



UNIT 8: OTHER SRH PRIORITIES FOR THE MISP

Unsafe abortion is present in all countries where safe abortion care is not accessible.¹²⁵ Access to safe abortion care for all women and girls is critical to saving their lives, given that unintended pregnancies and unsafe abortions account for nearly 8% of maternal deaths.¹²⁶ Safe abortion care should be available and accessible to all women and girls at the minimum for the indications permitted by law; post-abortion care has no legal restrictions and should always be available.

In the revised 2018 version of the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, another priority activity was identified beyond the priority objectives of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH). Specifically, the manual states it is important to ensure that safe abortion care is provided to the full extent of the law.

At the end of the unit, learners will be able to:

- ▶ explain why safe abortion care to the full extent of the law is important in humanitarian settings;
- ▶ describe how to find information about national policies for the provision of safe abortion care; and
- ▶ explain how to facilitate access and ensure safe abortion care is available to the full extent of the law at the onset of an emergency and when planning for comprehensive SRH services.

Other MISP for SRH priority activities:

- ▶ it is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

¹²⁵ *Women and Girls Continue to Be at Risk of Unsafe Abortion* (WHO, September 2017), https://www.who.int/reproductivehealth/topics/unsafe_abortion/abortion-safety-estimates/en/.

¹²⁶ "Induced Abortion Worldwide"; and *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, p. 48.

Why is safe abortion care important in humanitarian settings?

The need for safe abortion services likely increases in humanitarian settings. As sexual violence is associated with war and acute crises, the trauma resulting from sexual violence may be exacerbated if the incident results in a pregnancy. Because of this, many international agreements and human rights expert bodies support the provision of safe abortion care for women who are raped in crises; international human rights law supports access to safe abortion care across all settings.¹²⁷

In humanitarian situations, women and girls may also be at increased risk of unintended pregnancy due to loss of or decreased access to voluntary contraception. They may want to delay childbearing until their security and livelihoods are assured but may not have access to contraceptives due to disruptions in health supplies and services.

Unsafe Abortion

The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating an unintended pregnancy, carried out by persons lacking the necessary skills, in an environment that does not conform to minimal medical standards, or both.¹²⁸

How should safe abortion care be facilitated from the onset of an emergency?

Given its importance, it is critical that the SRH Coordinator, health program managers, and service providers ensure that safe abortion care to the full extent of the law is available at the onset of a crisis by direct service provision or referral to trained providers. When existing capacity is not present, safe abortion care to the full extent of the law should be made available once implementation of MISP for SRH priority activities are underway, ideally within three months after the onset of an emergency, if not sooner.

¹²⁷ International agreements supporting access to safe abortion care include the Geneva Convention, Article 3 (denial of safe abortion to a rape survivor can be considered in violation of her rights), UN Security Council, Resolution 2106 (supports access to complete RH services, including safe abortion for rape survivors), and the Maputo Protocol.

¹²⁸ *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO, 2012), http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf.

Post-abortion Care

Post-abortion care is the global strategy to reduce death and suffering from complications of unsafe and spontaneous abortion. It comprises five elements:¹²⁹

- ▶ Treatment of incomplete and unsafe abortion and complications that are potentially life-threatening
- ▶ Counseling to identify and respond to women's and girls' emotional and physical health needs and other concerns
- ▶ Voluntary contraceptive services to help women and girls prevent unintended pregnancy
- ▶ Reproductive and other health services that are preferably provided on site or via referrals to other accessible facilities in providers' networks
- ▶ Community and service provider partnerships for preventing unintended pregnancy, mobilizing resources (to help women and girls receive appropriate and timely care for complications from abortion), and ensuring that health services reflect and meet community expectations and needs

Comprehensive abortion care includes all the elements of post-abortion care as well as safe induced abortion.

Where can national policies for safe abortion care be found?

In most countries, induced abortion is legally permitted in at least some circumstances. In many countries, abortion is allowed if the pregnancy threatens the physical and mental health of the woman and when the pregnancy results from rape or incest. The SRH Coordinator should identify the conditions under which national policies, signed international agreements, and international humanitarian and human rights law permit the provision of safe abortion care. Additional resources on global abortion policies can be found at srhr.org/abortion-policies/.

What can be done to facilitate access and ensure safe abortion care to the full extent of the law is available?

It is essential that humanitarian responders collaborate to increase access to safe abortion care services. Promising entry points include but are not limited to:

- ▶ providing safe abortion care through health facilities run by organizations and/or staffed by willing, trained providers;
- ▶ offering technical support to qualified medical personnel already providing abortion services; and

¹²⁹ *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, p. 146.

