

AVERTING MATERNAL DEATH

Safe care for termination of pregnancy on request



Why is safe abortion care a medical issue?

When a woman or girl is determined to end her pregnancy, she seeks out an abortion regardless of the safety and legality of the procedure. Where safe abortion care is not available, she will risk her life to terminate the pregnancy, often because the alternative is unbearable (not being able to care for any other children, rejection, shame, repercussions for the family). When complications occur as a result of unsafe abortion, there is reluctance to seek professional help and to explain what has happened. The main complications resulting from unsafe abortion are severe bleeding, infection, peritonitis, trauma to the vagina and uterus, and death. Unsafe abortion can also result in long-term consequences for future pregnancies, infertility being one of them.

In the developing world, 56% of all abortions are unsafe,¹ compared with just 6% in the developed world, and this rises to 97% in Africa [see box overleaf].² This is what makes access to safe abortion care an urgent public health issue. That said, the mortality rates for unsafe abortion are underestimated; women and service providers are not willing to report it. In consequence the need for safe abortion care, while known, tends to be downplayed. The large part of the problem related to unsafe abortion is hidden ... women and girls die in silence, in shame and alone.

¹ It is estimated that 22 million unsafe abortions are performed yearly and that 47,000 women and girls die yearly as a consequence of unsafe abortion, and another 5 million sustain disabilities (WHO 2012).

Where safe services are available, deaths from abortion are greatly reduced. After South Africa liberalised its abortion law in 1996, studies found that related maternal deaths were reduced by 91% by 2000, and that the number of women suffering from infection resulting from unsafe abortion had halved over the same period. When the anti-abortion law was abolished in Romania in 1989, maternal mortality rates halved within a year.

Médecins Sans Frontières (MSF) aims to reduce death and suffering amongst people affected by conflict and crisis. The organisation is committed to addressing all the main causes of maternal death, including unsafe abortion [see box below]. However, while all MSF maternities and emergency rooms treat women and girls who present with complications of unsafe abortion, few projects offer an adequate response to women and girls who ask for an abortion. They are sent away without the appropriate care. Many will find a local solution and subsequently suffer life-threatening complications from unsafe abortion, but only a small number will have the courage to come back to MSF for treatment. This needs to change. The risk of unsafe abortion is known and can be entirely prevented by providing safe and timely care.



In 2013, 289,000 women died from preventable causes related to pregnancy and childbirth—that's 800/day.²

99% of all maternal deaths occur in developing countries.

Nearly 75% of all maternal deaths are due to:

- o Post-partum haemorrhage (severe bleeding after childbirth)
- o Infections
- o High blood pressure (pre-eclampsia and eclampsia)
- o Complications from unsafe abortion
- o Complications from delivery.

What makes termination of pregnancy a neglected need?

Preventing death and suffering from unsafe abortion involves three main actions: the provision of contraception to avoid unwanted pregnancy, the provision of safe termination, and care for abortion-related complications. However, in

TERMINOLOGY

There are different terms and common understandings of terms related to abortion. It is important to clarify them.

ABORTION

Expulsion of the products of conception from the uterus before the foetus is viable; either spontaneously (*miscarriage*) or as a result of a deliberate intervention (*induced abortion/termination of pregnancy*).

Note: The term "abortion" is often used when people refer to termination of pregnancy on request.

TERMINATION OF PREGNANCY and INDUCED ABORTION are synonymous.

Deliberate intervention to end pregnancy either for medical reasons (health of the mother, foetal malformations, etc) or any other reason that motivates a woman or girl to request termination of a pregnancy (*termination of pregnancy on request-TPR*).

UNSAFE ABORTION

Procedure for terminating unintended pregnancy by people lacking the necessary skills and in an environment that does not conform to minimal medical standards.

POST ABORTION CARE

Treatment of complications resulting from miscarriage or an abortion. The majority of post abortion complications are known to result from unsafe abortions. Post abortion care includes the offer of contraceptives.

SAFE ABORTION CARE

Procedure for terminating unintended pregnancy by skilled medical staff in an environment that conforms to medical standards.

