Check for updates

DOI: 10.1363/psrh.12209

ARTICLE

PERSPECTIVES on Sexual and Reproductive Health

Catalyst for change: Lessons learned from overcoming barriers to providing safe abortion care in Médecins Sans Frontières projects

Manisha Kumar[1] | Catrin Schulte-Hillen[2] | Eva De Plecker[3] | Ann Van Haver[3] | Sonia Guinovart Marques[4] | Maura Daly[1] | Hilde Vochten[3] | Lisa Merzaghi[5] | Brice de le Vingne[3] | Jean François Saint-Sauveur[4]

[1]Médecins Sans Frontières, Operational Centre Amsterdam, Amsterdam, Netherlands

[2]Médecins Sans Frontières, International Office, Geneva, Switzerland

[3]Médecins Sans Frontières, Operational Centre Brussels, Brussels, Belgium

[4]Médecins Sans Frontières, Operational Centre Barcelona, Barcelona, Spain

[5]Médecins Sans Frontières, Operational Centre Geneva, Geneva, Switzerland

Correspondence
Manisha Kumar, Médecins Sans Frontières Holland, Plantage Middenlaan 14, 1018 DD Amsterdam, Netherlands.
Email: manishakumar@gmail.com

Abstract

Context: Despite instituting a policy in 2004, Médecins Sans Frontières (MSF) continuously struggled to routinely provide safe abortion care (SAC). In 2016, the organization launched an initiative aimed at increasing availability of SAC in MSF projects and increasing understanding of abortion-related dynamics in humanitarian settings.

Methodology: From March 2017 to April 2018, MSF staff conducted support visits to 10 projects in a country in sub-Saharan Africa. Each visit followed a systematic approach with six key components and related tools that were later shared with teams worldwide. Data regarding women seeking abortion services and related outcomes were collected and analyzed retrospectively.

Results: From Q1 2017 through Q4 2019, SAC provision increased significantly in all 10 projects, rising from three to 759 safe abortions per quarter. Teams received 3831 patients seeking SAC and provided 3640 first and second trimester abortions, over 99% via medication methods. The overall complication rate was 4.29% and 0.3% for severe, life-threatening complications. No major security incidents were reported. MSF provision of SAC worldwide increased from 781 in 2016 (the year before this initiative began) to 21,546 in 2019.

Conclusion: Implementation of SAC in humanitarian settings—even those with significant legal restrictions—is possible and necessary. Both first and second trimester medication abortion can be safely and effectively provided through both home- and facility-based models of care. Programmatic data provide valuable insights into abortion-related dynamics which must shape operational decision-making. Addressing internal barriers and providing direct field support were key to stimulating organizational cultural change.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.
© 2022 The Authors. *Perspectives on Sexual and Reproductive Health* published by Wiley Periodicals LLC on behalf of University of Ottawa.

INTRODUCTION

The overwhelming majority (94%) of maternal deaths take place in low- or middle-income countries, with over half occurring in countries affected by conflict, displacement, or natural disasters.[1,2] Unsafe abortion is one of the top five causes of this mortality, responsible for at least 22,800 deaths annually and likely many more that remain unreported.[3,4] Beyond these deaths, each year an estimated 7 million women are treated for complications from unsafe abortion and many suffer life-long consequences and disability.[5] Yet death and suffering from unsafe abortion are almost entirely preventable via timely access to contraception and safe abortion care (SAC).

Despite the magnitude of the problem and the existence of well-known solutions, the availability of SAC in humanitarian contexts has remained very limited. A 2013 global assessment of sexual and reproductive health (SRH) services in humanitarian settings revealed that SAC was unavailable in all the evaluated facilities.[6] Key reasons cited by humanitarian organizations for not providing SAC include: (1) there is no need; (2) abortion is illegal in these settings; (3) donors are not willing to fund abortion services; and (4) abortion is too complicated to provide during acute emergencies.[7]

Médecins Sans Frontières (MSF) is a medical humanitarian organization that has long witnessed first-hand the maternal death and suffering which result from unwanted pregnancies and unsafe abortions. In 2019 alone, MSF teams treated over 25,800 women and girls presenting with abortion-related complications, including hemorrhage, infection, and uterine perforation, most of which were likely due to unsafe abortions.[8]

The need for greater access to SAC in humanitarian settings was formally recognized by MSF more than a decade ago. In 2004, MSF's International Council made a formal policy declaration that "*the availability of safe abortion care should be integrated as a part of reproductive health care in all contexts where it is relevant*."[9] However, this intention did not translate into action: in subsequent years, MSF, like many other humanitarian organizations, still did not routinely provide SAC as part of its medical care. Few staff did, however, provide it sporadically, often dependent on the initiative of an individual committed staff member but without dialogue or support from colleagues or managers and therefore subject to staff turnover. As a result, women and girls were largely denied access to this potentially life-saving health service in most MSF projects around the world.

From 2013 to 2015, MSF conducted multiple internal assessments to understand better what accounted for this failure to provide SAC. These assessments revealed that internal resistance—including social and cultural norms, personal values and attitudes, concerns regarding staff safety and security, and myths and misperceptions around abortion—was one of the main contributors and that dialogue within the organization was sorely needed. Arguments made by staff at all levels of the organization for not providing SAC echoed those mentioned above, such as "there is no need," "it is too complicated," "it's not the organization's role," and "it will put the project in danger."

In 2015, MSF's reproductive health and sexual violence care advisors proposed a 2-year Task Force initiative as a practical means to move from SAC policy to action. The working hypotheses of the Task Force were that: (1) addressing internal barriers and providing direct project support in a specific region would lead to increased SAC provision in that context; and (2) experience gained in these settings would catalyze change throughout MSF and lead to increased SAC in our operations worldwide.

In this paper, we describe the systematic approach of the Task Force and present the outcomes from this initiative in terms of its impact on SAC provision at 10 pilot sites and more generally across all MSF projects. We then analyze programmatic data to gain insight into abortion-related dynamics in humanitarian settings, including who seeks safe abortion services, safety and efficacy of medication abortion in the first and second trimester, frequency and severity of related security incidents, and populations at risk for exclusion from care.

METHODOLOGY

Setting

MSF's reproductive health and sexual violence advisors selected a country in sub-Saharan African for project support based on relevance and medical need, as indicated by the high volume of MSF-supported sexual and reproductive health activities, and the low volume of SAC provided by MSF and other health actors. Another criterion for country selection was the existence of a restrictive legal framework, so that the approach and outcomes could be relevant to other countries with minimal legal provision for abortion. The country is not named here to mitigate legal or security consequences from this publication for patients and staff and to preserve our capacity to continue assisting the population.

For over 35 years MSF, along with other actors, has provided medical humanitarian assistance in the selected country to address the health needs and high rates of mortality and morbidity. Most of our projects in this country are in rural areas affected by decades of protracted conflict, resulting in frequent population displacements, widespread poverty, and violence against civilians. Ten existing projects providing reproductive health and/or sexual violence care services in this country were selected for support. Prior to the Task Force, all 10 projects reported receiving women seeking SAC, but none systematically provided that care.

