Safe Abortion Care During Infectious Disease Outbreaks: Supplemental Guidance for Humanitarian and Fragile Settings

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INTERNATIONAL RESCUE COMMITTEE

IAWG Inter-Agency Working Group on Reproductive Health in Crises

Introduction

Purpose:

The purpose of this guide is to provide practical advice for health staff undertaking infectious disease preparedness and response activities to ensure that access to safe abortion care (SAC) is maintained when an infectious disease outbreak occurs. It is an operational guide which can serve to support health actors to maintain SAC services during outbreaks and ensure that necessary SAC considerations are integrated within outbreak responses; it is not a clinical guide. The locational focus of this document is humanitarian and fragile settings; however, recommendations may apply to infectious disease outbreaks in all low-resource populations. **This guide is intended to complement *Sexual and Reproductive Health and Rights During Infectious Disease Outbreaks: Operational Guidance for Humanitarian and Fragile Settings*.**

The target audiences for this guide are program managers and health care providers from governments and implementing partner agencies located in humanitarian and fragile settings that are at risk of, or experiencing, infectious disease outbreaks. This guide may also be useful to other cadres, such as social workers and gender-based violence case managers, who often serve clients with unintended pregnancies.

Key Terms:

- **Safe abortion care (SAC)**: Abortions that are carried out using one of the WHO-recommended methods, appropriate to the gestational age and by someone with the necessary skills, as applicable.
- **Post-abortion care (PAC)**: A series of medical and related interventions designed to manage the complications of spontaneous and induced abortions, both safe and unsafe, and address related healthcare needs.
- **Comprehensive abortion care**: Provision of information and abortion management for SAC and PAC, as well as contraception counseling and referral for additional services as needed.
- **Unsafe abortion**: An abortion that is carried out by a person lacking the necessary skills or in an environment that does not conform to minimum medical standards, or both.

Effects of infectious disease outbreaks on abortion care:

Infectious disease outbreaks are public health emergencies that require an acute response, particularly in humanitarian settings where health systems are already strained. The Minimum Initial Services Package (MISP) for Sexual and Reproductive Health (SRH) in Emergencies is the minimum standard for SRH services provision during infectious disease outbreaks, as in any emergency response, and the MISP incorporates safe abortion care as an additional priority.

It is estimated that unsafe abortion accounts for 8-13% of maternal deaths worldwide. Although the burden of unsafe abortion in humanitarian settings is poorly documented, the overall disruption of the health system, along with increased incidence of gender-based violence

(GBV), that occurs during crises suggests that the burden of unsafe abortion in humanitarian settings is likely as high as or higher than in stable settings. Indeed, the Interagency Working Group on Reproductive Health in Crises' 2012-2013 Global Evaluation found that SAC was entirely unavailable in the humanitarian settings assessed; this evaluation also found a complete lack of any requests for SAC funding within humanitarian appeals.[i] There has been some recent process, with SAC being provided as part of emergency responses in Bangladesh, Colombia and Eastern Europe, as well as with the inclusion of SAC in the "Minimum Initial Services Package for SRH in Emergencies" chapter of the Interagency Field Manual for SRH in Crises. Still, SAC is often unavailable in humanitarian settings despite the substantial need.

The strain that outbreaks place on health systems leads to reduced access to services like contraception and clinical care for sexual assault survivors and may increase the incidence of GBV.[ii] Furthermore, pregnancy complications, pregnancy loss, and decisions about whether to carry a pregnancy to term become more complex during outbreaks; for example, Zika virus, when contracted during pregnancy, can cause severe congenital malformations, such as microcephaly.[iii] Similarly, Ebola Virus Disease (EVD) when contracted in pregnancy nearly always results in adverse pregnancy outcomes, including spontaneous abortion, maternal death, or neonatal death.[iv] Hepatitis E infection and Lassa Fever both increase mortality risks for pregnant women and their fetuses, and the dehydration caused by Cholera can increase the risk of fetal death.[v,vi,vii] Although maternal and neonatal outcomes are less severe with COVID-19 compared to Zika and EVD, COVID-19 in pregnancy can increase the risk of some pregnancy complications, such as preterm birth and still-birth, and the sheer number of pregnant women infected with COVID-19 has led to greater morbidity and mortality than from other, less-common pathogens.[viii] These potential complications for the pregnant person, fetus and newborn present further challenges to health systems that are already under strain during infection disease outbreaks, as they require health systems to manage an increase in complicated spontaneous and/or therapeutic abortions.

