PROVISION OF SAFE ABORTION CARE:
a multicentre descriptive mixed-methods analysis, MSF OCB 2018-2020

Ann Van Haver[1]*, Daphne Lagrou[1], Rafael Van den Bergh[1], Margo Lynen[2], Marta Vaquero[3], Asil Sidahmed[1], Marc Biot[1], Catherine Van Overloop[1], Katie Whitehouse[1]

[1]MSF, Brussels, Belgium; [2]Institute of Tropical Medicine, Antwerp, Belgium; [3]Université Libre de Bruxelles, Brussels, Belgium
* Primary investigator and corresponding author Ann.Van.Haver@brussels.msf.org

INTRODUCTION

Despite a 43.9% reduction of maternal mortality globally between 1990-2015, unsafe abortion persists.

EVERY YEAR UNSAFE ABORTION LEADS TO AT LEAST :

22 800 Deaths

7 million Hospitalizations

Source: Guttmacher Intstitute

MSF endorses a comprehensive approach to unwanted pregnancies.

However, significant internal and external barriers limit the availability of Safe Abortion Care (SAC) in a diverse portfolio of MSF projects.

RESEARCH OBJECTIVES

To explore and describe MSF OCB's experience in providing SAC, including trends, different modalities of provision, human resource challenges and adapted solutions in different contexts.

METHODS

A multi-centric mixed-methods study design was selected, with three sequential phases:

1. Document analysis to review implementation models and critical events over time.
2. Retrospective analyses of routinely collected data from 2018-19 to highlight major trends in service provision.
3. Key informant interviews explored experiences of providers to design, implement and stabilize SAC.

The study protocol was approved by MSFs Ethics Review Board (ID 1973).

RESULTS

KEY TRENDS AND ACHIEVEMENTS

Retrospective analysis of data revealed a steady increase of SAC provision from 2018-19.

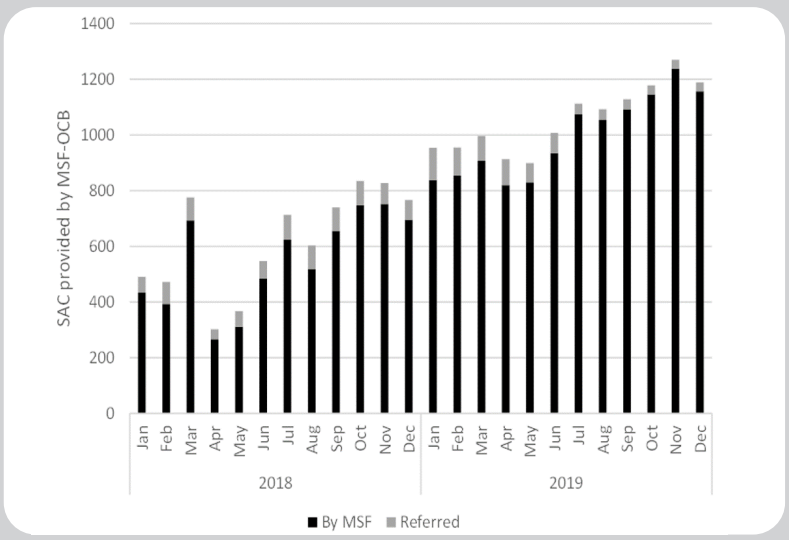

Figure 1: MSF OCB SAC provision by month, 2018 – 2019.

The gestational age limit for SAC applied by projects was dependent on the availability of health care structures and individual willingness or acceptance more than other elements. More than half of women requesting SAC during the second trimester did not receive the service.

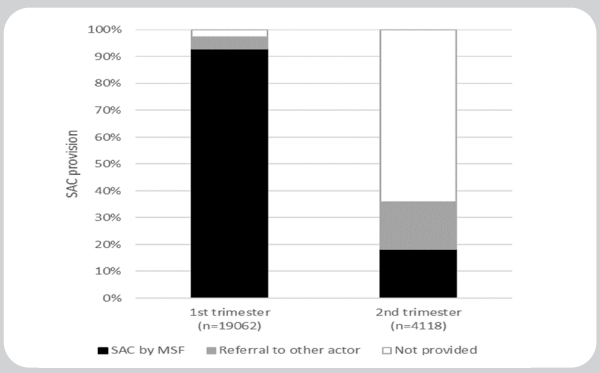

Figure 2: proportion of SAC provided, referred or not provided by gestational age amongst women requesting SAC in MSF OCB projects, in 2018 and 2019.

