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FIGO INITIATIVE

Achievements of the FIGO Initiative for the Prevention of Unsafe Abortion and its Consequences in South-Southeast Asia

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ABSTRACT

Since 2008, the FIGO Initiative for the Prevention of Unsafe Abortion and its Consequences has contributed to ensuring the substitution of sharp curettage by manual vacuum aspiration (MVA) and medical abortion in selected hospitals in participating countries of South-Southeast Asia. This initiative facilitated the registration of misoprostol in Pakistan and Bangladesh, and the approval of mifepristone for "menstrual regulation" in Bangladesh. The Pakistan Nursing Council agreed to include MVA and medical abortion in the midwifery curriculum. The Bangladesh Government has approved the training of nurses and paramedics in the use of MVA to treat incomplete abortion in selected cases. The Sri Lanka College of Obstetricians and Gynaecologists, in collaboration with partners, has presented a draft petition to the relevant authorities appealing for them to liberalize the abortion law in cases of rape and incest or when lethal congenital abnormalities are present. Significantly, the initiative has introduced or strengthened the provision of postabortion contraception.

1. Introduction

It is difficult to calculate the number of induced abortions in a country when population-based data are lacking. In the 5 countries of South-Southeast Asia that have been participating in the International Federation of Gynecology and Obstetrics (FIGO) Initiative for the Prevention of Unsafe Abortion and its Consequences since 2008, annual estimates differ as a function of the size of the population, the legal status of abortion, and the quality of, and access to, health services. Consequently, abortion estimates range from 523 808 — 769 269 in Bangladesh [1], from 219 000 — 255 000 in Sri Lanka [2], 890 000 in Pakistan [3], and 6.4 million in India [4]. A considerable proportion of these abortions are unsafe according to the World Health Organization (WHO) criteria [5]. In Nepal, where legal reforms were introduced in 2002, almost 500 000 safe abortions were performed between 2004 and 2011 [6].

Likewise, it is difficult to calculate to what extent abortion contributes to maternal mortality. Published data are largely the results of studies conducted in tertiary care hospitals, a few demographic household surveys, and the research findings of the Population Council, the Guttmacher Institute, and WHO. In South Asia, abortions account for an estimated 13% of maternal mortality [7,8]. Statistics from the 5 participating countries vary. In Bangladesh, abortion-related mortality decreased significantly from 13% in 2001 to less than 1% in 2010 [9,10]. In Pakistan, abortion-related deaths accounted for 5.6% of maternal mortality in 2006 — 2007 [11] and in India to 8%–9% [4]. In Sri Lanka, septic abortions are responsible for 10% — 15% of maternal deaths and represent the second most common cause of mortality [12]. Sri Lanka has the lowest maternal mortality ratio (MMR) in the region at 33 per 100 000 [12] compared with 194 in Bangladesh [10], 276 in Pakistan in 2006 — 2007 [11], and 212 in India for the 2007 — 2009 period [13]. In Nepal, the MMR was reported as 281 per 100 000 in a 2006 Nepalese Demographic Survey [14], but was estimated to have fallen to 229 by 2008/2009 [15] and to 170 in later studies [16,17].

With respect to legislation, abortion is legal up to 63 days of pregnancy in India under the Medical Termination of Pregnancy Act [18] and up to 90 days in Nepal, extended up to 18 weeks when the pregnancy is the result of rape and at any stage in pregnancy when required

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to save the mother's life [19]. In Bangladesh, "menstrual regulation" is allowed up to 10 weeks of pregnancy [20], while abortion has been permitted since 1997 in Pakistan not only when required to save the mother's life, but also in the early stages of pregnancy for "necessary treatment" [21]. In Sri Lanka, current legislation allows pregnancy termination only when required to save the life of the pregnant woman [22].

Restrictive laws do not deter women from terminating unwanted pregnancies, but rather drive them to unskilled healthcare providers to ensure confidentiality and escape punitive measures [23–25]. On the other hand, liberal laws do not guarantee safe abortions if necessary proactive measures are not taken by the government and by society. Therefore, unsafe abortions may result from a lack of awareness of the law by healthcare providers and by the public, a lack of availability or access to services, ignorance regarding the existence of healthcare facilities certified to provide abortion services [18], and the stigma associated with abortion.

2. The FIGO Initiative for the Prevention of Unsafe Abortion and its Consequences

The stimulus behind this global initiative introduced in 2007 by the then FIGO President Dr Dorothy Shaw was the high rate of induced abortions resulting from unwanted or mistimed pregnancies and the consequently significant mortality and morbidity in many countries [26–28].

