Pathfinder INTERNATIONAL

ADDRESSING *the* CONSEQUENCES *of* UNSAFE ABORTION

Insights from Pathfinder Program Experience

PATHFINDER INTERNATIONAL is a nonprofit organization that improves access to and use of quality family planning and reproductive health information and services, including STD/HIV-AIDS prevention and postpartum and postabortion care, with a focus on adolescents and young adults. Working with local organizations on three continents, Pathfinder builds their capacity to advocate for and provide quality services.

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Acronyms

AGI	Alan Guttmacher Institute
AIDS	acquired immune deficiency syndrome
COFAP	Consortium of Family Planning NGOs
D&C	dilation and curettage
DFID	British Department for International Development
ECP	emergency contraceptive pill
ESAR	Fundacion Educacion para la Salud Reproductiva
FIGO	International Federation of Gynecologists and Obstetricians
FP	family planning
FPIA	Family Planning International Assistance
HIV	human immunodeficiency virus
HRC	high risk clinic
INTRAH	Program for International Training in Health
IPPA	Indonesian Planned Parenthood Association
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
KNH	Kenyatta National Hospital
MCH	maternal and child health
MOH	Ministry of Health
MR	menstrual regulation
MSE	Marie Stopes International Ethiopia
MVA	manual vacuum aspiration
NGO	non-governmental organization
PAC	postabortion care
PATH	Program for Appropriate Technology in Health
PHS	Population and Health Services
PMH	Pumwani Maternity Hospital
PP/PA	postpartum/postabortion
RH	reproductive health
RHP	reproductive health program
SESAB	Secretaria de Saude do Estado da Bahia
STD	sexually transmitted disease
TOHS	Tanzania Occupational Health Services
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Preface

Unsafe abortion causes untold suffering to women throughout the world, despite being almost entirely preventable. It is a problem many have preferred to ignore, but one that has finally become recognized for the enormous toll it takes on women's lives, particularly poor women. Pathfinder has always believed that the key to reducing this toll is providing women with the means to control their own fertility safely. In the case of contraceptive failure, abortion should be made as safely available as possible under the law. Twenty-five years ago, when Pathfinder began working to improve the care provided to women experiencing unsafe abortion, the context was very different. Family planning programs were still new and largely inaccessible to key groups of women who needed them. It would take years of quiet support from courageous physicians and nurses at first, and then, increasingly, hospital administrators and public sector health officials, to demonstrate the critical importance of linking family planning to treatment for unsafe abortion. Today, many governments have declared a commitment to combat unsafe abortion and only need effective programs and funding to carry it out. The political challenges have diminished substantially, but tremendous programmatic challenges remain.

The ability of Pathfinder International and others to carry out this work, however, has been profoundly affected by U.S. domestic politics surrounding the issue of abortion. These effects were first felt in 1973, when the United States Congress passed the Helms Amendment which prohibited the use of U.S. foreign assistance funds "to promote abortion as a family planning method." Pathfinder complied fully with the Helms Amendment and used only private funds from individuals and foundations to support abortion-related projects, including postabortion family planning. In 1983, the U.S. Senate ordered Pathfinder to stop all abortion-related activities, maintaining that Pathfinder's work, although privately funded, violated the "spirit" of the Helms Amendment. In spite of the questionable constitutionality of this action, the threat to discontinue funding altogether led Pathfinder to cease all abortion-related projects. Pathfinder thus became the first organization to be affected by what would later become the "Mexico City Policy." The next year, U.S. Government funding was denied to any overseas non-governmental organization (NGO) that conducted abortion-related activities with private funds, under a policy articulated by representatives of the U.S. Government at the 1984 United Nations International Conference on Population in Mexico City. The Mexico City Policy had a widespread "chilling" effect on the field of family planning and reproductive health. Workers at all levels, from policy makers to medical professionals, hesitated to discuss abortion, abortion-related research, or postabortion family planning, uncertain of how even discussion would affect funding. For example, community-based service workers in Turkey, where abortion is legal, could not tell women in their communities that safe, free abortion services were available in government hospitals.

Seeking relief from the Mexico City Policy, Pathfinder initiated a lawsuit against USAID in 1987, with AVSC and the Population Council as co-plaintiffs. Although rejected in 1989, the suit led to critical clarifications of activities permitted under the Policy. USAID identified three areas where its funds could be used for abortion-related activities: demographic and health research on abortion, provision of training and equipment to treat septic and incomplete abortion, and postabortion counseling and services, including contraceptive services. Equally important, the lawsuit led to a public statement by USAID that the Mexico City Policy only prohibited U.S. organizations like Pathfinder from sub-granting USAID funds to foreign NGOs that performed or spoke about abortion, but U.S.-based organizations could use their private funds to support abortion-related projects.

The clarifications of the Mexico City Policy enabled Pathfinder and other reproductive health agencies to return to developing and improving programs. In 1993, President Clinton reversed the Policy as one of his first acts in office. Since then, Pathfinder has worked to improve care for unsafe abortion in a wide variety of settings, with a broad range of partners. Pathfinder has made particular efforts to make clear the role that postabortion family planning plays in saving lives, and to develop effective ways of institutionalizing its delivery.

There has been a high level of cooperation among U.S.-based reproductive health agencies in developing postabortion care approaches, perhaps best exemplified by the Postabortion Care Consortium that was formed in 1993, but also demonstrated through sharing operations research, programmatic experiences, and "on the ground" partnerships. In the spirit of this cooperation, Pathfinder shares its experience with efforts to prevent unsafe abortion and improve postabortion care.

Introduction

Studies show that women of all backgrounds everywhere resort to unsafe abortion despite legal codes, religious sanctions, and personal dangers. The risks attest to the depth of women's determination to control their reproductive lives. Because they have limited options, however, women, their families, and their societies pay an enormous cost for this determination.

Globally, more than one quarter of all pregnancies end in abortion, resulting in an estimated 46 million induced abortions every year. Despite its pervasiveness, the experience of many women who undergo induced abortion has not improved over time; they still face a risk of death from the procedure that is hundreds of times higher than that for women in developed countries.[1] Legal, safe, induced abortions carry few risks, but approximately half of all induced abortions are performed in unsafe conditions, causing the deaths of 78,000 women each year.[2] For each woman who dies from unsafe abortion, several others suffer lifelong disability and pain or elevated risks of complication in future pregnancies. Poor women and young women suffer especially since they often have few options other than to attempt the procedure themselves or turn to untrained providers who use methods that can cause bleeding, sepsis, infection, hemorrhage, or damage to the uterus, cervix, and bladder.[3] Women living in rural areas, even where abortion is legal, have particular difficulty finding and paying for safe services. An estimated one in every three to five women who has experienced an unsafe induced abortion requires hospitalization. Miscarriage, or spontaneous abortion, occurs in 15 percent of pregnancies worldwide and also typically requires hospitalization.

In most cases, women die or suffer disability from unsafe, induced abortions because they do not receive medical treatment for their complications soon enough.[4] Women themselves may delay treatment because they are scared or unable to travel to a facility where care is provided. Once in a facility, care may be delayed because staff are overworked and may have ambivalent or punitive attitudes toward postabortion patients, and because standard treatment protocols for postabortion care are lacking. After receiving emergency postabortion treatment, most women leave the hospital or clinic without being counseled about and provided with contraception, leaving them to face the same risks again.

[1] Alan Guttmacher Institute (AGI). 1998. *Sharing responsibility: Women, society, and abortion worldwide*. New York: AGI.

[2] Ibid.

[3] World Health Organization (WHO). 1994. Long-term complications of unsafe abortion include chronic pelvic pain, pelvic inflammatory disease, incontinence, tubal blockage, ectopic pregnancy, infertility, and increased risk of spontaneous abortion in subsequent pregnancies. *Clinical management of abortion complications: A practical guide*. Geneva: WHO.

[4] Salter, C., H.B. Johnston, and N. Hengen. 1997. Care for postabortion complications: Saving women's lives. *Population Reports*. Series L. 25:8.

While the immediate factors causing women to choose the option of induced abortion vary, it has become indisputable that access to and knowledge about contraception is essential to reducing the rate of abortion. An estimated 120 million couples in developing countries want to prevent or delay having children but do not use contraception because they lack knowledge about or access to it. Millions more either use family planning methods of limited reliability or use methods incorrectly. By helping women and couples prevent unintended pregnancies, family planning reduces women's reliance on abortion. Providing contraception to women who have just experienced an abortion helps them to avoid another unwanted pregnancy.

