HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Postabortion Family Planning:
A critical component of postabortion care

Postabortion Family Planning

What is the proven high-impact practice in family planning service delivery?

Proactively offer voluntary contraceptive counseling and services at the same time and location where women receive facility-based postabortion care.

Background

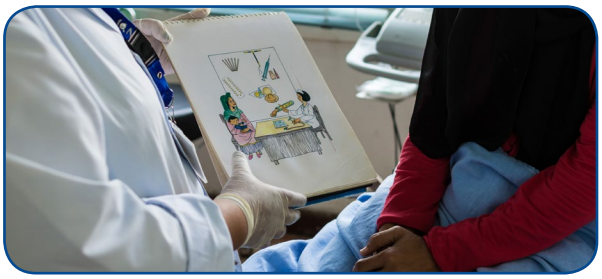


Photo credit: UNFPA

"If the woman we treat for postabortion complications is there because she could not get contraception, we have failed her. If she leaves without family planning, we have failed her twice." – Verme, 1994

Postabortion care (PAC), which includes treatment for complications from miscarriage or induced abortion, is an opportune time to counsel and offer clients voluntary contraception. Even if a woman wants to become pregnant again soon, she should probably wait six months to reduce the chances of low birth weight, premature birth, and maternal anemia.*[1] All PAC models include two essential services: (1) treatment of emergency complications, and (2) voluntary family planning counseling, including provision of contraception.[3] Research studies and data from program implementation consistently show that when clients are counseled and offered contraception as part of postabortion care most women will opt to leave the facility with an effective family planning method (see Figure 1).[4]

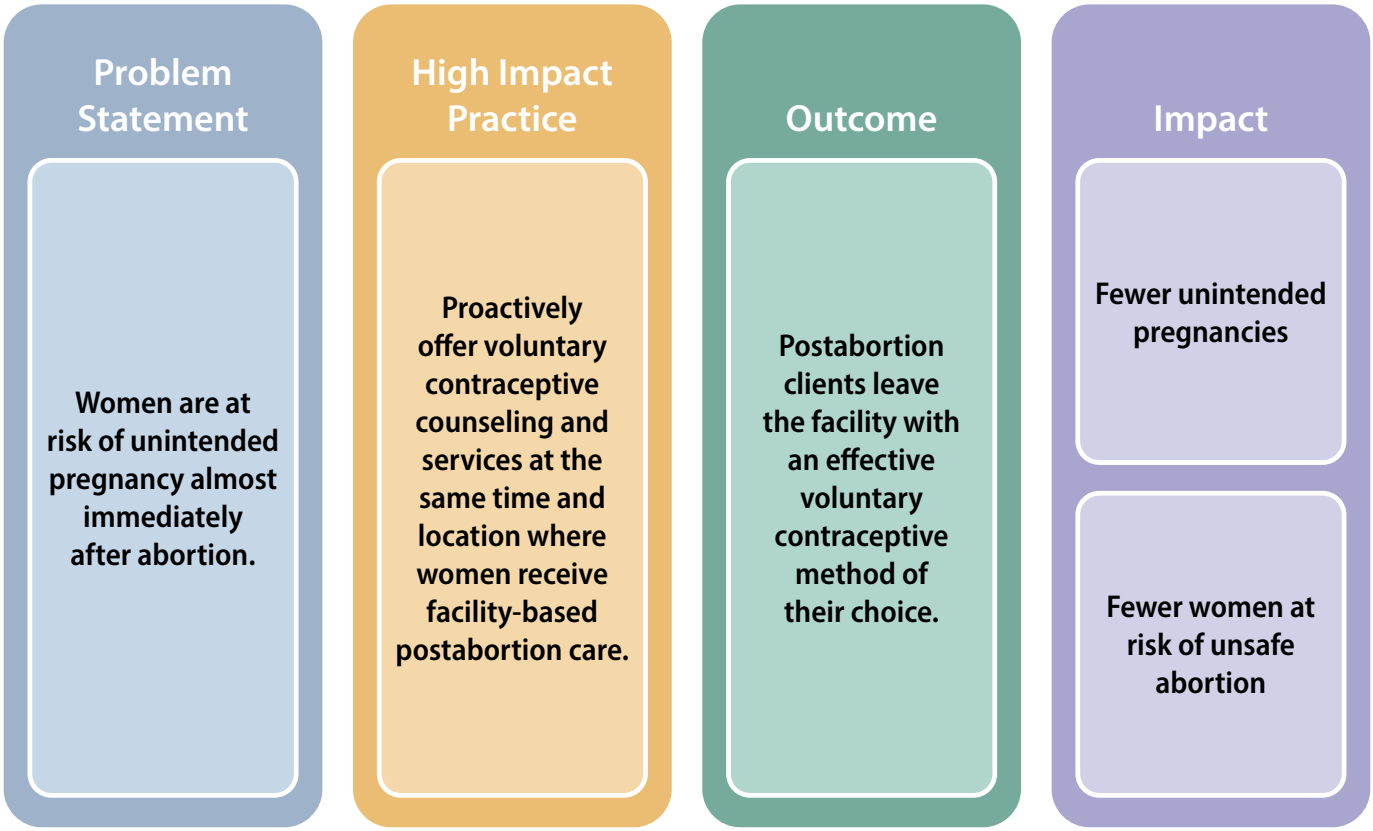
Despite this evidence and decades of investments to improve PAC programs, health care systems continue to fall short. In Bangladesh, only 18% of all facilities providing PAC routinely offer contraceptive methods to clients.[5] Similarly, only 6% of clients in Georgia, 17% in Tanzania, and 26% in Pakistan receive their contraceptive method of choice as part of PAC.[6-8] Furthermore, studies in Kenya and Nepal show that even when services are in place, method choice may be limited.[9,10] In Kenya, 9 of 10 postabortion clients left the facility with a method, but the vast majority left with male condoms due to limited contraceptive choice.[9] The study also found significant gaps in information provided to clients, such as how to use the method correctly and follow-up infor mation. In Brazil, only one-third of postabortion clients reported being counseled on contraception and less than 1 in 10 left the facility with a contraceptive method.[11]

