Closing the Gap: Improving Quality in Abortion Self-care

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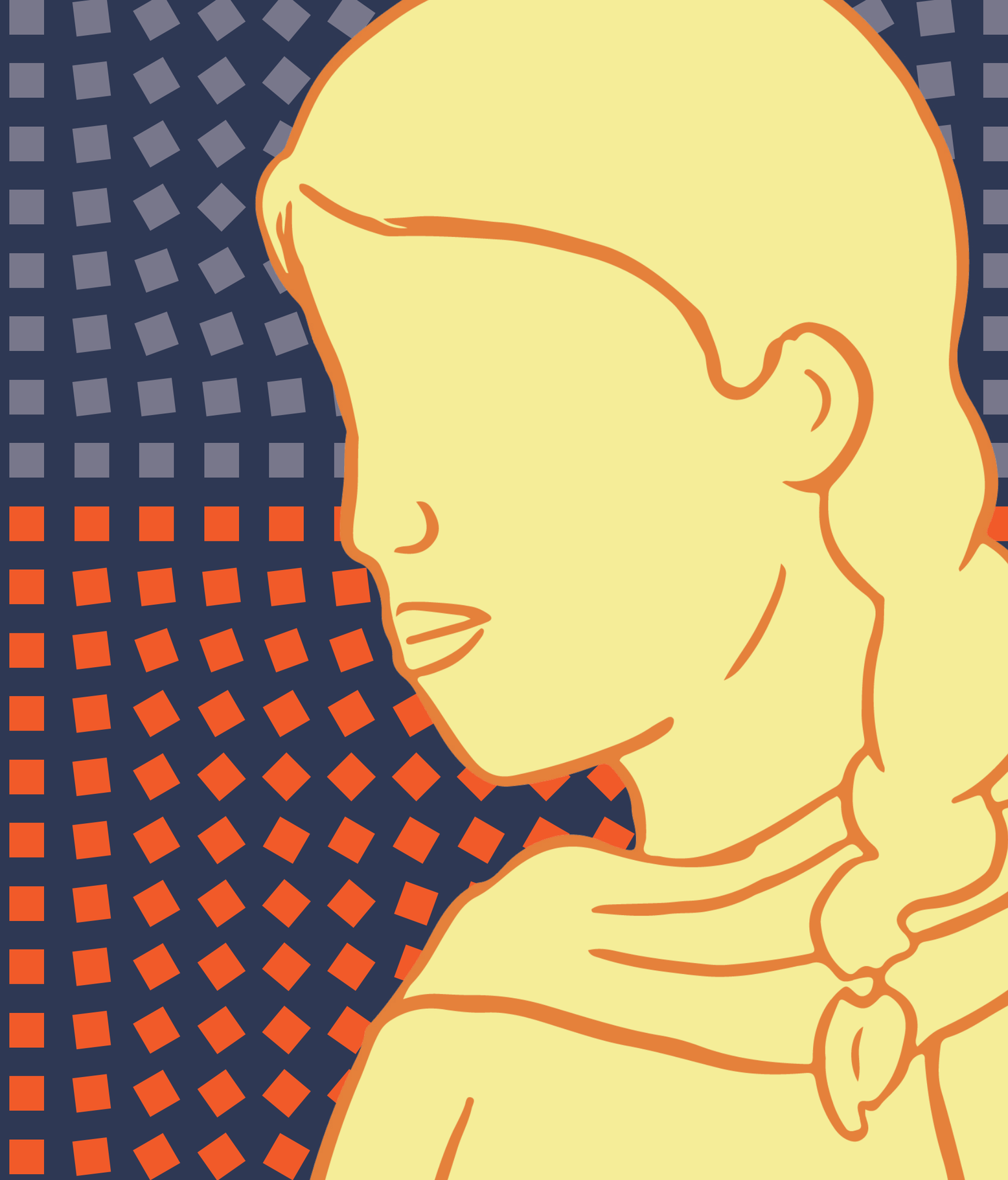

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*This is a working paper

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Background & Context

The purpose of this discussion paper is to present the initial findings from the abortion diaries research conducted by the Ipas Development Foundation (IDF) in two major states of India. The study aims to document and understand the abortion self-care (ASC) experience from women's perspectives. The research has a dual objective: firstly, to incorporate the key findings into policy and program initiatives, and secondly, to generate dialogue and discussion with the wider community working towards safe and high-quality abortion care.

Abortion care quality encompasses multiple dimensions, and recent advancements in this field have recognized the importance of non-clinical and non-biomedical aspects of the abortion experience[1]. Ipas, Ibis Reproductive Health, and Metrics for Management have identified measures for abortion quality as part of the Abortion Services Quality Initiative[2]. Ensuring quality in abortion care is a fundamental right of all women and girls, and this discussion paper seeks to analyse and discuss aspects of quality from the ASC journeys recorded in the research.