Richard Lord

Despite growing recognition that unsafe abortion is a major health concern, governments around the world have been slow to take concrete steps to address it. Many have liberalized restrictive abortion laws, but this has been insufficient to reduce the maternal mortality and morbidity rates associated with unsafe abortion.[5] In some countries, deeply held social and religious norms silence discussion of the topic and chill the political will to intervene. In others, these norms are held by policymakers and providers themselves. But this situation has been changing. Recent world conferences have provided an opening for action by specifically placing care for unsafe abortion within the context of public health and women's human rights. Mounting research and programmatic experience is demonstrating that significant health and financial costs can be avoided through a range of policies and programs. As a result, many governments, health care providers, and administrators have become more open to making improvements in the delivery of care for postabortion complications.

Pathfinder works with governments, private agencies, and non-governmental organizations to improve the quality of care for women who suffer from the complications of unsafe abortions and to provide comprehensive contraceptive counseling and services aimed at reducing the number of unintended pregnancies. To meet these objectives, Pathfinder provides funding for programs, as well as technical assistance in clinical and counseling training, research and evaluation, and institutional develop-

[5] Between 1988 and 1998, 26 countries "extended grounds for legal abortion," while four implemented more restrictive policies. From Cook, R., B. Dickens, and L. Bliss. 1999. International developments in abortion law from 1988 to 1998. *American J. of Public Health*. 89 (April):579.

ment to implementing partner organizations. These organizations include hospitals, private clinics, ministries of health, community organizations, medical schools, and professional medical societies.

This report presents a review of Pathfinder's efforts to address the consequences of unsafe abortion around the world. It is intended to provide a broad picture of the range of programs undertaken, how they evolved, what their effects have been, and what has been learned from them.

Early Pathfinder Efforts to Address Unsafe Abortion

Early Projects

Pathfinder has been concerned about the serious health consequences of unsafe abortion since it was founded in 1957. At first it worked to prevent unintended pregnancy by increasing the availability of family planning services around the world. In the late 1970s, Pathfinder began to carry out specific projects to mitigate the effects of unsafe abortion. These early projects provided support to fledgling efforts of reproductive health organizations and individual physicians in several countries. In Bangladesh, Pathfinder supported clinical training for physicians and midwives in menstrual regulation (MR) techniques,[6] laying the groundwork for what later became a well-established government program. Pathfinder also provided training and equipment to physicians from several Latin American countries, enabling them to begin treating the complications of unsafe induced abortion with the most current techniques. This support was important because few international agencies were then involved in reducing the effects of unsafe abortion. At the same time, many of the providers Pathfinder supported were pioneering these services in their countries, and doing so at personal risk because their work could be misinterpreted.

By the early 1980s, Pathfinder's work on the consequences of unsafe abortion included projects in Asia, Africa, and Latin America. The projects emphasized training physicians, nurses, and midwives in techniques to improve the treatment of incomplete abortions and to provide postabortion family planning. Pathfinder also supported policy initiatives, safe abortion services, and MR in countries where these were legal. Other projects carried out research on the incidence of abortion, promoted public discussion on abortion legislation, and provided supplies and equipment to clinics. To supplement its clinical training work, Pathfinder produced a series of training manuals and audiovisual materials. After a gap of seven years during which Pathfinder was prohibited from supporting abortion-related projects as a result of the US Mexico City Policy, Pathfinder in 1990 resumed support for programs to address unsafe abortion.

[6] Menstrual regulation (MR) is the practice of "bringing on" delayed menstruation when a woman misses her period by a maximum of 14 days and when pregnancy is not confirmed. The procedure is most commonly performed using vacuum aspiration, although medical methods are becoming available in some countries. MR is not generally considered to be a type of abortion and therefore does not conflict with abortion laws in many countries. MR is legal in all countries where abortion is legal, and is also permitted in several others where abortion is illegal, such as Bangladesh, Uganda, and Ethiopia.

The Evolution of Global Postabortion Care Efforts

Pathfinder's formulation of postabortion interventions evolved together with its involvement in the Postabortion Care Consortium,[7] which held its first meeting at Pathfinder's office in 1993. As an essential step in addressing the consequences of unsafe abortion, the Consortium developed the concept of "postabortion care," which defined critical abortion-related interventions, distinct from abortion procedures.[8] By making this distinction, the Consortium provided a framework for designing programs that would have maximum impact on maternal deaths, while bypassing the political stalemate surrounding abortion itself.

Since 1993, the concept of postabortion care has gained importance in the field of reproductive health, and the number of postabortion care projects has expanded rapidly. Accompanying this expansion has been the publication of several important manuals, references, and studies on postabortion care. In 1995, the Postabortion Care Consortium published *Postabortion Care: A Reference Manual for Improving Quality of Care* to increase awareness of the consequences of unsafe abortion and to provide medical practitioners with up-to-date information on the emergency treatment of abortion complications and the provision of postabortion family planning. In 1997, the World Health Organization produced *Post-Abortion Family Planning: A Practical Guide for Programme Managers*. These and similar publications established standards for safe, high quality, and comprehensive postabortion care and drew attention to postabortion care as an important, emerging area of reproductive health. In 1998, Pathfinder published *Postpartum and Postabortion Contraception,* a training module for providers on the combined topic, within its *Comprehensive Reproductive Health and Family Planning Training Curriculum.* In 1999, it completed and began testing a module on manual vacuum aspiration (MVA).

[7] The Postabortion Care Consortium seeks to promote the concept of postabortion care, develop and implement strategies for improving postabortion care, share information, expand funding from USAID and other donors, and promote compassionate attitudes toward postabortion patients. Its members include Pathfinder International, Ipas, AVSC International, IPPF, JHPIEGO, Family Care International, Pacific Institute for Women's Health, The Population Council, USAID, PATH, INTRAH, FPIA, Center for Policy Studies, Population Action International, and the Packard Foundation.

[8] The elements of postabortion care were defined as: emergency treatment for incomplete abortions, the provision of family planning counseling and services, and linkages to ongoing reproductive health care.

Current Efforts to Address Unsafe Abortion

Since 1993, Pathfinder's efforts to address unsafe abortion have been guided by a strategy that encompasses the elements of postabortion care (PAC) while taking a broader approach to the issue. Pathfinder works to reduce the maternal health toll caused by unsafe abortion by:

- Improving the ability of health care providers to manage and treat complications of incomplete abortion;
- Strengthening postabortion contraceptive counseling and services;
- Reducing the reliance on abortion in countries where it is legal; and
- Supporting informed policies on unsafe abortion.

The institutional, cultural, and legal contexts in which Pathfinder carries out this work vary considerably; Pathfinder's local approaches are tailored accordingly. Some projects focus on introducing, improving, and/or institutionalizing postabortion care, such as in Bolivia, Peru, Ecuador, Haiti, Tanzania, Ethiopia, and Uganda. Other projects combine postabortion and postpartum interventions, including those in Peru, Brazil, and Kenya. In other contexts, particularly where abortion is legal, such as in Viet Nam, Kazakhstan, and Azerbaijan, postabortion initiatives are part of efforts to improve the quality of comprehensive reproductive health care.

Underlying all of Pathfinder's postabortion care projects, however, is a desire to make care safer and more responsive to the needs of women. Pathfinder's operational approach to postabortion care is flexible and addresses improvements in care on the levels of the patient, the provider, and the facility. At the same time, Pathfinder supports long-term improvements in the way unsafe abortion is addressed by providing the information necessary for well-informed debate and policy. Pathfinder support includes training, monitoring, upgrading facilities, developing training materials and service delivery guidelines, and providing equipment and supplies.

What follows is a description of Pathfinder's postabortion care projects by component. While components are often carried out together within programs, this report discusses them individually in order to separate and examine issues related to each more closely.

Training

Betty Press

Training, followed by regular on-site coaching and monitoring, is an essential component of all postabortion care projects. Pathfinder programs train a range of providers, including physicians, nurses, midwives, and social workers in both clinical and counseling skills, and in both pre-service and in-service settings. The training increases providers knowledge and skills but also aims to help them understand the emotional state of postabortion patients so that their care is more sympathetic. Training topics include contraceptive technology, family planning services and counseling, pain management, the use of MVA, and infection prevention. Training activities include competency-based sessions, workshops, seminars, contraceptive technology updates, and updated guidelines and training curricula. Pre-service training is broadly interpreted to include residents in training at the facilities where PAC is being provided as well as medical and nursing students being introduced to the concept early in their training.

