USAID
FROM THE AMERICAN PEOPLE

Post Abortion Care

Strategy

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ACRONYMS

APHA	American Public Health Association
BCC	Behavior change communication
CA	Cooperating agency
CBO	Community-based organization
D&C	Dilation and curettage
E&E	Bureau for Europe and Eurasia
FBO	Faith-based organization
FCI	Family Care International
FP	Family planning
GH	Bureau for Global Health
GH/HIDN	Office of Health, Infectious Diseases and Nutrition
GH/PRH	Office of Population and Reproductive Health
GH/RCS	Office of Regional and Country Support
GH/SDI	Service Delivery Improvement Division
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IAG	Interagency Group (Safe Motherhood)
IEC	Information, education, and communication
IR	Intermediate Result
IUD	Intrauterine device
MOH	Ministry of Health
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
OR	Operations research
PAC	Postabortion care
PVO	Private voluntary organization
RH	Reproductive health
SDP	Service delivery point
SO	Strategic Objective
STI	Sexually transmitted infection
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

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EXECUTIVE SUMMARY

Complications from abortions kill at least 78,000 women every year, account for 13 percent of maternal deaths globally, and have a substantial impact on women's health and on health care systems. Postabortion care (PAC) has been widely embraced as an important intervention to address complications related to miscarriage and incomplete abortion through improving treatment and linking women to family planning and other reproductive health services. Since the early 1990s, the United States Agency for International Development (USAID) has spent approximately $20 million on PAC activities in more than 30 countries.

Building on a global PAC evaluation conducted in 2001, USAID undertook a process to develop a strategic plan and framework for PAC.

USAID has developed the following as the three core components of its PAC model:

1. emergency treatment for complications of spontaneous or induced abortion;

2. family planning counseling, service provision, STI evaluation and treatment, HIV counseling and/or referral for testing; and

3. community empowerment via community awareness and mobilization.

The overall goal of USAID's PAC strategy is to reduce maternal mortality, morbidity, and repeat abortions. The Global and Country Results Frameworks assert that the Strategic Objective (SO) of advancing and supporting the increased use of PAC can be achieved by demonstrating global leadership in PAC policy, advocacy and services (Intermediate Result [IR] 1); generating, organizing, and communicating advance practices in postabortion care (IR 2); and supporting state of the art (SOTA) postabortion care practices at all service delivery levels through community empowerment (IR3). This will ensure that quality services are expanded and supported through service delivery, policy, and community involvement. Monitoring and evaluation will cut across all of the IRs.

Over the next five years, USAID will continue to strengthen its leadership role in PAC by facilitating the standardization of tools for PAC, sharing best practices, and mobilizing support from other donors. Core funds will be concentrated in five focus countries in order to develop successful models for expanding the impact of PAC. It is important that assistance still be provided to strengthen services, but there also should be increased emphasis on policy and community work.

At the end of the five-year period, the following should be achieved:

- development of standardized tools for PAC training, guidelines, and policies;

- identification of successful models for expanding the impact of PAC within a country;

- PAC mainstreamed within USAID's portfolio; and

- increased global support for PAC.

There have been significant improvements in PAC programs worldwide in the past 10 years. It is anticipated that with a more strategic approach, USAID could help further strengthen and sustain these improvements, expand geographic coverage, and maximize the impact of these lifesaving services.

USAID does not support the promotion of abortion as a method of family planning. Support of PAC programs by the Bush administration was reaffirmed via the White House in a statement issued in conjunction with the reactivation of the Mexico City Policy on January 22, 2001. This statement notes, "The President's clear intention is that any restrictions (on family planning assistance) do not limit organizations from treating injuries or illnesses caused by legal or illegal abortions, for example, postabortion care."

I. BACKGROUND

Each year, approximately 515,000 women die worldwide as a direct result of complications that arise during pregnancy, delivery, or the postpartum period. The most common fatal complications related to pregnancy each year include hemorrhage (24 percent of all maternal deaths); sepsis (15 percent); and unsafe abortion (13 percent).[1] These complications have a substantial impact on women's health, health care systems, and child health. Children who are left motherless due to maternal mortality are up to 10 times more likely to die within two years than children with two living parents.[2]

Each year, at least 160 million women become pregnant. It is estimated that 20% of all pregnancies will end in spontaneous abortion or miscarriage. Causes for this include chromosomal anomalies, maternal factors, and some indirect complications of pregnancy such as malaria; anemia; viral hepatitis; sexually transmitted infections (STI); HIV/AIDS; and pulmonary tuberculosis. Numerous studies have found increased rates of spontaneous abortion among women who have malaria[3] and women who are HIV positive.[4][5][6][7] A WHO/UNAIDS literature review found that women with HIV in Africa were 1.47 times more likely to have had a miscarriage than HIV negative women[8]

Approximately 20 million unsafe abortions[9] take place annually; between 10 and 50 percent of women who undergo abortions need medical care for complications.[10] These include retained products that lead to infection and hemorrhage, injury to internal organs, and psychological trauma. Many women also face long-term health problems, such as chronic pain, pelvic inflammatory disease, and infertility. Women who have suffered miscarriage and/or stillbirth may experience some of these complications, and thus also need emergency follow-up treatment.

In response to increasingly difficult health challenges, the United States Agency for International Development (USAID) created the Bureau for Global Health (GH) to serve as the global leader in international public health and as the focus of technical leadership for USAID in health. Postabortion care (PAC) has been widely embraced as an important intervention to address complications related to miscarriage (spontaneous abortion) and incomplete abortion. USAID

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[1] World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA), *Maternal Mortality in 1995: Estimates Developed by WHO, UNICEF, UNFPA,* Geneva, WHO, 2001.

[22] The Safe Motherhood web site: www.safemotherhood.org.

[3] Ticconi, C., M. Mapfumo, M. Dorrucci, N. Naha, E. Tarira, A. Pietropolli and G. Rezza. 2003. "Effect of Maternal HIV and Malaria Infection on Pregnancy and Perinatal Outcome in Zimbabwe." *Journal of Acquired Immune Deficiency Syndromes* 34(3): 289-294.

[4] *Kumar, R., S. Uduman and A. Khurranna. 1995. "Impact of Maternal HIV-1 Infection on Perinatal Outcomes." *International Journal of Gynecology & Obstetrics* 49: 147-143.

[5] *Abeni, D., D. Porta and C. Perucci. 1997. "Deliveries, Abortion and HIV-1 Infection in Rome, 1989-1994." *European Journal of Epidemiology* 13: 373-378.

[6] Berer, M. 1999. "HIV/AIDS, Pregnancy and Maternal Mortality and Morbidity." Pp. 198-210 in *Safe Motherhood Initiatives: Critical Issues* edited by M. Berer and S. Ravindran. London, UK: Blackwell Publishers.

[7] de Bruyn, M. 2003. "HIV/AIDS, Pregnancy and Abortion: A Review of the Literature." Carrboro, NC: Ipas.

[8] *McIntyre, J. 1999. *HIV in Pregnancy: A Review.* Geneva, Switzerland: WHO and UNAIDS.

[9] WHO defines an unsafe abortion as one performed by an untrained person and/or taking place at a site lacking minimal essential conditions.

[10] Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG), *Safe Motherhood Fact Sheet: Address Unsafe Abortion*, 1998.

has supported PAC programs as a means of preventing further unplanned/mistimed pregnancies, decreasing the incidence of repeat abortion, and decreasing maternal mortality and morbidity. Since 1994, USAID has spent approximately $20 million on PAC activities in more than 30 countries. Support of PAC programs by the Bush administration was reaffirmed via the White House in a statement issued in conjunction with the reactivation of the Mexico City Policy on January 22, 2001:

> The President's clear intention is that any restrictions (on family planning assistance) do not limit organizations from treating injuries or illnesses caused by legal or illegal abortions, for example, postabortion care.[11]

In 2001, a global evaluation of USAID's PAC program was conducted. Findings highlighted many successes, particularly in improving treatment, but linkages to family planning still required improvement. Table 1 summarizes some of the key recommendations from the 2001 global evaluation.[12]

Table 1
Findings from the Global Evaluation of USAID's PAC Program

Topic	Recommendations
Comprehensive Postabortion Care	▪ Ensure comprehensive PAC for all patients, whether treated with manual vacuum aspiration (MVA) or dilation and curettage (D&C) ▪ Devote more attention in training, monitoring, and supervision to postabortion family planning ▪ Encourage efforts to work with the community, including partnerships with private voluntary organizations (PVOs) and nongovernmental organizations (NGOs) with community expertise
Accessibility	▪ Fund operations research to test ways to expand access to adolescents ▪ Develop country-level objectives, strategies, and indicators to expand and maximize geographic access
Organization of Services	▪ Institutionalize PAC into preservice training ▪ Designate model clinical sites as regional training centers ▪ Make PAC available 24 hours a day, 7 days a week ▪ Identify ways to motivate providers and managers to provide family planning (FP) and other RH services as an integral part of PAC
Quality of Care	▪ Begin programs with sensitization of providers, facility managers, community leaders, and other stakeholders ▪ Continue to emphasize changing punitive provider attitudes ▪ Fund research on pain management and clarify guidelines
Sustainability	▪ Countries without strategic national plans for expansion should develop such a plan ▪ USAID should continue to provide leadership in PAC

The global evaluation provided an assessment of the implementation and quality of PAC programs. The next important step is determination of the direction for future PAC programming. This report describes a five-year strategy proposal for USAID's PAC program, describing what should be achieved, how these goals will be accomplished, and the cost for carrying out the stated objectives.

[11] http://www.whitehouse.gov/news/releases/20010123.html
[12] Cobb, Laurel et al., *Global Evaluation of USAID's Postabortion Care Program*, POPTECH, October 2001.

II. PROCESS OF STRATEGY DEVELOPMENT

Building on the findings of the global evaluation, USAID undertook a process of developing a PAC strategy between October 2002 and December 2003. The strategy development took place in seven phases:

1. **Collection of information** through individual and group interviews (appendix A) and attendance at the PAC Consortium meeting at the American Public Health Association (APHA) conference on November 10, 2002.

2. **Synthesis of this information into a report of strategic alternatives**.

3. **Presentation of the report of strategic alternatives** to USAID staff in December 2002, followed by several internal meetings of USAID staff to develop a Results Framework, discuss funding mechanisms, and agree upon a PAC model for USAID.

4. **Formation of a Results Framework and global and country indicators** that resulted from additional internal meetings by the USAID PAC Working Group.

5. **Further review of the draft PAC Strategy and Results Framework and indicators** by the cooperating agencies (CAs), PVOs, and NGOs in May 2003.

6. **Establishment of the final PAC Strategy and Results Framework and indicators as a result of input** obtained after the May 2003 meeting (see appendix C).

7. **Documentation of recommendations for the final strategy** in this report.

III. CORE COMPONENTS OF THE PAC MODEL

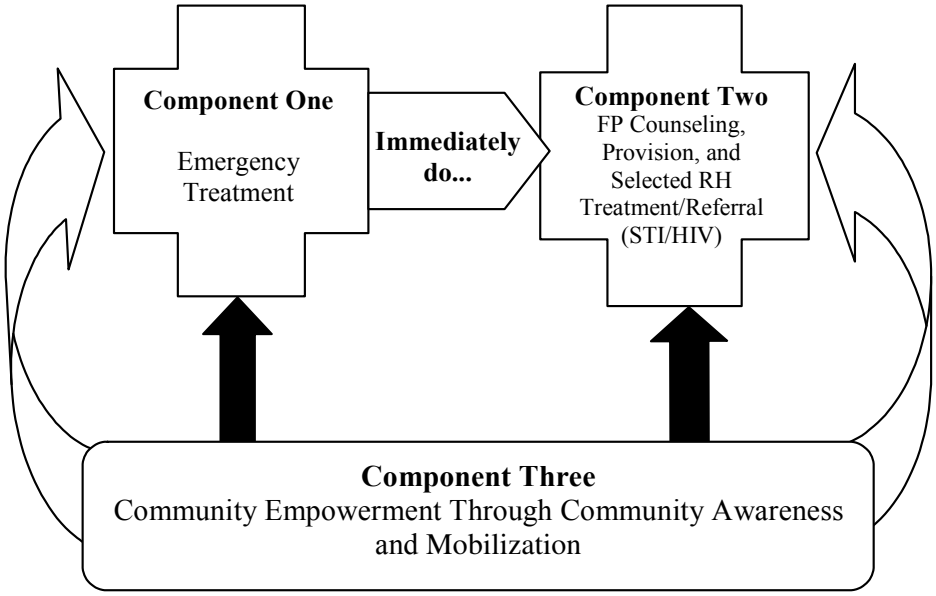
The original concept for postabortion care was first articulated by Ipas in 1991 and published by the PAC Consortium in 1994. The original model for PAC included three elements:

- 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.

The PAC Consortium has recently modified and expanded the original PAC model, based on experience gained and lessons learned in many countries over the past 10 years. This update reflected the progress and expanded vision of high-quality and sustainable PAC services. The model was expanded from three to five elements to include elements on counseling and community involvement.

In USAID's discussion of the new expanded model, it was appreciated that this model was mainly clinical in focus and did not completely represent the holistic environment that needs to be attained to ensure the delivery and sustainability of PAC programs. In reflecting the concerns of the PAC Consortium that placed additional emphasis on counseling and community, USAID preferred to use a three-component model for PAC, which encompasses these concerns (figure 1).

Figure 1
USAID's Core Components of the PAC Model



Although this is not very different in substance from the PAC Consortium's five-element model (the FP and RH elements have been combined into one element in USAID's model and there is no separate element for counseling), it was believed that it was easier to market and describe

PAC in a three-component model (see appendix B). This model includes the following elements:

- emergency treatment for complications of spontaneous or induced abortion,
- family planning counseling and service provision, sexually transmitted infection (STI) evaluation and treatment, and HIV counseling and/or referral for HIV testing, and
- community empowerment through community awareness and mobilization.

