Systematic review of early abortion services in low- and middle-income country primary care: potential for reverse innovation and application in the UK context

Jacy Zhou[1], Rebecca Blaylock[2], Matthew Harris[1]

1. School of Public Health, Imperial College London
2. Centre for Reproductive Research and Communication, British Pregnancy Advisory Service

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Background

In the UK, abortions must be provided in accordance with the 1967 Abortion Act. Removing abortion from the criminal framework could permit new service delivery models. We explore service delivery models in primary care settings that can improve accessibility without negatively impacting the safety and efficiency of abortion. Novel service delivery models are common in low-and-middle income countries (LMICs) due to resource constraints, and services are sometimes provided by trained, mid-level providers via “task-shifting”. The aim of this study is to explore the quality of early abortion services provided in primary care of LMICs and explore the potential benefits of extending them to the UK context.

Objectives

- Systematically review the evidence base for first-trimester abortion services in primary care of LMICs
- Use a narrative synthesis approach to analyse the quality of abortion services with specific indicators organised around the Donabedian model
- Consider the opportunities and challenges for the development of such services in the UK.

Methodology

We searched MEDLINE, EMBASE, Global Health, Maternity and Infant Care, CINAHL, and HMIC for studies published from September 1994 to February 2020, with search terms “nurses”, “midwives”, “general physicians”, “early medical/surgical abortion”. We included studies that examined the quality of abortion care in primary care settings of low-and-middle-income countries (LMICs), and excluded studies in countries where abortion is illegal, and those of services provided by independent NGOs. We conducted a thematic analysis and narrative synthesis to identify indicators of quality care at structural, process and outcome levels of the Donabedian model.

Results

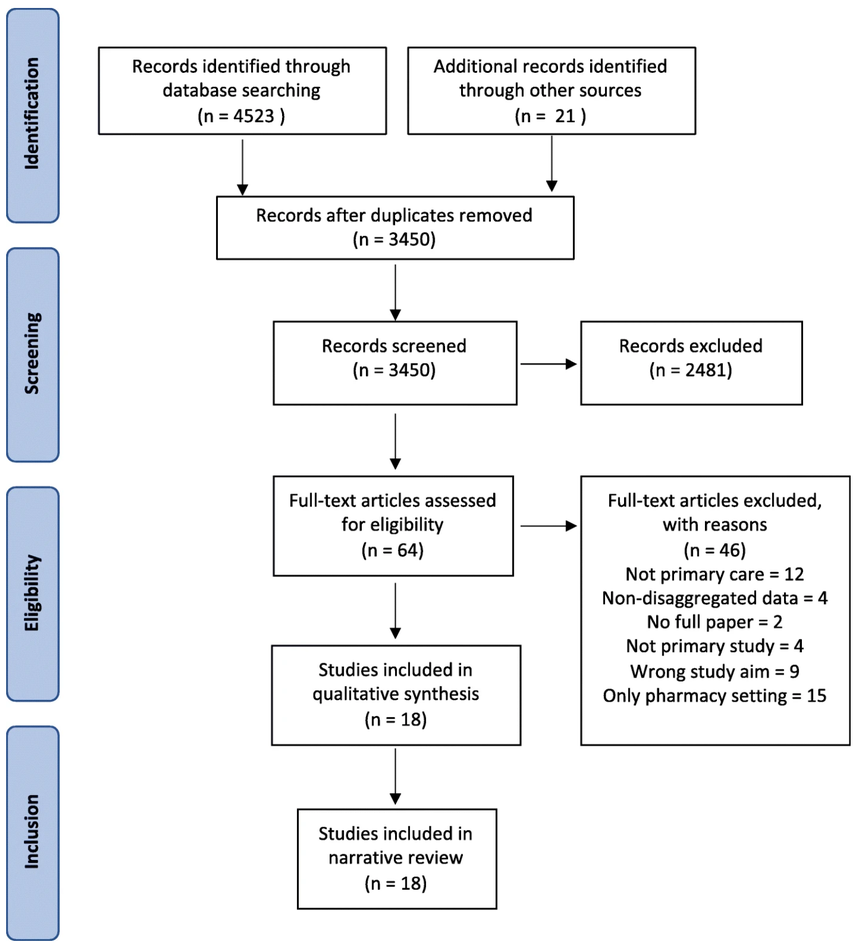


Fig 1. PRISMA flow diagram of this study.