Components of the Task Force intervention package

MSF's medical and operational directors approved the Task Force proposal in October 2016 and agreed to oversee activities and manage any related tensions. Improving access to SAC was therefore made an organizational priority with full acknowledgment of the subject's political relevance and potential contribution to global change.

From March 2017 to April 2018, an in-country coordinator organized project support visits to each pilot site. Visits were 2–3 weeks

19312393, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1363/psrh.12209 by Test, Wiley Online Library on [19/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

in duration and utilized a systematic approach to address barriers in six areas through the specific intervention components described below, with a preliminary package of tools created for implementing each component. During the visits, staff feedback helped refine these tools and develop additional ones. In this way, the Task Force process was dynamic, iterative, and collaborative. After project visits ended, the Task Force provided follow-up support remotely from May 2018 through 2019.

The intervention package comprises six components.

Exploring values and attitudes

To begin addressing internal resistance to providing SAC, MSF created the Exploring Values and Attitudes workshop. The Exploring Values and Attitudes workshop is an interactive one-day workshop where participants reflect upon, question, and affirm their values and attitudes about abortion. It is based on the Values Clarification and Attitude Transformation (VCAT) workshop developed by Ipas, a non-governmental organization focused on expanding access to abortion and contraception.[10] A recent study of outcomes from several hundred Ipas VCAT workshops in over 12 countries documented significant shifts among participants in knowledge, attitudes, and intention to provide, support, and advocate for SAC.[11] In 2016, MSF entered into a collaboration with Ipas to learn from and adapt their VCAT methodology for the contexts where we work.

Clinical trainings

We developed trainings for three main topics: contraception; post-abortion care (PAC), including manual vacuum aspiration (MVA); and medication abortion, using the safe abortion procedures described below. Trainings included both theoretical elements and hands-on practice with mannequins and/or role-plays.

Discussions with local stakeholders

The project team organized discussion with key interlocutors they identified in their context (e.g., Ministry of Health [MoH] officials, community leaders). A total of 14 meetings with 47 stakeholders were held across the 10 projects; the project team held two additional meetings at capital level (see Table 2). Due to the restrictive legal context, we used an indirect, public health approach rather than directly discussing the provision of SAC, which would have both exposed the organization and put the interlocutors in a difficult position. Staff introduced MSF's general activities in the region, explained our focus on reproductive health, and then drew attention to the problem of maternal death and suffering due to unsafe abortion. The project team asked stakeholders for their insights into the local dynamics of this issue and what they thought should be done to address the problem.

Threat and risk assessment

During the visit, the project team was guided through a project-specific security assessment. This was based on a template threat and risk assessment for SAC provision, developed using MSF's standard approach to security management: identification of threats, assessment of vulnerabilities, likelihood and impact of each, and elaboration of mitigation and contingency measures. This template served as the basis for discussion and was adapted to each project's unique circumstances.

Implementation planning

At the end of the visit, teams developed a SAC implementation plan with systematic examination of issues such as the patient circuit, staff roles and responsibilities, supplies, etc. SAC was provided mainly on an outpatient basis by midwives and nurses, without routine blood tests or ultrasound, in line with guidance from the World Health Organization (WHO).

Data collection and analysis

To assess the understanding and support of MSF project staff for provision of SAC, we conducted an anonymous written survey of Exploring Values and Attitudes workshop participants before and after the event. The project team collected data related to people seeking SAC at the pilot sites—including patient demographics, provision versus refusal of care, abortion method provided, medical complications, and security incidents—through a standardized, anonymized, electronic register. The register was password-protected and accessible only to staff involved in SAC provision. It was also based on patient ID number, which allowed staff to enter data from follow-up visits. Since routine follow-up appointments were not required, medical complications were only reported if the patient returned with a problem or concern. We then analyzed these patient data retrospectively using basic mathematical formulas (subsets of patients as percentages of the total). We used Pearsons chi-square to compare subsets of the total cohort in terms of patient age and gestational age.

Medical protocols for SAC

Staff estimated gestational age using last menstrual period and confirmed with physical exam when needed. Where MVA was available, patients in the first trimester were given the option of medication abortion or MVA.

Medication abortion was provided via the protocols described in Table 1. While routine follow-up was not mandatory, we informed all patients that they could return at any time with any questions or concerns.

19312393, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1363/psrh.12209 by Test, Wiley Online Library on [19/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

RESULTS

Implementation of the intervention package

Table 2 summarizes the implementation activities conducted at the 10 pilot sites and the numbers and staff roles of participants. The key activity that started each pilot site visit was the Exploring Values and Attitudes workshop. During the Task Force visits, a total of 40 Exploring Values and Attitudes workshops were organized for 746 staff and took place both at project sites and in the capital. Pre- and post-surveys of participants revealed a significant increase in support for and understanding of SAC provision in MSF projects (see Figure 1).

TABLE 1 Protocols for medication abortion during first and second trimester

	Medication protocol
Gestational age less than 13 weeks	Mifepristone 200 mg orally 1–2 days later: Misoprostol 800mcg sublingually Repeat dose of misoprostol 800mcg sublingually if needed If mifepristone was not available, then take misoprostol 800mcg sublingually every 3 hours for 3 doses. Mifepristone is usually taken at the clinic but can also be taken at home. Misoprostol is taken at home
Gestational age between 13 and 22 weeks	Mifepristone 200 mg orally 1–2 days later: misoprostol 400mcg every 3 hours until expulsion If mifepristone was not available, then misoprostol 400mcg sublingually every 3 hours until expulsion MSF guidance recommends facility-based care but allows outpatient or home-based management and self-administration of medications if desired by patient

Prior to the workshop, less than 50% of MSF staff agreed or strongly agreed that they support SAC provision; after the workshop, this figure increased to over 80%. Clinical trainings conducted with hundreds of staff during these visits focused on contraception care, provision of medication abortions and post-abortion care, while community engagement initiatives involved a total of 47 MoH workers and community leaders across all pilot sites (see Table 2).

Characterization of patients and care provided from the pilot sites

Characteristics of patients seeking SAC

From January 2017 to December 2019, teams in the 10 pilot projects reported receiving 3831 women seeking SAC. Patients seeking SAC were an average of 23 years old, with a large majority (85%) 18 years or older; gestational ages ranged from 2 to 36 weeks with a mean of 9.6 weeks (see Table 3). Over half (63%) of patients presented directly to MSF staff, while 13% were referred from a sexual violence care consultation and 16% were referred by MoH staff. Some disclosed prior abortion attempts via unsafe methods before seeking care, but this information was not systematically asked nor collected.