In 2007, the FIGO President and the Head of the International Planned Parenthood Federation (IPPF) wrote a letter to FIGO member societies of obstetrics and gynecology around the world, including 14 countries in South-Southeast Asia, explaining the rationale behind this initiative and the prerequisites for participation. These included compiling a situational analysis on unsafe abortion from available data and preparing a plan of action in collaboration with the government and relevant partner organizations. Involvement of the government agencies was emphasized to ensure "ownership" of the country plans and their implementation. The regional coordinator maintained follow-up communication and by 2008, 8 countries had joined the initiative. The delegates from those countries attended an initial regional workshop held in Mumbai, India, in August 2008. Only 5 of these countries now continue viz. Bangladesh, India, Nepal, Pakistan, and Sri Lanka; Malaysia has joined in 2012. The initiative is now in its implementation phase. The plans are dynamic, responding to the changing needs of the individual countries, the experiences gained, and the lessons learned.

3. Strategies

The strategies of the initiative were designed to ensure maximum use of all available resources through collaboration between the national societies of obstetrics and gynecology and the relevant government ministries/departments and international and national non-governmental organizations (NGOs) working in the fields of public health, abortion services, and family planning [26,28]. The regional coordinator and the selected focal points in the national societies wrote letters to the relevant government ministries and departments and to the NGOs. The involvement of government agencies was expected to ensure "ownership" and implementation of the plans of action, as well as continuation of the activities after the initiative was complete. These agencies included the Ministry of Health and ministries/directorates/departments related to family planning/welfare and family and maternal health in all of the participating countries.

Initially, each national society of obstetrics and gynecology, with the assistance of government organizations and NGOs, prepared a situational analysis of unsafe abortion from the data available in their respective countries. This analysis was presented at a national workshop in which representatives of these organizations participated. The country teams used this analysis to prepare a plan of action, defining the activities involved in attaining each objective. They adopted a comprehensive 4-pronged preventive approach [26,28] aimed at reducing the number of unwanted pregnancies and consequent unsafe abortions, ensuring that abortions that could not be prevented were safe, providing timely, effective and compassionate treatment of abortion-related complications and, finally, providing postabortion contraception to avoid repeat unwanted pregnancies.

4. Plans of action

The plans of action included advocating for different causes, reviewing abortion care guidelines, training healthcare providers, improving service delivery and, in some countries, implementing abortion-related research. As experience was acquired, the plans began to focus on activities that were achievable and measurable. Details of these plans are given below.

4.1. Advocacy

The plans of action included campaigning for several causes with various target groups. The Federation of Obstetric and Gynaecological Societies of India (FOGSI) held awareness-raising meetings on the legality and availability of safe abortion, targeting the media, policymakers, and the general public. In Nepal, wall chalking, radio programs, and a special logo placed on facilities informed the public of the venues that provided safe abortion services. The Society of Obstetricians and Gynaecologists of Pakistan (SOGP) repeatedly informed its members and other stakeholders of the changes in the abortion law. Pakistan's plan of action, drawn up in 2009, included petitioning the Pakistan Nursing Council to include safe methods of uterine evacuation—manual vacuum aspiration (MVA) and medical abortion—in the midwifery curriculum. The Sri Lanka College of Obstetricians and Gynaecologists (SLCOG) petitioned relevant policymakers and with their help prepared a draft document petitioning for the liberalization of the restrictive abortion law for victims of rape and incest, and for women bearing fetuses with lethal malformations. After reviewing the guidelines for postabortion care, the College recommended in its 2011 — 2012 plan that misoprostol be put on the Essential Drug List for the management of incomplete abortion.

In its 2012 plan of action, the members of the council of the Obstetrical and Gynaecological Society of Bangladesh (OGSB) sent a recommendation to the Director General of Health Services and the Director General of Family Planning that the use of MVA should be increased and that misoprostol should be introduced for postabortion care [20]. The Society also recommended that contraceptives, particularly long-acting reversible contraceptive (LARC) methods, be provided wherever uterine evacuation was performed.

4.2. Preparing/updating guidelines and training healthcare providers

Replacing sharp curette with MVA and medical abortion and improving the quality, availability, and access of family planning services immediately after uterine evacuation in accordance with WHO Safe Abortion Guidelines were items included in the plans of action of all the countries involved in the initiative [29,30].

The OGSB collaborated with the government to update the national MVA protocol and prepared a statement on this technique [31]. Later, this Society developed a manual for the use of misoprostol in postabortion care [32] and prepared information, education, and communication (IEC) material for postabortion care services. The SLCOG also updated its guidelines on postabortion care to include modern technology for the management of incomplete abortion and to introduce postabortion contraception. This Society applied for emergency funds from FIGO with which to conduct a pilot project to instruct 160 middle-grade doctors in 8 hospitals in 4 selected districts on the new guidelines.

In India, as part of a Government of India expert group working with WHO and other partners, FOGSI developed a draft document of