Improving the Treatment of Incomplete Abortion Complications

Most care for abortion complications takes place in the overburdened emergency and gynecology wards of public sector hospitals and is of limited quality in many ways. These include long waiting times to either be examined or receive treatment, lack of privacy, insufficient control of pain, inadequate infection prevention, and the use of dilation and curettage, an older, longer, and less safe technique in the first trimester than MVA. Communication between provider and patient is usually poor, with little or no information provided to the patient about the procedure itself and what to expect in terms of recuperation. In addition, where abortion is illegal, patients are often treated harshly; it is not uncommon for them to be made to "confess" the origin of their abortion, be charged more, or even be arrested if they are suspected of having induced it. Adolescents and unmarried women also are sometimes singled out for poor treatment.

Global efforts to improve the quality of treatment for abortion complications range from focusing on a single aspect of services, such as introducing the use of the MVA technique, to aiming for holistic treatment of the patient. The broader end of this spectrum involves improving technical competency through new surgical procedures, infection prevention practices, and better pain management, as well as improving interpersonal communication between all levels of staff and the patient.[9] Pathfinder works in a variety of ways to reorient services in this direction. It is a process that requires not only training providers and staff, but working with administrators to improve the organization of services and overcome the short-term burdens providers and staff may experience.

The MVA technique for treating incomplete or septic abortion is faster, simpler, and more cost-effective than conventional dilation and curettage (D&C).[10] It is also safer during the first trimester of pregnancy, less painful for patients, and less frequently associated with complications than D&C. MVA can be performed under local anesthetic, which allows providers to talk to patients during the procedure. This communication, which is sometimes called "verbal anesthesia," helps alleviate anxiety, manage pain, and build rapport between patients and medical staff, which in turn facilitates the provision of family planning counseling and services. The use of MVA with local anesthetic also speeds recovery time and allows incomplete abortion to be treated on an outpatient basis. In short, replacing D&C with MVA can drive many improvements in care, particularly with respect to provider-client interaction.

[9] Population Council. 1998. *Advances and challenges in postabortion care operations research: Summary report of a global meeting*. New York: Population Council.

[10] MVA is not indicated for certain cases of complicated incomplete abortion.

Some important improvements in postabortion care, however, can be achieved without (or before) the adoption of MVA. Proper infection prevention, including hand washing, wearing appropriate attire, and correctly processing reusable instruments significantly improve the safety of care. These simple practices, which can be followed in any level of health facility, are a critical part of provider training in postabortion care and have obvious spillover benefits to other kinds of care. Support staff, including those involved in cleaning, distributing food to patients, and disposing of waste also require clear guidance on infection prevention. Some programs have developed short and easy-to-follow curricula for support staff. For the MVA procedure itself, the "no-touch" technique, which prevents contact between the part of an instrument that enters the uterine cavity and potentially contaminated surfaces such as gloves, the examination table, or unsterile areas of the instrument tray, is recommended. Although basic, these practices often need to be reinforced after training during subsequent observation periods. Lapses are commonly due both to provider and staff error, as well as deficiencies in supplies or equipment.

Another basic improvement is better interpersonal communication throughout postabortion treatment, which has been shown to have many benefits. In public hospitals in Mexico, for example, a program that improved the quality and quantity of information given by staff, as well as the empathy displayed toward patients, put patients at ease, helped reduce their experience of pain, and even increased the likelihood that they accepted a postabortion contraceptive method.[11] Research also suggests that clients' key criteria for determining service quality is the counseling they receive. In Bolivia, where a pilot postabortion care program emphasized improved counseling and provider attitudes, clients nearly always evaluated "warm and compassionate" providers as excellent.[12]

However, because of the sensitive nature of the subject, improving communication in postabortion care can be complicated. In addition to improving their interpersonal skills, providers must learn to recognize and overcome biases that may affect their care giving. This can sometimes involve challenging deeply held beliefs, and in this sense, training to improve communication in postabortion care is unlike most other training medical providers receive. For example, providers often say that puni-

[11] Fuentes Velasquez, J., D. Billings, and J. A. C. Perez. 1998. *Women's experience of pain during the postabortion period in Mexico*. New York: Presented at the Global Meeting on Postabortion Care Operations Research.

[12] Diaz, J. et al. 1999. Improving the quality of services and contraceptive acceptance in the postabortion period in three public-sector hospitals in Bolivia. *Postabortion care: Lessons from operations research*. eds D. Huntington and N. J. Piet-Pelon. New York: Population Council.

Transforming Attitudes

Transforming the attitudes of providers towards their postabortion clients can be a delicate matter. Two elements of Pathfinder training help to ensure success. First, while most PAC training covers the issue of maternal mortality, Pathfinder finds it essential to have a session on unwanted pregnancy and its impact on women. In a participatory session, providers discuss a range of possible scenarios that may lead women to the conditions that they arrive at the hospital or clinic in, including rape, incest, economic hardship, or partner abandonment. This helps providers understand what their clients may be going through. Second, nurses and midwives who will be providing counseling and communicating most with clients take part in a session that uses psychotherapy techniques to explore their own feelings about induced abortion. Every participant verbalizes his or her own feelings and discusses the importance of separating these feelings from the care they provide.

An evaluation of postabortion care training for public hospital providers in Peru found that after the training, 90 percent of the trainees had changed their attitude toward providing postabortion care, and perhaps more importantly, toward the women receiving that care. Sixty-four percent of providers observed tried to make their patients feel secure and confident, and 36 percent had more contact with patients and their families. These changes resulted in care that was more humane.[13]

tive treatment of patients is a justifiable way to dissuade them from seeking future abortions. By helping providers to understand what their patients may be feeling, effective training can transform negative attitudes, and can do so without making providers feel defensive about their care. For some providers, training doesn't change attitudes, but instead enables them to express feelings they held but didn't feel com-

[13] Ferrando, D. 1998. *Improving the comprehensive care of incomplete abortion in Peru: Evaluation of training.* Watertown, MA: Pathfinder International. Note: These self-reported changes in the quality of interaction between providers and patients were observed by evaluators and corroborated in interviews with patients.

fortable expressing. Several nurses trained in Pathfinder's postabortion program in Peru said that the training had created an atmosphere in which they were no longer reluctant to display empathy toward patients.[14]

Clients also benefit when providers communicate with them throughout their stay at the clinic or hospital, including before, during, and after their procedure. This continuous communication should involve physicians, nurses, and when available, social workers or midwives. Other staff, such as doormen or guards, receptionists, and cleaning personnel, often need to be sensitized as well. To facilitate this kind of interaction, Pathfinder's training specifically encourages different levels of providers to work as a team. This enables them to not only better communicate with patients, but to provide more coordinated and better overall care. Pathfinder's training emphasizes this team approach in two ways. First, providers learn that postabortion care is much broader than the MVA procedure, that each component of this care is equally important, and that each provider has an important role to fulfill. Second, although nurses and midwives do not carry out the MVA procedure, they take part in the MVA training alongside the physicians so that they know as much as the physicians do about the procedure and are better able to provide support to them. An indirect result of this emphasis in some instances has been that providers relate to each other more as equals and feel less bound by hospital hierarchy.

Despite the benefits of MVA, it is often not adopted by providers right away, even after they are trained to use it. Letting go of a procedure that many providers are comfortable with and have used for years often takes time. Other factors can influence this decision too. For example, physicians are sometimes cautious about adopting a new technique without the involvement of other clinical staff. An emphasis on training providers as a team helps to address this problem because providers can more easily support one another through the transition, and the roles of each (including important tasks such as cleaning and caring for MVA equipment) can be clearly defined. Besides improving the likelihood that new skills will be used, the inclusion of nurses

[14] Crosbie, C. Personal interview. Massachusetts, 7 January, 2000.

Low-Cost Teaching Aid Improves Trainee Confidence

In 1996, Dr. Miguel Gutierrez needed a way for the doctors and nurses in his postabortion care training to gain experience using the MVA technique before carrying out the procedure on patients. Anatomical models available at the time were not designed for teaching gynecological procedures, and so were inadequate. They were also expensive. In response, Gutierrez, Coordinator of the Postabortion Care Program in Pathfinder s Peru office, devised a pelvic teaching model using simple materials from a hardware store. A fraction of the cost of other pelvic models, Gutierrez model allows trainees to see the steps of the procedure, including the process of applying local anesthesia, through parts made of clear tubing. The model can be placed on a gynecological exam table at the height and angle that a physician would treat a client, giving trainees a realistic sense of performing the procedure. Since its invention, the model has been used in 20 public hospitals and four health centers involved in the joint Pathfinder/Ministry of Health postabortion care program in Peru. Each hospital keeps a model for further training. The model has also been requested for use in postabortion care programs in Bolivia, Haiti, and Ecuador, and other agencies, such as IPAS and ESAR, are now using it in Bolivia, Colombia, and Ecuador.

and midwives in PAC training increases the total number of trained providers, which ultimately increases the availability of improved postabortion care. Since nurses and midwives often predominate in the lower level and rural health facilities of some countries, training them can have a positive impact on postabortion care in those areas. Another consideration in whether providers make the transition to using MVA is the selection of trainees. Selection criteria should take into account a provider's intent to use the skills, as well as the level of need for postabortion care in his or her facility. Finally, the training itself can be a factor. For example, six months after Pathfinder's clinical postabortion care training in Peruvian public hospitals, an evaluation found that some providers hadn't begun to use the new procedure because they felt they needed more practice in it. In response, the practical part of the training was expanded so that trainees were required to perform five supervised procedures before becoming certified by the training program. Trainees were also given the opportunity to practice on a pelvic model (see box at left). These changes helped many providers feel confident enough with the new technique to offer it to their patients.