Counseling and client–provider interaction are integral to all components of postabortion care. The focus is placed on family planning counseling to facilitate the integration of family planning service delivery into emergency treatment services.

See appendix D for a comparison of the USAID and PAC consortium models.

IV. THE BUREAU FOR GLOBAL HEALTH STRATEGIC OBJECTIVES AND RESULTS FRAMEWORK FOR POSTABORTION CARE

GH has focused its resources and built its portfolio on the dynamic synergies of global leadership, state-of-the-art research, innovation and dissemination, and superior technical assistance to the field as it continues to expand and improve its programs to meet the changing public health needs and realities of the field. The bureau's programs are directed toward the following five Strategic Objectives (SOs):

SO 1: Advance and support voluntary family planning and reproductive health programs worldwide

SO 2: Increase use of key maternal health and nutrition interventions

SO 3: Increase use of key child health and nutrition interventions

SO 4: Increase use of improved, effective, and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic

SO 5: Increase use of effective interventions to reduce the threat of infectious diseases of major public health importance

V. PROPOSED RESULTS FRAMEWORK

The overall goal of USAID's PAC strategy is to reduce maternal mortality, morbidity, and repeat abortions, and is congruent with SOs 1, 2, and 4 of GH's SOs.

The frameworks and indicators attempt to capture the new strategic thinking of the Office of Population and Reproductive Health in the Bureau for Global Health (GH/PRH) after its recent reorganization. They reflect the responsibilities of both the Bureau for Global Health and country/field programs in accomplishing the overall objectives. Figure 2 reflects the new GH/PRH Strategic Framework, and is intended to capture the results of activities funded through core support and highlight the efforts of the PAC Working Group. Figure 3 (on the following page) illustrates accomplishments at the country or program level. This framework was developed in an effort to improve monitoring of PAC programs at the country level and is intended to assist Missions in measuring the progress of country-specific activities. (Additional information regarding these indicators is included in appendix C).

Figure 2
Postabortion Care Global Results Framework (2003)

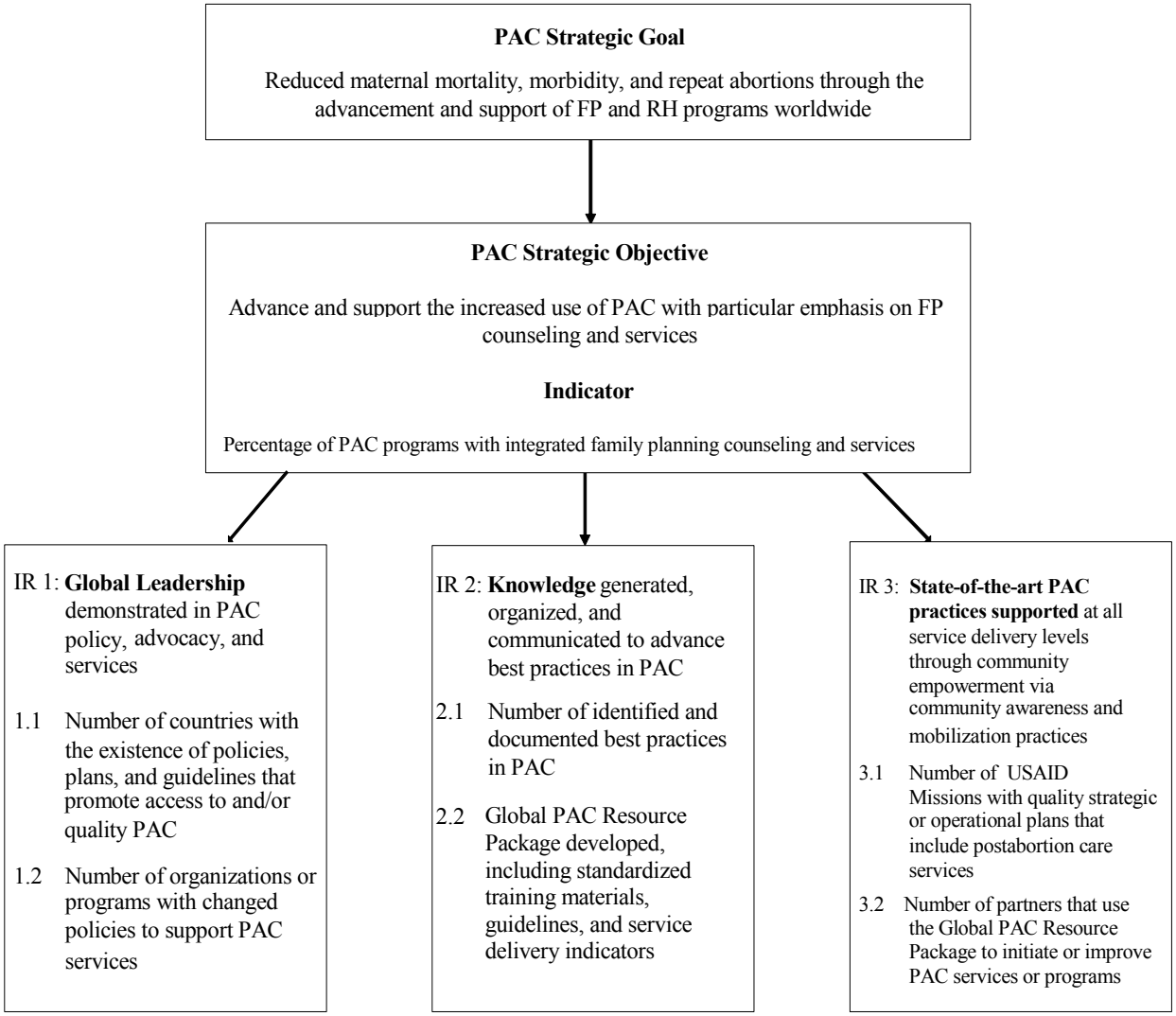
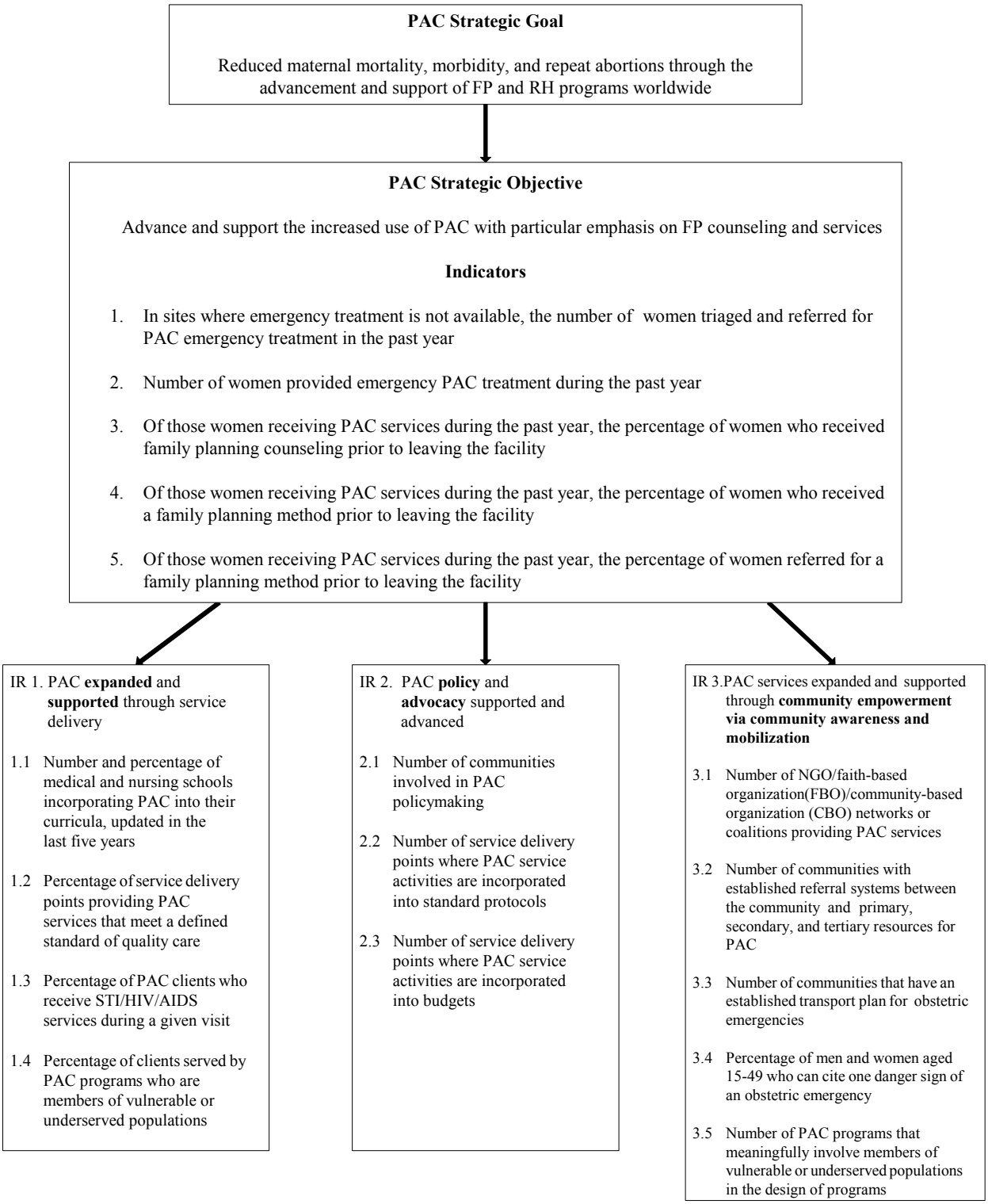


Figure 3
Postabortion Care Country/Field Results Framework (2003)



GLOBAL RESULTS FRAMEWORK

The Global Results Framework related to the Strategic Objectives of the Bureau for Global Health asserts that the increased use of PAC by women with complications related to miscarriage or incomplete abortion can be achieved by

- demonstrating global leadership in PAC policy, advocacy, and services;
- generating, organizing, and communicating state-of-the-art knowledge regarding postabortion care to advance best practices; and
- empowering the community via community awareness and mobilization to support state-of-the-art postabortion care at all service delivery levels.

Monitoring and evaluation will cut across all of the Intermediate Results (IRs).

Goal
Reduced maternal mortality, morbidity, and repeat abortions through the advancement and support of FP and RH programs worldwide

GH Objective
Advance and support the increased use of postabortion care with particular focus on family planning counseling and services

Indicator
Percentage of PAC programs with integrated family planning counseling and services

Intermediate Results

IR 1: **Global leadership** demonstrated in PAC policy, advocacy, and services

IR 2: **Knowledge** generated, organized, and communicated to advance best practices in PAC

IR 3: **State-of-the-art PAC practices supported** at all service delivery levels through community empowerment via community awareness and mobilization practices

Monitoring and evaluation will cut across all of the Intermediate Results (IRs).

COUNTRY RESULTS FRAMEWORK

The Country Results Framework related to country programs asserts that the objective of increasing the use of PAC by women with complications related to miscarriage or incomplete abortion can be achieved by expanding and supporting PAC through

- service delivery (IR 1);
- advancing and supporting postabortion care policy (IR 2); and

- expanding and supporting postabortion care services through community awareness, mobilization, and empowerment.

Goal

Reduced maternal mortality, morbidity, and repeat abortions through the advancement and support of FP and RH programs worldwide.

Country/Field Program Objectives

Advance and support the increased use of postabortion care with particular emphasis on family planning counseling and services

Indicators*

1: In sites where emergency treatment is not available, the number of women triaged and referred for PAC emergency treatment in the past year

2: Number of women provided emergency PAC treatment during the past year

3: Of those women receiving PAC services during the past year, the percentage of women who received family planning counseling prior to leaving the facility

4: Of those women receiving PAC services during the past year, the percentage of women who received a family planning method prior to leaving the facility

5: Of those women receiving PAC services during the past year, the percentage of women referred for a family planning method prior to leaving the facility

Intermediate Results

IR 1: PAC **expanded** and **supported** through service delivery

IR 2: PAC **policy** and **advocacy** supported and advanced

IR 3: PAC **services expanded and supported** through community empowerment via community awareness and mobilization

* **Country programs can choose from the menu of indicators under IR1, IR2, and IR3 depending on their program structure (see figure 3).**

VI. IMPLEMENTING THE PAC STRATEGY

The following key themes should guide the implementation of the PAC strategy:

- **standardization** of training materials, guidelines, and indicators;
- **expansion and institutionalization** of PAC at the country level;
- **identification of successful models** by working intensively in a number of focus countries;
- **leadership in identifying further research, compilation of research findings regarding the impact of postabortion care programs, and providing this information to donors** to mobilize global resources to enable the expansion and replication of postabortion care programs; and
- **monitoring and evaluation** throughout all the IRs in the Results Framework.

Over the next five years, there should be a **focus on improving linkages and coordination** at all levels to strengthen the implementation of PAC programs.

