

How Provider Attitudes Towards Abortion Can Impact the Quality of and Access to Abortion Services:

An Assessment of IPPF/WHR Provider Knowledge, Attitudes and Practices in 6 Latin American and Caribbean Countries

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ABSTRACT:

In Latin America and the Caribbean, where most countries have severely restrictive abortion laws and access to safe abortion is limited, complications of unsafe abortions are one of the major causes of maternal mortality. Even where some services are available, limited resources, lack of adequate provider training, and stigma surrounding abortion further limits women's access to quality abortion services. Providers may also be reluctant to offer any abortion services and/or unaware of the legal parameters for doing so. To address these barriers to accessing quality abortion services, IPPF/WHR and Gynuity Health Projects conducted a quantitative assessment of IPPF staff and provider knowledge, attitudes and practices in 6 LAC associations (1,811 staff, including 799 providers in 74 association sites). Data on provider perceptions and clinical practices suggest several important findings related to the quality of services offered and the potential to improve both access to and quality of abortion services in the 6 countries.

INTRODUCTION:

Unsafe abortions result in an estimated 68,000 annual deaths and continue to threaten the health of women globally, but particularly so in the developing world and where access to quality abortion services is limited. Of the 46 million abortions that occur each year, it is estimated that 19 million are performed under unsafe conditions. Unsafe conditions mean either procedures provided by insufficiently skilled providers, using hazardous techniques, and/or in unsanitary facilities. Deaths from unsafe abortions account for at least 13 percent of global maternal mortality. Almost all of these deaths occur in women in developing countries, where additionally, untreated complications of unsafe abortions can also leave women at risk of long-term disability, including infertility, and place tremendous strain on the over-burdened developing country health care.¹

Higher rates of unsafe abortion complications and mortality are generally associated with restrictive abortion legislation. At the 1994 International Conference on Population and Development (ICPD) in Cairo, governments committed themselves to addressing the health burden of unsafe abortion, while simultaneously strengthening the prevention of unwanted pregnancies. Despite improvements in economic indicators, unsafe abortion and its sequelae continue to factor disproportionately into the inexcusably high levels of maternal morbidity and mortality in developing countries. Since Cairo, efforts have continued to improve the quality of family planning services and strengthening treatment of post-abortion complications, yet only a few developing countries (Guyana, Nepal, and South Africa) have made the a dramatic legislative transition from restrictive to permissive abortion laws in recognition of women's human and reproductive rights to voluntary quality abortion services.

In Latin America and the Caribbean (LAC), where, with few exceptions, most countries have laws that severely restrict access to safe voluntary abortion, complications of unsafe abortions are one of the major causes of maternal mortality. An estimated four million unsafe abortions occur each year, and unsafe abortion is believed to be responsible for approximately 3700 deaths or one in six maternal deaths in the region. LAC, particularly South America, has the highest unsafe abortion ratios and rates, with an unsafe abortion mortality ratio of 30 per 100 000 live births.

The large toll of unsafe abortion in a region with relatively high contraceptive prevalence demonstrates what we know from the developed country context: that there will always be need for safe abortion services despite advances in contraceptive uptake. The regional experience also emphasizes women who decide to end an unwanted pregnancy will often go to any means to do so, regardless of whether the procedure is safe or legal. Thus, in the absence of access to quality abortion services, women remain the real victims of this highly politicized issue, particularly poor women in developing countries.

Legislation governing conditions under which a woman has the right to terminate an unwanted pregnancy is an important foundation for providing safe abortion services; however it is not the only determinant of access to and quality of safe abortion services. Quality has been defined as the capacity of a health care system to offer a range of services that are safe and effective and that satisfy clients' needs and desires. In reproductive health service frameworks like that

proposed by Bruce (Bruce 1990)², quality of care is generally defined by elements such as choice of methods, information given to clients, technical competence of providers, interpersonal relations, continuity of care, and appropriateness and acceptability of services. Similarly, the International Planned Parenthood Federation framework of client rights and provider needs takes these same elements into account in defining quality of care and adds a focus on access as an important element of quality.³ These frameworks thus suggest both the perspectives of clients and of providers are important in determining the quality of services. For services that are restricted or stigmatized, such as termination of pregnancy services, provider perspectives and practices are very likely to impact quality of services, particularly access. Providers may be entirely reluctant to offer any abortion services and/or unaware of the legal parameters for doing so in restrictive settings.

