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REPRODUCTIVE HEALTH

What can obstetrician/gynecologists do to support abortion access?

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ABSTRACT

Unsafe abortion causes approximately13% of all maternal deaths worldwide, with higher rates in areas where abortion access is restricted. Because safe abortion is so low risk, if all women who needed an abortion could access safe care, this rate would drop dramatically. As women's health providers and advocates, obstetrician/gynecologists can support abortion access. By delivering high-quality, evidence-based care ourselves, supporting other providers who perform abortion, helping women who access abortion in the community, providing second-trimester care, and improving contraceptive uptake, we can decrease morbidity and mortality from unsafe abortion.

1. Introduction

We are making progress in the global fight against maternal death. Recent estimates from WHO document a 45% decline in maternal deaths worldwide in the last two decades, from about 523 000 in 1990 to 289 000 in 2013 [1]. This trend reflects concerted attention by the international health community to achieve the Millennium Development Goals. Successful efforts have increased skilled birth attendance; improved prenatal, delivery, and postpartum care; increased contraceptive prevalence; and improved sexual and reproductive health services.

Unsafe abortion causes approximately13% of all maternal deaths worldwide, with higher rates in areas where abortion access is restricted [2]. Because safe abortion is so low risk, if all women who needed an abortion could access safe care, this rate would drop dramatically [2]. In high-resource regions, the death rate from safe, legal abortion is 0.7 per 100 000 cases. In contrast, the unsafe abortion death rate was estimated to be 520 per 100 000 procedures in Sub-Saharan Africa, 200 per 100 000 in south-central Asia, and 30 per 100 000 in Latin America as recently as 2008 [2].

In low-resource regions, 41% of unsafe abortions (nearly 9 million procedures) are among young women aged 15–24 years [3]. Young women are particularly likely to experience unwanted pregnancy and to seek abortion from unskilled providers. They are also more likely to delay seeking both abortion and treatment for resulting complications, significantly increasing their clinical risks [4].

As both healthcare providers and advocates for women, obstetrician/gynecologists have an important role in ensuring that all women and girls have access to comprehensive reproductive health care, including safe abortion. Effective strategies to increase access to safe abortion are available, affordable, and well known, but too few stakeholders prioritize—or even address—this critical issue. By supporting safe abortion in our clinical practice and beyond, we can significantly reduce a preventable cause of maternal mortality.

2. What can obstetrician/gynecologists do?

Obstetrician/gynecologists care for women throughout their life cycle, from adolescence through pregnancy and childbirth, to menopause. Unplanned pregnancy is common during the reproductive years; worldwide, an estimated 40% of all pregnancies are unintended [5]. Offering a full range of contraceptive options is part of our work and is as lifesaving a technology for obstetrician/gynecologists as cancer care or emergency obstetrics. Providing women with a method as soon as they request it, without unnecessary testing or requirements, can reduce the risk of unplanned pregnancy.

When a woman ends a pregnancy, obstetrician/gynecologists have a professional and moral obligation to assist in her care. FIGO's Resolution on Conscientious Objection [6] affirms our obligation to women who need abortion care. Even doctors who may have a personal objection to abortion must refer patients for services, provide timely care when referral is not possible and, in emergency situations, treat women regardless of their personal beliefs.

Beyond basic care, obstetrician/gynecologists may take a number of steps to improve abortion access and quality. Most simply, we can incorporate evidence-based abortion care into office practice and offer women a full range of contraceptive options as part of the abortion service. In addition, we can support nurses, midwives, and other health professionals to perform abortions, ensure that women who obtain medical abortion outside the health system can do so more safely, and

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expand our clinical practice to include second-trimester abortion care. Finally, obstetrician/gynecologists can bear witness to the impact of unsafe abortion and advocate for women's rights to safe care.

2.1. Offer women evidence-based, quality abortion care

Medical abortion (Box 1) and manual vacuum aspiration can be done safely, easily, inexpensively, and comfortably in the outpatient setting. Both WHO and FIGO recommend using medical abortion and vacuum aspiration rather than sharp curettage, which requires anesthesia, operating room time and resources, and carries increased risks to women [7,8].

