Addressing preventable maternal mortality and morbidity: the determinants and consequences of unsafe abortion in Solomon Islands

Presentation by

Rebecca Manehanitai, MHMS

on behalf of the study team

A collaboration between MHMS, SIPPA and Monash University (Australia)

Presentation of initial findings

A. Background to study
B. Methods: research questions and tools
C. Findings from five research questions
D. Recommendations

A. BACK GROUND
Why did we do the study?

- WHO defines abortion as unsafe if it is carried out:
  - *"by persons lacking the necessary skills;"* and/or
  - *"does not conform to minimal medical standards."*
- It's a global issue and one of the leading causes of maternal mortality; ~ 47,000 deaths globally per year
- Majority of mortality and morbidity occurs in low and lower-middle income countries, such as SI, where:
  - use of modern contraception is low;
  - Intimate partner violence is common; and
  - access to safe abortion is legally restricted.

Context in Solomon Islands

- Use of contraception is low: only 27% of married women and 16% of unmarried sexually active women use effective methods (DHS 2007)
- Unintended pregnancy rate is high: 57% of women reported their last pregnancy was unintended (DHS 2007)
- Safe medical abortion is only legal to save the life of the woman under the *Penal Code.* Life imprisonment for women seeking abortion and health workers providing abortion.

What do we know about abortion in Solomon Islands

- No published study on safe or unsafe abortion in SI, but other studies have found:
  - 71% of nurses were aware of female youth coming to the facility to seek advice about termination of pregnancy (Nicholls et al 2012)
  - 67% of nurses had provided treatment to young women following unsafe abortion (Nicholls et al 2012)
  - 2% of admissions at hospitals were related to pregnancy with abortive outcome (Lorgelly et al 2014)

What do we know about abortion in Solomon Islands

- No data on maternal mortality and morbidity arising from unsafe abortion
- Global burden of disease study estimates that spontaneous or induced abortion accounts for approximately 16% of maternal deaths in SI and is the second highest cause of maternal death in the country.

Purpose and aim of study

- Study was design to find out more about SI context
- Addresses the issues of unwanted pregnancy and unsafe abortion from a public health perspective
- Aims to help the MHMS reduce unwanted pregnancy And improve quality care provided to women with post abortion complications

B. Method: Research question and tools.

Research questions

1. The factors that contribute to unwanted pregnancy and abortion;
2. The practices related to unwanted pregnancy and unsafe abortion;
3. The health and other consequences of unsafe abortion;
4. The supply and demand-side barriers that impact on timely access to quality post-abortion care.

Research tool

- Data collection, in March 2015 throughout Honiara and Guadalcanal, included:
  - 18 semi-structured interviews with health workers (doctors, midwives, nurses or nurse aids, pharmacy technicians and kastom doctors);
  - 20 focus group discussions with young adult women and men (aged 18-30)
  - 100 inpatient records from the NRH gynae ward for patients with post-abortion complications.

Ethics for the study

- Ethics approval granted by SI National Health Training and Research Institute and Monash.

Limitation of the study :

Our approach was limited in two main ways.

- Did not include young people under 18 years of age in the FGD and did not capture their unique perspective.
- Only collected data in Honiara and Guadalcanal and missed how the situation varies throughout the country.

C. Findings from Four research questions Q1: The factors that contribute to unwanted pregnancy and abortion

- What causes unwanted pregnancy?

a) Limited knowledge and myths about safe and consensual sex

b) Norms that limit women's ability to access and use contraceptives

c) Women's lack of power to negotiate safe and consensual sex

Q1. The factors that contribute to unwanted pregnancy and abortion

a) Limited knowledge and myths about safe and consensual sex, including:
   - What constitutes sex, that sex leads to pregnancy, and that sex is only legal with their consent
   - The availability of contraception
   - The effectiveness of contraception – myths that use of modern contraception causes cancer, infertility, feeling or memory loss
   - How to correctly use contraception
   - The limits of traditional methods of contraception

Q1. The factors that contribute to unwanted pregnancy and abortion

b) Norms that limit women's ability to access and use contraceptives

- These norms centred upon deeply embedded cultural and religious views about women:
  - That women and sex were for procreation;
  - That women should only have sex when they were married and/or when they wanted to get pregnant;
  - That the use of any contraceptive methods was contrary to customary and religious teaching.
- Limit women's access to contraception at MHMS facilities and ability to negotiate use with partner

Example: Negotiating contraception

Us women, we are concerned about the danger of getting pregnant, so we think of using [contraception]. We understand our situation. But some men, honestly, they do not accept to use the condom. They say it's unsatisfying. That's what they tell us. No matter how much you push, how much you cry, how much you force, they say no…

Women are afraid of using contraception. Some husbands do not accept it.

