

**MATERNAL HEALTH
AND SAFE MOTHERHOOD PROGRAMME**

**THE PREVENTION AND MANAGEMENT
OF UNSAFE ABORTION**

Report of a Technical Working Group
Geneva, 12-15 April 1992



Division of Family Health
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PREFACE

The Safe Motherhood Initiative (SMI) is a global effort to reduce maternal mortality and morbidity. The target is to reduce maternal deaths by at least half by the year 2000 and to achieve substantial reductions in maternal morbidity. Activities within the Initiative take many forms: increasing awareness of the nature of the problem and the need for action; strengthening maternal health services; training of health workers and others; facilitating educational and economic opportunities for women; and research, particularly operational research. All these measures, which will help to reduce maternal mortality, will also exert at least equal effect on maternal morbidity which derives from the generally poor health of women and girls and inadequate care during pregnancy and labour and in treatment for the complications of unsafe abortion.

In order to be able to provide more effective support to Member States in technical fields, WHO's Maternal Health and Safe Motherhood Programme has been holding a series of meetings and consultations with experts on a variety of subjects relating to maternal health. Their task is to review current knowledge and experience of a given high priority topic, produce guidelines and, if necessary, to recommend needed epidemiological and operational research. Some technical groups have already produced guidelines such as *Studying Maternal Mortality in Developing Countries* (1), *Essential Obstetric Functions at First Referral Level* (2), and *The Prevention and Treatment of Obstetric Fistulae* (3). One working group has prepared guidelines on the measurement of the prevalence of reproductive morbidity (4) and another, on the prevention and management of postpartum haemorrhage (5).

This Technical Working Group on the Prevention and Management of Unsafe Abortion is part of the effort to provide more effective support to countries, particularly in areas where WHO has a unique contribution to make in norm-setting and the establishment of agreed standards. This report contains the collective view of a group of international experts and does not necessarily represent the stated policy of the World Health Organization.

Resulting from this report will be a set of clinical guidelines for emergency treatment of abortion complications at the first contact and first referral levels.

A companion document to this report *Technical and Managerial Guidelines for Abortion Care* (6) is currently in preparation. Together these documents will provide a strong basis for designing, implementing, and evaluating programmes for improving abortion care throughout the health care system.

1. INTRODUCTION

Global attention is increasingly being focused on the primary causes of maternal mortality and morbidity. WHO and other agencies involved in the Safe Motherhood Initiative are working to identify practical solutions which can significantly reduce these tragedies.

Complications resulting from unsafe abortion are an important cause of maternal mortality and morbidity. On a country-specific basis deaths related to complications of unsafe abortion range from under 10% to almost 60% of maternal deaths (7). These statistics are all the more compelling as the majority of these deaths are preventable with currently existing, but not universally available, drugs, technologies and management systems.

The World Health Organization has assisted Member States for more than 25 years in addressing the public health concerns surrounding unsafe abortion, including awareness raising, identification of priority areas for intervention, prevention of unsafe abortion through family planning information and services, and training of health workers. At the Twentieth World Health Assembly in 1967, Resolution WHA 20.41, noted that "abortions... constitute a serious public health problem in many countries" and recommended that the Organization continue to work "in the field of health aspects of human reproduction".

In keeping with WHO's mandate to provide the most up-to-date technical information in the health field, in 1992, the Maternal Health and Safe Motherhood Programme of WHO convened a Technical Working Group of experts in the area of unsafe abortion. The Group's task was to review clinical management materials and make suggestions for additional clinical and operational research in the areas of treatment of abortion complications and post-abortion contraception.

Ninety-nine per cent of maternal deaths occur in the developing world. The Technical Working Group's discussions, therefore, focused on the situation in those countries rather than in the developed countries.

The specific objectives of the meeting were to:

1. review draft guidelines on the clinical management of complications of unsafe abortion and modify them as necessary;
2. review the background paper on provision of immediate post-abortion contraception (i.e. before discharge from hospital), and modify as necessary;
3. review the need for additional clinical research in the two areas above;
4. review the need for operations research to evaluate the impact of the adoption of the guidelines;
5. suggest appropriate indicators for monitoring progress made.