Given reduced access to essential services and increased incidence of GBV during infectious disease outbreaks in humanitarian settings, as well as the link between adverse pregnancy outcomes and some pathogens, it is critical that all pregnancy options, including SAC, remain available and accessible during infectious disease outbreaks. Although data on the availability of SAC during infectious disease outbreaks are limited, the data that are available suggest that infectious disease outbreaks exacerbate already poor availability of SAC in humanitarian settings. During the 2018-2020 EVD outbreak in the Democratic Republic of Congo (DRC), the International Rescue Committee found very limited availability of safe abortion care and high levels of abortion stigma among respondents.[ix] An assessment of the impact of COVID-19 on SRH services in six countries that experience humanitarian crises found reduced contraception access and use, increased risk of adolescent pregnancy and increased need for SAC that was largely unmet, particularly in the DRC.[x] Another study by the Ipas Development Foundation in India found that travel restrictions and reallocation of resources to COVID-19 in the first three months of the pandemic compromised abortion access for 1.85 million women.[xi] Similarly, a simulation model study conducted by Ipas in Nigeria found that lockdowns in particular had a detrimental effect upon access to safe abortion care.[xii] A study of abortion care access during

the COVID-19 pandemic in Europe found that maintaining abortion access depended on whether health systems prioritized adaptations such as shifts to telemedicine and early medication abortion, with additional barriers faced within countries that did not liberalize abortion access policies.[xiii]

In general, regardless of setting, the redirection of resources toward outbreak response, combined with abortion stigma and ambiguous or restrictive abortion policies, further limit abortion access during infectious disease outbreaks. For these reasons, it is critical that governments, civil society organizations and donors prioritize outbreak preparedness for SRH services and ensure access to the MISP, including SAC, when an infectious disease outbreak occurs.

Policy considerations:

The World Health Organization (WHO)'s guidance is clear in its recently published *Abortion Care Guideline*: "strengthening access to comprehensive abortion care within the health system is fundamental to meeting the Sustainable Development Goals (SDGs) relating to good health and wellbeing (SDG3) and gender equality (SDG5)."[xiv] Furthermore, following the COVID-19 pandemic and other disease outbreaks, the WHO has included comprehensive abortion care as part of its list of essential services in recent guidance, such as *Maintaining essential health services: operational guidance for the COVID-19 context: interim guidance*.[xv]

Similarly, as noted above, the MISP for SRH in Emergencies—a standardized set of priority lifesaving services and activities that prevent excess morbidity, mortality and disability in crisis-affected populations—includes SAC as a priority. Comprised of six core objectives, the most recent version of the MISP, published in 2018, incorporates SAC under the second objective, which is to prevent and treat the consequences of GBV. The prioritization of SAC within this objective acknowledges that women and girls in humanitarian settings may be at increased risk of both unintended pregnancy and unsafe abortion, leading to increased need for access to SAC. The 2018 MISP chapter also highlights SAC as an "other priority", stating that "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."[xvi]

It is important to note that, although abortion in one or more circumstances is lawful in most countries, there is considerable variation in the specific circumstances under which individuals may access abortion. Furthermore, "almost all countries where abortion is lawfully available regulate abortion differently to other forms of health care. Unlike other health services, abortion is commonly regulated to varying degrees through the criminal law in addition to regulation under healthcare law."[xvii] Therefore, legal barriers, which are generally not evidence-based, further amplify the risks faced by pregnant women and girls who are in need of high-quality care.

