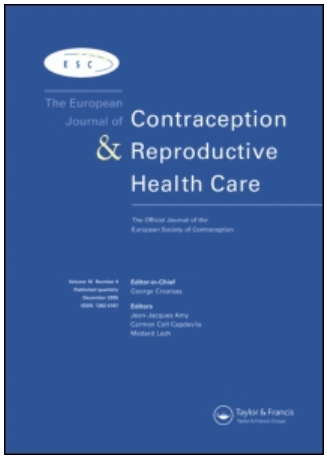

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Medication abortion in the private sector in South Africa

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ABSTRACT

Objectives To collect information about how private physicians in South Africa provide medication abortion services to their patients.

Methods In April 2003 we asked physicians in private practice in South Africa who had purchased mifepristone (Mifegyne®) from the South African distributor about the medication abortion regimen they offered, satisfaction with the method, and how services have been incorporated into their practices.

Results Forty-four providers participated in the survey. They report using a range of doses and regimens. Most respondents offer mifepristone–misoprostol to their patients, although a significant minority also offer misoprostol-alone for pregnancy termination. While the majority of medication abortion providers also offer surgical abortions, a significant number of non-surgical providers were only offering medication abortion.

Conclusion South African medication abortion providers find the method acceptable, indicate that their staff are largely supportive of offering it to their patients, and report that clients like the method. Those surveyed believe that most of their patients are eligible for the regimen, although uptake has been limited.

KEYWORDS Medication abortion, South Africa, Mifepristone

INTRODUCTION

The mifepristone–misoprostol medication abortion regimen has been used by millions of women worldwide to terminate early pregnancies[1]. Numerous research studies have shown it is safe and effective, and mifepristone is now approved for early abortion in 32 countries[2–4].

The standard mifepristone–misoprostol regimen, generally approved for use through 49 days' gestation, is 600 mg oral mifepristone followed 48 h later by 400 μg oral misoprostol. This regimen was approved for use in France in 1988, in Great Britain in 1991, in Sweden in 1992 and in the United States in 2000. Simplifications of the standard regimen have been studied and many health care providers now use a regimen of 200 mg oral mifepristone followed by 800 μg of vaginal misoprostol, which has been shown to be highly effective up to 63 days of pregnancy[6–10]. Additionally, more women are being

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given the option to take the misoprostol at home, which simplifies its use and eliminates the need for an additional clinic visit, thus saving time and money[1,4,5]. Throughout this paper we refer to these alternative regimens supported by clinical evidence as 'evidence-based' regimens.

Six hundred milligrams of mifepristone followed by 400 μg oral misoprostol was approved for use in South Africa in 2001. The approved regimen in South Africa differs from the standard regimen in two important ways: mifepristone is labeled for use up to 56 days' gestation as opposed to the standard 49 days, and the labeling allows for home use of misoprostol. Although providers in a number of countries give women the option of using misoprostol at home, South Africa was the first country to approve a label that does not explicitly instruct women to return to the clinic for misoprostol[11].

Private providers in South Africa were surveyed to collect information on the mifepristone medication abortion regimen they are offering, satisfaction with the method, and how medication abortion has been incorporated into their practices. Previous studies have investigated patterns of medication abortion provision among providers in the United States, France, Great Britain and Sweden[12–14]. To our knowledge, this is the first study to examine South African physicians' experiences of providing medication abortion.

METHODS

The South African mifepristone (Mifegyne®) distributor (MediChallenge, Johannesburg, South Africa) compiled a list of providers who had purchased mifepristone directly from them. The list included 104 private physicians or clinics. In March 2003, the distributor sent each provider on the list a letter explaining that they would be contacted about the study and asked to participate. Providers were asked to contact the company if they did not want to be included. No providers declined at this point. In April 2003, we attempted to contact all of the providers and clinics on the list by telephone. Up to five attempts to contact each provider or clinic were made. The interviewer asked to speak to someone qualified to answer questions about services provided in the office or clinic. Staff members other than the physician named on the list, including medical secretaries or nurses, were considered appropriate respondents; their position in the office was recorded on the questionnaire.

