HIP FAMILY PLANNING HIGH IMPACT PRACTICES

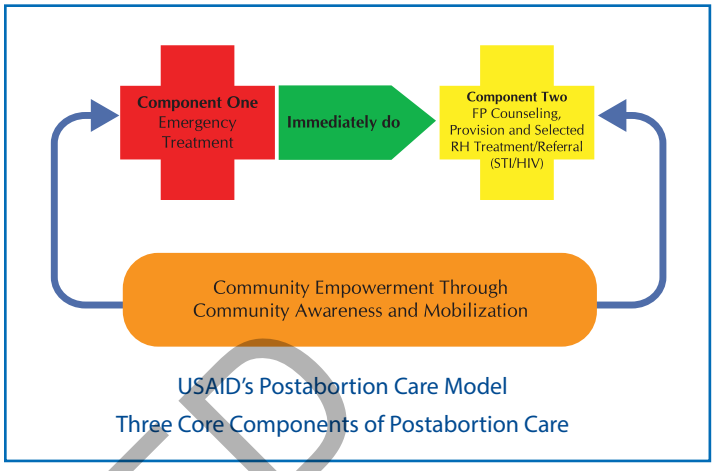
Postabortion Family Planning:

Strengthening the family planning component of postabortion care

Postabortion Family Planning

What is the proven high-impact practice in family planning service delivery?

Provide family planning counseling and services at the same time and location where women receive services related to spontaneous or induced abortion.



USAID's Postabortion Care Model
Three Core Components of Postabortion Care

Background

Postabortion clients are women and girls with a clear need for family planning. Even if a woman wants to have a child immediately, WHO guidelines recommend she wait at least six months after an abortion before getting pregnant again (WHO, 2006). Postabortion care (PAC) includes three components: (1) emergency treatment for complications of spontaneous or induced abortion; (2) family planning counseling and service provision and, where financial and human resources are available, evaluation and treatment for sexually transmitted infections (STIs) as well as HIV counseling and/or referral for testing of postabortion women; and (3) community empowerment through community awareness and mobilization (USAID, 2004). Strong evidence demonstrates the feasibility, acceptability, and effectiveness of providing family planning services at the same time and location as postabortion services. Despite this evidence, many postabortion clients leave facilities without providers offering them family planning counseling or services. This brief focuses on the importance of strengthening family planning as an integral component of postabortion services and shows how it can contribute to national programs.

> ***"If the woman we treat for postabortion complications is there because she could not get contraception, we have failed her. If she leaves without family planning, we have failed her twice."***
>
> – Verme, 1994

Postabortion family planning is one of several high-impact practices in family planning (HIPs) identified by a technical advisory group of international experts. When scaled up and institutionalized, HIPs will maximize investments in a comprehensive family planning strategy (USAID, 2011). For more information about other HIPs, see http://www.fphighimpactpractices.org/overview.

Why is this practice important?

Abortions—safe and unsafe—and miscarriages or spontaneous abortions are common. In 2008, 21% of pregnancies, or 44 million, were voluntarily terminated worldwide. Nearly half of those were considered unsafe (Sedgh et al., 2012). An estimated 25% of all pregnancies result in miscarriage within the first six weeks (Wilcox et al., 1999).

Unmet need for family planning is high among postabortion care clients. A review of PAC research from 10 studies found that, on average, nearly 20% of postabortion clients report having had a previous induced abortion. Among five studies with data, more than a quarter (27%) of PAC clients wanted to wait more than two years to have additional children. Furthermore, more than half of PAC clients expressed an interest in using contraception (10 studies), yet only about one-quarter (27%) left the facility with a contraceptive method (6 studies) (Kidder et al., 2004).

Unsafe abortion is a major contributor to maternal morbidity and mortality in developing countries. Despite global efforts, in 2008, 47,000 women died from complications of unsafe abortion, and the percent of maternal deaths attributed to unsafe abortion remains unchanged at 13% worldwide (WHO, 2011). Consequences of unsafe abortion may be more severe for the disadvantaged. Several studies document higher complication rates and mortality from unsafe abortion among women of low socioeconomic status (Briozzo et al., 2004; Chowdhury et al., 2007; Gasman et al., 2006; Korejo et al., 2003). In 2008, nearly all abortions in Africa were unsafe (Sedgh et al., 2012) and 41% of unsafe abortions in developing regions were among young women ages 15 to 24 years (Shah and Ahman, 2012).