I'm married with two children. My husband stops me from using family planning, so I use the loop [intrauterine device] in secret. I don't want to have any more children; I want to go to school and find work. I think two is enough.

Female participants in focus group discussion

Example: Access to contraception

The methods at the clinic, everyone can go to the clinic and take them. But the men at the church, they stop people, they stop anyone they hear [is taking methods from the clinic] and report them to the Big Man at the Church. Then they cut keys [to the clinic] and they look up the names there too… They cut the keys and they check the names of those who take methods from the clinic [from the family planning register]. I'm not against the law, but if you look at the life of families at this time, some are not free.... So how do you scale back the problem? Because they have stopped us from taking the methods from the clinic... We don't want to be pregnant, but we're pregnant.

Female participant in focus group discussion

Q1. The factors that contribute to unwanted pregnancy and abortion

c) Women's lack of power to negotiate safe and consensual sex

- Women may be raped (i.e.: being forced to have sex when they did not want to), including at times when they knew that they could get pregnant
- Abstinence or periodic abstinence was ineffective because women may be forced to have sex
- Withdrawal method also problematic as men also do not always withdraw
- Alcohol considered a contributing factor

Example: Sexual violence

In some cases, how do I say it, it's like rape, but some [boys] nowadays are the type to force girls to have sex. The kind of boyfriend who forces their girlfriend [by saying], "if you don't love me, then I'll force you..."

Female participant in focus group discussion

Women are not safe because their husbands are drunk. They and their husbands don't want to have more children, but then he drinks… Some men like to have sex... The woman tries to say no, but it's hard, so she ends up pregnant with her second or third child. They both don't want to be pregnant, but they end up pregnant because of the man.

Male participant in focus group discussion

Q1. The factors that contribute to unwanted pregnancy and abortion

- What makes a pregnancy unwanted?

1. Relationship context: if unmarried women may face stigma, be forced to marry their partner, or pay compensation.
2. Impact on education, or social and work life: women (and in some circumstances their partner) in school will be expelled.
3. Lack of ability to support a child for both married and unmarried women.

Q2. Practices related to unwanted pregnancy and unsafe abortion

- Women who have an unwanted pregnancy may seek advice from their friends or female relatives. They may or may not seek advice from their partner (boyfriend or husband).
- They may choose to continue with the pregnancy; give the child up for adoption; commit infanticide; commit suicide; or to end their pregnancies (induced abortion).
- Methods used to terminate pregnancies are shown on the following table.

	Type	Examples mentioned more than once
Kastom medicine (consumed unless stated)	Bark	Bark, including bark with lime or salt water Bark from a sour tree
	Fruit	Lime (called lemon or bush lime), including lime with sugar, salt or sea water, cough medication, ginger, coffee or Panadol Unripe (young) coconut juice Vuruvare (an indigenous fruit)
	Leaf	Tea leaves (from a tree or packet) White flower, including white flower with lime or Sprite Neem leaves Grass (inserted into the vagina)
	Root	Ginger with tea leaves Ginger tree (walking past at dusk)
Self-harm	Pressure on stomach	Hitting, kneeing, jumping, or walking on the stomach or back while lying on the ground Massage Climbing trees
	Physical exertion	Extended exercise (running, jumping, skipping) Lifting heavy loads while working Falling down or jumping down from trees
	Overdose of recreational drugs	Alcohol, including beer and kwaso (a local homebrew) Coffee mixture
	Overdose of medication	Chloroquine, including chloroquine with Panadol
Other	Misoprostol	

Q2. Practices related to unwanted pregnancy and unsafe abortion

- Kastom medicine: methods that women already know; find out from other women; or obtain from a kastom doctor. Kastom doctor may be paid in cash (SBD 100 - 300) or kind (food, betel nut, cigarettes or sex).
- Self-harm: methods that women already know; or find out from other women. Generally no cost.
- Misoprostol (*Cytotec*): obtained from a private doctor or pharmacy (with or without a prescription) for between SBD100 - 500.

