MEETING HEALTH CARE NEEDS OF WOMEN EXPERIENCING COMPLICATIONS OF MISCARRIAGE AND UNSAFE ABORTION: USAID'S POSTABORTION CARE PROGRAM.

Carolyn Curtis, CNM, MSN

Corresponding Author: Carolyn Curtis, CNM, MSN
United States Agency for International Development
GH/PRH/SDI
Room 3.6.56
1300 Pennsylvania Ave., NW
Washington, DC 20523
(202) 712-4982 – office
(202) 216-3046 - fax

Acknowledgements:

There was no financial, didactic, or other support that contributed to the writing of this article. The opinions expressed herein are those of the author and do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Word Count: 3993

Citation:

Curtis, C. Meeting health care needs of women experiencing complications of miscarriage and unsafe abortion: USAID's Postabortion care program. J. Midwifery Women's Health. 52(4), July/August, 2007

http://dx.doi.org/10.1016/j.jmwh.2007.03.005

Precis: The United States Agency for International Development's global postabortion care program provides treatment for complications related to miscarriage and unsafe abortion.

Abstract

Every year, an estimated 210 million women become pregnant. Worldwide, more than one fourth of these pregnancies will end in abortion or unplanned birth. While many abortions may result from the desire to delay or avoid pregnancy, 15% to 20% of pregnancies will end in miscarriage or stillbirth with some causative agents being malaria, HIV/AIDS, and physical violence. Postabortion care (PAC) is needed to provide treatment for complications due to incomplete or spontaneous abortion and critical family planning counseling and services to prevent future unplanned pregnancies that may result in repeat abortions.

In 2003 the United States Agency for International Development (USAID) initiated a 5 year strategy wherein seven countries were provided additional funding and technical assistance. Since 2003, over 3000 women have been seen in health centers and health posts for PAC services; more than 14,000 community members have received messages on unsafe abortion; family planning, and complications of unsafe abortion and miscarriage; and more than 600 documents were reviewed for inclusion in a Global postabortion care resource package. This package has been used for developing Cambodia's national PAC policy and for developing patient education materials and provider job aids in Cambodia and Tanzania. Promising methodologies will be replicated in other countries.

Key words:
Family planning services
Abortion, incomplete
Abortion, spontaneous
Pregnancy, unplanned
Maternal mortality
Miscarriage

Biographical Sketch:

Carolyn Curtis, CNM, MSN, FACNM, is the team leader for the postabortion care (PAC) working group at the United States Agency for International Development (USAID) and the Cognizant Technical Officer for the ACQUIRE project. Ms. Curtis provides oversight and technical assistance to all global postabortion care programs funded by USAID.

"*…In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health aspect of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling…Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions*."[1]

INTRODUCTION

Every year, an estimated 210 million women become pregnant.[2] Worldwide, more than one fourth of these pregnancies will end in either abortion or an unplanned birth. Often women have abortion due to the desire to delay or avoid pregnancy.[3, 4] Fifteen to twenty percent of pregnancies will end in miscarriage or stillbirth.[5] Some causes for spontaneous abortion include malaria, HIV/AIDS, and physical violence.[6, 7, 8, 9] Postabortion care is needed to provide treatment to women experiencing complications due to incomplete or spontaneous abortion and to provide critical family planning counseling and services to prevent future unplanned pregnancies that may result in repeat abortions.

Post Abortion Care

In 1993, the term "postabortion care" (PAC) was developed. Three critical elements of PAC include 1) emergency treatment for complications of spontaneous or induced abortions, 2) postabortion family planning counseling and services; and 3) referral between emergency care and other reproductive health services such as management of sexually transmitted infections. Women presenting for postabortion care come for services due to complications they experience either with spontaneous or induced abortion. This article highlights the need for PAC programs in developing countries, describes the United States Agency for International Development (USAID) PAC program, related policies, and reviews results of selected activities of the USAID PAC working group.

SPONTANEOUS AND INDUCED ABORTION IN DEVELOPING COUNTRIES

Spontaneous abortion

Fifteen percent of all pregnancies end in spontaneous abortion due to either fetal or maternal causes. Fifty percent of spontaneous abortions are due to fetal chromosomal anomalies. Maternal age; structural anomalies of the genital tract; infections; maternal disease and environmental factors are maternal causes for spontaneous abortion.