Postabortion family planning is one of several high impact practices in family planning (HIPs) identified by a technical advisory group of international experts.

When scaled up and institutionalized, HIPs will maximize investments in a comprehensive family planning strategy.[12] For more information about other HIPs, see http://www.fphighimpactpractices.org/overview.

* A systematic review and meta-analysis suggests that an interval of less than six months following miscarriage is not associated with adverse outcomes.[2] The meta-analysis was mainly of studies from developed countries.

Figure 1: Postabortion Family Planning Theory of Change
Context: Large numbers of women seek care for services related to abortion or miscarriage.



It is recommended that programs implementing postabortion family planning include the following indicators:

- Percentage of postabortion clients who were counseled on family planning (disaggregated by age group, <20 years vs. ≥20 years)
- Percentage of postabortion clients who leave the facility with a modern contraceptive (disaggregated by type of method and age group, <20 years vs. ≥20 years)

What challenges can postabortion family planning help countries address?

Postabortion family planning can reach many women and girls in need of contraceptive counseling and services. Induced and spontaneous abortions (miscarriages) are common. Together, they account for an estimated one-quarter of all pregnancies worldwide.[13] Globally, the number of induced abortions is on the rise, increasing from 50.2 million in 1990–1994 to 55.9 million in 2010–2014. Nearly half of these are considered unsafe, with the overwhelming number being in developing countries.[14,15] Moreover, while induced abortions fell by 44% in developed regions (from 11.8 million to 6.6 million), they increased by 28% in developing regions (from 38.4 million to 49.3 million).[15]