In most LAC countries, doctors may legally terminate a pregnancy that threatens the life of the woman, results from rape or incest, or for fetal malformation, yet this option is rarely exercised. Arguably for similar reasons, in the handful of Caribbean nations where abortion is within a woman's legal rights, access to abortion services outside major tertiary facilities and choice of methods remain limited. Where some services are available, limited resources, lack of adequate provider training, and stigma surrounding abortion further limits women's access to quality care. In such environments, providers may also have little training and experience with methods for termination of pregnancy, further contributing to misinformation and stigma, which can translate into poor quality information and counseling.

To address these barriers to women's sexual and reproductive rights, International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) has embarked on a regional initiative to contribute to the reduction of maternal morbidity and mortality. To inform activities of this initiative, including training, IEC and technical support, IPPF/WHR in collaboration with Gynuity Health Projects conducted research to assess provider perceptions of and experience with abortion in order to identify individual and institutional facilitating factors and barriers to the introduction of abortion services. This work was carried out in 6 member associations in 6 countries, none of which were formally providing voluntary abortion services at the time the research was conducted. Given the sensitivities surrounding the provision of abortion services in the region, provider findings will be presented on the aggregated data without identification of individual countries or naming member associations.

The aim of this research was not to assess the quality of reproductive health care currently offered by associations but rather to assess the knowledge, attitudes, and practices (KAP) of staff as indicators of their willingness and capacity to engage in planned expansion of activities with the goal of increasing access to safe abortion. Findings presented in this paper on provider perspectives and experiences are thus presented in relationship to their potential impact on quality of care, including women's access to safe termination of pregnancy services.

METHODS:

Between September 2003 and May 2004, all staff working in IPPF association sites in 74 clinical sites associated with 6 member associations participated in this research to assess staff knowledge, attitudes and practices related to abortion. Research questions, were based on

information gained from a review of the literature on the provision of abortion services and similar studies that sought to assess staff perceptions of abortion services in other settings. All instruments were pre-tested with several individuals familiar with the provision of abortion services and refined to include more explanations of clinical terms used after implementation in sites in the first 2 association countries.

Research questions explored the knowledge, attitudes and practices (KAP) of all staff and volunteers about abortion in general, and also as related to individuals' specific roles at the member association sites. For the purposes of this paper, only the responses of clinical providers (n=799), which includes physicians, nurses, nursing assistants and other providing direct services to clients in those sites. Provider questionnaires included questions regarding knowledge and perceptions about abortion, complications of unsafe abortion in their settings and regionally, knowledge and perception of legislation governing abortion in their countries, as well as medical eligibility criteria and any clinical guidelines for performing abortion or treating abortion complications. The availability of abortion services was also explored with physicians as were their experiences in offering abortion services at the IPPF affiliate site or any other facility where they work. Physicians' experiences with and perceptions of both surgical and medical methods for providing termination of pregnancy and treating incomplete abortion were also explored. Finally, all providers were asked about their interest in providing a broader range of abortion services at that site along with their perceptions of any facilitating factors and barriers to such an expansion of services.

To implement the research, all IPPF/WHR staff and volunteers (n=1811) were provided with confidential questionnaires at a scheduled staff meeting. After a brief explanation of the research, staff were given one of four structured self-administered questionnaires according to one of four categories (physicians, clinical support staff, administrative, or board member). Questionnaires and envelopes provided for sealing completed questionnaires were pre-labeled using serial numbers to allow identification of the respondent's site and staff category but not their specific position or identity. Completed questions were collected in a drop box and forwarded to the association's headquarters to be sent back to New York for data entry and analysis. Site meetings were repeated at some sites where staff were missing on the day of implementation.

Questionnaires were entered into SPSS 12.0 for statistical analysis by Gynuity Health Projects in New York. Baseline findings were presented to individual associations to be shared with staff and to guide association-level efforts under this initiative.

