Improving access to abortion care in high-income countries

SAM ROWLANDS

BOURNEMOUTH UNIVERSITY

WWW.SAMROWLANDS.NET

Non-legal barriers only

- Working within the existing framework of the law (usually criminal)
- Decriminalisation does not automatically sweep away all barriers: Canada and Australia (Australian Capital Territory, Victoria and Tasmania)

Responsibilities of health ministries

- Clarity is needed on precisely what the abortion law allows
- Otherwise criminal law has a ‘chilling effect’ on clinicians
- Health Ministries may need to clarify law and how it should be interpreted so there are no doubts about its meaning

Payment for abortion

- Exemptions or reimbursement needed in jurisdictions in which women pay for abortions
- The women of N Ireland pay for abortions even when carried out in other parts of the UK, whereas abortions are free to women of England, Wales and Scotland
- High costs of abortion result in self-induced abortions or resort to unsafe providers/conditions with costly hospitalisation for serious complications

Public funding for abortion

Funding system	Countries with liberal/liberally interpreted laws
Full funding	34
Partial funding	25
Funding only in exceptional cases	10
No funding	11
Total	**80**

Grossman et al Contraception 2016

Professional guidelines

- Clinicians feel more confident if they can follow an evidence-based guideline
- These can be disseminated international guidelines or ideally country-specific
- Guidelines that specify maximum acceptable waiting times between referral and assessment and assessment and treatment have a positive influence on local services
- Guidelines need to be kept up to date

Advocacy

- Clinicians can be powerful advocates for access to quality abortion services because of their first-hand experience of abortion care
- Formation of national provider groups e.g. British Society of Abortion Care Providers www.bsacp.org.uk

Information about services

- Wide dissemination needed to ensure choice for women
- Media should include websites, telephone directories, public libraries, pharmacies, GP premises

Choice

- Hospital or community services
- Ideally both medical and surgical methods should be available up to the gestational limit that applies in a particular jurisdiction

Shift to community care

- First trimester abortions (medical and surgical) can be safely provided for most women outside a hospital setting
- General practitioners provide abortions in France, Switzerland and the Netherlands
- Services provided by community sexual and reproductive health teams in Great Britain, not by OB/GYN
- Beware hospital staff becoming deskilled

Central booking systems

- A single telephone number can be regional or even national
- Direct access (self-referral) avoids delays
- Operators can perform triage after asking about any medical history
- Choice of appointments can be offered

Rural areas

- Treatment should be as close to home as possible
- Remote parts of Australia, New Zealand and Canada
- Canadian women can travel up to 1000 km
- No abortions on Prince Edward Island 1986 – 2016 (nearest clinic 330 km away)
- Young, indigenous and poor disproportionately affected
- Telemedicine
  - Full remote medical consultation (woman in distant clinic or at home)
  - Internet-based screening and drugs by post (Women on Web and Women Help Women)

Care pathways

- Seamless pathways are needed so that women's journeys are unimpeded
- Bypass needed around GP referral (one quarter of GPs do not refer for abortion)
- Second-trimester service provision has implications for clinician training and maintenance of skills
- Provision is needed for special arrangements for women with complex medical conditions who cannot be treated in free-standing clinics

Mid-level providers

- Non-doctors can provide medical and surgical abortion
- This is safe and highly acceptable to women
- Task-sharing allows women more choice, is highly acceptable to women and saves money
- Laws limit what MLPs can do in many countries

Facilities/equipment

- Clinical space: free-standing clinics have many benefits
- Surgical equipment (manual vacuum aspiration needs minimal equipment)
- Ultrasound scanning – not routinely required
- Hospitals: in some jurisdictions Catholic hospitals are permitted to refuse to offer abortion services
- Drugs (mifepristone licensed in only 62/196 countries – first available 1988; cost variable)
- Competent personnel

Conscientious objection

- Freedom of thought, conscience and religion is a fundamental human right for clinicians
- Widespread abuse of right to CO
- Unregulated CO is detrimental to pregnant women
- Situation needs monitoring in each Region
- Good example of regulation of CO is Norway: ensures availability of willing and able providers

Support women who access abortion outside the health system

- Information, support and clinical care needed in jurisdictions in which self-administered abortion is prevalent
- Harm-reduction model first introduced in Uruguay
- Respectful, quality services for women who present with complications after self-induced or community-based abortions

References

- Doran F, Nancarrow S. Barriers and facilitators of access to first trimester abortion services for women in the developed world: a systematic review. J Fam Plann & RHC 2015; 41: 170-180.
- Rowlands S, López-Arregui E. How health services can improve access to abortion. Eur J Contraception & RHC 2016; 21: 1-3.