Health actors in infectious disease outbreaks should make every effort to ensure access to safe abortion care in line with global evidence and best practice.

Maintaining the Safety and Continuity of Comprehensive Abortion Care During Infectious Disease Outbreaks

SAC is both essential medical care and time-sensitive, and access to services should be maintained even when non-essential or elective care is discontinued during an acute phase of an outbreak. Given the gestational age limits on certain methods of abortion care, delays in access to care should be minimized as much as possible. However, ensuring the continuity of SAC during an infectious disease outbreak requires more than maintaining existing services. Abortion care services and interventions must be proactively adapted in response to the changing health system and reallocation of resources, as well as client preferences and experiences.

Making facility-based abortion care safe:

Facility-based abortion care services must be enhanced and adapted during infectious disease outbreaks to minimize unnecessary provider-client interactions, as well as to improve infection prevention and control in an effort to reduce the likelihood of nosocomial transmission. Direct provider-client interaction should be minimized, and clients should only be asked to come to a health facility if the benefits of attendance outweigh the risks of contracting the disease. Specifically:

- ➔ **Medication abortion should be the first-line treatment** for SAC up to 12 weeks, to minimize provider contact with blood, fluids, and respiratory droplets during an outbreak. If a client prefers vacuum aspiration to medication abortion, it may still be offered provided that the facility has appropriate infection prevention and control procedures. Women and girls may have their own reasons for preferring one method over another (privacy and safety issues, history, etc.), reasons which should always be respected to the fullest extent possible.
- ➔ **Provider consultations and non-judgmental, confidential abortion counseling and screenings should be done by phone or video**, where possible. If phone or video screenings are not possible, consultations should be conducted using appropriate infection and prevention and control (i.e., socially distanced with enhanced ventilation).
- ➔ **Clients receiving medication abortion should be provided with an additional dose of misoprostol** in case the abortion has not occurred within 4 hours of the first dose. This reduces the need for further visits in case the initial dosing is unsuccessful.
- ➔ **Clients should be provided with a sufficient pain management method** taking into account that public pharmacies may not be open or accessible. Furthermore, a mental state of stress and uncertainty may increase clients' perceived pain.
- ➔ **Women should be provided with their preferred method of contraception** at the same time as the abortion medication(s), when possible (i.e., pills, injectables and implants), as well as a backup method, such as condoms, when referral to another location is required (i.e., for an intrauterine device or tubal ligation).

Increasing access to self-managed abortion:

When facility-based abortion services are disrupted or overstretched, and/or under circumstances in which clients fear facility-based healthcare, programs should be adapted to make abortion care available through safe abortion self-management in line with global evidence. Self-managed abortion refers to an individual's management of their own abortion safely using misoprostol, with or without mifepristone and outside the context of the formal health system. When performed in line with recommendations and gestational age limits, self-managed abortion is safe and effective. The following should be considered when working to increase access to safe self-managed abortion:

- ➔ **Launch self-managed abortion care programs during stable times as part of preparedness efforts** so that programs can be more easily and successfully expanded during infectious disease outbreaks.
- ➔ **Information on safe abortion self-management should be distributed discretely through multiple channels** that align with the preferences of women and adolescent girls in each context. Though some aspects of programming are similar to the provision of medication abortion described above, the person seeking an abortion may not have direct contact with a clinical care provider during the process of self-managed abortion. Instead, the person may receive information on how to safely manage their abortion online, by calling a hotline, through printed media or from trained, non-clinical counselors. Clients seeking abortion should receive information about appropriate dosage and timing, pain management, expected side effects, danger signs and where to access emergency care in the unlikely event of a complication.
- ➔ **Map the availability of high-quality misoprostol and mifepristone.** These products can be accessed at many pharmacies, through the mail, and/or through community-based distribution, depending on the context. In some cases, implementers will need to assess drug quality and increase the availability of misoprostol and/or mifepristone in the market through partnerships with pharmacists in order to make abortion self-management accessible.

