POSTABORTION CARE CONSORTIUM

Meeting at the
Women Deliver Conference
Kuala Lumpur, Malaysia
May 27, 2013
Cathy Solter, Pathfinder International
Maureen Corbett, IntraHealth International, Inc.
Ricky Lu, Jhpiego
OVERVIEW OF THE PAC CONSORTIUM

• Opening Remarks
  • Cathy Solter, Pathfinder International

• Introduction to the PAC Consortium
  • Maureen Corbett, IntraHealth International

• Postabortion Care 101: Essential Technical and Programmatic Elements
  • Ricky Lu, Jhpiego
THE BURDEN OF UNSAFE ABORTION

Annually

- 205 million pregnancies
- 40% of them unplanned
- 215 million women have unmet need for FP
- 20 million unsafe abortions
- 67,000 women die from unsafe abortion: 13% of all pregnancy-related deaths
- Half of all deaths from unsafe abortion are in Asia
- WHO estimates that in Africa, 1:7 maternal deaths result from unsafe abortion

Adapted from Curtis, ESD Bangkok 2010
PAC CONSORTIUM

- Established in 1993 to encourage donors to address unsafe abortion in their policies and programs
  - Postabortion care: a strategy to reduce maternal mortality and morbidity due to unsafe and incomplete abortion
- Additional organizations joined – membership now represents an estimated 30 organizations worldwide
- Mission expanded to include sharing experience and resources across countries and continents
**BRIEF HISTORY**

1993: Consortium established

1994: ICPD in Cairo – Consortium promoted the importance of recognizing unsafe abortion as a major cause of maternal mortality and emphasized the unmet need for FP services

1995: Published *Postabortion Care: A Reference Manual for Improving Quality of Care*

1995: Created MVA Drawdown Account. Packard Foundation and other donors provided more than $250,000 in MVA equipment to PAC programs around the world

2002: Redefined the *Essential Elements of PAC* model

2006: Provided technical guidance of *Youth Friendly PAC Services* and published *Indicators for Essential Elements of PAC*

2012: *Supplemental Training for Youth Friendly PAC*
HOST ORGANIZATIONS

• 1996-1998: Ipas
• 1998-2000: EngenderHealth
• 2000-2002: Pathfinder International
• 2002-2004: Jhpiego
• 2004-2006: IntraHealth International
• 2006-2008: Population Council
• 2008-2011: Family Care International
• 2011-2013: Pathfinder International
GOVERNANCE AND STRUCTURE

• Governed by a Steering Committee
  • Pathfinder International
  • EngenderHealth
  • Ipas
  • Population Council
  • Venture Strategies Innovations
  • IntraHealth International

• Task Forces
  1. Service Delivery
  2. Misoprostol and PAC
  3. Essential Supplies
  4. Youth Friendly PAC

• Two meetings/year
CURRENT PRIORITIES

- **Task Forces**
  - Service Delivery
  - Youth-Friendly PAC
  - Misoprostol for PAC
  - Essential Supplies

- **Country Teams**
  - Pakistan
  - Tanzania
  - Rwanda
  - Senegal

- **Strategic Partnerships**

- **Five Essential Elements of PAC**
  - Community and service provider partnerships
  - Counseling
  - Treatment
  - Contraceptive and family planning services
  - Reproductive and other health services
**How You Can Get Involved**

- Participate in meetings
- Join a Task Force
  - Learn more today
- Create a Task Force
  - Do you see a need not being met by the current Task Forces?
  - Each task force should identify an important gap or need, determine a strategy, and set objectives, deliverables and deadlines → Submit to Steering Committee c/o Coordinator
  - Task Forces have the opportunity to present their work and solicit input during Consortium meetings
  - *Proposal to Form a Task Force* form on the website
HOW TO ACCESS NEWS AND RESOURCES AND ENGAGE IN THE LARGER PAC COMMUNITY

• Sign up on: www.pac-consortium.org

• Join the PAC Consortium Community on the Implementing Best Practices (IBP) Knowledge Gateway: www.knowledge-gateway.org
POSTABORTION CARE 101: ESSENTIAL TECHNICAL AND PROGRAMMATIC ELEMENTS

• Why PAC?
• What are the essential elements?
• What about misoprostol?
• Challenges
• Q&A
Basic Information: Abortion and Miscarriage

- Spontaneous abortion
  1. Threatened abortion
  2. Inevitable abortion
  3. Complete or incomplete abortion
  4. Missed abortion
  5. Recurrent abortion

- Elective/Induced Abortion
  1. Safe abortion
  2. Unsafe abortion

- Fertility returns:
  - In 2 weeks time for abortion <12 weeks
  - In 4 weeks time for abortion 12–24 weeks

- Waiting 6 months:
  - Improve maternal health
  - Better newborn outcomes
Who Has Unsafe Abortions and Who Dies from Them?