When incorporating abortion into clinical practice, protocols need to remain updated. This is especially pertinent with medical abortion. Resources for updated clinical information include WHO's Reproductive Health Library (http://apps.who.int/rhl/en) and Ipas's Clinical Updates in Reproductive Health (www.ipas.org/clinicalupdates).

Staying current with protocols and regimens can be challenging, especially for practitioners working in low-resource or rural settings with limited internet access. Reaching remote providers is a priority for organizations concerned with maternal health outcomes. New avenues for disseminating evidence, including peer-to-peer support, clinical mentorship, and mobile networks need to be explored. For example, Ipas Nigeria piloted a text messaging service for trained uterine evacuation providers to keep them updated on current evidence and give them remote support. Over the course of a year, Ipas sent 50 to 77 text messages with clinical updates, support, and announcements to 163 providers. The messages were well received, with 90% of providers reporting that the messages influenced their patient care and 99% reporting that they wanted to continue receiving the messages.

Creating a safety culture in health care promotes teamwork, communication, evaluation, and learning from error. When a safety culture is in place, error reporting improves, adverse events are reduced, burnout decreases, and patients have better outcomes [10]. Quality improvement processes promote data tracking and use of quality indicators to improve patient safety and experience. While much work has occurred to define quality in other areas of health care, the definition of quality in abortion is still evolving. Abortion quality may include technical skills (for example, whether vacuum aspiration or medical abortions are used instead of sharp curettage) along with patient experience (for example, waiting times at the health center) [11]. Defining quality in abortion and then putting the processes in place to monitor and improve it can engage staff, increase safety, and improve women's satisfaction with care.

Box 1
Medical abortion in the first trimester (up to 12 weeks).

Mifepristone and misoprostol
Up to 9 weeks:
Mifepristone 200 mg orally followed in 24 − 48 hours by misoprostol 800 μg buccally, vaginally, or sublingually. Buccal misoprostol can be used from 9 to 10 weeks.

9 to 12 weeks:
Mifepristone 200 mg orally followed 36 to 48 hours later by misoprostol 800 μg vaginally then 400 μg vaginally or sublingually up to four further doses until expulsion of the products of conception.

Misoprostol only (when mifepristone is not available)
Up to 12 weeks:
Misoprostol 800 μg vaginally or sublingually every three but no more than 12 hours for up to three doses.
Source: WHO [7] and Winikoff et al. [9].

2.2. Support other abortion providers

Task-sharing, where mid-level clinicians deliver reproductive health interventions, improves women's access to care. WHO recommends that nurses, midwives, associate clinicians, and nonspecialist doctors give all types of reversible contraception, including intrauterine devices and implants [12]. In addition, first-trimester medical abortion and manual vacuum aspiration are provided as safely and effectively by nurses, nurse practitioners, midwives, and other health professionals as by doctors [13]. Expanding the provider pool gives women increased access and choice about whom they see when they need abortion. When other health professionals perform abortion, obstetrician/gynecologists can be a supportive referral partner for complex cases and women who present at more advanced gestations.

2.3. Support women who access abortion outside the health system

Women have long known about misoprostol's abortifacient effect and used it on their own to end unwanted pregnancies, especially in Latin America, where it has been linked to a decline in abortion-related morbidity and mortality from more harmful methods [14].

Pharmacists [15], women's groups, clinicians who deliver information in a harm-reduction model [16], and telemedicine or internet providers [17] assist women in accessing misoprostol outside the health system. More comprehensive research needs to be done to explore where women obtain drugs, how they determine eligibility and gestational age, what regimens and medications they use, and the success and complication rates of medical abortion outside the health system.

Supporting women who obtain medical abortion outside the health system is important for clinicians who work in areas where this practice is prevalent. Partnerships between clinicians and community providers can ease referrals to the health system for women who are not good candidates for community-based care or for women who experience complications.

Women who present to the health system with bleeding or incomplete abortion after self-induced or community-based abortion need safe, respectful, quality services. Treating women for complications of abortion or incomplete abortion, often known as postabortion care, is always permissible even if induced abortion is restricted [7].