Postabortion family planning can help clients achieve their reproductive intentions and is likely to provide cost savings for women, families, and the health system. Individuals and health systems alike bear significant costs for treating complications from unsafe abortions. In many African countries, a high proportion (15%–30%) of hospital gynecological admissions are due to complications of unsafe induced abortion.[16] Treatment for abortion-related complications can consume nearly half of obstetrics and gynecology budgets.[16] Costs could

be reduced by investing in improving access to high-quality family planning services and increasing fertility awareness. Subsequent abortions are common[17,18] and are an indication that the health system failed to facilitate access to effective contraceptives and information during the woman's first encounter with PAC. One multi-country review found that, on average, nearly 20% of postabortion clients reported having had a previous induced abortion.[19] Furthermore, more than half of postabortion clients expressed an interest in using contraception, yet only about one-quarter (27%) left the facility with a contraceptive method. Providing voluntary contraception to women who wish to delay or limit childbearing would cost just a fraction of the average expenditure on PAC: one year of modern contraceptive services and supplies costs, on average, 3%–12% of the cost of treating a PAC patient.[20]

Many postabortion clients and health workers do not know that postabortion clients are at risk of pregnancy almost immediately after abortion. Fertility can return within two weeks after a first-trimester abortion or miscarriage, within 4 weeks after a second-trimester abortion or miscarriage,[1] and, on average, within three weeks following medical abortion with mifepristone or misoprostol.[21] However, one cross-sectional study showed that nearly two-thirds of women who received PAC did not know when fertility returns after abortion, and this same group was not intending to use contraception despite three-quarters wanting to postpone childbearing.[22] Women who leave a facility without a clear understanding of their pregnancy risk are almost three times more likely to have another abortion than women with accurate knowledge.[23] Timely family planning counseling and services can help women prevent a subsequent unplanned pregnancy and possible abortion.

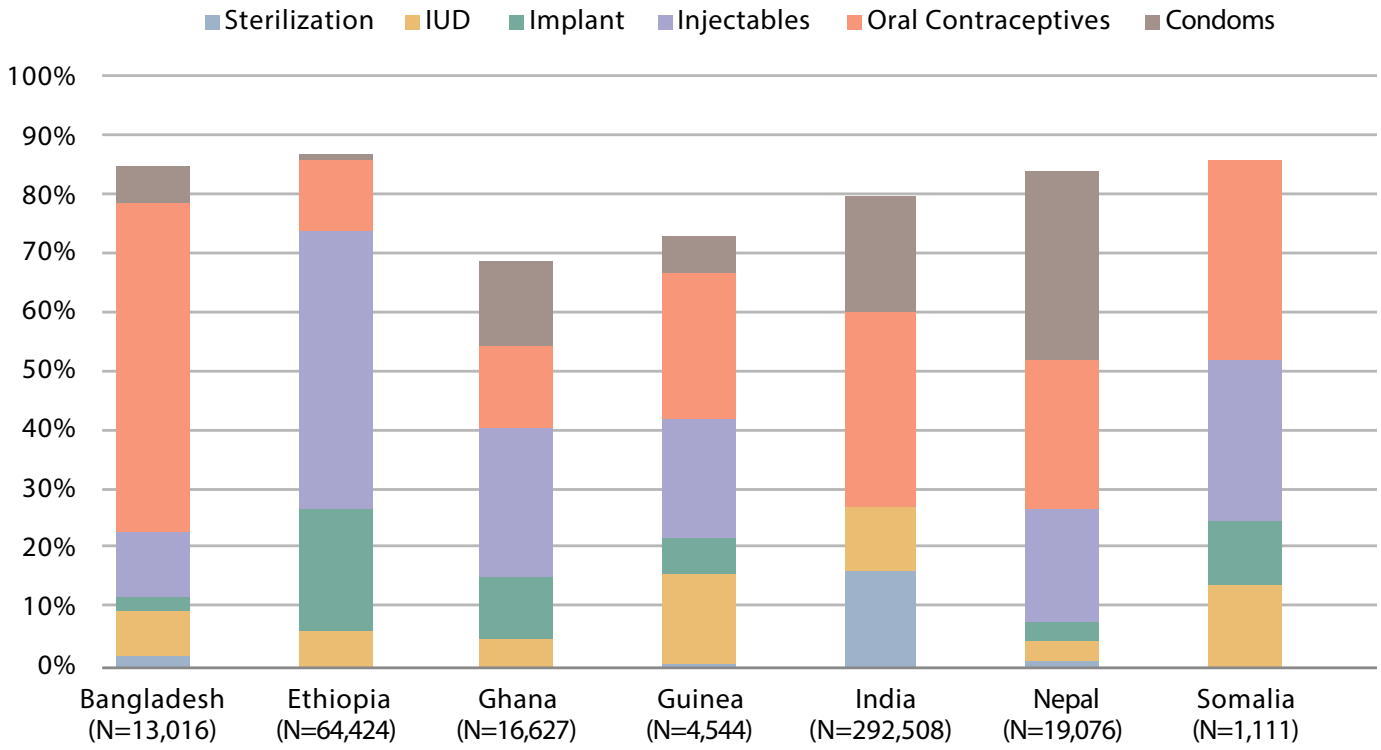
Unsafe abortion is a major contributor to maternal morbidity and mortality in developing countries, and postabortion family planning can reduce subsequent abortions. Globally, an estimated 25 million unsafe abortions occur each year,[24] and between 4.7% and 13.2% of maternal deaths each year can be attributed to unsafe abortion.[25] Around 7 million women are admitted to hospitals every year in developing countries as a result of unsafe abortion.[15] The annual cost of treating major complications from unsafe abortion is estimated at US$553 million.[20] Unsafe abortion is the fifth leading direct cause of pregnancy-related maternal mortality.[25] Preventing unintended pregnancy, including among PAC clients, is fundamental to reducing the consequences of unsafe abortion.