Note: Commonly understood to cover (1) management of abortion related complications (2) termination of pregnancy on request and (3) provision of contraceptives as part of post-abortion care.

many contexts women and girls face significant barriers in accessing care that is sensitive to these needs. These barriers may be in the form of lack of services, or religious, cultural or socio-economic constraints, or stigma. Gaps in the health system may mean that the necessary care is not available or is withheld; or, it may be priced out of the woman's reach. The more affluent are more likely to find safe abortion care (because they can afford to travel to a foreign country or access a quality private practice).

What is MSF policy on termination of pregnancy on request?

MSF responds to the life-preserving needs of people. As a medical-humanitarian organisation working in contexts where the population is threatened, deprived of healthcare and where mortality is high, MSF can make access to safe abortion care available – a measure that can dramatically reduce maternal mortality.

Our own field experience is at the origin of this commitment. Every day we see women dying from consequences of unsafe abortion, knowing that these deaths could have been prevented. Termination can either be provided by MSF staff or MSF can ensure that the woman receives the necessary care from a quality provider that MSF has validated for this purpose.

MSF's International Council (IC) passed a resolution to this effect in 2004, as a formal step in recognising the needs, and establishing a framework to support staff and patients. "The availability of safe abortion should be integrated as a part of reproductive health care in all contexts where it is relevant ... MSF's role in termination of pregnancy must be based on the medical and human needs of our patients."

Despite established policies and protocols, guidance to the field and staff training, and making the appropriate equipment available, implementation of safe termination has lagged in MSF's projects [see box overleaf].

In many regions of the world, unsafe abortions vastly outnumber safe abortions.³ It is estimated that the proportion of abortions that are unsafe is:

- o 97% in Africa
- o 95% in Latin America
- o 65% in south central Asia
- o 60% in western Asia.

In the developed world 6% of abortions are unsafe.

Concerned by the limited scope of action, in 2012 the International Board (IB) stated that “unsafe abortion and unwanted pregnancy contribute significantly to the burden of ill health, suffering and maternal mortality in contexts where we work.” Not responding to requests for termination of pregnancy means recognising that women and girls may have to opt for a potentially unsafe alternative to address their need – this is unacceptable for a medical organisation.

Please consult your medical referent for further details of the policy if you do not already have the information.

How does MSF approach implementation?

The need for safe abortion care is present in all contexts where MSF works. The aim for the future is to ensure that MSF has the capacity to respond to these needs in all relevant projects and that women or girls in need are not turned away.

As with any medical act undertaken by MSF health workers, MSF strives to ensure quality of care. Quality of care requires staff training; clear directives in terms of policy, guidelines and protocols; validated drugs; good quality medical materials; high standards of hygiene; and adequate patient information and consent.

In MSF projects, termination of pregnancy on request is generally supported until the end of the first trimester. For later gestational age it is considered on a case-by-case basis, and will require access (can be by referral) to a facility with surgical capacity to handle any potential complication.

Termination of pregnancy using quality drugs and the correct techniques, carried out by skilled attendants in sanitary conditions, is safe and can be implemented at basic maternity level. International data shows adverse effects in 0.65% of medical abortions (induced by abortive drugs) and practically no mortality;⁴ for surgical abortion the risk is shown to be similar to that of a penicillin injection.

Modern medical science moves increasingly towards less invasive abortion methods with lower risks, such as manual vacuum aspiration and medical abortion. MSF guidance recommends the use of these.

Termination of pregnancy is coupled with counselling for the woman or girl, and provision of contraceptives. The request must be based on informed choice, and MSF staff must also ensure patient confidentiality at all times.

Details are available in MSF's 2015 Essential obstetric and newborn care guidelines. Please consult your medical referent if you need further guidance.

In 2013, in 122 projects, MSF assisted 182,000 deliveries and over 17,000 caesarean sections.

Since 2007 the number of obstetric projects has changed little, but MSF teams are now caring for more than double the number of women.