Comparison of patients provided and refused SAC

Of the 3831 women seeking SAC, MSF teams provided SAC to 3640 (95%) patients, did not provide SAC to 190 (5%), and referred one patient to another SAC provider (see Figure 2). Patients younger than 18 years were significantly less likely (90%) to receive SAC compared to women aged 18 and above (96%) ($\chi^2 = 36.1$, $p < 0.0001$). Patients with a gestational age of 13 or more weeks were significant less likely (75.8%) to receive SAC compared to women with a gestational age of less than 13 weeks (99.5%) ($\chi^2 = 695.3$, $p < 0.0001$). Patients who were refused SAC were not followed.

TABLE 2 Intervention activities and participants at the 10 Médecins Sans Frontières (MSF) pilot sites

		Participants	
Activity	Number of activities held	Number	Characteristics
Exploring values and attitudes workshops	40	746	492 men, 204 women, 51 no info 336 medical staff, 380 non-medical staff (logistics, human resource staff, drivers, guards, cleaners, etc.), 30 project coordination-level
Clinical trainings			
Contraception	12	226	80 MSF, 146 Ministry of Health
Post-abortion care	12	219	64 MSF, 155 Ministry of Health
Medication abortion	10	148	MSF staff
Local stakeholder meetings	14	47	Ministry of Health; community leaders
Threat and risk assessment	10	59	MSF staff
Implementation planning	10	42	MSF staff
Data collection	10	12	12 MSF

19312393, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1363/psrh.12209 by Test, Wiley Online Library on [19/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

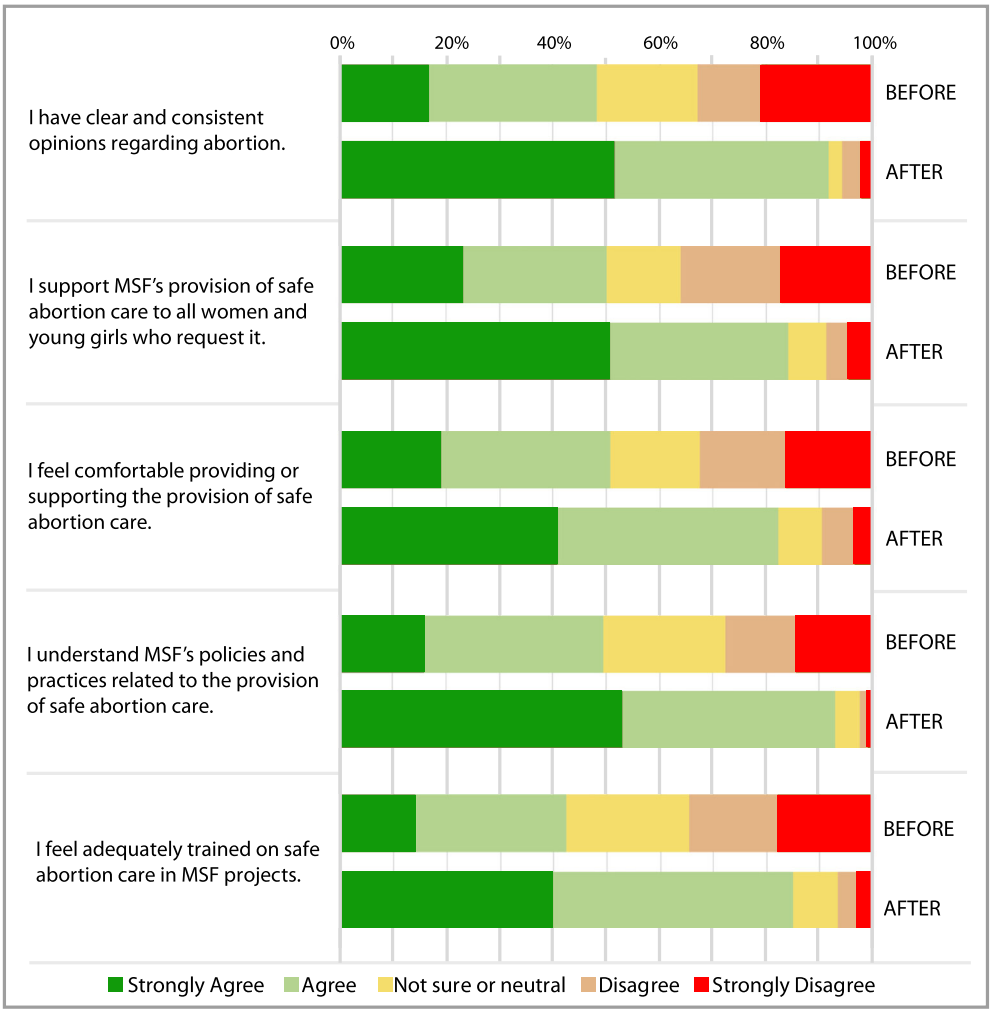

FIGURE 1 Pre- and post-Exploring Values and attitudes workshop survey of participant attitudes ($N = 746$). Responses of exploring values and attitudes workshop participants to a pre- and post-workshop questionnaire, expressed on a 5-point scale of strong agreement to strong disagreement with the indicated statement. Data show responses of 746 participants in 40 exploring values and attitudes workshops conducted at the 10 pilot sites over the course of the Task Force initiative. MSF, Médecins Sans Frontières

TABLE 3 Characteristics of women seeking safe abortion care (SAC) through the 10 Médecins Sans Frontières (MSF) pilot sites

	All women seeking SAC	Women who received SAC by MSF	Women who were denied SAC
Patient age (years)			
Mean	23.3 ± 6	23.4 ± 6	20.8 ± 5
Range	13–46	13–46	14–38
Gestational age (weeks)			
Mean	9.6 ± 5	8.9 ± 4	23.1 ± 6
Range	2–36	2–27	3–36

Characteristics of patients who received SAC

The ages of women who received SAC ranged from 13 to 46 with a mean of 23 years, while gestational age ranged from 2 to 27 weeks with an average of 9 weeks (Table 3). MSF staff provided 3018 (85%) abortions before 13 weeks gestation, 520 (14%) between 13 and 22 weeks, and 2 (0.05%) beyond 22 weeks (see Figure 3).

Abortion method

The overwhelming majority of patients ($n = 3632$, >99%) patients received a medication abortion (abortion with pills) and eight (0.2%) underwent MVA or another surgical procedure as the primary abortion method. Almost all patients undergoing a medication abortion ($n = 3607$, 99%) received the combined regimen of mifepristone and misoprostol, and 25 (1%) received misoprostol only (see Figure 2).