What is the evidence that postabortion family planning is high impact?

Across a wide variety of settings, data consistently show that acceptance of contraception is high when women are offered counseling and services as part of PAC. A review of evidence from the last 20 years concluded, "Postabortion family planning uptake generally increases rapidly—and unintended pregnancies and repeat abortions can decline as a result—when a range of free contraceptives, including long-acting methods, are offered at the point of treatment …"[4] These findings are consistent with earlier systematic reviews.[26] Rates of contraceptive uptake in small-scale intervention studies range between 25% and 98%.[27,28] Figure 2 provides illustrative examples of voluntary contraceptive uptake achieved in large-scale routine service delivery programs when high-quality postabortion family planning services were in place.

Postabortion family planning reduces unplanned pregnancy and subsequent abortions. Studies show that providing voluntary family planning services as part of PAC can increase contraceptive use and reduce subsequent abortions. In Zimbabwe, postabortion clients who were referred to a nearby maternal and child health facility and charged a nominal fee for contraception were more than three times as likely to experience an unplanned pregnancy in the 12 months following an abortion as postabortion clients who were offered on-site, ward-based family planning services and methods for free.[33] Similarly, in Georgia multiple abortions were significantly more common among women who did not receive postabortion contraception at the site of PAC compared with those who did.[6]

Figure 2: Percentage of Postabortion Clients Leaving the Facility With a Modern Contraceptive Method Method in Selected Countries With High-Quality Postabortion Family Planning Services



Source of data: Bangladesh, Ethiopia, Ghana, and Nepal from public-sector facilities (NGO-supported) data collected from 2011-2013.[29] India from public-sector facilities (NGO-supported) data collected from 2011-2014.[30] Somalia from NGO-run facilities in the Puntland data collected from 2013–2015.[31] Guinea from public-sector facilities (NGO-supported) data collected from 2013.[32]