Training providers is only part of what is necessary to improve postabortion care. Poor planning and lack of support can prevent some otherwise willing providers from using new skills. MVA equipment can be unavailable (assigned to staff who keep it locked up when they are not on the premises), incomplete, or broken. Providers who have been trained can be assigned to responsibilities other than postabortion care. To avoid these obstacles and facilitate permanent changes within institutions, training needs to be part of a wider organizational process to improve or introduce postabortion care. There is a growing body of experience with this approach that aims to transform whole facilities.[15]

For hospitals or clinics considering beginning this process, Pathfinder has developed a specific self-assessment tool to serve as a guide. Based on Pathfinder's general Clinic Assessment Tool, the specialized tool allows hospital or clinic staff to evaluate the family planning, reproductive health, and obstetrical and gynecological services offered at their facility in order to gauge the resources available for postabortion care and family planning services. The tool identifies which reproductive health services need to be strengthened, which staff need to be trained in what, and what equipment needs to be provided, updated, or fixed. It also provides baseline information for assessing the quality of care and for creating a comprehensive workplan. Because staff are actively involved, they know what to expect from the program, are better prepared for potential problems, and perhaps most importantly, are more likely to be personally committed to the program's goals. All of these help a postabortion care

[15] The "whole-site" approach is a concept originated by the organization AVSC International.

program function more smoothly and become institutionalized within a facility. Hospitals in Peru, Bolivia, Ecuador, and Haiti have used the tool successfully to plan their introductions of postabortion care services.

Beyond these improvements in the quality of treatment, more can be done to reorient services. A typical problem in busy hospitals is long waits for patients. Since this can be especially problematic for women going through the trauma of an unsafe abortion, Pathfinder developed an analytical tool for assessing the path of care given at a facility, including the time spent at each step, from the perspective of a postabortion client. When this tool was used in hospitals in Peru, it revealed that resources were being misspent by admitting clients with uncomplicated incomplete abortions. Since these cases can be treated on an outpatient basis, the clients, who made up 90 percent of the incomplete abortion cases seen, were being made to wait for services that they did not require, resulting in higher costs. With the information from this analysis, hospitals can better justify and plan improvements to postabortion care, particularly from the point of view of the client.

Strengthening Postabortion Contraception

After a woman is treated for complications of an incomplete or septic abortion, her health—and even life—depend greatly on being provided with family planning counseling and a choice of contraceptive methods. Without immediate access to family planning, she is at risk of having another abortion because she can become pregnant again in as little as two weeks. In Viet Nam, a study among abortion patients at three sites revealed an average of 2.2 abortions per patient.[16] In Kenya, an evaluation of the Pathfinder-supported High-Risk Clinic in Kenyatta Hospital in Nairobi showed that among patients admitted for the treatment of abortion complications, 55 percent of those interviewed had had a previous abortion. Because of this risk, many feel that postabortion contraception provides the most important health benefit of all of the elements of PAC.

Although hospitals incur only minor additional costs by introducing postabortion family planning, few have done so successfully for several reasons. To begin with, family planning services and incomplete abortion treatment are typically delivered or administered separately—in different areas of one building, in separate buildings, or even within different institutions. Peruvian hospitals, for example, house delivery, postabortion treatment, and family planning services in separate units. In addition to separately administered services, lack of appropriate training, time, or institutional support can make physicians and nurses in the wards where patients receive abortions or postabortion care reluctant or unable to take on the duty of providing family planning services.

Despite these obstacles, postabortion family planning is often the first element of postabortion care to be introduced, and it therefore can serve as an entry point for other service components. Although starting to offer contraceptive services involves providing training and logistical assistance, it is something providers generally support.[17] Once providers see how family planning benefits their clients, they are often open to incorporating other elements of postabortion care. This process also requires working closely with hospital managers to convince them that providing family planning benefits the hospital as well as its clients. It is sometimes necessary to "appeal" to medical and administrative staff to tolerate a temporary increase in workload in return for an eventual payoff when fewer postabortion clients arrive at the hospital for treatment.

[16] Nguyen, M.T. et al. 1998. *Client perspectives on quality of contraceptive and abortion services at three sites in Viet Nam*. Hanoi, Viet Nam: Center for Population Studies and Information (Hanoi).

[17] Some providers, however, resist offering contraceptive counseling and methods because they do not want to jeopardize the income they earn from providing abortions.

In Latin America and other settings where abortion is illegal and controversial, an effective first step in eventually institutionalizing postabortion care has been to combine postpartum and postabortion interventions because postpartum care is more widely accepted. This combination benefits maternal health care in general and has the potential to significantly increase access to family planning within public sector programs. When introducing postpartum and postabortion family planning services simultaneously, however, training and other support must take into account the important clinical, social, and psychological factors that differentiate the two groups of clients. Pathfinder's experience has been that it is easy for providers to assume that since postpartum and postabortion family planning are grouped together, the care they provide for both groups of patients should be the same.

In Peru, Pathfinder worked with the Ministry of Health to introduce postpartum and postabortion family planning services in 42 public sector hospitals. With funding from USAID, 3,897 physicians and midwives received clinical training in contraceptive methods, family planning services including postpartum/postabortion intrauterine device (IUD) insertion, and infection prevention. Prior to the project, only a negligible percentage of patients received contraceptive methods. After the project ended, 52 percent of postpartum and postabortion clients left the hospital with a contraceptive method according to a 1996 evaluation. Since the training, the percentage of physicians or midwives providing postpartum or postabortion IUD insertion in the hospitals has risen from four to 90 percent. The providers also expressed that they had gained a better understanding of the importance of providing family planning to these groups of patients. The project also contributed to making family planning a routine component of postpartum and postabortion care in the hospitals involved.

Either way it is introduced, postabortion family planning must include good counseling and a choice of appropriate methods. The quality of the information a client receives can affect not only whether she accepts a method, but whether she is successful in using it. Since fertility returns so quickly after an abortion, clients need to understand both their risks of becoming pregnant again and their contraceptive options. Clients need to know what physical symptoms to expect in the days following their treatment and how to care for them, what side effects their contraceptive method may have, and where to obtain their contraceptives and other reproductive health care in the future. Whenever possible, a private room or area is designated for counseling. This, however, does not guarantee a calm exchange of questions and concerns between the patient and counselor. Postabortion patients are under consid-

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erable stress, and providers need to be specially trained to provide counseling under these circumstances. For providers used to counseling traditional family planning clients, the training must emphasize the different needs of postabortion patients.[18]

When postabortion patients are referred to other sites for contraceptives instead of being offered a method immediately, they often end up without one. Having family planning services available to postabortion patients at the site where they are treated enables them to leave with a method and gives them immediate protection from an unwanted pregnancy. For future supply and care, however, many women need to be referred to a local supplier because returning to the hospital or clinic is neither convenient nor feasible. What is important is that a client selects a method she is comfortable with. This requires counseling to reveal the client's needs and situation. For example, does she want to become pregnant again, and if so, how soon? If she has used a family planning method before, did she have any problems using it?[19] Most family planning methods can be started immediately. For traditional methods (rhythm or periodic abstinence), however, the client should wait until the resumption of menstruation. There are some medical conditions that preclude the use of certain methods, and counselors must be aware of these.

A new option that is being made available with private funds in several programs is the emergency contraceptive pill (ECP). When taken within 72 hours of unprotected intercourse, ECPs prevent pregnancy from occurring. ECPs are particularly useful for adolescents and young women for whom patterns of sexual behavior are often sporadic or unpredictable. They are also a good option for women who have experienced a sexual assault. Although ECPs are not suitable for use as a regular contraceptive method, their availability can provide an opportunity for clients to learn about regular methods. Pathfinder has trained providers to offer ECPs in conjunction with postabortion care in Kenya, Nigeria, and Ethiopia.