- ▶ reducing harm from unsafe abortion through the distribution of information and commodities for safe medication abortion.

Not all organizations will have the capability to provide safe abortion care, so it is important to identify and refer to providers and organizations that have capacity.

Who should provide safe abortion care services in an acute emergency?

At the onset of a crisis, services should be provided by health care providers already skilled in the provision of safe abortion care. In many cases, rapid, on-the-job training, in partnership with national counterparts where feasible, can be provided to qualified health care workers to build their skills when previously trained providers are not available. When transitioning to comprehensive SRH services, organizations should plan for competency-based training, ongoing clinical mentorship, and continued improvement of staff attitudes to support high-quality service provision.¹³⁰ Task shifting should also be integrated into comprehensive services. With appropriate training and support, nurses, midwives, and other trained health providers can safely provide first-line abortion and post-abortion care services, even in outpatient settings.¹³¹



Other MISP for SRH Priority: The Reality of Implementing Safe Abortion Care to the Full Extent of the Law

An organization recognized the need for greater access to safe abortion care and decided to introduce comprehensive abortion care services as part of services already offered by nurses and midwives in government health facilities in the affected setting.¹³² The organization conducted on-the-job training on misoprostol and manual vacuum aspiration for comprehensive abortion care and provided all the necessary supplies and equipment. To maintain client privacy and confidentiality, a system was devised to record safe abortion care clients in the post-abortion care register with a confidential mark. Information about comprehensive abortion care services was provided during one-on-one community outreach sessions to maintain a low profile within the community.

¹³⁰ *Abortion Attitude Transformation: A Values Clarification Toolkit for Humanitarian Audiences* (Ipas), accessed April 8, 2019, <https://ipas.org/resources/abortion-attitude-transformation-a-values-clarification-toolkit-for-humanitarian-audiences>.

¹³¹ *Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception* (WHO, July 2015), http://apps.who.int/iris/bitstream/10665/181041/1/9789241549264_eng.pdf. See Chapter 8 in the *Inter-Agency Field Manual for Reproductive Health in Humanitarian Settings* for further information.

¹³² *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, p. 157.

Management of abortion and post-abortion care in the first trimester

	Lay health workers	Pharmacy workers	Pharmacist	Doctors of complementary system of medicine	Auxiliary nurses/ ANMs	Nurses	Midwives	Associate/ advanced associate clinicians	Non-specialist doctors	Specialist doctors
Vacuum aspiration for induced abortion	**	**	**						*	*
Vacuum aspiration for management of uncomplicated incomplete abortion/ miscarriage	**	**	**						*	*
Medical abortion in the first trimester	Recommendation for subtasks (see below)	**	Recommendation for subtasks (see below)						*	*
Management of uncomplicated abortion/ miscarriage with misoprostol		**	**						*	*

*considered within typical scope of practice; evidence not assessed

**considered outside of typical scope of practice; evidence not assessed

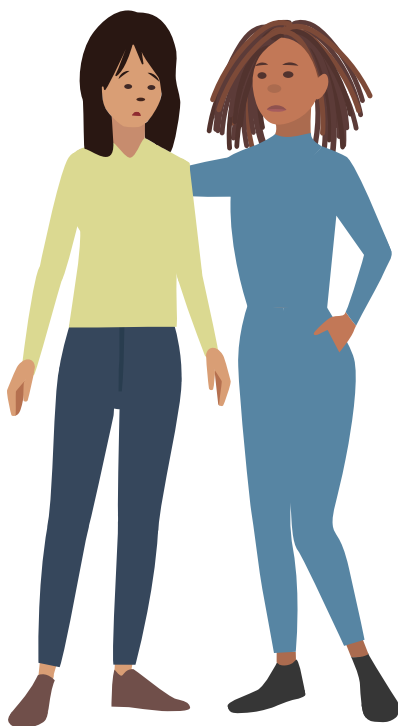
Recommendation category	Symbol	Explanation
Recommended		The benefits of implementing this option outweigh the possible harms. This option can be implemented, including at scale.
Recommended in specific circumstances		The benefits of implementing this option outweigh the possible harms in specific circumstances. The specific circumstances are outlined for each recommendation. This option can be implemented under these specific circumstances.
Recommended in the context of rigorous research		There are important uncertainties about this option (related to benefits, harms, acceptability, and feasibility) and appropriate, well designed and rigorous research is needed to address these uncertainties.
Recommended against		This option should not be implemented.

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, p. 147.

If a woman chooses an abortion, what should a health provider do?

