Addressing the demand for termination of pregnancy services in district health facilities in Johannesburg

To the Editor: The Choice of Termination of Pregnancy (CTOP) Act instituted safe, effective, affordable and acceptable methods of fertility regulation for women. Universal access to reproductive health services is available through the district health services.[1]

By 2001, there had been a 91% decline in maternal mortality from unsafe abortions in South Africa (SA) as a result of the CTOP Act.[2] However, despite the availability of free reproductive health services, few women are utilising family planning services in SA.[3] Recent studies have reported that unsafe abortions are on the increase.[4-6]

We wished to determine the number of terminations of pregnancy (TOPs) requested and the number of TOPs performed from January 2008 to December 2009 in the Johannesburg Metropolitan District (JM). We conducted a descriptive cross-sectional study including TOP data from district health information systems in the JM. All health facilities offering TOP services at the district level were included.

The analyses showed that a total of 14 683 and 16 031 women requested TOPs in 2008 and 2009 respectively; these figures might have included women in their second trimester, at district facilities. A third of requests were performed, with 4 921 and 5 338 first-trimester TOPs performed in 2008 and 2009 respectively (Fig. 1). In 2008, a total of 6 clinics offered TOP services in the JM. The majority (68%) of the first-trimester TOPs were performed by 2 facilities. Two clinics which collectively had performed 15% of the total number of TOPs in 2008, ceased offering TOP services in 2009; only a new clinic initiated TOP services in 2009.

Although the number of TOP requests increased from 2008 to 2009, the facilities offering first-trimester TOP services declined. In addition, the number of first-trimester procedures performed was far less than the number of requests received. A major concern is that if the demand for TOPs remains unmet in the public sector, the incidence of unsafe abortions may continue to rise further.

J F Mendes
D Basu

School of Public Health
Charlotte Maxeke Johannesburg Academic Hospital, and
University of the Witwatersrand
Johannesburg
jacqui.mendes@wits.ac.za

J K Basu
Department of Obstetrics and Gynaecology
Charlotte Maxeke Johannesburg Academic Hospital, and
University of Witwatersrand
Johannesburg

1. Choice of Termination of Pregnancy Act No. 92 of 1996. Pretoria: Department of Health, 1996.
2. Jewkes R, Rees H. Dramatic decline in abortion mortality due to choice of Termination of Pregnancy Act. S Afr Med J 2005; 95: 250.
3. MacPhail C, Pettifor AE, Pascoe S, Rees H. Contraception use and pregnancy among 15 - 24 years old South African women: a nationally representative cross-sectional survey. BMC Med 2007; 28: 31.
4. Meel B, Kaswa RP. The impact of Choice of Termination of Pregnancy Act of 1996 (Act 92 of 1996) on criminal abortions in the Mthatha area of South Africa. African Journal of Primary Health Care and Family Medicine 2009; 1: 79-81.

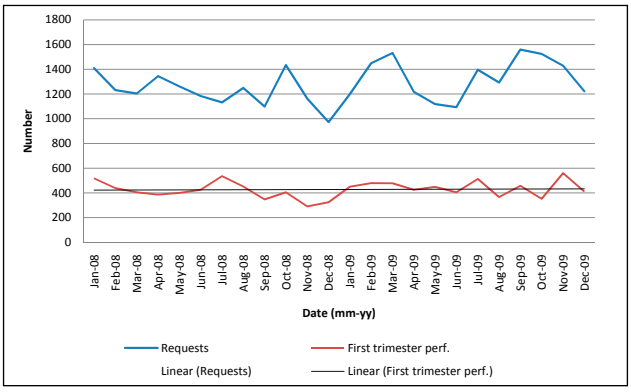

Fig. 1. Distribution of number of TOP requests and first trimester TOP procedures performed per month from January 2008 to December 2009 in the Johannesburg Metropolitan District.

5. Basu JK. Legal unsafe abortion in South Africa. Conference proceeding XIX FIGO World Congress of Gynaecology and Obstetrics, Cape Town, South Africa, 4 - 9 October 2009.
6. Morroni C, Moodley J. Characteristics of clients seeking first and second trimester termination of pregnancy in public health facilities in Cape Town. S Afr Med J 2006; 96: 574.

Medical indemnity regulations: MPS maintains commitment to South Africa

To the Editor: I want to reassure members of the Medical Protection Society and readers of the *SAMJ* that the surprise new government regulations on indemnity will not diminish our longstanding and strong commitment to the South African medical and dental professions.

We had no warning of the new regulations and we know their publication has caused a great deal of uncertainty, but the regulations will not affect MPS members until the end of December and in the meantime we are committed to doing everything we can to find a long-term solution.

The MPS has operated in South Africa for over 50 years and we want to be here for another 50. We have 25 000 members in South Africa, and each of them is important to us. As a mutual, our ethos, when looking at whether to offer our services and support in a country, is to ask the question: does the profession want us? We have been overwhelmed by the support we have received from our members over the past week, and this has galvanised our search for a solution that will allow the MPS to continue to indemnify and support doctors and dentists in South Africa. We are also encouraged by the response of government agencies and regulators who have voiced a strong desire for us to remain.