[18] Botsh, L., S.E. Chitsungo, and J.L. Potts. 1998. Postabortion family planning launched in Zimbabwe. *Dialogue* 3 (Oct.):–2.

[19] Rogo, K, V. Lema, and G. Rae. 1999. *Postabortion care: Policies and standards for delivering services in sub-Saharan Africa.* Chapel Hill, NC: IPAS.

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Unsafe Abortion and Young Women

In 1991, staff in Nairobi s busy Kenyatta National Hospital (KNH) noticed that nearly a third of the young women who were treated in KNH s emergency gynecological ward for incomplete abortion returned within a year requiring the same treatment. This observation set in motion an unprecedented effort to address one of the biggest yet most often ignored health risks facing young women. Although it is illegal and unsafe in Kenya, abortion is nevertheless an option for growing numbers of young women. Hospital studies show that teenagers account for between 30 and 80 percent of abortion complications in sub-Saharan Africa. In recent years, young Kenyan women, like their counterparts in many other developing countries, are marrying later, and as a result, experiencing more sex before marriage. Many adolescents choose to become sexually active, but others are coerced or forced, either physically or because of economic need.[20] Since they often have limited knowledge of or access to contraception, many are faced with unwanted pregnancies.

Young women are particularly vulnerable to the consequences of unsafe abortion. They are more likely than older, married women to seek abortions from untrained providers and to attempt dangerous, late, and often self-induced abortions.[21] Young women are also more likely to delay seeking medical care for abortion complications. As a result, they often account for a disproportionate share of both complications and deaths due to abortion.[22] Typically left to shoulder the consequences of an unwanted preg-

[20] Salter, C., H.B. Johnston, and N. Hengen. 1997. Care for postabortion complications: Saving women's lives. *Population reports* Series L 10 (Sept.).
[21] Ibid.
[22] Ibid.

nancy alone, many young women choose abortion over the social condemnation that a pregnancy out of marriage usually elicits.[23] Girls may choose abortion over getting married, being forced to leave school, or becoming single mothers. Others make this choice because their pregnancies are the result of rape or incest.

KNH staff realized that they could make a difference by providing counseling and contraception to the young women they treated. They also hoped to reduce the strain on hospital resources financial, physical, and human posed by the 20—25 abortion complication cases they treated each day. This heavy load had led to a deterioration of quality of care and poor staff morale. In response, KNH s Department of Obstetrics and Gynecology and the University of Nairobi established an urban family planning clinic within the hospital geared to the needs of young women. Supported by Pathfinder since it began, the High-Risk Clinic (HRC) targeted single women under age 25 who had suffered abortion complications. It soon extended services to young women who had experienced an unintended pregnancy and carried it to term.

The clinic is staffed by three full-time nurses and one counselor and is open seven days a week. The staff make regular visits to the acute gynecological ward to talk with young women and offer them services at the clinic. Of the 40—60 new clients seen daily in the ward (including women who have just delivered babies), 12—15 come to the HRC for services. There, the young women receive information and counseling on contraception and reproductive health, including diagnosis and referrals for treatment of sexually transmitted diseases (STDs) and HIV-AIDS. Those interested receive a contraceptive method from among those available, which include pills, condoms, the IUD, injectables, implants, and voluntary surgical contraception. In addition, emergency contraceptive pills are available, and clients are counseled to take advantage of this option over an unsafe abortion in case of a future unintended pregnancy. The HRC has also established referral links with clinics in the neighborhoods where many of its clients live so that clients can more easily receive follow-up care and contraceptives. In a 1997 evaluation of the clinic, clients said they appreciated being able to receive services confidentially and away from adults.

The HRC now serves more than 5,000 women annually,[24] and has been a model for the creation of four similar clinics in the district and provincial hospitals of Pumwani, Mombasa, Machakos, and Eldoret. Perhaps the most far-reaching success has been the recognition by the Ministry of Health of the importance of such services and its pronouncement that all hospitals should include postabortion care services.

[23] Rogo, K., L. Bohmer, C. Ombaka. 1999. *Community level dynamics of unsafe abortion in western Kenya and opportunities for prevention.* Los Angeles, CA: Pacific Institute for Women's Health.

[24] Mati, JKG. 1997. *Evaluation of reproductive health services: High-risk young adults clinic.* Watertown, MA: Pathfinder International.

Reducing Reliance on Abortion

In countries where abortion is legal and easily accessible and where contraceptives have generally been unavailable, women have come to rely heavily on abortion to regulate their fertility. While most abortion procedures in these countries are safe, they are not provided in the context of other reproductive health services, especially contraception. In these countries, women and couples need more contraceptive choices.

Reducing the reliance on abortion in these settings presents unique challenges and opportunities. Because there are no restrictions on the availability of abortion in Azerbaijan, Kazakhstan, and Viet Nam, three countries where Pathfinder has worked, efforts to improve postabortion care and other reproductive health services meet with different cultural and institutional barriers. They often are strongly supported by the government, but generally less so by medical practitioners. While training providers in postabortion care is still the central activity, the training focuses less on emergency treatment and more on updating techniques and integrating family planning services. One of the particular challenges is training providers who have little or no experience with a range of contraceptive methods and very often have outdated or mistaken beliefs about the side effects of specific ones. The public, too, has little experience with most modern contraceptive methods. Pathfinder has contributed in these countries by supporting comprehensive reproductive health programs that include quality postabortion care and family planning services. These programs have led to dramatic increases in the number of women receiving family planning counseling and services after undergoing an abortion, as well as to increases in contraceptive use.

Inexperience with a range of modern contraceptive methods was one of many factors preventing Viet Nam's reproductive health program from meeting the country's fast-growing demand for family planning. Until the mid-1990s, the only modern contraceptive method widely available was the IUD, accounting for 50 percent of overall use. Withdrawal was the second most common method. Because a choice of methods was not readily available, unwanted pregnancies were common, and women often opted for abortion. Legal in Viet Nam, abortion is performed in hospitals and health centers. Most clinical services, including abortion, are administered separately from family planning, which has resulted in postabortion patients often leaving facilities without contraceptive counseling or methods. In response, Pathfinder joined with AVSC International and IPAS in 1994 in a collaboration with the Vietnamese Ministry of Health to carry out the Reproductive Health Program (RHP). Aimed at improving the quality of reproductive health services, the RHP has

focused primarily on improving the organization of services and training doctors and midwives using the RHP comprehensive reproductive health curriculum. To increase the selection of methods available to clients, the RHP has worked to institute a secure supply of a range of methods, held reproductive health technology updates on contraceptive methods, and emphasized improving the counseling skills of providers.

Counseling is viewed by many Vietnamese providers as health education, which informs clients but does not solicit their concerns, questions, or needs. What information is provided often exaggerates the side effects of methods, particularly hormonal ones. In addition, there were, and still are, financial disincentives to counseling clients because of the income providers earn from abortion procedures. The RHP has worked with clinics to find ways to reward providing counseling and to elevate the status of this task. It is also training providers in interpersonal communication and problem-solving skills in order to give them the confidence to "go off the checklist" during their counseling sessions. One problem some providers were having was remembering all the information they needed to include during counseling sessions. To help them give consistent and complete information about contraceptive methods, the RHP developed a set of family planning "cue cards." Each card contains the advantages, disadvantages, and side effects of a method on one side and instructions for the client should she choose the method on the other. Providers at RHP clinics now are aware of the importance of counseling and are providing it to clients more than they did before the program began. The RHP has contributed to documented increases in the number of women using modern family planning methods. Averaged across clinics participating in the program, postabortion contraceptive acceptance rose from 12 to 49 percent between 1994 and 1997. Methods now available in most clinics now include IUD, sterilization, pills, condoms, and Depo Provera.

Misinformation about contraceptive methods is also widespread in Azerbaijan and Kazakhstan, where the Soviet era left a persistent legacy of widely available abortion and almost nonexistent reproductive health and family planning services. Like Viet Nam, Azerbaijan and Kazakhstan needed to begin to provide postabortion care that included contraception and other reproductive health care. In these two countries, however, Pathfinder placed particular emphasis on providing accurate information in order to overcome the common myths and misconceptions among providers and clients alike about contraceptive methods. Several factors explained the prevalence of these views. Providers in the former Soviet Union tended to be isolated from news about developments in contraceptive technology. In addition, the oral contraceptives that first became available were high dosage pills with stronger side effects than the current, low-dose pills. Finally, most people were simply unfamiliar with modern contraceptive methods.

