



INTRODUCTION TO POSTABORTION CARE

International Agreement on PAC

Abortion complications are among the major reasons women seek emergency obstetric care. Postabortion care (PAC) consists of emergency treatment for complications related to spontaneous or induced abortions, family planning and birth spacing counseling, and provision of family planning methods for the prevention of further mistimed or unplanned pregnancies that may result in repeat induced abortions. PAC also includes services such as evaluation for sexually transmitted infections, including HIV/AIDS.

PAC has become more of a focus in reproductive health programs during the past decade, particularly since the 1994 International Conference on Population and Development (ICPD), when nearly 180 countries agreed that no matter what an individual country's official position on the legality of abortion:

“In all cases, women should have access to quality services for management of complications arising from abortion. Postabortion counseling, education and family planning services should be offered promptly, which will help to avoid repeat abortions” (ICPD, 1994 paragraph 8.25).

“Improving PAC is an important way to help address the problem of unsafe abortion, reduce maternal morbidity and mortality, and improve women's reproductive health. PAC can be implemented in any country, no matter how prohibitive the law against abortion, as it deals with treating a woman after she had experienced an induced or spontaneous

abortion” (Solo, 2000: 45). Moreover, quality PAC is a relatively simple, effective, and cost-efficient way to lower maternal death rates (AED, 2003: 21).

The Magnitude of the Problem

Worldwide, the World Health Organization (WHO) estimates that 67,000 women, mostly in developing countries, die each year from untreated or poorly treated abortion complications. This number, which likely understates the true statistics, represents 13 percent of all pregnancy-related deaths and is the tip of the iceberg, as many more women live with resulting morbidities including chronic pain, chronic pelvic inflammatory disease, and infertility as a result of incomplete abortion. Serious social problems are also often caused or exacerbated by these illnesses. Most deaths and disabilities resulting from abortion complications are preventable (AGI, 1999; WHO, 1998; WHO, 2003 cited in Corbett and Turner, 2003).

The Health System and PAC

Many national health services dedicate a high percentage of beds in third and second level facilities to accommodate the large number of women who require postabortion emergency treatment. In sub-Saharan Africa, up to 50 percent of gynecological beds are occupied by patients with abortion complications (UNICEF, 1997 cited in Dabash, 2003). Incomplete abortion is the most prevalent abortion-related complication treated in Bolivian hospitals. Health officials estimate that 47 to over 50 percent of hospital beds on gynecology wards in secondary and tertiary level hospitals are occupied by



women admitted for abortion complications (Billings et al., 2003b). In some countries, more than half of all obstetric/gynecologic expenditures in public hospitals are incurred on the treatment of women with abortion complications (Rance, 1994; World Bank, 1994). The complications bringing women to the attention of health services include “sepsis, hemorrhage, genital and abdominal trauma, tetanus, perforated uterus, and poisoning from abortifacient medicines” (Institute of Medicine, 2003: 49).

One in four women who seek abortion lives in countries where abortion is forbidden or allowed only to save a woman’s life (Rahman et al., 1998 cited in Corbett and Turner, 2003). Where abortion is legally restricted or not accessible, or even if legal, many women with unwanted pregnancies that result from lack of use of contraception or from contraceptive failure, resort to clandestine and often unsafe abortion, and in many cases suffer complications that require emergency medical care (Huntington et al., 1998).

“The pool of women seeking postabortion care is diverse, but all have urgent psychological and physiological needs. All are bleeding. Those who have induced the abortion may be fearful of the consequences of being discovered and eager to ensure that their unwanted pregnancy has been terminated. Those who have miscarried—especially those who desired the pregnancy—are experiencing the grief of pregnancy loss” (Abdel-Tawab et al., 2002: 191-192). Interviews with postabortion patients during a project conducted in Egypt revealed that the most salient issue confronting them was “physical survival” (Abdel-Tawab et al., 2002).

Women in countries in which abortion is legal, such as India and Russia, also require access to PAC (Johnson et al., 2003). Even where abortion is legal and performed in safe facilities, some women will have complications. A study in Perm, Russia, of women who had facility-based abortions, found that 17 percent of the women reported having to return to the facility for a postabortion complication and 7 percent were hospitalized (Savelieva et al., 2003). Women who suffer from spontaneous abortion or miscarriage—an estimated 15 percent of pregnant women—may also have complications that require medical follow up (Laferla, 1986 and Hammerslogh, 1992 cited in Nielson, 1997).

The PAC Consortium

In 1993, the PAC Consortium was established with representation of AVSC International (now EngenderHealth), Ipas, IPPF, the JHPIEGO Corporation, and Pathfinder International. The Consortium continues to function as a 15-plus agency networking group.