Integrating SRH Needs Within Infectious Disease Outbreak Response

Screening, triage and testing:

It is common for health facilities to implement a screening and triage system during infectious disease outbreaks, with screening usually occurring next to the facility entrance. In establishing such screening spaces, the privacy of women and girls entering the facility should be maintained, facilitating the discussion of more detailed information.[xviii]

- ➔ **Triage should be designed to allow for confidential consultation and privacy** from other staff and patients, and staff should be well trained in how to respond sensitively and appropriately, including when pregnant women and girls request access to SAC .

Staff should be able to signpost women and girls to available SAC when appropriate, ensuring that accurate and relevant information is provided.

- ➔ **Women should be counseled about all pregnancy options, including SAC, when pregnancy tests are administered as part of the triage and screening process**.

Case management and treatment centers:

- ➔ **Coordinate with SRH actors to ensure that referral pathways are established** between facilities in order to maintain the availability of SAC. Pregnant women and girls who are admitted in health facilities and treatment centers during an infectious disease outbreak, and wish to access SAC, should be referred and receive treatment when clinically appropriate. This recommendation is applicable to those who are either considered non-infectious or potentially infectious (i.e., in quarantine, admitted for testing and initiation of treatment, or considered a suspect). If the facility to which the patient is admitted does not have the capacity to provide SAC, it is then recommended that there be a functioning referral pathway in place to ensure accessibility to SAC.
- ➔ **Case management and treatment centers that treat pregnant women should at minimum have staff who are able to manage complications of abortion**, such as bleeding or retained products of conception. To the extent possible, these facilities should have trained staff and supplies for first and second trimester abortion; if not, rapid and safe referral should be available. Where the skills and supplies are available to safely offer instrumentation abortion procedures, such as dilation and evacuation, procedures should be implemented with respect to infection prevention and control (IPC) guidance for the infectious disease pathogen. Infectious disease outbreaks that lead to severe illness in pregnant women and girls can also lead to threatened or spontaneous abortions that require SAC or PAC care to protect the life or health of the woman, and in such cases, there may not be sufficient time to transfer the client to a different facility. Depending on the pathogen and modes of transmission, enhanced IPC measures are likely to be needed to safely provide abortion care to clients under these circumstances.
- ➔ **When the disease-causing pathogen is associated with poor fetal outcomes, neonatal abnormalities, and/or severe maternal disease, pregnant women should receive accurate information about their options and have access to SAC.** They should be supported in the choices they make regarding continuation or termination of the pregnancy. For example, Congenital Zika Virus Syndrome refers to the range of manifestations, in addition to congenital microcephaly, that have been reported following exposure to Zika virus in utero; in such cases, it is recommended that the case be referred to fetal medicine specialists if available, and when significant brain abnormality or microcephaly is confirmed in the presence of Zika virus infection, the option of termination of pregnancy should be discussed with the woman, regardless of gestation.[xix] Similarly, although data are limited, reports from EVD outbreaks indicate that spontaneous fetal loss is high among pregnant women with EVD, and that neonates born to women with EVD are often premature and have high mortality rates.[xx] It is important to recognize that evidence is limited and context-specific: there is currently insufficient evidence to determine whether induced abortion or induction of labor impacts acute EVD.[xxi] However, the WHO clearly recommends that women who have recovered

from EVD and wish to terminate a pregnancy should receive accurate information about their options, have access to SAC, and be supported in their choice.[xxii] Given that the pregnancy remains EVD-positive after the pregnant woman herself has recovered, it is safest for the abortion to be performed inside the Ebola Treatment Center rather than at home or at a primary health care facility.

Risk Communication and Community Engagement (RCCE)

It is critical that providers work hand-in-hand with communities and partners, including those within the SRH sector, to understand the health beliefs and concerns of the community and collaborate on the development and implementation of messages, materials, and activities. Concerns about an outbreak may compound underlying abortion stigma to magnify misconceptions and inhibit care-seeking. If a community's questions and concerns are addressed ineffectively, people may attempt to fill knowledge gaps with information that makes most sense to them, including rumors and misinformation, which can have detrimental consequences in the context of abortion care. Therefore, to facilitate SAC, it is essential to ensure clarity and consistency of messaging relating to SRH and the outbreak.

