



Postabortion Care Research

As countries initiate or scale up postabortion care programs, it is critical that interventions be evidence-based. The PAC research compendium entitled “What Works: A Policy and Program Guide to the Evidence on Postabortion Care” functions as the foundation for building solid evidence-based programs. When compiling the research compendium, more than 400 documents from 1994 through 2004 were reviewed and evaluated against Gray’s Level of Evidence to determine the strength of the evidence. Gray (1997) lists the five strengths of evidence in research as noted in the accompanying table.

Following is a summary listing of evidence-based postabortion care practices that were found to be “Strong Evidence” when compared to the Gray Level of evidence. These key practices should be considered for integration into your postabortion care program. A listing of pertinent research findings is also found on each assessment guide for Policy, Service Delivery Guidelines, and Training to assist in the review of the research and the inclusion of evidence-based practices when writing or revising these documents.

Gray’s Level of Evidence

Type	Strength
I	Strong evidence from at least one systematic review of multiple well-designed, randomized controlled trials.
II	Strong evidence from at least one properly designed, randomized controlled trial of appropriate size.
III	Evidence from well-designed trials without randomization, single group pre-post, cohort, time series, or matched case-control studies.
IV	Evidence from well-designed, non-experimental studies from more than one center or research group.
V	Opinions of respected authorities, based on clinical evidence, descriptive studies, or reports of expert committees.

“What Works: A Policy and Program Guide to the Evidence on Postabortion Care” can be found in its entirety on the enclosed CD and on the website: www.postabortioncare.org. A Summary Listing of the evidence of all the research findings can be found in the back of the research compendium.

STRONG EVIDENCE

Emergency Treatment

- Vacuum aspiration (VA) (electric, footpump, manual vacuum aspiration) is as effective as sharp curettage for the treatment of incomplete abortion.
- VA (electric and manual vacuum aspiration) is associated with less bleeding than sharp curettage.
- Using manual vacuum aspiration (MVA) for PAC instead of sharp curettage along with associated changes in protocols and an improved service delivery model can significantly reduce costs of care in most cases.
- Use of misoprostol to evacuate the uterus after early pregnancy failure can:
 - ▶ Completely evacuate the uterus 50 to 96 percent of the time if given orally or vaginally, and is more effective than expectant management in reducing the need for surgical intervention.
 - ▶ Be administered orally, sublingually, or vaginally with good results; however optimal dose/route combinations have not been firmly established.
 - ▶ Have side effects including chills, fever, nausea, vomiting, diarrhea and headache, but are generally mild and self-limiting.
 - ▶ Cause slightly more blood loss in women experiencing first trimester pregnancy failure compared to women treated with surgical evacuation, but the difference is not clinically significant.

Pain Management

- Women require pain management for emergency treatment with sharp curettage and VA.
- The evidence on the effectiveness of paracervical block using 1% lidocaine on pain reduction is conflicting.
- Neither the paracervical block technique nor psychological support alone is sufficient in pain management for PAC patients undergoing MVA.
- The use of systemic analgesia with sharp curettage for incomplete abortions with dilated cervix up to 14 weeks is safe, effective, has a smaller chance of requiring a blood transfusion, and does not require the use of the operating theater.
- The use of general anesthesia with suction curettage is associated with increased risks of blood loss, cervical injury, uterine perforation, and subsequent abdominal hemorrhage.

Postabortion Family Planning Counseling and Services

- Postabortion family planning (FP) counseling and services reduces repeat abortions.
- Use of dedicated FP nurse/counselors as compared to FP referrals for contraceptives can increase immediate contraceptive acceptance for PAC patients.
- PAC delivery models that offer FP counseling and methods at the same location where the woman receives emergency treatment can increase the proportion of women leaving with a contraceptive method; and result in fewer unplanned pregnancies, and a reduction of repeat abortions one year later.
- Women who experience either induced or spontaneous abortion and desire another pregnancy 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.
- Use of IUDs in the immediate postabortion period is safe.

Male Involvement with Counseling and Family Planning Service Delivery

- Hospital policies that ban men from obstetrical and gynecology wards make it difficult for male involvement and discourage male participation.
- Many women want their husbands/partners present for counseling, to be informed about their conditions, treatment they are receiving, follow-up care, and family planning methods they intend to use.
- Many male partners want more information about their partners' conditions during PAC and more information on family planning.
- Counseling husbands of PAC patients on follow-up care, return to fertility, and family planning can increase family planning usage and physical, material, and emotional support for PAC patients during recovery.

