Globally, 20 million unsafe abortions take place each year and roughly 70,000 women die as a result. Countless other women suffer short and long term illnesses. Unsafe abortion is a leading contributor to maternal mortality and morbidity; it is estimated that in sub-Saharan Africa, unsafe abortion accounts for between 20-30 percent of all maternal mortality. Since the endorsement of postabortion care (PAC) at the International Conference on Population and Development (ICPD) in 1994, there has been increased attention paid to PAC as an intervention to reduce maternal morbidity and mortality. Essentially, this intervention calls for a more comprehensive approach to care for women who suffer complications from spontaneous or unsafely induced abortion, including providing safer treatment, family planning services and links to other reproductive health care. Better management can help to reduce mortality and morbidity associated with complications, while providing family planning counselling and services can help women avoid unwanted pregnancies and repeat abortions. This summary presents findings from three OR studies conducted in Burkina Faso, Kenya and Senegal.

**Elements of Postabortion Care**

- emergency treatment services for complications of spontaneous or unsafely induced abortion
- postabortion family planning counselling and services
- linking emergency abortion treatment services and comprehensive reproductive health care

**ACTIVITIES UNDER THE AFRICA OR/TA PROJECT II**

<table>
<thead>
<tr>
<th>Country</th>
<th>Study Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BURKINA FASO</td>
<td>Introducing integrated treatment of abortion complications and family planning counselling and services in two hospitals in Burkina Faso</td>
</tr>
<tr>
<td>KENYA</td>
<td>Testing three alternative approaches to providing integrated treatment of abortion complications and family planning in six hospitals in Kenya</td>
</tr>
<tr>
<td>SENEGAL</td>
<td>Introducing integrated treatment of abortion complications and family planning in three hospitals in Dakar, Senegal</td>
</tr>
</tbody>
</table>
Findings

How extensive is the problem of unsafe abortion?

Unsafe abortion constitutes a major public health concern. This is evident in the high proportion of gynaecological ward admissions for postabortion care, either as a result of spontaneous or induced abortion. This proportion ranged from 11% at the study sites in Burkina Faso to over one-third (35%) in Kenya. It should be pointed out that this only represents a portion of the overall problem of unsafe abortion, as many women never come to the hospital to seek services.

A significant proportion of staff interviewed during Situation Analysis studies indicated that women seek PAC from their health facilities. This ranged from a low of 25 percent of providers in Zanzibar to 37 percent in Botswana to highs of over half of providers in Senegal and Kenya (57 and 58 percent, respectively).

What are the characteristics of women seeking treatment of incomplete abortion?

Though a large number of incomplete abortion patients are young (under 25 years), there is a substantial proportion that are over 30 (figure 1). The mean ages ranged from 25 years in Kenya to 26 in Burkina Faso and 29 years in Senegal. In addition, the majority are married (66 percent in Burkina Faso, 71 percent in Kenya and 85 percent in Senegal). These findings show that the profile of incomplete abortion patients goes beyond the common perception of them being single adolescents.

Most women were not using family planning at the time of pregnancy, though a significant number were: 22 percent in Kenya, 12 percent in Senegal and 11 percent of women interviewed in Burkina Faso. The majority of these women were using either the pill or rhythm and experienced either method or user failure.

Figure 1: Age distribution of incomplete abortion patients

In Africa, 3.7 million unsafe abortions occur every year, leading to 23,000 deaths. This means the risk of death from unsafe abortion in Africa is 1 in 150, higher than any other region.
The following case studies illustrate some of the circumstances that can lead to women arriving at the hospital with an incomplete abortion, as well as some of the challenges and issues around providing appropriate and effective services.

**Women from Kenya tell their stories**

*W01nen from Kenya tell their stories*

**A 20 year old unmarried woman who was a farmer came to the hospital after an induced abortion. It had been her first pregnancy. She had a regular partner, but did not want to have children until she was married. When she arrived in the hospital, her cervix was torn since the “quack” had used scissors to perform the abortion. Asked why she was not using a family planning method at the time she became pregnant, she said whenever she asked her boyfriend to use a condom he bought a sweet and asked her to eat it with the wrapper on. This, she said, is the same way he would feel if he had sex with a condom on. She was afraid to use the pill because she thought it could make her barren. (pre-intervention)*

