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INCREASING ACCESS TO ABORTION – PERSPECTIVES ON PROVIDER AVAILABILITY FROM DIFFERENT SETTING

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Susanne Sjöström is an Obstetrician Gynecologist who defended her thesis ”Increasing access to abortion – perspectives on provider availability in different settings” at Karolinska Institutet in January 2017. Her work has been published in Contraception, BMC Medical Education, Plos One, and is accepted for publication in BJOG. Her email address is susannesjostrom@hotmail.com.

More information and the thesis can be found at: http://ki.se/nyheter/fler-vardgivare-for-saker-abort-kan-radda-tiotusentals-kvinnoliv

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Unplanned pregnancies and unsafe abortion has existed since beginning of times and still causes substantial morbidity and mortality. During the last centuries women have been increasingly empowered in most societies and important advances has been made to enhance women's rights and life conditions. Important scientific advances have also been made in the field of reproductive health and rights with development of contraceptive methods as well as methods of safe abortion. This increased knowledge and awareness as well as changes in the legal framework has contributed to decreased maternal mortality caused by unplanned pregnancies and unsafe abortion, especially in high income countries and where the legal framework is permitting, but also increasingly so in lower income settings. Despite this progress access to abortion and contraception remains controversial in a global perspective and numbers of preventable maternal deaths are still high. Access to safe abortion has yet to reach its full potential.

The Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 was launched in 2015 and aims to end all preventable deaths of women, children and adolescents, and to create an environment in which these groups not only survive, but thrive [1]. In addition 17 sustainable development goals (SDGs) were set including targets for all countries to lower the maternal mortality rate to 70 by 2030, and to increase the global access to sexual and reproductive healthcare.

Facts:

Abortion and maternal mortality

- Maternal Mortality is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes [1] .
- Measuring unsafe abortion and abortion related maternal mortality is difficult due to stigma. It is estimated that at least 7.9% of all maternal death, or at least 23000 deaths occur yearly due to unsafe abortion. [2] [3].
- Around 25 per cent of all pregnancies are estimated to have ended in abortion between 2010-2014[4].

- Around 40% of all pregnancies were reported to be unintended in 2012[5]. In the US, where almost half of all pregnancies were unintended, 42% of those pregnancies ended in abortion [6]. Unintended pregnancies lead to unsafe abortion and abortion related morbidity and mortality, as well as unintended births which have negative impact on the mothers and children's future socio-economic status and mental health [7].
- At least one in three women who want to avoid or delay an unintended pregnancy have limited or no access to modern contraception thus putting them at risk for unplanned pregnancy [8].

Medical methods of abortion

- Medical abortion using mifepristone and misoprostol, or misoprostol alone is recommended by the WHO for abortion in the first and second trimester and using the combined regimen complete abortion is attained in more than 95% of cases[9]. [10]. Ultrasound or prophylactic antibiotics are nog needed before treatment.
- Misoprostol, that is widely available under the brand name Cytotec® for prevention of gastric ulcer, is represented on WHO's list of essential medicines for treatment of induced abortion, incomplete abortion, labor induction, and prevention and treatment of post-partum hemorrhage [11]. In addition, it is recommended for cervical priming prior to surgical abortion. The current status of misoprostol approval and updated clinical guidelines is available at http://www.misoprostol.org.
- Use of misoprostol to induce abortion could reduce abortion related maternal mortality by 45% [12].

Post-abortion care (PAC)

- PAC is a method to treat complications of unsafe abortions. The model includes treatment for incomplete abortion with sublingual of oral misoprostol, contraceptive counseling, and management of sexually transmitted diseases when needed [13]. Success rates are high [14]. Treatment for PAC by midlevel providers is equally effective and safe as treatment by physicians in low resource settings [15].

Midlevel providers

- Task shifting and sharing of medical services with trained non-physician providers has become an important strategy to ensure medical services where there is shortage of healthcare providers and has the potential to increase access to safe abortion.
- The WHO recommends that medical abortion and treatment for incomplete abortion in the first trimester can be managed by trained auxiliary nurse midwives, nurses, midwives and associate clinicians [16].

Barriers to safe abortion include

- providers (including numbers of caregivers, knowledge an willingness to provide abortion and claim of conscientious objection) , legal proscriptions, poor infrastructure, costs, stigma and women's lack of knowledge.
- Legal restrictions
- Administrative barriers
- Infrastructure
- Costs both to women and health care systems
- Women knowledge
- Stigma

Summary of thesis

The overall aim of my thesis was to study factors that influence access to comprehensive abortion care focusing on increasing provider availability in different settings. Four studies were included that explored factors influencing provision of, and treatment for abortion including post abortion care.

In India, where abortion has been legal since 1971 but where abortion-related maternal mortality rates remain high, we found that students commonly misunderstood the laws regulating abortion and were uninformed about available abortion methods. The students were hugely affected by the stigma connected with abortion and even though the majority

of medical students recognised that unsafe abortions are a huge problem in India, many claimed to be worried about reprisals and said that they were afraid to perform the procedure in their future practice[17, 18].

A study conducted in Sweden showed that abortion care given by midwives is not only as safe but also much cheaper than when given by doctors[19].

A systematic overview of randomised studies of abortion care also showed that women find that medical abortions and treatments for incomplete abortions administered by nurses and midwives are just as acceptable as those administered by doctors[20].

Conclusion and future implications

Despite the global ambition to decrease global maternal death, unsafe abortion, which is easily preventable, remains high. Why is progress so slow?

Our studies of medical student attitudes, although not necessarily generalizable to other settings, show that despite a national initiative and focus on including family planning and abortion in the medical curricula attitudes and knowledge remains poor. In order to influence intentions to provide abortions and we conclude that it is necessary to educate and conduct values clarification in order to secure future abortion providers. Increasing knowledge and improving attitudes is a continuous process and continued education in peer networks is important also for established health care providers.

The systematic review of midlevel provision of medical abortion and medical treatment of incomplete abortion added the evidence that treatment for abortion and incomplete abortion by non-doctors is as acceptable to women as provision by physicians. Women's acceptability of services is crucial when aiming to increase access to comprehensive abortion care and provides further support for implementation of midlevel provision of comprehensive abortion care. Previous studies on acceptability are few, and acceptability has not been systematically reviewed

We also showed that midlevel provision of medical abortion is cost-effective. Determining cost-effectiveness is important since most countries have limited healthcare budgets.

Overall, the context is an important determiner of access to comprehensive abortion care. When communicating research findings, it is important to reflect on who the audience is. Developing increasingly complex explanation models is not necessarily a way to create understanding among stake holders such as politicians and health system executives and clinicians.

In order to improve access to safe abortion care, it is necessary to increase knowledge among providers and women. Further expansion of the provider base for safe abortion is possible by including trained non-physicians or midlevel providers. This approach is cost-effective, effective and acceptable to women.

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