Challenges and opportunities in providing postabortion family planning services

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Introduction

Unsafe abortion is a major public health problem, especially in developing countries. Each year approximately 19 million women undergo unsafe abortion worldwide, with more than 90 percent of those women living in developing countries (WHO, 1993). 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. The phrase unsafe abortion also refers to the inappropriate management of complications caused by spontaneous abortion or miscarriage.

Women experiencing incomplete abortion as a result of miscarriage or unsafely induced abortion face many health risks such as hemorrhage and sepsis, permanent disability , e.g. infertility or even death. It is estimated that close to 70,000 women die each year as a result of complications of unsafe abortion. Unsafe abortion also poses a burden on the health care system. The WHO estimates that 10-50 percent of women who undergo unsafe abortion need medical care for treatment of hemorrhage, sepsis or other complications. A study conducted in 86 public hospitals in Egypt reported that approximately one of every five patients admitted to the Ob/Gyn ward was for treatment of abortion (spontaneous or induced) (Huntington et al., 1998).

There is enough evidence to suggest that postabortion women need family planning services to help them space pregnancies or avoid unwanted pregnancy. Most women who have undergone an induced want to avoid pregnancy (Salter, Johnston and Hengan, 1997). However, only a small proportion of postabortion women have ever used effective contraception, for many reasons such as inaccessibility of services, partner opposition or fear of side effects. Other women experienced unintended pregnancy due to contraceptive failure. In the above mentioned Egypt study only 38 percent of postabortion women reported that the lost pregnancy was planned, while 42 percent planned to use a contraceptive soon after discharge (Huntington et al., 1998).

Postabortion women are likely to have a repeat abortion unless they receive appropriate family planning services (Huntington, 2000). Studies in several countries have shown that between 11 and 48 percent of women seeking emergency treatment of abortion complications have already had a previous abortion (Salter, Johnston and Hengen, 1997). The fact that a woman's fertility is resumed as early as two weeks after an abortion places those women at risk of another unintended pregnancy.

Even women who have lost a desired pregnancy need to use family planning to improve maternal and newborn outcomes. A recent report by WHO Technical Consultation on Birth spacing recommended that after a miscarriage or induced abortion a woman should wait at least six months before becoming pregnant again to reduce the risks of maternal anemia, premature rupture of membranes, low birth and preterm delivery in the next pregnancy (WHO, 2006).

Postabortion family planning is essential to help break the cycle of repeat abortions and to help reduce maternal morbidity and mortality. Provision of family planning counseling is one of the essential elements of postabortion care, along with emergency medical treatment, and linkages with other reproductive health services (Postabortion Care Consortium Community Taskforce, 2002). Offering family planning services at the time of emergency treatment can help future unintended pregnancies, reduce women's needs for abortion and subsequent emergency postabortion care (Huntington, 2000).

Several models for linking family planning with emergency postabortion care services have been examined. Those models range from referring postabortion women to family planning clinics without any information or counseling to on-site provision of family planning counseling and methods at the same location where the woman receives emergency treatment. This paper will review different models of linking family planning with postabortion care, with emphasis on the pros of cons of on-site delivery of family planning services. Finally, the paper will present recommendations to enhance the delivery of postabortion family planning services.

Models of providing postabortion family planning

In many settings postabortion women first present to the formal health care system with complications of an abortion (e.g. incomplete abortion, bleeding, infection … etc.). Medical treatment of abortion women (spontaneous or induced) often takes place in the emergency care unit or the Ob/Gyn ward of a secondary or a tertiary care government facility. The environment in those settings is crisis-oriented and geared towards treating complications of abortion. Staff in those facilities have a curative approach to care and many of them hold negative attitudes towards postabortion patients (Benson et al., 1992).

Family planning services are not routinely provided in the emergency ward or the Ob/Gyn ward mostly because family planning and emergency / curative care services are physically and administratively segregated. A woman who wants to receive postabortion family planning can either seek services at the hospital family planning clinic which works for limited hours during the day and is located away from the emergency ward where the woman had received treatment. Or she can go to a family planning near her residence after she is discharged from the hospital.

In Kenya, Solo and her colleagues tested three different models of linking family planning to postabortion care services. In the first model family planning services (counseling and methods) were provided on the gynecological ward by the same staff who provided postabortion care. In model II, family planning services were provided on the Gyn ward by MCH-FP staff from the clinic while in model III family planning services were provided in a hospital based clinic by MCH-FP staff (Solo et al., 1999). The study results showed that when ward staff provided family planning services (i.e. model I) a higher proportion of women who decided to begin using contraception left the hospital with a family planning method (82 percent for model I, compared with 63 percent and 75 percent for models II and III respectively). According to Solo, many

providers noted the advantages of allowing the same nurse to be responsible for a patient's management at the facility from treatment to counseling to discharge. This approach by many providers as optimal for staffing. On the other hand, the coordination between different units required for the staffing of model II (i.e. having an MCH-FP nurse come to the Ob/Gyn ward to provide FP services) proved to be particularly difficult. Moreover, patients in sites which applied model III had to wait until the morning to be escorted as a group to the MCH-FP clinic to receive FP services, adding to the time they spend in the hospital. Also, the long distance from the ward to the family planning clinic was viewed as burdensome to both patients and staff.

