

Essential Elements of Postabortion Care: Origins, Evolution and Future Directions

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Complications from spontaneous abortions and unsafely induced abortions pose a serious global threat to women's health and lives. An estimated 46 million induced abortions are performed annually;¹ about 20 million are unsafe, and 95% of these take place in the developing world.² Unsafe abortion accounts for an estimated 13% of pregnancy-related deaths³—representing approximately 67,000 women⁴—every year. In many other cases, unsafe abortion causes such long-term consequences as chronic pain, pelvic inflammatory disease, tubal occlusion and secondary infertility.⁵ Hospital records from developing countries suggest that 38–68% of women treated for complications of abortion are younger than 20;⁶ while these data suggest that abortion complications take a high toll on adolescents, they represent only young women who make it to a hospital for treatment. The World Health Organization (WHO) estimates that 10–50% of women who have an unsafe abortion need medical care;⁷ some women who experience spontaneous abortion also need treatment.

The tragedy of unsafe abortion—which WHO defines as “any procedure for terminating an unwanted pregnancy [carried out] either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both”—is that it is the most easily prevented cause of maternal death.⁸ Unmet need for acceptable contraceptive services results in large numbers of unwanted or unintended pregnancies. With one in four women living in countries where abortion is forbidden or allowed only to save a woman's life,⁹ safe and legal abortion services are out of reach for many women with an unwanted pregnancy.

Some barriers to addressing unsafe abortion and related maternal morbidity have been reduced or eliminated over the last several decades—for example, some laws restricting access to contraception have been lifted or liberalized.¹⁰ Other barriers, however, remain; these include limited resources, restrictions on midlevel providers' performance of uterine evacuation and political sensitivities about abortion-related issues.¹¹ Although modern contraceptives have become increasingly accessible, use remains low in many countries. An estimated 120–165 million women, including 12–15 million unmarried women, want to prevent or space their pregnancies but are not using a method;¹² many resort to unsafe abortion. Even if all contraceptive users were to use methods perfectly all the time, nearly six million unintended pregnancies would occur annually.¹³

While most health systems provide treatment for abortion complications as part of emergency obstetric care, the infrastructure to make these services widely available usu-

ally is lacking in developing countries. Policies that prohibit midlevel providers from offering treatment for abortion complications result in reduced services. Global initiatives with the potential to address unsafe abortion as a preventable cause of maternal mortality—specifically, the Safe Motherhood Initiative, launched in 1987—have been hindered by the perception that unsafe abortion is not a “core” safe motherhood issue (because it is the result of an unwanted pregnancy and is not related to childbirth), and by social and political sensitivities regarding abortion.¹⁴

In this comment, we chronicle the development and expansion of a postabortion care model designed to promote interventions that address abortion-related public health concerns even when abortion laws and policies are restrictive. We review years of program experience with the original model, which led to the development of an expanded and updated model, Essential Elements of Postabortion Care (PAC). Implementing the model challenges global public health leaders, donors, technical assistance agencies and ministries of health to work with communities to ensure that all women who want to prevent or space pregnancies can obtain contraceptive services; that all women have access to services to manage complications from abortion, whether induced or spontaneous; and that all women receiving treatment also receive counseling and the reproductive and other health services they need at the treatment visit, as well as follow-up care and contraceptive resupply.

ORIGINS OF POSTABORTION CARE

Since the 1950s, many developed and some developing countries have liberalized their abortion laws, although this trend is not much evident in Africa or Latin America. Arguments for legal reform usually center on public health concerns such as reducing maternal mortality and improving reproductive health, as well as on the recognition of reproductive rights as an essential element of human rights. The political situation and commitment of advocacy groups in each country largely determine the success of liberalization efforts.¹⁵ However, the Helms Amendment has prohibited the direct use of U.S. foreign aid for most abortion-related activities since 1973. At the 1984 International Conference on Population in Mexico City, the U.S. government further restricted population funding: Under the “Mexico City policy,” foreign nongovernmental organizations that used their own funds to perform abortion (in cases other than those in which the pregnancy threatened the woman's life or resulted from rape or incest), to

provide counseling and referral for abortion, or to lobby to make abortion legal or more available could no longer receive family planning support from the U.S. Agency for International Development (USAID).¹⁶ That policy was lifted in 1993, under the Clinton administration, but was reinstated in 2001 under the Bush administration.