Reducing the Incidence of Spontaneous Abortions

- Women are at an increased risk for spontaneous miscarriage if they:
 - ▶ Experience physical violence during pregnancy.
 - ▶ Are HIV positive.
 - ▶ Have malaria during pregnancy.
 - ▶ Smoke cigarettes or exposed to smoke during pregnancy.
 - ▶ Drink high levels of caffeine during pregnancy.
 - ▶ Have bacterial vaginosis.
 - ▶ Are exposed to environmental contamination including pesticides and fungicides.

Abuse and Psychological Sequelae

- Women may report suffering negative psychological effects after a spontaneous or induced abortion.
- Between 27 and 39 percent of women seeking abortion have been victims of abuse sometime during their lifetime.

In-Service Training

- Providing contraceptive technology updates, counseling workshops and in-service training in PAC can:
 - ▶ Increase the number of PAC patients who report that they received important information on their care and FP options;
 - ▶ Increase the number of PAC patients who leave with a FP method regardless of whether MVA or sharp curettage is used; and
 - ▶ Improve the quality of care.
- Training increases physician satisfaction with MVA.
- Training midwives to counsel PAC patients on FP, STIs/HIV and nutrition (in addition to midwives undertaking other aspects of PAC, including emergency treatment using MVA) can increase counseling on these topics.

Systems Issues for Delivering PAC Services

- Allowing trained midwives to provide PAC (using MVA) will help increase access to PAC services.
- Health policy changes, the development and dissemination of protocols and service delivery guidelines for PAC, and the reorganization of services are needed to institutionalize PAC in hospital settings or provide PAC as an outpatient procedure.
- PAC services are needed even where abortion is legal.

RECOMMENDED DOCUMENT

Document Name: What Works: A Policy and Program Guide to the Evidence on Postabortion Care

Date: February 2007

Summary: This guide provides a summary of the evidence that documents the effectiveness of various interventions. The modules provide information complementary to the biomedical information from clinical studies in the WHO Reproductive Health Library, based on the Cochrane Collaboration. This guide also adds to the ongoing work on best practices in reproductive health. It draws on unpublished reports to supplement the research published in peer-reviewed publications because of the limited amount of published literature on PAC. Biomedical information is included insofar as it is relevant to programmatic considerations. The modules in this guide categorize these interventions by those that are effective, those that may be on the cutting edge but for which sufficient evidence has not yet been gathered, and common interventions that are not effective. This guide includes policy and program issues related to reproductive health. Most evidence cited in the guide comes from studies in developing countries; however, when such research was not available, evidence from developed countries was included. This guide will be useful to those developing guidelines for best practices.

Relevant PAC Content

I. Emergency Treatment

- A. Privacy and Confidentiality in History and Physical Assessment
- B. Triage
- C. Medical Treatment

II. Family Planning Counseling and Service Delivery, STI Evaluation and Treatment, and HIV Counseling and/or Referral for Testing

- A. Postemergency Treatment Counseling (Pre, during, and post-treatment counseling)
- B. Male Involvement with FP Counseling and FP Service Delivery
- C. STI Evaluation and Treatment
- D. HIV Counseling and Treatment
- E. Other Counseling Concerns Related to Postabortion Care

III. Community Empowerment through Community Awareness and Mobilization

- A. Health Promotion for PAC
- B. Reducing the Incidence of Induced and Spontaneous Abortions Can Reduce the Need for PAC

(continued)

Relevant PAC Content (*continued*)

IV. Policy, Program, and Systems Issues in Postabortion Care

- A. Provider Training for PAC
- B. Systems Issues for Delivery of PAC Services
- C. Increasing Access to Care, Including Types of Facilities that Provide PAC
- D. Ensuring Quality Care (including use of on-site quality improvement techniques)
- E. PAC for Women in Countries Where Abortion is Legal and Available
- F. Integration of PAC with Emergency Obstetric Care Services at all Levels of the Health System, Including within the Health Facility
- G. Scaling up and Sustainability
- H. Non-training Contributions to Establishing and Supporting PAC

Summary List of Evidence