The health provider should:

- ▶ provide medically accurate unbiased information about abortion services in a format that the woman can understand and recall;
- ▶ explain any legal requirements for obtaining safe abortion care;
- ▶ explain where and how to obtain safe, legal abortion services and their costs;
- ▶ provide medication abortion with mifepristone/misoprostol if available or misoprostol alone if mifepristone is unavailable, vacuum aspiration, dilatation and evacuation, or induction procedures as recommended by the WHO;
- ▶ provide information and offer counseling to women on post-abortion contraceptive use and provide contraception to women who accept a method; and
- ▶ consider providing presumptive treatment for gonorrhea and chlamydia in settings with a high prevalence of sexually transmitted infections (STIs).



Special Considerations

Adolescents

There are many social, economic, logistical, policy, and health system barriers to safe abortion care for adolescent girls, including stigma and negative attitudes toward adolescent sexuality, fear of negative repercussions, lack of access to comprehensive sexuality education, limited financial resources/cost of care, transportation, third-party involvement laws, and concerns over privacy and confidentiality. These dynamics explain why young women often find no alternative other than resorting to unsafe abortion, even in settings where safe abortion is legal. Compassionate and confidential abortion services should be available and accessible to all adolescent girls regardless of their marital status.

Women Who Have Experienced Violence

It is likely that providers will encounter women who have experienced sexual violence. Women who have experienced such violence will often experience health-related conditions, such as physical injury, STIs, psychological distress, or unintended pregnancy. Physical or psychological violence during pregnancy may also contribute to miscarriage or the desire for an abortion. Abortion care visits may be the only contact that women who have experienced violence have with the health system. Counselors should develop a standard method for asking all clients about violence in their lives and incorporate those questions into routine counseling. Survivors of sexual violence should be offered compassionate abortion care if they wish to terminate a pregnancy, and abortion clients disclosing experiences of sexual violence should be referred for psychosocial support. See Unit 3 for more information.

Unit 8: Key Points

- ▶ Safe abortion care should be available and accessible to all women and girls to the full extent of the law. Post-abortion care has no legal restrictions and should always be available.
- ▶ Access to safe abortion care for all women and girls is critical to saving their lives, given that unintended pregnancies and unsafe abortions are major causes of maternal mortality.
- ▶ In most countries, induced abortion is legally permitted in at least some circumstances. In many countries, abortion is allowed if the pregnancy threatens the physical and mental health of the woman and when the pregnancy results from rape or incest.
- ▶ The SRH Coordinator should identify the conditions under which national policies, signed international agreements, and international humanitarian and human rights law permit the provision of safe abortion care.
- ▶ The SRH Coordinator, health program managers, and service providers should ensure that safe abortion care is available to the full extent of the law at the onset of a crisis by direct service provision or referral to trained providers.
- ▶ Rapid, on-the-job training can be provided to qualified health care workers, in partnership with national authorities where feasible, to build their skills in providing safe abortion care when previously trained providers are not available.
- ▶ If existing capacity is not present, safe abortion care to the full extent of the law, should be made available once implementation of the MISP for SRH priority activities is underway, ideally within three months after the onset of an emergency, if not sooner.



Challenges and Solutions

Challenges	Solutions
<p>What should be done from the beginning of an emergency to ensure safe abortion care to the full extent of the law is available?</p>	<p>Understand the law and when safe abortion care is legal.</p> <p>Undertake a mapping of existing providers in the host community or among international nongovernmental organizations. Support local providers with any additional human and financial resources, including supplies to support the facility and facilitate referrals as possible.</p>
<p>What should be done if the circumstances under which abortion is legally permitted are limited and do not meet the needs of women and girls?</p>	<p>Interpret legal indications for abortion as widely as the law allows, and take international humanitarian and human rights law into account to increase access to safe abortion care for as many women and girls as possible.</p> <p>All women seeking abortion may not meet the legal criteria for abortion. When women seeking abortion are turned away from services, they often seek unsafe methods that can result in injury or death. In these cases, providers may counsel clients seeking abortion on safer self-management of abortion using misoprostol alone or misoprostol in combination with mifepristone. Often referred to as “harm reduction,” this approach may be feasible in contexts where misoprostol is available and accessible in the local market.</p>
<p>What can be done if providers are not competent in WHO-recommended methods of safe abortion care?</p>	<p>In collaboration with national authorities where feasible, engage or refer to providers who are already competent in safe abortion care, where possible.</p> <p>Conduct rapid, on-the-job clinical coaching to improve provider skills.</p>
<p>What are ways to address providers’ and/or staff’s negative attitudes about abortion or women and girls who seek abortion?</p>	<p>Conduct abortion values clarification and attitudes transformation activities with providers, program staff, and support staff.¹³³ This should be done as part of preparedness efforts but can also be done rapidly during program implementation if needed.</p> <p>Screen for favorable attitudes toward safe abortion care access when hiring providers and staff.</p>

¹³³ *Abortion Attitude Transformation.*

What can be done if providers and staff lack knowledge about the circumstances under which safe abortion care can be provided?