Other aspects of unsafe abortion are not covered by these objectives but may be covered by future meetings of the Technical Working Group.

Following the opening of the meeting, Dr. Halida Akhter was selected as Chairman and Katie McLaurin as Rapporteur. A list of participants is attached to this report (Annex 2).

Several background documents were prepared in advance of the meeting. These included the draft manuals, Clinical Guidelines for Emergency Treatment of Abortion Complications at the First Referral Level and Clinical Guidelines for Emergency Treatment of Abortion Complications at the Primary Care Level prepared by International Projects Assistance Services (IPAS) and the working paper on contraception after an unsafe abortion prepared by Nadine Burton.

2. BACKGROUND

2.1 Definitions

An integral objective of the WHO Maternal Health and Safe Motherhood Programme is that family planning information and services should be available, accessible and affordable to all. Unfortunately this ideal has not been universally attained. In addition, contraceptive methods may fail. As a result large numbers of women throughout the world continue to rely on abortion as a means to end an unwanted pregnancy. Too often these women are risking their lives and health when the services they find are unsafe. This need to rely on unsafe abortion signals a failure of health systems to provide appropriate care to these women who are seeking a means to control their fertility. Within every health care context when there is a threat to health, a moral obligation exists to assess its impact and to ensure that humane and appropriate care is available and accessible. In the case of unsafe abortion, women's lives and health are clearly threatened (8).

The term **Unsafe Abortion** was used by the Technical Working Group to reflect concern for the safety of abortion services, which were the focus of its discussions rather than the legal issues surrounding abortion. Unsafe abortions are characterized by the lack or inadequacy of skills of the provider, hazardous techniques and unsanitary facilities. Unsafe abortion with its many resulting complications is responsible for the deaths and illness of hundreds of thousands of women each year. The legality or illegality of the services, however, may not be the defining factor of their safety. To prevent the deaths of women, the safety of abortion (whether elective induced abortion or the treatment of spontaneous or incomplete abortion) must be considered within both the legal and legally restricted contexts.

An effective mechanism for reaching women more promptly with the care they require for complications of unsafe abortion is for appropriate and timely care to be available as close to women as possible. The Technical Working Group, therefore, was principally concerned with describing the types of clinical services, trained staff, and systems that need to be in place at the primary care and first referral levels.

The **Primary Care Level** is the most basic level of the formal health care system and includes first aid stations, nursing posts, dispensaries, and health posts or centres. Primary care facilities seldom are staffed by a full complement of health care professionals. At this level, the staff often have not been trained in care of abortion complications. Training health workers to provide emergency abortion care is a practical solution to staff shortages, particularly where few medical doctors and limited paramedical staff and/or other non-physicians may be available.

The **First Referral Level** is the hospital or health centre to which a woman is referred when she requires care beyond the capabilities of the primary level. This is most often the district, sub-district, or cottage hospital where care is available 24 hours a day. The first referral level is usually staffed by at least one physician. Physicians who have been trained in life-saving obstetric and gynaecological procedures may be available in some facilities. However, trained non-physicians may perform certain surgical procedures such as uterine evacuation when doctors are not available. Other reproductive health services provided at this level typically include caesarean section, surgical contraception, and elective abortion as allowed by local regulations.

2.2 Overview of the Contribution of Unsafe Abortion to Maternal Mortality

An overview of the contribution of unsafe abortion to maternal mortality was presented by the Secretariat. The legal status of abortion by percentage of the world's population affected imply the following statistics: 40% have access to abortion on request; 12% have access to abortion on grounds such as social, economic, or fetal indication; 23% have severely restricted access to abortion, usually only in cases such as saving the life of the mother; and for 25% abortion is prohibited through the health services on all grounds.(9)

Even in countries where abortion services are ostensibly available (roughly 50% of the world), services may not be accessible to women or women may be unaware that services are available. As a result a large proportion of the world's women are without access to safe termination of pregnancy.

In developed countries where safe abortion is readily available, abortion-related mortality is extremely low, at less than 1/100,000 procedures. In less optimal settings, when women are only able to find unsafe abortion, mortality can be high.