To reach as many people in Azerbaijan as possible with accurate information, Pathfinder used a two-part approach. It included community-based outreach that linked people to local clinics and hospitals for services (see box on page 23) and a mass education campaign. The program also provided the training and equipment necessary for six existing polyclinics and hospitals to offer quality reproductive health and family planning services, particularly postabortion contraception. Physicians, nurses, midwives, and "feldshur," local representatives from the public health authority, took part in comprehensive reproductive health and family planning training. It sometimes took repeated efforts to get rid of biases held by providers. These efforts took the form of contraceptive technology updates, on-the-job observations of providers, and study tours to learn from the reproductive health programs in Turkey and Indonesia. Workshops and seminars were used to counter physicians' reluctance to provide family planning options after abortion. Physicians now report providing immediate postabortion contraception to more than half of their patients, and the contraceptive practice rate has increased significantly in the areas where the project has taken place.

The second part of the Azerbaijan program aimed to raise awareness of reproductive options, dispel myths, and draw attention to population issues through the national media. Pathfinder funded the production of thousands of booklets on reproductive health and family planning, specific contraceptive methods, and infertility, as well as the creation of television information spots, radio programs, newspaper articles, and seminars for journalists on family planning topics. Attitudes in Azerbaijan have changed significantly after two years of Pathfinder's work in the region. Preliminary data suggests a 40–50 percent decline in the number of abortions performed.

Community-Based Services Expand Contraceptive Choices in Azerbaijan

Five years after Azerbaijan became independent, modern contraceptive information and services remained as unavailable as they had been in the Soviet era, leaving women caught in a chronic cycle of unwanted pregnancy and abortion. To complement a national public education campaign and the improvement of clinical reproductive health services, Pathfinder used an old model in a unique way. In partnership with the Ministry of Health and the Azerbaijani Women s Development Center, Pathfinder designed a program to use community-based services to educate Azerbaijani men and women about reproductive health and their contraceptive options. Sixty village health workers were trained to visit families in their homes or worksites five or six times over an 18-month period. They provided RH information, answers to questions, and referrals to local clinics for contraceptive methods. Repeat visits over 18 months allowed the health workers to address new questions or concerns that came up. After two years, the modern contraceptive rate in the two cities where the program operated increased from three percent in both cities to 21 percent in Sumgait and 25 percent in Sheiki.

Supporting Informed Policies and Practices on Unsafe Abortion

Although the legality of abortion has little effect on the incidence of abortion—overall abortion rates are fairly similar across regions—it has a major effect on the conditions under which the procedure is performed. In countries where it is legal, abortion is likely to be performed under safe conditions by trained doctors or nurse midwives. In settings where both women seeking abortions and people providing them may face prosecution, abortions are often performed hastily, under unclean conditions using unsafe traditional methods and unaccompanied by physical examinations or counseling. However, regardless of the legal status of abortion, providers, policy makers, and the public are often insufficiently aware of the magnitude of unsafe abortion in their countries and of the link between women's health and postabortion care. Without this understanding, policies and practices cannot be based on accurate assessments of women's health.

Pathfinder works on a variety of levels to promote informed policies and practices on unsafe abortion.[25] These include developing PAC service delivery guidelines, promoting networking and collaboration among medical providers, and disseminating the results of research and evaluations.

In the period since the lifting of the Mexico City restrictions on abortion research, Pathfinder and other organizations have gained considerable insight into the factors involved in providing high quality postabortion care. This and other research has guided improvements in the delivery of care and informed policy at both the facility and national levels. Pathfinder conducts research and evaluations of its own projects in addition to studies requested of it by ministries of health and other agencies. For example, a study conducted in a Peruvian public hospital comparing the use of MVA and D&C for treating incomplete abortions (see box on page 25) demonstrated the considerable savings the former could bring to hospitals and patients alike. A similar study is being carried out in 21 maternity hospitals in Brazil that are part of the Secretariat of Health in the Northeastern state of Bahia. Other Pathfinder research in Peru raised awareness within the government about the quality of postabortion care in public hospitals. A series of hospital needs assessments identified deficiencies in postabortion care at certain public hospitals, while a patient flow analysis that examined the path of care from the perspective of a postabortion patient, including the time spent at each step, identified bottlenecks and weak points in care. These two studies resulted in concrete improvements in the organization of services and the quality of care.

[25] Pathfinder does not engage in efforts to change legislation on abortion.

Use of MVA versus D&C

A 1995 Pathfinder evaluation comparing the treatment of incomplete abortion using MVA and D&C in the largest maternity hospital in Peru demonstrated the considerable cost and time savings associated with MVA.[26] Using MVA reduced the patients hospital stay by 90 percent. The evaluation found that MVA on an outpatient basis required an average of 40 hours less hospital time than D&C with hospitalization, with most of the difference lying in the postoperative phase. This timesaving led to a reduction in costs as well. Total mean patient cost for D&C with hospitalization was US $68, compared to US $16 for outpatient MVA. Finally, good postabortion care with effective family planning counseling and services may also result in long-term savings as the number of unsafe abortions decrease and institutions need to treat fewer postabortion patients.

In the study, physicians also reported greater satisfaction with MVA. Sixty-five percent of physicians said they were more comfortable with MVA because it was simpler and less dangerous than D&C. Sixty percent reported no difficulties with MVA, compared to 30 percent who reported no difficulties with D&C. Ninety-five percent of physicians perceived advantages for patients in using MVA, including the relative speed, simplicity, safety, and lower level of trauma compared to D&C procedures. Seventy-five percent of patients said they felt no pain or only minor discomfort during the MVA procedure, and 76 percent described the overall service as good.

In addition to research, close collaboration with public sector entities in carrying out postabortion care programs has stimulated improvements in national PAC policy and practice. This has especially been the case in Latin America and the Caribbean, where the public response to postabortion care has changed dramatically over the past 10 years (see box on page 27). Pathfinder has successful partnerships that focus on improving postabortion care with public sector entities in Bolivia, Brazil, Haiti, and Peru.

[26] Guzman, A., D. Ferrando, L. Tuesta. 1995. *An evaluation of MVA versus curettage at the Maternal Perinatal Institute in Lima, Peru.* Watertown, MA: Pathfinder International.

Informed, high quality, and uniform postabortion care practices require service delivery guidelines and standards that providers and administrators can follow. These often do not exist, are not used, or are outdated. Pathfinder works on several levels to support the development and use of PAC service delivery standards. Pathfinder collaborates with ministries of health, teaching hospitals, non-governmental organizations, and medical societies to develop and review guidelines and standards for postabortion care. It has done so in Ethiopia, Kenya, Viet Nam, Bolivia, and Peru. For example, in Bolivia Pathfinder is a member of the Interinstitutional Postabortion Care Committee that is drafting national service delivery guidelines for postabortion care. In Ethiopia, where a substantial proportion of family planning services are provided by the private voluntary sector, Pathfinder supports a consortium of family planning NGOs (COFAP) that has developed and disseminated standards of practice for the NGO sector. COFAP, which coordinates the expansion of FP/RH services throughout the country and trains providers, has created standardized training and service delivery curricula, protocols, and manuals for both clinic- and community-based family planning services. In Africa, Pathfinder is part of a Regional PAC Initiative that enhances communication, coordination, and sharing of lessons learned in PAC programming in the region.

In a broader sense, Pathfinder, as part of the Postabortion Care Consortium, contributed to the text *Postabortion Care: A Reference Manual for Improving Quality of Care*. Pathfinder's training module for providers, *Postpartum and Postabortion Contraception*, puts these standards into specific skills and principles to help ensure their implementation. In addition to guidelines, networking among their peers enables providers to learn from one another. Pathfinder disseminates new technical information from WHO and FIGO (International Federation of Gynecologists and Obstetricians), sponsors professional seminars, and presents research findings at professional meetings on a variety of related topics, including PAC, ECP, and MVA. Country-to-country exchanges have also proved to be helpful in sharing experiences. Pathfinder has supported such exchanges between Peru and Bolivia, Peru and Haiti, Tanzania and Brazil, Kenya and Tanzania, Azerbaijan and Kazakhstan, and Indonesia and Turkey.

Scaling Up Postabortion Care in Bolivia and Peru

A decade ago, most women in Peru and Bolivia could expect very little in terms of the care they received after experiencing an incomplete abortion. Those with little money expected even less. At that time, efforts to improve postabortion care in these countries were rare and small in scope. The use of MVA was prohibited in Bolivia. Today, both governments have not only publicly acknowledged the importance of providing high quality postabortion care to combat maternal mortality, but have begun programs to include postabortion care among a set of services offered to women free of charge.