As clarified by a presidential memorandum in 2001, the policy does not prohibit support for “treatment of injuries or illnesses caused by legal or illegal abortions, for example, post-abortion care.”¹⁷ However, with widespread restrictive abortion policies, a new language and a new strategy were needed to enable agencies to implement programs and conduct operations research on abortion-related treatment and related reproductive health services.

The term “postabortion care” was first articulated as a critical element of women’s health initiatives in Ipas’s 1991 strategic planning document, which encouraged “the integration of postabortion care and family planning services in health care systems” as a means of breaking the cycle of repeat unwanted pregnancy and improving the overall health status of women in the developing world.¹⁸ In 1991, Ipas listed postabortion family planning and other reproductive health care as essential elements of a framework for providing quality abortion care,¹⁹ based on Bruce’s quality of care framework;²⁰ in 1998, Ipas and PRIME published a framework for quality of postabortion care.²¹

In 1993, AVSC International (now EngenderHealth), Ipas, the International Planned Parenthood Federation (IPPF), the JHPIEGO Corp. and Pathfinder International formed the Postabortion Care Consortium²² to educate the reproductive health community about the consequences of unsafe abortion and promote postabortion care as an effective public health strategy. In 1994, Ipas published the original postabortion care model, which comprised three elements: emergency treatment services for complications of spontaneous or unsafely induced abortion; postabortion family planning counseling and services; and links between emergency abortion treatment services and comprehensive reproductive health care.²³

The original model presented postabortion treatment as an essential emergency obstetric service. Health systems often relied on resource-intensive uterine evacuation methods, such as sharp curettage (also known as dilation and curettage, or D&C), that prevented them from offering services at every health care level. To reduce barriers to treatment for women, services needed to be high-quality, locally accessible and sustainable by the health care system. Vacuum aspiration has a typical effectiveness rate of more than 98% and, compared with sharp curettage, is associated with lower rates of the four most common uterine evacuation complications. In 1991, a WHO technical working group identified vacuum aspiration as an essential element of care at the first referral level (i.e., at sites to which primary-level providers refer women needing treatment for abortion complications).²⁴ Electric vacuum and manual vacuum aspiration have equivalent effectiveness rates.²⁵ Manual vacuum aspiration, an accessible and low-cost method, enables

midlevel providers and other health professionals in primary-level facilities that do not have operating theaters, general anesthesia or electricity to offer uterine evacuation on-site. Offering uterine evacuation at primary-level facilities also creates an opportunity for providers (often the same ones who perform uterine evacuation) to offer reproductive and other health services at the treatment visit.

Second, the model emphasized the need for postabortion family planning services. A working group at a pivotal 1993 conference in Bellagio, Italy, recommended that “a range of contraceptive methods, accurate information, sensitive counseling and referral for ongoing care should be made available and accessible to all women who have undergone abortion.” The group further recommended that “at a minimum, women should leave abortion-care facilities understanding their immediate return to fertility, that there are ways to prevent future unwanted pregnancies and where to obtain contraceptive methods, if they so desire.”²⁶ Research has since demonstrated the benefits of contraceptive services in preventing abortion.²⁷

The third element of the model linked emergency abortion treatment and comprehensive reproductive health services. In many developing countries, a woman’s first or only contact with the formal health care system may be when she visits a facility for postabortion care. That visit creates an opportunity for providers to assess her health needs and to offer appropriate reproductive health or other services.²⁸

Through the 1990s, international conferences and organizations increasingly began to press population, safe motherhood and women’s health initiatives to support women’s right to postabortion care. The 1994 International Conference on Population and Development (ICPD) Programme of Action urged all governments and organizations to “strengthen their commitment to women’s health” and “deal with the health impact of unsafe abortion as a major public health concern” (para. 8.25).^{*} The Fourth World Conference on Women, held in 1995 in Beijing, recognized that “unsafe abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and youngest who take the highest risk,” and referred to the ICPD Programme of Action for solutions.²⁹ IPPF and the International Federation of Gynecology and Obstetrics defined women’s rights related to sexual and reproductive health in 1995 and 1997, respectively.³⁰ In 1996, the International Confederation of Midwives passed a resolution promoting the participation of midwives in the provision of postabortion care services.³¹ The 1999 ICPD +5 Conference Programme of Action strengthened the call to “recognize and deal with the health impact of unsafe abortion as a major public-health concern by reducing the number of unwanted pregnancies through the provision of family planning counselling, information