An initial search yielded 3450 titles. We identified 18 studies for inclusion. Included studies were conducted in eight countries: Bangladesh, Democratic People’s Republic of Korea (DPRK), Ethiopia, India, Kyrgyzstan, Nepal, Nigeria, and South Africa.

We identified a total of 21 indicators to assess the quality of abortion services in eight subthemes, organised under three sections: (1) **structural indicators:** law and policy, infrastructure; (2) **process indicators:** technical competency, information provision, client-provider interactions, ancillary services; (3) **outcome indicators:** abortion outcomes, client satisfaction.

The majority of studies showed ≥95% complete abortion rate. Most clients were satisfied with the abortion services they received and would recommend them to their friends. Surgical abortion outcomes were not investigated as cross-sectional studies did not allow for patient follow-up.

Discussion

This review showed that provision of EMA in primary care services is safe, feasible and acceptable.

Multiple studies also showed the success of task-shifting. Nurses and midwives can effectively replace doctors in abortion services when well-trained and supported.

Innovations from LMICs are often given shorter shrift. Evidence suggests research from these settings is rated worse based on their country of origin.

This review suggests that there is much that could be learned from LMICs.

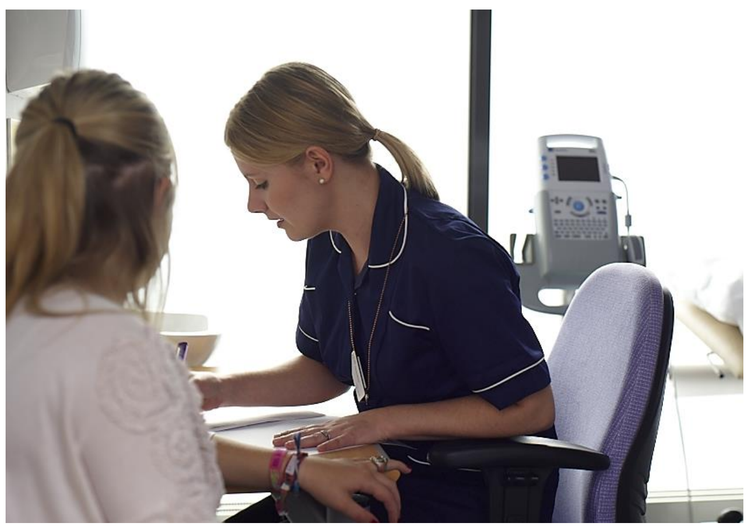
There is a risk that introducing EMA into primary care in the UK may increase the burden on staff.

Strengths and limitations

- There is a paucity of evidence relating to the provision of surgical abortion services in primary care.
- A majority of included studies were in a controlled environment, where provider practice was standardised by strict protocols – results may not represent actual practice.

Conclusion

Our review is the first to review the quality of abortion services provided in primary care clinics of LMICs. We conclude that EMA provision in primary care is safe and feasible, and that implementing a similar service in the UK could improve access without compromising on quality. Implementing EMA in the UK primary care system can complement recently introduced telemedical services to provide women with face-to-face care in their own community.



Next steps

- Cost estimation of integrating an EMA service into primary care, and an economic evaluation to make a strong business proposition.
- Acceptability and feasibility studies to explore the underlying conditions of primary care EMA.
- Qualitative studies for an in-depth understanding of attitudes primary care providers and women have towards primary care EMA.
- We also recommend that further research is conducted to inform and enable task-shifting of first trimester surgical abortions to nurses and midwives in UK primary care.