A major cause of spontaneous abortion in the developing world is malaria. In areas of epidemic or low (unstable) malaria transmission, adult women without a significant level of immunity against malaria usually become ill once infected with P. falciparum (the primary infective agent). Pregnant women living in endemic areas have a 2-3 times greater risk of developing severe malaria when compared to the risk non-pregnant women living in the same area have for becoming severely ill. A range of adverse pregnancy outcomes may ensue including maternal anemia which may contribute to low birth weight, stillbirth and premature delivery.[10, 11]

In the developed and developing world, the human immunodeficiency virus types 1 and 2 (HIV-1 and HIV-2) are common causative agents for spontaneous abortion. Both HIV-1 and HIV-2 have the same modes of transmission and are associated with similar opportunistic infections and AIDS. Women who are HIV positive have a greater risk of spontaneous abortion. HIV damages the placenta and interferes with the normal transfer of nutrients to the fetus which causes either abnormal development or fetal death and expulsion. HIV-1 may also cause injury or abnormalities to the fetal thymus gland resulting in the altered production of enzymes leading to a hostile uterine environment that may disrupt the pregnancy. [6,7] Depression of the maternal immune system encourages the ascension of opportunistic bacteria and viruses from the lower genital tract to the uterus causing placental infection and ultimately fetal death.[8] A WHO/UNAIDS literature review found that women with HIV in Africa were 1.47 times more likely to have had a miscarriage than HIV negative women.[9] In Italy a cohort study of 423 women from 12 cities found a 67% increase in risk for miscarriage among women positive for HIV-1.[9]

Some women presenting for PAC services may come secondary to miscarriage or spontaneous abortion caused by physical violence. Between 1996 and 1998, the World Bank conducted a study with a sample size of 765 married women. Women who experienced physical violence during pregnancy had a 10% rate of spontaneous abortion compared to a rate of 5.7%

for women who did not experience physical violence during pregnancy. For women who experienced sexual violence during pregnancy, the rate of spontaneous abortion was 5.9% percent compared to 3.8% for women who did not report sexual violence during pregnancy. [12] Community mobilization activities in Bolivia and Kenya validate this phenomenon. In a PAC community mobilization activity involving more than 1600 men, youth and women in Bolivia, women reported having miscarriages due to hemorrhage caused by physical violence (Catalyst consortium PAC compilation document, 2004). Domestic violence was cited as a main cause of spontaneous abortion in 18 community groups that discussed postabortion care in Kenya. [13]

Unmet need and induced abortion

While it is estimated that more than 150 million married women of reproductive age have an unmet need for contraception, many women either do not use an effective contraceptive method or experience contraceptive failure. This may be due to a lack of knowledge of modern methods; religious values regarding modern contraceptive use; concern about side effects; partner objections; or difficulty paying for or obtaining a modern contraceptive method. [3]

Numerous studies and surveys note that women undergo abortion as a means of pregnancy resolution because they desire to delay or avoid pregnancy.[3, 14, 15] Bankole et al [3] reviewed 32 studies from 27 developing and developed countries of women ages 15 to 49 regarding why women had induced abortions. Between 39% and 89% of women stated that the primary reason for seeking abortion was to postpone their pregnancies or stop childbearing altogether. The second most common reason cited was socioeconomic concerns such as disruption of education or employment; lack of support from the father; desire to provide schooling for children; unemployment; or the inability to afford more children. Other reasons included relationship problems and feeling that they were too young to have a child.

Youth presenting for postabortion care services may have had forced or coerced initial sexual experiences. In thirteen case studies reviewed by WHO, between 5% and 15% of young females reported a forced or coerced sexual experience. [14] In Tanzania, 25% of young women suffering postabortion complications were impregnated by men who were about 25 years their senior [15].