Q3. Health and other consequences of unsafe abortion

- Immediate: bleeding and incomplete abortion, anaemia, infection which participants reported has resulted in death.
- Long term: infertility.
  - Note: Participants also commonly reported that women may suffer cancer but this is not supported by scientific evidence.
- Women may also experience
  - Relief
  - May face separation from boyfriend or husband
  - Acceptance or rejection/violence from family
  - Stigmatisation (for example, being called "*sex driver*", "*solfish*", "*rubbish*" or "*murderer*")

Q4. Post-abortion care

	Bleeding	**Anaemia**	**Infection/lower abdominal pain**	**Fee**
NRH	Saline and Syntocinon. Ultrasound scan or speculum to check for RPOC, treated with surgery or misoprostol. Blood transfusion.	Blood test for haemoglobin. Treated with blood transfusion and/or iron (*Fefol*).	Antibiotics (amoxicillin, ampicillin, gentamicin and/or metronidazole), If septicaemia then cephalosporin.	No fee
Lower level clinics	Speculum to check for RPOC, treated with sponge forceps. Saline, antibiotics (ampicillin amoxicillin and/or metronidazole), iron (*Fefol*) and *Panadol*.	Iron (*Fefol*) and antibiotics. Monitor. Refer to NRH if necessary.	Antibiotics (amoxicillin, ampicillin and/or metronidazole), saline, and *Panadol*.	SBD 5-10 if admitted (outside HCC).
Private doctor or private pharmacy	Progestin (*Norethisterone*) and/or refer to NRH.	Iron (*Fefol*) and anaesthetic (*Lidocaine*).	Antibiotics (amoxicillin, and/or metronidazole) and/or refer to NRH.	SBD 20-150
Kastom doctor	Bark or leaf to drink. Tying rope in hair.	Leaf with water (for weakness)	Grass leaf or lime to drink.	SBD 10-50 or cigarettes.

4. Barriers to quality post-abortion care

1. Access
2. Confidentiality
3. Provider attitudes
4. Availability of drugs and other supplies
5. Treatment protocols
6. Human resources

4. Barriers to quality post-abortion care

3. Provider attitudes
4. Availability of drugs and other supplies
5. Treatment protocols
6. Human resources

D. Recommendations. Process for developing the recommendations

- The recommendations build on the actions in the MHMS National Health Strategic Plan 2016-2020 (NHSP).
- The recommendations were initially developed by the study team.
- A workshop was then held with 27 participants from across the MHMS, the Ministry of Women, Youth and Children, civil society organisations, church organisations and development partners to discuss the findings and refine the recommendations.

Existing measures in NHSP 2016 - 2020

- Increase access to modern contraception:
  - improve knowledge amongst parliamentarians, stakeholders, women and men about contraception;
  - develop a certified FP training course for health workers; and
  - integrate FP into maternal and child health community based care programs.
- Increase the competency of health workers and educators on adolescent health and on creating youth friendly spaces.

Recommendations

1. Strengthen activities in the NHSP:

1.1 All efforts to increase contraceptive use should address the gendered norms that define women's power to access and use modern contraception, and negotiate consensual sex, as well as misconceptions about contraception and abortion

Recommendations

1. Strengthen activities in the NHSP:

1.2 Community-based programs should engage with village, church and other leaders who may be currently limiting and/or better able to use lend their influence to increase women's access to and use of modern contraception

Recommendations

Strengthen activities in the NHSP:

1.3 Certified FP training for health workers should include how to engage young people in the design of youth friendly clinic spaces.

1.4 Certified FP training should be offered to all PHC staff

1.5 The MHMS should form an active partnership with MEHRD to develop comprehensive reproductive and sex education in schools

Additional recommendations

2. Strengthen systems to support women with unwanted pregnancy
3. Address legislation to improve access to safe abortion services
4. Improve access to quality post-abortion care

Tanggio tumas and questions

- Study team: A. Professor Paula Lorgelly, Katherine Gilbert, Professor Jane Fisher from Monash and Dr. Elissa Kennedy from the Burnet Institute; and Dr. Divi Ogaoga from the MHMS
- Researchers: Rebecca Manehanitai and Florentina Vunagi from the MHMS; and Veronica Esibaea, Paul Muller, Kelly Samani and Daisy Teho from SIPPA
- Informal advisory group: Kathy Gapirongo and Nancy Pego from the MHMS reproductive health team; Grace Fafale and Ben Angoa from SIPPA; Joanna Spratt from Australian National University; and Michelle O'Connor from University of New South Wales