REPRODUCTIVE HEALTH matters

FEATURE

Perceptions of misoprostol among providers and women seeking post-abortion care in Zimbabwe

M Catherine Maternowska,[a] Alexio Mashu,[b] Precious Moyo,[c] Mellissa Withers,[d] Tsungai Chipato[e]

a Scholar, Bixby Center for Global Reproductive Health, University of California, San Francisco, CA, USA. *Correspondence*: cmaternowska@gmail.com

b Project Manager, Department of Obstetrics and Gynaecology, School of Medicine, University of Zimbabwe, Harare, Zimbabwe

c Analyst, Department of Obstetrics and Gynaecology, School of Medicine, University of Zimbabwe, Harare, Zimbabwe

d Assistant Clinical Professor, Institute for Global Health, Keck School of Medicine, University of Southern California, Los Angeles, CA, USA

e Professor, Department of Obstetrics and Gynaecology, School of Medicine, University of Zimbabwe, Harare, Zimbabwe

Abstract: *In Zimbabwe, abortions are legally restricted and complications from unsafe abortions are a major public health concern. This study in 2012 explored women's and providers' perspectives in Zimbabwe on the acceptability of the use of misoprostol as a form of treatment for complications of abortion in post-abortion care. In-depth interviews were conducted with 115 participants at seven post-abortion care facilities. Participants included 73 women of reproductive age who received services for incomplete abortion and 42 providers, including physicians, nurses, midwives, general practitioners and casualty staff. Only 29 providers had previously used misoprostol with their own patients, and only 21 had received any formal training in its use. Nearly all women and providers preferred misoprostol to surgical abortion methods because it was perceived as less invasive, safer and more affordable. Women also generally preferred the non-surgical method, when given the option, as fears around surgery and risk were high. Most providers favoured removing legal restrictions on abortion, particularly medical abortion. Approving use of misoprostol for post-abortion care in Zimbabwe is important in order to reduce unsafe abortion and its related sequelae. Legal, policy and practice reforms must be accompanied by effective reproductive health curricula updates in medical, nursing and midwifery schools, as well as through updated training for current and potential providers of post-abortion care services nationwide. Our findings support the use of misoprostol in national post-abortion care programmes, as it is an acceptable and potentially life-saving treatment option.* © 2015 Reproductive Health Matters

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The World Health Organization estimated that in 2008 21.6 million women worldwide had unsafe abortions, nearly all of them in developing countries, with an overall unsafe abortion rate at about 14 per 1,000 women aged 15–44 years. In sub-Saharan Africa, unsafe abortion rates are about 31 per 1,000 women aged 15–44 years.[1]

In Zimbabwe, unsafe abortions account for 10% of all maternal deaths,[2–4] and post-partum haemorrhage and unsafe abortion are two of the five main causes.[5] The Ministry of Health and Child Welfare has long expressed concern about the high level of deaths, and as part of its support for reproductive health care, it has supported the development of post-abortion care services.

Currently, abortion in Zimbabwe is only legally permissible on three grounds: in circumstances of rape and/or incest, when the pregnancy endangers the health of the woman and where there is a risk that the child will be born with serious mental or physical disabilities (Termination of Pregnancy Act of 1977. No. 29). Despite the law, Harare Hospital records show that the number of admissions for abortion complications has increased over time, along with high rates of maternal mortality.[2,5] Unwanted pregnancy in

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Zimbabwe appears to be increasing due to the erosion of traditional cultural values in the wake of rural–urban migration, the increased desire to limit family size, delay in the age at marriage given increased educational opportunities for women, and the fact that contraceptives are not readily available to women under age 18.[4]

Post-abortion care in Zimbabwe consists of a package of services designed to address complications from incomplete abortion and miscarriage. Since 2006, the Ministry, with the University of Zimbabwe, has established three post-abortion care referral and training centres, located in the capital Harare and Chitungwiza, an adjacent peri-urban area. The main objective of this programme has been to train health care providers to use manual vacuum aspiration (MVA) instead of dilatation and curettage (D&C), with the goal of abolishing D&C in Zimbabwean health care facilities.* The World Health Organization also recommends mifepristone plus misoprostol, or misoprostol alone, as a safe and effective treatment for incomplete abortion,[6] based on a substantial body of evidence, including from sub-Saharan Africa.[7–16] Some of these studies have also documented women's satisfaction with misoprostol for abortion-related care.[7–9,13,14]

Mifepristone is not registered in Zimbabwe, however, and misoprostol is registered through the Medicines Control Authority of Zimbabwe only to treat gastric ulcers. Manual vacuum aspiration (MVA) is also recommended by WHO for post-abortion care.[6] Because misoprostol is inexpensive, easy to use, and can be administered through several routes (oral, sublingual, buccal, and vaginal), it is well suited for use in resource-constrained settings.[17] However, in Zimbabwe, as in many countries in sub-Saharan Africa, the use of misoprostol in the management of post-abortion complications is restricted, due to registration delays with the relevant regulatory body.

In line with the goal of expanding post-abortion care services in Zimbabwe to include misoprostol for treatment of complications, this study aimed to: 1) explore women's and provider's perspectives and knowledge of misoprostol in urban Zimbabwe; 2) explore the existing and potential use of misoprostol in the management of abortion complications as part of existing guidelines in Zimbabwe; and 3) inform discussions and advocacy around increasing access to safe abortion and improving policy in Zimbabwe with the goal of saving women's lives.

*D&C is no longer recommend by the WHO or the University of Zimbabwe School of Medicine, but the practice still persists, despite national efforts to institutionalise MVA.

Methods

The study employed a primarily qualitative approach, using semi-structured interview guides with open-ended questions – one for women and another for providers. Data were collected in seven facilities in Harare and Chitungwiza, from June to December 2012. They were chosen both based on the mix of institution types providing post-abortion care services and because they are among the best nationwide and typically attract women from around the country. They were comprised of two privately owned hospitals, three government- or state-owned tertiary level (referral) hospitals, and two non-governmental organization-supported (NGO) facilities, which taken together are typical of the framework of the health care system in Zimbabwe. General practitioners and casualty providers were also part of the provider sample, giving a more comprehensive assessment of the landscape of practitioners offering post-abortion care services in Zimbabwe.

In-depth interviews were conducted with 73 women and 42 service providers. We used a consecutive recruitment strategy for the women, within a purposive sample of consenting women. The criteria for inclusion were to have been admitted with a diagnosis of incomplete abortion or another pregnancy-related complication requiring treatment at one of the facilities.

Providers included doctors (n = 7), nurses (n = 15) and midwives (n = 10), who were recruited from among emergency reproductive health care providers (n = 21) evenly divided among the seven study sites, as well as general practitioners and casualty staff (n = 21) practising in the greater Harare area. Nine of the 42 providers were male and 33 were female, with a mean age of 41 years. They had been working in the field of reproductive health for a mean of 9.8 years (range 1 month to 38 years) and had been based at their current medical facility for a mean of 7.2 years (range 1 month to 27 years).

In an effort to be even more inclusive, ten other 'practitioners' (n = 10) such as clerks, a monitoring and evaluation specialist and other non-clinical staff were also included in the provider sampling frame, but in the end their narrative was neither