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*

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