PRECONGRESS WORKSHOP

Putting provider abortion skills into practice

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ABSTRACT

Global progress to reduce maternal deaths from unsafe abortion is inadequate. Clarifying abortion values and attitudes, using updated WHO safe abortion technical guidance, networking with other providers, and securing adequate abortion and contraceptive supplies can support providers to put induced abortion, postabortion care, and contraceptive skills into practice. Revised national guidelines based on updated WHO guidance can support women’s healthcare providers to offer safe abortion for all legal indications and other measures to protect women’s life and health. Recommendations of the United Nations and partner agencies can be used to support integration of abortion into other health programs, to expand provision of abortion care by midlevel providers, such as midwives, and to advocate for resources and results based on an expanded reproductive, maternal, newborn, and child health Continuum of Care. Together, these efforts can generate concerted progress toward eliminating unsafe abortion, which is an entirely preventable cause of maternal mortality.

1. Introduction

With 2015 fast approaching, there is intensified focus on global commitments and strategies for achieving the Millennium Development Goals (MDGs) [1], which include reducing maternal mortality and ensuring universal access to reproductive health. At the 2012 United Nations General Assembly, nation states and the global development community took stock of progress on the Global Strategy for Women’s and Children’s Health. While there is encouraging progress in improving maternal health, there remain significant gaps in addressing maternal mortality, especially due to unsafe abortion [2,3]. The independent Expert Review Group reporting progress on the Global Strategy for Women’s and Children’s Health found “a pervasive neglect of safe abortion” and contraception [3].

Training and equipping healthcare providers continues to be a cornerstone for ensuring health systems can reach women with comprehensive abortion care (CAC), which includes safe induced abortion for all legal indications, postabortion care, and contraception to prevent avoidable deaths from unsafe abortion. The recently updated WHO document “Safe abortion: technical and policy guidance for health systems. Second edition” [4] contains clinical recommendations that facilitate provision of abortion services, and other service delivery and policy measures that health systems can take to make abortion safe and accessible. Additional policy and programmatic guidance by UN agencies and partners support provision of abortion care. Over the next 3 years, these recommendations and guidance should be used to make concerted progress on reducing abortion-related maternal deaths.

2. Training and supporting women’s healthcare providers

2.1. Attitudes of providers

Individual provider characteristics, experiences, and attitudes about abortion influence whether providers are willing to be trained, to provide CAC services, and the quality of services provided [5,6]. Negative attitudes toward contraception, abortion, and women seeking abortion-related care are typically prevalent in settings where abortion laws are restrictive, but also exist in settings with liberal indications for abortion. Providers who have had direct experience with a woman facing an unplanned pregnancy or abortion may also be able to better empathize with women in these circumstances. Providers practicing in restrictive abortion settings often describe turning a woman away for a safe abortion only to learn that she subsequently obtained an unsafe abortion, and in some instances died. Regardless of the legal status of abortion in a country and attitudes of healthcare providers about abortion, providers are ethically obligated to ensure that women receive lifesaving care. Some direct providers of care claiming conscientious objection—more accurately described as conscientious refusal of care—need to ensure that a woman receives the care she needs and her life is not jeopardized by a refusal to provide care.

The WHO safe abortion guidance identifies values clarification exercises as useful for helping providers to differentiate their personal beliefs and attitudes from the needs of women seeking abortion care. The Values Clarification Attitude Transformation (VCAT) methodology can be used prior to or as part of training providers to improve attitudes about abortion and help providers recognize their ethical responsibility to provide care [7–9]. Results from use of values clarification in 30 workshops across 20 countries showed an overall
increase in positive provider attitudes about abortion that can affect practice [9]. Values clarification interventions can also be used with facility managers, other health facility staff, and broader stakeholders who influence whether providers can put skills into practice. The methodology has also been used to focus on attitudes toward second trimester abortion and attitudes about young women’s sexuality, use of contraception and abortion services, and ways that care can be improved for these women. While the VCAT methodology measures intent to provide or support abortion services at completion of the workshop, there is also documentation underway to determine whether actual behavior and practices change as a result of participation in the workshops.

