RECOMMENDATIONS AND BEST PRACTICE:
PROJECTS ON SELF-MANAGED ABORTION CARE

Background

The WHO Abortion Care Guidelines (2022) for medical abortion at <12 weeks' recommend the option of self-management of the medical abortion process in whole or any of the three component parts of the process: 1) self-assessment of eligibility (determining pregnancy duration; ruling out contraindications), 2) self-administration of abortion medicines outside of a health-care facility and without the direct supervision of a trained health worker, and management of the abortion process, 3) self-assessment of the success of the abortion. In the Zambian context progress has been made by permitting part 2 and 3 to be available as options for the client (i.e. take medication abortion outside of the facility and self-assess completion).

The Zambian Association of Gynecology and Obstetrics (ZAGO) implemented a self-management of abortion (SMA) project to ensure this is being implemented in high priority districts in the country. The project sought to remove barriers related to knowledge, skills, and resources both on the side of the health facility/workforce, and from the client/community side.

Aim of this document and anticipated audience

The following recommendations have been developed through our experience implementing the SMA project. It is hoped that these insights will be helpful for others seeking to move towards the WHO recommendations pertaining to self-management of medical abortion in early pregnancy. The anticipated audience is Ministry of Health, regional, district and facility heads, civil society organisations and NGOs.

Prior to implementing a project working towards removing barriers to effective provision of SMA in any part of the world, several factors need to be considered if its success is to be assured. In any case, SMA projects should aim to provide women and girls with the knowledge, skills, and resources to safely manage an abortion at home. Therefore, to ensure successful implementation of an SMA project, it is recommended to adhere to the following recommendations:

1: Recommendations for Success

1.1 Using data to identify barriers and assess progress

Collecting baseline data in the sites selected for project implementation through use of survey tools is key to identifying existing barriers and designing interventions to overcome them. These barriers need to be identified at different levels, such as at client, community, provider, and health systems levels. In this project we used a Barriers Assessment Tool (BAT) with specific questions to identify existing or potential/anticipated barriers in implementing SMA project. In addition, the baseline survey should capture data on the Knowledge, Attitudes and Practices (KAP) of the healthcare providers again to identify existing challenges to SMA with interventions designed to address the specific problems inhibiting access to SMA in that context. Collecting the same data after an intervention period can show whether the barriers were successfully removed or if more must be

done. This data can also be used as evidence to base advocacy messages on and to petition for scale-up.

1.2 Orientation and continual involvement of key stakeholders

There is a need to obtain buy-in of the SMA project by key stakeholders. These may include the Ministry of Health and its structures (including at local/state level if necessary), other line ministries, like-minded international and local NGOs, and community health volunteers. A meeting can be held at which the project is introduced and aimed at generating consensus and participation with key stakeholders. The orientation should include CAC providers and those involved in the supply chain, such as pharmacists. Also, involving women's groups or representatives from the communities would serve to include them from the beginning. Maintaining involvement of the key stakeholders ensured results can be shared quickly and they can support any issues identified.

2: Barriers to SMA and Recommended Approaches

An enabling environment is key to the provision and uptake of SMA. The following areas are potential barriers to SMA access with recommendations for overcoming them based on our experience:

2.1 Policy and regulatory Frameworks

Existing legal frameworks should support provision of self-managed abortion. Therefore, SMA needs to be decriminalized. Furthermore, national sexual and reproductive health policies should be developed, and/or harmonized to enable providers to offer the option of self-managed medical care. The policies and guidelines must explicitly provide room for self-managed medical abortion so that the providers do not have to resist the option citing lack of supporting documents.

2.2 Health workers' Knowledge, Attitudes, Practices

Health workers play a critical role in the move away from facility-based abortion care and towards self-managed medical abortion care. Health workers are the ones that may assess, counsel the woman/girl and offer the available options. Therefore, engaging and training health workers in SMA, especially those in rural and peri-urban areas is a necessity. Training enables the health workforce to have: (1) better knowledge of safe abortion services that can be provided in their context; (2) improved attitudes towards service provision; and (3) the necessary competencies to provide quality, cost-effective abortion care services in accordance with national standards and guidelines and human rights.

2.3 Pre-service training

The option of self-managed medical abortion must be made available in all health facilities. Therefore, the concept of SMA needs to be included in pre-service training so that healthcare providers must have the information as they graduate from training schools. Similarly, SMA must be included in in-service training programs such as CAC training.

