

Title: A 2006 National Audit of the Availability of Comprehensive Abortion Services (CAC) in the Republic of South Africa: Availability, Method Mix and Spatial Concentration of Services

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Introduction

This paper describes the availability, method mix and spatial concentration of induced abortion services in South Africa. In 2000, in its five-year strategic plan, the National Department of Health (NDoH) of South Africa announced goals of scaling-up access to early termination of pregnancy (TOP) services throughout the nation. In order to meet the national objective of reducing maternal mortality and morbidity, the 2001-2005 NDoH strategic plan called for increasing the number of facilities providing TOP from the current level of 30% of eligible sites to 75%. Although progressive abortion legislation and a Constitution based on equality protect women's health and rights, South Africa still struggles to expand equal access to appropriate reproductive health technologies. The NDoH Strategic plan for the Implementation of the Choice of Termination of Pregnancy Act (CTOPA) (2004) advocated for a national audit to identify obstacles to service delivery among eligible services. Experts have argued that at least one comprehensive abortion service should be available per 500,000 population (Healy et al forthcoming). Using a population-based benchmark, the adequacy of provincial and municipal distribution of abortion services can now be calculated, and policies enacted to address disparities.

The 2006 audit answers three main questions:

1. How accessible are first and second trimester CAC services in South Africa?
2. What clinical methods of CAC are available in South Africa?
3. What is the spatial concentration of CAC services in South Africa?

Methods

The latitude and longitude coordinates of all the public and private health facilities in the republic were obtained from the NDoH (n=5496). From these, facilities eligible to offer TOP were selected using infrastructural criteria¹ (n=878). A telephone survey of the TOP Coordinators from the nine provinces was conducted to obtain a list of all officially designated public and private TOP sites (n=173). A census of the remaining eligible SDPs (n=705) was conducted to determine which facilities were offering any abortion care, including miscarriage management (PAC). All facilities offering any abortion services were recruited to participate in a second telephone interview on the clinical aspects of care.²

¹ Under the new amendment to the CTOP Act, facilities are automatically designed to offer TOP if they already provide labor and delivery care on a 24 hour basis.

² The two-part telephone survey consisted of questions regarding service delivery and questions regarding equipment access and re-supply. This paper focuses solely on the service delivery issues.

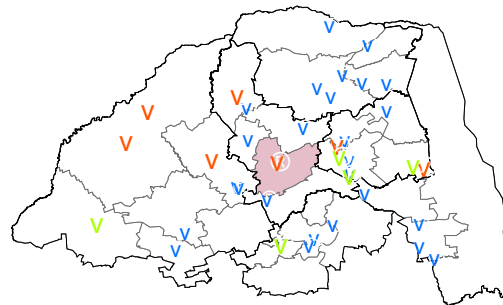
The research protocol and instruments were reviewed and approved by the Ethics Committee of the University of Witwatersrand. As incentives to participate, respondents received a scientific calculator and CD ROM with information on (unrelated) reproductive health issues by postal mail.³ Four trained multi-lingual survey researchers from a large commercial call center collected the data between May and September 2006 using three pre-tested instruments. Data were entered directly into CATI (Computer Assisted Telephone Interviewing) software and using SPSS 14.0 simple descriptive frequencies and population and provincial proportions will be calculated.

The geo-coded data will be imported into ARC GIS 9.0 and overlaid against density maps of women of reproductive age (WRA) derived from the 2000 Census data to identify the spatial access of this population to TOP services (see sample map for designated sites for Limpopo Province color-coded by service delivery criteria: on-line (blue), fragile (green), or off-line (red)).

Results

The follow information will be shared in the paper:

1. The recruitment rate
2. The non-contact rate
3. The refusal rate for the initial canvass
4. The refusal rate for the telephone interview
5. The final facility sample size
6. The proportion of designated TOP facilities that are operational nationally and by province
7. The proportion of facilities automatically eligible for designation that are offering TOP or miscarriage management services ***nationally and by province***
8. The proportion of facilities automatically eligible for designation that are offering TOP or miscarriage management services ***by clinical method***
9. The proportion of facilities automatically eligible for designation that are offering TOP or miscarriage management services ***by weeks of pregnancy***
10. The equity of the spatial distribution of TOP services by population of women of reproductive age.
11. The sufficiency of the spatial distribution of TOP services according to UN met-need indicators.
12. The reported rationales for not offering TOP or miscarriage management services ***nationally and by province***



Discussion

The discussion section will explore the noteworthy or counterintuitive results and compare 2006 findings with related nationally-representative studies of abortion care access in 1994, 2001 (Fawkes et al 1997, Jewkes et al 2002, 2005).

Limitations

The limitations of a telephone survey, self-reported service delivery, and potential biases introduced by non-response, social desirability, and recall will be discussed.

³ A compendium of MEASURE publications on CD ROM or health commodity management tools from JSI DELIVER

Conclusion

The conclusion section will explore the implications of the policy findings including opportunities to acknowledge provincial leadership on the TOP issue, needs for training in specific clinical techniques, and strategies for addressing the barriers to service delivery identified in the survey.

This study will be the first study to summarize the national abortion access picture of South Africa which includes both miscarriage management and TOP as essential elements of comprehensive abortion care (CAC). Moreover, it will show which provinces and municipalities suffer from an inequitable distribution of lifesaving services and essential health technologies. These findings will be an important contribution to advocates and policy makers to assist them in identifying persistent access disparities and targeting scarce resources to areas where women's health and rights are most endangered.

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