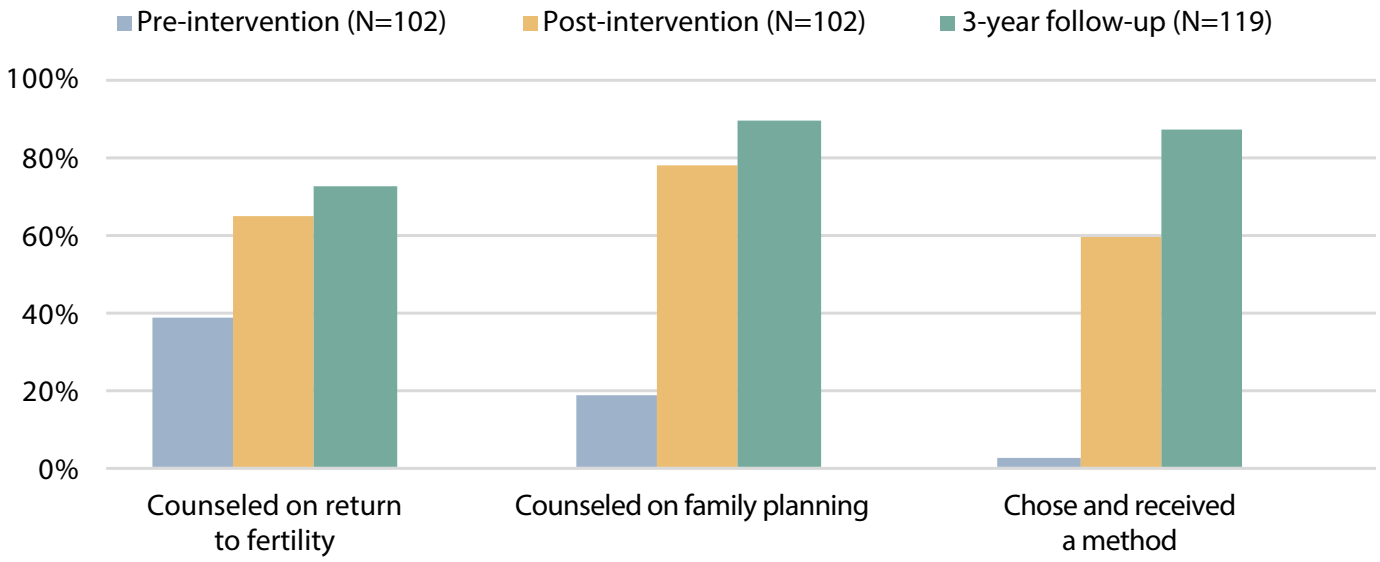
Postabortion family planning is scalable and sustainable, and program effectiveness can increase over time. The programs included in Figure 2 represent large-scale implementation in a diverse range of settings. Figure 3 shows data from Peru, where institutions have strengthened the family planning component of PAC and sustained or improved on these gains well after technical assistance ended.[34] Specifically, three years after technical assistance ended, over 80% of postabortion clients received a method prior to leaving the facility compared with just under 60% during the technical assistance period. Similar findings have been shown in Turkey.[28]

How to do it: Tips from implementation experience

Offering information and services to women at the same ***place*** and ***time*** they receive facility-based PAC is key to implementing effective PAC services. Additionally implementers should consider the following elements in their programs.

Address stigma and social and community barriers. Abortion is often stigmatized, particularly in settings where abortion is legally restricted. Seeking care to address complications of abortion or to choose a contraceptive

Figure 3: Postabortion Family Planning Outcomes in Peru Before, During, and Three Years After Technical Assistance



Source of data: Benson and Huapaya (2002).[34]

method can be particularly difficult for individuals in these settings or among individuals whose autonomy is limited because choosing to use a method implies her abortion was induced.[4] Offering family planning counseling and voluntary contraception to *all* postabortion clients—both those seeking treatment for miscarriage and those seeking treatment for induced abortion—helps reduce that potential stigma.