Complications of miscarriage and unsafe abortion

Every year, approximately 19 million unsafe abortions occur. [16] Unsafe abortion as defined by WHO is a procedure for terminating an unwanted pregnancy either by persons.[18] Annually 67,000 women die from abortion complications which represents 13% of all pregnancy

related deaths.[17] Almost all (97%) abortion-related maternal deaths occur in developing countries; 3% occur in countries where abortion is legal. (Table 1) Complications of unsafe abortion include incomplete abortion, hemorrhage, sepsis, uterine perforation, intra abdominal injury, psychological trauma and maternal death.[2] Women who have suffered miscarriage and/or stillbirth may experience some of these complications, thereby also needing emergency follow-up treatment. In women of reproductive age who have had unsafe abortion, prevalence rates of infertility and reproductive tract infections are estimated at 2% and 5% respectively.[18]

Table 1 - Comparison of WHO Global and Regional Estimates of Unsafe Abortion and Related Deaths, 2000

Region	Annual number of unsafe abortions (in millions)	Annual number of deaths from unsafe Abortion	Risk of death from unsafe Abortion
World total	19	70,000	1 in 300
Developed countries	.5	300	1 in 3,700
Developing countries	18.5	69,000	1 in 250
Africa	4.2	29,800	1 in 150
Asia	10.5	34,000	1 in 250
Latin America and Caribbean	3.7	3,700	1 in 800

Source: WHO, 2000[17]

RESPONDING TO UNSAFE ABORTION AND MATERNAL MORTALITY WITH FAMILY PLANNING PROGRAMS

The US government and international agency responses

A United States Agency for International Development (USAID) priority in funding postabortion care programs is to increase access to family planning counseling and services to reduce the incidence of unintended pregnancy and thereby reduce the incidence of repeat abortion. Population funds rather than maternal child health funds are used to support postabortion care programs (USAID briefing materials on improving women's health through post-abortion care – 1994).

In June 1990, Duff Gillespie, Director of the USAID Office of Population, distinguished the components of postabortion care.[19] At a meeting of USAID cooperating agencies in 1993, USAID Administrator Brian Atwood made a speech in which he highlighted the important role of family planning in preventing unsafe abortion and spoke of the need to work for

"compassionate treatment of all women who are in such desperate circumstances that they are driven to seek an unsafe abortion." (written communication, Brian Atwood, 1993) In March 1993, the first reproductive health/family planning working group on postabortion care (PAC) was convened by USAID.

High rates of maternal mortality and unsafe abortion became a central focus of many international meetings in the early 1990's. In the Programme of Action of the the1994 International Conference on Population and Development in Cairo, governments agreed that abortion would not be promoted as a method of family planning; that governments should deal with unsafe abortion as a major public health issue; that family planning services should be expanded and improved to help eliminate the need for abortion; and that ready access to postabortion counseling, education, and family planning should be readily provided to help avoid repeat abortions.[1]

In 1994, a meeting held in Mauritius by the International Planned Parenthood Federation resulted in a declaration calling for countries in Africa to strengthen family planning information, education and services; to emphasize male responsibility in family planning and in preventing unwanted pregnancies; to increase availability of high-quality, prompt, humane emergency treatment for women with complications of unsafe abortions including adolescents; and to ensure the provision of postabortion counseling and family planning services.[20] [21] In 1995 at the Fourth World Conference on Women held in Beijing, the importance of providing emergency medical care to women suffering postabortion complications was reaffirmed. [21]

In 1994, USAID authorized the use of population funds for postabortion care and treatment for the first time. While family planning was the top priority for population funds, additional activities such as policy support, female genital cutting, postabortion treatment, and family planning services could also be supported with these funds.

Although USAID decided to support postabortion care programs, USAID chose not to fund the purchase and distribution of manual vacuum aspiration (MVA) kits. Manual vacuum aspiration is a portable hand held syringe with flexible cannulae used for uterine evacuation that does not require electricity for use. This device is used not only for treating complications of unsafe abortion but also to carry out abortions. Since this equipment can also be used for abortions and United States policy prohibits the funding of abortion, USAID felt it was best to leave the procurement and distribution of equipment to others. (written communication, Sally Shelton, October 25, 1994.)

US Government statutes and policy requirements

USAID postabortion care programs abide by the same statutory and policy requirements as other family planning activities. These included the Helms Amendment, the Siljander Amendment; the Deconcini Amendment, the Tiahrt Amendment, the Kemp-Kasten Amendment, the Mexico City Policy as well as USAID's Guidance on the use of Child Survival and Health Program Fund. (Table 2) The FY 06 Foreign Operations, Export Financing and Related Programs Appropriations Act states…

> "*USAID funds may not be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortion. USAID funds may not be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations. No USAID funds may be made available to any organization or program that, as determined by the President of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization. No USAID funds may be used to pay for biomedical research that relates in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning. However, epidemiological or descriptive research to assess the incidence, extent, or consequences of abortion is permitted. USAID funds may not be used to lobby for or against abortion.*"