This paper is a supplement to the main research findings of the study "Self-Managed Abortion Journeys of Women: A research study using diary method in two states of India" and aims to stimulate discussion on key insights around quality in ASC. The study was conducted among women who chose self-managed abortion and had varying levels of knowledge and support available to them. It is important to note that all women in the research had a successful completion of the abortion, and some sought reassurance and additional care during their self-managed abortion process. The findings reveal several gaps relating to information, social support, and clinical practices. Based on the above insights, the paper presents a few emerging themes for discussion.

Awareness on ASC is high, but information is incomplete, leading to gaps in quality during the ASC journey

Women in this research demonstrated high levels of awareness and were able to identify and access the necessary drugs, but without an in-depth understanding of specific areas that impact their overall experience. While most women in this research were already aware of medical abortion pills to undertake an abortion, others learned about these pills from a family member, friend/neighbour, the internet, and in some cases a health worker or pharmacist.

Although the awareness of these pills was high or easily accessible, there was a lack of information and understanding on how to take them, what to expect during the medical abortion process, the potential side effects, and how to manage them. This inconsistency in information and understanding was observed across the group, including women who had prior experience using the pills. They were unsure about when and how to take the pills and what to expect after consumption.

In addition to the impact on the overall abortion journey, the lack of information and understanding of the process also contributed to fear, nervousness, and anxiety during the abortion process. In this research, only a handful of women actively sought out information on the entire process prior to consuming the medical abortion drugs. For all others, they decided and acted “on a need basis” as symptoms developed or the need arose. This approach indicated that women were often unprepared to act or seek support during the process and impacted the overall quality of ASC experience.

Discussion: Information gaps (not awareness) within the ASC and the related lack of action are evident from this research. Women have a general awareness about medical abortion pills and its use outside of facilities through their social networks and other channels. They however do not seek specific (to their needs) information until they are faced with an unwanted pregnancy that they want to end. This finding is in alignment with pervious formative research done using human centric design by IDF. While this general awareness assists women broadly with charting the path, it often leaves large information gaps (e.g., on what to expect after taking the pills, side-effects and its management, need for planning additional care etc.) which affect the overall ASC experience. In this context,

- How can ASC programming prioritise addressing information gaps to improve the overall abortion experience?

- Would it be more effective to focus on improving general awareness of medical abortion to close these gaps, or should there be on-demand information support available to women on ASC journeys? Should both approaches be pursued, or should alternative strategies be considered?

Insights on lack of social support affecting overall experience

For most women who underwent the ASC process, their experience was shaped significantly by the social aspect. The social dimension of ASC was associated with various challenges, concerns, and hardships as women tried to balance their social roles within their families, primarily as wives, mothers, and daughters-in-law, during the abortion process.

The physical experience of the medical abortion process and its side-effects were often compounded by the lack of empathetic care at home and the need to manage day-to-day responsibilities such as childcare, cooking, household duties, and work in the garden or on farms. Women were expected to continue performing these duties despite undergoing the abortion process, which added to their stress. This was perceived differently from seeking healthcare in a formal facility and contributed to expectations around continuing with these household duties by their mothers-in-law and other family members. It is likely that the lack of disclosure of the abortion process to family members could have contributed to a lack of support.

While this research examined the physical and emotional experiences of women undergoing ASC, it focused primarily on their immediate physical experiences and within the context of their interpersonal relationships. The study did not delve into the experiences of women as individuals, their conditioning, and feelings. Further exploration of this aspect could provide a deeper understanding of how abortions fit within women's reproductive life journeys and a more nuanced appreciation of the emotional aspects of self-care. It would also provide insights into understanding drivers and level of abortion stigma for ASC.

Discussion: The social dimension of ASC has a significant impact on women's overall experience and the provision of social support is crucial. Women often face challenges in balancing their social roles within their families during the abortion process. It is important for abortion programming to recognize and address this aspect of women's ASC journeys. Preplanning and empathetic support are necessary for women to effectively manage their responsibilities within their homes while experiencing a self-managed abortion (SMA). In this context,

- What measures can be taken by abortion programs and stakeholders to acknowledge and provide support to the social dimension of women's ASC experiences? In what ways can stakeholders contribute to improving this aspect of women's journeys?

Gaps in quality of the physical experience of ASC: The combi pack helps but other aspect of clinical care is lacking that impacts the overall SMA experience

One of the biggest areas of gaps identified from the journeys of the 68 women are the variations in MA protocol followed as compared to current WHO recommendations. Specifically, three areas of gaps were identified from this research that merits further exploration and discussion.