^{*}The Programme further specified that “in circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion” and “post-abortion counselling, education and family-planning services should be offered promptly.”

and services and by ensuring that health services are able to manage the complications of unsafe abortion.”³²

Significantly, even though the Bush administration reinstated the Mexico City policy, the policy explicitly permits the continuation of postabortion care programs.³³ Nonetheless, integrating postabortion care into global and national programs has been a slow process.

EXPERIENCE WITH THE ORIGINAL MODEL

As postabortion care gained global support, governments and agencies began to implement programs; a USAID evaluation in 2001 confirmed that more than 40 countries had postabortion activities.³⁴ During the middle and late 1990s, programs following the original model focused mainly on introducing manual vacuum aspiration at tertiary-level facilities and strengthening linkages between treatment and family planning services. Results from a study in Kenya showed that the most effective approach to integration in a hospital setting was for staff to provide family planning on the gynecologic ward.³⁵ A 1997 *Population Reports* provided recommendations for postabortion care service improvements and expansion beyond hospital facilities.³⁶ Although an increasing number of tertiary facilities were offering services, only a small proportion of women who experienced complications from unsafe or incomplete abortion were finding their way to hospitals for treatment and postabortion family planning services. Operations research from several countries contributed significantly to increased momentum for decentralized postabortion services.³⁷

To expand access, some ministries of health authorized midwives and other providers at primary-level facilities to offer postabortion care services, including treatment with manual vacuum aspiration. In many cases, this occurred once services at tertiary and other hospital facilities were functional and could accept referrals for abortion complications that could not be managed by primary-level providers. In the late 1990s, with funding from USAID and assistance from cooperating agencies, the governments of Ghana, Kenya and Uganda demonstrated that midwives in primary-level facilities could provide high-quality postabortion care services using manual vacuum aspiration and that primary-level services increased postabortion family planning counseling and method provision.³⁸

The momentum created by project results, together with revised country-level reproductive health service policies and standards supporting postabortion care by mid- and primary-level providers,³⁹ led to the expanded availability of services. Results from a study with private-sector nurse-midwives in Kenya,⁴⁰ as well as anecdotal evidence from a pilot project in Uganda,⁴¹ illustrated that additional health services should be offered or were being offered to women following the provision of treatment and contraceptive ser-

*The organizations whose representatives actively participated in the task force were IntraHealth, Ipas, the JHPIEGO Corp., Pacific Institute for Women's Health, Pathfinder International and USAID/Washington. Originally intending only to add an element on community, the task force responded in 2001 to requests to add counseling as a separate element.

Essential Elements of Postabortion Care

Community and service provider partnerships

- Prevent unwanted pregnancies and unsafe abortion
- Mobilize resources to help women receive appropriate and timely care for complications of abortion
- Ensure that health services reflect and meet community expectations and needs

Counseling

- Identify and respond to women's emotional and physical health needs and other concerns

Treatment

- Treat incomplete and unsafe abortion and potentially life-threatening complications

Family planning and contraceptive services

- Help women practice birthspacing or prevent an unwanted pregnancy

Reproductive and other health services

- Preferably provide on-site, or via referrals to other accessible facilities in provider's network

Source: Postabortion Care Consortium Community Task Force, *Essential Elements of Postabortion Care: an expanded and updated model, PAC in Action*, 2002, No. 2, Special Supplement.

vices. During this time, several other agencies and countries independently added to their postabortion care model a reproductive health counseling element to support women in resolving issues related to abortion and a community element to promote education for community members, reduce the need for abortion and improve reproductive health.⁴² These well-documented efforts prompted further expansion of service delivery into primary health care facilities and communities, and increased support for prevention-oriented postabortion care activities. Results from the USAID global evaluation of postabortion care reinforced this momentum. Inspired by the trend toward more comprehensive postabortion care services, in June 2000, PAC Consortium participants formed a task force* to initiate an update and expansion of the original postabortion care model.

