The Royal College of Obstetricians and Gynaecologists submission to the APPG on Population, Development and Reproductive Health

Call for evidence on Abortion in the Developing World and the UK

RCOG Centre for Women’s Global Health Submission

The Royal College of Obstetricians and Gynaecologists (RCOG) works to improve health care for women everywhere, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women’s health care worldwide.

This submission, from the RCOG’s Centre for Women’s Global Health, outlines the College’s Leading Safe Choices programme (LSC) which aims to strengthen the competence and raise the standing of reproductive healthcare professionals in South Africa and Tanzania.

Summary

South Africa:

1. Despite South Africa having one of the most progressive abortion laws in the world, with abortion being legal without restriction in the first trimester, unsafe and illegal abortions remain a significant public health problem. Unsafe abortion is difficult to quantify, as women who eventually present with complications following unsafe abortion commonly present as miscarriages or at later gestations with pre-term labour.

2. Multiple barriers to abortion care provision exist including provider conscientious objection, stigma, poor knowledge of abortion legislation, healthcare worker shortages, lack of trained providers (leading to referrals and long waiting times), and a lack of fully equipped facilities. Task shifting abortion care to mid-level providers increases the number of abortion care providers, which can reduce waiting times and numbers of onward referrals.

3. The RCOG Leading Safe Choices programme comprises short, interactive training courses addressing the knowledge, skills and attitudes essential for the provision of high quality comprehensive abortion care. Training is followed by a mentorship model to provide on-the-job support, and strategies to tackle systems barriers, such as Values Clarification workshops and close liaison with facility and district management.

4. Training interventions like Leading Safe Choices can make a localised impact in relation to increasing skilled providers, reducing provider opposition, and improving quality of abortion care (especially uptake of postabortion family planning). However, training interventions must be supported by high-level engagement from facility level managers and the Department of Health, good-quality mentoring and provider engagement using, for example, Values Clarification Workshops and provider peer-to-peer support groups.

Tanzania:

5. Unsafe abortion contributes to high levels of maternal mortality and morbidity in Tanzania. Each year 405,000 women have an abortion, almost all illegal (and therefore unsafe). For each
6. Legal abortion is severely restricted in Tanzania, and laws and policies on abortion are ambiguous and often confusing for providers. Fear of prosecution among women and health care providers alike drives women to seek clandestine abortions. In addition to socio-economic barriers, ambiguity and misinterpretation by health care providers regarding the legality of abortion and postabortion care, and provider objection impact on the availability and quality of services provided to women.

7. The Leading Safe Choices programme trains mid-level health care providers (nurses and midwives) in postpartum family planning (PPFP), and comprehensive abortion care (CAC) in South Africa and comprehensive postabortion care (CPAC) in Tanzania. This includes training in postabortion family planning, as when a woman seeks healthcare for abortion care, she is ideally placed for her contraceptive needs to be assessed and met.

8. While training interventions such as Leading Safe Choices are an opportunity to scale up CPAC services, health systems barriers prevail including restrictions on teaching materials and training format.

Background:

9. The RCOG Leading Safe Choices programme trains mid-level health care providers (nurses and midwives) in postpartum family planning (PPFP), and comprehensive abortion care (CAC) in South Africa and comprehensive postabortion care (CPAC) in Tanzania. This includes training in postabortion family planning, as when a woman seeks healthcare for abortion care, she is ideally placed for her contraceptive needs to be assessed and met.

10. Despite a liberal abortion law, illegal abortion remains high in South Africa. Any woman in South Africa can request abortion without giving a reason if below 13 weeks pregnant, and with relatively liberal restrictions until 20 weeks. Reasons why women do not use legal abortion services in South Africa are: there is a lack of willing and skilled providers; women not being aware of their rights to legal abortions; not knowing where to seek safe and legal care; anticipation of staff rudeness; fear of being discovered for seeking an abortion; and being too late in the pregnancy. This results in 25% of abortions being carried out in the second trimester.

11. Legal abortion is heavily restricted in Tanzania, and due to ambiguities around abortion laws and policies it is not clear to many health providers or women what abortion procedures and aspects of postabortion care are legal. For example, according to the Penal Code, abortions are authorised to save a woman’s life, but it remains unclear if they are legal to preserve a woman’s physical or mental health. Additionally, Tanzania ratified the 2007 African Charter’s Protocol on the Rights of Women in Africa to allow abortion in cases of rape, incest or if the pregnancy endangers the woman’s life, mental, or physical health or the life of the foetus, but the government has not yet incorporated the protocol into its national law (despite being obligated to under regional human rights law). Significant reductions in postabortion complications and maternal mortality from unsafe abortion could be achieved by publicising and implementing current laws and policies.
12. The Leading Safe Choices intervention comprises didactic classroom teaching plus on-the-job mentorship. The programme uses obstetrician gynaecologist clinical leads, mentors, and facility champions to drive service delivery, motivate abortion care providers, and help unblock system blockages. The LSC programme adopts a systems approach, working through existing Department/Ministry of Health structures in country and with local programme and clinical teams, to better ensure sustainability of impact.