- **Service Delivery Level:** Improved linkages within health facilities so that PAC clients receive emergency treatment, family planning, STI evaluation and treatment, HIV/AIDS counseling, and/or referral for HIV/AIDS testing
- **Country Level:** Improved linkages at the country level to strengthen efforts of expanding and institutionalizing PAC
- **CA/NGO/PVO/Faith-Based Organization (FBO) Cooperation and Coordination:** Improved linkages between CAs, NGOs, PVOs, and FBOs to minimize duplication of effort, achieve synergy, and promote national-level access to services
- **USAID/Washington:** Improved linkages between different units at USAID; the Office of Population and Reproductive Health should examine ways to link with the Office of Health, Infectious Diseases and Nutrition (GH/HIDN) Maternal and Child Health Division, the Office of HIV/AIDS, and regional bureaus

This focus would lead to the following main achievements over the course of the five-year strategy:

- **standardized tools** for PAC training, guidelines, policies, and indicators;
- **successful models** for expanding PAC within a country developed through intensive work in five countries;
- **PAC mainstreamed within USAID's portfolio**; PAC moves from being vertical and a Global Leadership Priority to an integrated and integral component of USAID's global health program;

- **increased global support for PAC;** and therefore, most importantly,

- **improvements in women's health.**

ROLE OF THE BUREAU FOR GLOBAL HEALTH

USAID created the Bureau for Global Health (GH) to serve as a global leader in international public health and as the focus of technical leadership for USAID in health. Within GH, the Results Framework for the Office of Population and Reproductive Health (GH/PRH) includes:

- global leadership exercised in FP/RH policy, advocacy, and sevices;
- knowledge generated, organized, and communicated to advance best practices; and
- support provided to the field to implement effective and sustainable FP/RH programs.

With over 222 technical and program experts and a global network of field offices and partnerships, GH is well placed to provide important leadership in introducing postabortion care programs or strengthening existing postabortion care programs worldwide.

GH should facilitate the standardization of materials for PAC programs to minimize duplication of effort and to assure standardization of the message and technical components. In addition, USAID has supported important research over the past 10 years to help improve PAC, and GH should continue to identify key areas where research is needed and help ensure that existing research findings are disseminated and used.

GH can have a crucial role in encouraging other donors to fund PAC activities. GH should develop an action plan to work with other donors, including

- identifying existing and potential donors for PAC,
- developing PAC promotion and education tools,
- sponsoring a conference for donors, and
- raising funds.

Recommendations for obtaining these goals are noted in the following proposed activities.

PROPOSED KEY ACTIVITIES

Proposed activities that should take place over the next five years are divided into two lists: first, activities that will be coordinated from the central level by GH and USAID's PAC Working Group; and second, activities that will take place at the country level.

Bureau for Global Health

<u>IR 1: Global Leadership Demonstrated in PAC Policy, Advocacy, and Services</u>

Today, many new public and private partners are joining forces with traditional bilateral and multilateral donors to invest in global health. Expenditures of the top 10 private U.S. foundations in the area of international health now exceed U.S. government spending. GH is refocusing its efforts to develop strategic alliances with new public and private partners in order to use substantial resources, ideas, and technologies to address global health issues. Participation

as a member of an international consortium is another way for USAID to combine funds and influence with other organizations to increase the profile of a particular global health issue. These new approaches involve working more closely with nontraditional partners and incorporating commercial sector strategies into global health programs. In bringing these new approaches to bear, it is recommended that GH do the following.

Determine five focus countries in consultation with CAs, Missions, ministries of health (MOHs), and other donors (see Geographic Focus section below for more details).

Encourage other donors to provide additional funding for PAC programs. This should include developing an action plan to work with other donors and convening a conference for donors. The goal of the conference would be to provide data regarding maternal mortality and morbidity related to unsafe abortion, the need and importance of PAC programs, and the impact of PAC programs on family planning usage and reduction in repeat abortion as well as enlisting the assistance of varied donors in the replication of global PAC programs.

Disseminate the PAC strategy to Missions and other donors.

IR 2: Knowledge Generated, Organized, and Communicated to Advance Best Practices

GH is the repository for state-of-the-art thinking in postabortion care. Along with its cooperating agency partners, GH has developed, tested, and disseminated new technologies and methodologies that contribute to the successful field implementation of PAC programs. GH is a pioneer in results monitoring and is the world leader in the development of tools for program evaluation and trend analysis in the global health sector. Key lessons learned over the past 10 years about the care of women experiencing complications related to miscarriage and incomplete abortion are shown below.

Key Lessons Learned in PAC

- ✓ A high demand for family planning services exists among postabortion patients.
- ✓ Postabortion family planning acceptance is highest when services, including both counseling and methods, are provided at the same location where treatment is offered.
- ✓ Postabortion family planning services can reduce subsequent unplanned pregnancies and the incidence of repeat abortions.
- ✓ MVA does not equal PAC. Where MVA is not available, D&C is an effective practice for providing lifesaving emergency care.
- ✓ MVA is safer, less costly, and as effective as D&C for treating postabortion complications.
- ✓ MVA can be provided safely by midlevel providers.
- ✓ PAC training can effectively change provider attitudes to be less judgmental toward PAC patients.

It is recommended that GH do the following in the areas of research, innovation, and dissemination.

Continue research on establishing PAC services in primary and secondary level sites integrating current research findings. To date, most of the research on postabortion care has

been within urban tertiary care settings. Studies have been conducted to evaluate taking postabortion care services closer to the recipients. A study, *Taking Abortion Care Services Where They Are Needed: An Operations Research Project Testing PAC Expansion in Rural Senegal* (EngenderHealth 2003) was conducted in collaboration with the MOH, using 18 sites (three district health centers and two corresponding health posts) in six rural districts.
Postintervention findings documented that the introduction of PAC services in these sites resulted in

- improved quality of treatment services,
- enhanced integration of services,
- an improved referral network,
- better infection prevention practices, and
- strengthened client–provider interactions.

While these improvements existed, the study also documented challenges in carrying PAC to the district level. These challenges identified

- the need to provide sites with equipment, medications, and staff training in infection prevention;

- increased treatment costs to clients when regional or national funds for PAC expansion are insufficient;

- that costs for transportation and physical access to services were barriers to care; and

- that PAC services needed to be expanded to the health posts, which requires educating more providers to provide PAC services.

Pilot projects in Ghana, Kenya, Nigeria, and Uganda indicate that nurse-midwives from the public and private sectors are able and competent to provide postabortion care services, thus bringing services from the hospital to community settings.[13,14] Use of midlevel providers, such as nurse-midwives and clinical officers, has enabled the decentralization of postabortion care services, improved access to postabortion services, and maintained quality in service provision.[15]

Integrate postabortion care into services provided in primary and secondary level sites of care. Women in Senegal reported to interviewers of the research team that they did not understand why services could not be available to them at more proximal health posts. They also commented on their frustration with the costs of having to travel so far to access emergency care.

Conduct additional research regarding the impact of postabortion care on repeat abortion. Findings of a study conducted in Perm, Russia, demonstrated that the one-year repeat abortion rate for women participating in the study dropped by more than one half, with the greatest decline (59.1 percent) experienced by women in the control group. Sixty-one percent of clients

[13] EngenderHealth and Ipas, *Taking Postabortion Care Services to Scale: Quality, Access, and Sustainability*, Report of an International Workshop held in Mombasa, Kenya, May 2000.
[14] Nelson et al., *The Right Provider for the Right Place: Private Nurse Midwives Offering Primary Level Postabortion Care in Kenya*, Intrah/PRIME II, 2002.
[15] Huntington, D., and N.E. Piet, *Postabortion Care: Lessons from Operations Research*, The Population Council, 1999.

left the facility with a family planning method after induced abortion.[16] This study has great implications for options for implementing postabortion care programs in countries with permissive abortion legislation.

Identify further gaps in knowledge where operations research should be used. Explore the possibility of working with FRONTIERS/Population Council or other groups to address the key gaps identified.

Develop communication/advocacy materials with a brief overview of key lessons learned/best practices in PAC to share with Missions and other donors. This will help ensure that existing research and lessons are used. These materials should also highlight the disease burden of unsafe abortion and the rationale for PAC.

Assess the impact of PAC. This can be done in two ways: through modeling (follow up on the POLICY Project's efforts) or by selecting three countries to conduct indepth studies to assess the impact of PAC (one in Africa, one in Asia, and one in Latin America). There is evidence from studies in Zimbabwe and Russia that postabortion family planning reduces repeat unwanted pregnancies and repeat abortions.[17,18]

IR 3: State-of-the-Art PAC Practices Supported at All Service Delivery Levels Through Community Empowerment via Community Awareness and Mobilization Practices

GH follows a field-driven and field-centered approach to developing and testing new technologies and methodologies. GH has developed cost-effective, field-based tools regarding postabortion care. USAID has long recognized the valuable role of collaboration among many partners and stakeholders in the quest to achieve development objectives. Therefore, the following activities are recommended for technical support to the field.

Convene a group of experts to agree upon standardization of the following:

- indicators,
- training curriculum content (both inservice and preservice),
- standards and service delivery guidelines, and
- policy content.

USAID will need to identify individuals/organizations to be in charge of writing, printing, and disseminating these materials. Although there will be an emphasis on standardizing various tools for PAC at the central level, there will be great variation in the specifics of implementation in each country. Therefore, it will be essential to adapt to each local situation.

Integrate PAC into USAID tools, such as tools to conduct assessments; USAID's Office of Regional and Country Support, which is housed in the Bureau for Global Health, has a strategic

[16] Savelieva, I. et al., *Increasing Effective Postabortion Contraceptive Use and Reducing Repeat Abortions in Perm, Russia,* APHA presentation, Philadelphia, Pennsylvania, November 9–13, 2002.
[17] Johnson, Brooke R. et al., "Reducing Unplanned Pregnancy and Abortion in Zimbabwe Through Postabortion Contraception," *Studies in Family Planning*, Volume 33, Number 2, June 2002.
[18] Savelieva, I. et al., *Postabortion Family Planning Operations Research Study in Perm, Russia*, EngenderHealth, July 2003.

planning toolkit for country coordinators. This toolkit is an aid for country coordinators to use in assisting Missions in developing and reviewing their Country Strategy Plan and Integrated Strategy Plans. Currently, postabortion care is noted as a priority intervention. Inclusion of the new PAC model and strategy in this toolkit may assist Missions and country coordinators in their knowledge of PAC and its possible need to interface with their country programs. The National Postabortion Care Survey, which was used in Peru, should be evaluated for its usefulness as part of this toolkit.

Country Level

In partnership with GH, USAID country programs should do the following.

Develop national plans to expand the impact of and institutionalize PAC (where they do not already exist) with the MOH in charge of coordination. This should include strategic mapping to determine the most appropriate way to expand to effectively address the problem of abortion-related complications. (For example, see the National Postabortion Care Service Survey in Peru,[19] which adapted the *Guidelines for Monitoring the Availability and Use of Obstetric Services*[20] to look at PAC.)

Focus on strengthening family planning and other reproductive health counseling and services for PAC clients. There should be increased efforts in providing family planning services at the point where women receive treatment.

Work with governments, training institutions, and professional organizations to establish policies to support PAC. This includes institutionalizing PAC into preservice training and developing and implementing standards and guidelines, including MVA kits on MOH essential supplies lists.

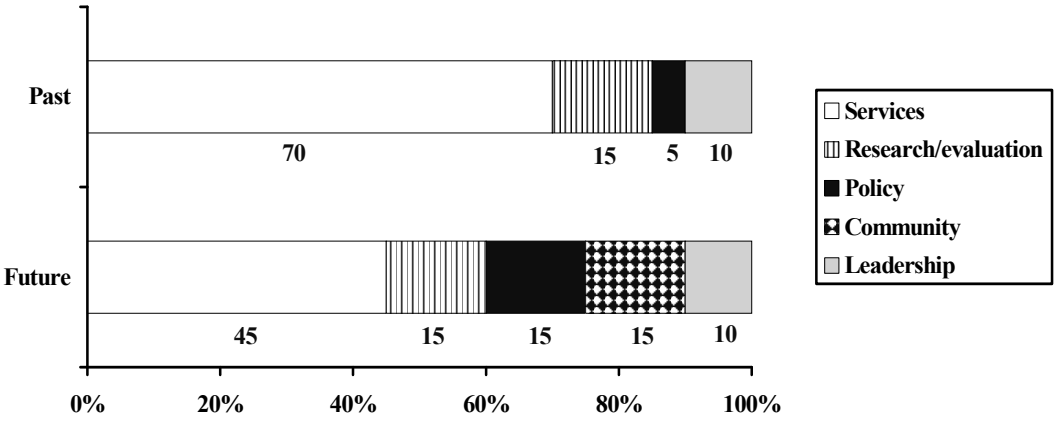
Identify appropriate local groups to collaborate within community efforts. The majority of organizations that have been providing technical assistance in PAC have expertise on the clinical/service delivery side, and it will be important to identify partners to address IR 3, which concerns improved community practices and support for PAC. This could include creating closer linkages with safe motherhood efforts in addressing the three delays.

MECHANISMS AND FUNDING

USAID/Washington, in collaboration with five focus countries, should allocate $2–3 million a year for five years (from 2003 to 2008) to achieve the goals of the PAC strategy, for a total of $10–15 million. As shown in the estimates in figure 4, there should be a shift in how PAC funds are allocated among different areas. While the majority of funding has been used for training activities (services), it is recommended that over the next five years, additional funds be spent on policy and community work (IR 2 and IR 3, as described above). It is important, however, that this shift does not come at the expense of emergency treatment and family planning service provision, the most critical components of PAC services.

[19] Huapaya et al., *Results of a NationalPostabortion Care Service Survey in Peru*, APHA presentation, Philadelphia, Pennsylvania, November 2002.
[20] UNICEF, WHO, and UNFPA. *Guidelines for Monitoring the Availability and Use of Obstetric Services*, 1997.