Professional associations can undertake efforts at a country level to sensitize their membership and cultivate an attitude of compassion toward women in need of safe abortion, postabortion care, and contraception to prevent unwanted or unplanned pregnancies. These efforts can be important for destigmatizing abortion and underscoring the professional obligation to provide care. An abbreviated version of a values clarification exercise was conducted during a working group session at the Alliance for Women’s Health Pre-Congress workshop, held prior to the XX FIGO World Congress in October, 2012, Rome, Italy. The activity illustrated how among professionals dedicated to women’s reproductive health, personal backgrounds, experiences, and legal status of abortion in one’s country influenced participant responses to various statements about abortion, as well as how participants’ interpretations of statements sometimes changed after hearing a response by another participant that provided a different viewpoint.

2.2. Knowledge and skills

Provision of safe abortion, postabortion care, and contraception are recommended as essential interventions for reducing maternal mortality [10,11]. Induced abortion is one of the safest medical procedures [12]. Provision of safe induced abortion reduces the need for complicated treatment and management of hemorrhage, sepsis, and uterine perforation from unsafe abortions. The recent FIGO policy statement recommending that vacuum aspiration and medications should be used and not sharp curettage further supports efforts to use safer, simpler methods [13]. Medical abortion does not require intrauterine instrumentation and so may be easier to learn and to put abortion skills into practice than vacuum aspiration. Although medical abortion is potentially easier to learn and provide than vacuum aspiration, wherever possible all recommended methods of uterine evacuation should be offered to women.

Evidence-based knowledge and skills are central to provider performance. The updated WHO document [4] can be used to ensure that provider training and skills are based on the most up-to-date clinical evidence. The updated guidance is timely, in particular for consolidating recommendations about the dosage, timing, and route of administration of medications for both induced abortion and postabortion care. The WHO guidance underscores that ultrasound is not required for medical abortion provision and a routine follow-up visit is not required for uncomplicated medical abortion. These are examples of measures that help to “demedicalize” the care.

Evidence has shown that counseling and provision of contraception immediately after safe induced abortion or postabortion care in the location where services are provided increases contraceptive uptake [14–17]. Updated WHO recommendations on contraception following medical abortion allow for provision of hormonal methods on the first day of taking mifepristone or misoprostol, increasing the opportunity for provision of implants and injectables rather than returning for a follow-up visit to receive these methods. The guidance also notes that provision of an intrauterine device (IUD) after a vacuum aspiration procedure rather than returning later for insertion also offers better protection against unintended pregnancy [4].

This updated evidence and recommendations further simplify comprehensive abortion care and enhance providers’ ability to put abortion skills into practice.

2.3. Support networks

Providers of abortion-related care may need ongoing encouragement and recognition for their work, as well as ongoing professional support to put skills into practice. Peer professional networks is one way to assist providers in obtaining accurate technical information on an ongoing basis, sharing best practices, and encouraging immediate feedback loops from implementation. Virtual technologies can further facilitate this exchange. The success of health professional networks, such as communities of practice, in influencing provider practice and health outcomes depends on the network characteristics and structure [18]. The advantages of supporting women’s healthcare providers through professional networks need to be further studied to determine whether and how they enhance provider performance, especially in low-resource settings where providers practicing in rural areas may be geographically isolated.

3. Equipping providers

The availability of abortion technologies is a fundamental building block for providers to put abortion skills into practice. Tools for forecasting and ordering adequate numbers of manual vacuum aspiration (MVA) instruments and medications for postabortion care and induced abortion based on caseload can assist healthcare providers and health facilities to reduce stock-outs and the number of providers reporting nonprovision of services due to lack of supplies [19–21]. With emerging introduction of mifepristone and misoprostol into countries, registration and incorporation of these drugs into distribution channels can require significant lead time that needs to be taken into account in the timing of provider training. The FIGO statement on recommended technologies for uterine evacuation also serves as an important tool at the country level for advocating that health systems register, procure, and distribute recommended abortion technologies.

In addition to the logistical challenges of ensuring providers have adequate commodities in their settings to provide CAC, MVA instruments and medical abortion drugs bear the additional challenge of stigma surrounding abortion and policies preventing their purchase. The recently produced WHO document, “Priority life-saving medicines for women and children” [22], and the “WHO Model List of Essential Medicines” [23] appropriately include mifepristone and misoprostol for provision of safe abortion and misoprostol for postabortion care. However, despite a request by FIGO and other reproductive health organizations, recommendations of the “UN Commission on Life-Saving Commodities for Women and Children Commissioner’s Report” [24] did not include vacuum aspiration, mifepristone, or misoprostol for abortion-related indications, even though misoprostol is identified in the report for postpartum hemorrhage. These gaps serve as continual barriers to ensuring providers who are trained are also equipped to provide services.