Among the factors that fuelled this transformation have been constructive partnerships between ministries of health and agencies such as Pathfinder, which have demonstrated how postabortion care can be integrated into existing health systems. In Peru, Pathfinder has been a key partner of the Ministry of Health (MOH) in introducing and institutionalizing postabortion care since 1993. That year, Pathfinder joined the MOH and Social Security Institute in a project to train providers in 42 public sector hospitals to provide postpartum and postabortion (PP/PA) family planning services. More than 3,800 physicians and midwives were trained, and the hospitals were supplied with medical equipment and patient informational materials. The training was one of few opportunities for providers to gain new skills, particularly in PP/PA IUD insertion and minilaparotomy. When it ended, the MOH issued new regulations requiring all hospitals to assign permanent staff to PP/PA FP services, making the project an important step in the institutionalization of family planning as a routine part of PP/PA care. Building on this momentum, Pathfinder and the MOH in 1997 began the *Pilot Project to Improve the Treatment of Incomplete Abortion and the Provision of Postabortion Family Planning Services* in 13 major hospitals. Since then, the MOH has asked Pathfinder to expand this project to 15 new hospitals and 15 health centers around the country, which it is doing with funding from the British government. The active involvement of the MOH in this partnership has made it easier for hospital managers to support the project s goals. For example, the MOH sends letters introducing Pathfinder to the hospitals, both the MOH and Pathfinder sign the diplomas for the training courses, and all training and supervision visits are coordinated with local MOH offices. The MOH is also developing National Administrative and Clinical Guidelines for Maternal and Perinatal Care, which will include guidance on treating uncomplicated incomplete abortion cases. In addition to direct support to services, the climate for improving postabortion care in Peru has benefited from open dialogue. Pathfinder has shared its project experiences and evaluations broadly in forums such as the annual Obstetrics and Gynecology meeting.

In Bolivia, the changes have taken place in a shorter timespan. Although it has one of the highest maternal mortality rates in the hemisphere, Bolivia has only recently acknowledged the contribution that unsafe abortion makes to this problem. Now it is actively promoting far-reaching programs to counter the effects of unsafe abortion with the assistance of Pathfinder and other agencies. Among these are the inclusion of postabortion care into the free *Salud Basico*, or basic health services, and the incorporation of care for abortion cases into the nation s Emergency Obstetric and Neonatal Care Network. The network, which is a priority of the government, teaches community members to recognize the clinical signs of danger that require emergency care in the closest medical facility. When transportation is required, it is paid for by *Salud Basico*.

Lessons Learned

Planning

- When introducing PAC into the overburdened setting that characterizes most hospitals, it is important to work with managers to address needs for additional human and financial resources to absorb the extra workload that PAC will cause initially. It is helpful to explain that, over the long term, this burden will decrease as the numbers of unwanted pregnancies and abortions decrease.
- Introducing the MVA technique can be the most difficult part of improving postabortion care. For this reason, a flexible approach that does not hinge on the transition from D&C to MVA is most effective at yielding improvements in postabortion care.
- Planning for PAC sustainability needs to be done up front. Hospital commitment from top management needs to be ensured early on, including agreements to create protocols for services and assign space and personnel. It is difficult to get protocols in place and/or change service organization in the middle of a training or project.
- Program budgets should allow for monitoring visits to sites where trainees are practicing their new skills. Problems that are easy for outside observers to resolve sometimes jeopardize the functioning of part or a facility's entire postabortion care program.
- Top-level management commitment is necessary for PAC to be institutionalized.

Training

- Training doctors and nurses as a team enables them to provide more coordinated care and better communication to their patients.
- Provider attitudes can be more punitive and restrictive than even the law requires. Special focus on sensitizing providers and improving their counseling skills can change these attitudes.
- Good counseling requires interacting with clients in ways that may be new to many providers. Extra guidance on exploring clients' needs and situations and on helping them solve problems can give providers the confidence they need to do more than simply "go through their checklist."

- For provider training to be effective, trainees need to carry out a minimum number of actual procedures under observation. When there are not enough clients at the provider's facility to fulfill this minimum while the training is ongoing, arrangements can be made for providers to complete the practical part of the training in another facility.
- Giving providers many opportunities to practice using MVA under observation, as well as the chance to visit other providers who are regularly using MVA, helps to build their confidence with the new technique.

Services

- The equipment, supplies, and commodities involved in providing PAC are essential to the provision of quality services. Managers must ensure that a range of contraceptives, MVA equipment, and educational materials are available where PAC services are offered.
- To supplement counseling, brochures and fact sheets on contraceptive options and post-procedure care should be available for clients to take with them.
- Postpartum and postabortion FP can be effective entry points for eventually offering and improving postabortion care.
- Although PAC and postpartum care complement each other well, PAC has greater and different challenges. Grouping them together can lead providers and staff to minimize the differences in the two groups of patients.
- The practical benefits of MVA can make some providers more open to other components of PAC.
- Postabortion care does not offer easy opportunities for client follow-up, which is why it is important for women to leave the care setting with an appropriate method and knowledge about where to receive future contraceptives. Referring clients to outpatient clinics often fails because many clients do not go to them.
- Measurements of progress in introducing or improving postabortion care should include the perspectives of clients who have received care.
- Despite the controversial nature of postabortion care, experience has shown that it is possible to engage the public sector in collaborative partnerships aimed at making concrete improvements in services.

Conclusion

The programs described in this document are evidence that progress has been made in tackling the problem of unsafe abortion. There is greater awareness and willingness to take action; there is more experience on which to base decisions about how to deliver better care. But the pace of progress must be quicker.

An enormous amount remains to be learned about how best to provide quality postabortion care, but this should not limit the growth of programs. As Malcom Potts, a well-known expert on FP and RH issues, has said, postabortion care is an area where "practical achievements are possible, even in resource-poor situations with highly constrained budgets."[27] With basic improvements in the organization of services and infection prevention, and by offering family planning to postabortion clients, lives can be saved. To reach more women, programs need to be expanded. The examples of Bolivia and Peru show that governments can decide to make access to postabortion care nearly universal by adding it to national maternal and child health services. Where programs operate on a smaller scale or without the active involvement of the government, expansion can take place strategically so that hospitals and clinics with large caseloads are chosen as postabortion care sites. At both levels, the increasing number of governments and medical societies developing service delivery standards for postabortion care can help guide service expansion. It is critical, however, that the introduction or improvement of services be carefully monitored and an emphasis on responding to the needs of clients is maintained.

Outside of the clinical setting, more needs to be done for the women who do not make it to hospitals, since they make up the bulk of deaths from unsafe abortion. Community-based approaches that teach women and community members about the risks of unsafe abortion and the warning signs of septic or incomplete abortion have yet to be fully explored.

[27] Huntington, D. and N.J. Piet-Pelon, eds. 1999. *Postabortion care: Lessons from operations research*. New York: Population Council.

Appendix

Following is a list of projects focused on improving care for unsafe abortion and postabortion care supported by Pathfinder International over the past 10 years. It includes both completed and ongoing projects.

Africa

Ethiopia

Reproductive Health and Family Planning Services Support Project

Assisted the Kirkos Marie Stopes International Ethiopia (MSE) clinic in a project to improve quality of and access to reproductive health and family planning services in Addis Ababa. Specific strategies included improving the quality of menstrual regulation services and techniques used to treat septic and incomplete abortion through a training curriculum review and assessment. Pathfinder provided equipment, as well as financial and technical assistance, to the clinic.

Strengthening the Institutional Capacity of Family Planning NGOs in Ethiopia

Supports the efforts of the Consortium of Family Planning NGOs in Ethiopia (COFAP) in their efforts to coordinate and standardize FP services in the country, including postabortion care. Helps member organizations institutionalize service delivery and infection prevention curricula and guidelines and produce culturally appropriate IEC materials.

Kenya

Training in Reproductive Health Services for Marie Stopes Clinics

Supports safe, high quality menstrual regulation services provided by Population and Health Services, a local NGO serving poor female clients. The project includes postabortion care and family planning training and services.

High Risk Adolescent Clinics in Kenya

Supports the High Risk Urban Clinics based at Kenyatta National Hospital (KNH) and Punwani Maternity Hospital (PMH), and established three new project sites in clinics in Eldoret, Nakuru, and Kisumu. This project was designed to target the unmet need for adolescent and postpartum/postabortion counseling and services throughout Kenya.

Tanzania

Minimizing Unintended Pregnancies Among Young Women in Dar es Salaam, Tanzania

Worked with Population and Health Services (PHS) in an effort to strengthen incomplete and septic abortion care services for young women between the ages of 15 and 25 at five Dar es Salaam area clinics. Strategies included procuring equipment, training staff in postabortion care and counseling, and implementing community-based distribution services and follow-up visits.