A study conducted in 71 hospitals and 115 health care centers in Cambodia found that approximately 42 percent of postabortion women accepted contraception at the conclusion of care. After controlling for individual and facility characteristics, women who presented at facilities where a nurse / mid-wife (as opposed to a physician) managed abortion services, where contraceptives and abortions were provided in the same room, and where a large range of methods were offered had significantly higher odds of contraceptive acceptance following abortion care. The authors argue that staff in small health centers may have had more time to attend to patients, or were more empathetic to clients. Midwives may also provide higher quality counseling and contraceptive provision in general compared with physicians (McDougall et al., 2009).

In China, Liang Zhu and colleagues compared two postabortion family planning service packages on contraceptive use and repeat abortion rate among young women in three cities in China. One package included provision of limited information and referral to existing FP services. The other package included individual counseling, free provision of FP methods and involvement of the male partner. Women undergoing abortion were followed up for six months. A total sample of 2336 women participated in the study. Both packages increased use of any contraceptive method, but the comprehensive approach increased the use of more effective methods. Odds ratio for consistent and correct use of condoms were 2.32 and 2.78 compared with the simple package. The rates of unwanted pregnancies and repeat abortions were somewhat reduced for both packages with no significant statistical difference between them.

In Perm, Russia, Population Council researchers tested two models of providing postabortion family planning services. Model I consisted of training providers in pre-discharge family planning counseling, and providing provider job aids and client education materials on postabortion family planning. Model II had the same intervention components and in addition offered a free initial three months supply of condoms, pills, DMPA, or an IUD to all postabortion clients requesting a modern contraceptive method. The availability of commodities on the ward increased the likelihood that providers would discuss family planning with postabortion clients. Also, significantly more clients left the facility with a family planning method under model II, but there were no significant differences in family planning use at one year postabortion. Also, receiving counseling at the follow up visit was an important factor in reducing repeat abortion (Savelieva et al., 2002).

A study conducted in Egypt reported somewhat different results from the above findings. The first model that was tested in the Egypt study involved family planning counseling and referral of the woman to a family planning clinic near her place of residence while the second model involved counseling and provision of family planning services on site. The study results showed no significant differences between the two models with regard to contraceptive use at two weeks or three months post-discharge. However, availability of family planning methods on the ward was associated with improved quality of family planning counseling and increased patient knowledge of time of return to fertility. Patient acceptance of family planning methods before discharge was very low in this study. Desire for more children, concern about method side-effects, and need to consult with husband approval were major obstacles to accepting a family planning method before discharge (Youssef et al., 2007).

In summary, research evidence suggests that provision of postabortion family planning services at the same location as emergency care can increase the proportion of women leaving with a contraceptive method and eventually reduce repeat abortions (Wood et al., 2007). Provision of postabortion family planning is also associated with better outcomes for clients, providers and programs (Foreit, 2005). Women save time and money and avoid the risks of unintended pregnancy when provided with complete family planning services before discharge. It might be more convenient for a client to receive family planning services by the same provider who had treated her from abortion complications, as he / she would be knowledgeable of her medical condition and /or circumstances that have led to the abortion (spontaneous or induced). Also, with this model, the client does not have to make a visit to the hospital family planning clinic which might be closed or overcrowded at the time the woman is discharged from hospital. Needless to say, provision of family planning methods before the woman is discharged from hospital ensures timely initiation of contraception before ovulation is resumed hence minimizes risk of another unintended pregnancy.

Last but not least, emergency postabortion care may be one of the few contacts postabortion women have with the formal health system and thus becomes an opportunity for receiving family planning services (Benson et al., 1992). This often leads to savings for the program as more unintended pregnancies and more unsafe abortions are averted hence fewer women would need the costly emergency services for treatment of abortion complications.

Challenges in providing on-site postabortion family planning

Despite its benefits to clients, providers and the health care system, on-site provision of planning services faces many challenges. In curative or emergency care settings where staff has multiple responsibilities (e.g. management of deliveries, obstetric emergencies … etc.) staff may find little time to provide family planning services. The curative care orientation that Ob/Gyn providers have and the little emphasis they place on preventive services or interpersonal aspects of care makes provision of family planning counseling let alone method provision a challenge in many developing countries. Health care providers often view counseling as a non-medical function requiring specific training, a specially designated time apart from the provision

of other postabortion services and a separate private facility (Tabutt – Henry and Graff, 2003). At one Turkish government hospital only 14 percent of women reported receiving family planning counseling and information despite the fact that the doctors treating them were trained in family planning counseling and services (Bulut and Toubia, 1994). Segregation of curative care and family planning services further reinforces the above attitudes by service providers and limits their accountability for family planning services.

Providers on the Ob/Gyn ward who do not routinely provide family planning services know little about family planning methods or are misinformed about contraceptive technology. Others have their own biases and misconceptions about postabortion family planning. In the above mentioned Egypt study , only 30-40 percent of providers believed that all postabortion women should receive family planning counseling and only one quarter believed that all family planning methods could be suitable for postabortion women (Youssef et al., 2007).