In addition to the central role abortion technologies play in the provision of services, availability of a range of contraceptive methods in the location where abortion-related care is provided is equally important. If a service delivery location providing abortion-related care is not located in a family planning clinic, typically, they do not receive commodity supplies through family planning distribution channels or only receive short-term methods. Advocacy and technical support are needed to ensure that the full range of contraceptive supplies is available wherever abortion services are provided.

4. Additional measures

While training and equipping of healthcare providers may be necessary, it is oftentimes not sufficient to ensure providers can put
knowledge and skills into practice. A whole range of additional interventions such as supportive supervision, quality improvement efforts, and job aids are also used to support provision of abortion services by trained providers. Summaries of clinical and programmatic experience and results of operations research document the results of efforts to improve access to and quality of postabortion care and abortion care services, including postabortion contraception, that draw on a range of interventions [17,25–27].

There is a significant effort underway in the healthcare field to better understand which interventions improve and sustain provider performance in low- to middle-income countries [28–30]. Evaluating the evidence for factors affecting healthcare provider performance is challenging given multifaceted interventions, the range of expected provider practices across different health outcomes, and different study designs. The use of results from systematic reviews can help to identify factors and potentially inform interventions to further support providers putting abortion skills into practice.

Given intensified efforts to reduce maternal mortality over the next 3 years, the following are specific additional measures and strategies to support providers to put abortion skills into practice.

4.1. Updating national abortion care standards and guidelines

Since the 2009 FIGO Congress, at least 11 countries have updated abortion-related standards and guidelines [31], oftentimes as part of systematic efforts to improve reproductive health or abortion services in a country, or in response to evolving evidence on medical abortion regimens for induced abortion and treatment of postabortion care. Ghana updated abortion care standards and guidelines in 2012, which are consistent with the new WHO guidance [32]. While updating and disseminating standards and guidelines is a necessary step to influencing provider practice, ensuring adherence to guidelines requires additional measures. Various approaches, such as dissemination workshops for program managers and providers, together with tools, such as checklists and job aids, can assist providers to translate guidelines into practice [33].

The recent update of WHO safe abortion guidance, in addition to updated clinical care, includes new information on global and regional abortion statistics, and service delivery and policy recommendations that are central to supporting abortion care providers’ ability to put skills into practice. Importantly, the updated WHO safe abortion guidance advances the human rights framework for abortion. Almost all countries in the world have an indication for abortion to save the life of the woman, or additionally, to protect the health of the woman, and/or in cases of rape or incest; yet these indications may not be reflected in national guidance. Release of the updated WHO guidance provides the opportunity for countries to ensure that national standards and guidelines specify provision of abortion for all legal indications. Even when laws are restrictive, the WHO guidance calls for those laws to be interpreted and implemented to promote and protect women’s health. Risk reduction and harm reduction strategies are proving to be an innovative approach for promoting and protecting women’s health in settings with restrictive abortion laws [34].

4.2. Integration of abortion with reproductive health programs

Integrating sexual and reproductive health programs to improve efficiency of service provision, improve health outcomes, and increase satisfaction of clients has been promoted as a health priority [35]. There are renewed efforts, through systematic reviews of existing studies, to understand the effects of adding one service onto an existing service, and linking or integrating reproductive and maternal health interventions [36,37]. The challenges of delivering vertical abortion services are familiar in the USA, where these services are often targeted by antiabortion groups and providers are stigmatized and harassed.

Because safe abortion, coupled with contraception as well as postabortion care, is effective for reducing abortion-related maternal deaths, it is logical for abortion programs to be integrated with other maternal health programs to reduce maternal mortality. Typically providers implementing these programs are one and the same. Also, for the woman who experiences contraceptive failure, her family planning provider is oftentimes the first point of contact. Ideally, the family planning provider should be able to respond to her needs and provide a safe abortion, or, at a minimum, have knowledge and skills to counsel and refer the woman.

A review of reductions in maternal mortality after liberalization of abortion laws and policies in South Africa, Romania, and Bangladesh identifies the importance of multifaceted and complementary reproductive health reform to achieving these results [38]. Programmatic efforts in Vietnam also utilized a strategy of providing comprehensive reproductive health services that resulted in improved quality of abortion care services and choice and quality of contraceptive services. However, HIV and sexually transmitted infection counseling was not consistently provided [39,40].