Figure 4
Illustrative Percentages for Shifts in Funding Allocations for PAC



Core funding will be used to identify lessons learned in PAC and to apply best practices in the replication of global programs. Illustrative figures for core funds could be budgeted approximately as follows (the lower number is for an overall budget of $10 million over five years, and the higher number is for an overall budget of $15 million):

- 75 percent for country activities: $300,000–450,000 per year per focus country (for a total of $1.5–$2.25 million per country over five years in five countries); and

- 25 percent for central activities: $2.5–3.75 million over five years. It should be noted that a larger proportion of this would be spent in the first year when a number of meetings would be held for standardization, country selection, and developing communication materials.

In addition to these core funds, there should be efforts to encourage additional funding from USAID Missions via the preparation of a country-level PAC package and a matching grants program. The funding levels noted above should be a combination of USAID/Washington Global Leadership Priority funds and Mission country support.

GEOGRAPHIC FOCUS

Given the goals of PAC—reducing maternal mortality, morbidity, and repeat abortions—there is a need to determine how efforts can have priorities established geographically to maximize program impact. USAID should focus on countries with high maternal mortality and high rates of unsafe abortion. As table 2 on the following page shows, large numbers of unsafe abortions occur in Africa, Asia, and Latin America, with most deaths concentrated in Africa and Asia.[21] While Asia has the largest number of unsafe abortions, Latin America has the highest rate of unsafe abortions (26 per 1,000 women), Africa has the highest death rate from abortions (680 per 100,000 abortions), and Eastern Europe has the highest percentage of maternal deaths due to abortion-related complications. This highlights the global impact of abortion-related complications. The recommendations for USAID follow.

[21] WHO, *Maternal and Newborn Health, Safe Motherhood, Unsafe Abortion, Global and Regional Estimates of Incidence of and Mortality Due to Unsafe Abortion With a Listing of Available Country Data*, 1998.

- Select focus countries in each of these regions, with at least one focus country from each region. There should be slightly more emphasis in Africa, which has the highest maternal mortality ratios; 22 of the 23 countries with maternal mortality ratios of 1,000 or more are in Sub-Saharan Africa. Therefore, if five focus countries are selected, there should be one from Latin America, one from Asia, one from the Europe and Eurasia region, and two from Africa. Or,

- Choose countries that are designated as focus countries by GH/PRH/Service Delivery Improvement Division (SDI) and GH/HIDN.

Table 2
Unsafe Abortions: Regional Estimates per Year

Location	Number of Unsafe Abortions	Number of Deaths Due to Unsafe Abortions	Percentage of Maternal Deaths Due to Unsafe Abortions
Africa	5,000,000	34,000	13
Asia	9,900,000	38,500	12
Latin America	4,000,000	5,000	21
Eastern Europe	800,000	500	24
Northern Europe	<30,000	<20	2
North America	Negligible	negligible	negligible

Country selection of the focus countries should be done in consultation with CAs, Missions, MOHs, and other donors. Focus countries would be selected based on MOH support, matching grants from USAID Missions for a five-year term, and some existing work in PAC. There should be efforts to mobilize resources for other countries as well, both from other USAID funds (e.g., other USAID contracts working in service delivery, policy, community, and operations research) and from other donors.

VII. NEXT STEPS FOR THE REPLICATION OF GLOBAL PAC PROGRAMS

Over the next five years, the following steps can provide a framework for the replication and expansion of global postabortion care programs.

YEAR 1

Bureau for Global Health

- **Selection of Five Focus Countries for Target Focus for the Development of PAC Programs**

  The PAC Working Group has decided that Global Leadership Priority funds should be used for those countries that have the highest maternal mortality rates, while also comparing contraceptive prevalence, total fertility rates, and abortion rates. It is desirable to have countries represented from each region and countries with varied legislation regarding abortion. Other criteria for country selection will include Mission buy-in, PAC programs in existence in the country, and buy-in from the ministries of health and/or education. A short questionnaire will be sent to selected Missions to determine the following:

  - description of the current postabortion care program;
  - commitment from the ministries of health and, as appropriate, the ministries of education;
  - discussion of how Global Leadership Priority funding would enhance their current program;
  - available funding to enhance Global Leadership Priority funding, and
  - ability to carry on a PAC program when Global Leadership Priority funding is no longer available.

Countries being considered for selection include Ghana, Kenya, Senegal, Nepal, Indonesia, Bolivia, Haiti, and Russia.

- **Initiate a study on the sustainability of comprehensive PAC services among private sector nurse-midwives in Kenya.** This study will provide information on costs related to different components of PAC services, including emergency treatment and family planning counseling and provision as well as the cost of commodities, nutrition and fertility counseling, and other reproductive health care.

- **Develop a standardized PAC resource package** that will include all that is necessary to initiate/expand PAC programs. This package would include the country assessment tool; a template for a national policy for PAC; service delivery guidelines; guidelines for clinical practice sites; policies for licensure/certification of FP/PAC providers; information, education, and communication materials; a standard curriculum for PAC training; a

curriculum for postemergency treatment and family planning counseling and provision; lessons learned; and recommendations for initiating PAC programs.

- **Develop an educational package for donors/stakeholders.**

- **Host a workshop for global donors and stakeholders** to provide information regarding the impact of PAC programs on maternal morbidity, mortality, and repeat abortion associated with unsafe abortion or miscarriage and the need for increased monetary support.

Country Level

- **Community Empowerment Through Community Awareness and Mobilization: Developing and Documenting Models for PAC Community Service Partnerships**

  Identify and begin meetings with community partners (to include local, district, and national governments; ministries of health and education; NGOs; PVOs; professional organizations; women's groups; male leadership; FBOs; traditional birth attendants; community-based distribution workers; and other stakeholders appropriate to each specific community) for planning and mobilizing community PAC programs as well as the strategic placement of these programs.

- **Preintervention Assessment and Baseline Study (Minimal Information To Be Included)**

  - Assessment of current PAC programs to minimally assess the number and type of providers offering PAC and family planning services, to include doctors, nurses, nurse-midwives, traditional birth attendants, and counselors

  - Health site assessment to include availability; condition of site resources, including equipment, supplies, and medications necessary for providing integrated PAC services; and infection prevention practices examined and evaluated

  - Presence of integration of family planning counseling and services

  - Referral networks for all levels of PAC services: emergency treatment, family planning counseling and service provision, STI identification and treatment, HIV counseling and testing

  - Presence of monitoring and evaluation processes

  - Cost of PAC services

  - Accessibility of services

  - Presence of insurance schemes for community health care costs

  - Presence of necessary policy/legislation supporting community-based PAC programs and midlevel providers as PAC providers

YEAR 1 TO YEAR 2

- Identify current research, policy, tools, curricula, and information, education, and communication/behavior change communication (IEC/BCC) materials related to PAC and compile a Global PAC Resource Package for the initiation and replication of PAC programs.

- Meet with experts to create a standardized curriculum for postabortion care services, garnering collaboration from WHO, UNFPA, UNICEF, ICM, and FIGO.

YEAR 2

Bureau for Global Health

- Review and begin implementation of selected recommendations from consultants involved with the Global PAC Resource Package.

- Begin dissemination of the Global PAC Resource Package with particular emphasis on PAC focus countries, through field testing of the Resource Package in four regions.

- Translate the standardized Global PAC Resource Package into Spanish and French.

- Begin dissemination of the Global PAC Resource Package through

  - SOTA meetings,

  - placement on the INFO Project web site,

  - training of staff from CAs/PVOs/NGOs/FBOs on how to use the package, and

  - technical assistance from USAID/Washington to introduce the package in the focus countries.

- Begin field testing the standardized curriculum.

- Conduct ongoing research as needs are identified through the findings of the PAC research compendium.

Country Level

- Program intervention with comprehensive PAC services should be provided at health posts and primary and secondary levels with ongoing monitoring and evaluation. This can be done with the help of lessons learned from the Senegal study, *Taking Abortion Care Services Where They Are Needed: An Operations Research Project Testing PAC Expansion in Rural Senegal.*[22]

[22] EngenderHealth, *Taking Postabortion Care Services Where They Are Needed: An Operations Research Project Testing PAC Expansion in Rural Senegal*, February 2003.

- Begin implementation of postabortion care best practices regarding community mobilization in country programs.

- Introduce the Global PAC Resource Package in country programs.

- Other activities to be determined.

YEAR 3 TO YEAR 4

Bureau for Global Health

- Continue coordination and advocacy with other donors.

- Field test the standardized curriculum.

- Provide ongoing technical assistance to the field as needed to replicate and expand the use of the Global PAC Resource Package and PAC programs.

- Document proven models for initiating PAC programs on all service levels.

- Perform ongoing research as needs are identified through the findings of the PAC research compendium.

- Other activities are to be determined based on lessons learned and the need to assist countries in replicating postabortion care programs.

Country Level

- Program intervention with comprehensive PAC services should be provided at health posts and primary and secondary levels, with ongoing monitoring and evaluation.

- Apply best practices from the previous two years in PAC focus countries to ongoing postabortion care programs in PAC focus countries.

YEAR 4 TO YEAR 5

- Evaluation should be completed, including the publication of PAC program interventions with proven models for initiating PAC programs on all service levels (health posts and primary and secondary levels).

- Conference to follow up dissemination results should be held in conjunction with the Global Health Council's annual meeting.

- Workshops/meetings with CAs and other donors should be convened to disseminate research findings.

- Continue to expand PAC on all service levels in additional countries.

- Other activities to be determined.

VIII. CONCLUSIONS

There have been significant improvements in PAC programs worldwide in the past 10 years. It is anticipated that with a more strategic approach, USAID can

- help further strengthen and sustain these improvements;
- have postabortion care be an integral part of national service delivery systems;
- expand geographic coverage, making PAC services available at health posts and primary, secondary, and tertiary facilities; and,
- maximize the impact of these lifesaving services.

APPENDICES

A. **Interviewees**

B. **Core Components of the PAC Model (USAID 2003)**

C. **Global and Country Results Frameworks, Indicators, and Commentary for Use**

D. **Comparison of the USAID PAC Core Components, the PAC Consortium's Essential Elements of PAC, and the USAID Global and Country Results Frameworks and Indicators**

E. **References**

APPENDIX A

INTERVIEWEES

INTERVIEWEES

Telephone Interviews

Brad Barker and Julia Henn, USAID/Senegal
Kathy Jacquart, Neil Woodruff, and Mariama Bah, USAID/Guinea
Polly Dunford, USAID/Haiti
Maricarmen Estrada, USAID/El Salvador
Brenda Doe and others at the Mission, USAID/Egypt
Monica Kerrigan, USAID/Indonesia
Kerry Pelzman and others at the Mission, USAID/Russia
John Townsend, FRONTIERS/Population Council
Stanley Henshaw, Alan Guttmacher Institute
John Ross, Futures Group
Eva Bazant, International Planned Parenthood Foundation/Western Hemisphere
Maureen Corbett, PRIME/Intrah
Orlando Hernandez, CATALYST Consortium
Mary Beth Powers, Save the Children
Ann Starrs, Family Care International
Robin Davis, Global Health Action
Gordon Perkin, Bill and Melinda Gates Foundation
Elmar Vinh-Thomas, David and Lucile Packard Foundation
Anwar Islam, Canadian International Development Agency
Iqbal Shah, WHO
France Donnay, UNFPA

Group Meeting With PVOs

Karen Angelici, Johns Hopkins University Center for Communication Programs
Lorelei Goodyear, Program for Appropriate Technology in Health
Nina Pruyn, Advance Africa
Shyam Thapa, YouthNet/Family Health International
Nazo Kureshy, NGO Networks

Group Meeting With Cooperating Agencies

Harshad Sanghvi, JHPIEGO
Amy Rial, JHPIEGO
Constance Newman, Intrah
Ines Escandon, EngenderHealth
Sara Gardner, EngenderHealth
Cathy Solter, Pathfinder
Mary Luke, Ipas
Milka Dinev, CATALYST Consortium
Diane Bushley, CATALYST Consortium
Reynoldo Pareja, CATALYST Consortium

Group Meetings With USAID/Washington

Group 1
Duff Gillespie
Margaret Neuse
Lily Kak
Amanda Huber
Sandra Jordon
Dana Vogel
Michelle Moloney-Kitts
Mary Ellen Stanton
Lindsay Mayka

Group 2
Jim Griffin
Mary Vandenbroucke
Julie Chitty
Kelly Stewart
Sarah Harbison
Maureen Norton
Mary Jo Lazear
Barbara Seligman
Carolyn Curtis

APPENDIX B

CORE COMPONENTS OF THE PAC MODEL (USAID 2003)

CORE COMPONENTS OF THE PAC MODEL (USAID 2003)

Postabortion care (PAC) serves to reduce maternal mortality, morbidity, and repeat abortions. The following components—emergency treatment; family planning counseling, provision, and referral for selected reproductive health services; and community awareness and mobilization—are crucial components of PAC. The delivery of postabortion care should be seen as a tiered service delivery paradigm, with components of PAC provided at each level of the health care system. The type of PAC services to be delivered at each level is determined by the level of the health care facility and available trained staff. Thus, PAC services provided at the primary level will differ from those provided in secondary or tertiary settings. While all settings may not be able to provide all components of postabortion care, all providers can provide counseling and preventive measures. Established linkages between all levels of service are imperative to facilitate client access to all appropriate components of PAC. USAID's three core components of PAC follow.[23]

Component 1
Emergency Treatment

Component one provides a guideline for emergency treatment based on the level of the health care facility and available staff. This guideline is in accordance with the 1994 WHO document, *Complications of Abortion: Technical and Managerial Guidelines for Prevention and Treatment Provision of Care by Level of Health Care Facility and Staff.* Adherence to this guideline would expand emergency treatment services from the tertiary care facility to the community, thus enabling a woman to have access to emergency treatment closer to her place of residence. Triage and emergency treatment based upon the type of facility and available staff will allow timely evaluation, stabilization, and referral as needed to the appropriate level of care, thus assisting in the reduction of maternal mortality inherent in delays in seeking and obtaining timely appropriate care. In addition, counseling regarding postabortion complications, emergency treatment modalities available and their inherent risks, postprocedure complications, and answers to the clients' questions or concerns about future pregnancy, incomplete abortion, treatment, and resumption of ovulation should be integral in emergency treatment. Emotional support should occur throughout the visit. Counseling of family planning methods can be initiated at the time of admission, thus enabling the integration of component two.