We do not dispute the principle behind the regulations; we agree that medical professionals should have compulsory professional indemnity so that they and their patients are protected if something avoidable goes wrong. We also support the requirement that indemnifiers should be capable of regulation. Our objection – our strong objection – is the preclusion of the indemnity that the MPS provides, which is widely regarded as the best available. Although it is discretionary, it allows us the flexibility to provide help and support in circumstances where a claim may otherwise be rejected by an insurer. In our long history there has been no case of the MPS declining to meet a proven claim of negligence that has resulted in a patient being left uncompensated. The occurrence-based nature

of MPS indemnity means that doctors only need to be a member of the MPS at the time something goes wrong; after that, assistance can be requested at any time even if the doctor has moved away, taken a career break or retired. This provides comfort and peace of mind for the doctor and his or her patients.

In contrast, insurance contracts are complex and are governed by the wording of the policy conditions. They also are invariably based on the 'claims made' principle, which means that cover ceases at the end of the policy unless the individual doctor purchases 'run-off' cover to meet past incidents that have yet to be reported as claims. It is because we so firmly believe in providing our members with what is best for them and their patients that we remain so committed to our discretionary occurrence-based model of indemnity.

I want to emphasise that the MPS is far more than a provider of professional indemnity against claims of negligence. We also assist with any problem that arises from a doctor or dentist's professional practice. This might include advice on ethical issues or support with disciplinary proceedings, inquests or medical council inquiries.

One of the core benefits of membership is our confidential counselling service, which we fund because the pressures facing those working within health care are such that the consequences of even the smallest error can be personally devastating for the individual doctor.

The MPS has accumulated a vast wealth of experience and expertise in medico-legal issues over many years and from more than 30 countries – we are truly world experts in our field. The MPS is committed to help improve patient safety, and we share our expertise to help prevent future problems occurring. We do this through lectures, seminars, courses and workshops. For doctors our influential publications such as *Casebook* and *Junior Doctor* are core components of continuing education, and we regularly develop materials on important matters such as consent and risk management issues.

We have evolved over the many years we have been in South Africa and, with the support of members and the profession, we want to evolve further in the future. We hope you will support our campaign to persuade the Minister of Health to review the new regulations and to allow us to continue to provide a high-quality service to our members and their patients. As our attempts to secure a solution progress, we will update you on progress regularly via the MPS website. No one should be in any doubt of the intensity of our activity to find a solution that is acceptable to the profession and to government.

South Africa is and will remain of immense importance to the MPS.

A D Mason
Chief Executive
Medical Protection Society
UK
tony.mason@mps.org.uk

Solubility tests and the peripheral blood method for screening for sickle-cell disease

To the Editor: We refer to the paper by Okwi *et al.*[1] Cost benefit analysis of screening for sickle cell disease (SCD) using different methods cannot be done in isolation, and the following are important principles to take into account.

1. Reasons for screening: (*i*) early detection of the disease for timely intervention to minimise morbidity and mortality; (*ii*) patient and family education on SCD; (*iii*) genetic counselling as part of a long-term strategy to prevent live homozygous SCD (SS) births; and (*iv*) short- and long-term cost saving by means of (*i*), (*ii*) and (*iii*) above.
2. The method of detection needs to be very sensitive. Subjects with false-negative results will remain undiagnosed and may well present with an acute crisis or organ damage, with major cost implications.

The sensitivities of the sickling and solubility tests for detection of the sickle cell trait (AS) as reported by the authors were 65% and 45%, respectively, essentially translating to high 35% and 65% false-negative rates, an unacceptable scenario regardless of cost saving.

Clearly the methodologies need to be questioned, since the sickling test is sensitive enough to detect AS.[1,2] In addition, the article advocates that negative sickling tests be regarded as negative for the disease, evidently with no further testing required. This means that 35% of the subjects tested will walk around with undiagnosed AS despite having been tested, which defeats the objectives of screening as stated above.

The recommendation by the group that the sickling test be the preferred and sole method for screening, purely on the basis of economics, is disconcerting, while with its observed shortcomings the proposed screening method would be of short-term benefit.

We conclude that a cost benefit analysis of methods with such low sensitivities is ineffective and futile.

N A Alli
S B Loonat
Department of Molecular Medicine and Haematology
School of Pathology
University of the Witwatersrand/National Health Laboratory Service
Johannesburg
nazeer.alli@nhls.ac.za

1. Okwi AL, Ocaido M, Byarugaba W, Ndugwa CM, Parkes A. Solubility tests and the peripheral blood film method for screening for sickle cell disease: A cost benefit analysis. S Afr Med J 2009;99(12):887-891.
2. Dacie JV, Lewis SM. Practical Haematology. 5th ed. Edinburgh: Churchill Livingstone, 1975.
3. Chanarin J. Laboratory Haematology. 1st ed. Edinburgh: Churchill Livingstone, 1989.

Okwi *et al*. reply: Our cost benefit analysis was not done in isolation, as suggested above. The paper was published together with others that appeared elsewhere and addressed the issues raised. Sensitisation of communities (patient and family education on SCD) and timely intervention were covered in a publication in the *East African Medical Journal*.[1] Another paper addressing some of these issues was published in *BMC Blood Disorders*.[2]

All the false negatives with the sickling test were cases of AS (carriers), not SS. The sickling test demonstrated all SS cases, as did Hb electrophoresis – i.e. sickling was sensitive in SS detection but not in AS detection. The sickling test would therefore be sensitive enough to detect all the children with SS, who would benefit most since they suffer from crisis, while carriers (AS) do not.

Lastly, the authors state that our article advocated interpreting a negative sickling test as the patient being negative for the disease, with no further testing required. We did not assume or recommend this. Our assumption was that all the children who might accidentally be missed by the sickling test and develop symptoms later would be tested by Hb electrophoresis.