19312393, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1363/psrh.12209 by Test, Wiley Online Library on [19/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

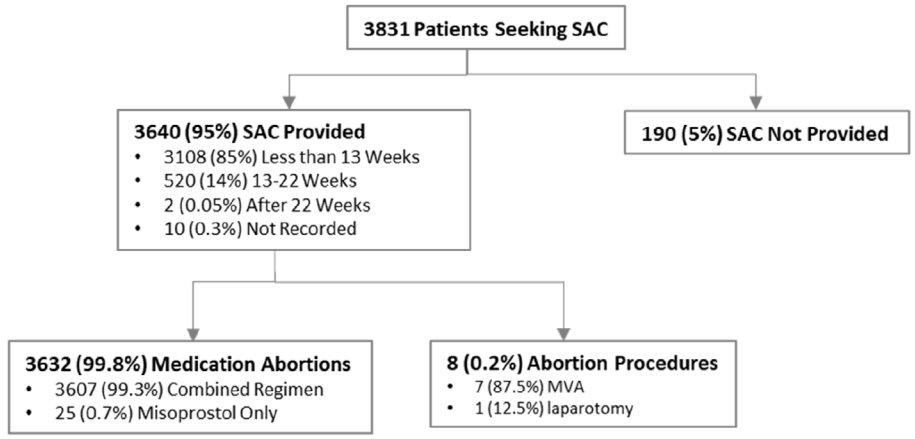

FIGURE 2 Flowchart of patients seeking and receiving safe abortion care (SAC) through the 10 Médecins Sans Frontières (MSF) pilot sites. MVA, manual vacuum aspiration

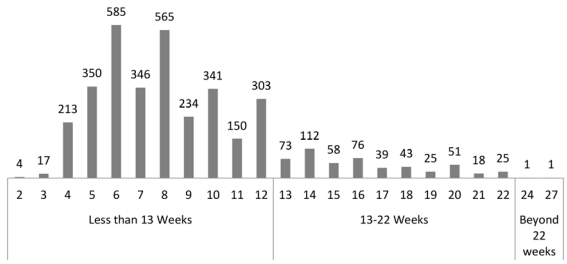

FIGURE 3 Gestational age of patients who received safe abortion care (SAC) through the 10 Médecins Sans Frontières (MSF) pilot sites

Complication rates

Patients reported a total of 156 (4.28%) complications for the 3640 abortions provided (see Table 4). The total complication rate for medication abortions with the combined regimen before 13 weeks' gestation ($n = 3083$) was 3.02% (93 patients). The complication rate for medication abortions with the combined regimen between 13 and 22 weeks' gestation ($n = 514$) was 9.72% (50 patients); for the subset of 180 patients in this gestational age range who managed the process at home, the complication rate was 10.6% (19 patients). The most commonly reported complication was incomplete abortion (2.8%), followed by continuing pregnancy (0.74%); both were managed through repeat doses of misoprostol or a procedure (MVA or curettage). The overall rate of severe, life-threatening complication such as infection or hemorrhage requiring blood transfusion was 0.3% (12 patients).

Security of patients, staff, and programs

During the three-year period in which teams provided 3640 abortions, there were no reported major security incidents (e.g., kidnapping, injury or death of patients or staff, etc.) There were 19 minor incidents reported, including tension with the patient's family, within the team, or with local authorities. All minor incidents were resolved at the local level using routine MSF security management strategies without long-term consequences for staff or projects.

Change in SAC provision over time

From January 2017 to December 2019 there was a significant and steady increase in the number of abortions provided collectively at the 10 pilot sites: from a total of three safe abortions provided in Q1 of 2017 to 759 provided in Q4 of 2019 (see Figure 4), resulting in 3640 abortions provided during this time period. We also assessed changes in SAC provision at MSF projects globally, since the Task Force approach—including tools and resources, implementation strategies, trainings, and lessons learned—was shared with and implemented by MSF staff in projects worldwide starting after the first Task Force visit. MSF's provision of SAC worldwide during this period increased from 74 safe abortions at 27 projects in five countries in 2015 (the year the Task Force was originally proposed) to 21,546 at 90 projects in 30 countries in 2019 (see Figure 5).

DISCUSSION

Despite a longstanding policy to provide SAC, MSF, like many humanitarian actors, struggled to implement this service systematically within our medical programs. To move from policy to action, MSF created a Task Force to overcome internal barriers and support SAC implementation at 10 pilot projects in a sub-Saharan African country. This direct support resulted in a substantial and sustained increase in provision of SAC—from three safe abortions in Q1 2017 to 759 in Q4 2019. This is one of the few reports in the literature on how a global health actor achieved expansion of its SAC services in extremely fragile settings.

This successful scale-up uprooted many long-held beliefs about the feasibility of providing SAC in humanitarian contexts and served as a catalyst for organizational change, resulting in a significant increase in SAC provision across MSF operations worldwide.

19312393, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1363/psrh.12209 by Test, Wiley Online Library on [19/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

TABLE 4 Reported medical complications by abortion method and gestational age (GA)

Complication	Medication abortion						Abortion procedure		Total $n = 3640$
	Mifepristone + misoprostol				Misoprostol only				
	<13 weeks $n = 3083$	13–22 weeks $n = 514$	>22 weeks $n = 2$	GA not recorded $n = 8$	<13 weeks $n = 22$	13–22 weeks $n = 3$	<13 weeks $n = 5$	13–22 weeks $n = 3$	
No complication	2990 (96.98%)	464 (90.27%)	2 (100%)	7 (87.5%)	15 (68.2%)	1 (33.33%)	2 (40%)	3 (100%)	3484 (95.7%)
Incomplete abortion	60 (1.95%)	35 (6.81%)	0	1 (12.5%)	4 (18.18%)	2 (66.67%)	0	0	102 (2.8%)
Continuing pregnancy	18 (0.58%)	8 (1.56%)	0	0	1 (4.55%)	0	0	0	27 (0.74%)
Other minor complication	10 (0.32%)	3 (0.58%)	0	0	0	0	2 (40%)	0	15 (0.41%)
Infection	4 (0.13%)	1 (0.19%)	0	0	2	0	1	0	8 (0.22%)
Hemorrhage requiring blood transfusion	1 (0.03%)	3 (0.58%)	0	0	0	0	0	0	4 (0.11%)
Total complications	93 (3.02%)	50 (9.72%)	0	1 (12.5%)	7 (31.8%)	2 (66.7%)	3 (60%)	0	156 (4.29%)

Considering that thousands of people sought and received SAC from MSF during the study period, our experience demonstrates that provision of SAC is not only possible but essential for saving lives in humanitarian and fragile settings. It also shows that the barriers to providing SAC were more internal than external and related to values, stigma, and personal beliefs, which highly influence perception of risk and feasibility of SAC implementation. These lessons are potentially also valuable as a roadmap that other non-governmental organizations (NGOs) struggling to implement SAC in fragile contexts can use and adapt.

The programmatic data captured in this process are among the few such reports providing insight into abortion-related dynamics in humanitarian settings. Within MSF, data collection regarding both SAC and PAC was sporadic and inconsistent prior to the Task Force, due to low priority given to the subject together with fear of exposure; thus there was little visibility regarding peoples' actual needs. The Task Force experience shows that data collection around abortion in humanitarian and fragile contexts is not only possible but also critically important and can provide valuable insights which in turn can help identify gaps in service delivery and inform operational decision-making.