Component 2
Family Planning Counseling and Provision, STI Evaluation and Treatment, and HIV Counseling and/or Referral for HIV Testing

Component two is the hallmark of comprehensive postabortion care. While timely emergency treatment is paramount to the reduction of maternal mortality, the provision of postabortion family planning is imperative for the reduction of future mistimed pregnancies and repeat abortions. Recent studies indicate an increase in postabortion family planning usage when services are provided in the same place as emergency treatment and when couples are counseled together regarding family planning options. Evidence of linkages with referral sites for family planning follow up in all levels of the health care delivery system is necessary to ensure ongoing

[23] USAID sees these three core components as the basic components for a comprehensive PAC program. However, USAID recognizes that other services may be added to these core components, based on program needs and other donor interests.

service provision close to where women live. STI counseling, evaluation and treatment should be a part of emergency treatment. Countries experiencing high incidences of HIV should consider the inclusion of HIV counseling and./or referral for testing as an integral pat of postabortion care. Listings and linkages for services, that are not provided at the service site (i.e. STI evaluation and treatment; HIV counseling and testing) should be provided as appropriate. Evidence of these linkages at community, primary, secondary, and tertiary levels will identify health care systems that are integrated and comprehensive in service delivery for postabortion care and that are able to offer the appropriate level of services close to women's residences.

Component 3
Community Empowerment Through Community Awareness and Mobilization

Effective community awareness and mobilization is needed to empower the community to provide and demand quality effective postabortion care services. The term community is meant to be inclusive of governments, ministries of health and education, PVOs, NGOs, women's groups, professional organizations, community associations, male leadership, FBOs, traditional birth attendants, community-based distributors, donors, and other stakeholders appropriate to each community. The community is needed to

- identify its health needs as it relates to postabortion care;
- plan for resources necessary to meet identified health needs;
- mobilize required resources to provide PAC, whether this be policy, development of primary sites for service delivery, monetary, equipment, personnel, transportation, and/or social marketing to meet its identified needs;
- determine how to make care accessible in the community;
- educate its constituents regarding possible consequences of miscarriage and unsafe abortion, the three delays in seeking care and the inherent consequences, and postabortion complications; and
- establish relationships with health care providers/facilities on all levels (community/primary/secondary/tertiary) to ensure comprehensive service delivery for postabortion care.

Core Component 1: Emergency Treatment Provision of Care by Level of Health Care Facility and Staff (adapted from WHO 1994)			
Level	**Staff May Include**	**Emergency PAC Provided**	**Postabortion FP (Component 2)**
Community	Community residents with basic health training, traditional birth attendants, traditional healers	1. Recognition of signs and symptoms of abortion and postabortion complications Referral to facilities where treatment is available	1. Provision of pills, condoms, diaphragms, and spermicides 2. Referral and follow up for these and other methods
Primary (Primary health clinics, family planning clinics, or polyclinics)	Health workers, nurses, trained midwives, general practitioners	**All Primary Facilities: Above Activities Plus** 3. Diagnosis based on medical history; physical examination and pelvic examination 4. Resuscitation/preparation for treatment or transfer 5. Tetanus vaccination 6. Referral, if needed	**Provision of Above Plus** IUDs, injectable contraceptives, Norplant implants, and standard days method 4. Referral for voluntary sterilization
		If Trained Staff and Appropriate Equipment Available: Above Activities Plus 7. Counseling regarding treatments/emotional support 8. Hematocrit/hemoglobin testing 9. STI evaluation and treatment 10. Initiation of emergency treatments ▪ antibiotic therapy ▪ intravenous fluid replacement ▪ oxytocics 11. Uterine evacuation during first trimester for uncomplicated cases 12. Appropriate pain control ▪ simple analgesia and sedation ▪ local anesthesia (paracervical block	5. Family planning follow up and referral to primary and community level for long-term FP follow up 6. HIV counseling 7. F/U appt or referral for HIV counseling and testing (as program dictates) 8. Referral to primary/secondary/ tertiary sites as appropriate for gender- based violence, psychological/emotional needs; HIV counseling and testing
First Referral Level (District Hospital)	Nurses, trained midwives, general practitioners, obstetrician/ gynecologists, specialists	**Above Activities Plus** 13. Emergency evacuation for fetal death through second trimester 14. Treatment of most postabortion complications 15. Local and general anesthesia 16. Diagnosis and referral for severe complications (septicemia, peritonitis, renal failure) 17. Laparotomy and indicated surgery (including for ectopic pregnancy) 18. Blood crossmatch and transfusion	**Provision of Above Plus** 9 Voluntary sterilization
Secondary and Tertiary Level (Regional or Referral Hospital)	Nurses, trained midwives, general practitioners, obstetrician/ gynecologists, specialists	**Above Activities Plus** 19. Uterine evacuation as indicated for all cases 20. Treatment of severe complications (including bowel injury, severe sepsis, renal failure) Treatment of bleeding/clotting disorders	**All Above Activities**

Core Component 2: See Component One for Level of Health Facility and Staff
Family Planning Counseling and Provision ; STI Evaluation and Treatment, and HIV Counseling and/or Referral for HIV Testing (HIV counseling and testing in countries with high HIV prevalence)

1. Counseling regarding the return of ovulation within 2 weeks after emergency treatment
2. Counseling regarding self-care at home, including any emotional sequelae
3. Counseling regarding the ability to carry a future pregnancy as desired
4. Counseling regarding behaviors that put one at risk for HIV/STI transmission
5. Counseling regarding contraceptive methods that can be used (oral contraceptives, diaphragm, condom, Norplant, Depo-Provera, standard days method, spermicides, intrauterine device [IUD], voluntary sterilization)
6. Provision of oral contraceptives, condoms, diaphragms, spermicides, IUD, Norplant, Depo-Provera, voluntary sterilization, and instruction regarding the standard days method
7. Listing and evidence of linkages to community/primary/secondary/tertiary referral sites for contraceptive methods not available at treating facility
8. Evidence of linkages and referral mechanisms to/from community, primary, secondary, and tertiary facilities for the provision of the following services:
   - prepregnancy family planning counseling and provision
   - initial emergency treatment
   - postabortion family planning (initiation of method and appointment and/or referral for long-term FP follow up, incorporating all methods, including standard days method and lactational amenorrhea method, enabling women to continue FP services in their communities)
   - STI evaluation and treatment
   - HIV counseling and VCT
9. Referrals to community/primary/secondary/tertiary sites for family planning follow up; HIV/STI counseling/ screening/treatment follow up; counseling for emotional/psychological needs; counseling for gender-based violence.

Core Component 3: Community Empowerment Through Community Awareness and Mobilization

1. Educate community about unsafe abortion and postabortion complications
2. Educate community regarding three delays and their effect on maternal mortality
3. Each community with evidence of listings and/or linkages between community and community/primary/secondary/tertiary resources that can provide
   - Family planning counseling and services
   - Counseling regarding three delays and their effect on maternal mortality/morbidity
   - Emergency treatment
   - HIV voluntary counseling and testing and HIV treatment
   - STI counseling, testing, and treatment
4. Have communities make decisions about type and number of PAC facilities for their community
5. Have communities make decisions regarding transporting of women for emergency treatment
6. Have community generate resources for PAC services (facility, funds for payment of services, transportation, equipment)

Note: Community includes local, district, and national governments; ministries of health and education; NGOs; PVOs; women's groups; professional organizations; FBOs; traditional birth attendants; traditional healers; male leadership; community-based distributors; and other stakeholders appropriate to each specific community.

APPENDIX C

GLOBAL AND COUNTRY RESULTS FRAMEWORKS, INDICATORS, AND COMMENTARY FOR USE

GLOBAL AND COUNTRY RESULTS FRAMEWORKS, INDICATORS, AND COMMENTARY FOR USE

The framework and indicators included in this text attempt to capture the new strategic thinking of the Office of Population and Reproductive Health, Bureau for Global Health (GH/PRH) after its recent reorganization. MEASURE *Evaluation* is assisting the office in the development of a new strategic framework that will better capture the unique contributions of GH/PRH. Figure C–1 reflects the new GH/PRH Strategic Framework and is intended to capture the results of activities funded through core support and reflect the efforts of the Postabortion Care Working Group. The indicators identify key results of interest to GH/PRH; however, the working group may support activities not captured by these indicators as long as they lead to the accomplishment of the Intermediate Results (IRs) and, eventually, the Strategic Objective.

Figure C–2 illustrates accomplishments at the country or program level. This framework was developed in an effort to improve monitoring of PAC programs at the country level and is intended to assist Missions in measuring the progress of country-specific activities. Again, the indicators included reflect the priority areas of PAC programs for GH/PRH and should not be considered an exhaustive list. Projects may also receive core or Global Leadership Priority funding for work on country programs and these IRs. Results of these activities should be reported to the Global Leadership Priorities Champion or the cognizant technical officer (CTO) under the global framework IR 3, "State-of-the-art PAC practices **supported**."

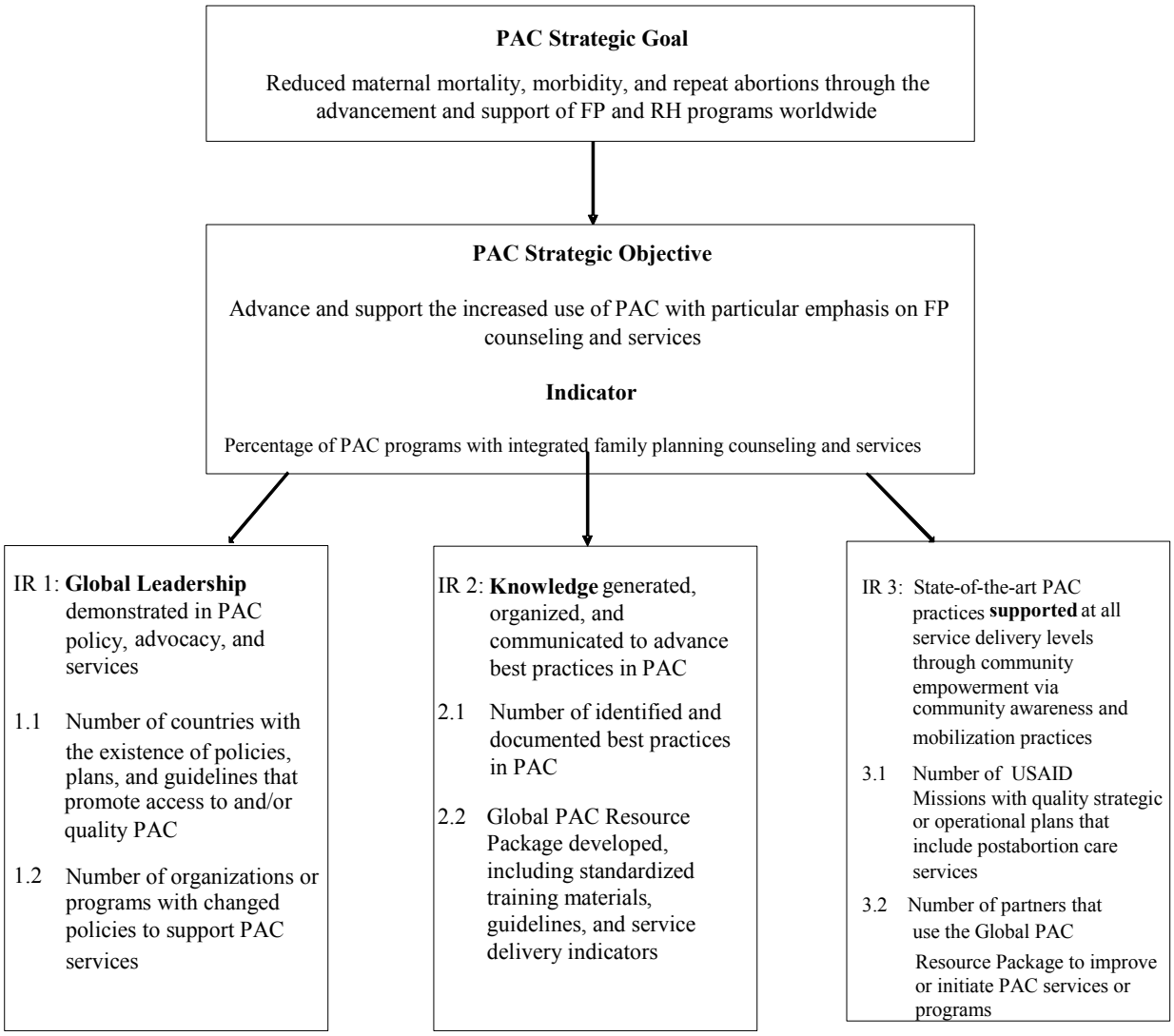
Country-level indicators may need to be adapted to meet the specific context and needs of each program. The information included in this document was adapted from MEASURE *Evaluation's Compendium of Indicators for Evaluating Reproductive Health Programs.*

GLOBAL RESULTS FRAMEWORK

AND INDICATORS

(Indicators adapted from MEASURE *Evaluation)*

Figure C–1
Postabortion Care Global Results Framework (2003)



IR 1.1
Number of countries with existence of policies, plans, and guidelines that promote access to and/or quality postabortion care

Definition

"Policies, plans, and guidelines" include broad health and population policies and laws. They also include programmatic and organizational documents that aim to regulate the kinds of services to be delivered, by whom, and under what conditions. They appear in constitutional provisions, legislation, implementing rules and regulations, executive orders, ministerial level decrees, and other measures of a regulatory nature (including related regulations and enforcement mechanisms), official goals and plan programs, statements and other formally documented government directives, standards, guidelines, and decrees (The EVALUATION Project 1998).

