Postabortion Care (PAC): New Treatments, Better Family Planning and Real Progress

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Overview

• Methodology: PAC Research Review

• Research findings 1994-2013

• Implications for programs and policy

• Building progress for the future
PAC Research Compendium Methodology

• 550+ articles over 20 years, 1994-2013
• Modified Gray scale to assess strong evidence
• Areas of content:
  1. Emergency treatment
  2. Family planning counseling, service delivery & STI/HIV evaluation & treatment
  3. Community empowerment, awareness, mobilization
• Application for practices & programs
Emergency Treatment--Surgical

• Vacuum aspiration (VA) reduces procedure time, blood loss & pain

• Pain management: individualized with interpersonal support

• Paracervical block: little or no benefit with VA & open cervix—OK to omit

• Costs: reduced with manual VA (MVA)
Emergency Treatment: Medical

- Misoprostol: safe, effective, & high acceptance

- Misoprostol: 400 mcg sublingual or 600 orally equally effective—simple pain management

- Success rates increase with provider confidence & 2 week window for completion

- Surgical option still needed for women presenting with complications, failure or personal preference
Emergency Treatment: Medical (2)

- Ultrasound unnecessary on site: usually available within one hour (clinical studies)

- Task-shifting & extension to lower level facilities—good potential for programs

- Misoprostol now a first-line treatment option

- Clinical studies did not report family planning uptake—needs program & research focus
Postabortion Family Planning (FP)

- FP uptake increased 32 to 69% points when provided at time of treatment: 15 studies

- Post-Ab FP reduces unintended pregnancies & repeat abortions, especially with IUDs & implants

- IUD insertion immediately post-VA: safe; few expulsions; high continuation

- IUD following misoprostol: delayed to one week or when evacuation complete
Postabortion FP Imperatives—Health Professional Societies

• Family planning counseling & services before discharge offered to all women

• Written & oral information on:
  1. Rapid return of fertility—two weeks
  2. Complications—e.g., fever, pain, bleeding—when to return
  3. Written & oral info on chosen contraceptive method—how to use, changes to expect
A guide to family planning

for community health workers and their clients

Adapted from the WHO's Decision-Making Tool for Family Planning Clients and Providers
Injection

What it is
- Hormone injection.
- Prevents release of egg.

How to use
- Get an injection every 2 months (NET-EN) or 3 months (DMPA).
- If breastfeeding, can start 6 weeks after childbirth.
- Works best if you get your injections on time.

If late for an injection:
- DMPA: Can still get an injection up to 4 weeks late.
- NET-EN: Can still get an injection up to 2 weeks late.
If later, use condoms and return for an injection as soon as possible.

What to expect
- Irregular bleeding at first, then spotting or no monthly bleeding. This is common and safe.
- Possible slight weight change.
- After stopping injections, it can take several months to become pregnant.

Key points
- Does not cause infertility.
- Be sure to get next injection on time.
- Use condoms if you need protection from STIs or HIV/AIDS.
Program Implications for Family Planning

• Postabortion FP is a universal requirement & needs documentation in programs & HMIS

• Focus on key elements for success:
  1. Ensure free contraceptives
  2. Deliver universal counseling & provision of wide range of methods, including LARCs at point of treatment
  3. Utilize nurses & midwives for FP services
  4. Involve men (with women’s concurrence)
Misoprostol Potential for Programs

• Provide misoprostol as an option to VA--& especially to D&C—cost studies needed

• Task shifting to nurses & MWs with extension to primary health facilities

• Maximize postabortion FP: program documentation & research a priority

• Misoprostol integrated into maternity care for PPH & PAC