Association countries are not named in this paper; however some analysis examines the responses of providers as related to abortion legislation in their settings. Responses in this cohort of associations are heavily weighted towards settings where abortion is restrictive¹ (4 of the 6 association countries) which account for 93% of provider respondents in this sample. Only one association in this sample is located in a country where abortion can be characterized as fairly permissive², but providers from this association constitute only 1% all provider respondents.

¹ **Restrictive** (n=4) refers to settings where legislation permits abortion is restricted with the exception of some extreme circumstances, including to save woman's life, physical and/or mental health, or cases of rape or incest.

² **Fairly permissible** (n=1) refers to settings where elective abortion is legal for a range of indications with few restrictions.

Similarly the responses of providers from the highly restrictive³ setting comprise 6% of all providers.

FINDINGS

Provider Profiles

Findings are based on the responses of the 799 providers (349 physicians and 450 clinical support providers, such as nurses, counselors, lab personnel, psychologists). Figure 1 details the profile of provider respondents, including socio-demographic characteristics such as gender, age category, marital status, and religious practice. Also included are data on the length of services at the association and the relationship to the IPPF association clinic for physicians (n=349). The majority of physicians (61%) surveyed worked primarily in the association clinic, but many also provided care primarily in public and private institutions outside the association. A similar proportion (58%) of other providers (i.e. clinical support staff) were full-time employees of the medical association.

Perceptions of the Magnitude of Unsafe Abortion and Need for Services

Eight in ten providers characterized complications of unsafe abortion, including mortality as a “very serious” health problem in their setting. The vast majority (83%) of providers also agreed that greater access to abortion services could reduce maternal mortality.

Provider perceptions of the appropriateness and acceptability of abortion services as part of the continuum of reproductive health services reveals support for broader access to safe voluntary termination of pregnancy but some reluctance and personal opposition to offering abortion services. While most providers (67%) agreed that expansion of access to quality abortion services was a key step to reducing the toll of unsafe abortion only half of providers believed that their association should be directly involved in the provision of safe abortion services to meet that need. A considerable proportion of providers (44%) said that they personally would not feel comfortable working in a site that performed terminations of pregnancy. Providers working in associations under restrictive

Figure 1: Profile of Provider Respondents		%
		(n=799)
Gender		
Male		33.0
Female		67.0
Age		
Under 25		13.1
25-39		61.3
40 and over		25.6
Marital Status		
Married/in union		52.0
Religion		
Practice a religion		86.0
Catholic		86.0
Other Christian		7.5
Other		6.5
Attend religious service at least weekly		21.0
Type of Provider		
Physicians (<i>ob-gyn</i>)		16.0
Physicians (<i>General of family medicine</i>)		13.3
Other physician specialty		14.4
Nurses/ Auxiliary nurses		21.0
Counselors		7.8
Community outreach worker		4.9
Clinical laboratory staff		7.9
Other		14.4
Length of service at association		
Less than a year		17.4
1-3 years		35.4
More than 3 years		47.2
Primary Workplace of Physicians (n= 345)		
Association clinics		60.8
Public institution (part-time in facility)		15.8
Private institution (part-time in facility)		23.4

³ **Highly restrictive** (n=1) refers to settings where abortion is entirely prohibited or only allowed to save the woman’s life.

abortion legislation were more likely report this discomfort than those working in either a setting where abortion was either fairly permissible or highly restricted.

One in three providers said they believed abortion to be a sin. Only four in 10 providers surveyed said they would support the decision of a friend or relative to terminate an unwanted pregnancy.

Beliefs about Why Women Seek Abortion

Providers suggested several main reasons for which women seek abortion in their countries. These included poverty (50%), sexual violence (49%), lack of preparedness on the part of women to have a child (40%), and lack of sufficient access to contraceptive information and/or services (31%). Some (40%) providers believed that the need for abortion was indicative of irresponsibility on the part of women. Despite broad recognition of the highly restrictive abortion legislation in most of the association countries, the majority (57%) of providers still perceived women who physically or chemically induce an abortion as irresponsible.