Conversely, between 2007 and 2013, the number of projects reporting on termination of pregnancy on request dropped significantly. In 2013, only 1 in 5 projects offering sexual violence care and 30% of projects offering obstetric care reported the capacity to respond to requests for termination of pregnancy.

How does MSF deal with legal considerations?

There are very few countries (total 6) where termination of pregnancy is completely illegal. None of them are in Africa or Asia.⁵ In 97% of the world's countries, abortion is permitted when it is necessary to save a woman's life and in 60% it is permitted to safeguard women's health.

In many contexts where MSF works the legal framework limits termination of pregnancy on request, but allows for termination of pregnancy for medical reasons, to protect the women's physical and mental health. It is commonly admitted that justification based on health also applies to pregnancies of young minors. Over half of the world's countries allow termination of pregnancy resulting from rape and/or incest.

In practically all contexts there are various legal possibilities regarding termination of pregnancy depending on how the law and other directives are interpreted, enforced, and what is practised. Adherence and application are also influenced by community perceptions and acceptance.

What we do know generally is that:

- Legally restricting abortion does not reduce the number of abortions that occur in a country.
- The liberalisation of abortion (e.g. in South Africa and Romania) results in a decrease in abortion related mortality.
- Legal status and availability of services affect the safety of abortion. Where abortion is legal and safe services are available, deaths from disability and abortion are greatly reduced.

The law should not deter MSF and the teams in the field. Rather, MSF teams have to understand how they can work,

taking into account the possibilities of the national legal frame and the best interest for the patient. Logically, to best understand the context, an analysis should be undertaken at country and project level including: legal provisions and their common interpretation; perception amongst the community and health staff; and an assessment of any existing services providing safe abortion care, which could also be considered for the referral of patients. MSF's mission and field coordination teams are instrumental to this assessment, which will guide field teams in framing the right space and process for providing women with the safe and timely abortion care they need. How to implement safe abortion care will be decided on a context by context basis. There is not one model that fits all countries or all MSF projects.

Importantly for MSF and the teams in the field, the legal context cannot serve as a general argument to refuse implementation of safe abortion. This argument is always proof of a poor understanding of existing provisions and places the importance of "medical necessity" below other considerations. When women are forced to resort to clandestine providers, they are not protected: there are no rules regarding hygiene conditions, quality of care or price. Abortion in these circumstances leads to higher rates of complications and death. Preventing this can be considered life-saving action.

Safe abortion care is an obvious and neglected medical need. MSF should not shy away from addressing it just because it is challenging.

What does this mean for MSF staff?

It is not MSF's role to judge a woman's motivation in seeking termination of pregnancy; it is MSF's role to make safe medical care available in order to reduce mortality and suffering. The attitude of all MSF staff needs to reflect this.

If a woman or girl requests a termination of pregnancy, the first responsibility of all MSF staff is to respect her reason for coming and her courage in seeking safe care. The second responsibility is to ensure that she can discuss her request with a medical person, who can provide all information necessary to allow her to take an informed decision. The third responsibility is to provide quality medical care. All MSF staff need to contribute to MSF's capacity to make safe care available, regardless of personal convictions.

Women and girls may not be aware that they can approach MSF for termination of pregnancy. In dialogue with

authorities and communities it is the responsibility of MSF staff to underline concerns related to the main causes of maternal mortality, including those relating to unsafe abortion. National staff need to be aware of MSF's policy regarding reproductive health and sexual violence care, including the organisation's attitude to termination of pregnancy on request. In most places the responsibility for providing safe abortion care will remain with international staff, but the commitment to making it available and accessible to women and girls in need involves everyone in the organisation.

Contact your medical referent for further details or if you want to discuss the policy further.

MSF has three documents available for your reference.

- o MSF policy *Reproductive health and sexual violence care*
- o *Context analysis for implementation of safe abortion care*
- o *Essential obstetrics and newborn care, 2015 edition*

References

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MÉDECINS SANS FRONTIÈRES INTERNATIONAL

78, rue de Lausanne 1202 Geneva, Switzerland

email: womenshealth-IO.GVA@geneva.msf.org