Interviewers used a structured questionnaire that included both closed- and open-ended questions. Two trained interviewers conducted the interviews. Data were analyzed using SPSS version 11.0 (SPSS, Chicago, IL). Respondents gave oral consent to participate in the survey. The protocol was deemed exempt from IRB review according to guidelines at the Population Council.

RESULTS

Characteristics of respondents

Staff from 44 provider offices or clinics participated in the survey, for a response rate of 42%. Of the remaining 60 providers and clinics (58%), 41% did not respond to numerous messages, 7% were not contactable at the phone number that the distributor had on file, 5% refused to participate, and 4% stated that they did not perform abortions in the office or clinic.

Ninety-one percent of respondents reported they worked in the private sector (as opposed to the public sector or government services) and 84% reported that theirs was a for-profit clinic or office (Table 1).

Services provided

Most providers and clinics reported that they offered a variety of women's health services to their patients, including medication abortion (96%), surgical abortion (71%), HIV testing (100%), STI screening (91%), family planning (96%), well-woman services (73%) and well-baby services (46%) (Table 1).

Surgical abortion services

Most of the physicians surveyed performed a small number of abortions per month (surgical and medication), although a few clinics reported larger numbers of procedures (Table 1). Among those who provided surgical abortion ($n = 31$), the majority performed terminations in the first trimester using manual vacuum aspiration (Table 1). Fewer respondents

Table 1 Characteristics of providers and clinics surveyed

	N	%
Facility information		
Public sector	3	7.0
Private sector (including private practice)	39	90.7
Not-for-profit	7	16.3
For-profit	36	83.7
Level of care		
Primary health care facility	9	52.9
Secondary	3	17.6
Tertiary	4	23.5
Services offered		
Medication abortion	42	95.5
Surgical TOP	31	70.5
HIV testing	44	100
STI screening	40	90.9
Family planning	42	95.5
Well-woman services	32	72.7
Well-baby services	20	45.5
Among those who provide abortion ($n=41$)		
Number of abortion clients		
Less than 10/year	11	26.8
1–10/month	18	43.9
11–30/month	5	12.2
31–100/month	2	4.9
More than 100/month	5	12.2
Among those who provide surgical abortion ($n=29$)		
Gestational limit for surgical abortion		
Through 12 weeks lmp (first trimester)	18	62.1
Through 14 weeks lmp	2	6.9
Through 20 weeks lmp (second trimester)	5	17.2
Above 20 weeks	4	13.8
First trimester surgical method used		
Manual vacuum aspiration	19	67.9
Sharp curettage	6	21.4
Other*	3	10.8

*'Electric vacuum aspiration', 'manual vacuum aspiration & sharp curettage' and 'misoprostol, suction & curettage' were each given as a response by one physician.
Missing data are excluded from calculations in the table.

reported using sharp curettage ($n=6$). Thirty-four percent of respondents performed abortions through the second trimester. The most common methods used in second trimester terminations were medication abortion with misoprostol (40%, $n=6$) or dilation and extraction (27%, $n=4$).

Medication abortion services

Most of the providers who offer medication abortion started providing it to their patients in 2002. Thirty-seven (84%) physicians who offer medication abortion use mifepristone–misoprostol, 17 (32%) use misoprostol-alone, and one (2.3%) uses methotrexate–misoprostol (Table 2). A number of respondents ($n=9$) indicated that they offered more than one medication abortion regimen; most reported offering both mifepristone–misoprostol and misoprostol-alone, although one respondent reported offering methotrexate–misprostol in addition to mifepristone–misoprostol (data not shown).

Thirty-one medication abortion providers (70%) also offer surgical abortion to their patients. However a significant proportion of providers who have incorporated medication abortion into their practices are not surgical abortion providers ($n=11$, 26%) (data not shown).

Those respondents who use misoprostol-alone report using a wide variety of regimens and routes of administration (Table 2). There is slightly less variation in the regimens reported for mifepristone–misoprostol abortions; respondents report using evidence-based protocols as well as the standard regimen. Six respondents (16%) report using the evidence-based regimen of 200 mg mifepristone followed by 800 μg vaginal misoprostol, while 11 (30%) report using the approved regimen of 600 mg mifepristone followed by 400 μg oral misoprostol. Other providers report using additional off-label regimens, including 200 mg mifepristone followed by 800 μg of oral misoprostol ($n=6$) and 600 mg of mifepristone followed by 800 μg of oral misoprostol ($n=4$).