In 1994, Ipas developed the original postabortion care model, *Essential Elements of PAC*, which was subsequently adopted by USAID and the PAC Consortium. This innovative model emphasized the need not only to provide for women’s emergency needs, but also to help women avoid further mistimed or unplanned pregnancies and other reproductive health problems. The PAC model, as it became known, listed three essential elements:

- Emergency treatment for complications of spontaneous or induced abortion;
- Postabortion family planning counseling and services; and



- Linkages between emergency care and other reproductive health services, for example, management of STIs.

To transform the largely medical PAC model to a public health model, the PAC Consortium added two elements in 2002, (Postabortion Care Consortium Community Task Force, 2002):

- Counseling tailored to each woman's emotional and physical needs; and
- Community and service provider partnerships.

U.S. Government and USAID Position on PAC

Currently, “over half of the developing world's population lives in countries in which at least some PAC activity has been initiated” (Cobb et al., 2001: 13). USAID, which has supported PAC activities in over 30 countries since the early 1990s, specifically identifies postabortion care as a priority in reproductive health (EngenderHealth and Ipas, 2001). Support of postabortion care programs by the U.S. government was evidenced in January 2001 by a statement made by the White House Press Secretary on the restoration of the Mexico City Policy: “...the President's clear intention is that any restrictions do not limit organizations from treating illnesses caused by legal or illegal, abortions, for example, postabortion care” (see <http://www.whitehouse.gov/news/releases/20010123.html>). This position is allowed under previous policies that have had wide congressional support.

Support of the administration was further emphasized by the Assistant Administrator of USAID in an email that was sent globally to

all USAID population, health, and nutrition officers dated September 10, 2001. The memo stated “The U.S. Agency for International Development's (USAID) Population, Health and Nutrition Center places high priority on preventing abortions through the use of family planning, saving the lives of women who suffer complications arising from unsafe abortion, and linking those women to voluntary family planning and other reproductive health services that will help prevent subsequent abortions. Postabortion care should be a key component of both our Safe Motherhood and family planning programs” (USAID. 2003. Guidance on the Definition and Use of the Child Survival and Health Program Funds, FY 2003 Update—Final, May 23).

In 2003, building on an evaluation of its global PAC program in 2001 (Cobb et al., 2001), USAID revised its model for postabortion care and developed a five-year strategic plan results framework and indicators for PAC. These documents serve as the framework for USAID's efforts to reduce maternal mortality, morbidity, and repeat abortions by supporting improved access to and quality of PAC services over the next few years. USAID adopted the principles proposed by the PAC Consortium in *Essential Elements of Postabortion Care* and maintained a streamlined model via integrating the community and service delivery partnerships component into its three core components while maintaining counseling tailored to each woman's emotional and physical needs as an integral part of all its quality postabortion care services. The three core components of the USAID PAC Strategy (USAID, 2003) are:

- Emergency treatment for complications of spontaneous or induced abortion;



- Family planning counseling and service provision, STI evaluation and treatment, and HIV counseling and/or referral for HIV testing; and
- Community empowerment through community awareness and mobilization.

International Donors and PAC

A number of other donors, including the Department for International Development of the UK and UNFPA, support PAC. Numerous countries have come to recognize the contribution that PAC can make to saving women's lives. For example, the government of Kenya's 1997 reproductive health guidelines and standards for service providers states, "the prompt treatment of postabortion complications is an important part of health care that should be available at every district-level hospital" (cited in Cobb et al., 2001: 7).

Addressing the needs of women who are experiencing abortion complications is a clear public health mandate; women should have all needed emergency care to prevent death and disability, and the information and services they need in order to make healthy decisions for themselves and their families.

The "What Works-PAC" Module

This document describes what is known about PAC interventions and addresses lessons learned by multiple studies largely conducted since 1990. It includes peer reviewed publications, and gray literature where appropriate, and is organized in sections describing which interventions have given positive results, which have not been shown to be effective, as well as common practices that are unnecessary or can be harmful. The

interventions that have provided evidence on PAC services are subdivided into the three components of the USAID PAC Strategy.

The module also identifies knowledge gaps for which there is a need for further PAC research, including care needs of HIV positive women, refugee women and women who are subject to trafficking and such issues as demand generation and the community level contributions for PAC services. For the evidence related to each intervention, the Gray Type strength of evidence (I to V) is listed and for each intervention, a summary of the strength of the evidence is included.

Since 1994, PAC programs have been initiated in at least 40 countries around the world, 30 of which receive USAID funds (Cobb et al., 2001). This module will assist program managers and policymakers in using evidence to expand and improve quality of and access to their programs. In addition, it may become an important resource in countries which have not yet introduced PAC programs.