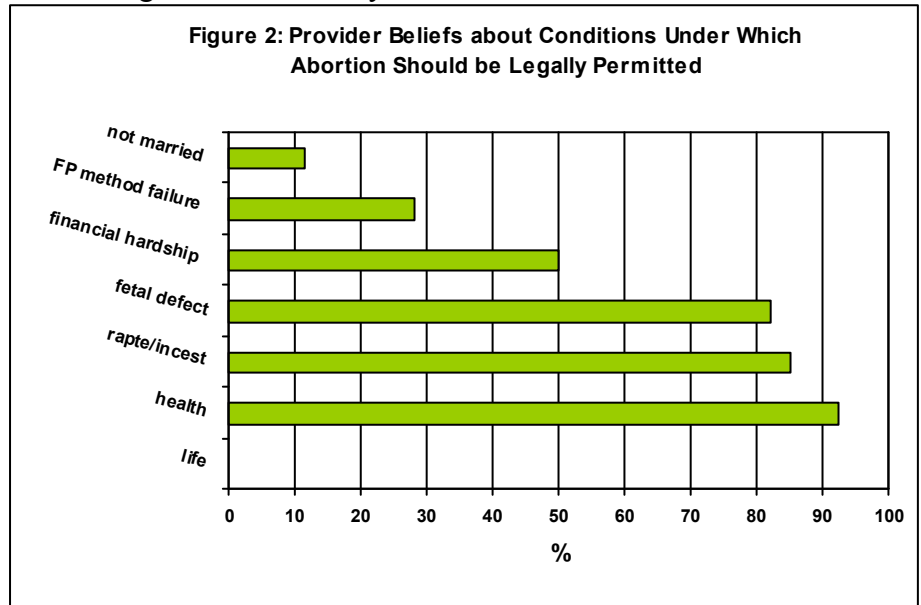
Perceptions of Existing and Ideal Abortion Legislation

Provider perceptions of reasons why women seek abortion and provider attitudes toward the legislative and institutional regulations governing access to termination service are important determinants of the messages given to clients during counseling. Asked to choose which actions they thought would be the most appropriate to take with a woman presenting to their facility to terminate an unwanted pregnancy that was the result of rape, 37% of providers said that they would inform her that abortion was illegal. Almost 36% of providers said they would counsel the woman on the risks and benefits of the procedure and perform the termination of pregnancy; 4 in 10 said they might also refer the woman to a site where they knew she could have a safe abortion. In contrast, 3 in 10 providers said they would counsel her about the risks of an abortion and recommend that she continue with the pregnancy and 11% said they thought it would also indicated that it would be appropriate to advise the woman to speak to a pastor or religious cleric.

Provider knowledge of and attitudes towards laws governing women's rights to abortion in their settings suggest that some providers themselves may be barriers to women's already limited access to services. The majority of providers in each of the associations could accurately report the general national legislative parameters for elective abortion in their setting, however, a proportion of providers in restricted settings (18%) and providers in highly restrictive settings (12%) categorized abortion as "illegal under all circumstances". About 13% of providers in restrictive settings reported that legislation did not allow abortion even in the case of danger to the mother's life or did not know whether threat to the mother's life was a legal indication for abortion. Some providers in restrictive settings were also not aware of specific indications for abortion such as fetal abnormality, rape or incest, or to protect the physical health of the mother.

The vast majority of providers concurred that existing abortion legislation was too restrictive and agreed with the need to expand the legal parameters for abortion in order to save the health and lives of women; however almost one in three providers reported that they believed women had sufficient rights and access to abortion under existing laws. The majority of providers (71%) in support of liberalization of abortion legislation were only in favor of nominal liberalization of the law to allow women the right to access abortion services under certain very restricted circumstances (Figure 2).

While the majority (62%) of providers agreed that only a woman should have the right to decide whether she should terminate a pregnancy, only 36% of providers said they believed that a woman should have that right regardless of her reason for not wanting to continue the pregnancy.



Otherwise, the majority said they believed that women should have legal access to abortion under specific conditions, such as to save a women’s life (92%), in cases of sexual violence such as rape or incest (85%), in cases of fetal malformation (82%), or in case of endangerment to the health of the mother (69%). Half said that it should also be allowed in cases of financial hardship but only 28% believed that it should be legally permitted in case of contraceptive failure. Very few providers (4%) accepted the idea that a woman should be legally allowed to terminate a pregnancy because it could negatively impact her career.