Exact numbers of deaths from unsafe abortion are difficult to determine, in large part because it is almost impossible to estimate accurately a) abortion rates (i.e. number of abortions per women of reproductive age) and b) case fatality rates (i.e. number of abortion deaths per total abortions).

Data are usually derived from several sources, including hospital-based data, civil registration, and community-based data. Each of these sources can present a challenge to researchers for a variety of reasons, including lack of specificity of the cause of deaths, misclassification of the deaths, or reluctance to provide complete information.

Given the data available, however, a range of estimates emerges, from a minimum of 50,000 to 150,000 abortion-related deaths annually. Some researchers believe that the often quoted 200,000 abortion-related deaths per year, which may have been true several years ago, is now in fact lower. This potential decline in annual abortion-related deaths may be attributable to safer abortion care being more widely available. Whatever the number, the fact is that our health systems continue to fail women by letting preventable deaths occur.

3. DISCUSSION OF DRAFT GUIDELINES FOR THE CLINICAL MANAGEMENT OF COMPLICATIONS OF UNSAFE ABORTION

3.1 Expanding Access to Care

Care for complications of unsafe abortion must be extended throughout the health care system, particularly to the primary care level. Currently, many primary care centres do not provide any emergency stabilization or intervention for women with abortion complications prior to referral. Decentralization of services is essential, bringing with it more immediate life-saving care and preventing unnecessary deterioration in the woman's condition when referral and transport is required.

A critical step in the process of expanding access to care is the creation of a continuous chain of care, with providers at each level understanding their role in this chain. Providers, particularly at the primary and first referral levels of care, must receive training which clearly identifies their essential role in the prevention of maternal mortality and morbidity from abortion complications.

Personnel at every level of care must recognize that complications from unsafe abortion are potentially life-threatening. Many women seeking care encounter health care providers who view this serious medical problem as a lower priority than other disorders. Training about the serious nature of abortion complications can help change these attitudes. In addition, staff's judgemental or punitive approaches toward women seeking care for abortion complications often result in delay of life-saving care and in undue suffering. It is essential to identify and address these punitive attitudes so that women receive prompt, safe, and respectful care and are not made to suffer unnecessarily.

For every woman seeking care for abortion complications, whether from spontaneous or from unsafe induced abortion, her reproductive desires and plans must be considered at the time of treatment. To prevent future unwanted pregnancies, this at-risk group of women must be provided contraceptive information and services as an essential element of care. Each provider must accept responsibility for integrating such care into the treatment of women with abortion complications.

3.2 Services at the Primary Care Level

The availability of trained staff, supplies and equipment at the primary level varies widely. However, it is the responsibility of the health system to see that life-saving care is available to the extent possible at this level. This will include:

- recognition of the signs and symptoms of incomplete abortion and abortion complications such as sepsis and haemorrhage;
- basic physical and pelvic examinations (especially vital signs and determination of uterine size), including digital extraction of any products of conception visible at the cervical os;
- diagnosis of the stages of abortion;
- emergency resuscitation and preparation for treatment or transfer (including management of the airway and respiration), beginning antibiotic therapy, control of bleeding, and control of pain;
- laboratory tests of hematocrit or hemoglobin;
- referral, including arrangements for transportation, to the first referral or higher level facility for treatment of complications beyond the capability of this level;
- family planning information and counselling.

When trained staff and equipment are available, the services listed above can be extended to include a broader range, thus making care more accessible to women. The expanded range of emergency abortion care services that can be made available at the primary level includes:

- beginning essential treatments, including intravenous fluid replacement and oxytocics as needed;
- uterine evacuation during the first trimester;
- basic pain control (paracervical block, simple analgesia) and sedation;
- family planning information, education, counselling, and provision of services and/or contraceptives.

3.3 Services at the First Referral Level

First referral facilities should have available trained staff and equipment to carry out all of the functions enumerated above. In addition, these facilities should be prepared to provide expanded care with the necessary equipment and trained staff who can diagnose and treat most abortion complications, including:

- emergency uterine evacuation, as indicated, through the second trimester;
- treatment of most abortion complications;
- blood crossmatch and transfusion;

- local and general anaesthesia;
- laparotomy and indicated surgery, including surgery for ectopic pregnancy;
- early diagnosis of pregnancy;
- diagnosis and referral, including arrangements for transport, for major complications such as renal failure and any other cases that cannot be managed at the facility;

These services, linked to those of the primary and secondary or tertiary levels will provide a chain of essential care for women seeking treatment of abortion complications.