Client follow up after receiving postabortion family planning is another challenge that faces hospital based family planning programs. First, some women may find it inconvenient to return to the hospital for method follow-up if emergency postabortion care was delivered far from the woman's home. Moreover, in most hospital settings follow up of postabortion family planning is provided by staff at the hospital family planning clinic and not by Ob/Gyn staff who provided medical care to the woman. This arrangement allows no opportunity for continuity of care. It is therefore recommended that if the facility is not the one that a woman would go to for resupply of her method, or if does not have her method of choice, providers need to refer her to a referral site. Ideally, the woman would leave the treatment facility with an interim method to use until she receives her preferred method at the referral site (Corbett and Turner, 2003).

The woman's emotional state during treatment from abortion complications may not be suitable for making voluntary informed decisions about contraception (Benson et al., 1992). Some women may have concerns about their health or future fertility (Huntington, Nawar and Abdel-Hady, 1997) while others may be afraid of the legal or social consequences of the abortion (Tabbutt-Henry and Graff, 2003). A review of evidence in postabortion care reported that 1-41 percent of women who have had abortions were likely to experience feelings of loss, guilt, shame, anxiety, and depression (Wood et al., 2007). Long-term provider dependent methods thus should not be offered to those women. Temporary methods and a referral for longer acting methods are suggested. Alternatively, those women could receive family planning counseling (if their condition permits) and be given a follow up appointment or referred to a family planning clinic to receive a contraceptive method within two weeks postabortion.

Last but not least, some women would not accept a family planning method because they want to become pregnant soon. Others can not make a decision about contraception before consulting with their partner / families. If those women receive a family planning method before discharge from hospital they might be reprimanded by their partner or forced to discontinue the method. In the above mentioned Egypt study, 88 percent of women believed

their husband would be upset with them if they accepted a family planning method before discharge (Youssef et al., 2007). In fact, many women are exposed to pressure from their husband / in-laws to become pregnant soon after an abortion. Also, women and their families are concerned about effects of contraception on their future fertility (Huntinton, Nawar and Abdel-Hady, 1997; Abdel-Tawab, Loza and Zaky, 2008), while others would not accept a family planning immediately after abortion because they believed their body needed some rest (Youssef et al., 2007). Involving partners / family members in postabortion family planning counseling would solicit their support for family planning and increase likelihood of contraceptive uptake (Abdel-Tawab et al., 1999).

Conclusion

Provision of family planning services to postabortion women is crucial for ensuring healthy timing and spacing of pregnancies and for preventing additional unintended pregnancies and unsafe abortions. There is enough evidence to suggest that offering family planning counseling and methods at the same location where the woman receives emergency treatment can increase the proportion of women leaving the facility with a family planning method. However, on-site delivery of family planning counseling and methods within postabortion services may not be feasible for all women or all settings. Before implementing the model a needs assessment must be conducted to determine whether certain conditions are met, e.g. availability of trained staff, private space for counseling, space to store FP commodities … etc. (Solo et al., 1999).

Choice of a model of providing family planning services should be based on the individual needs of every woman. Contraceptive protocols should be based on the assessment of each woman as an individual (personal characteristics, clinical conditions, and service delivery capabilities) (At a minimum all women treated for abortion complications need to know that their fertility returns rapidly, modern family planning methods are safe and effective after treatment for abortion complications and family planning information and services are available (Salter, Johnston and Hengen, 1997). Women who are interested in family planning and who are willing and ready to make a decision can be offered a choice of receiving a family planning method on-site or at a family planning clinic within two weeks postabortion. Even where a woman can receive a method on site, referral to a provider from whom she can receive on-going contraceptive care is necessary to ensure continuity of care and method resupply.

Policy recommendations

- Family planning counseling and services should be an integral component of postabortion care, regardless of location of treatment;

- Structural and administrative barriers to provision of postabortion family planning services should be overcome. Integrating family planning into postabortion care services can not be achieved without the input and commitment of top level officials in both curative care and family planning sectors;

- Consolidating services to use space and staff time more efficiently can make family planning services more accessible to postabortion women (e.g. by designating one or two nurses on the ob/Gyn ward for family planning counseling, setting up a private space for postabortion family planning counseling on the Ob/Gyn ward);

- Pre-service and on the job training for Ob/Gyn staff on postabortion family planning counseling and contraceptive methods. Moreover, service delivery guidelines should emphasize the importance of family planning as an integral component of postabortion care;

- Adequate referral mechanisms should be established between the Ob/Gyn ward and the hospital family planning clinic or other family planning clinics in the area. This would ensure adequate services for women who choose not to receive family planning services on site and would allow continuity of care and method resupply.

- Partners of postabortion women should be involved in family planning counseling, after obtaining the woman's informed consent. A space for counseling partners of postabortion women should be set up on the Ob/Gyn ward.

- Service providers must work with community leaders, advocacy groups and lay health workers to counter fears and misconceptions about postabortion family planning and thereby help women prevent unwanted or closely spaced pregnancies.

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