2.4 Delivery (support materials)

Guidelines, job aids, and clinical protocols in support of SMA need to be made available in the target health facilities. These documents could be printed and distributed in all the sites. This would enable the providers to read the materials to internalize the contents and refer to them as often as they could so that practice is informed by prevailing guidelines. Dissemination of these materials could be through formal workshop, webinars and or shared via electronic means or in hard copy to facilities.

2.5 Quality Products, Pharmacists and Supply Chain

The success of SMA Project hinges on availability of abortion medicines. Medical abortion drugs must always be in stock. Therefore, it is critical to streamline commodity supply chain systems in order to ensure smooth supply of the medicines at all times. In our project, we identified pharmacists as a critical group to train and sensitise, in order to ensure drug availability. In addition, it may be useful to provide information materials on SMA such as leaflets, brochures for clients to be reading as they visit the health facilities.

2.6 Community level awareness

The success of a SMA Project requires a mindset change and demand for the service. In an environment where SMA is totally new, there is likely to be resistance by providers and clients alike. The use of community health volunteers and peer educators proved to be helpful in raising awareness of the service to the clients. The community health volunteers, and peer educators need to be trained with right messages on SMA so that they help with community sensitizations.

3: Recommendations for Service Delivery

There are several considerations that need to be made for SMA service delivery.

3.1 SMA Service Delivery Approaches

Self-managed abortion care can be delivered to women and girls supported by strong health systems – using several service-delivery approaches including:

- **Accompaniment models:** In this approach, a community health volunteer such as safe motherhood action groups (SMAGs) or youth peer educators are able to provide support by accompanying the individual through the medical abortion process (by phone, or in person), including providing information, counselling, emotional/moral support and/or logistical support (such as referrals to and/or support interacting with local health-care facilities).
- **Community outreach**: This includes health services that mobilize health workers to provide services to the population or to other health workers, away from the location where they usually work and live. SMA services, especially less than 10 weeks' gestation, can safely be provided using mobile and outreach clinical services.
- **Hotlines:** This typically refers to telephonic information services that can support women and girls in accessing quality abortion care. Abortion hotlines may be embedded within hotlines providing other health care messages such as reproductive health in general.
- **Telemedicine:** This is a mode of health service delivery where providers and clients, or providers and consultants, are separated by distance. The interaction may take place in real time (synchronously), using telephone or video link, or asynchronously where response can be provided later via email, text or voice/audio message. Telemedicine can be useful in situations where legal requirements for more than one signature is needed before providing an abortion service.

3.2 Providing Information

All women and girls should be provided with accurate, scientifically generated data and evidence on abortion care services. Considerations must include:

- Information about the self-management process as well as other options available, to enable informed decision making on whether to self-manage as a whole or parts of the process;
- Information related to free and informed consent;

- Information on what the woman/girl is likely to experience during and after the abortion procedure or process, appropriate pain management options, and how long the recovery is likely to take;
- Information on management of abortion-related side effects such as bleeding at home;
- Information on self-assessment of the success of abortion using check lists of signs and symptoms and use of low-sensitivity pregnancy tests, if possible;
- Information on when normal activities can be resumed, including sexual intercourse;
- How to recognize potential side-effects and symptoms of ongoing pregnancy; and
- Offer follow-up care to patients to ensure that they are recovering well and address any concerns or questions they may have. During this time, additional services that may be desired such as counselling, contraception and other services.

3.3. Offering and Providing Counselling

Some individuals may wish to receive counselling before or after an abortion. Counselling should be focused, and an interactive process through which a person voluntarily receives support, information and non-directive guidance from a trained person, in an environment that is conducive to openly sharing thoughts, feelings, perceptions and personal experiences. Considerations should ensure that:

- Counselling is person-centred and tailored to the needs of the individual and age-appropriate;
- Counselling must be provided freely and voluntarily, i.e. it should not be mandatory. The right to refuse counselling when offered must be respected;
- Counselling must be available to individuals in a way that respects their privacy and confidentiality;
- Counselling must be acceptable and of good quality, i.e. it must be provided in a way that is understood by the recipient and it must be accurate, and evidence based;
- Counselling must be non-discriminatory and non-biased;
- Counselling should be available to all persons without the consent or authorization of a third party; and
- Patient confidentiality is maintained throughout the service provision, taking into account that some patients may need culturally sensitive care.

Summary:

There may be multiple barriers to SMA adoption. These barriers could be at health systems level, healthcare providers level, community or clients' levels. In addressing the barriers, multiple approaches need to be employed. These include ensuring stakeholder buy-in from the onset, designing activities to work on specific barriers and regular monitoring. In other contexts, similar interventions that address knowledge, attitudes and practices with healthcare workforce as well as community level interventions may be useful to successfully implement SMA as an option for those seeking abortion care.

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