Women are at risk of pregnancy almost immediately after abortion. Fertility returns as soon as one week after an abortion (Wilcox et al., 2000). Timely family planning services can prevent a subsequent unplanned pregnancy.

Spacing between pregnancies is important for women's and children's health. After a miscarriage or an induced abortion, women should wait at least six months before becoming pregnant again to reduce the incidence of maternal anemia, premature rupture of membranes, low birth weight, and preterm delivery in the next pregnancy (WHO, 2006).

What is the impact?

Postabortion family planning increases contraceptive acceptance in varied settings. Studies from different regions of the world have shown increases in the proportion of postabortion clients leaving a health facility with the contraceptive method of their choice after strengthening the family planning component of PAC (see Table 1, next page).

Postabortion family planning reduces unplanned pregnancy and repeat abortion. Studies show that providing family planning services as part of postabortion care can increase contraceptive use and reduce repeat abortions. For example, in Zimbabwe in standard practice, abortion clients had to obtain contraceptives from a nearby maternal and child health facility for a nominal fee. A study found that clients receiving standard PAC services were more than three times as likely to experience an unplanned pregnancy in the 12 months following an abortion as PAC clients who were offered ward-based family planning services and methods for free, after adjusting for marital status, desire to have another child, and previous contraceptive use (Johnson et al., 2002). Program implementers note that providing additional family planning counseling at follow-up visits is also an important factor in reducing repeat abortions (Johnson et al., 2002; Savelieva et al., 2003).

Table 1. Percent of PAC clients receiving a contraceptive method before and after family planning services were strengthened

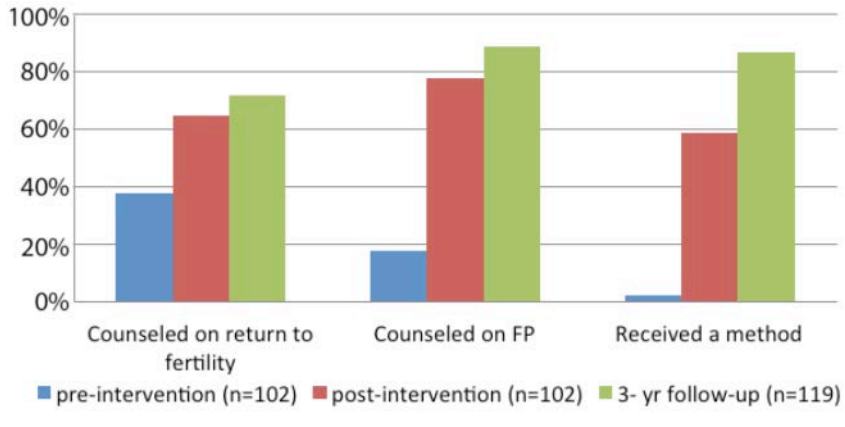
Country (N/N*)	Pre-intervention (n)	Post-intervention (n*)	Reference
Argentina (205/209)	40% (82)	65% (134)	Romero et al., 2010
Burkina Faso (330/456)	57% (188)	83% (378)	Frontiers, 2000
Cambodia (1085/1970)	15% (158)	40% (792)	Delvaux et al., 2008
Ethiopia (2301/2231)	31% (709)	78% (1746)	Alemayehu et al., 2009
Ghana (–/323)	–	52% (168)	Billings et al., 1999
Kenya[1] (481/319)	<1% (3)	48% (154)	Solo et al., 1999
Malawi (–/464)	–	80% (373)	Lema and Mpanga, 2000
Nepal (–/282)	–	70% (194)	Malla et al., 1997
Peru[2] (99/102)	31% (31)	59% (60)	Benson and Huapaya, 2002
Senegal (318/543)	10% (32)	25% (138)	CEFOREP, 1998
Tanzania[3] (–/752)	–	70% (525)	Wanjiru et al., 2007
Tanzania (–/788)	–	90% (708)	Rasch et al., 2004
Turkey (–/342)	–	81% (277)	Ortayli et al., 2001
Turkey (4100/3623)	65% (2665)	98% (3514)	Senlet et al., 2001
Zimbabwe (903/1009)	34% (307)	92% (928)	Mahomed et al., 1997

N/N*: Total sample sizes of pre-intervention and post-intervention groups, respectively
n/n*: Number of women in pre-intervention and post-intervention groups receiving a contraceptive method, respectively

[1] Pre- and post-intervention contraceptive use measures were calculated among all PAC clients for family planning services provided by: (1) gynecology staff on gynecology ward, (2) family planning clinic staff on gynecology ward, and (3) offsite provider at a family planning clinic.
[2] Pre-intervention results include a small number of women who received a method within 30 days of leaving the hospital. Researchers report in the pre-intervention stage that "the majority [of women] stopped by the family planning clinic immediately after being discharged but before leaving the hospital." The post-intervention results include only women who received a method prior to discharge.
[3] Two facilities were removed from the analysis because they did not provide family planning counseling and methods on site.