3.4 Use of the Clinical Guidelines

The clinical guidelines under review and accompanying managerial guidelines (not attached) will serve several purposes in the expansion of emergency abortion care services. These uses include:

- clinical guidance for health personnel in the direct provision of care;
- guidance for service managers in the support (both in training and supplies/equipment) of abortion care services;
- guidelines for trainers in expanding or improving care in a clinical setting;
- assistance to policy makers in the review and adaptation of care to be available at the primary and first referral levels;
- identification of abortion complications as a priority emergency service requiring a prompt, skilled response.

To meet these goals, the guidelines will accomplish the following: specify care to be delivered, including instructional guidance for training; designate the most essential life-saving services which must be delivered immediately; and list essential drugs and equipment to be available for the provision of abortion care.

For **providers**, a single clinical document¹ will describe the full continuum of care required to treat the range of complications which may result from an unsafe abortion. This document will start with the point of entry for the woman, indicating the care to be delivered there, provide referral guidelines and describe the more advanced care which should be available at the first referral level. This clinical information is presented in both text and decision tree format. The decision trees are action-oriented and may be used as a quick reference guide for treatment. The text complements the

¹ *The draft documents reviewed were separate for the primary health care level and the first referral level. The Technical Working Group, however, preferred a single document.*

decision trees by describing more fully the details of clinical management of abortion complications.

The clinical guidelines and managerial text may be used by **trainers** in designing training for introducing or improving care. Areas of need for training may be identified by a simple review of existing services as compared with recommended services. A training programme can be designed which, over time, integrates the essential elements of care into standard practice. Guidelines for **managers** in identifying additional supplies, equipment or drugs required are included so that arrangements may be made to obtain those items.

Policymakers may also use the guidelines to identify areas of training needs for categories of health workers. Specific programmes may be established or adapted to provide full training in essential emergency abortion care services to workers at all levels of care.

4. **DISCUSSION OF NEED FOR ADDITIONAL RESEARCH IN MANAGEMENT OF COMPLICATIONS OF UNSAFE ABORTION**

The management of unsafe abortion has been neglected as an area of research. Needs for additional research were considered in the context of clinical research needs and operations research needs. It was the consensus that there are few needs for clinical research in the treatment of abortion complications. However, there are many areas of need for operations research in implementing improved service delivery throughout the health care system.²

The Technical Working Group also concurred that large scale prevalence studies are not a priority. Sufficient data are available already to demand resource allocation to this important aspect of maternal mortality and morbidity. The consensus was that smaller, focused research which will shed light on specific mechanisms to expand and improve care will be more useful.

² **HIV infection and AIDS**

Dr Malcolm Potts, who was unable to attend the meeting made a written contribution on HIV/AIDS. The problem of transmission of HIV infection requires considerable further research. The Division of Family Health and the Global Programme on AIDS have issued guidelines for MCH/FP managers.(13) Research topics identified include:

- protection of health care providers from HIV transmission;
- prevention of cross infection between patients;
- ensuring a supply of uninfected blood for transfusion.

4.1 Referral and Communication

A significant area of need for research is in the area of referral. Poor or inadequate referral can significantly delay the provision of essential services, leading to increased levels of morbidity and mortality. A clinical tool (such as a scoring system) for assessing the urgency of referral, particularly for primary level health care workers, would be extremely helpful in training providers in conditions requiring referral, as well as how, where, and when to refer women to higher levels of care.

Poor communication between centres can be a significant impediment to effective referrals. Research on mechanisms for communication between centres, such as use of cordless phones, two-way radios, or other devices, could provide insight into ways to improve this linkage.

Research on mechanisms to assess a provider's appropriate use of referral are needed. After training, an assessment of the provider's ability to identify when to refer is an important step in establishing a continuous chain of safe services.