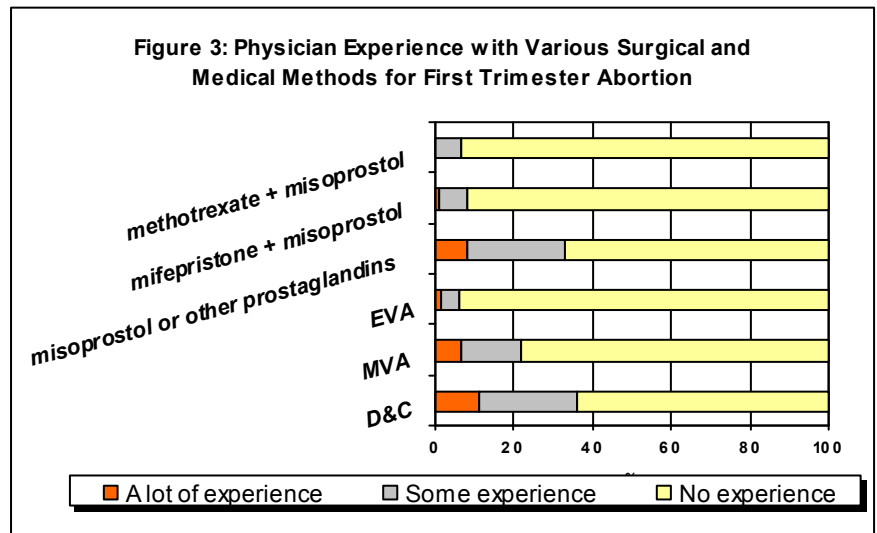
Technical Capacity to Offer Abortion Services

Since the associations surveyed had not formally begun offering abortion services, exploring the existing capacity of physicians to offer clinical services, including termination of pregnancy and treatment of incomplete abortions, was important to understand what resources should be dedicated to supporting the expansion of services.

Physicians reported considerable experience using medical and surgical methods for the treatment of abortion complications. Physicians had the most experience using D&C (66%), misoprostol (55%) and MVA (42%). Many physicians reported having received formal training in use of these methods for the treatment of abortion complications. Considerably fewer provides reported experience or training using the same methods for termination of pregnancy services (Figure 4). Few of the physicians (8%) surveyed reported that they were already providing any first trimester abortion services to clients. The majority (67%) of those providing termination of

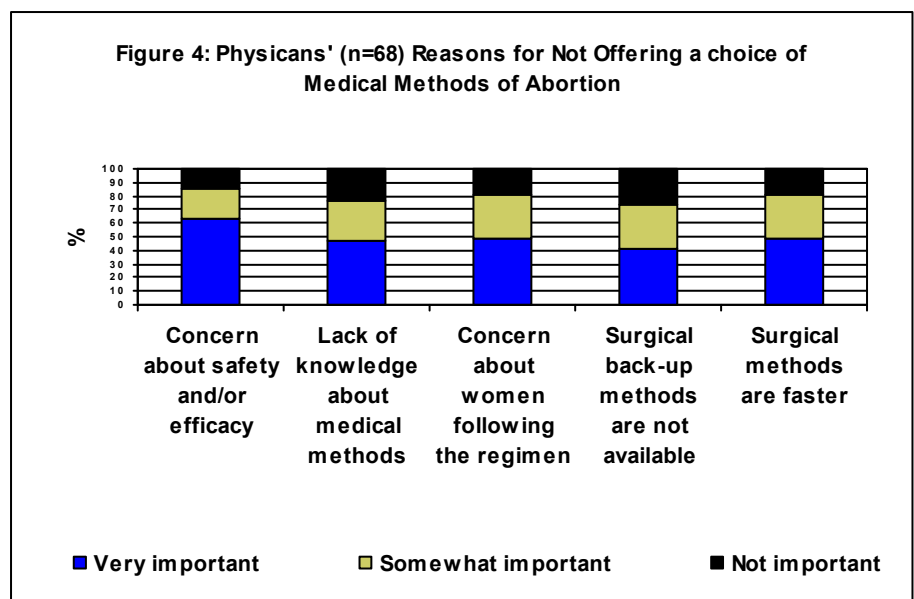
pregnancy services said they were mostly doing so in their private facilities. A minority (18%) of those providing services were doing so at the IPPF association.