Postabortion family planning improves sustainability and institutionalization of postabortion family planning counseling and services over time. In Peru and Turkey, studies show that institutions that have strengthened the family planning component of PAC have sustained or improved family planning counseling and services well after technical assistance ended (Benson and Huapaya, 2002; Senlet et al., 2001). In Peru, over 80% of postabortion clients received a method prior to leaving the facility three years after the initial technical assistance ended (see Figure 1).

Figure 1. Percent of PAC clients receiving family planning services prior to leaving the facility, Peru



Source: Benson and Huapaya, 2002

How to do it: Tips from implementation experience

- **Provide family planning services at the same time and location where a woman receives postabortion services.** This leads to higher contraceptive acceptance than when women are referred for contraceptive services and supplies. A study in Kenya that tested three models of providing postabortion family planning found that providing family planning counseling and methods on the ward was the most effective, acceptable, and feasible model (Solo et al., 1999). Studies in Cambodia and Tanzania also found that PAC clients served in facilities with on-site family planning services were significantly more likely to accept a contraceptive method than clients served in facilities that refer for family planning services (McDougall et al., 2009; Wanjiru et al., 2007). Family planning guidance indicates that, "Helping a woman initiate an effective method of contraception is an essential task in providing postabortion care, and it should not be deferred to a follow-up visit" (Hatcher et al., 2009, p. 666).

Considerations for Scaling Up

When scaling up and institutionalizing HIPs, make sure to plan for changes needed in:

- financing
- policy and guidelines, particularly for task shifting
- health information systems
- logistics and supply needs
- community sensitization
- health communication
- supervision
- training

- **Provide a service environment that protects the dignity of women seeking postabortion care.** Take necessary measures, such as provider training and values clarification exercises, to ensure that women are treated with respect and to prevent stigmatization and negligence.

- **Ensure equitable access to family planning services, regardless of the uterine evacuation method used.** The contraceptives which can be used after surgical or medical uterine evacuation treatment are the same, and most can be initiated on the day of treatment of an incomplete abortion with a few exceptions.[1] Some evidence suggests that postabortion clients are either more or less likely to be offered family planning counseling and services depending on which method of uterine evacuation they receive (Nielsen et al., 2009). It is important that all providers and facilities treating women for incomplete abortion offer immediate and on-site family planning counseling and services as an integral part of postabortion care (Rasch et al., 2004), regardless of the uterine evacuation method.

- **Consider client costs and motivation.** In Perm, Russia, a study found that the financial cost of an abortion for a woman was significantly lower than the cost of using contraception for a year (Savelieva et al., 2003). These findings do not take into account social costs or increased financial and time burdens on the health system. However, they do indicate the importance of providing quality counseling to better understand personal motivation and costs—both financial and social—in order to promote women's informed decision-making about their postabortion contraceptive choices.

- **Offer a wide range of contraceptive methods.** According to WHO guidance, in the immediate postabortion period, if there are no complications, women can safely use a full range of contraceptive methods, including condoms, spermicides, oral contraceptives, emergency contraceptive pills, injectables,

[1] An IUD can be inserted immediately after an induced abortion. In the case of postabortion complications, an IUD can be inserted after ruling out infection and/or genital tract injury. After medical (misoprostol) treatment, it is recommended to insert the IUD after it is reasonably certain that the woman is no longer pregnant. Tubal ligation, which must be decided upon in advance, can be done on the day of surgical evacuation of the uterus, unless infection or severe blood loss is present. No data is available for the timing of tubal ligation after misoprotol treatment; it is recommended to schedule it for a follow-up visit.

implants, IUDs, and male and female sterilization[2] (WHO, 2010). Offering a wide range of methods is likely to increase family planning uptake. In Honduras, after introducing a wider range of contraceptive methods, the percentage of PAC clients leaving with a method increased from 13% to 54% (Medina et al., 2001). In Cambodia, the predicted probability of a client leaving with a contraceptive method was significantly higher in facilities offering more than four methods than in facilities offering one to three methods (42% versus 14%, respectively) (McDougall et al., 2009).