Most developing countries now have some national reproductive health (RH) policies or laws in place (although few have a stand-alone RH or postabortion care policy). Experience has shown, however, that macrolevel policies, laws, councils, and programs do not guarantee RH service availability and quality. Therefore, it is strongly recommended that any policy review include operational policies.

"Promote access" refers to mechanisms that encourage the provision of PAC services and increase the number of service delivery points (SDPs) offering services and/or type of services and methods available.

"Promote quality" refers to mechanisms that encourage quality PAC services, such as technical competence of providers and responsiveness to client needs.

When evaluators measure both access and quality, they should construct separate indicators for each to maintain uni-dimensionality of each.

Not all individual policies will be complete. For example, a national development statement may cite postabortion care as a development issue without dealing with the steps necessary to improve reproductive health or postabortion care. In cases where policies are incomplete, evaluators should consider the aggregate of all policies related to postabortion care, rather than examining individual documents. To measure changes over time, the indicator should consider only those policies developed or modified during a specific reference period.

Data Requirements

Data requirements include evidence of policies, plans, and/or guidelines. Supporting documentation should include the policy, plan, or guideline, where or by whom it was issued or published, and an explanation of how the policy, plan, or guideline promotes access to or quality of postabortion care services. For example, is support given to the full range of postabortion care services, or for only a single program element? Are all populations—teenagers and women—covered? Is accountability discussed?

At times, evaluators may wish to measure progress towards supportive policies. In this case, they can construct separate indicators for each stage of development (e.g., draft, submitted for approval, and approved) or devise an ordinal rating scale to track progress from draft to final approval.

Data Source

The data source includes the actual policy, plan, or guideline document with evidence of approval (or submission for approval). A content analysis of the documents should include the level (e.g., national or provincial) and topic area addressed (e.g., access, quality, and FP).

Purpose and Issues

The purpose of this indicator is to measure the degree of explicit support for access to and/or quality of postabortion care services on the part of the government and other bodies, including service delivery institutions. However, the presence or absence of policies alone is of limited usefulness. It is encouraged that evaluators also include the indicator, **Adequacy of Policy Planning Process.**

An important limitation to this indicator is related to the collection and analysis of all the relevant policy documents. In assessing implementation, evaluators must determine whether the health and population policies and laws include an implementation plan that designates institutional roles and responsibilities, timeframes and activity plans, budgets, and monitoring and evaluation plans. When assessing the implementation of policies and laws, evaluators should first consider whether or not an approved implementation plan exists (which will be an indicator in its own right) and then whether the activities have been conducted according to plan. Operational policies are more specific; evaluation of their implementation should focus on whether their provisions are being carried out in practice.

IR 1.2
Number of organizations or programs with changed policies to support PAC services

Definition

This indicator constitutes a subset of indicator 1.1. Whereas the previous indicator includes the broad rubric of policies, laws, and program documents that encourage provision and quality of postabortion care services, this indicator focuses on modifying existing policies to eliminate obstacles to service access and quality.

This indicator is especially pertinent to legal and regulatory reform in RH. Policy barriers affect service providers and/or potential clients. They may affect both the public and private sectors or primarily the private sector.

Data Requirements

Data requirements include old and new policy documents that show evidence of a change in policy that will lead to increased access to PAC services.

Data Sources

Data sources include legal and regulatory reviews, actual policy documents with evidence of governmental approval, and submissions for approval.

Purpose and Issues

The purpose of the indicator is to measure the extent to which national governments expand participation in developing policy and providing postabortion care services, and to facilitate increased access to PAC services.

Removing barriers to the provision of PAC services by nurses, midwives, and medical officers empowers these providers to provide needed services. Private sector participation in policy development may ensure that postabortion care programs address the needs of all women. The private sector can also be an important provider of PAC services, especially in countries where government programs are either overburdened by demand or are unable to reach certain population groups.

This indicator can be quantified in several ways. As a baseline measure, it may be expressed as the number and type of policy barriers that significantly hinder private sector participation. To measure change over time in a country application, the evaluator should count and qualify the policy barriers identified at the baseline, which were subsequently removed. Evaluators can measure change through naming and counting those identified policy barriers that do not appear in the new policy. Evaluators should link clearly the barriers identified at the baseline, the policy interventions carried out, and the barriers identified at follow up.

Because policy barriers tend to be very specific, evaluators can readily assess whether the new policy removes them.

IR 2.1
Number of identified and documented best practices in PAC

Definition

To be considered a best practice, a practice or program needs to include substantial evidence that it has had an impact and/or has successfully met its program objectives. In addition, a best practice needs to show evidence that it has been transferred to or replicated in various settings. (Advance Africa)

"Impact" is generally defined as change attributable to the project. (MEASURE *Evaluation*)

Data Requirements

Data requirements include program evaluation or research findings that can specify the level and area of impact, consensus from a group of technical experts identified as leaders in the field, and documentation of program implementation.

Data Sources

Data sources include evaluation reports, progress/implementation documentation, and research reports.

Purpose and Issues

Documenting successful strategies is the first step in ensuring evidence-based programming, policymaking, and improving programs. By recording best practices and lessons learned, it is also made certain that limited resources are used in the most efficient manner possible and duplication of effort is limited.

Limitations

There are no set standards for how long it takes to evaluate impact; however, it usually takes two to three years to allow adequate time for an organization to adopt and institutionalize changes.

IR 2.2
Global PAC Resource Package developed, including standardized training materials, guidelines, and service delivery indicators

Definition

The Global PAC Resource Package consists of three components:

- research compendium,
- curricula and policy review, and
- behavior change communication materials.

Each component was funded by the PAC Global Leadership Priority, and responsible parties have been identified. The Resource Package is intended for use as a policy/advocacy tool and to assist program managers/designers in the development, implementation, and monitoring of programs.

Data Requirements

The date requirements include USAID approval of outputs.

Data Sources

Data sources include a POPTECH final report or USAID approval.

Purpose/Limitation

This indicator represents the completion of a key activity for USAID/Washington's PAC Working Group. The completion of the Global PAC Resource Package denotes the first step in a long-range strategy to provide technical assistance to the field in the development, expansion, or improvement of PAC programs.

IR 3.1
Number of USAID Missions with quality strategic or operational plans that include postabortion care services

Definition

A strategic plan is a written document stating the key elements of the strategy and goals of an organization or program, with priorities and focuses for the medium to long term (three to five years). An operational plan, a document generally written annually, guides the activities of an organization or program in the immediate future.

Data Requirements

The data requirements include evidence of the existence of strategic and operational plans, which includes PAC and an assessment of the plans.

Data Sources

Data sources include USAID Mission strategic plans, operational plans, and budgets.

Purpose and Issues

A quality strategic plan contains

- reference to the mission statement of the program or organization;
- a listing of key strategies for the near term (e.g., the next one to three years) that includes PAC and the priorities of said list; and
- a vision for the long term (e.g., how the strategic plan will enhance the long-term goals of PAC beyond the next five years).

A quality operational plan for PAC includes

- detailed activities and tasks,
- a definition of resources required to accomplish the activities,
- a link to a detailed budget of PAC activities, and
- a planned activity to review and adjust the plan to adapt it to changing conditions.

When assessing the quality of an organization's strategy, the evaluator needs to first examine the PAC strategy and assure consistency with the organization's mission.

IR 3.2
Number of partners that use the Global PAC Resource Package to initiate or improve PAC services or programs

Definition

The Global PAC Resource Package consists of three components:

- a research compendium,
- curricula and policy review, and
- behavior change communication materials

Use of the Resource Package implies that at least one of its components was used in the planning or implementation of a new PAC program or in the improvement of any element of an existing PAC program.

Partners include CAs, NGOs, FBOs, ministries of health, and other donors.

Data Requirements

The data requirements include evidence of use of the Resource Package, such as references to the package in policy or program documents, and use or adaptation of the training materials and BCC materials provided in the package in program implementation.

Data Sources

Data sources include policy or program documents, work plans, and interviews with program planners and implementers.

Purpose and Issues

The purpose of the Global PAC Resource Package is to provide technical assistance to the field in the development, expansion, or improvement of PAC programs. The Resource Package can be used in whole to initiate an entire program, or in part to help expand or improve existing programs.

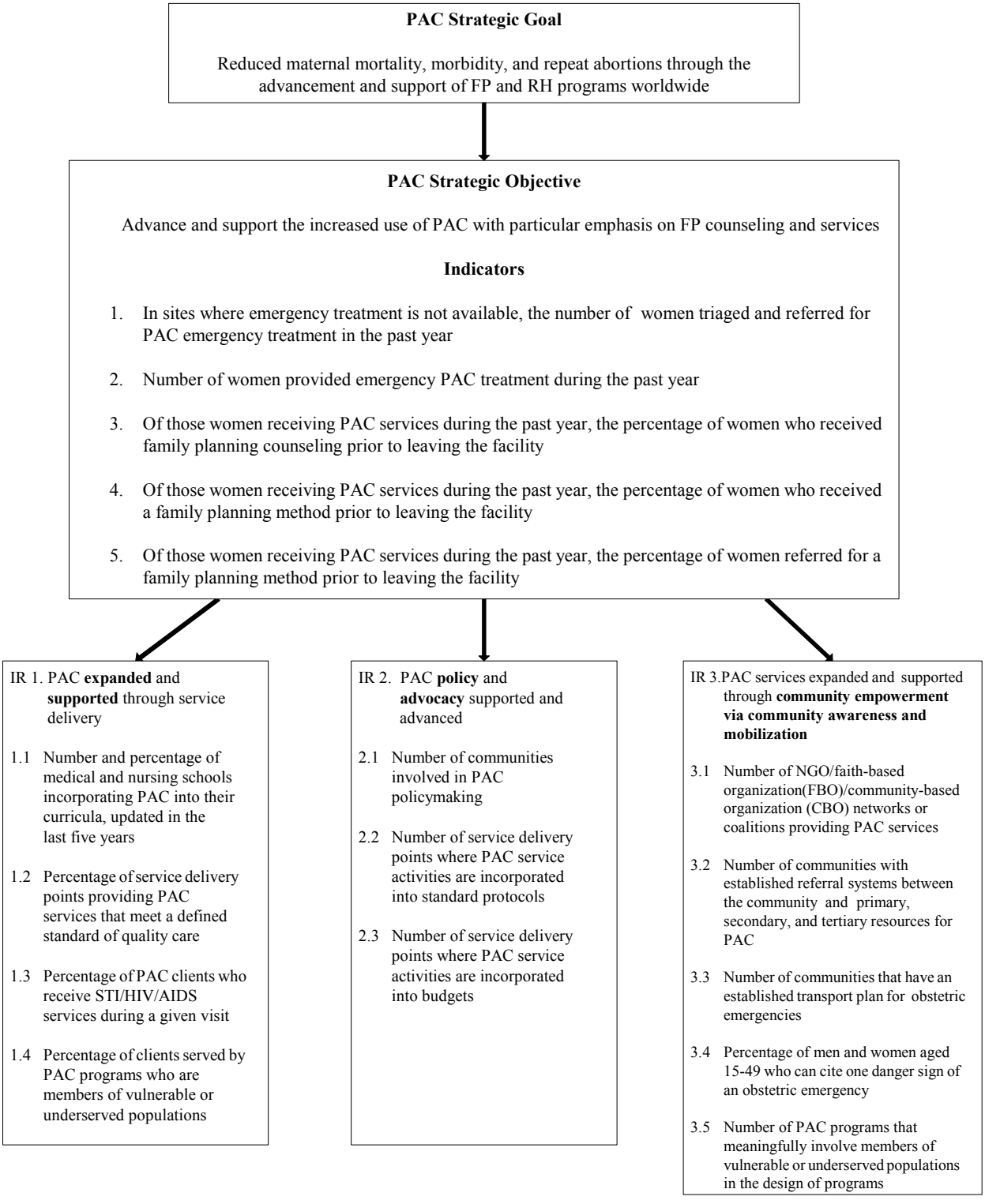
The purpose of this indicator is to show the degree to which the Global PAC Resource Package influences PAC program improvement and creation.

COUNTRY RESULTS FRAMEWORK

AND INDICATORS

(Indicators adapted from MEASURE *Evaluation*)

Figure C–2
Country Level Strategic Framework



COMMENTARY FOR PAC RESULTS FRAMEWORK INDICATORS: COUNTRY INDICATORS

Indicator 1
In sites where emergency treatment is not available, number of women triaged and referred for PAC emergency treatment in the past year

Definition

The total number of women in the past year who presented to a lower level facility, such as a health hut, health post, or health facility for complications and were triaged, stabilized, and referred to a higher level facility for further treatment of complications.

The indicator includes both complications resulting from spontaneous abortion (miscarriage) and those occurring as a result of induced abortions.

Postabortion complications include hemorrhage, local and systemic infection, injury to the genital tract and internal organs, and toxic or chemical reactions from attempts at self-induced or unsafe abortions. This indicator omits long-term sequelae (physical impairment, pain, pelvic inflammatory disease, secondary infertility, increased rate of ectopic pregnancy).

Data Requirements

Data requirements include counts of women presenting to a health care facility (private offices, health hut, health post, health center) for treatment of abortion-related complications during a one-year period.

