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The costs of accessing abortion in South Africa: women's costs associated with second-trimester abortion services in Western Cape Province☆

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Abstract

Objectives: To assess women's costs of accessing second-trimester labor induction and dilation and evacuation (D&E) services at four public hospitals in Western Cape Province, South Africa.
Study design: From April to August 2010, in interviews immediately after completion of their abortion, we asked women about specific direct and indirect costs incurred. We collected information on recurring costs (i.e., per visit) and one-time expenditures and calculated total costs.
Results: In total, 194 patients participated (136 D&E; 58 induction). Their median age was 26; 37.6% reported being employed or doing paid work. Most (73.2%) women visited two different facilities, including the study facility, while seeking the procedure. Induction women reported a median of three required visits [interquartile range (IQR) 2.0–3.0] to the study facility, while D&E women reported two required visits [IQR 1.0–2.0]. Twenty-seven percent of women missed work due to the procedure, and few (4.6%) paid for childcare. At each visit, almost all women (180, 92.8%) paid for transportation costs and reported additional one-time costs (177, 91.2%) such as sanitary supplies or doctor's fees. The total median cost incurred per woman was $21.23 [IQR 11.94–44.68]. Roughly half (49.0%) received help with these costs.
Conclusions: Although technically offered freely or low cost in the public sector, women accessing second-trimester abortion lost income and incurred costs for transport, fees, supplies and childcare. Their total costs could be reduced by minimizing the number of required visits to facilities and freely offering supplies such as sanitary pads and pregnancy tests.
Implications: Limited access to second-trimester, safe abortion services in South Africa may result in some women incurring unnecessary costs. Women make multiple visits in attempting to obtain an abortion, often because of facility or health systems requirements, and incur costs for lost income, child care, transport, fees and supplies.

Keywords: Labor induction; Dilation and evacuation; Termination of pregnancy; Economic

1. Introduction

In most countries where data are available on second-trimester abortion, these services account for approximately 10% of procedures performed [1–3]; though in some settings, the proportion is much higher. In South Africa, second-trimester abortion may account for as much as a third of all abortion services [4,5]. The South African Choice on Termination of Pregnancy Act (CTOPA) allows for abortion on request up to 12 weeks of gestation and up to 20 weeks in cases of socioeconomic hardship, rape, incest and for reasons related to the health of the pregnant woman or fetus [6]. In the public sector, where 80% of South African women receive their health care [7], first-trimester abortion is largely provided by trained midwives, while second-trimester abortion is provided by doctors, usually with the assistance

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of a nurse or nursing team. Labor induction with misoprostol used alone is the current standard of care nationally, although mifepristone was recently added to the regimen in Western Cape Province. Dilation and evacuation (D&E) is also available in the public sector on a limited basis. All services in the public sector are offered freely to unemployed persons or are greatly subsidized for persons with low income [8,9].

The passing of the CTOPA resulted in significant reductions in maternal mortality attributable to unsafe abortion [10]. However, access to safe, legal services remains a challenge. Women's economic costs (i.e., financial and other, nonmonetary costs) associated with accessing abortion services and the potential for these to serve as a barrier to access have not been well evaluated. Costs to women obtaining safe abortion services may include service fees and other out-of-pocket costs; productivity losses; loss of income before, during and after treatment; and impact on household income [11]. In one of a few studies to address this issue in a developing country setting, in 2008, Potdar et al. indicated that, for women attending public and private, first- and second-trimester abortion services in Cambodia, where abortion is legal, lost productive time and earnings varied depending on a woman's employment situation. However, as the number of required visits per termination and gestational age increased, lost productive time and earnings increased [12].

In this study, we assessed women's costs associated with accessing second-trimester induction and D&E services at public hospitals in Western Cape Province, South Africa.

2. Materials and methods

The data presented here are derived from a larger, cross-sectional study of women undergoing either D&E or second-trimester induction with misoprostol alone. We conducted the larger study in two waves (February–July 2008 and April–August 2010) at large, tertiary facilities offering either D&E or induction services [13]. Data presented here represent the second wave. Approval for this work was obtained from the Human Research Ethics Committee at the University of Cape Town, the Committee for Human Research at the University of Stellenbosch, Allendale Investigational Review Board, the Western Cape Department of Health and the study facilities.

Whether women attended D&E or induction facilities was largely determined by the facility's catchment area. The approved service protocols often required multiple visits. A nurse performed a preliminary "work-up" at a clinic near or on the grounds of the hospital. The work-up may have involved a pregnancy test, blood tests, ultrasound and discussion with a social worker — sometimes on different days. The work-up usually ended with booking an appointment for the procedure. At D&E facilities, on the day of the appointment, women took misoprostol for cervical ripening at home before coming to the clinic or first thing on arrival. The D&E was done later the same day. In contrast, at study induction facilities, women returning for appointments were admitted and given repeat doses of misoprostol until expulsion.

On days when study staff were present at the study hospitals, the interviewers invited all eligible women arriving for scheduled abortion services to participate. Eligibility criteria included being age 18 years or older, gestational age between 12 weeks 1 day and 20 weeks 6 days and ability to communicate in English or Xhosa. All enrolled participants signed a written informed consent.

Trained interviewers interviewed women immediately after completion of their abortion. Clinical outcomes, experiences and acceptability of the procedure have been published separately [13]. The interviews also addressed women's costs associated with having procured the abortion. The cost assessment included questions about the number of visits to facilities, travel costs and time, missed work, lost income, childcare and "any other costs." (See Appendix A for a full listing of questions.) We did not ask women to formally report on the affordability of these costs in relation to their household income or household consumption; however, we did ask women if anyone helped them to manage the costs.

We entered data for this analysis into an EpiData database (v2.2, The EpiData Association, Odense, Denmark) and then exported the data to SPSS (v22, IBM SPSS Statistics, Armonk, NY, USA) for analysis. We calculated proportions for categorical data and medians with interquartile ranges (IQRs) for continuous data because of nonnormal distribution. Results were compared by procedure type using chi-square or Fisher's exact tests as appropriate. Medians for specific costs (e.g., travel, childcare, etc.) were calculated using only women who incurred the cost. In contrast, the median, overall procedure cost per woman, was calculated considering all women and represents the sum of any recurring (i.e., per visit) costs for each woman multiplied by the number of visits to the facility, plus any additional, reported one-time expenditures. Costs are presented in 2010 US$ (in the text and tables) and South African Rands (R) (in the text only) using an average exchange rate for 2010 obtained from www.oanda.com.

3. Results

During the study period, 698 (606 D&E and 92 induction) women underwent abortion procedures at the study sites. Of those, we interviewed 196 women (28.0%) [136 (22.4%) undergoing D&E; 60 (65.2%) undergoing induction] for the main study. Two induction women did not complete the costing questionnaire and are not included here. Basic demographic information and housing characteristics are provided in Table 1. Age and educational attainment were similar across the two groups. Just 37.6% of all respondents reported currently being employed or doing any kind of paid work.

As shown in Table 2, when asked about facilities they had visited while seeking an abortion, most women (73.2%)