Experiences and perceptions of health care professionals in Macedonia regarding abortion and contraception

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Introduction

The health system in Macedonia and other former communist countries faced enormous challenges in the last two decades. These transition countries embarked on major reform processes with a main focus on the promoting private healthcare delivery, introducing universal access to high quality primary (preventive and curative) care, and creating a financially sustainable sector (World Bank, 1994; Milevska 2006). These dramatic health reforms were necessary because of a lack of provision of high quality care, underdeveloped primary care, lack of trained professionals in several specialized areas, lack of coordination between facilities, duplication, and gaps in services (McKee 1991; Rechel et al. 2009; World Bank, 1994; Tozija, 2001). The reforms required large sums of money, the reconstruction of the health insurance system, and reforming medical education for health practitioners (McKee,1991).

The privatization and commercialization of primary health care, as a result of establishing a market-based economy in the transitioning countries, is associated with multiple problems such as regarding quality care for a minimal cost, patient-oriented care, and responsiveness of the health system to the needs of society. These trends are also observed in the health practices of family planning and contraception, and Gynecology in general. Commercialised relations increased the number of patients treated, while paying little attention to how health practices are performed, and without considering improvement of professionalism of health workers (Roemer 1984; Cichon, 1991). Medical education in Macedonia (secondary and higher education) pays little attention to, for instance, communication skills, patient counseling, and changing health attitudes (UNFPA, 2012). Kornai (2001) recommends that the health sector in Central and Eastern Europe (CEE) should refocus by giving attention to individual sovereignty and choice, while increasing awarenes of the ethical challenge for the health sector to contribute to social solidarity, improved health status, and the welfare of society.

The transition process creates challenges for professionalism of health staff and training programmes. Providers' and clients' perceptions of what the tasks of health workers are changed considerably, so that established norms and habits need to be reinvented, and knowledge and educational curricula need to be innovated. In Macedonia, especially medical education regarding contraceptive practices and communication with patients, is outdated. Some international organizations provide informal training to health professionals in different health areas (UNFPA 2012). Like in most CEE countries, medical schools train health practitioners with a technical focus on medical and clinical knowledge. A recent evaluation of reproductive health services in Macedonia notes that the official institutions have no registered training for health practitioners in contraceptive practices, thus causing difficulties for the development of a future comprehensive strategy in this field (UNFPA 2012). Likewise, a study of patients' relationships with physicians in 2006 found that the physicians' relationships with patients and physicians' behavior is weak, and the public laments the poor quality of patient treatment by the health practitioners (Milevska, 2006).

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Contemporary international academic literature on professionalism suggests that apart from the technical knowledge other skills are required to deal with complex and uncertain situations in health care using a progressive education. These skills include ethical knowledge and moral qualities integrated into practical action (Banks 2009; Gustavson 2009). Quality professionalism thus involves abilities such as self-reflection, empathy, expressing feelings and emotions within the community, and responding to the needs of society; thus acting like "*reflective practitioners*" (Schön 1982; Gustavson 2009; Dewey 1938; Wegner 1998). In this way, the academic literature on professionalism suggests a direction for change in professional practices, norms and habits, as well as in educational orientation of the health care sector in transition countries.

However, it would be too easy, and probably ineffective, to propose externally designed models for 'modernisation' of professionalism in the health sector in Macedonia. Imposing foreign models is rarely successful. In addition, such an approach would be rather disrespectful for the Macedonian health professionals themselves, practicing according to existing standards of professionalism (despite these being challenged from various sides). A better approach is therefore to explore ways for 'change from within', that is, from the health care professionals themselves. Such an approach involves an *emic* approach towards professionalism in the health sector in Macedonia; an *emic* approach that does not stop at mapping existing systems of meaning, norms and practices in the health care sector but that can also explore the various dilemmas that practitioners face, as well as the options professionals themselves develop to reinvent their professionalism in the face of the challenges resulting from the transition from the socialist system. Such reinvention is aspired because it can also renew the societal respect for the medical practitioners who were traditionally held in high esteem but are often tarnished in the public eye today, for instance because of changing expectation of the patients regarding care, or informal payments and gratuities for providing certain health services in public hospitals (Janevic et all. 2011; Kornai 2001).

The present study takes up the challenge of obtaining an *emic* view of ideas, practices, and dilemmas of professionalism among health practitioners dealing with contraception and family planning practices in Macedonia. **The study aims to get insight into the:**

- Perceptions, motives, experiences of health care practitioners and their clients dealing with contraceptives and family planning practices, especially in the context of very high rates of abortion.
- How the health care professionals (especially relating to abortion, contraceptives and family planning) view the challenges facing their profession, its shortcomings, and options for change towards norms and practices of a professionalism that respond to the needs of patients and the broader community.
- What policies from government, NGOs, and the sector itself could support the reinvention of professionalism in order to face the challenges of societal and health system transition in Macedonia.