13. The Leading Safe Choices programme places emphasis on task shifting for mid-level providers. This involves training in key skills including first trimester Manual Vacuum Aspiration (MVA) for abortion or incomplete abortion, which is an important skills upgrade for mid-level providers as it reduces reliance on medical doctors. In Tanzania, MVA skills are essential as despite misoprostol being on the essential medicines list for postpartum haemorrhage, medical management of incomplete abortion is not mandated for use in CPAC.

Health Provider Workforce:

14. There is a critical shortage of trained staff willing and able to provide abortion services in South Africa and Tanzania. In South Africa, conscientious objection at all levels results in service gaps and complex patterns of service delivery at facilities, and providers often work in isolation, experiencing stigma from colleagues and facility managers. An increased number of trained professionals are needed to provide these essential and often life-saving services. Task shifting for mid-level providers, Values Clarification workshops and on-the-job mentorship can address workforce shortages and promote provider wellbeing.

“There’s always staff shortages, I practically work alone in this service. I prepare the patients myself, I counsel the patient, I administer the medication, I do the procedures & I discharge them with medication.”  Sister Judiac Ranape, Lady Michaelis Community Day Centre, Western Cape, South Africa

15. In South Africa many health care providers are resistant to providing abortion care services, citing conscientious objection. Conscientious objection is poorly understood and often incorrectly managed in facilities, with some managers accommodating providers’ refusal of care rather than instituting a coordinated approach that would ensure abortion services can still be delivered. Healthcare providers that do provide abortion care services often experience burnout from being victimised, stigmatised, and isolated from their peers and community.
RCOG respects the beliefs of every individual healthcare provider, while affirming a woman’s right to access safe and high quality care.

16. To address these challenges the Leading Safe Choices programme initiated Values Clarification workshops. Values Clarification workshops allow healthcare professionals a safe space, in which they can explore their personal doubts and concerns about reproductive health issues, empathize with women seeking abortion care services and acquire knowledge to reaffirm their own values. The workshops further allow participants to develop the necessary skills to provide respectful, holistic care to those women seeking abortions. All cadres of healthcare professionals including facility managers are included in the Value Clarification workshops as patients are exposed to the whole team on the care pathway and there is a need to address possible barriers at all levels. In addition, the workshops help to encourage support for abortion care providers from the rest of their colleagues who are not directly providing the service, addressing stigmatisation and working in isolation.

17. In Leading Safe Choices health facilities in South Africa it was evident that managers at various levels objected to providing CAC services at their facilities, were resistant to sending their staff for CAC training and were unsupportive of current CAC providers. Some pharmacists were also resistant to procuring medication for Medical Abortion due to conscientious objection. Only a handful of CAC providers were providing services and, should they leave, no succession plans were in place. Alongside facility management attending Values Clarification workshops, the Leading Safe Choices programme has initiated monthly meetings with relevant managers to monitor progress of the CAC trainees and the continued attendance at the Values Clarification workshops. Recruitment of a dedicated CAC mentor improved the responsiveness of some managers to support CAC service providers on the ground.

18. Values Clarification workshops have contributed to an increase in the number of training requests for CAC. Senior managers in the South African pilot sites are requesting that all their facility and operational managers attend values clarification workshops in an attempt to transform attitudes and improve access to CAC services.

19. In South Africa, high-level buy in from facility management and the Department of Health has been instrumental when addressing blockages impacting the abortion provider workforce. The re-allocation of the Leading Safe Choices portfolio to the Chief Director of Medical District Health Services put CAC Services high on the agenda. The Member of the Executive Council for Health in the Western Cape, Dr Nomafrench Mbombo, fully supports the scale up of CAC services in all districts which she confirmed in her opening speech at the recent RCOG World Congress hosted in March 2017, in Cape Town. Senior managers now invite the Leading Safe Choices programme manager to attend their monthly meetings to input on the CAC training and the progress of mentorship.