Despite provider recognition that women may prefer medical methods of abortion (59%), physicians showed strong preference for surgical methods as well as misconceptions about the safety and efficacy of medical methods such as mifepristone and misoprostol, with which they had considerably less experience (Figure 3). Six in 10 physicians said that they would prefer to use surgical methods should they offer termination of pregnancy services and 8 in 10 of physician preferred surgical methods to medical methods for treatment of incomplete abortion.



One reason for physicians' reluctance to offer medical methods may stem from negative perceptions about the methods, which only a minority (21.3%) perceived to be as safe and effective as surgical methods. In addition to lack of familiarity with these methods, physicians also cited concerns about women being able to follow a medical abortion regimen, the lack of availability of surgical backup should medical methods fail, and preference for the speed of a surgical method (Figure 4).

Despite misinformation and concerns, physicians reported openness to receiving training in both surgical (79%) and medical (79%) methods of abortion and to expanding the provision of surgical (56%) and medical (52%) methods offered in their respective facilities. When asked about, only 18% of physicians but one in three clinical support staff had a favorable view of the possibility of



engaging mid-level providers, such as nurses, in the provision of abortion services in order to increase women's access to services.

Despite interest in building individual and site capacity to address unsafe abortion, providers noted many challenges to expanding surgical abortion services in their facilities, including some perceived resistance from colleagues (18%). More providers were concerned with the limitations imposed by restrictive national or state legislation (66%), insufficient provider training (27.5%), lack of clear institutional guidelines and protocols for abortions services (38%), and the scarcity of necessary equipment and supplies (33%). Despite the fact that 48% of physicians and 39% of other providers reported feeling that the introduction of abortion services would greatly increase the workload of staff and providers, only 10% reported this to be a major challenge to expansion.

DISCUSSION:

Findings of this research provide valuable information intended to guide efforts to the quality of and access to abortion services at local and regional levels. However, since findings are based solely on provider responses to a KAP questionnaire exploring knowledge, attitudes, and practices rather than directly evaluating quality of care, they should be interpreted with caution. Furthermore, given the restrictive nature of abortion legislation in many country settings and despite all efforts to ensure confidentiality, provider responses may be biased by socio-cultural and legal norms and dependent on the degree to which each individual respondent felt comfortable stating attitudes and practices contrary to such standards.

Nonetheless, provider attitudes and practices do have potential consequences for women's already scarce access to safe abortion services in mostly restrictive settings. In restrictive settings, women's access to safe abortion services is completely dependent on providers' willingness to offer service, offer a choice of methods, and provide clients with quality services. While the focus on quality of care generally includes an assessment of continuity of care, accessibility and appropriateness of services, one must understand how individual, socio-cultural, and institutional barriers can be addressed in order to provide women with higher quality services. .

Importantly, providers on the whole were less opposed to the idea of having services available for specific conditions than to offering them personally. This suggest that perhaps a vertical or specialized service model whereby a select number of providers offer abortion services for a larger referral network of clinics rather than an integrated reproductive health model may be a more efficient initial strategy to create some access for women to services for pregnancy termination.

Results also suggest that sensitizing health care providers to the essential nature of safe abortion services may be essential to improving the quality of such services. Existing perceptions of the magnitude of the problem and the belief that women have insufficient rights under existing conditions may be entry points to changing attitudes. Values clarification exercises, taking religious beliefs into account, may also be useful to help determine the extent to which individual providers are willing to be involved in the provision of services. Provider training could also

build on the interest and openness of clinicians to explore new technologies and skills as well as their sense of ethical obligation to provide accurate evidence-based information about safe interruption of pregnancy regardless of legislation or personal beliefs. A service delivery model focusing on harm reduction approaches may be useful given staff recognition of the toll of unsafe abortion on the health and lives of women.

This research demonstrates why provider attitudes and perceptions must be addressed within the context of service expansion and quality of care improvement, particularly when services relate to a complex and stigmatized issue such as abortion. Institutions that offer abortion services can play a role in influencing providers' attitudes and increasing their understanding of their legal rights and protections and those of their clients. Based on the findings of this research, IPPF/WHR and participating member associations are attempting this very strategy: addressing provider biases and concerns about abortion as a key step in expanding women's access to high quality reproductive health services.

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