Finally, understanding why at times women prefer community-based abortion even when legal services are available can help the health system improve to meet women's needs. Women may evaluate safety differently than obstetrician/gynecologists, preferring services where they are able to maintain privacy, avoid time off work or away from family, and prevent legal involvement in their decision to end a pregnancy even if the clinical risks of community-based treatment are unknown. Women may not know that they have a legal right to abortion. When clinics and hospitals create barriers for women through cost, abusive or judgmental handling, unnecessary or expensive testing, reporting, lack of confidentiality, or inconvenience, women will seek care elsewhere [18,19].

2.4. Provide second-trimester abortion

Abortions performed at over 12 weeks of gestation make up a relatively small proportion of cases in areas where safe abortion is easily accessible. However, where abortion is restricted, women have a higher likelihood of presenting in the second trimester, with presentation rates as high as 17% in Cambodia [20], 35% in Malawi [21], and 41% in Kenya [22]. Risk factors for second-trimester abortion include young age, financial hardship, domestic violence, and late recognition of pregnancy. Adolescents in particular are likely to present for care later in pregnancy [23,24]. Unsafe abortion in the second trimester disproportionately contributes to maternal morbidity and mortality from abortion, as these women are more likely to suffer severe complications and death [25].

Box 2
Medical abortion in the second trimester (12 to 24 weeks).

Mifepristone and misoprostol
Mifepristone 200 mg orally followed 36 − 48 hours later by misoprostol 800 μg vaginally then 400 μg vaginally or sublingually every three hours for up to four further doses.

Misoprostol only (when mifepristone is not available)
Misoprostol 400 μg vaginally or sublingually every three hours for up to five doses.
Source: WHO [7].

WHO recommends both dilation and evacuation and medical methods for second-trimester abortion. Dilation and evacuation requires specific training, specialized instruments, and an ongoing case volume to maintain skills. Alternatively, medical abortion using the WHO-recommended dose of mifepristone and misoprostol in the second trimester is highly effective, with complete expulsion rates of over 98% at 24 hours and 99% at 36 hours, and a median time to fetal expulsion of 6.25 hours [26]. Misoprostol alone is recommended when mifepristone is not available (Box 2).

Rarely, complications or failure may occur. Because second-trimester medical abortion complications are similar to obstetric emergencies (for example, hemorrhage or retained placenta), obstetrician/gynecologists and other obstetric providers already have the skills and knowledge to treat women. By expanding practice to include second-trimester medical abortion, obstetrician/gynecologists can provide a life-saving intervention using familiar skills.

2.5. Advocate for women's access to safe abortion

In addition to making changes to clinical practice, obstetrician/gynecologists can make invaluable contributions as advocates. Their first-hand experience caring for women makes them powerful witnesses to the harmful impact of restrictive abortion laws and the need for reform of both policies and practices. Because of their respected position in society, when doctors speak out, they influence their peers, the public, the media, and policymakers. When Dr Nozer Sheriar speaks to a global audience about why he performs abortion in India (https://www.youtube.com/watch?v=O6b6huiAOv4), or Dr Willie Parker testifies in front of the Senate Judiciary Committee to support legislation that protects abortion access in the USA (http://www.judiciary.senate.gov/imo/media/doc/07-15-14ParkerTestimony.pdf) their stories put a human face on the value of safe abortion.

In Ethiopia and Nepal, the support of national obstetrician/gynecologist associations contributed to successful abortion law reform and to development of clinical standards and guidelines to help clinicians apply the law. Professional associations in many countries contribute to FIGO's Initiative for the Prevention of Unsafe Abortion and its Consequences and implement the country-based action plans developed through the initiative. Other advocacy opportunities include serving on ministry of health advisory boards, mentoring medical students and trainees, conducting research, writing letters to the editor, visiting legislative offices, and serving as expert witnesses.

3. Conclusion

Whether telling our patients' stories, performing abortions ourselves, or supporting those who do, the obstetrician/gynecologist's role as advocates for women can profoundly affect the attitudes and practices that give women access to safe, respectful, high-quality care.

Conflict of interest

The authors have no conflicts of interest to declare.

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