Thirty-four respondents (92%) have had fewer than 50 mifepristone–misoprostol clients since they started offering the service. Three clinics reported larger numbers of women who chose medication abortion (>50 mifepristone–misoprostol clients). All three high-volume clinics offer mifepristone–misoprostol through 56 days' gestation but do not offer regimens other than mifepristone–misoprostol, and all three clinics provide surgical abortions as well as medication abortion (data not shown).

When respondents were asked what percentage of their patients were eligible for mifepristone–misoprostol medication abortions, the most common response was that nearly all of their abortion patients

Table 2 Medication abortion services.

	N	%
Medication abortion methods used		
Mifepristone–misoprostol	37	84.1
Misoprostol-alone	17	31.8
Methotrexate-misoprostol	1	2.3
Among those who use misoprostol-alone		
Misoprostol dosage		
400 μg	3	21.4
600 μg	1	7.1
800 μg	4	28.6
>800 μg	2	14.3
Dose not specified	4	28.6
Misoprostol route		
Oral	5	28.6
Vaginal	5	35.7
Combination	4	35.7
Among those who use mifepristone–misoprostol		
Mifepristone dosage		
200 mg	20	54.1
600 mg	16	43.2
800 mg	1	2.7
Misoprostol dosage		
400 μg	24	64.9
600 μg	1	2.7
800 μg	11	29.7
Other	1	2.7
Misoprostol route		
Oral	23	62.2
Vaginal	11	29.7
Combination	2	5.4
Route not specified	1	2.7
Gestational limit for mifepristone–misoprostol		
49 days	1	2.7
56 days	26	70.3
63 days	4	10.8
>63 days	5	13.5
Number of mifepristone–misoprostol clients		
<10	27	73.0
10–50	7	18.9
>50	2	5.4
Don't know	1	2.7
Percentage of eligible clients who have chosen mifepristone–misoprostol		
75–100%	18	48.6
50–75%	3	8.1
<50%	13	35.1
Don't know	3	8.1
Percentage of women who had complete abortions		
90–100%	25	67.5
50–89%	10	27.0
<50%	2	5.4
Used ultrasound to diagnose ongoing pregnancy		
Yes	39	92.9
No	3	7.1
Perception of patients' satisfaction with method		
Very satisfied	30	83.3
Somewhat satisfied	4	11.1
Very unsatisfied	1	2.8
Don't know	1	2.8
Perception of staff opinion of method		
Supportive	7	23.3
Neutral	15	50.0
Opposed	5	16.7
Don't know	3	10.0

were eligible (40%, $n = 14$). Despite reporting that large proportions of women were eligible, few women ultimately chose the method (Table 2). Three respondents (8%) indicated that the cost of mifepristone was a barrier for their clients (data not shown).

Most respondents (63%, $n = 27$) reported that none of their mifepristone–misoprostol patients had experienced ongoing pregnancies. Thirty-one percent of respondents indicated that at least one of their patients had experienced an ongoing pregnancy after using mifepristone–misoprostol, but all reported ongoing pregnancy rates in the single digits (data not shown). The vast majority of respondents (93%) use ultrasound to diagnose ongoing pregnancy.

As shown in Table 2, patient and staff opinions of medication abortion are overwhelmingly perceived as positive. Nearly all respondents believe that their patients have been 'very satisfied' or 'somewhat satisfied' ($n = 34$, 94%) with their mifepristone–misoprostol abortions and most respondents indicate that staff are supportive or neutral about providing medication abortion to patients ($n = 22$, 73%).

DISCUSSION

As is the case in other countries where mifepristone–misoprostol abortion is available, many respondents

indicated that they are using evidence-based regimens instead of the approved regimen of 600 mg mifepristone followed by 400 μg misoprostol orally up to 56 days' gestation. Approximately a quarter of respondents provide mifepristone–misoprostol medication abortion beyond 56 days' gestation and many more indicated that they use a different dose of mifepristone and/or misoprostol than specified in the approved label.