- ➔ **RCCE sub-groups involved in the outbreak response should coordinate closely with the SRH group (usually comprised of SRH providers and partners), health cluster, GBV sub-cluster and other coordinating bodies to ensure coordinated and well-integrated messaging around SRH and the infectious disease outbreak.** This provision encompasses messaging involving information about all pregnancy options, including SAC.
- ➔ **Given the context, carefully choose the most appropriate channels to transmit information about SRH and the infectious disease outbreak.** In some cases, word of mouth, one-on-one conversations, or discrete distribution of written materials may be more effective and acceptable than group information sessions or mass media. These strategies can prove particularly helpful during an infectious disease outbreak, when outside responders are sometimes regarded with suspicion.

Preparedness and Response Quick Reference Checklists

Preparedness checklist:

Conduct competency-based refresher trainings on comprehensive abortion care using medication and manual vacuum aspiration	
Ensure the following are included in contingency plans for outbreaks: (1) Train community providers on early medication abortion and how to counsel women on self-management; (2) Supply providers with medications and post-abortion contraceptives; (3) Plan for remote/telephone screening of clients; and (4) Establish referral pathways for abortion care, particularly for care after the first trimester if not available on-site or in the community.	
Advocate for task-shifting abortion care and the development of community-based and self-care guidelines for medication abortion. Where abortion care is restricted, advocate for the expansion of indications for voluntary SAC.	
Procure and pre-position supplies for facility-based and self-managed abortion (including packaging of medications and informational, educational and communication materials outlining instructions for use).	
Actively advocate and ensure that SRH services are part of transition and recovery plans through the SRH working group, outbreak preparedness coordination mechanisms, and other related coordination mechanisms.	

Response checklist:

Provide medication abortion as a frontline option; where manual vacuum aspiration is required, follow standard IPC and personal protective equipment guidance	
Expectant ("watch and wait") or medication management should be first-line options for incomplete abortions. Where the patient is deemed stable and safe to go home, treatment can continue outside the facility. Advice/phone number should be given in case of complications.	
Halt routine facility-based follow-up and set up phone line for remote follow-up support, if and when indicated.	
Provide post-abortion contraception at consultation, if desired.	
Ensure privacy and confidentiality at screening and triage locations.	
Establish referral pathways for comprehensive abortion care between facilities, including treatment centers.	
Ensure (at minimum) that treatment centers are equipped to provide treatment for complications of abortion and (ideally) the presence of trained staff and supplies for first and second trimester abortion, wherever possible.	
In contexts where mifepristone is unavailable and health facilities become inaccessible, the misoprostol-only regimen should be considered for self-managed abortion.	
Distribute information about safe self-managed abortion and ensure availability of combined or misoprostol-only regimens at the community level.	
Distribute supplies as required.	

Additional Resources

- Abortion Care Guideline (WHO)
- Chapter 8: Comprehensive Abortion Care (Interagency Field Manual on SRH in Crises, IAWG)
- Chapter 3: Minimum Initial Services Package for SRH in Emergencies (Interagency Field Manual on SRH in Crises, IAWG)
- COVID-19 Infection and Abortion Care (RCOG)
- Guideline on self-care interventions for health and well-being, 2022 revision (WHO)
- Guidelines for the management of pregnant and breastfeeding women in the context of Ebola virus disease (WHO)
- How to Use the Abortion Pill (MSF)
- Medical Abortion Commodities Database
- How to buy abortion pills that are safe and effective, FAQs (Ipas)
- Abortion Attitude Transformation: A values clarification toolkit for humanitarian audiences (Ipas)
- Abortion clinical training tools (Ipas)
- Improving Access to Abortion in Crisis Settings: A legal risk management tool for organizations and providers (Ipas)
- Trauma-informed care for abortion providers treating sexual violence survivors in humanitarian settings (Ipas)

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