis using Stata (Release 14; StataCorp LP, College Station, TX, USA). We calculated proportions for categorical data based on non-missing responses. For continuous variables, we calculated medians and interquartile ranges (IQRs) due to non-normal distribution of the data. We present the results by procedure type and gestational age. Following STROBE guidelines for observational studies, we present the descriptive results without statistical testing [17].

For women's cost data, we present the median cost and IQR for each cost type considering only the women who incurred those costs. We define recurring costs as those incurred at every visit to a facility (i.e., lost income, transportation costs and child care costs), with one exception: because a follow-up visit is not part of standard of care for MVA in South Africa, we have excluded recurring costs incurred at the study-required follow-up visit for women who had an MVA at ≤ 9 weeks. Once-off costs represent one-time expenditures for pregnancy tests and other supplies. Total costs represent the sum of recurring costs and once-off expenditures and are presented as the median cost across all study participants. All costs were collected in South African Rands (ZAR) and inflated to 2015 values using local Consumer Price Indices [18]. Costs were then exchanged to 2015 US dollars (\$US) based on an average annual exchange rate of 14.39 for 2015 [19].

Some cost data were systematically not collected from women in the study. Child care costs were not included in the interview with women who presented at 10–12 weeks' gestation, and medication, supply and "any other" costs were captured at follow-up from women who were ≤ 9 weeks at enrollment, and thus not obtained from women who did not have a follow-up visit. To assess the potential impact of these

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