20. Lack of professional recognition and/or financial compensation negatively impacts health provider esteem and provides no incentive to train in CAC. The South African Nursing Council does not recognise the provision of first trimester abortions (especially surgical) as a speciality, and there is currently no extra compensation for CAC skills upgrading.
Quality of Care:

21. The prevalence of unsafe abortion in both South Africa and Tanzania is in part due to a lack of clarity on the legality of abortion care for women and healthcare professionals alike. A highly restrictive abortion law in Tanzania further restricts a woman’s access to safe abortion or postabortion care. In Tanzania many providers are not aware that abortion is legal to save a woman’s life, and are hesitant to break the poorly understood law. In both Tanzania and South Africa misunderstanding and reluctance to break laws is compounded by a lack of clarity around conscientious objection, which limits the provision of quality life-saving services.

22. In South Africa, a lack of providers results in long waiting times for abortion which often pushes women over the below 13 week on request limit. Anecdotally, the RCOG has learned that often women who have sought safe abortion at a clinic have to wait so long to get a referral appointment that they are then told they are too late to get an abortion. Consequently they turn to unsafe abortions. The Leading Safe Choices programme focuses on task shifting to mid-level providers to streamline service delivery (and one that is not dependent on doctor-delivered services in the first trimester).

23. In South Africa, the Leading Safe Choices programme has seen quality of care improvements and increased willingness of health care providers to be trained in CAC, which is supported by high level commitment at the facility and regional Department of Health level.

24. Absence or poor quality of national comprehensive abortion care curricula acts as a barrier to the provision of high-quality abortion care. In South Africa, the Leading Safe Choices Best Practice Papers have been incorporated into the Western Cape Government “Local Policy Guidelines & Protocols for Choice on Termination of Pregnancy Service”. Historically, all provinces in South Africa follow the IPAS curriculum for CAC training. Abortion care should be mainstreamed and incorporated to standard physician and nursing training.

25. The Leading Safe Choices programme was invited to contribute to the Tanzanian national CPAC curriculum. The original curriculum was a week in length and included little postabortion family planning. Providing contraception services is a crucial component of CPAC as it can prevent future abortions and reduce the numbers of unwanted pregnancies. CPAC provides the opportunity to minimise barriers in accessing contraception as women are already in the health...
care setting. After a series of meetings with the Ministry of Health and other stakeholders, the latest draft supported by the MoH includes a week of postabortion family planning and a week of practical training, making the training three weeks in length. Though the importance of postabortion family planning has been recognised, taking health care workers away from their facilities for this length of time will have a detrimental impact on normal health service delivery. As there is no agreed curriculum at present, training has come to a halt. The Leading Safe Choices programme advocates short effective classroom-based training with ongoing supportive supervision and on-the-job mentorship.

26. In South Africa, abortion counselling often does not meet the needs of the clients and is of poor quality. Studies have shown that many women feel that the information provided during counselling was insufficient or not relevant to their personal situation, that pre-abortion counselling in group settings did not allow them a chance to discuss their needs with the provider in a confidential manner, and some women also found counselling to be judgemental, or were told that they could not have more than one legal abortion.

27. Impact has been seen in uptake of postabortion family planning in South Africa. There has been a reduction in use of short term contraceptive methods and a corresponding increase in Long Acting Reversible Contraceptive (LARC) methods. This is evidence of improved family planning counselling pre-abortion and improved provision of LARC family planning methods postabortion. Results over 12 months show immediate effect of the ‘training-plus’ model.

Influencers:

28. The success of a health workforce intervention ultimately depends on political will. Healthcare provider skills are not sufficient to break down multi-level or socio-cultural barriers that surround the complex topic of abortion.

29. A lack of high-level and facility-level political will in Tanzania is a barrier to quality abortion or postabortion services, and limits access to life saving care. For example, the length of the CPAC training in Tanzania currently takes key providers out of health facilities for three weeks, causing detriment to normal service delivery within an already constrained health workforce environment. So far the MoH has been inflexible to a reduction in training length. The Leading Safe Choices programme has faced limitations due to a lack of national trainers available to teach the CPAC course, and has not been allowed to train more (using a “train the trainers” approach) as the MoH requires all trainers to complete an expensive two week facilitator’s course. Even following financial support to deliver a ‘Facilitation course’ new trainers have not been allowed or encouraged to train or facilitate training courses.

30. The importance of local champions and multi-level ownership - In South Africa leadership from influential obstetricians and gynaecologists, Department of Health ownership (high-level political will), and local level/facility level political will, as well as support provided to CAC ‘lone-rangers’ through LSC networks and competency certification, has been essential for embedding and sustainability of programme activities. This has not yet changed access to abortion services (also affected by more distal factors and community-level barriers), however clear improvements are visible in quality of care in CAC (particularly in postabortion family planning). CAC access is driven by wider population-based and socio-cultural determinants, requiring multi-level multi-sectorial approaches.
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