EDITORIAL

How health services can improve access to abortion

Sam Rowlands*†

*Contraception & Sexual Health Service, Dorset HealthCare, Bournemouth, UK

†Faculty of Health and Social Sciences, Bournemouth University, UK

Eduardo López-Arregui‡

‡Euskalduna Clinic, Bilbao, Spain

On behalf of the Expert Group on Abortion, European Society of Contraception and Reproductive Health

SHORT TITLE: Improving access to abortion services

KEYWORDS: abortion, access, barriers, obstacles, health services

Word count: 1,320

Correspondence to:

Sam Rowlands, Visiting Professor, Faculty of Health and Social Sciences, Bournemouth University, R506 Royal London House, Christchurch Road, Bournemouth BH1 3LT, UK Tel: +44 (0)1202 962782

srowlands@bournemouth.ac.uk

Previous editorials have dealt with unsafe abortion in Africa[1] and the law in Spain[2]. This editorial will confine itself to factors within health services that affect access to abortion in high-income countries. Factors that either obstruct or facilitate access to abortion in such countries have recently been reviewed[3].

The quality of the health services of the country in which the woman resides will affect access, both generally and more specifically the abortion services. Health Ministries often fail to take a lead in abortion care. Where there is not enough confidence in how the law should be interpreted, there may be unnecessary restrictions as is the case in Northern Ireland[4]. WHO guidance recommends that policy-makers and healthcare managers should ensure that safe abortion care is readily accessible and available to the full extent of the law[5]. Abortions are already being provided by general practitioners (GPs) in countries such as France, Switzerland and The Netherlands; WHO supports more abortion care at primary care level.

Information on local abortion services should be widely available on websites, in telephone directories, in public libraries, in pharmacies and in GP premises. A system of direct access (self-referral) to abortion services avoids any delays associated with the need for referral. Central booking systems have been shown to facilitate access[6].

In many countries fees are charged for abortion[7]. Some countries subsidise abortions performed for medical reasons, rape and in the case of minors. In the USA, under the Hyde amendment, 32 out of the 50 states do not provide Medicaid funding for abortion and federal funding is prohibited[8]. For individuals without health insurance in systems in which charges for healthcare apply, an abortion may be simply unaffordable. In other countries abortion procedures are free, although there may be some charges for hospital stay and investigations. More needs to be done to assist women in those countries that are charging fees for abortion that cannot be reimbursed. Where fees are charged for abortion, such fees should be matched to women's ability to pay, and procedures should be developed for exempting the poor and adolescents from paying for services[5]. As far as possible, abortion services should be mandated for coverage under insurance plans. The barrier of high costs to women is likely to generate much higher costs for the health system, by increasing the number of women who attempt to self-induce abortion or go to unsafe providers and, as a result, require hospitalisation for serious complications[5].

Depending on whether a referral is needed by the provider, the responsiveness of health services generally to booking appointments can affect a woman's pathway to the appropriate provider. The need for a referral from a GP can cause a delay if that doctor has a negative attitude or is a conscientious objector. About one quarter of GPs do not refer women for abortions[9;10]. Professional guidelines on maximum acceptable waiting times between referral and assessment[11;12] and assessment and treatment[12] will tend to be incorporated into local service delivery and should be encouraged.

There may or may not be a choice of provider. Some individuals may prefer not to go to a hospital. Choice is a highly valued element of services by women[13].

Negative staff attitudes and imposition of artificial requirements such as gestational limits will both tend to deter women seeking abortion[3]. Unregulated conscientious objection results in high conscientious objection prevalence areas where abortions are hard to access[14]. The system operated in Norway is the best example of how conscientious objection can be overseen to ensure proper service delivery in all regions of the country. Regulations on conscientious objection ensure that all conscientious objectors are known about and that local providers have enough non-objectors to ensure the availability of adequate services[14].