4.2 Antibiotics

The use of antibiotics in emergency abortion care has been an area of uncertainty for many providers. This confusion has resulted in misuse and overuse of antibiotics in many settings. The development of a scoring system to determine who should be given or not given antibiotics would give concrete guidance to providers in making these clinical decisions.

Concerns about the interactions of hormonal contraceptives and other drugs, specifically antibiotics, have been widely discussed. The Technical Working Group concurred that systematic evidence shows little or no effect of antibiotics on serum levels of hormones. Although research could be helpful in dispelling the concern of reduced efficacy, it was the consensus that other research needs are more compelling given the strength of the existing research.(10,11)

4.3 Training and Staff Roles

Research is needed on the effectiveness and impact of training different levels of health care personnel in attitudes to, and management of, abortion complications. Efforts to decentralize care must include expanded roles for non-physician providers, thus research on the impact of training non-physicians to provide services often reserved for doctors would highlight procedures most appropriate for such training.

Training individuals during their medical school or residency can be an important step in ensuring that successive cadres of medical/health professionals begin their careers already skilled in life-saving procedures for treatment of abortion complications. Mechanisms to assess the effectiveness of this training and to highlight needs for additional in-service support can be helpful in maintaining a high level of proficiency among health care personnel.

4.4 Women's Perspectives

Research into the factors most important to women who seek care for abortion complications would provide insight for designing services that more closely reflect women's needs and for improving the overall quality of services. These efforts will also assist in identifying the reasons for underutilization of some services and suggest ways that services could be adapted to be utilized more fully.

Women's groups in the community can serve as a resource in communicating women's needs to health care providers and educating women about the dangers of complications related to unsafe abortion. Mechanisms to link health services with community women's groups, therefore, can be important to removing obstacles to access and designing care which is acceptable to women.

Other strategies to encourage women to recognize complications of abortion early and to seek care as soon as possible should be tested as delay in seeking care is an important element in increased morbidity and mortality.

Strategies to empower women as consumers of care are important in the field of abortion complications as many women encounter punitive attitudes from their providers.

Some groups of women may have particular needs which can be identified by their patterns of seeking care. For example, adolescents who have denied the existence of their unwanted pregnancy frequently seek care during the second trimester. Efforts to identify populations with special needs and to design strategies to reach them with focused interventions are needed.³

4.5 Management Issues

Many efforts to improve care for abortion complications fail because of managerial or administrative obstacles. Specific areas for research consideration are:

- efforts to assess the overall quality of care delivered and to identify areas needing improvement (12);
- mechanisms to improve supply and logistic networks to support expanded services or to support services in new settings;
- effectiveness of improved distribution of hand held vacuum aspiration syringe;
- adoption of a health care team approach to providing care for abortion complications, including non-physician team managers;

³ *However, one study funded by WHO's Maternal Health and Safe Motherhood Programme was not able to identify characteristics which showed sensitivity in identifying adolescent women at risk for abortion.*

- cost factors in shifting care from an in-patient procedure with use of an operating theatre, to an out-patient procedure performed in a treatment room;
- administrative barriers to changing care such as restrictive discharge policies or health system reimbursement strategies which ignore out-patient services;
- infection prevention issues in decentralizing care (6).

4.6 Attitudes toward Abortion

Research is needed on the attitudes of staff toward abortion and toward the women who seek care for complications of unsafe abortion. Identification of these attitudes and strategies to change punitive attitudes are essential to improving the care women receive for abortion complications.

The speed with which women receive treatment after arriving at a health facility is also affected by staff attitudes. Currently, women seeking care for abortion complications are often the last to receive treatment, only after all other patients have been treated. Research into the staff's perceptions of the seriousness of abortion complications and the woman's need for care will highlight mechanisms to improve the speed of the care delivered.

4.7 Specific Areas of Focus for the WHO's Maternal Health and Safe Motherhood Programme

The objectives and priorities of WHO's Maternal Health and Safe Motherhood Programme focus efforts on health services research to prevent maternal mortality and severe morbidity. In the area of care of abortion complications the issue is primarily the implementation of known technologies and provision of high quality care. In this context, research into the following areas would be relevant. However, the Group noted that none is of the highest priority at this stage of the programme.