In collaboration with national authorities where feasible, define the circumstances under which safe abortion care can be legally provided, and educate providers and other stakeholders about the legal criteria.

What can be done if community leaders and other key stakeholders are opposed to abortion?

In collaboration with national authorities where feasible, inform community leaders and other key stakeholders about the burden of unsafe abortion on women and girls in their communities.

Identify those who are supportive of your work and engage them to encourage the support of others. Abortion values clarification and attitudes transformation activities are also helpful to improve attitudes of community stakeholders.

THE MISP FOR SRH MONITORING CHECKLIST: OTHER PRIORITY ACTIVITY: SAFE ABORTION CARE TO THE FULL EXTENT OF THE LAW

The MISP for SRH Monitoring Checklist, below, can be used to monitor SRH service provision in humanitarian settings.

8. Other Priority Activity: SAC to the Full Extent of the Law		
8.1	Coverage of SAC: (number of health facilities where SAC is available/number of health facilities) x 100	%
8.2	Number of women and girls receiving SAC	
8.3	Number of women and girls treated for complications of abortion (spontaneous or induced)	

MATERIALS AND SUPPLIES

Which supplies are needed or which IARH Kits could be ordered to provide safe abortion care?

IARH Kits (2019)

The IARH Kits are categorized into three levels, targeting the three health service delivery levels. The kits are designed for use for a three-month period for a specific target population size.¹³⁴

Note: The IARH Kits are not context specific or comprehensive. Organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies but also enable the expansion of SRH services from the MISIP to comprehensive care.

Supplies for abortion and post-abortion care can be found in the IARH Kits below and include manual vacuum aspiration and misoprostol. The mifepristone/misoprostol regimen is the global gold standard for medication abortion and should be provided in settings where mifepristone is registered and available.

Health Care Level	Kit Number	Kit Name
Primary health care facility (BEmONC)	Kit 8	Management of Complications of Miscarriage or Abortion
Primary health care facility (BEmONC)	Kit 9	Repair of Cervical and Vaginal Tears

Complementary commodities

Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. Complementary Commodities will be available from UNFPA in 2020.

Service Delivery Level	Item	To Complement
Community/health post	Misoprostol*	Kit 2B, 6A, 8
Primary health care facility (BEmONC)	Misoprostol*	Kit 8

*Misoprostol can also be procured to complement Kits 6A and 8 for the primary health care facility level.

134 The 2019 IARH Kits will be available for procurement in early 2020. Check with UNFPA (<https://www.unfpa.org/>) or IAWG (<http://iawg.net/resource/inter-agency-reproductive-health-kits-2011/>) to verify whether the revised kits are available. For information regarding kits available before 2020, see the *Inter-Agency Reproductive Health Kits for Crisis Situations* (5th ed., 2011) at <http://iawg.net/resource/inter-agency-reproductive-health-kits-2011/>.

Unit 8 Quiz: Other SRH Priorities to the MISP

1. Which of the following types of health care workers can provide first-line safe abortion care with manual vacuum aspiration and medication when properly trained and supported?
 - a. Physicians
 - b. Nurses
 - c. Pharmacists
 - d. a and b
2. What can be done to facilitate access to safe abortion care to the full extent of the law?
 - a. Provide safe abortion care to the full extent of the law through health facilities staffed by skilled providers
 - b. Offer technical support and resources to qualified medical personnel already providing abortion services to the full extent of the law
 - c. Distribute information and commodities for safe medication abortion
 - d. Identify and refer to providers and organizations that have capacity
 - e. All of the above
3. Cost of care, fear of negative repercussions, and stigma are barriers to safe abortion care for young women.

True or False

4. Safe abortion care is permitted for one or more circumstances in the majority of countries in the world.

True or False

5. At what point in a crisis should safe abortion care be prioritized?
 - a. After expanding SRH services from the MISP to comprehensive programming
 - b. In development settings—safe abortion care is not a priority during crises
 - c. In the MISP for SRH as a clinical component of care for survivors of sexual violence
 - d. When implementing the MISP for SRH as an other priority
 - e. c and d