Implementation package

While individual components of the implementation package were not evaluated separately, our experience suggests that success of the Task Force initiative reflected its comprehensive approach to addressing the common barriers to providing SAC. The first component, the Exploring Values and Attitudes workshop, worked to break the silence around abortion and provided a safe space for project staff to reflect on their beliefs, share their experiences, and learn about the medical need for SAC. Conducting Exploring Values and Attitudes workshops at all levels of our organization—headquarters, country-level coordination, and field projects—and all levels of staff, including non-medical, increased support for providing SAC and helped to shift organizational culture. Consequently, it also enabled a more receptive environment for implementing subsequent components of the Task Force strategy. Exploring Values and Attitudes workshops have since been adapted for MoH staff, community members, and online platforms, and have engaged thousands of people in dozens of countries.

The second contributor to success was a focus on clinical trainings and support materials for medication abortion. Medication abortion is safe and effective, and has several advantages compared to abortion procedures (including MVA and dilatation and evacuation): it is non-invasive, easy to learn, and does not require the infrastructure or skilled staff needed for abortion procedures. While medication abortion is relatively simple and straightforward, we found that most health care workers are not properly informed about this topic during their general medical education. Thus, trainings provide much-needed guidance and reassurance for health care workers to feel comfortable and supported in providing this care. Moving forward, humanitarian actors could make great strides in advancing abortion provision by

19312393, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1363/psrh.12209 by Test, Wiley Online Library on [19/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

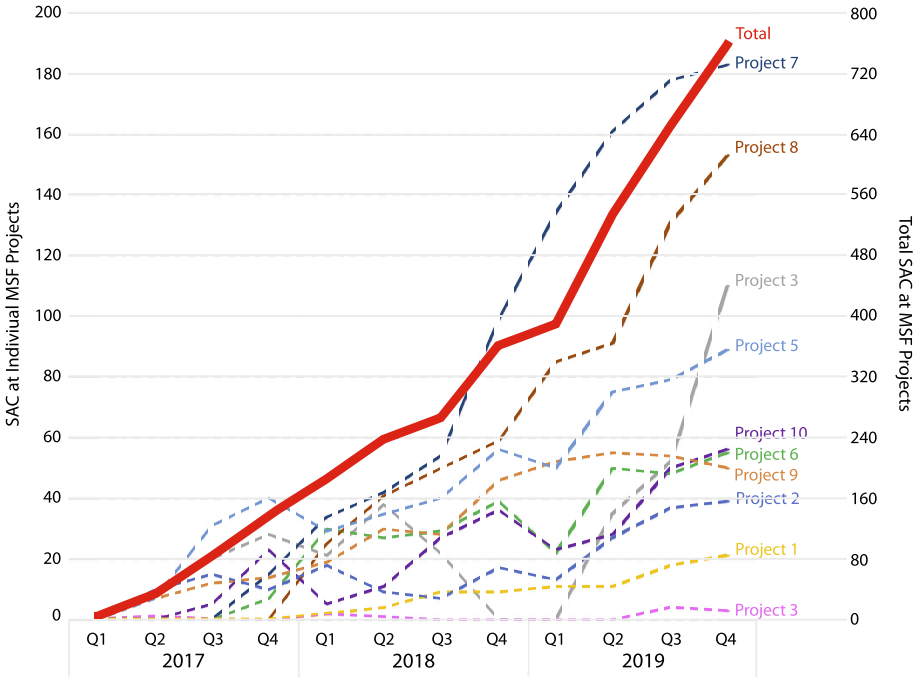

FIGURE 4 Number of abortions provided at the 10 Médecins Sans Frontières (MSF) pilot sites, 2017–2019. SAC, safe abortion care; Q, quarter

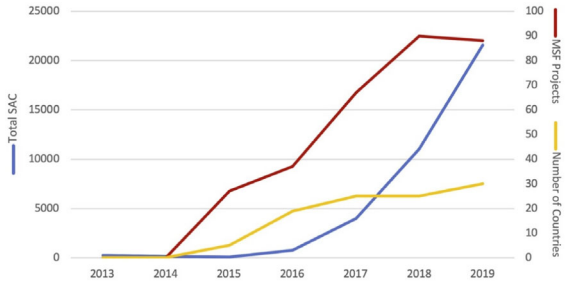

FIGURE 5 Number of abortions provided by Médecins Sans Frontières (MSF) worldwide (2013–2019). SAC, safe abortion care

focusing on medication methods. At the same time, it is important to acknowledge the full spectrum of abortion services and strive toward ensuring populations also have access to abortion procedures when needed or desired.

The Task Force experience also demonstrated that engagement with community and local stakeholders is possible—even in places where abortion is legally restricted or considered taboo. Framing the conversation as part of a shared goal to reduce maternal death and suffering can foster understanding and support. The frankness of dialogue varied according to the interlocutor, but in general stakeholders appeared to appreciate the medical need for SAC and be aware of MSF's intentions to provide SAC, even if this was not explicitly stated. While many staff were initially hesitant to initiate these conversations, in practice these discussions were usually not only positive but also welcomed—especially by MoH staff, who are often well aware of the complications from unsafe abortion and can be discreet partners in successful SAC implementation. Moreover, these discussions often yielded valuable insights into local abortion dynamics.

The fourth component, the template threat and risk matrix, was a breakthrough for MSF in addressing the security concerns often cited as a key reason for inaction on SAC provision. It utilized an approach and terminology familiar to staff responsible for security management: describing the risk (threat, likelihood, impact) and elaborating ways to reduce and manage risk (contingency and mitigation). Practical tips on how to avoid and handle potentially problematic situations increased staff confidence to implement SAC. While each analysis was approached afresh and adapted for each project, ultimately they did not differ significantly among projects. The main threats discussed were those arising from breaches of confidentiality; protection of medical confidentiality thus became a primary means of risk mitigation.

The fifth and sixth components, the implementation plan and data collection, were rolled out relatively smoothly, but are nevertheless important for delineating patient circuits, assigning responsibilities, and monitoring and evaluating services. Crucially, data collected at the pilot sites allowed for new insights and lessons learned regarding abortion-related dynamics in these and similar humanitarian settings.

The impact of self-managed abortion

One of the most striking points to emerge from our data is that over 99% of the abortions provided in these pilot locations were

19312393, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1363/psrh.12209 by Test, Wiley Online Library on [19/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

medication abortions. This is additional supporting evidence for what has already been proposed[12]: medication abortion, specifically self-managed medication abortion, has the potential to revolutionize access to SAC in humanitarian and fragile settings. Self-managed abortion is a type of self-care where individuals conduct some or all steps of the abortion process on their own or with varying levels of support from the health care system.[13] For many patients, self-managed abortion has the potential to meet their needs for privacy and support their autonomy compared to facility-based care. Due partly to the COVID-19 pandemic, there has been a recent surge in evidence and sharing of experiences around "no test" and telehealth abortion,[14–16] yet there is very little research evaluating related interventions in humanitarian contexts.