Availability of abortion depends on adequate equipment, adequate availability of theatre time for surgical procedures[15], necessary drugs being licensed for use and trained, experienced health personnel. Furthermore, for surgical abortion in the second trimester, access to abortion depends on doctors having the necessary skills which can become a problem unless younger doctors have the motivation and training to acquire these skills[15]. Abortion care is not usually integrated into doctors' residency programmes[16].

Insistence on all women having an ultrasound scan can limit availability of services. World Health Organization (WHO) policy is that ultrasound scanning is not routinely required for the provision of abortion[5]. This should be kept in mind in the organisation of abortion services particularly in more rural areas[17].

In some countries there is no access to mifepristone. This limits what can be offered in primary care and greately reduces choice for women. Mifepristone should be included on national essential drugs lists. Ideally mifepristone should be licensed, but it is acknowledged that in smaller countries there is a lack of economic viability for pharmaceutical companies in marketing a drug where profits will be small. However, some countries allow importation through the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce[5].

In some countries, Catholic hospitals are permitted to refuse to offer abortion services. In the USA, Catholic-sponsored healthcare companies are gradually taking over non-Catholic hospitals; one in nine beds is now in a Catholic hospital system[18]. A solution to this problem needs political will.

Providers tend to be concentrated in more urban areas. This means that those living in rural areas may have to travel long distances for their care. Examples are the more remote parts of Australia, Canada and New Zealand[3]; for instance, abortion is unobtainable in the Canadian province of Prince Edward Island. Young women, indigenous women and women on low incomes are disproportionately affected. To ensure adequate care for women living in rural areas, telemedicine and task sharing are two ways of facilitating delivery of care nearer to the woman's home. Two types of telemedicine are in operation. The first is a full medical consultation by remote communication with the patient[19;20]. The second is an internet-based medical screening questionnaire to assess eligibility before sending out pills for medical abortion by post[21]. The latter is used in high-income countries that have restrictive abortion laws such as the Republic of Ireland as well as in low/middle-

income countries. Two organisations in particular operate internet-based telemedicine services: Women on Web and Women Help Women.

In some high-income countries health professionals other than doctors are permitted to do surgical abortions[22]. In a Swedish study, women undergoing medical abortion who expressed a preference chose nurse-midwives rather than physicians for their care[23]. Comparative studies of both medical and surgical abortion have shown no difference in complication rates between women who undergo first trimester abortions performed by mid-level healthcare providers and those who have the procedure performed by a physician. Task sharing allows women more choice, is highly acceptable and saves money[24].

SUMMARY

Health Ministries ought to facilitate and make explicit precisely what the abortion law allows. Professional societies should write their own abortion guidelines or disseminate international guidelines for the benefit of health care professionals.

Wide dissemination of information about abortion services is needed to allow choice for women. Services should be delivered as close to women's homes as possible. Where possible, primary care facilities are an ideal setting for first trimester procedures. Special arrangements should be considered for women who live far away from cities or towns.

Care pathways should be mapped out for the whole of a woman's journey, making this as seamless as possible. Medical and surgical methods of abortion at all legal gestations should be available.

Women should be able to make their own appointments via a centralised booking system. Efforts should be made in countries where woman currently pay for abortions to enable exemptions or reimbursement.

Consideration should be given to greater participation in all elements of abortion procedures by staff other than doctors. Conscientious objection by clinical staff should be tightly regulated and monitored.

Declaration of interest

The authors report no conflict of interest. The authors alone are responsible for the content and the writing of the paper.

Reference List

(1) Brookman-Amissah E. Saving women's lives in Africa through access to comprehensive abortion care. *European Journal of Contraception & Reprod Hlth Care* 2012; 17:241-244.

(2) Lete I, Calaf J, López-Arregui E. Is there a need for a new abortion law in Spain? *European Journal of Contraception & Reprod Hlth Care* 2014; 19:75-77.

