

# Integrating the midwifery model of care into abortion services

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Midwives can provide a safe, respectful, and highly satisfying model of care that contributes to achieving Sustainable Development Goals 3 and 5.<sup>1</sup> Midwives have been suggested as a solution to rising rates of obstetric violence and unnecessary intervention in childbirth<sup>2</sup> and can be safe and appropriate abortion care providers.<sup>3</sup>

Abortion was legalised in Mexico City in 2007 and in the state of Oaxaca in 2019 and is legal nationwide in cases of rape. Abortion is provided through public and private health systems by obstetricians and general physicians. Despite the changes in the legal framework, research has revealed that pregnant people still mistrust the public healthcare system and feel disrespected during abortion care.<sup>4</sup> In 2016, 33% of women in Mexico stated having experienced obstetric violence during childbirth.<sup>5</sup> Pregnant people in Mexico undergo structural stigma through restricted access to abortion services; social stigma due to public opinion on why and what kinds of pregnant people have an abortion; and internalised stigma of feeling guilt.<sup>6</sup> Healthcare providers also experience stigma and are not trained in abortion provision or on a rights-based framework to support pregnant people's choice and safety. The Ministry of Health does not provide continued education to providers and, in certain parts of the country, district health offices refuse to request abortion equipment or medication for their units due to their own objections.

In Mexico, both direct-entry midwives and nurse midwives can be licensed to practice. Abortion protocols and regulations in the public sector do not include midwives as abortion care providers and Mexico lacks a regulatory body to oversee midwifery practice. Despite these limitations, a group of midwives in Mexico provide comprehensive abortion care, including counselling, provision of medical and surgical abortion services, and post-abortion

contraception. Pregnant people who seek abortion care often mistrust the public healthcare system and associated obstetric violence, so seek abortion care with midwives outside the public system. This commentary describes how midwives who practice outside the public healthcare system in Mexico use the midwifery model of care as described in Jefford et al.'s framework.<sup>7</sup> The five overarching philosophical pillars include the promotion of human rights through care based on justice, equity and respect; optimising care through supportive, non-interventive approaches; relationship-based care with the goal of self-determination for the woman; professional autonomy; and evidence-informed, competent, and ethical care.<sup>7</sup>

## *Promotion of human rights*

Autonomy and dignity are central to the application of human rights. In applying a rights-based model to abortion care, midwives uphold the capacity of choice of the pregnant person by focusing decision-making on them. Choices are offered and respected. Procedures are carefully explained, step by step, and with full and informed consent. If the pregnant person chooses medical abortion, they are given the choice to complete the procedure in their home or at the midwives' office. Questions such as why the pregnant person is choosing to terminate their pregnancy or why they selected certain lifestyle choices are not asked, and no limits are placed on how many abortions a pregnant person can access.

## *Optimising non-intervention*

Pregnancies can be terminated through dilation and curettage, manual vacuum aspiration (MVA), and medication. In the public healthcare sector

in Mexico City, most pregnancies under 9 weeks gestation are terminated using medication and those between 9 and 12 weeks commonly undergo MVA.<sup>8</sup> However, this protocol ignores pregnant people's realities. Approximately, 30% of people who accessed abortions in Mexico City between April 2007 and September 2019 were from out of state.<sup>9</sup> Individuals who travel may not be able to undergo a medical abortion procedure in a hotel room or in their home state. Those whose families do not know or disagree with the termination may put themselves at risk by undergoing an abortion at home. Irrespective of gestation, some may prefer to choose MVA as a faster method which can be carried out in a clinical setting, while others may prefer medical abortion.

Optimising non-intervention requires ensuring that the method used best matches the pregnant person's lifestyle and choices and optimises their capacity to access care. The midwives adhering to this philosophical pillar explain different methods and their implications fully to the pregnant person. They use non-pharmacological methods of pain management centred around the pregnant person having control over the timing and context of the procedure. A further small, but significant detail in this model is the use of long flowing skirts to replace the use of hospital gowns. Individuals have stated that this small symbol de-medicalises the process and helps to keep them calm.

### **Relationships**

Many pregnant people have accessed other forms of midwifery, well-woman, or contraceptive care from the midwives before. Many are referred by friends or family members. In accordance with the model, the midwives prioritise building trust with the pregnant person through continuously handing decisions to them. The midwives openly acknowledge that abortion is a complicated decision that involves many layers and is open to discussing these many layers if needed. The provision of comprehensive abortion care includes continuity of care: the pregnancy test, counselling over options, the procedure itself, post-abortion contraception, as well as any additional services such as referral for therapeutic support to psychologists, endocrinologists, or other specialists. The pregnant person is regarded as a whole person who has cultural and spiritual values and personal desires. This may mean that the midwife and the

pregnant person perform a culturally appropriate ceremony to honour the abortion.