**A 22 year old married woman came to the hospital after experiencing a miscarriage. She had had three pregnancies, but had only one living child, having lost the other two pregnancies. This miscarriage had come only four months after the other. Before she became pregnant with this last pregnancy, she had not been using a family planning method because she wanted to get pregnant. She said she would like one more child but is not sure when because she felt very weak. She said she would want her husband also to be counselled on family planning. She went home with the combined pill. (post-intervention)*

**Elements of PAC**

**How is emergency treatment best provided?**

Manual vacuum aspiration (MVA) has been shown to be safer and less costly than dilation and curettage (D&C) in the treatment of incomplete abortion, while being just as effective for cases of up to a uterine size of 12 weeks. The introduction of MVA and the accompanying restructuring of services have been key components of PAC activities.

- Many facilities still rely on methods other than MVA for treatment of incomplete abortion, including D&C and digital curettage. MVA was both highly acceptable and quickly accepted at sites in the three studies, as shown in figure 2. For example, in Burkina Faso, the proportion of appropriate cases treated with MVA rose from 0 to 97 per cent.

- Because MVA can be provided without general anaesthesia, women can be treated outside of major operating theatres. This allows for restructuring services, including creating small treatment rooms directly on the ward, to reduce duration of patient stay and thereby save hospital resources. At one hospital in Kenya, the average duration of patient stay decreased from 60 to 21 hours after treatment services were moved to a room on the gynaecological ward.

---

1 This technique is quite common in francophone West Africa and involves digital evacuation of the uterus, often without anaesthesia, on women whose cervices are open and accessible.
While it is recommended that D&C be performed under general anaesthesia, MVA can be done with low level pain control, e.g. analgesia and paracervical block. However, the Kenya study found that in practice this was often translated into no pain control; only three percent of MVA patients received any pain medication prior to or during the procedure. As a result, almost two-thirds (60 percent) of the women described the pain they experienced as extreme. Providers indicated that they would like clearer guidelines on the use of pain control with MVA.

The main problem encountered in creating sustainable MVA services is maintaining a supply of MVA kits. Though kits can be reused numerous times, it is essential that health care systems develop ways to ensure a continued supply of kits. In addition, hospitals need to have a regular supply of decontamination and sterilizing solutions. In many cases, patients were required to buy these solutions in order to receive services.

Training of providers in PAC has been shown to improve provider-patient relations. In the words of one provider in Kenya, it “has made me change and have a good attitude towards patients who have procured an abortion whether induced or not. They all need love and care.” This change is essential to offering high quality services, as negative provider attitudes were shown to be a barrier to improved care for incomplete abortion patients.

There is essential information that women should be given before leaving the hospital, including problems for which they should return to a health facility and the fact that they could have an almost immediate return to fertility. This information provision did increase, with the proportion told about return to fertility increasing from 13 to 41 per cent in Kenya, and from 12 to 90 per cent in Burkina Faso. However, many women still went home without vital reproductive health information. These issues must be further emphasised in training and supervision of PAC services.
How best can family planning services be provided to postabortion patients?

It is still rare to find family planning services routinely offered to postabortion patients. Yet most providers and patients indicate a desire for these services. Providing postabortion family planning (PAFP) is essential to enable women to avoid the recurrence of an unwanted pregnancy, or to allow women who have experienced a miscarriage to wait and rest before becoming pregnant again.

Routine PAFP was new to all the hospitals involved in these studies but was rapidly accepted into hospital practice. In Burkina Faso the proportion of women receiving family planning information increased from 30 percent to 94 percent (Figure 3).

**Figure 3: Proportion of women receiving family planning counseling**

- In the Kenya study that tested three models of PAFP, having gynaecological ward staff provide PAFP to women on the ward before discharge was shown to be the most effective, acceptable and feasible model of service delivery. With this model, almost all women (92%) received family planning counselling, as compared to 62% for model 2 (having staff from the FP clinic come to the ward) and 54% for model 3 (escorting women to the FP clinic for services).
- In Kenya, the three most commonly chosen methods, (pills, injectables and condoms) were made available on the gynaecological ward, with clients being referred to the FP clinic for other methods. Similarly in Burkina Faso, the pill was the most commonly chosen method (74%) followed by the injectable (12%).
- Although MVA can only be used for treatment for a portion of incomplete abortion patients, PAFP can be provided to all. In hospitals in Kenya, PAFP was provided to all postabortion patients, including those treated with D&C. This means that even if a site cannot provide MVA, they can still include other elements of PAC in their services.
How can operations research help in improving PAC?

