

# Medical abortion in primary health care

Delivery of medical abortion in relation to other reproductive technology and commodities

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# Pill, process, procedure.....

- For centuries, women have attempted to use oral herbs and medication to restore a delayed period or terminate an unwanted pregnancy. Abortifacient herbs are found across countries and continents
- Today, medical abortion offers women a scientific pill to prevent an unwanted birth
- Getting an abortion can now mean taking a pill rather than subjecting oneself to a surgical procedure
- Taking the pill is followed by an extended process of change from pregnant to non-pregnant state

# Primary health care

- For women living “interior” lives, primary health -- public, private or traditional -- remains the only source of health care
- Generic weaknesses impede the delivery of any health technology through the primary health system, be it that for rolling back malaria, stopping TB, reducing infant mortality, controlling or stabilising population, or dealing with unwanted pregnancy
- By matching technology to the local primary health context, access could be significantly improved

# Strategic influences on access to primary health technology

- Ideology and values
- Regulation and licensing
- Level of medicalisation
- Market influences
- Access to information
- Control over use

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# Ideology and values

What goals drive the introduction of health technology in public health settings?

- Reduction of mortality: MMR, IMR, mortality from communicable diseases
  - Preventive or routine measures
  - Emergency or rescue measures
- Reduction of fertility
- Enhancement of sexual function
- Termination of unwanted pregnancy

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# Regulation and licensing - 1

- Registration of drugs - issues of efficacy and safety. Eg. oral contraceptives -- high levels of efficacy overrode issues of side-effects in the early years after approval
- Approval for health programmes. Eg. Cotrimoxazole for acute respiratory infections (ARI) among children, chloroquine for fever, oxytocics for the 3rd stage of labour
- Prescription vs OTC drugs -- emergency contraception, combined oral pills

# Regulation and licensing - 2

- Licensing of facilities - eg. laboratories, EOC centres, blood banks -- feasible when service is facility based i.e. requires either a clinical surgical procedure or inpatient care
- Approval of different classes of providers
  - Midwives for basic emg obstetric care, including uterine evacuation
  - Health workers/ volunteers for childhood pneumonia management
  - CBD workers /volunteers for oral pills, chloroquine
  - Ob-Gyns and doctors for providing abortion

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# Over-medicalisation

- Has been justified on grounds of maintaining service-quality for those who seek care, while ignoring denial of service to the rest
- Over-medicalisation is mediated through norms regarding facilities, providers, training, technology and protocols
- Penalties prescribed for violation of these norms or the provider is open to legal or consumer action
- Receives support from the courts in the name of safeguarding quality -- judges rely on “medical expert opinion” for this purpose

# Implementing de-medicalisation

# Implementing de-medicalisation-1

- Facility requirements simplified, minimised or eliminated
  - Birthing centres for normal delivery
  - Vaccine carriers and disposable syringes for immunisation
  - Home treatment (DOTS) for TB
- Using simpler “low-tech” devices and methods
  - Long acting IUDs in place of sterilization
  - Partograph for detecting prolonged labour
  - ORS for childhood diarrhea
  - Analgesia instead of anesthesia for MVA

# Implementing de-medicalisation-2

- Authorizing and training appropriately qualified providers
  - Life saving procedures by midwifery-trained persons (skilled attendants)
  - Barefoot doctors for basic health care
  - Paramedics for delivering immediate trauma care
- Avoiding elaborate screening and investigations
  - Screening checklists for oral pill and IUD insertion
  - Fast breathing and chest in drawing as criteria for detecting childhood pneumonia

# Implementing de-medicalisation-3

- Standard treatment protocols
  - Chloroquine for fever
  - IMCI case management
  - IMPAC management protocols
- Reducing follow-up visits / allowing home treatment or home-use
  - Alternate day TB regimens
  - Radical treatment of malaria
  - Door step delivery of oral or inject able contraceptives

# Implementing de-medicalisation-4

- Better communication with clients
  - Counseling and demystification of terms
  - Simple, local-language messages & materials
- Prior arrangements for referral transport and treatment, willingness on part of hospitals to accept over-referral or even incorrect referral
  - Referral to emergency obstetric care facilities
  - Referral for sick children

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# The cost of primary health care

- Where public health systems are weak or unable to provide a service, a private primary health sector thrives with little regulation
- Such a private sector guarantees access, arranges for drugs and commodities, allows credit or payment in kind, and assures a desired outcome, even at the cost of safety and rational practice
- Micro-economics of abortion:
  - Charges for outcomes rather than for processes - uncertain delay between treatment and outcome in case of MA
  - Cost of drugs, referral and surgical back-up
  - Opportunity costs of getting an abortion, matter to women

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# Asymmetry of information

- “What women don’t know, does hurt them”
- In the absence of sources of information other than the provider, the user is unable to exercise choice
- Where abortion services are not accessible, care-seeking is marked by higher levels of desperation. This makes the provider-client relationship more unequal and potentially exploitative
- An asymmetry of information therefore reinforces an asymmetric power relationship
- The flow of information tends to be restricted even more, in legally restricted environments

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# Provider and user control

- Provider-controlled technology (certain contraceptives, surgical procedures) imply greater skill and facility requirements that might not be readily accessible
- In matters related to sexuality, moral and ideological authority is mediated through control of technology
- Oral pills, emergency contraceptives, the pregnancy test kit, inhalers for asthma and medical abortion drugs, all challenge the traditional provider-user power relationship
- Resistance to loss of control (and income) must be anticipated

# Locating medical abortion services within primary health care

# Locating medical abortion services within primary health care-1

- Laws and policies that recognise the difference between taking pills and undergoing a surgical procedure
- Regulation that acknowledges that abortion can and should be provided as a primary health service
- Facilities: Simplification or elimination of facility requirements, increased home-use
- Providers: Appropriately qualified and trained, arrangements for coping with staff turnover
- Drugs and supplies that reliably reach the point of use and are affordable

# Locating medical abortion services within primary health care-2

- Dose and follow-up protocols that recognize women's convenience and give them greater control
- Referral arrangements for surgical back-up
- Costing and financing abortion services to ensure equity
- Information that enhances options, destigmatises abortion and balances the asymmetry of power between women and providers
- Accountability mechanisms to link primary health systems to community, especially women's needs