### ***Midwifery as an autonomous profession***

The provision of abortion care by midwives without medical supervision is an example of professional autonomy. Within this model, the midwives rely on already existing relationships with back-up specialists for additional services such as ultrasound, laboratory testing, or referrals when gestational age is beyond the first trimester or health conditions require specialised care. Back-up obstetricians are aware that the midwives offer abortion care and are supportive of the practice. They may even refer individuals to midwives for abortion care if they prefer not to provide the service themselves. Obstetricians provide prescriptive support for antibiotics or additional medication. Out-of-hospital midwives in Mexico are not overseen by physicians and practice autonomously. They rely on national and regional networks such as Ipas for training and supplies.

### ***Evidence-based care***

Including midwives as providers of comprehensive abortion services is a direct application of evidence-based care,<sup>3</sup> particularly in contexts where mortality from abortion is still significant. The midwives who provide abortion services in Mexico are educated in evidence-based standards and encouraged to seek continued education, despite the lack of a Mexican regulatory body for midwifery. The midwives have adjusted protocols according to international guidelines as well as medication and supplies available within the country. Although the public healthcare system uses mostly medical and surgical abortion techniques, it is well known in Mexico that private obstetricians often perform the procedure using dilation and curettage in a hospital environment. This practice is not evidence-based and also makes the cost prohibitive to most pregnant people in the country. By ensuring access to cost-effective and respectful care through the midwives, pregnant people in Mexico have safe and dignified options for terminating the pregnancy.

It is worthwhile noting that during the COVID-19 epidemic, the midwifery centres in Mexico continued to perform abortions. Individuals were given the option to self-manage at home or have an MVA at the midwives' office. In the latter case,

personal protective equipment was provided for both the pregnant person and their support person, as well as the midwives. Preliminary internal data from the midwifery centres note a surge of five times as many abortions performed from March to May 2020 as compared to the same dates in 2019. The midwives note this is due to public services restricting care and not providing abortion procedures in timely ways, despite public statements to the contrary.

This commentary describes the practice of Mexican midwives who provide abortion care outside the public healthcare system. The midwifery model for abortion care is important: beyond surviving an abortion, pregnant people should be empowered through shared decision-making and by receiving respectful care that upholds their dignity and choices at all times. Abortion provision must go beyond biomedical training and include

a framework to uphold dignity. Although the midwifery model is mostly practiced by midwives, the philosophical pillars that define the model should be intrinsic to any healthcare provider. A rights-based approach to abortion provision would be that all providers were trained in the midwifery model to ensure that all pregnant people can access the safest care with the most respectful and dignified experience.

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## References

- Hoope-Bender Pt, Bernis Ld, Campbell J, et al. Improvement of maternal and newborn health through midwifery. *Lancet*. 2014;384(9949):1226–1235. DOI:10.1016/S0140-6736(14)60930-2.
- Freedman LP, Kruk ME. Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. *Lancet*. 2014;384(9948):e42–e44. DOI:10.1016/S0140-6736(14)60859-X.
- World Health Organization. *WHO | Health worker roles in providing safe abortion care and post-abortion contraception*. World Health Organization; 2015. Available from: [http://www.who.int/reproductivehealth/publications/unsafe\\_abortion/abortion-task-shifting/en/](http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/).
- Hernandez-Rosete D., Estrada-Hipolito R. Difficulties accessing abortion in legal termination contexts: high school students' narratives in a rural community in Mexico. *Cad. Saúde Pública*. 2019;35(3):e00046218. DOI:10.1590/0102-311x00046218.
- Castro R, Frías SM. Obstetric violence in Mexico: results from a 2016 national Household Survey. *Violence Against Women*. 2019;26(6-7):555–572. DOI:10.1177/1077801219836732.
- Ipas. How might we radically improve access to, and quality of, sexual and reproductive health education and services for young people? – Reducing abortion stigma in Mexico among adolescents and health-care personnel in communities with high unintended pregnancy rates. 2017. Available from: <https://challenges.openideo.com/challenge/youth-srh/research/reducing-abortion-stigma-in-mexico-among-adolescents-and-health-care-personnel-in-communities-with-high-unintended-pregnancy-rates>.
- Jefford E, Alonso C, Stevens JR. Call us midwives: critical comparison of what is a midwife and what is midwifery. *Int J Childbirth*. 2019;9(1):39–50. DOI:10.1891/2156-5287.9.1.39.
- Secretaria de Salud, Ciudad de Mexico. Estadísticas sobre Interrupción Legal del Embarazo, 2007-2019 (Datos Preliminares). Secretaria de Salud: 2020. Available from: <http://ile.salud.cdmx.gob.mx/estadisticas-interrupcion-legal-embarazo-df/>.
- Saavedra-Avendano B., Schiavon R., Sanhueza P., et al. Early termination of pregnancy: differences in gestational age estimation using last menstrual period and ultrasound in Mexico. *Reproductive Health*. 2020;17(89):1. DOI:10.1186/s12978-020-00914-x.