Data Source

The data source includes special studies or service statistics from health facilities providing triage, stabilization, treatment, and/or referral.

Note: In hospitals in developing countries, treatment of abortion complications may be performed in many different locations within the facility, such as the gynecological ward, emergency room, or operating room; data collection should therefore include encounters from all locations.

Purpose and Issues

This indicator monitors changes in caseloads and has important administrative implications. Evaluators and managers can also use it to track resource use and needs for treatment of abortion-related complications. It also has policy implications in that it is useful for assessing the cost of unsafe, induced abortions to individual facilities or to a national health system. Numbers of encounters for abortion complications can also provide denominators for other useful indicators, such as the percentage of PAC patients under the age of 20 or the percentage of PAC patients presenting at 12 or fewer weeks of pregnancy. In some individual facilities, such as private offices, health huts, health posts, and health centers, however, the number of encounters for abortion complications may be small, so the calculation of percentages may be inappropriate.

This indicator includes both complications due to spontaneous abortion and induced abortions. While it is often of interest to distinguish between the two types in order to estimate the number of induced abortions, this information is often difficult to obtain. Moreover, many would question the ethics of asking young women if they have had an abortion in restrictive legal settings. Clinical evidence is often inconclusive, and reports may also be heavily biased in restrictive environments. Even where service providers are fairly certain that an abortion-related complication resulted from an induced abortion, they may choose not to report this in the records due to a legally and/or socially restrictive environment. This omission results in service data that are potentially misleading in terms of the number of spontaneous versus induced abortions.

Indicator 2
Number of women provided emergency PAC treatment during the past year

Definition

The total number of women in the past year who presented to a facility, such as a health center or hospital, for complications related to miscarriage or unsafe abortion and had any of the following: a D&C, electrical or manual vacuum aspiration of the uterus, a blood transfusion, antibiotic therapy for further treatment of complications, laparoscopy, or pelvic surgery.

The indicator includes both complications resulting from spontaneous abortion (miscarriage) and those occurring as a result of induced abortions.

Postabortion complications include hemorrhage, local and systemic infection, injury to the genital tract and internal organs, and toxic or chemical reactions from attempts at self-induced or unsafe abortions. This indicator omits long-term sequelae (physical impairment, pain, pelvic inflammatory disease, secondary infertility, increased rate of ectopic pregnancy).

Data Requirements

Data requirements include counts of women presenting to a health facility (private office, health center, or hospital) for emergency treatment of abortion-related complications during a one-year period.

Data Source

The data source includes special studies or service statistics from health facilities providing triage, stabilization, treatment, and/or referral.

Note: In hospitals in developing countries, treatment of abortion complications may be performed in many different locations within the facility, such as the gynecological ward, emergency room, or operating room; data collection should therefore include encounters from all locations.

Purpose and Issues

This indicator monitors changes in caseloads and has important administrative implications. Evaluators and managers can also use it to track resource use and needs for treatment of abortion-related complications. It also has policy implications in that it is useful for assessing the cost of unsafe, induced abortions to individual facilities or to a national health system. Numbers of encounters for abortion complications can also provide denominators for other useful indicators, such as the percentage of PAC patients under the age of 20 or the percentage of PAC patients presenting at 12 or fewer weeks of pregnancy. In some individual facilities, such as private offices, health huts, health posts, and health centers, however, the number of encounters for abortion complications may be small, so the calculation of percentages may be inappropriate.

This indicator includes both complications due to spontaneous abortion and induced abortions. While it is often of interest to distinguish between the two types in order to estimate the number of induced abortions, this information is often difficult to obtain. Moreover, many would question the ethics of asking young women if they have had an abortion in restrictive legal settings. Clinical evidence is often inconclusive, and reports may also be heavily biased in restrictive environments. Even where service providers are fairly certain that an abortion-related complication resulted from an induced abortion, they may choose not to report this in the records due to a legally and/or socially restrictive environment. This omission results in service data that are potentially misleading in terms of the number of spontaneous versus induced abortions.

Indicator 3
Of those women receiving PAC services during the past year, the percentage of women who received family planning counseling prior to leaving the facility

Definition

Of those women receiving either triage, stabilization, referral for emergency treatment, or emergency treatment services for complications related to miscarriage or unsafe abortion during the past year, the percentage of women who received family planning counseling prior to leaving the facility.

This indicator is calculated as follows:

$$\frac{\text{Number of women receiving family planning counseling}}{\text{Number of women receiving PAC services}} \times 100$$

The indicator includes family planning counseling for oral contraceptives, Norplant, and intrauterine devices; Depo-Provera, vasectomy, and bilateral tubal ligation; contraceptive foam and condoms; and the standard days method.

Data Requirements

The data requirements include counts of women presenting to a health facility (private office, health center, or hospital) for emergency treatment of abortion-related complications during a one-year period.

Data Source

The data source includes special studies or service statistics from health facilities providing triage, stabilization, treatment, and/or referral.

Note: In hospitals in developing countries, treatment of abortion complications may be performed in many different locations within the facility, such as the gynecological ward, emergency room, or operating room; data collection should therefore include encounters from all locations.

Purpose and Issues

This indicator monitors changes in caseloads and has important administrative implications. Evaluators and managers can also use it to track resource use and needs for treatment for family planning methods. It also has policy implications in that it is useful for assessing the cost of unsafe, induced abortions and family planning programs to individual facilities or to a national health system. Numbers of encounters for abortion complications can also provide denominators for other useful indicators, such as the percentage of PAC patients under the age of 20 or the percentage of PAC patients presenting at 12 or fewer weeks of pregnancy. In some individual facilities, such as private offices, health huts, health posts, and health centers, however, the number of encounters for abortion complications may be small so the calculation of percentages may be inappropriate.

This indicator includes both complications due to spontaneous abortion and induced abortions. While it is often of interest to distinguish between the two types in order to estimate the number of induced abortions, this information is often difficult to obtain. Moreover, many would question the ethics of asking young women if they have had an abortion in restrictive legal settings. Clinical evidence is often inconclusive, and reports may also be heavily biased in restrictive environments. Even where service providers are fairly certain that an abortion-related complication resulted from an induced abortion, they may choose not to report this in the records due to a legally and/or socially restrictive environment. This omission results in service data that are potentially misleading in terms of the number of spontaneous versus induced abortions.

Indicator 4
Of those women receiving PAC services during the past year, the percentage of women who received a family planning method prior to leaving the facility

Definition

Of those women receiving either triage, stabilization, referral for emergency treatment, or emergency treatment services for complications related to miscarriage or unsafe abortion during the past year, the percentage of women who received a family planning method prior to leaving the facility.

This indicator is calculated as follows:

$$\frac{\text{Number of women who received PAC services and a family planning method}}{\text{Number of women receiving PAC services}} \times 100$$

Data Requirements

The data requirements include counts of women presenting to a health facility (private office, health center, or hospital) for emergency treatment of abortion-related complications during a one-year period and referred for a family planning method not available at the time of the PAC services.

Data Source

The data source includes special studies or service statistics from health facilities providing triage, stabilization, treatment, and/or referral.

Note: In hospitals in developing countries, treatment of abortion complications may be performed in many different locations within the facility, such as the gynecological ward, emergency room, or operating room; data collection should therefore include encounters from all locations.

Purpose and Issues

This indicator monitors changes in caseloads and has important administrative implications. Evaluators and managers can also use it to track resource use and needs for treatment for family planning methods. It also has policy implications in that it is useful for assessing the cost of unsafe, induced abortions and family planning programs to individual facilities or to a national health system. Numbers of encounters for abortion complications can also provide denominators for other useful indicators, such as the percentage of PAC patients under the age of 20 or the percentage of PAC patients presenting at 12 or fewer weeks of pregnancy. In some individual facilities, such as private offices, health huts, health posts, and health centers, however, the number of encounters for abortion complications may be small, so the calculation of percentages may be inappropriate.

This indicator includes both complications due to spontaneous abortion and induced abortions. While it is often of interest to distinguish between the two types in order to estimate the number of induced abortions, this information is often difficult to obtain. Moreover, many would question the ethics of asking young women if they have had an abortion in restrictive legal settings. Clinical evidence is often inconclusive, and reports may also be heavily biased in restrictive environments. Even where service providers are fairly certain that an abortion-related complication resulted from an induced abortion, they may choose not to report this in the records due to a legally and/or socially restrictive environment. This omission results in service data that are potentially misleading in terms of the number of spontaneous versus induced abortions.

Indicator 5
Of those women receiving PAC services during the past year, the percentage of women referred for a family planning method prior to leaving the facility

Definition

Of those women receiving either triage, stabilization, referral for emergency treatment, or emergency treatment services for complications related to miscarriage or unsafe abortion during the past year, the percentage of women who received a referral for a family planning method prior to leaving the facility.

This indicator is calculated as follows:

$$\frac{\text{Number of women who received PAC services and a referral for a family planning method}}{\text{Number of women receiving PAC services}} \times 100$$

The indicator includes family planning counseling for oral contraceptives, Norplant, and intrauterine devices; Depo-Provera, vasectomy, and bilateral tubal ligation; contraceptive foam and condoms; and the standard days method.

Data Requirements

Data requirements include counts of women presenting to a health facility (private office, health center, or hospital) for emergency treatment of abortion-related complications during a one-year period.

Data Source

The data source includes special studies or service statistics from health facilities providing triage, stabilization, treatment, and/or referral.

Note: In hospitals in developing countries, treatment of abortion complications may be performed in many different locations within the facility, such as the gynecological ward, emergency room, or operating room; data collection should therefore include encounters from all locations.

Purpose and Issues

This indicator monitors changes in caseloads and has important administrative implications. Evaluators and managers can also use it to track resource use and needs for treatment for family planning methods. It also has policy implications in that it is useful for assessing the cost of unsafe, induced abortions and family planning programs to individual facilities or to a national health system. Numbers of encounters for abortion complications can also provide denominators for other useful indicators, such as the percentage of PAC patients under the age of 20 or the percentage of PAC patients presenting at 12 or fewer weeks of pregnancy. In some individual facilities, such as private offices, health huts, health posts, and health centers, however, the number of encounters for abortion complications may be small, so the calculation of percentages may be inappropriate.

This indicator includes both complications due to spontaneous abortion and induced abortions. While it is often of interest to distinguish between the two types in order to estimate the number of induced abortions, this information is often difficult to obtain. Moreover, many would question the ethics of asking young women if they have had an abortion in restrictive legal settings. Clinical evidence is often inconclusive, and reports may also be heavily biased in restrictive environments. Even where service providers are fairly certain that an abortion-related complication resulted from an induced abortion, they may choose not to report this in the records due to a legally and/or socially restrictive environment. This omission results in service data that are potentially misleading in terms of the number of spontaneous versus induced abortions.

IR 1.1
Number and percentage of medical and nursing schools incorporating PAC into their curricula, updated in the last five years

Definition

Number and percentage of medical and nursing schools incorporating evidence-based PAC education and training into their curricula, updated in the last five years.

State-of-the-art PAC education and training includes

- emergency treatment of complications from spontaneous or unsafely induced abortions,
- family planning counseling and services,
- STI evaluation and treatment,
- HIV counseling, and
- HIV testing or referral for testing.

This indicator is calculated as follows:

$$\frac{\text{Number of medical and nursing schools that incorporate PAC training into their curricula}}{\text{Total number of medical and nursing schools}} \times 100$$

Data Requirements

Data requirements include the total number of medical and nursing schools and the total number of medical and nursing schools providing evidenced-based PAC training.

Data Sources

Data sources include national program records and training institution records and curricula.

Purpose and Issues

Providing PAC services requires skills often lacking in preservice training. This indicator measures the extent to which schools are training providers with the skills necessary to treat PAC clients, which in turn influences the availability of such services. Note that this indicator measures not only the number of schools but also the quality of the training.

A limitation of this indicator relates to the follow-up monitoring of practitioners applying their skills to their jobs. Once providers are assigned to their posts, they may find it challenging to apply the skills they learned. Once providers are spread out geographically in a given country, evaluators may have difficulty monitoring how and whether they are using the skills they learned in training.

IR 1.2
Percentage of service delivery points (SDPs) providing postabortion care services that meet a defined standard of quality care

Definition

The percentage of SDPs providing PAC services by types of facility (primary, secondary, and tertiary levels) that meet a defined standard of quality care. Service delivery points should include those in both the public and private health care sectors.

This indicator is calculated as follows:

$$\frac{\text{Number of SDPs of a particular type that deliver PAC services and that meet a defined standard of quality care}[24]}{\text{Total number of SDPs of that type}} \times 100$$

Postabortion care consists of

- emergency treatment of complications from spontaneous or unsafely induced abortions,
- family planning counseling and services,
- STI evaluation and treatment,
- HIV counseling, and
- HIV testing or referral for testing.

The standard of quality care is

- appropriate technologies for uterine evacuation,
- technical performance in PAC services,
- patient–provider interaction,
- information and counseling on PAC, and
- availability of equipment, supplies, and medications.

[24] This indicator can be disaggregated by service delivery level (primary, secondary, or tertiary) to better evaluate the access of PAC services.

Data Requirements

Data requirements include the total number, type, and standard of care of facilities providing PAC services, and the total number of SDPs by type and standard of care.

Data Sources

Data sources include national program records, private and NGO records, provider interviews, and observation of services.

Purpose and Issues

The purpose of this indicator is to measure the degree to which quality postabortion care services are available within a given country. Although measurement of service quality is challenging, managers and providers can use standardized tools to assess their own programs.

All countries should be able to monitor the availability of PAC services for the treatment of abortion complications, although it may be more difficult in countries with severely restrictive abortion laws. If population figures are available, information collected for this indicator may help determine if the number and type of facilities providing services are sufficient for the population served.