- **Connect clients to a continuous contraceptive supply and to ongoing support.** After initiating a contraceptive method, ensure that women are connected to a continuous contraceptive supply and to ongoing support to assist with contraceptive continuation. Providers should also give women information, education and communication (IEC) materials that include instructions about how to use their preferred method.

- **Promote provision of PAC services by mid-level providers.** Several countries, such as Kenya, Mozambique, Nepal, Senegal, Tanzania, and Uganda, have demonstrated that trained, competent mid-level providers can provide PAC services safely, including emergency treatment using manual vacuum aspiration or misoprostol, counseling about family planning and provision of methods, and counseling about STIs, HIV/AIDS, and nutrition. Mid-level providers, such as midwives and nurses, are more widely accessible to women in remote or underserved areas than physicians. In addition, some studies have shown that establishing family planning as part of PAC services is easier in places where midwives are responsible for all reproductive health services (Kiggundu, 1999).

- **Address cultural and organizational barriers to family planning use.** In Egypt, a study found low family planning uptake among PAC clients, even in facilities that offered clients contraceptives on the hospital ward (Youssef et al., 2007). Study authors noted that providers on the maternity ward lacked motivation and incentives to provide family planning services; rapid staff turnover reduced effectiveness of the service delivery models; and women lacked the authority to make family planning decisions without involvement of men (Youssef et al., 2007). Providing training to sensitize facility management and staff on the importance of postabortion family planning can improve provider attitudes (Cobb et al., 2001).

[2] Fertility awareness-based methods, such as the Standard Days Method, are not recommended for women in the immediate postabortion period. Women can start using calendar-based methods after they have had at least one postabortion menses.

Elements of Successful Postabortion Family Planning Programs

- Champions provide leadership to make changes in organization of services
- Facility management and staff sensitized on the importance of postabortion family planning
- Services organized to facilitate family planning provision and to engage male partners with clients' consent
- Job descriptions modified as necessary to expand access to postabortion family planning
- Service delivery guidelines or clinical protocols aligned with international standards
- Information systems, forecasting, procurement, and supply chain created or updated to ensure a steady supply of contraceptive methods, IEC materials, and consumables

Factors Contributing to Failure of Postabortion Family Planning Services Provision

- Lack of family planning skills and knowledge among maternal health staff
- Lack of consistent contraceptive supplies
- Provider bias and/or resistance to providing family planning to postabortion clients due to abortion-related stigma and cultural barriers
- Women disempowered to make decisions regarding contraceptive use
- Unnecessary medical barriers to family planning provision
- Failure to build teamwork between maternal health and family planning staff

- **Engage men and support networks.** Many women want their partner, husband, or other support person present for PAC counseling. Likewise, many male partners want more information about their partner's condition during PAC and about family planning (Solo et al., 1999). With client consent, counseling partners about follow-up care, contraceptive side effects and complications, and return to fertility can increase contraceptive use and strengthen physical, material, and emotional support for PAC patients during recovery (Abdel-Tawab et al., 1999).

- **Engage community health workers (CHWs).** A study in Kenya found that training CHWs to raise awareness about postabortion care and to counsel women about family planning can increase both the number of women using PAC services and of those using contraception. The study found that 90% of PAC clients were referred by CHWs for treatment (Magak and Mukenge, 2003).

Tools and Resources

Postabortion Care Resource Site, available in English, French, Spanish, and Russian
www.postabortioncare.org

VSI Contraceptive Guide for Postabortion Care Services, a pocket reference for clinicians
http://vsinnovations.org/assets/files/Resources/VSI_Contraceptive%20Pocket%20Guide.pdf

For more information about High-Impact Practices in Family Planning (HIPs), please contact the HIP team at USAID at fphip@k4health.org.

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The World Health Organization/Department of Reproductive Health and Research has contributed to the development of the technical content of this document, which is viewed as a summary of evidence and field experience. It is intended that this brief be used in conjunction with WHO Family Planning Tools and Guidelines: http://www.who.int/topics/family_planning/en/.

Access the current, up-to-date version of this HIP: http://www.fphighimpactpractices.org/briefs/postabortion-family-planning/