Operations research (OR) has been an effective way of introducing and gaining support for new and innovative services. This was certainly the case for PAC, an intervention addressing one of the more controversial topics in reproductive health care. This was particularly evident in Francophone Africa, where virtually no work had been done in PAC, and OR helped convince providers and MOH decision makers to accept and endorse these new services. The study in Burkina Faso developed a team of trainers who now support the PAC activities in Senegal. This sharing of experience has also expanded beyond these two countries and has influenced Guinea to implement PAC activities based on Senegal and Burkina Faso research results.

Implications for Implementation of PAC

Improved PAC services were clearly shown to be acceptable, feasible and effective in multiple settings. Implementation of these services requires the following:

- Training of providers in both MVA and PAFP
- Provision of necessary equipment, including MVA kits
- Facility upgrading
- Re-organisation of services

In order to ensure sustainability of these services, it is important to:

- Create supportive policies, e.g. including MVA kits in MOH lists of essential supplies and in national logistics systems
- Institute on-the-job training so that trained providers transfer their skills to other staff and services continue even if staff are transferred
- Institutionalise training in relevant medical schools so that all providers are knowledgeable about PAC services

Future Directions

- Expansion of successful services. Expansion efforts are already underway in Burkina Faso, Kenya, and Senegal. It is now important that the information gained through these studies be used to expand improved PAC services both in the countries where the studies have taken place as well as in other countries.

- Links to other reproductive health services. The research and services to date have focused on the first two elements of PAC, and there is now a need to test ways of effectively addressing the third element of PAC. Other linkages could include, for example, primary prevention, detection and management of sexually transmitted infections (STIs).
Decentralisation. Most work in PAC has been limited to hospital based services. There is still a great need to look at effective and safe ways of decentralising services to lower level facilities to increase access to and utilisation of services. This includes obtaining a better understanding of where women currently seek or would seek PAC services. It also includes training appropriate staff at these levels and changing policy to enable cadres other than doctors to provide MVA and testing effective referral mechanisms. There is work to be done too in creating greater community awareness about the need to seek care for complications from spontaneous or unsafely induced abortion. Interestingly, in Senegal the MVA training included midwives together with the physicians.

Men as Partners. Men can play an important role in the PAC process. Many women were accompanied to the hospital by their partners (41 percent in Kenya), and these men expressed a desire to receive more information about their partners’ conditions. In addition, both men and women generally wanted the men to be involved in the family planning services. However, any services that involve men should be careful to consult the woman first about including her partner, as some women in Kenya indicated that they would not want their partner included in counselling, either because they were secretly using family planning or for other reasons.

Measure Impact of PAC. It is expected that improved emergency treatment of incomplete abortion helps to reduce morbidity and mortality, while PAFP reduces repeat unwanted pregnancies and repeat abortions. However, there is a need for research to document whether this impact is being achieved.

Resources available from Africa OR/TA Project II


Moussa, Cheikh. Revue de la littérature sur les avortements à risque au Sénégal

Africa OR/TA Project II
These studies were supported by the Population Council’s Africa Operations Research and Technical Assistance Project II. The Africa OR/TA Project II is funded by the U.S. Agency for International Development (A.I.D.), Office of Population Contract No. CCC-3030-C-00-3008-00, Strategies for Improving Family Planning Service Delivery.

For further information, contact any of the following Population Council offices:

Nairobi. P.O. Box 17643, Nairobi, Kenya.
Tel: 254-2-713488; Fax: 254-2-713479
Email: mwanjiru@popcouncil.or.ke.

Dakar. BP 21027, Dakar, Senegal.
Tel: 221-8-241993; Fax: 221-8-241998

Ouagadougou. 01 BP 6250, Ouagadougou, Burkina Faso.
Tel: 226-361607; Fax: 226-361625

New York. One Dag Hammarskjold Plaza,
NY, NY 10017, USA
Tel: 212-339-0500; Fax: 212-755-4052

Washington. 4401 Connecticut Avenue
NW Suite 200
Washington DC 20008
USA
Tel: 1 202 237 9400;
Fax: 1 202 237 8410