Table 2 US Policy Governing USAID Family Planning Funds

Helms Amendment “”None of the funds made available under this Act may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions. Source: HR. 2673 Omnibus Appropriations Bill, Division D. FY 2004
Kemp-Kasten Amendment “None of the funds made available in this Act nor any unobligated balances from prior appropriations may be available to any organization or program which, as determined by the President of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization” Source: HR. 2673 Omnibus Appropriations Bill, Division D. FY 2004
Method Mix (DeConcini) Amendment “That in order to reduce reliance on abortion in developing nations, funds shall be available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services.” “…In awarding grants for natural family planning under section 104 of the Foreign Assistance Act of 1961 no applicant shall be discriminated against because of such applicant’s religious or conscientious commitment to offer only natural family planning; and additionally all such applicants shall comply with the requirements of the previous provision.” Source: HR. 2673 Omnibus Appropriations Bill, Division D. FY 2004
Siljander Amendment “Provided further that none of the funds made available under this Act may be used to lobby for or against abortion.” Source: HR. 2673 Omnibus Appropriations Bill, Division D. FY 2004
Mexico City Policy This regulation prohibits non-US, nongovernmental organizations to which USAID provides family planning assistance funding either directly or through subawards from using their own or other, non-USAID donor funds to provide or promote abortion as a method of family planning

From: the United States Agency for International Development [9]

THE 2001 USAID GLOBAL PAC EVALUATION

From 1994 to 2001 USAID played a critical technical leadership role in postabortion care in its support of organizations that implemented PAC programs in over 40 countries. More than

$20 million supported work in the areas of policy and advocacy, operations research, training, service delivery, and health communication. In 2001 USAID conducted a global evaluation of its PAC programs. It was found that PAC programs had been embraced internationally in more [22]than 40 countries and PAC services were available in the public and private sector and in refugee camps. Governments had developed policies, standards, and protocols to guide and support PAC services.

Findings regarding the PAC elements were that clients receiving sharp curettage for emergency treatment due to gestational age, severe hemorrhage, infection, or abdominal injury were not receiving the same level of family planning counseling and services as were women who had MVA for emergency treatment. More attention was needed to ensure that family planning counseling and services were provided to all clients regardless of the method used for emergency treatment (MVA or sharp curettage). Emphasis on high quality family planning was not as strong as the emphasis on high quality emergency treatment. This was apparent in training for family planning counseling, the lack of patient education materials and provider job aids, and the lack of contraceptives supplies that would support method mix and contraceptive choice. Linking emergency care to other reproductive health services had not been well defined and was a very weak component in the PAC model. This component was almost non-existent in most public sector settings. [23]

THE 2003 USAID POSTABORTION CARE STRATEGY

Acting upon recommendations of the 2001 USAID Global evaluation, a five year strategic plan was developed. USAID revised its model for postabortion care in 2003 to include community mobilization, an evaluation strategy (results framework) and global and country benchmarks (indicators) of progress and successful outcomes for PAC programs. The three core components of the revised USAID PAC model are: 1) emergency treatment for complications of spontaneous or induced abortion; 2) family planning counseling and service provision, STI evaluation and treatment, and HIV counseling and/or referral for HIV testing (optional serviced depending on disease prevalence and human resources); and 3) community empowerment through community awareness and mobilization. [23][24] (See Appendices A and B) Proposed activities of the five year PAC strategy include standardization of training materials, guidelines, and benchmarks; expansion and institutionalization of PAC at the country level; identification of successful models; leadership in identifying further research, compilation of research findings; and monitoring and evaluation of activities.

Focus countries chosen

In 2003, seven focus countries were chosen to receive a small amount of funding to expand and institutionalize PAC. These countries were selected due to their high maternal mortality and induced abortion rates; low prevalence of contraceptive use; and total fertility rate. To help assure sustainable PAC programs, commitment from the Ministry of Health and matching funds from local USAID offices were required. The selected countries were Bolivia, Cambodia, Haiti, Kenya, Nepal, Senegal and Tanzania.