Abortion and contraceptive and behavior in Macedonia

In addition to the general challenges to professionalism in transition societies outlined above, the situation relating to abortion in Macedonia provides a special point of attention. It also justifies the focus in the present study on abortion and contraceptive in the health care system. The following factual account justifies this focus. In Macedonia, as well as in other transition countries, it has been observed that abortion rates have declined considerably in the last two decades. However, these rates

remain still very high in comparison with other regions in Europe. Whereas the induced abortion rate[2] in Western Europe was 0.4, in the countries of SEE it was 4.2 in 2003 (Guttmacher Institute, 2012). Many women from the Western Balkans use abortion as their primary method of family planning (Rasevic 1994; UNFPA 2008; UNFPA 2013). In Macedonia, the official induced abortion rate of 20.5 per 1000 pregnancies among women ages 15-49 (Population Reference Bureau 2008) (in 2011 the official abortion ratio was 23.4 per 100 live births (IPH, 2012)). In the nineteen nineties the induced abortion rate was still much higher, at 48.4 per 1000 pregnancies among women in union (David 1999; UNFPA 2008). Unfortunately, abortions performed in private health care institutions remain unregistered and, consequently, unreported. Data regarding abortion by age, place of residence, and ethnic backgrounds is also lacking, as it is not recorded systematically. Macedonia had been reported to have the lowest contraceptive prevalent rate[3] (CPR) in Europe with 13.5 per cent of women in relationships reporting using any contraceptive method in 2005-2006 (UN Contraceptive Use, 2009). By comparison, the CPR in Ireland is 88 per cent, in the UK – 84 per cent, in Portugal – 63 per cent, in Romania – 38 per cent, in Moldova – 43 per cent (UNFPA 2010). In addition, only 28.7 per cent of women in relationships had their contraceptive demands satisfied (Statistical Office Macedonia, 2007). While this is estimated to have increased to 40.6 per cent, 20 per cent of women are using traditional methods[4] and only 13 per cent modern methods (2011 MICS). Yet the fertility rate in Macedonia is only 1.46 per woman of reproductive age. The women who are seeking an abortion are mainly married women, which make up 78 percent (UNFPA 2008, ESE 2012) of the total. Also, in 2008, 69.8 per cent of the legal abortions were performed among women aged twenty to thirty five and 5 percent among women aged sixteen to twenty. More recent reports show even higher number among adolescents and youth; in 2011, 11 percent of abortions were performed among teenagers (IPH and UNFPA 2012).

The legal framework in reproductive health was designed with the legalization of abortion in 1950, within the framework of the Federation of Yugoslavia (Law on Pregnancy Termination as amended in 1972, 1976 and 1995). The law guarantees the right of every woman to freely decide on the outcome of her pregnancy to the tenth gestation week (UNFPA 2008). Despite declining fertility rates, Macedonia was known as having a liberal abortion policies amongst Eastern European countries, and abortion rates were high. However, with a liberal legal policy still the abortion rates are high compared to other countries in EU. The accessibility and availability of abortion health services network is on a secondary level organized. Since 6 months ago the Government policies regarding abortion performance were amended which influence the decision-making in seeking abortion. Within the amendments the woman has to think about her decision regarding the abortion within 3-5 days and to inform the partner/husband by the gynecologist about the abortion.

Theoretical framework

In order to approach the issue of evolving professionalism, and especially the challenges for professions in times of transition, we can benefit from a highly interesting body of academic literature. From this literature we derive well-framed concepts and theoretical views, including different views on what in fact a profession is, what the basis is of professional integrity, how moral virtues and professional action relate, and how moral capability is embedded in routines practices among professionals. The literature also reflects on the societal role of professions and the role of institutions

[2] Abortion rate: The number of induced abortions per 1000 pregnancies that resulted in a live birth, stillbirth, or induced termination.
[3] Contraceptive prevalence rate is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time

[4] Traditional methods of contraception include the rhythm (periodic abstinence), withdrawal, lactational amenorrhea method (LAM) and folk methods.

and professional organizations in guiding the evolution of professionalism in particular fields. This will help the present study in investigating questions of professional integrity, accountability of the professional practitioners, norms that guide their work and their perceptions, motives, values, experiences and actions embedded in their professional practice as actors. The problem definition of this study focuses upon the meso level of professional action, interaction, and norms in health institutions, but tries to do so with a clear view of the macro level of national and international policy trends affecting the Macedonian health sector. But in elaborating this focus we will have much attention to the micro level of actions, reflections, and motives of individual health professionals.

Methodology

The study uses an explorative approach with qualitative methods. In order to understand practitioner's perceptions and experiences, we use in-depth-interviews, observations and focus groups discussions with women in reproductive period how they perceive the professionalism among health care professionals dealing with abortion and contraception.

Data is collected from September 2013 – November 2013. This will include 4 focus group discussions with women and 24 in-depth interviews with health care professionals who are dealing with abortion and family planning based on a semi-structured interview.

Conclusions

We use the findings from the in-depth interviews and focus groups to learn more about the range of professional integrity and professionalism validate the domains that will be included on our study. We hope to learn more about the domains that should be covered in a future measure of virtuous experience and perceptions.