One of few examples comes from Foster and colleagues,[17] whose work on community-based distribution of abortion pills at the Thailand-Burma border provides important evidence for the safety and effectiveness of this model of abortion care. While MSF teams provided abortion care in a more traditional set-up, with women coming to a healthcare facility and having an in-person consultation with a healthcare worker, they typically returned home to self-administer the pills and self-manage the abortion process. The success of this experience, and the increased confidence in women's ability to self-manage the abortion process, encouraged MSF to explore more self-managed and community-based models of abortion care that do not require a visit to a healthcare facility, for example with support from peer educators, telephone hotlines, and community health workers. This work further supports the findings from Foster and colleagues, as well as more recent interventional studies in Nigeria and Pakistan,[18,19] and is an example of the synergy between health care organizations and communities to support self-care and uphold people's dignity in humanitarian settings.

The WHO has recognized the safety and importance of self-managed abortion and recently produced new guidance recommending it until 12 weeks.[13] While this is a much-welcomed development, the data reported here suggests that self-management of medication abortion until 13 weeks and well into the second trimester is safe and effective. Reports from staff suggest that self-management at home is markedly preferred by patients because it better meets their needs for privacy, confidentiality, and less time away from home. Therefore, any requirement that restricts abortion services beyond 12 weeks to health facilities may result in limiting access to much-needed care. Moving forward, increased research and sharing of experiences regarding abortion services in general—and self-care in particular—beyond 12 weeks and throughout the second trimester is urgently needed.

Safe abortion in the second trimester

While second trimester abortions comprise a minority (roughly 10%–15%) of abortions worldwide,[12] they account for the majority (up to 60%–100%) of the morbidity and mortality from unsafe abortion.[20] Moreover, women who seek abortion in the second trimester are more likely to be younger, victims of sexual violence, have detected their pregnancy later, and/or have financial or logistical barriers to care.[21] Therefore, second trimester abortion services are a crucial, life-saving component of reproductive health services, especially in humanitarian and fragile settings.

Despite this reality, second trimester abortion remains an often-neglected service, even by organizations and agencies that provide and advocate for SAC. Prior to the systematic data collection reported here, there was little visibility on the need for second trimester services in MSF projects, and MSF policy and guidance extended only to 12–14 weeks. Once teams started to report women seeking second trimester services, the need was more clearly identified and MSF expanded its abortion policy and clinical guidelines to 22 weeks' gestation (and beyond on a case-by-case basis).

The guidelines recommended medication abortion via facility-based care and gave an option for home-based self-care only if the patient was unable or unwilling to be hospitalized. Using this guidance, the 10 pilot sites successfully provided a remarkable volume (520) of second trimester medication abortions, with 35% (181) managed at home. No patients required dilatation and evacuation. To our knowledge, this is the first report to document the safety and effectiveness of second trimester medication abortion services in a humanitarian context using both facility- and home-based models of care.

At the same time, MSF teams still did not manage to consistently address the need for second trimester abortions: our pilot site data indicate that patients with gestational ages above 13 weeks were significantly more likely to be refused SAC than patients with first trimester pregnancies. Challenges to second trimester abortion provision include heightened stigma, longer duration of the abortion process, management and disposal of the products of conception, and pain management. Moving forward, humanitarian actors, including MSF, must be willing to not only change policy and provide clinical guidance, but also to tackle these issues head-on and proactively support staff in providing this much-needed second trimester care.

Re-framing success in abortion care

Our data show that the rate of incomplete abortion in the second trimester at our sites (6.8%) was higher than that of recent studies[22] using unlimited misoprostol dosing (less than 1%). Much of the literature and discussion around abortion focuses on completion rate as an indicator of success and quality of care. While completion rates are important, we view an exclusive focus on this outcome as problematic for several reasons. First, incomplete abortion is a subjective diagnosis: what is perceived as abnormal bleeding by one person may be interpreted as normal by another. Over the three-year period of the Task Force, the rate of incomplete abortion reported by staff gradually decreased, suggesting that success rates do not simply reflect inherent properties of the pills themselves, but are highly influenced by individual comfort, fears, attitudes, and experience. Therefore, high rates of incomplete abortion may indicate that staff need additional support and reassurance, rather than reflecting problems with the medical protocol or intervention strategy per se. Second, incomplete

19312393, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1363/psrh.12209 by Test, Wiley Online Library on [19/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

abortion by itself is not a sign that a patient's health or well-being is in jeopardy. As long as there are no warning signs, some patients simply need more time and/or doses of misoprostol for the uterus to completely empty. This notion is supported by the work of Moseson and colleagues,[18] who found higher success rates when more time was given for the abortion to be considered complete. This should be normalized and expected as part of the abortion process, which means ensuring that people are given adequate time and that multiple doses of misoprostol are easily available in case of need. Finally, a focus solely on quantitative completion rates fails to consider broader, qualitative measures of what success in abortion care means to women (e.g., ease of access, privacy, autonomy, etc.). As the safety and efficacy of abortion pills is well documented, future research should seek to understand better other key elements of high-quality abortion care, such as people's experience and satisfaction with the abortion experience.

Who seeks and who receives SAC

Our pilot site data shed light on some populations who face especially high obstacles in accessing SAC. In particular, adolescents were significantly more likely to be denied SAC than adults. Adolescents face multiple barriers in their path to accessing SAC, present for care at later gestations, and are at higher risk of complications from unsafe abortion.[23,24] When they do manage to reach a facility, they are often turned away due to lack of parental consent, which ultimately jeopardizes their health and well-being. Moving forward, targeted efforts should be made to ensure that young people have access to this essential reproductive health service.

We also found that most people who sought SAC did not report a history of sexual violence. Yet much of the dialogue about SAC in humanitarian settings centers around victims of sexual violence,[25,26] with some authors advocating that access to abortion services in fragile contexts should start with this group as an "entry point" or step-wise approach for increasing access to care for all.[7] While ensuring access to SAC for sexual violence victims is crucial, our experience suggests that a targeted focus on this population may miss the majority of people in need of care, and that a more inclusive approach, for example based on reducing maternal mortality and morbidity or upholding autonomy, would have broader impact. Moreover, disclosing a history of sexual violence is a highly personal, and in some cases risky, decision, and access to SAC should not be contingent on reporting this history. Lastly, prioritizing access exclusively for victims of sexual violence reinforces a hierarchy of abortion deservedness that perpetuates abortion stigma and ultimately undermines efforts to expand access. People need SAC for variety of reasons and all action must be directed toward providing non-judgmental care that is available to all.

Security around SAC provision

Security risks are often cited by NGOs, including MSF, as the main reason for not providing SAC. However, our data show that security incidents were very infrequent (approximately 0.5% of abortions provided). When such incidents did occur, they were generally of low severity and could be successfully managed without long-term consequences for staff, patients, or organizational capacity to continue assistance.