Percentage distribution of unsafe abortion and associated mortality, by age

(WHO, 2007)
Unsafe abortion is a key indicator of unmet need for FP

Failure to provide FP is a major contributor to the problem of unsafe abortion

Emergency treatment is not linked to FP counseling or services
FACTORS CONTRIBUTING TO THE RISK OF REPEAT UNSAFE ABORTION

• Lack of understanding of patients’ reproductive health needs (provider)
• Lack of FP information and services for some groups of women (e.g., adolescents, single women, living in rural areas)
• Separation of treatment services from FP services
• Misinformation about which FP methods are appropriate postabortion (provider and patient)
• Lack of recognition of problem of unsafe abortion and patient FP needs (provider)
• Limited access to emergency contraception
COMPONENTS OF POSTABORTION CARE

USAID Model
- Emergency
- FP/RH
- Community

Essential Elements of PAC Model
- Community/Provider Partnerships
- Counseling
- Treatment
- FP Services
- RH Services

Emergency Treatment

FP Counseling, Provision; Selected RH (STI,HIV)

addresses current threat to life

prevents future threat to life

Community Empowerment through Community Awareness and Mobilization
Emergency Treatment

• Initial screening (triage) for emergency conditions
• Talk to client about her condition
• Medical assessment
• Stabilization
  — Referral or transfer for treatment
  — Prior to uterine evacuation
• Uterine Evacuation
  — Curretage
  — Manual Vacuum Aspiration (MVA)
  — Misoprostol
UTERINE EVACUATION: SURGICAL

- Principle: Vacuum to evacuate the uterus
  - 60 cc syringe
  - Cannulae

- Rationale for using MVA
  - Fewer complications
  - Can be safely provided by trained midlevel providers
  - Can be offered in low resource setting
  - Earlier and increase access to service
UTERINE EVACUATION: MISOPROSTOL

• Rationale for using Misoprostol
  – Non-invasive
  – Can be provided by trained midlevel providers safely
  – Can be offered in low resource setting
  – Earlier and increase access to service

• Misoprostol
  – Prostaglandin Analogue
  – Uterine contraction

• Dose and Route
  – Abortion < 12 weeks
  – Oral (600 mcg) SD
  – Sublingual (400 mcg) SD

• Side Effects/Complications
  – Mild diarrhea, vomiting, abdominal pain, fever, shivering (5-60%)
  – Uterine rupture/bleeding
  – Mobius syndrome
REGISTRATION OF MISOPROSTOL IN AFRICA AND ASIA

*Misoprostol may or may not be registered for gastric ulcers
Registered for gastric ulcers only
Registered for postpartum hemorrhage (PPH)*
Registered for PPH and another ob/gyn indication*
Registered for other ob/gyn indication (not PPH)*

- NEPAL
- INDIA
- TANZANIA
- NIGERIA
- BANGLADESH
- ZAMBIA
- UGANDA
- KENYA
- SOMALILAND
- SUDAN
- GHANA
- SOMALILAND
- MOZAMBIQUE

VSI Document
## Postabortion Care and Level of Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Health Post</th>
<th>Health Center</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Refer for postabortion care services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provide pain medication</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Treatment of incomplete abortion &lt; 12 weeks with Vacuum Aspiration (Manual/Electrical*)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Treatment of incomplete abortion ≤ 12 weeks with misoprostol</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Administer antibiotics and IV fluids</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Second trimester uterine evacuation (IUFD, incomplete abortion)</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Treatment of complications</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

* Where available
## Postabortion FP

<table>
<thead>
<tr>
<th>METHOD</th>
<th>WHEN TO START</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hormonal Contraception</strong> (COC, DMPA, Implants)</td>
<td>Immediate</td>
<td>Effective immediately Can be used even if infection is present</td>
</tr>
<tr>
<td><strong>Intrauterine Device</strong>&lt;br&gt;a) 1\textsuperscript{st} Trimester</td>
<td>Immediate or Delayed</td>
<td>No infection present</td>
</tr>
<tr>
<td>b) 2\textsuperscript{nd} Trimester</td>
<td>Immediate or 4-6 weeks</td>
<td>Similar to postpartum IUD</td>
</tr>
<tr>
<td><strong>Tubal Occlusion</strong></td>
<td>Immediate Delayed</td>
<td>Clean procedure Allow for infection to resolve</td>
</tr>
</tbody>
</table>

**ALL METHODS ARE ACCEPTABLE**
- Counseling
- Screening for Medical Eligibility
MISSING THE MARK: POSTABORTION FP

DR, HAITI, NICARAGUA

- Using FP before pregnancy (method failure): 15%
- Desire to space or limit next pregnancy: 39%
- Desired a FP method before leaving facility: 30%
- Left facility with FP method: 10%

Curtis, ESD Bangkok 2010
### Barriers to Postabortion FP

#### National Norms and Policies
- Some cadres not allowed to provide PAC treatment
- Limitations on who can receive FP
- Limited availability of services
- Inadequate budget for commodities

#### Health System
- Lack of policies and guidelines
- Lack of organized services to provide FP
- Stock-outs of contraceptives
- Limited method mix
- Additional fees

#### Provider
- Negative attitude
- Inadequate training and linkages with BmOC
- Lack of knowledge about rapid return to fertility
- Inadequate referral for FP (when not available in treatment room)

#### Client
- Lack of counseling on FP methods and availability
- Additional charges for FP

#### Other
- Provider training focuses on emergency treatment

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Adapted from Curtis, ESD Bangkok 2010
TAKE HOME MESSAGES

• Postabortion care saves lives
• Prioritize postabortion FP for all clients
• Prioritize FP to prevent future unwanted pregnancy and unsafe abortion
PAC CONSORTIUM COUNTRY TEAMS

- **Country Teams:**
  - Pakistan, Tanzania, Rwanda, Senegal

- **Purpose:**
  - Assess quality and coverage of PAC services in country
  - Disseminate results to MOHs and other entities to gain support and policy champions
  - Create or support national plan for scaling-up PAC services

- **Criteria for Country Team Selection:**
  - High maternal morbidity and mortality due to unsafe abortion
  - Abortion is highly restricted (due to policy or stigma) and PAC is not widely accessible
  - At least one steering committee organization and one or more PACC-affiliated organization(s) working on PAC in the country
  - Existing local partners