- evaluation of the impact of implementing these clinical guidelines;
- documenting the cost effectiveness of shifting treatment of incomplete abortion from an in-patient to out-patient basis.
- creating a scoring mechanism for the urgency of referral to assist in the process of efficient and appropriate referral;
- investigating communication and logistical linkages in referral, including voice linkages, transport, and established referral links;
- studying the decision-making, planning, and support system in the community to improve the interaction between the community and the levels of care.

The Technical Working Group concurred that the *Technical and Managerial Guidelines on Abortion Care* (6) will be an important element alongside the *Clinical Guidelines for the Emergency Treatment of Abortion Complications*. Together, these documents give a firm basis for designing and implementing a programme for improving emergency abortion care.

5. DISCUSSION OF INDICATORS OF PROGRESS IN THE MANAGEMENT OF UNSAFE ABORTION

It is essential to monitor the progress of efforts to improve access to and quality of care for abortion complications. Some indicators which could be measured over time are:

- number of providers trained in a variety of tasks, including uterine evacuation and resuscitation at the primary care level;
- number of service delivery points providing quality care, including a safe method of uterine evacuation;
- waiting time: a) from admission to treatment, and b) from treatment to discharge;
- existence of a quality assurance mechanism at each facility or in each system to review; a) complications and how they are handled and b) selected process indicators, such as number of times transport is called and how well the system functioned;
- presence of essential supplies in each setting providing emergency abortion care;
- presence of hand held vacuum aspiration syringe;
- reduction in gestational size/age at which women present; proportion of women presenting in 1st or 2nd trimester;
- length of delay from onset of bleeding or symptoms to seeking care;
- an increase in use of lower level care for earlier, relatively uncomplicated cases, and a decreased proportion of uncomplicated cases referred to the next level of care;
- community perceptions of the quality of care and women's access to care;
- reduction in case fatality rates.

6. PROVISION OF IMMEDIATE POST-ABORTION CONTRACEPTION

Throughout much of the developing world women who have experienced complications of an unsafe abortion, whether or not they have been fortunate enough to reach a health facility for treatment, often receive no contraceptive information or services. These cases represent one group of women at high risk of unwanted pregnancy and repeat unsafe abortion. When the health system fails to provide appropriate family planning services it must be counted as a missed opportunity to assist women in the safe regulation of their fertility.

A majority of both the clinical and service delivery studies which have been done with regard to post-abortion contraception have focused on issues unrelated to the specific circumstances of women who have been treated for complications of an unsafe abortion. Much of the clinical literature dates from the seventies and early eighties and, therefore, does not take into account newly developed or refined methods of contraception (e.g. Norplant, NET microspheres, new injectables, and multiphasic pills). In the area of the health system and its delivery of contraceptive information and services immediately following abortion, most of the existing literature is devoted to information and services following elective induced abortion.

6.1 Socio-Medical Characteristics to be Considered Regarding Post-Abortion Contraception

The Technical Working Group discussed a variety of medical, social, and system issues which must be taken into account when considering appropriate contraceptive options for women following an unsafe abortion. Among them are:

- the woman's desire for a subsequent pregnancy;
- the timing of a future planned pregnancy;
- blood loss and/or anaemia;
- presence or risk of sepsis, PID, and/or STDs (especially chlamydia);
- potential, especially in the case of first trimester abortion, for rapid return to fertility;
- contraceptive knowledge; education profile and motivation of woman regarding contraception in general and the method selected in particular;
- consistent availability of contraceptive commodities;
- health infrastructure accessible to woman for socio-medical follow-up;
- total cost to user, including opportunity and other costs and the timing/amount of payments.

In general, guidelines for contraceptive use after unsafe induced abortion are similar to those for interval or post-elective induced abortion. However, several issues in contraceptive use following unsafe abortion do require elaboration.

While barrier methods were considered generally acceptable following an unsafe abortion, the universal concern about condoms as a male method over which women have little decision-making power was reiterated.

In regard to IUDs, a specific concern is the possibility of increasing the risk or severity of infection. As many incomplete abortions are of uncertain safety and in many other cases infection is readily apparent, the Technical Working Group concluded that IUDs should not be recommended immediately following treatment of an unsafe abortion unless no other alternative exists. However, where the possibility of increasing the risk or severity of an infection appears to be minimal the IUD may be considered an acceptable method.