LIMITATIONS

While we believe the approach described here can be adapted to many other contexts and organizations, there are some limitations to implementing, reproducing, and sustaining our results. First, the Task Force approach itself is relatively means-intensive. However, once the strategy was established, MSF has taken a lighter approach in other contexts (e.g., without an in-country coordinator) and still achieved improvements in SAC provision. Notably, MSF has the benefit of strong financial and administrative independence and is experienced managing tensions with various local actors when it comes to defending medical priorities and managing security risks. The increase in SAC provision cannot only be attributed to the work of the Task Force: other MSF entities invested resources into implementation of SAC which also contributed to organizational momentum and overall increase in SAC provision. Finally, maintaining interest and momentum around a stigmatized topic in such a large, rapidly-evolving organization remains a challenge. Regarding sustainability, the organization created plans to integrate the work of the Task Force into its daily Operations and continue abortion-related efforts after its closure; however the long-term impact of these plans is yet to be seen.

There are also limitations to the data collected. Information was not systematically recorded by the projects until after the Task Force visit, so it is possible that not all SAC cases prior to the Task Force visit were documented. However, dialogue with staff suggests that the number of SAC that they provided but did not report were very few. In addition, it is likely that many women seeking SAC were not recorded if they were turned away before reaching a provider, or that providers may not have documented patients who were denied care. There may also have been more complications or undesired outcomes than what was reported, since routine follow-up visits were not required. However, since all patients who received SAC had by definition been able to access the health care facility, and given MSF's strong relationship with the community in the pilot sites, the number of unreported complications is likely minimal.

CONCLUSION

The MSF initiative for improving access to SAC has shown that implementation of SAC in humanitarian settings—even those with significant legal restrictions—is both possible and urgently needed. The significant increase in SAC provision achieved at the pilot projects and across MSF at large did not result from favorable external, contextual or legal changes. Implementation of SAC only became systematic and available in multiple contexts by addressing barriers internal to the organization, and internal to each and all of us.

19312393, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1363/psrh.12209 by Test, Wiley Online Library on [19/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

The data collected from the pilot projects reveal that both first and second trimester medication abortion can be safely and effectively provided in low-resource, conflict settings without requiring routine testing or follow-up appointments. The complication rate was low and all cases were successfully managed without a single death or major security incident. Additionally, the data provide valuable insights regarding populations seeking abortion services and their outcomes, which must shape programmatic decision-making to better meet the needs of the most vulnerable.

This experience suggests that even in fragile and conflict-affected settings, old excuses for not providing SAC do not hold up. Barriers can be overcome, frank dialogue is possible, safe and effective abortion services can be provided very simply, and women and girls can successfully self-manage most or all of the abortion process. The global health community can no longer sit back and wait for political and legal change while the complications from unsafe abortion continue their devastating toll on people's lives in humanitarian settings. Strong organizational commitment, trust in the populations served, and bold action are urgently needed to ensure that people in humanitarian settings have access to safe abortion services.

ACKNOWLEDGMENTS

Above all we would like to recognize the fundamental contribution of the MSF staff in over 150 projects around the world, whose dedicated efforts make it possible to provide safe abortion care, as well as other sexual and reproductive health services. We are especially grateful to the local staff who support and carry out this work but cannot be named due to legal and security concerns. We are grateful to the Medical and Operational Directors of MSF who supported this initiative from its early stages. We would also like to acknowledge the encouragement from the MSF Association, including the International Board, to further MSF's work on safe abortion care. We thank the MSF Reproductive Health and Sexual Violence Care Working Group for its work and dedication on this topic. We also give thanks to Patricia Kahn (MSF-USA) for medical editing support and input to the manuscript, to Zoe Fanning and Amelia Zhao (MSF-USA) for editorial assistance, and to Annick Lenglets and Anika Apfel for support with data analysis and management, respectively. We also thank Ipas for their agreement to collaborate with MSF and to work together on their values clarification and attitudes transformation toolkit to adapt it to MSF needs.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

REFERENCES

1. UNFPA, World Health Organization, UNICEF, et al. Trends in Maternal Mortality: 2000–2017. Accessed April 10, 2022. https://www.unfpa.org/sites/default/files/pub-pdf/Maternal_mortality_report.pdf
2. World Health Organization. WHO says address protracted emergencies to achieve Sustainable Development Goals. Accessed April 10, 2022. https://www.un.org/sustainabledevelopment/blog/2016/04/who-says-address-protracted-emergencies-to-achieve-sustainable-development-goals/
3. Say L, Chou D, Gemmill A, et al. Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health*. 2014;2(6):e323-e333. doi:10.1016/S2214-109X(14)70227-X
4. Guttmacher Institute. Accessed April 10, 2022. https://www.guttmacher.org/
5. Singh S, Maddow-Zimet I. Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. *BJOG: Int J Obstet Gynaecol*. 2016;123(9):1489-1498. doi:10.1111/1471-0528.13552
6. Casey SE, Chynoweth SK, Cornier N, Gallagher MC, Wheeler EE. Progress and gaps in reproductive health services in three humanitarian settings: mixed-methods case studies. *Confl Heal*. 2015;9(1):S3. doi:10.1186/1752-1505-9-S1-S3
7. McGinn T, Casey SE. Why don't humanitarian organizations provide safe abortion services? *Confl Health*. 2016;10(1):8. doi:10.1186/s13031-016-0075-8
8. Médecins Sans Frontières. International Activities Report 2019. Accessed April 10, 2022. https://www.msf.org/international-activity-report-2019
9. Médecins Sans Frontières. MSF International Council resolution on abortion, 2004 (Internal document).
10. Turner KL, Page KC. Abortion attitude transformation: a values clarification toolkit for global audiences. 2014. Accessed April 10, 2022. https://www.ipas.org/resource/abortion-attitude-transformation-a-values-clarification-toolkit-for-global-audiences/
11. Turner KL, Pearson E, George A, Andersen KL. Values clarification workshops to improve abortion knowledge, attitudes and intentions: a pre-post assessment in 12 countries. *Reprod Health*. 2018;15(1):40. doi:10.1186/s12978-018-0480-0
12. Jayaweera R, Powell B, Gerdts C, et al. The potential of self-managed abortion to expand abortion access in humanitarian contexts. *Front Glob Womens Health*. 2021;13(2):681039. doi:10.3389/fgwh.2021.681039
13. Abortion care guideline World Health Organization. 2022. Accessed April 10, 2022. https://www.who.int/publications/i/item/9789240039483
14. Upadhyay UD, Schroeder R, Roberts SCM. Adoption of no-test and telehealth medication abortion care among independent abortion providers in response to COVID-19. *Contracept X*. 2020;21(2):100049. doi:10.1016/j.conx.2020.100049
15. Aiken A, Lohr PA, Lord J, Ghosh N, Starling J. Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. *BJOG*. 2021;128(9):1464-1474. doi:10.1111/1471-0528.16668
16. Raymond EG, Grossman D, Mark A, et al. Commentary: no-test medication abortion: a sample protocol for increasing access during a pandemic and beyond. *Contraception*. 2020;101(6):361-366. doi:10.1016/j.contraception.2020.04.005
17. Foster AM, Arnott G, Hobstetter M. Community-based distribution of misoprostol for early abortion: evaluation of a program along the Thailand-Burma border. *Contraception*. 2017;96(4):242-247. doi:10.1016/j.contraception.2017.06.006
18. Moseson H, Jayaweera R, Egwuatu I, et al. Effectiveness of self-managed medication abortion with accompaniment support in Argentina and Nigeria (SAFE): a prospective, observational cohort study and non-inferiority analysis with historical controls. *Lancet Glob Health*. 2022;10(1):e105-e113. doi:10.1016/S2214-109X(21)00461-7
19. Foster AM, Messier K, Aslam M, Shabir N. Community-based distribution of misoprostol for early abortion: outcomes from a program in Sindh. *Pak Contraception*. 2022;109:49-51. doi:10.1016/j.contraception.2022.01.005
20. Harris LH, Grossman D. Confronting the challenge of unsafe second-trimester abortion. *Int J Gynaecol Obstet*. 2011;115(1):77-79. doi:10.1016/j.ijgo.2011.05.018
21. Ipas. Who has abortions at 13 weeks or later?. Accessed February 7, 2021 https://www.ipas.org/clinical-update/english/recommendations-for-abortion-at-or-after-13-weeks-gestation/who-has-abortions-at-13-weeks-or-later/
22. Louie KS, Chong E, Tsereteli T, Avagyan G, Abrahamyan R, Winikoff B. Second trimester medical abortion with mifepristone