Compilation of standardized tools in the Global PAC Resource Package

The purpose of the Global PAC Resource Package is to provide countries with standardized information and tools needed to initiate PAC programs or enhance existent programs. The materials include a research compendium which synthesizes research related to postabortion care; examples of recommended policies, tools, curricula, and service delivery guidelines for PAC programs; communication tools, patient education materials and provider job aids; a facilitator's manual for implementing a successful community mobilization activity; benchmarks (indicators) for evaluating progress in PAC country programs; and a User's Guide to the Global Postabortion Care Resource Package.

More than 600 documents from 12 organizations and 15 countries were reviewed for the Global PAC Resource Package. This tool has been used for the development of national PAC policy in Cambodia. Many patient education materials and provider job aids were translated and adapted for national PAC programs in Cambodia and Tanzania. Research findings from the Research Compendium on family planning were presented at a meeting in Senegal in which "Best Practices" for family planning were discussed. This presentation resulted in much interest in using postabortion care as an entry point for reinvigorating interest in family planning by the World Health Organization's Implementing Best Practices group.

Community mobilization

The development of community and service delivery partnerships was also promoted. Community and service delivery partnerships can a) provide education about obstetric emergencies; appropriate care seeking behaviors; and contraceptive methods; b) allow community members to participate in decisions about availability, accessibility and cost of

services; and c) mobilize community resources to ensure that women experiencing obstetric emergencies receive timely care.[24]

The USAID PAC working group funded a PAC community mobilization model in Bolivia that reached more than 1600 community residents Pre and post-test findings in Bolivia (n=1217) found a significant increase in knowledge of types of contraceptive methods (88 to 94%) and use of family planning in last sexual intercourse (46 to 54%). In 2006, the PAC community mobilization model from Bolivia was replicated in Kenya and reached 412 men, women, and youth in 16 community groups in an effort to educate and involve men in family planning activities. Causes of unplanned pregnancy and unsafe abortion identified by community members included lack of knowledge and misconceptions about pregnancy; bleeding during pregnancy; family planning; peer pressure; and poor couple and inter-family communication. Pre and post tests showed a dramatic increase in knowledge regarding vaginal bleeding as a danger sign of pregnancy (66% to 90.5%); causes of maternal death(vaginal bleeding from 41% to 64%; violence against women was 24% in post test); and delays in seeking care (96% post test). Condoms were cited by 77% of respondents as having dual protection against HIV. The development of action plans helped with identifying and prioritizing problems, problem-solving and identifying community resources for pregnancy, family planning, and PAC and was seen to be applicable to other problems such as drug use and abuse, alcoholism, deviant behavior, and water and sanitation.[13]

In Peru, this activity involved the Centro Materno-Perinatal and a local women's organization that included 373 participants in 14 communities groups. Some results of the implementation of action plans were the establishment of a Committee for Monitoring and Transparency in Health and having family planning supplies made available in the room where emergency treatment was performed. This resulted in 100% of clients being counseled on family planning and 30% of clients accepting a method prior to leaving the facility.

In Egypt, male religious leaders were trained about problems related to unintended pregnancy and complications of spontaneous and induced abortion. Community education materials were made to conduct community awareness activities. More than 12,600 persons were reached through 246 community awareness sessions in 54 communities. The facilitator's manual used for this activity has been finalized and field tested among 1300 residents in 82 community groups and 149 facilitators in Bolivia and adapted for use in Kenya, Peru, and Egypt [25]25 (

Decentralization of postabortion care services to primary and secondary levels

Decentralization of postabortion care services allows services to be extended from the tertiary hospital down to district and community levels. Training nurses, midwives and chief medical officers to provide PAC services is crucial in the decentralization process. Since 2003, over 3,000 women have received PAC services in health centers and health posts in Nepal, Tanzania and Senegal through the decentralization of PAC services. In Nepal, establishment of two PAC services at health centers have been brought these services 30 and 80 miles closer to women. Of the 147 PAC cases performed, only one had to be referred to the hospital. In the Geita district hospital in Tanzania, the PAC caseload decreased by 64% from June 2005 to June 2006 after PAC services were decentralized to health centers and health posts. An average of 73% of clients accepted a postabortion family planning method (51% in Senegal; 80% in Tanzania; and 91% in Nepal). A cost-analysis done in Tanzania showed that just over $2,000 per hospital and $700 in per health center (US dollars) is needed to introduce PAC services (PAC activities implemented, July 2004 to June 2005, annual report to USAID).