With emphasis on meeting MDG 5, efforts to increase skilled attendance at birth and to provide emergency obstetric and neonatal care (EmONC) should include postabortion care, postabortion contraception, and safe abortion for legal indications. Tools have been developed to monitor safe abortion care consistent with monitoring EmONC [41–44]. Nepal is one country that is integrating CAC within overall safe motherhood efforts. Provision of postabortion care with MVA is included in skilled birth attendant training for auxiliary nurse midwives. Since approval of mifepristone, auxiliary nurse midwives are receiving medical abortion training, as well. Given the significant geographic barriers to health service access in Nepal, CAC with medical abortion is now being decentralized to the health-post level, where infrastructure is limited for providing MVA services. Integration of safe abortion in broader maternal health efforts is one of the elements highlighted as contributing to the success of scaling-up abortion services in Nepal over a 10-year period [45].

4.3. Supporting abortion provision by midlevel cadres

Current evidence demonstrates that midlevel providers can acquire the knowledge and skills to provide safe abortion [46]. Use of midlevel providers for postabortion care treatment, safe abortion, and contraception allows more highly skilled providers to focus on specialized care. The International Confederation of Midwives has a policy statement supporting midwifery provision of abortion-related care and inclusion of abortion in core competencies [47,48].

The expanded role of nurse-midwives in implementation of the Termination of Pregnancy Act in South Africa was a contributing factor in the reduction in abortion-related maternal mortality [49], which was calculated to have dropped 91% between 1994 and 2001 after liberalization of the abortion law [50]. In Ethiopia, primarily midwives and nurses are trained to provide CAC in the first trimester. A study in India demonstrating that nurses can provide abortion as safely as physicians [51] is supporting legal and policy change efforts in India to expand who can provide abortion. Such a change has the potential to dramatically increase providers’ ability to meet women’s needs for comprehensive abortion care and contraception at the primary care level in India. Policy changes to promote task sharing with midlevel providers will help reach women with lifesaving abortion-related care and is critical for making further progress on MDG 5.

4.4. Advocacy for the Continuum of Care

The ability of providers to put abortion skills into practice is affected by the overall policy and enabling environment in which services are provided. Historically, policies and programs to reduce maternal
mortality have not adequately addressed the needs of millions of women for whom pregnancy is not desired and for whom birth is not an outcome. The Continuum of Care concept for reproductive, maternal, newborn, and child health (RMNCH) was recently expanded to include pregnancy prevention, safe abortion, and broader reproductive health interventions, and to address the needs of young women. The Continuum of Care concept suggests that a woman’s healthcare provider should be able to address her needs across her reproductive lifespan, or alternatively, help to coordinate care to ensure that the full spectrum of her needs is met. The following key documents reflect this expanded Continuum of Care. They can also serve as advocacy tools for adapting program strategies and mobilizing resources for provision of abortion services as part of broader RMNCH efforts:

• Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health [10].


• State of the World’s Midwifery Report: Healthy Women, Healthy Lives [52].

Consistent with recommendations in the Global Strategy, professional associations need to promote and hold governments and global partners accountable for implementing this full Continuum of Care.

5. Conclusion

While there have been significant gaps in addressing abortion as a cause of maternal death, the increased focus on meeting MDG 5 and commitments to the Global Strategy for Women’s and Children’s Health presents opportunities for better supporting providers to put abortion skills into practice. Updated WHO technical guidance for providing uterine evacuation with recommended methods further simplifies provision of abortion-related care, including contraception. Inclusion of technologies on recommended essential supply lists and capacity to project supplies will further ensure that providers have the reproductive health technologies required to serve women. Adoption and use of updated WHO abortion guidance at the country level, along with other interventions based on research and programmatic experience improving abortion-related care and the broader field of healthcare provider performance can provide additional support to optimize providers putting abortion skills into practice. Programmatic strategies, such as integration of abortion within broader reproductive and maternal health programs and expanding training and services through midlevel providers, will expand availability of services, potentially increase efficiency of services, and better serve women’s needs. Promotion of the expanded Continuum of Care concept will help to mobilize the reproductive health community to better address abortion. FIGO has played and continues to play a critical leadership role at a global and country level to ensure continued progress in reducing maternal mortality.

Conflict of interest

The author has no conflicts of interest to declare.

References


