Implementing And Expanding Safe Abortion Care: An International Comparative Case Study Of Six Countries

Study Objective

- To describe the health sectors' roles in the implementation or expansion of abortion services in Colombia, Ethiopia, Ghana, Portugal, South Africa, and Uruguay
- To describe key findings, remaining challenges, and lessons useful for other countries

Principal investigators:
Prof Wendy Chavkin, Global Doctors for Choice
Dr Mary Favier, Global Doctors for Choice

Funding: World Health Organisation

Conflicts of Interest: None

Publication: FIGO supplement Oct 2018

Methods

- Multiple case study methodology,
  - *in-depth analysis of each case*
  - *comparison of cases*
- Countries eligible for inclusion if they had reinterpreted or implemented new abortion laws or policies in past fifteen years
- Diverse geographic distribution of countries across the human development index
- Columbia, Uruguay, Ethiopia, Ghana, South Africa, Portugal.

Ethics Approval

- The WHO Research Ethics Review Committee approved this study
  - *No further review was required for Colombia, Ethiopia and Portugal*
- The Ghana Health Service Ethical Review Committee approved the protocol in Ghana
- The Ethics Committee, School of African and Gender Studies, Anthropology and Linguistics of the University of Cape Town approved the protocol in South Africa
- The Ethics Committee of the Faculty of Psychology of the Universidad de la República approved the protocol in Uruguay.

Data Collection

1. In-depth desk review of each country's health system and legal landscape related to abortion
2. With in-country partners, identified key stakeholders and experts in the field, conducted 1-2 hour in-country, semi-structured, in-depth interviews.
   - *We interviewed 8-13 respondents in each country*
   - *Interviewees included healthcare providers, public health and government officials, academics, and members of NGOs and advocacy groups.*

Limitations

- Selection bias in identification of interviewees
- Variable time intervals between actual implementation and time of interviews
- Limited exploration of legal and socioeconomic context

Findings: Context

- **Key finding: in all study countries a high proportion of maternal mortality could be attributed to unsafe abortion**
- Religion or religious groups associated with opposition in all countries

Findings: Framing Abortion Services

- Public health frame
  - *Harm reduction*
- Rights frame
  - *Human rights: right to health*
  - *Women's rights: autonomy, dignity*
- Integration into comprehensive reproductive health care bundle

Findings: Actors

- **Key finding: commitment by national-level (MoH/NHS) actors is critical**
- The key players were similar in all countries:
  - *The Ministry of Health (MOH)/National Health Service (NHS)*
  - *NGOs, UN orgs, and CSOs, in some countries they created or lead guidelines/training.*
  - *Physicians, other clinicians, and professional associations tended to be supportive*

Findings: Data and Monitoring

- **Key finding: data and monitoring facilitated implementation**
  - *Allows for trends to guide policy and implementation*
  - *Data demonstrates health impacts of law implementation, provides justification and support*
- In Ghana, data and evaluation key to improving provision, and in both Ghana and Portugal, to bolstering public support
- In Ethiopia, data on medication abortion led to expanded use

Data and Monitoring: Challenges

- In Uruguay and Ethiopia, MoH data collection considered to be insufficient and/or overly aggregated
  - *In Ethiopia data collection is supplemented by private sector and academic organizations*
- In South Africa, insufficient data collection, and related lack of monitoring and evaluation
- In Colombia, no initial monitoring plan, lack of procedure codes

Findings: Ensuring Initial Access

- Dept of Health/Min of Health buy-in
- Values clarification early and often
- Integrating abortion in to current RH services (with contraception)
- Activists/advocates staying involved after change in the law

Findings: Expanding Access

- Use of low technology procedures for first-trimester abortions
  - *MVA and medical abortion*
- Expanded categories of clinicians eligible to provide; task-shifting to non-physician cadres
- Public sector provision covered by insurance or with low copay

Findings: Continuing Concerns

- Remaining legal restrictions
- Misunderstanding/misinterpretation of the law
- Inadequate second trimester provision
- Conscientious objection/obstruction
- Provider and client stigma
- Cost of private provision
- Inadequate data and monitoring

Lessons Learned

- Public health framework works best and political will is key
- Focusing on low tech procedures facilitates scale-up of services
- Task shifting addresses human resource limitations
- Integrating abortion into existing services is most effective
- Monitoring and data collection must be included in initial implementation plan
- Conscientious objection remains a barrier to access despite regulation
- Access to abortion after the first trimester remains limited
- In some settings, barriers to access lead to the persistence of unsafe abortion

Implementing And Expanding Safe Abortion Care: An International Comparative Case Study Of Six Countries