CONCLUSIONS

Each year, at least 210 million women become pregnant. It is estimated that 20% of all pregnancies will end in spontaneous abortion (miscarriage). While it is estimated that more than 150 million married women of reproductive age have an unmet need for contraception, many women either do not use an effective contraceptive method or experience contraceptive failure.

In an effort to address the problem of maternal mortality secondary to spontaneous and/or induced abortion, USAID has provided more than $20 million to support PAC programs in more than 40 countries. The 2001 global evaluation of PAC programs found that PAC services had been embraced internationally with PAC services available in the public and private sectors, and in refugee camps. Governments had developed policies, standards, and protocols to guide and support PAC services. While MVA had become widely accepted for emergency treatment, clients receiving D&C for emergency treatment were not adequately included in the PAC program. More attention was needed to ensure family planning counseling and services for all clients whether they received MVA or D&C emergency treatment. In 2003, USAID chose seven focus countries to receive additional funding and technical assistance. Since the initiation of the strategy, promising methodologies for PAC programs have emerged. USAID plans to evaluate and replicate these methodologies in other countries as well as work with the World Health Organization, the International Federation of Gynecologists and Obstetricians and the

International Confederation of Midwives to craft global policies and standards and identify best practices for the expansion of global postabortion care programs.

APPENDIX A USAID POSTABORTION CARE STRATEGY: Provision of Care by Level of Health Care Facility and Staff for Postabortion Care

Component One - Emergency Treatment	**Component Two Postabortion Family Planning Services**
Community Level: Community residents with basic health training, traditional birth attendants, traditional healers	
Recognition of signs and symptoms of abortion and postabortion complications, Referral to facilities where treatment is available	Provision of pills, condoms, diaphragms, and spermicides, Referral and follow up for these and other methods
Primary health clinics, family planning clinics or poly clinics staffed by health workers, nurses, trained midwives, general practitioners	
All Primary Facilities: All activities conducted above and: Diagnosis based on medical history; physical examination and pelvic examination, Resuscitation/preparation for treatment or transfer, Tetanus vaccination, Referral, if needed	All activities conducted above and: IUDs, injectable contraceptives, Norplant implants, and standard days method, Referral for voluntary sterilization
If Trained Staff and Appropriate Equipment Available: All activities conducted above and: Counseling regarding treatments/emotional support, Hematocrit/hemoglobin testing, STI evaluation and treatment, Initiation of emergency treatments, Antibiotic therapy, Intravenous fluid replacement, Oxytocics, Uterine evacuation during first trimester for uncomplicated cases, Appropriate pain control, Simple analgesia and sedation	Family planning follow up and referral to primary and community level for long-term FP follow up, HIV counseling, follow up appointment or referral for HIV counseling and testing (as program dictates), Referral to primary/secondary/ tertiary sites as appropriate for gender- based violence, psychological/emotional needs; HIV counseling and testing
First Referral Level/District Hospital staffed by nurses, trained midwives, general practitioners, obstetrician/gynecologists, specialists	
Above activities and: Emergency evacuation for fetal death through second trimester Treatment of most postabortion complications, Local and general anesthesia, Diagnosis and referral for severe complications (septicemia, peritonitis, renal failure), Laparotomy and indicated surgery (including for ectopic pregnancy), Blood crossmatch and transfusion	Above activities and: voluntary sterilization
Secondary and Tertiary Level/ Regional or referral hospital staffed by *nurses, trained midwives, general practitioners, obstetrician/gynecologists, specialists*	
Above Activities and: Uterine evacuation as indicated for all cases, Treatment of severe complications (including bowel injury, severe sepsis, renal failure), Treatment of bleeding/clotting disorders	All activities listed above

Adapted from WHO, 1994, Clinical management of abortion complications: A practical guide

APPENDIX B

USAID POSTABORTION CARE STRATEGY: CORE COMPONENT 2 AND 3

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

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

Core Component 3: Community Empowerment Through Community Awareness and Mobilization

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

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

References

[1] United Nations. Report of the International Conference on Population and Development, Cairo, September 5-13. 2004. Available on:www.un.org/popin/icpd/conference/offeng/poa.html.

[2] The Alan Guttmacher Institute: Sharing responsibility: women, society, and abortion worldwide. New York, The Alan Guttmacher Institute, 1999.

[3] Bankole, A., Singh, S., and Haas, T. Reasons why women have induced abortions: Evidence from 27 countries. Int. Fam. Plann. Perspect. 24(3), 1998. 117-127 & 152.