Integrating STD and HIV/AIDS with Family Planning at the Workplace

Collaborates with Tanzania Occupational Health Services (TOHS) to provide workers and their families with workplace-, clinic-, and hospital-based reproductive health services. In 1999 postabortion services were integrated into the existing RH activities at the main TOHS hospital.

Uganda

Minimizing Unintended Pregnancies and Improving Postabortion Care in Uganda

Worked with Uganda Population and Health Services to strengthen the reproductive health services provided by four Marie Stopes clinics targeting women ages 15 to 25. Pathfinder provided equipment to manage incomplete and septic abortions and trained staff in counseling to promote high postabortion contraceptive acceptance. Community-based distributors were trained to provide initial counseling to potential clients and to make follow-up visits.

MVA Training and Postabortion Care in Uganda

Provides the Ministry of Health and Uganda Private Midwives Association with funding and technical assistance in educating staff at the Makerere University Department of Obstetrics and Gynecology in Mulago Hospital, as well as nurses and midwives, in MVA and postabortion care.

Asia

Azerbaijan

Azerbaijan Reproductive Health Program

Trains service providers in a variety of family planning and reproductive health service delivery skills, including the MVA technique and counseling skills.

Reproductive Health and Family Planning Program through Community-Based Services in Sumgait

Works with the Azerbaijan Women and Development Center to expand access and availability of family planning and reproductive health services in the industrial region of Sumgait through a community-based information and services project to reach 40,000 women of reproductive age.

Reproductive Health and Family Planning Program through Community-Based Services in Sheki

Works with the Azerbaijan Women and Development Center to expand access and availability of family planning and reproductive health services in the underserved region of Sheki. Through a community-based information and services program, 15,000 women have been offered information and services.

Indonesia

IPPA Comprehensive Family Planning and Reproductive Health Clinic

Assisted Indonesia Planned Parenthood Association (IPPA) in providing a range of family planning services, including counseling to promote high postabortion contraceptive acceptance.

IPPA Comprehensive Health Clinic, Yogyakarta

Assisted IPPA in providing a range of family planning services, including counseling to promote high postabortion contraceptive acceptance.

IPPA Adolescent Clinic, Jakarta

Assisted IPPA in establishing the first adolescent clinic in Jakarta to provide young adults with a range of reproductive health information and services, including counseling to promote high postabortion contraceptive acceptance. Counseling was provided in person and via a telephone hotline, and general health, reproductive health, and STD services were provided. Various means were used to inform adolescents, including promotional meetings, articles in magazines, posters, pamphlets, stickers, sex education outreach efforts, and radio spots.

Kazakhstan

Improving Reproductive Health Services and Access to Family Planning in Kazakhstan

Trained service providers in a variety of FP and RH service delivery skills, including the MVA technique and counseling skills.

Community-Based RH and FP services in Rural Kazakhstan

Worked with the Kazakhstan Pedagogical Public Association on Sexual Education to expand FP and RH in rural southern Kazakhstan.

Community-Based RH and FP services in Shymkent

Worked with the Business Women's Association of Kazakhstan to expand FP and RH in Shymkent through community-based information and services.

Viet Nam

Reproductive Health Program

Partners with IPAS and AVSC to work with the Viet Nam Ministry of Health on the implementation of a comprehensive reproductive health program in eight provinces. The program focuses on improving quality of service, primarily in the areas of contraception, safe abortion, counseling, and postabortion and postpartum services. This comprehensive service delivery model includes training in infection prevention, STD screening and treatment, and HIV awareness and counseling, as well as in management issues.

At each sight, the RHP works with maternal and child health (MCH) and FP provincial staff to train MCH/FP workers at the provincial, district, and commune levels. Training emphasizes counseling skills, infection control, and improved knowledge about contraception, abortion, and basic maternity care and includes on-site monitoring and coaching. The RHP also provides basic equipment and facility renovation. The following projects are part of the RHP:

Hanoi Obstetrics and Gynecology Hospital

MCH/FP Center of Thua Thien Hue

MCH/FP Center of Ho Chi Minh City

MCH/FP Center of Soc Trang

MCH/FP Center of An Giang

MCH/FP Center of Can Tho

MCH/FP Center of Vinh Phuc

MCH/FP Center of Quang Ninh

Latin America

Bolivia

Reproductive Health and Family Planning Services in Periurban Areas of Cochabamba

Assists COMBASE, a local NGO, in incorporating adolescent services and postpartum/postabortion contraception into its general health care program.

Reproductive Health Services in Cochabamba

Supports an expansion of services for PROMEFA, an NGO providing high quality health services to the residents of Cochabamba, at four peri-urban health centers and one referral clinic. The expansion includes the addition of adolescent services and postpartum/postabortion care and contraception.

Support for the Ministry of Health RH Program in Selected Areas

Supports the improvement and expansion of access to services through motivational seminars to change attitudes of service providers regarding the treatment of women with incomplete abortion. Improve the quality of services by contributing to the preparation of administrative and clinical norms and protocols for service provision.

Brazil

Improved Postabortion Care and Family Planning

Supports the integration of counseling, the introduction of high quality MVA for the treatment of incomplete abortion, and the provision of family planning services at the public Maternity Hospital in Carmela Dutra.

Treatment of Incomplete Abortion and Family Planning Counseling and Services in the State of Bahia

Supports the creation of a training-of-trainers team, together with the Secretariat of Health of the State of Bahia (SESAB), to educate health professionals in high quality treatment of abortion complications, including use of MVA and subsequent counseling.

Family Planning Services with Postabortion Care

Works with Santa Casa de Misericordia, a privately funded hospital in Rio de Janeiro, to optimize family planning services, particularly through the improvement of PP/PA family planning and care.

Family Planning for Postpartum/Postabortion Women in North/Northeastern Brazil

Supported a series of family planning training courses focusing on high-quality IUD insertion in the postpartum/postabortion period at maternity hospitals in the north and northeastern regions. This program was later integrated into the Implementation and Consolidation of Family Planning Services with SESAB.

Implementation and Consolidation of Family Planning Services with SESAB

Works with SESAB to integrate postpartum and postabortion services into 21 maternity hospitals.

Cost-Study of Incomplete Abortions in Maternity Hospitals of the SESAB Network

Conducted a cost-study related to the use of manual vacuum aspiration versus the curettage technique for treating incomplete abortions in SESAB health network maternity hospitals.

Ecuador

Strategies to Improve Integrated Postabortion Care Services in Guayaquil

Provided financial and technical support to the Midwives Association of the Guayas launch of a pilot program to improve postabortion care services in Guayaquil. Trained physicians to use the MVA technique to treat incomplete abortions and trained midwives and nurses to counsel clients on MVA, assist in the procedure, and provide postabortion family planning services. Assisted the Midwives Association in developing a program to educate midwives on the consequences of, treatment for, and prevention of unsafe abortion.

Mexico

Improving the Quality of Incomplete Abortion Services in the Public Hospital of San Luis Potosi, Mexico

Optimizes family planning services at the public hospital of San Luis Potosi by providing physicians, nurses, and nursing students with postabortion counseling training and MVA training for the treatment of incomplete and septic abortions.

Peru

Peru Action Plan for Family Planning

Initiated a PP/PA family planning program through the network of hospitals located in Peruvian Ministry of Health Reproductive Health and Social Security Institute priority regions. Strategies focused on increasing the availability of long-term contraceptive methods with an emphasis on offering high quality IUD insertion in the PP/PA period.

Support for Reproductive Health Program

Strengthens the RH and FP service delivery capacity of the MOH throughout its network of health posts, centers, and hospitals in priority regions, including PP/PA family planning services. Supports community-based FP and RH services through public sector "functional networks" in the priority regions of Chavin, Mariategui, and Libertadores-Wari. Trained providers in counseling and infection prevention among other topics, and introduced a modified infection prevention course for maintenance and cleaning personnel.

Immediate Postpartum/Postabortion Family Planning Program

Improves postabortion care at 13 public hospitals in Peru, including postabortion family planning counseling and the provision of contraceptive methods. Assessed the ability of MOH hospitals to provide high quality postabortion care, then provided MVA training and pre-procedure and postabortion family planning counseling training to staff members at eligible hospitals.

Postabortion Care Program

Improves the treatment of incomplete abortion and the quality of postabortion services within public sector institutions. Expanding postabortion care services to 15 new MOH hospitals and 15 health centers, while continuing to provide support to the original hospitals from the previous project.

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