One surprising finding of this study was the substantial number of providers who report using misoprostol-alone in addition to mifepristone–misoprostol, which would indicate that there are certain patients or circumstances that providers believe warrant the use of misoprostol-alone instead of mifepristone–misoprostol. Until recently, an optimal regimen for abortions using misoprostol-alone had not been established, and the diversity of doses and routes of administration reported by respondents reflects this situation. In 2003, experts on the use of misoprostol-alone for early abortion determined that 800 μg vaginal misoprostol, repeated after 24 h (2 × 800 μg) is the most effective misoprostol-alone regimen for abortions up to 63 days' gestation[15]. Misoprostol-alone abortion is significantly less expensive than an abortion using mifepristone–misoprostol, which may account for its appeal among providers and clients, but it is also less effective and associated with more severe side-effects than mifepristone–misoprostol abortions[16,17].

Cost may also partly explain the fact that the majority of respondents believe that nearly all of their patients with early pregnancies are eligible for medication abortions using mifepristone–misoprostol, yet they say that fewer patients ultimately choose medication abortion. In South Africa, 600 mg of mifepristone (three tablets) costs approximately $150/€130. Without prompting, a number of physicians cited the high cost of mifepristone as a barrier to uptake, and also reported that many women prefer surgical procedures because they are completed more quickly. The question of why eligible women do not choose mifepristone–misoprostol in South Africa should be addressed through further research. In addition to cost, it would be interesting to evaluate provider preferences and how they present information to women, as well as the impact of lack of general information on medication abortion and mifepristone in particular. Women may feel uncomfortable using a method if they do not have information on women's experiences or if they do not know someone who has used it before.

An analysis of medication abortion in Great Britain, France and Sweden found that the proportion of eligible women choosing mifepristone medication abortion has risen steadily every year since the drug was approved in each country[13]. This indicates that as providers and women become more familiar with medication abortion, they are more likely to offer and choose the method. While medication abortion is still not widely available in South Africa, there are a small number of clinics doing a large number of procedures, which indicates that at least some South African women are interested in the method.

Women's health advocates have long hoped that the availability of medication abortion would increase the number of abortion providers by enrolling non-surgical abortion providers into providing medication abortion services. The results of this study indicate that this is in fact the case in South Africa, where 25% of medication abortion providers surveyed were not surgical abortion providers.

We did not collect information about important aspects of medication abortion care, including how the providers learned about medication abortion, why they offer particular services, how much they charge, and whether they have experienced problems or successes that were unexpected. Further quantitative and qualitative research is needed to address these important aspects of the provision of medication abortion in South Africa.

There are additional limitations to this study. Only people who purchased mifepristone from the South African distributor of the drug were surveyed, so these results may under-represent providers or clinics that provide other types of medication abortion. This is particularly significant because mifepristone–misoprostol medication abortion is more expensive than other regimens, and cost probably affects its use. Additionally, while the list provided by the mifepristone distributor should represent the universe of South African mifepristone–misoprostol medication abortion providers at the time, the response rate was quite low and a number of physicians on the list said that they did not provide medication abortion using mifepristone–misoprostol. They may in fact provide medication abortion but gave that response as a way of refusing to participate or to avoid being

publicly identified as an abortion provider. The low response rate and the small number of abortions performed by some respondents may bias these results.

The results of this study indicate that South African mifepristone–misoprostol medication abortion providers find the method acceptable. Providers also report that their staff and clients like the method. Many providers surveyed believe that nearly all of their abortion clients are eligible for mifepristone–misoprostol, but the high cost of medication abortion may be a barrier to more frequent use in the private sector in South Africa.

While mifepristone–misoprostol is a relatively new option in South Africa and is not widely available, the number of patients who have chosen medication abortion at the higher-volume clinics indicates that there is patient interest in this alternative to surgical abortion. Expanding the availability of medication abortion among both private and public health care providers and ensuring that it is an affordable option for women will improve access and increase uptake of this safe and effective method for termination of pregnancy.

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