Evidence-based practices can improve safety and timeliness of care for women needing safe termination of pregnancy

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[Correction added on 17 August 2016, after first online publication: the term 'abortion' has been changed to 'termination of pregnancy (TOP)' throughout the article'.]

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Even where legal grounds for providing safe termination of pregnancy (TOP) care exist, additional legal stipulations—such as the need for two or more healthcare providers to certify the need for pregnancy termination, national guidelines that contain non-evidence-based restrictions on the types of providers and the place where care can be provided, and poor provider attitudes—can act as additional barriers. Heller et al. (BJOG 2016; 123:1684–91) identify several such barriers in the context of rural Scotland. Here, as in similar settings, such barriers increase anxiety, stress, travel time and costs for the woman and lead to clinically significant delays or even denial of care if legal gestational limits are crossed in the process. The effects of such barriers are magnified in low- and middle-income countries, drive women to unsafe TOP and increase the likelihood of severe morbidity and mortality. As Bartlett et al. found when analysing 10 years of data from the USA (Bartlett et al. Obstet Gynecol 2004;103:729–37), the overall mortality rate from legal induced abortion is negligible (0.7 per 100 000 legal abortions). However, the risk increased exponentially by 38% per additional week of gestation, up to 8.9 per 100 000 for TOP performed at ≥21 weeks of gestation.

The earlier the TOP can take place, the more decentralised care can be. Current guidance from the World Health Organization (Health Worker Roles in providing safe abortion care. Geneva: World Health Organization; 2015) stipulates that mifepristone-misoprostol TOP up to 64 days pregnancy duration is an outpatient, primary-care level intervention, and after the initial consultation to determine medical eligibility, women can self-manage both medications outside the health facility and without direct supervision of a healthcare provider. Furthermore, women can self-assess completion of the medical TOP using simple check lists and low-sensitivity pregnancy tests, further reducing the need for multiple clinic visits. First-trimester medical TOP can be provided not only by specialist providers but also general practitioners, midwives, nurses and auxiliary nurse midwives. Expanding the provider base as well as identifying innovative approaches to providing women with accurate information and back-up care (e.g. approaches using telemedicine) need to be further explored as ways of reaching women in rural or remote areas.

Multiple visits for consultation, referral and laboratory investigations as seen in Heller et al. negate the scientific advances of moving to simpler, decentralised care without affording any increase in safety. Similarly, most women approaching the healthcare provider for TOP have already made their decision. Yet as in this study and elsewhere, many women must 'convince' their providers that their reasons are justified and providers often impose their own value judgements in acting as gatekeepers to access. Such attitudes and provider-imposed waiting periods cause unnecessary delays. It is important to put the woman’s needs at the centre of care, fully respecting her as an autonomous and competent decision-maker. Once the decision is made by the woman, TOP should be provided as soon as possible to do so (Safe abortion: technical and policy guidance for health systems. Geneva: World Health Organization; 2012).

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Disclosure of interests
None declared. Completed disclosure of interests form available to view online as supporting information.