19312393, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1363/psrh.12209 by Test, Wiley Online Library on [19/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

followed by unlimited dosing of buccal misoprostol in Armenia. *Eur J Contracept Reprod Health Care*. 2017;22(1):76-80. doi:10.1080/13625187.2016.1258461
23. Sowmini CV. Delay in termination of pregnancy among unmarried adolescents and young women attending a tertiary hospital abortion clinic in Trivandrum, Kerala. *India Reprod Health Matters*. 2013;21(41):243-250. doi:10.1016/S0968-8080(13)41700-7
24. Olukoya AA, Kaya A, Ferguson BJ, AbouZahr C. Unsafe abortion in adolescents. *Int J Gynaecol Obstet*. 2001;75(2):137-147. doi:10.1016/s0020-7292(01)00370-8
25. International Committee of the Red Cross. Abortion for raped women and girls: a humanitarian and legal issue. Accessed October 18, 2013. https://www.icrc.org/en/doc/resources/documents/statement/2013/sexual-violence-abortion-statement.htm
26. United Nations Security Council. Women and girls who become pregnant as a result of sexual violence in conflict and children born of sexual violence in conflict: Report of the Secretary-General. Accessed January 31 Jan 2022, 2022 https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2022/02/report/auto-draft/N2223437.pdf

AUTHOR BIOGRAPHIES

Manisha Kumar is a family medicine doctor with a master's in public health and fellowship training in obstetrics. She has worked for Médecins Sans Frontières (MSF) in a variety of contexts and positions since 2014.

Catrin Schulte-Hillen started working with MSF in 1989 as a midwife, in operations and as technical advisor and working group leader on SRH. In the past 3 years she has worked with UNHCR and presently with UNFPA supporting SRH in Humanitarian settings; she continues supporting MSF as an association member.

Eva De Plecker started her humanitarian career with Médecins Sans Frontières (MSF) in 2004. She worked in various Sexual and Reproductive Health (SRH) care projects and now works as an SRH advisor in the headquarters of the MSF operation centre Brussels. She is currently leading the MSF Reproductive Health and Sexual Violence Care Working group. In 2016 she completed her master's in public health, Disease Control with ITM, Antwerp, Belgium.

Ann Van Haver has worked with MSF since 2007 as a midwife and project medical referent in several projects in Africa and Asia, covering all aspects of sexual and reproductive health care. In 2013, she became a mobile implementer for SRH activities, offering support to MSF projects regarding SRH strategy, training, improving quality of care and implementing new activities.

Sonia Guinovart Marques has a Medical Degree from the University of Barcelona and is specialized in OBGYN since 2013. In 2014 she joined MSF as a field OBGYN, working in a variety of contexts and emergency settings, and since 2017 she works as OBGYN referent for MSF Spain while combining clinical work in Barcelona.

Maura Daly is a midwife specialized in sexual and reproductive health care in humanitarian settings. She currently works as a specialist advisor for MSF where she provides technical and programming support to a diverse global portfolio of medical humanitarian projects worldwide.

Hilde Vochten became a medical doctor in 2003. She did 1 year of surgical and 1 year of gynecological specialization and a postgraduate in tropical medicine at the Institute of Tropical Medicine in Antwerp. In 2006, she started working for MSF in different positions including the field in Headquarters.

Lisa Merzaghi started working with MSF in 2014 as a nursing and medical-operation manager. She implements and monitoring SAC activity at project level.

Sonia Guinovart Marques has a Medical Degree from the University of Barcelona and is specialized in OBGYN since 2013. In 2014 she joined MSF as a field OBGYN, working in a variety of contexts and emergency settings, and since 2017 she works as OBGYN referent for MSF Spain while combining clinical work in Barcelona.

Maura Daly is a midwife specialized in sexual and reproductive health care in humanitarian settings. She currently works as a specialist advisor for MSF where she provides technical and programming support to a diverse global portfolio of medical humanitarian projects worldwide.

Hilde Vochten became a medical doctor in 2003. She did 1 year of surgical and 1 year of gynecological specialization and a postgraduate in tropical medicine at the Institute of Tropical Medicine in Antwerp. In 2006, she started working for MSF in different positions including the field in Headquarters.

Lisa Merzaghi started working with MSF in 2014 as a nursing and medical-operation manager. She implements and monitoring SAC activity at project level.

Brice de le Vingne has a master's degree in economics and is currently the Head of the Emergency Unit at MSF.

Jean François Saint-Sauveur has over 20 years experience working in the humanitarian health sector in many conflicts and epidemic settings. He was medical director for MSF Spain (2014–2019) and MSF Intersectional representative for Ebola in the DRC (2019–2020); he is currently working as a Public Health Specialist for the Global Fund.

How to cite this article: Kumar M, Schulte-Hillen C, De Plecker E, et al. Catalyst for change: Lessons learned from overcoming barriers to providing safe abortion care in Médecins Sans Frontières projects. *Perspect Sex Reprod Health*. 2022;1-12. doi:10.1363/psrh.12209

19312393, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1363/psrh.12209 by Test, Wiley Online Library on [19/02/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License