- **Engage communities and community health workers.** In Kenya, training community health workers to raise awareness and change community attitudes about PAC and to counsel women about family planning increased both the number of women using PAC services and the number using contraception. According to program implementers, the vast majority of PAC clients were referred by community health workers. A key approach is to engage communities in dialogue to define the need for PAC services, design PAC services that fit within the community culture, and develop local ownership for ensuring equitable access to and quality of PAC.[35-37]
- **Engage support networks.** Many women want their partner, husband, or other support person present for PAC counseling.[4] After discussing the client's preferences, including loved ones in counseling and clinical instruction has been shown to improve adherence to care instruction.[38]

Offer PAC at primary care facilities and allow nurses and midwives to provide care in order to expand access and reduce costs. Several countries, such as Ghana, Kenya, Mozambique, Nepal, Senegal, Tanzania, and Uganda, have demonstrated that trained, competent nurses and midwives can provide PAC services safely.[39-44] Task-sharing policies that expand the range of health care workers who can provide PAC, including family planning, may result in cost savings for the health system by reducing the work load at tertiary care facilities.[45,46] Several international health professional associations have endorsed this approach.[3] Task sharing may also result in savings for clients by making services more convenient and easier to access. Midwives and nurses are more widely accessible than physicians to women in remote or underserved areas. In addition, some studies have shown that establishing family planning as part of PAC services is easier in places where midwives are responsible for all reproductive health services.[39]

Invest in quality. In Bangladesh, clients who rated the postabortion services they received as medium- or high-quality were more likely to report using contraception three months later than clients who rated their services as low-quality.[47] Some of the elements of quality care include the following:

- **Offer a wide range of contraceptive methods.** Offering a wide range of methods, including long-acting methods, is likely to increase voluntary family planning uptake.[4] In Honduras, after introducing a wider range of contraceptive methods, the percentage of PAC clients leaving with a method increased from 13% to 54% after 20 months.[48] In Cambodia, the predicted probability of a client leaving with a contraceptive method was significantly higher in facilities offering more than four methods than in facilities offering one to three methods (42% versus 18%, respectively).[49]
- **Encourage and support providers to treat all clients respectfully.** Such support often includes, but is not limited to, provider training and values clarification to address provider bias. Training should be reinforced through supportive supervision, job descriptions, operational guidelines and policies, and other types of institutional support.

A woman holds a family planning display case containing a mix of contraception options.

- **Link clients to resources for ongoing support.** After initiating a contraceptive method, provide clients with information on where to access ongoing support and resupply, if necessary. Offer clients written instructions about how to use their preferred method for future reference. Digital technologies, hotlines, and community health workers may provide additional means to support clients. While offering follow-up support, health workers should be sensitive to client preferences and respectful of client privacy. Providing family planning counseling at follow-up visits is also an important factor in reducing subsequent abortions.[33,50]

Address the needs of PAC clients facing gender-based violence. Multiple studies highlight the relationship between gender-based violence and the increased risk of spontaneous abortion and/or increased likelihood to seek induced abortion.[51-56] Addressing these particular needs within PAC services requires training health care providers on how to identify survivors of intimate partner violence and sexual violence and respond to their needs, in addition to providing the necessary clinical care.[32,57]

Make contraception free or bundle it with the cost of postabortion treatment. In Burkina Faso, the cost of postabortion contraception is a significant barrier for many PAC clients.[58] For adolescents and other vulnerable women, costs contribute to delays in seeking PAC as well as in accessing family planning before discharge from the facility. In Senegal, management of client payments often leads to cumbersome processes, which serve as a barrier to access.[59] In Tanzania, where PAC and family planning services are supposed to be free, the average total out-of-pocket cost for PAC clients was more than US$20 (including transportation and treatment of complications, but with no charge for contraception).[60] In Russia, the financial cost of an abortion is substantially lower than the cost of using pills or condoms for a year.[50] Free contraception, waivers for poor and vulnerable clients, and streamlined payment systems are likely to enhance equitable access to contraception for PAC clients.