IR 1.3
Percentage of PAC clients who receive STI/HIV/AIDS services during a given visit

Definition

The percentage of PAC clients who received HIV/AIDS counseling during a given visit and who accepted an offer of testing or a referral for testing. It is not required that HIV services be part of the initial PAC visit and may be included in follow-up visits.

"A given visit" generally equates with attendance at the clinic on a specific day.

This indicator is calculated as follows:

$$\frac{\text{Number of PAC clients who received HIV/AIDS counseling/testing}}{\text{Total number of clients served by PAC}} \times 100$$

Postabortion care consists of

- emergency treatment of complications from spontaneous or unsafely induced abortions,
- family planning counseling and services,
- STI evaluation and treatment,
- HIV counseling, and
- HIV testing or referral for testing.

Data Requirements

Data requirements include PAC service statistics indicating the number of PAC clients that receive HIV counseling, tests, and results.

Data Sources

Data sources include national program records and private and NGO records.

Purpose and Issues

Knowledge of HIV status may affect future reproductive choices. Ideally, women would learn their HIV status at a VCT clinic. However, the gap between this ideal and reality is often very wide. In practice, the first opportunity some women have to be counseled about HIV and to be offered tests may be at the time they receive PAC services.

A common limitation of this indicator relates to the inability to track clients from counseling to testing. To learn their HIV status during a PAC visit, women have to complete a number of steps. First, they must receive PAC services. Then, they must be counseled and offered an HIV test. Next, they must accept a test. Finally, they must return to receive the test results (if the rapid response test is not available). These steps are not necessarily part of the initial PAC visit but may be included in follow-up visits.

IR 1.4
Percentage of clients served by PAC programs who are members of vulnerable or underserved populations

Definition

The percentage of clients receiving PAC services who are members of vulnerable or underserved populations. Vulnerable or underserved populations include but are not limited to adolescents, refugees, young married women, and unmarried women.

The evaluation can further classify participants by relevant characteristics, such as age, marital status, socioeconomic status, employment status, pregnancy history, STI history, and contraceptive use history.

This indicator is calculated as follows:

$$\frac{\text{Total number of clients served by PAC who are members of vulnerable or underserved populations}}{\text{Total number of clients served by PAC}} \times 100$$

Postabortion care consists of

- emergency treatment of complications from spontaneous or unsafely induced abortions,
- family planning counseling and services,
- STI evaluation and treatment,
- HIV counseling, and
- HIV testing or referral for testing.

Data Requirements

Data requirements include PAC service statistics indicating the number and/or characteristics of members of vulnerable or underserved populations served by PAC.

Data Sources

The data sources include national program records and private and NGO records.

Purpose and Issues

The purpose of this indicator is to measure the volume and characteristics of clients who are members of vulnerable or underserved populations who use PAC services. Evaluators can readily compile data on the number and characteristics of the members of these populations that seek clinical services at fixed sites. To measure the reach of communication programs, evaluators can survey the intended audience and thus obtain counts or estimates of the percentage of these populations that are exposed.

The percentage of clients who are members of vulnerable or underserved populations may tell whether services are "friendly" to that specific population, that is, if they have policies that attract members of vulnerable or underserved populations to the facility or program, provide a comfortable and appropriate setting for them, meet the specific needs of vulnerable or underserved populations, and are able to retain those clients for follow-up and repeat visits (Senderowitz 1999). Aspects of a friendly environment can include space or rooms dedicated to serving those populations, policies and procedures to ensure privacy and confidentiality, peer educators on site, nonjudgmental staff, and acceptance of drop-in clients.

IR 2.1
Number of communities involved in PAC policymaking

Definition

This qualitative indicator measures the number and breadth of communities that participate in the PAC policymaking process and the nature of their participation. Mechanisms may include public hearings, multisectoral boards or consultative committees, and appointment of civil society representatives to official decision-making bodies.

Data Requirements

Data requirements include evidence of individuals and agencies involved in the policy process with information on the nature of their involvement.

Data Sources

Data sources include meeting agendas and attendance lists, focus group discussions, and/or key informant interviews.

Purpose and Issues

Because many health policies, including PAC, transcend central decision-makers and even the health sector itself, it is important to open up the policy development process to stakeholders traditionally excluded from decision-making. This indicator relies on the assumption that the greater the number and the more varied the type of organizations involved, and the greater the opportunity for their substantive input, the more that policy will reflect the population's needs.

For participation to occur, public institutions must be open to wide involvement in all phases of the policy process, including formulation, implementation, and oversight. For this involvement to occur, mechanisms must exist for the exchange of information and views on the key issues (USAID 1998).

IR 2.2
Number of service delivery points where postabortion care service activities are incorporated into standard protocols

Definition

Number of service delivery points at any level (primary, secondary, and tertiary) where postabortion care service activities are incorporated into standard protocols.

Postabortion care consists of

- emergency treatment of complications from spontaneous or unsafely induced abortions,
- family planning counseling and services,
- STI evaluation and treatment,
- HIV counseling, and
- HIV testing or referral for testing.

Data Requirements

Data requirements include the standard protocols.

Data Sources

Data sources include facility protocols and program records.

Purpose and Issues

The purpose of this indicator is to measure the degree to which organizations are planning and preparing to offer PAC services. If the provision of PAC services is included in the facility protocols, it should also be included in the training curricula, budgets, and supply orders for the facility.

IR 2.3
Number of service delivery points where postabortion care service activities are incorporated into budgets

Definition

The number of service delivery points where postabortion care service activities are incorporated into budgets. Examples of items to be budgeted include supplies, human resources, and training.

A budget is a document that projects the costs, and in many cases, the revenues, of a defined activity, program, project, or organization. It is also a financial plan that quantifies programmatic goals and objectives by guiding the allocation of financial and human resources (MSH 1999).

Data Requirements

Data requirements include evidence that PAC activities have been included in budget plans and that resources have been allocated for PAC programs.

Data Sources

Data sources include budgets, charts of accounts, and operational plans.

Purpose and Issues

This indicator measures the degree to which organizations are planning and preparing to offer PAC services. The PAC budget, or single activity budget, should roll up into the total operating budget for the facility.

Measurement of this indicator assumes a certain level of clarity of the budget. For this reason, those preparing budgets must provide information on the costs of a PAC program, such as the number of clients they expect and the specific number and type of materials needed.

IR 3.1
Number of NGO/FBO/community-based organization (CBO) networks or coalitions providing PAC services

Definition

This indicator is based on the premise that there is greater power in numbers. In other words, the more organizations that come together to provide PAC services, the more effectively they can serve the population's needs.

In this section, "network" and "coalition" are used interchangeably to refer to groups of organizations and individuals working together to achieve quality and accessible PAC services.

Postabortion care (services) consists of

- emergency treatment of complications from spontaneous or unsafely induced abortions,
- family planning counseling and services,
- STI evaluation and treatment,
- HIV counseling, and
- HIV testing or referral for testing.

Data Requirements

Data requirements include evidence of network status and functioning based on the number of members, activities, and the degree of sustainability.

Data Sources

Data sources include membership lists of networks or coalitions, management and/or financial information systems, meeting minutes, and external assessments of sustainability.

Purpose and Issues

The greater the number or breadth of networks, the greater is the number of clients receiving PAC services. It is assumed that through these networks or coalitions, clients are referred to the facility that can best provide the range of services necessary for the client.

IR 3.2
Number of communities with established referral systems between the community and primary, secondary, and tertiary resources for PAC

Definition

An established referral system is one that is up to date and functional and fosters communication between the community and the service delivery facilities.

A "referral" means that when a service is not available to a client at one facility, he/she is directed to an appropriate facility that can provide the needed service. A referral may come from one service delivery point to another or from a nonhealth organization into the health system.

Data Requirements

Date requirements include evidence of a functioning referral system based on the number of referrals, the number and types of facilities, and the degree of sustainability.

Data Sources

Data sources include membership lists of those in the referral system, and service statistics.

Purpose and Issues

The purpose of this indicator is to evaluate the degree to which functional referral systems exist to serve a population. Because not all service delivery points provide the same level of services, a referral system should exist for the client to receive the full range of postabortion care services, including emergency obstetric care, family planning counseling services, STI evaluation and treatment, and HIV counseling and testing.

IR 3.3
Number of communities that have an established transport plan for obstetric emergencies

Definition

The number of communities that have an established transport plan for obstetric emergencies.

An emergency transportation plan may include community agreement on such issues as

- transportation to the nearest health facility equipped to handle emergency obstetric cases,
- alternative funding sources for individuals/families requiring medical services for a fee,
- a plan for the care of family members,
- awareness of signs of obstetric emergencies, and
- appropriate first aid for safe transportation.

Data Requirements

The development of an emergency plan is a process and may require several steps to obtain an efficient, effective community plan. Progress on the process of plan development may be reported on this indicator.

Data Sources

Data sources include community meeting minutes, CA progress reports, and anecdotal evidence of system use.

Purpose and Issues

The success of the emergency treatment of complications from spontaneous or unsafely induced abortions is often time dependent. Women need timely access to treatment in order to save their lives. This is especially important in rural areas where transportation systems are nonexistent or unreliable and health facilities are often located far from the communities.

IR 3.4
Percentage of men and women age 15–49 who can cite one danger sign of an obstetric emergency

Definition

Community knowledge and awareness of the warning/danger signs of obstetric complications.

"Cite" refers to the percentage who can spontaneously name at least one primary warning sign of specific obstetric complications.

Obstetric complications include

- hemorrhage,
- local and systemic infection,
- injury to the genital tract and internal organs, and
- toxic or chemical reactions from attempts at self-induced or unsafe abortion.

This indicator is calculated as:

$$\frac{\text{Total number of men and women age 15–49 who can cite one danger sign of an obstetric emergency}}{\text{Total number of men and women age 15–49}} \times 100$$

Data Requirements

Data requirements include the number of men and women age 15–49 who can cite at least one danger sign of an obstetric emergency and the total population of men and women age 15–49.

Data Source

The data source includes population-based surveys.

Purpose and Issues

The purpose of this indicator is to assess community knowledge and awareness of the warning/danger signs of an obstetric emergency in order to plan and monitor the impact of behavior change communication (BCC) initiatives at a community level.

Knowledge of the danger signs of obstetric emergencies is the essential first step in the appropriate and timely referral to essential obstetric or PAC services.

Knowledge of the danger signs of an obstetric complication is only one aspect of obstetric problem recognition at the community level. Knowledge about the severity of an obstetric complication and knowledge about the appropriate lifesaving action for each complication are also important. Moreover, adequate knowledge does not guarantee that an individual will recognize a complication in practice, or they may choose not to act on the knowledge because of cultural beliefs.

IR 3.5
Number of PAC programs that meaningfully involve members of vulnerable or underserved populations in the design of programs

Definition

This qualitative (yes/no) indicator measures participation of members of vulnerable or underserved populations in the design of a PAC program. The evaluator assigns a "yes" score if members from the intended audience participated in designing the PAC program in a meaningful way by communicating their needs and preferences.

Vulnerable or underserved populations include but are not limited to adolescents, refugees, young married women, and unmarried women.

Data Requirements

Data requirements include program documents or other evidence that

- the PAC program designers assessed the needs of the program's intended audience through a participatory process entailing significant input from members in the program's intended audience, and
- findings from the assessment helped shape the program design and strategy development.

Data Sources

Data sources include program records, interviews with program staff, and interviews with members of vulnerable or underserved populations participating in the assessment and program design.

Purpose and Issues

Most experts concur that participation in program design enhances program appeal and effectiveness. This indicator provides a qualitative measure of the extent of meaningful participation by members of vulnerable or underserved populations in the program's design. Members of these populations have meaningful participation if they have a major role in carrying out the assessment, in deriving conclusions from the assessment data gathered, and in designing the program.

APPENDIX D

COMPARISON OF THE USAID PAC CORE COMPONENTS, THE PAC CONSORTIUM'S ESSENTIAL ELEMENTS OF PAC, AND THE USAID GLOBAL AND COUNTRY RESULTS FRAMEWORKS AND INDICATORS

Comparison of the USAID PAC Core Components, the PAC Consortium's Essential Elements of PAC, and the USAID Global and Country Results Frameworks and Indicators

In 2002, the Postabortion Care Consortium expanded the original concept of postabortion care that was first articulated by Ipas in 1991. Per the PAC Consortium, the essential elements of postabortion care are based on a continuum of care approach. These essential elements of postabortion care encompass indicators of the USAID Country Results Framework only; these elements **do not** include indicators noted in the Global Results Framework.

Indicators in the USAID Country Results Framework included in the essential elements of postabortion care include IRs 1.2, 1.3, 1.4, and IR 3. The core components of postabortion care as articulated by USAID include all the elements of the PAC Consortium's essential elements. A comparison of the models is shown in the following table.

	PAC Consortium Essential Element 1 Community and service provider partnerships	**PAC Consortium Essential Element 2** Counseling	**PAC Consortium Essential Element 3** Treatment of incomplete and unsafe abortion	**PAC Consortium Essential Element 4** Contraceptive and family planning services	**PAC Consortium Essential Element 5** Reproductive and other health services
USAID Core Component 1 Emergency treatment		**x**	**x**		
USAID Core Component 2 Family planning counseling and service delivery; evaluation and treatment for STI; and counseling or referral for HIV/AIDs counseling and testing		**x**		**x**	**x** (Services limited to evaluation and treatment for STI and counseling and/or referral for HIV counseling and testing)
USAID Core Component 3 Community empowerment through community awareness and mobilization	**x**	**x**			

APPENDIX E

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REFERENCES

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