ESSENTIAL ELEMENTS OF PAC MODEL

The Essential Elements of PAC model, endorsed by the PAC Consortium in May 2002, reflects, from both a provider and a consumer perspective, an enhanced vision of high-quality, sustainable services. The model's five elements (see box) shift the focus from facility-based medical treatment to a public health approach that responds to women's broader sexual and reproductive health needs.

Community and Service Provider Partnerships

This element of the model recognizes community members' vital role in treatment, prevention and advocacy efforts. Community health education and mobilization have been identified as key strategies to combat unsafe abortion, increase access to and quality of postabortion care programs, and improve women's reproductive health and lives.⁴³ To achieve universal local access to sustainable, high-quality postabortion care and related health services, community leaders and advocacy groups, lay health workers, traditional

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healers and formally trained service providers must work in partnership. Components of this partnership include the following:

- education to increase contraceptive use and thereby help women prevent unwanted pregnancy, space births and reduce unsafe abortion;
- participation by community members in decisions about availability, accessibility and cost of services;
- education about obstetric emergencies and appropriate care-seeking behaviors;
- mobilization of community resources, including transportation, to ensure that women experiencing obstetric emergencies receive timely care;
- access to services for special populations of women, including adolescents, women with HIV or AIDS, women who have experienced violence or genital cutting, women who have sex with women, refugees, commercial sex workers, and women with cognitive or physical disabilities;
- advocacy for holistic, human rights–based reproductive health policies and services that meet community expectations, priorities and needs; and
- planning for sustainability.

Counseling

Effective counseling enhances a woman's understanding of the psychosocial circumstances surrounding her reproductive past and future, and increases her confidence in her ability to participate in her health care. Client-centered counseling ensures that women, rather than their providers, make voluntary choices about their treatment, contraceptive methods and other options. Postabortion care counseling covers more than fertility and contraception—although it must emphasize these elements—and consists of more than information provision and sensitive communication. This counseling provides an opportunity to help women explore their feelings about their abortion, assess their coping abilities, manage anxiety and make informed decisions.

Counseling is a vital element of care, moving postabortion services from being purely curative to being preventive. It helps providers determine when women need special care because of extreme emotional distress or circumstances such as young age, inexperience with the health care system or fear of discrimination. Some expected benefits of counseling are that client-provider interactions will be more respectful, treatment will be less painful and more effective, women's understanding and use of other health services will increase, their satisfaction with the health care encounter will rise and health outcomes will improve. The aims of counseling are to

- solicit and affirm women's feelings and provide emotional support throughout the postabortion care visit;
- ensure that women receive accurate and appropriate information about their medical conditions, test results, treatment and pain management options, and follow-up care;
- ensure that women understand how to prevent complications after the procedure and that they know when and

where to seek care for complications if they arise;

- help women clarify their thoughts and decisions about pregnancy, abortion, treatment, resumption of ovulation and future reproductive health; and
- enable providers, by listening to and asking questions of women, to better understand and respond to factors that can affect a woman's health care needs, such as experiences with sexually transmitted infections (including HIV), violence-induced trauma or the effects of female genital cutting.

Treatment

The first element of the original model and the focus of many postabortion care activities, treatment remains a critical part of care, because women who have had an incomplete spontaneous or unsafely induced abortion will, in many cases, need uterine evacuation and other medical intervention. The revised model includes language recognizing that postabortion care does not always involve complications, and that complications are not always life-threatening but may be in the absence of swift and appropriate medical attention. It further recognizes that safe, effective treatment involves the use of vacuum aspiration wherever possible and includes standard infection prevention precautions, informed consent, appropriate pain management, sensitive physical and verbal patient contact, and follow-up care.

Family Planning and Contraceptive Services

The revised postabortion care model recognizes that some women receiving postabortion treatment need family planning services to help them space births, while others need contraceptive services because they have no plans to conceive. Therefore the model emphasizes the importance of overcoming barriers to offering family planning and contraceptive services during the same visit and at the same location as postabortion treatment. When a facility does not provide these services at the time of abortion-related treatment, the opportunity to provide them may be lost. Women may not make another visit, to that facility or another, for such services. In addition, if the facility is not the one that a woman would go to for resupply of her method, or if it does not have her method of choice, providers need to link her to a referral site. Ideally, the woman would leave the treatment facility with an interim method to use until she obtains her preferred method at a referral site. For this to happen, facilities' contraceptive service infrastructure must be adequate, and providers must be knowledgeable about which methods are appropriate for women following treatment.