Ensure equitable access to postabortion contraception, regardless of:

- **Client's age.** In Kenya postabortion youth clients between the ages of 15 and 24 were less likely to receive a contraceptive method compared with adult clients (35% versus 48%, respectively), and 49% of youth reported not using contraception due to concerns of infertility, side effects, or lack of knowledge, compared with 22% of adults.[61] Specialized training on youth-friendly PAC was associated with a sustained greater voluntary uptake of contraception among young women in Ethiopia when compared with standard training.[62] Several countries including Angola, Ethiopia, Ghana, Kenya, Mozambique, Nigeria, Tanzania, and Uganda have assessed the quality of PAC for younger clients, and assessment tools are available.[63]
- **Local contexts.** In humanitarian settings, women and girls may be at increased risk of unintended pregnancy and unsafe abortion. Furthermore, they may not be able to continue with their contraceptive method as it was lost during displacement. Women, girls, and couples may not wish to become pregnant during a crisis situation and prefer to wait until security returns, livelihoods are assured, and their situation stabilizes.[64] Research has documented that approximately one in five women in complex humanitarian settings experienced sexual violence, which is likely an underestimate.[65] In Puntland, Somalia, an area of chronic conflict, an NGO implemented a package of interventions including competency-based training of providers, community engagement including with religious leaders, regular use of data for decision making, and medical supply chain strengthening. 98% of PAC clients were counseled on contraception, 88% of whom accepted a contraceptive method before leaving the facility, demonstrating that comprehensive PAC services can be successfully implemented in politically unstable and culturally conservative settings.[31]
- **The type of evacuation procedure received.** All contraceptives, with a few exceptions, can be offered after surgical or medical evacuation for treating complications (see Box 1). Most can be initiated on the day of treatment. However, postabortion family planning may be more or less frequently offered to women based on which evacuation procedure they received.[4,66] Family planning services should be offered to all postabortion clients on-site irrespective of evacuation procedure as an integral part of PAC.[67]

Box 1. Contraceptive Methods for Postabortion Care

Can start immediately:

- **Hormonal methods:** implants, monthly injectables, injectables, combined oral contraceptive pills, progestin-only pills, progestin-only injectables, combined patch, emergency contraceptive pills.
- **Barrier methods:** male or female condoms.
- **Intrauterine devices (IUDs):** copper-bearing or levonorgestrel-releasing. These can be provided immediately after emergency treatment of complications if there is no infection—or when infection is ruled out and resolved, and any injury has healed. However, IUD insertion following medical treatment of emergency complications requires the patient to return for a follow-up visit.
- **Diaphragms, cervical caps, and combined vaginal ring:** can be offered once injury is ruled out or after any injury to the genital tract has healed.
- **Permanent methods:** tubal ligation or vasectomy (for her partner). Permanent methods can be offered after the client has had time to rest and recover from any sedation, and is not stressed or in pain. Counsel carefully and be sure to mention available reversible methods.

Delay use:

- **Fertility awareness methods:** Standard Days Method or TwoDay Method. It is recommended that women start these methods after their regular menstrual pattern returns.

Source: WHO (2018).[1]

Tools and Resources

Postabortion Care e-learning course (published May 2018) provides an overview of postabortion care including its definition, objectives, justification, programming best practices, indicators for monitoring and evaluation, and strong evidence base, including evidence-based approaches to strengthen postabortion family planning. Available in English from https://www.globalhealthlearning.org/course/postabortion-care-pac.

Postabortion Care resource site is a one-stop source for basic instruments to assist policy makers, program managers, clinical staff, and donors in program design, implementation, and evaluation. Available in English, French, Russian, and Spanish from http://www.postabortioncare.org/.

Family Planning: A Global Handbook for Providers (2018 edition) includes a section on family planning in postabortion care. Users can download printable files or order a copy of the handbook at http://www.fphandbook.org/order-form.

For more information about High Impact Practices in Family Planning (HIP), please contact the HIP team at fphip@k4health.org.

References

A complete list of references used in the preparation of this brief can be found at:
https://www.fphighimpactpractices.org/briefs/postabortion-family-planning

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The World Health Organization/Department of Reproductive Health and Research has contributed to the development of the technical content of HIP briefs, which are viewed as summaries of evidence and field experience. It is intended that these briefs be used in conjunction with WHO Family Planning Tools and Guidelines: http://www.who.int/topics/family_planning/en/.

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