MODELS OF CARE

SAC models commonly included facility-based counselling, self-administration of pills and home-based expulsion.

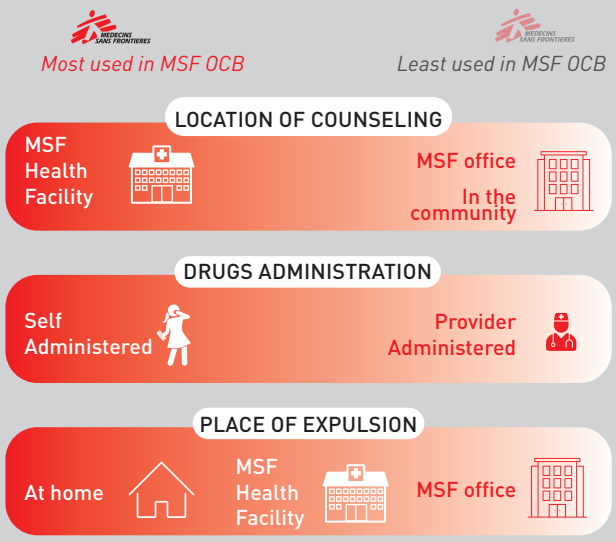

Figure 3: Components of and options within models of care for SAC identified in MSF OCB.

Highly similar models of care were applied by project regardless of different national legal frameworks or restrictions.

HUMAN RESOURCES FOR HEALTH

The majority of SAC was provided by international midwives, with national colleagues providing translation

Key informants identified that suitable profiles for SAC provision included national midwives, as well as community health workers, pharmacists and anyone with adequate training.

"Anyone can provide, as long as they are trained"

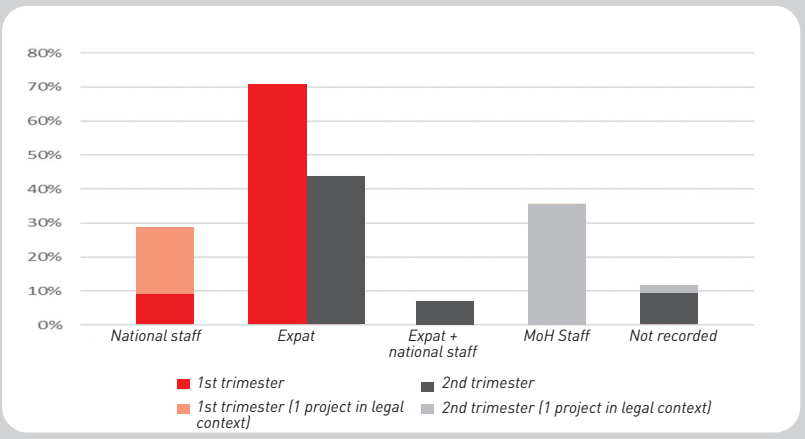

Figure 4: Breakdown of provider profiles for first and second trimester SAC provided by MSF OCB, 2018 – 2019.

CONCLUSIONS AND RECOMMENDATIONS

A consolidation of experience and confidence in implementing SAC services has occurred, with further room to diversify the models of care.

1. **SELF MANAGED ABORTIONS IS A GAME-CHANGING APPROACH, REPRESENTING BOTH AN EFFICIENCY OPPORTUNITY, AS WELL ENSURING GREATER ACCESS TO AND CONTROL OVER ABORTIONS BY WOMEN:** → Encourage the development and implementation of innovative models of care for SAC.
2. **NATIONAL STAFF HAVE THE POTENTIAL TO BECOME THE HR BACKBONE OF SAC SERVICES:** → For consistent provision, give national colleagues the choice and opportunities to provide SAC.
3. **STANDARDIZING 2ND TRIMESTER ABORTIONS IN ALL PROJECTS CURRENTLY PROVIDING SAC:** → Bolster confidence and capacity concretely through guidelines, trainings and field visits.

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