Making a wide range of birthspacing practices and contraceptive methods—including, where authorized, emergency contraception—available to all women of reproductive age is an effective strategy for preventing unwanted pregnancies and unsafe abortion, and for helping women achieve their reproductive desires. Facilities must ensure that treatment is not contingent upon women's acceptance of a contraceptive method.

Reproductive and Other Health Services

An important relationship in the new model is between effective counseling and increased use of the reproductive and other health services women want. The model encourages the provision of all appropriate health services at the time women receive postabortion care, preferably at the same facility. When a facility is unable to provide needed services, it should have functional mechanisms in place for making referrals (either within the facility or to another one), receiving feedback from referral sites or providers, and performing follow-up; such mechanisms should include consistent and accurate record-keeping. The following additional services might be offered:

- education about the prevention of sexually transmitted infections, including HIV, as well as screening, diagnosis and treatment;
- services addressing gender-based violence, including screening, counseling and referral;
- infertility diagnosis, counseling and treatment;
- nutrition screening and education, and treatment of nutritional deficiencies;
- hygiene education; and
- screening, counseling and treatment for reproductive-related cancers.

CHALLENGES IN IMPLEMENTATION

Implementers of the Essential Elements of PAC model face some of the same obstacles that hampered both the original model and new ones. Service delivery challenges include establishing sustainable procurement and resupply mechanisms for uterine evacuation instruments, contraceptives, and essential drugs and supplies; improving contraceptive method provision, infection prevention and pain management practices; and ensuring that services are high-quality, accessible and sustainable. Another challenge is meeting the growing expectation that community partnerships and counseling can increase access to and use of reproductive health services, improve the quality of clinical interventions and even prevent health problems from occurring.

Social, religious, policy and legal restrictions on abortion and contraception continue to pose challenges to programs offering postabortion care. Advocacy will be needed to increase awareness and implementation of postabortion care in Safe Motherhood, essential emergency obstetric care and other global health initiatives. Continued advances in women's rights are necessary as opinion leaders, partners and family members persist in limiting women's contraceptive, pregnancy and childbirth choices. One of the greatest challenges will be finding creative ways to meet the increasing need for high-quality contraceptive, postabortion care and other reproductive health services in a context of stable or declining resources. As countries and organizations embrace the Essential Elements of PAC model, they will need strategies such as introducing elements of the model in prioritized order over time or altering service provider guidelines and networks to maximize the use of already overburdened and limited resources.

FUTURE DIRECTIONS

The PAC Consortium will reach out to global partner organizations to share best practices for expanding postabortion care activities to include the five essential elements. As programs based on the Essential Elements of PAC model are designed, implemented and evaluated, and our understanding of high-quality, sustainable services is further informed, further revisions to the model are likely. In communities implementing the model, we can expect to see increased use of reproductive health and postabortion care services; earlier emergency care-seeking behavior; increased contraceptive use; fewer unwanted pregnancies; fewer unsafe and repeat abortions; and, most likely, fewer maternal deaths. Anticipated results at health care facilities include increased quality and use of contraceptive, postabortion care and other reproductive health services that respond to community needs and priorities; enhanced provider performance in meeting women's postabortion care and other health needs; and improved referral systems and follow-up mechanisms for contraceptive, postabortion care and other health services.

As health care evolves from a strictly medical to a broader public health focus, to reflect both consumer and provider perspectives and to encompass curative and preventive services, leaders and consumers should demand that women's sexual and reproductive health care be made still more comprehensive and accessible. Leaders and consumers must also continue to strengthen advocacy networks to promote women's broader health needs and concerns, and call on health systems to offer a complete range of high-quality preventive, diagnostic and treatment services linked to social and legal support systems. Implementing such a vision of comprehensive, integrated services will reduce the need for treatment of abortion complications and enable women to exercise their full sexual and reproductive rights.

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Acknowledgment

The authors thank the following people for their assistance with this article: Deborah Billings, Barbara Crane, Carolyn Curtis, Kate DeMayo, Emily Evens, Joan Healy, Ronald Magarick, David Nelson, Amy Rial, Cathy Solter, Mary Ellen Stanton and Merrill Wolf.

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