[4] DaVanzo, J. Adamson D, Bulatao RA. Population Matters Policy Brief: The unmet need for contraception in developing countries. Santa Monica, California. 1998.

[5] Fraser, D.M, Cooper, M. A. Myles Textbook for Midwives, (14th edition). Philadelphia: Churchill Livingstone, 2003

[6] Shearer, W.T., Langston, C. Lewis, DE, Pham, E.L, Hammill, H.H., Kozinetz, C.A., et al. Early spontaneous abortions and fetal thymic abnormalities in maternal-to-fetal HIV infection. Acta Paediatrics Suppl. 1997., J421: 60-64.

[7] D'Ubaldo, C., Pezzotti, P, Rezza, G, Branca, M, Ippolito, G, and the DIANAIDS Collaborative Study Group. The Association between HIV-1 infection and miscarriage: a retrospective study. AIDS. 1998 12: 1087-1093.

[8] Brocklehurst, P., and French, R. The association between maternal HIV infection and perinatal outcome: A systematic review of the literature and meta-analysis. Br. J. Obstet.Gynaecol. 105(8), August, 1998.

[9] United States Agency for International Development. What Works: A policy and program guide to the evidence on family planning, safe motherhood, and STI/HIV/AIDS interventions. Module 2: Postabortion Care. Washington, DC 2007. Available at: www.usaid.gov

[10] Newman, R.D., M. Quakyi, I. Malaria during pregnancy: epidemiology, current prevention strategies, and future directions. Emer Infect Dis [serial on the Internet] available at http://www.cdc.gov/NCIDOD/eid/vol1Ono11/04-0624 09.htm

[11] World Health Organization Roll Back Malaria Partnership Web site. Africa Malaria Report 2003. Malaria during pregnancy. Available at http://www.rbm.who.int/amd2003/cb4.htm.

12. Hakimi M, Nur Hayati E. Ellsberg M. Winkvist A. Silence for the sake of harmony: Domestic violence and health in central Java, Indonesia. Yogaarta, Indonesia: Gadjah Mada University, PATH, Rifka Annisa, Umea University, 2002.

[13]. Joseph M. Community mobilization for postabortion care in Kenya. Presentation to USAID, June 2006.

[14] Salter, C., Johnson, H.B., and Hengen, N. Care for postabortion complications: Saving women's lives. Population Reports, Series L., No. 10. Baltimore, Johns Hopkins School of Public Health, Population Information Program, September, 1997.

[15] Brown, A., Jejeebhoy, S.J., Shah, I., Yount, K.M. Sexual relations among young people in developing countries: Evidence from WHO case studies. World Health Organization. Geneva: World Health Organization, 2001.

[16]. The World Health Organization. The World Health Report 2005: Make every mother and child count. Geneva: World Health Organization, 2005.

[17]. World Health Organization: The prevention and management of unsafe abortion, report of a technical working group. Geneva: World Health Organization, 1992.

[18] World Health Organization. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000. 4th edition. Geneva. World Health Organization. 2004.

[19] United States District Court, District of Columbia. Pathfinder Fund v. Agency for International Development. Federal Supplement 1990: 746:192-9.

[20] International Planned Parenthood Federation African Region (IPPF/AR). Unsafe abortion and postabortion family planning in Africa. The Maritius Conference. Namibia.IPPF/A. 1994, p.38.

[21] United Nations. Fourth World Conference on Women. Beijing, China, 4-15 September 15. (Unpublished) p199.

[22] Cobb L., Buono N. Dunlop J. Putney P. Rochet R. Solo J et al. Global evaluation of USAID's postabortion care program. Presented at United States Agency for International Development, October 9, 2001. Washington, DC.

[23] United States Agency for International Development. USAID Postabortion care strategy. Washington, DC. United States Agency for International Development. 2004.

[23] United States Agency for International Development. USAID postabortion care strategy. Washington, DC: United States Agency for International Development, 2004.

[24] Corbett, M.R., and Turner, K. Essential Elements of Postabortion Care: Origins, evolution, and future directions. Int. Fam. Plann. Perspect.29(3), 2003. 106-110.

[25] Tran C, Giri K. Adaptation of the Bolivia Community PAC Model in Egypt and Peru. Washington, DC: Extending Service Delivery Project, 2006.