ELSEVIER
www.rhm-elsevier.com

Reproductive Health Matters 2008;16(31 Supplement):135–144
0968-8080/08 $ – see front matter
PII: S0968-8080(08)31387-1

REPRODUCTIVE HEALTH matters
www.rhmjournal.org.uk

Establishing Second Trimester Abortion Services: Experiences in Nepal, Viet Nam and South Africa

Alyson G Hyman,[a] Traci L Baird,[b] Indira Basnett[c]

a Senior Training and Services Advisor, Ipas, Chapel Hill, NC USA. E-mail: hymana@ipas.org

b Director, Medical Abortion Initiative, Ipas, Chapel Hill NC, USA

c Country Program Manager, Technical Committee for the Implementation of Comprehensive Abortion Care/Ipas, Family Health Division, Kathmandu, Nepal

Abstract: *This paper describes experiences and lessons learned about how to establish safe second trimester abortion services in low-resource settings in the public health sector in three countries: Nepal, Viet Nam and South Africa. The key steps involved include securing the necessary approvals, selecting abortion methods, organising facilities, obtaining necessary equipment and supplies, training staff, setting up and managing services, and ensuring quality. It may take a number of months to gain the necessary approvals to introduce or expand second trimester services. Advocacy efforts are often required to raise awareness among key governmental and health system stakeholders. Providers and their teams require thorough training, including values clarification; monitoring and support following training prevents burn-out and ensures quality of care. This paper shows that good quality second trimester abortion services are achievable in even the most low-resource settings. Ultimately, improvements in second trimester abortion services will help to reduce abortion-related morbidity and mortality.* ©2008 Reproductive Health Matters. All rights reserved.

Keywords: second trimester abortion, abortion methods, abortion providers and services, training of service providers, Nepal, Viet Nam, South Africa

WHEN provided by trained clinicians using sound practices, second trimester abortions are safe.[1] However, in the many settings where they are not provided safely, they contribute disproportionately to abortion-related morbidity and mortality.[2,3] The World Health Organization and others have promoted the availability of safe abortion in the second trimester, yet little has been published about *how* to establish safe services, particularly in developing countries where resources are limited.

Ipas, a US-based non-governmental organisation, has worked on abortion service delivery for more than 35 years in a wide variety of settings in Africa, Asia, Latin America and Eastern Europe. In Viet Nam, our work to strengthen public sector abortion care identified problems in second trimester abortion services resulting from outdated clinical techniques.[4] We provided technical assistance to the Vietnamese Ministry of Health to improve second trimester services, followed by similar assistance to the Family Health Division in Nepal and provincial reproductive health departments in South Africa.

This paper describes experiences and lessons learned in Nepal, and to a lesser extent Viet Nam and South Africa, and recommendations based on these experiences for delivering safe, effective second trimester abortions. Key steps include securing necessary approvals, identifying the need for the methods available, organising the facility, obtaining necessary equipment, preparing the health care team, managing the services, and ensuring high quality care.

Securing approval and selecting abortion methods

Nepal

Prerequisites to providing safe second trimester abortion services include educating policymakers and clinicians about grounds permitted in existing abortion laws, and obtaining the necessary government approval, which can take many months to complete.

In Nepal, advances in women's rights have enabled women to obtain legal abortion since 2002, on request through 12 weeks of pregnancy, in the case of rape or incest through 18 weeks, and at any time in pregnancy with the approval of a medical practitioner for fetal impairment or risk to the woman's life or physical or mental health. A guardian's consent must be obtained for women younger than 16.[5] To implement the law, the Nepal government established the Technical Committee for the Implementation of Comprehensive Abortion Care (TCIC) in 2003. The TCIC trained providers in comprehensive abortion care, but services were initially established primarily for first trimester abortions.

According to a national, facility-based study in 2006, 4,245 women (13% of those seeking abortion) were denied abortion services because they were more than 12 weeks pregnant.[6] Advocates and policymakers therefore began a dialogue aimed at introducing safe second trimester services in the public sector.[7,8] Consultative meetings with health professionals and programme managers resulted in a Strategic Plan on Second Trimester Abortion, which outlined standards and guidelines for clinical protocols and health facility requirements, and specified that only obstetrician–gynaecologists could provide second trimester abortions. The Plan includes both surgical and medical abortion as recommended by the World Health Organization: dilatation and evacuation (D&E) and medical abortion with mifepristone–misoprostol.

Before services could be implemented, it was necessary to obtain approval from the Ministry of Health and Population for the Strategic Plan. Advocacy efforts were directed at policymakers regarding the need for second trimester services, evidence-based clinical protocols and the Plan. As a result of these efforts, in April 2007 the Ministry endorsed the Plan.

First trimester medical abortion was only being used in research studies at the time (it has subsequently been approved for routine use), so approval had to be obtained from the Drug Department Administration, on the basis of global evidence of safe and acceptable regimens, particularly using data from India.

The TCIC's goal is to increase access in all regions by having at least one and, where possible, two second trimester methods available. The Family Health Division of the Ministry decided that both medical abortion and D&E should be offered at all tertiary care facilities, in a staged manner. This would allow women a choice of method, and because the caseload is high in these facilities, providers would be able to maintain their skills. TCIC and government colleagues felt strongly, however, that medical abortion was safer outside major urban areas and tertiary centres, where caseloads are smaller and providers may lack training and proficiency in D&E. The lower cost of medical abortion as compared to D&E also means that rural and lower-level sites are more likely to be able to offer it. Where medical abortion is the only choice, however, tertiary referral needs to be in place in cases where women want D&E and for back-up for failed medical abortion. At present, many providers remain unaware of these issues.

Viet Nam

In Viet Nam, although second trimester abortion has been legal since the 1960s and providers are aware of the law, the Kovacs method, an outdated technique, has remained in use.[4] To change this, a one-year, small introductory D&E study (n=100 women) was conducted at one hospital in 1999, after which D&E was added to the national abortion standards and guidelines. The guidelines, however, required a nearly two-year approval process involving national expert review meetings, dissemination of drafts to provincial health leaders, regional review meetings to incorporate feedback and finalise the drafts, and submission to the Ministry of Health for signature (Do Thi Hong Nga, Country Director, Ipas Viet Nam, personal communication, 25 April 2008) Unfortunately, the guidelines excluded second trimester medical abortion, despite its use at major hospitals, as some decision-makers had concerns about second trimester misoprostol use. The government is now considering authorising second trimester medical abortions nearly a decade after D&E