Challenges and opportunities in providing post abortion family planning services

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New Evidence and Strategies for Scaling up Post abortion care

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Population Council

Background

- It is estimated that close to 70,000 women die each year as a result of complications of unsafe abortion.
- Unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking necessary skills or in an environment lacking the minimal medical standards, or both (WHO, 1993).
- The phrase ‘unsafe abortion’ also refers to the inappropriate management of complications caused by spontaneous abortion or miscarriage.

Background

- Post abortion care refers to emergency treatment of abortion complications, counseling, referral to other reproductive health services and provision of family planning services. (Post abortion Care Consortium Community Task Force, 2002)

Why post abortion family planning?

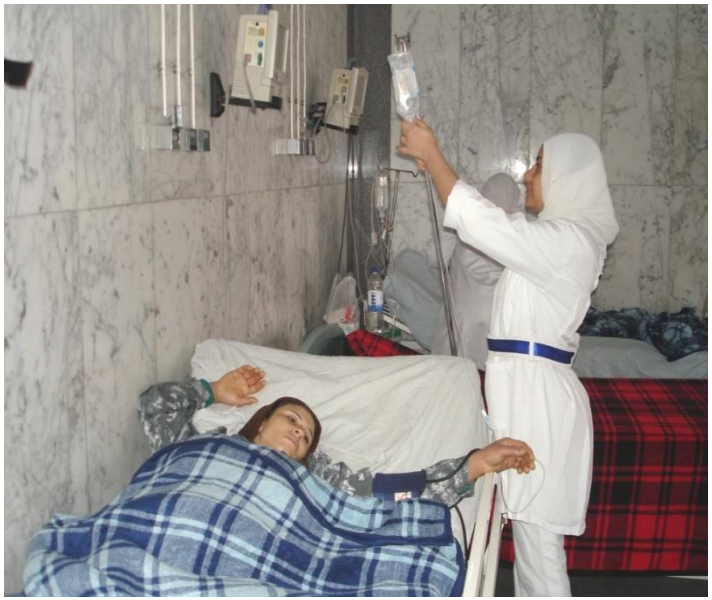
- Most women who have undergone an induced abortion want to avoid or delay pregnancy.
- However, many of them have never used contraception.
- Others experienced contraceptive failure.
- Post abortion women are likely to have had one or more previous abortions.

Why Post abortion Family Planning?

- Ovulation is resumed within two weeks following induced abortion / miscarriage
- WHO has recommended six-month inter-pregnancy intervals following abortion or miscarriage to reduce maternal and fetal complications.
- For some women emergency treatment of abortion complications may be one of their very few contacts with the health care system
- **Emergency treatment services followed by family planning (FP) is essential to reduce unplanned or closely spaced pregnancies.**

Context of receiving post abortion care

- Emergency unit or Ob/Gyn ward of a secondary or tertiary care hospital
- Crisis-oriented environment geared towards treatment of complications
- Staff has a curative approach
- Family planning and emergency / curative care services physically and administratively segregated.



Models of linking FP with post abortion care services

- Referral with no FP counseling
- “FP counseling” with no referral
- Counseling plus referral to a FP clinic
- Offering FP counseling and methods *on-site*

Research evidence suggests that …

- Offering comprehensive FP services (i.e. counseling and methods) on-site is associated with better outcomes for clients, providers and programs (e.g.Brazil, Honduras, Kenya, Peru)
  - Higher contraceptive uptake
  - Timely initiation of contraception
  - Women save time and money
  - Better quality of care
  - Program savings
- However, in some settings on-site provision of FP methods was not associated with long term contraceptive use or reduced unintended pregnancy (Egypt and Russia).

Egypt study

- Tested feasibility, acceptability and effectiveness of two models of linking FP with PAC
- Model I: Family planning counseling + referral to a nearby FP clinic
- Model II: Family planning counseling + provision of FP method on the ward
- Only 2.7 % of women accepted FP method before discharge while
- 13.4 % said they would have liked to receive a method

Egypt study

- 87% of patients believe their husband would be upset with them if they received a method before discharge.
- 85% of patients said they would not want to receive a method before discharge:
  - Desire for more children
  - Body needs some rest
  - Need to consult with husband

Challenges in providing on-site post abortion family planning services

- Ob/Gyn staff find little time to provide FP services
- Curative care orientation of Ob/Gyn staff
- Curative care staff not accountable for FP services
- Providers on the Ob/Gyn ward are misinformed about family planning
  - Only 40% believe *all* PA patients should receive FP counseling
  - Only 25% believe *all* FP methods are suitable for post abortion patients

Challenges in providing on-site FP services

- Limited opportunity to counsel women about PAFP during pregnancy
- No continuity of care in method follow up or obtaining resupplies.
- Woman's emotional state may not be suitable for making voluntary informed decisions.
- Some women are concerned about their health or future fertility.

Challenges in providing on-site FP services (cont.)

- No place on the ward for FP counseling
- Some women are under pressure to become pregnant too soon.
- No opportunity to involve husband / partner in decision-making or method choice.

Conclusion

- It is necessary to provide FP services to post abortion women on the ward
- Choice of a PA FP model should be based on the individual needs of every woman, social context and capabilities of the health system.

Conclusion

- At a minimum, all women treated for abortion complications should know that:
  - Their fertility returns within two weeks
  - Modern FP methods are safe and effective after an abortion
  - They can receive a family method on-site before discharge or at a FP clinic within two weeks post-discharge

Recommendations

- Overcome structural and administrative barriers e.g. develop a joint supervision system for staff on the ward
- Make space for PA FP services on the ward
- Designate one or two nurses for PA FP counseling
- Provide pre-service and on the job of training on PA FP for Ob/Gyn staff

Recommendations

- Establish adequate referral mechanisms between Ob/Gyn ward and FP clinics
- Involving husbands of post abortion women in family planning counseling (if the woman desires)
- Work with community leaders, advocacy groups and community health workers to:
  - enlist support for FP use and inter-pregnancy spacing
  - counter misconceptions about contraceptive side-effects.

Recommendations

- Conduct Operations Research to identify:
  - Adequate supervision mechanisms
  - Mechanisms for securing commodities on the Ob/Gyn ward
  - Division of roles among staff on the ward
  - Adequate referral mechanisms
  - Involving husbands of PA patients without undermining patients rights to privacy