(3) Doran F, Nancarrow S. Barriers and facilitators of access to first trimester abortion services for women in the developed world: a systematic review. *J Fam Plann Reprod Health Care* 2015; 41:170-180.

(4) Northern Ireland: barriers to accessing abortion services. London: Amnesty International; 2015.

(5) Safe abortion: technical and policy guidance for health systems. 2nd ed. Geneva: World Health Organization; 2012.

(6) Rowlands S. The development of a nationwide central booking service for abortion. *European Journal of Contraception & Reproductive Health Care* 2006; 11:210-214.

(7) IPPF European Network. Abortion legislation in Europe. Brussels: International Planned Parenthood Federation; 2007.

(8) Boonstra HD. Insurance coverage of abortion: beyond the exceptions for life endangerment, rape and incest. *Guttmacher Policy Review* 2013; 16:2-8.

(9) Westfall JM, Kallail KJ, Walling AD. Abortion attitudes and practices of family and general practice physicians. *Fam Pract* 1991; 33:47.

(10) Finnie S, Foy R, Mather J. The pathway to induced abortion: women's experiences and general practitioner attitudes. *J Fam Plann Reprod Health Care* 2006; 32:15-18.

(11) Agence Nationale d'Accréditation et d'Évaluation en Santé. Prise en charge de l'interruption volontaire de grossesse jusqu'à 14 semaines. 2010.

(12) The care of women requesting induced abortion. 3rd ed. London: Royal College of Obstetricians and Gynaecologists; 2011.

(13) Slade P, Heke S, Fletcher J, Stewart P. A comparison of medical and surgical termination of pregnancy : choice, emotional impact and satisfaction with care. *British Journal of Obstetrics & Gynaecology* 1998; 105:1288-1295.

(14) Chavkin W, Leitman L, Polin K. Conscientious objection and refusal to provide reproductive healthcare: a White Paper examining prevalence, health consequences, and policy responses. *Int J Gynecol Obstet* 2013; 123:S41-S56.

(15) Ferris LE, McMain-Klein M, Iron K. Factors influencing the delivery of abortion services in Ontario: a descriptive study. *Family Planning Perspectives* 1998; 30:134-138.

(16) Dehlendorf C, Brahmi D, Engel D, Grumbach K, Joffe C, Gold M. Integrating abortion training into family medicine residency programs. *Fam Med* 2007; 39:337-342.

(17) Kaneshiro B, Edelman A, Sneeringer RK, Ponce de León RG. Expanding medical abortion: can medical abortion be effectively provided without the routine use of ultrasound? *Contraception* 2011; 83:194-201.

(18) Miscarriage of medicine:the growth of Catholic hospitals and the threat to reproductive health care. New York: American Civil Liberties Union/MergerWatch; 2013.

(19) Grossman DA, Grindlay K, Buchacker T, Potter JE, Schmertmann CP. Changes in service delivery patterns after introduction of telemedicine provision of medical abortion in Iowa. *Am J Public Health* 2013; 103:73-78.

(20) Wiebe ER. Use of telemedicine for providing medical abortion. *Int J Gynecol Obstet* 2014; 124:177-178.

(21) Gomperts RJ, Jelinska K, Davies S, Gemzell-Danielsson K, Kleiverda G. Using telemedicine for termination of pregnancy with mifepristone and misoprostol in settings where there is no access to safe services. *BJOG* 2008; 115:1171-1175.

(22) Weitz TA, Taylor D, Desai S. Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver. *Am J Public Health* 2013; 103(454):461.

(23) Kopp Kallner H, Gomperts R, Salomonsson E, Johansson M, Marions LG-DK. The efficacy, safety and acceptability of medical termination of pregnancy provided by standard care by physicians or by nurse-midwives: a randomized controlled equivalence trial. *BJOG* 2015; 122:510-517.

(24) Department of Reproductive Health and Research. Health worker roles in providing safe abortion care and post-abortion contraception. Geneva: World Health Organization; 2015.