Challenges to full, timely and accurate dosing of misoprostol was observed among all women in this research: Only 4 out of the 68 women took the recommended 800 mcg of misoprostol. The records showed that 67 of the 68 women did not take misoprostol tablets in the recommended routes of administration. While many women in this study self-reported a complete abortion between days 7 -10 (after taking the first tablet), a good number of them also reported completion by day 14. While all women self-reported completion without additional clinical intervention, several of them experienced a wide variety of signs and symptoms (continued or prolonged bleeding, significant pain, uneasiness, and tiredness) that contributed to fear and anxiety around both the health of the woman and the fear of the abortion failing.

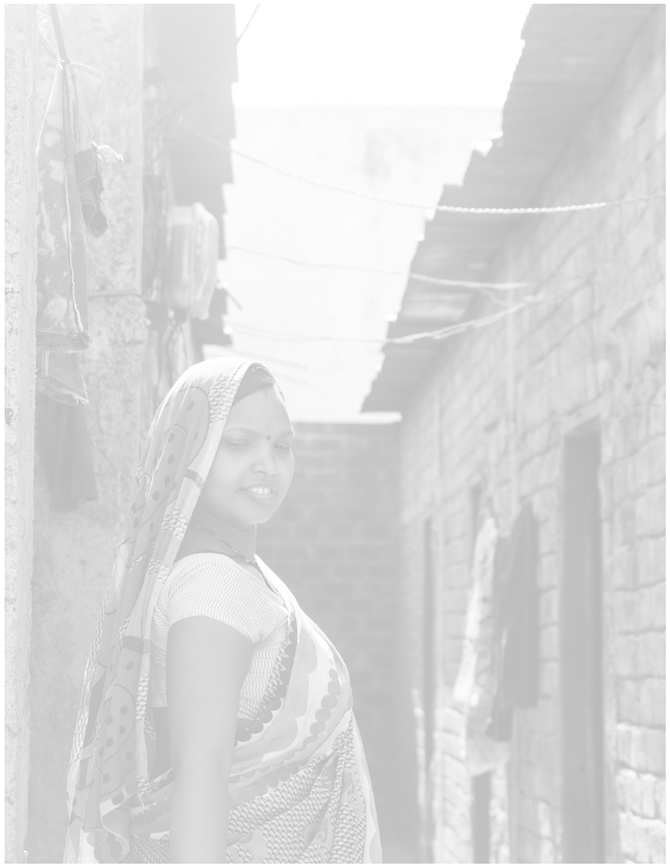
The absence of supplementary care, particularly for pain and nausea as a standard of care, was striking as most women in this cohort did not receive/or were aware of the need for additional medication to manage side-effects. Only a few women received additional medication for stomach -ache, likely to be pain medication, but at a later stage of the abortion process and after they had endured pain for some time. In addition, many women in the research did not receive any supplementary medication and underwent the SMA without pain or other side effect management. This is a critical area to address that has the potential to improve the overall experience for women undergoing SMA.

Finally, the lack of cues, information, or linkages to contraception was a missed opportunity for these women. Not surprisingly, the paucity of touchpoints for information on family planning methods within the ASC journey was a key driver in missed opportunities to provide adjacent information on abortion care to women in this research. While the research did not actively explore interest or use of contraception, particularly after the completion of a SMA, there was little reference to use of contraception or motivation to prevent a future unwanted pregnancy. This is an area that needs further exploration both from the angle of what is the understanding of the post-abortion period by women undergoing ASC and their knowledge, attitudes and preferences for use of contraception after an ASC.

Discussion: The recommended routes of misoprostol administration (particularly the buccal and sublingual) routes are poorly understood and followed by women with many of them using a lower (than 800 mcg) dose. However, all women in this research self-reported a complete abortion and did not require additional clinical intervention to achieve a complete abortion. Further research is needed to identify:

- How can safe abortion practitioners and supporters facilitate the use of misoprostol and improve adherence to the protocol among women seeking medical abortion?
    - » Should dosing regimens for home use of medical abortion be explicitly studied and recommended?
    - » What is the minimum effective dose of misoprostol for a successful first-trimester abortion outside of health facilities?
    - » Are there evidence-based recommendations to simplify the administration of misoprostol, such as using enteric-coated doses or adjusting for first-pass metabolism by increasing the dose?

- One notable issue is the failure to utilise additional medication to mitigate side-effects and enhance the overall medical abortion experience. What interventions at an upstream and program level could be implemented to address this concern and enhance the quality of care for medical abortions?



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2. Ipas, Ibis Reproductive Health, Metrics for Management. Abortion Service Quality Initiative, 2021.

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