The Technical Working Group considered sterilization immediately following treatment for complications of unsafe abortion and arrived at the following consensus. There is considerable potential for later regret if a woman chooses a permanent method at the time of abortion. The Group acknowledged that delaying a sterilization procedure could (a) present interference with fully informed consent due to stress and/or physical impairment related to the circumstances of the unsafe abortion, and (b) limit the potential for coercion by the health care provider. The other side of the coin, however, is that women wanting sterilization must wait for it. Interest was expressed in gaining a clearer understanding of the optimal timing for delay of sterilization following an unsafe abortion to minimize regret.

All hormonal methods were considered acceptable for use following an unsafe abortion, and can be started following treatment, before the woman leaves the health facility.

6.2 Development of the Guidelines on Contraception After an Unsafe Abortion

The Technical Working Group recommended that the background document on contraception serve as the basis for further study of the issue.

7. NEED FOR ADDITIONAL CLINICAL AND OPERATIONS RESEARCH IN IMMEDIATE POST-ABORTION CONTRACEPTION

For too long women have been neglected in the quality and availability of the medical and social services they receive at the time of treatment for complications of unsafe abortion. For example, the term postpartum/post-abortion contraception is often used when, in fact, only postpartum programmes are designed and implemented.

7.1 Clinical Research Topics

Several clinical research questions were identified which look at issues of importance for increased understanding of the circumstances surrounding the use of contraceptives following an unsafe abortion.

- Retrospective long-term follow-up study of regret of sterilization in women sterilized at the time of the treatment for an unsafe abortion. Focus should be on women's perceptions of the appropriateness of counselling she received at the time, the memory of the content of counselling, and suggestions for better future counselling.
- Post-abortal bleeding patterns for all contraceptives used immediately following unsafe abortion.
- Continuation rate and cost-effectiveness of various methods of contraception introduced immediately following an abortion.
- The use of progestogen and oestrogen/estrogen-progestative injectables during the immediate post-abortion period.

7.2 Operations Research Topics

An unsafe abortion usually implies that the health system itself has in some way failed the woman. Several operations research questions could address a range of issues related to the quality of counselling and services a woman receives at the time of treatment for an abortion complication.

The Technical Working Group acknowledged that many of the operations research questions posed during its review will not yield demographically significant results, yet stress their importance, nevertheless. These include:

- quality of counselling, for example about bleeding patterns;
- impact of peer counselling for contraceptive use by women who have experienced abortion;
- use of traditional or "network" counsellors;
- comparative study of vertical family planning programme coming into the health centre/hospital vs. specifically trained counsellors on the ward/at the treatment room;
- assessment of where the system failed (i.e. factors which contributed to the woman having an unwanted pregnancy);
- women's and providers' perspectives of optimal timing for contraceptive information and service delivery;

- impact of improved management of abortion complications (outpatient Manual Vacuum Aspiration) on the ability to deliver contraceptive information and services;
- staff attitude toward the importance of linking abortion and family planning services and their willingness to provide appropriate joint services;
- effectiveness of community-based follow-up and support services for contraceptive methods provided at the hospital facility (e.g. Norplant);
- assessment of clinical and contraceptive guidelines: do they have an impact?

The Technical Working Group's consensus was that every woman who is seen at a health facility for treatment of abortion complications should be provided with contraceptive information and services and referral, as required. Staff must be sensitive to each woman's individual needs and must develop good listening skills to complement their technical expertise. No woman should be forced, however, to accept any method she does not want or any method at all if she believes it is not in her own best interest.

8. INDICATORS OF PROGRESS IN THE PROVISION OF POST-ABORTION CONTRACEPTION AND PREVENTION OF REPEAT UNSAFE ABORTION

Mechanisms must be established to assess progress in implementing programmes which integrate family planning services with the treatment services of abortion complications. Some indicators which could be considered as markers of that progress are:

- the number of programmes that exist which provide integrated care;
- the number of providers of abortion care who are also trained in provision of family planning services;
- evidence of linkage of emergency abortion care and family planning by the private sector;
- reports from women of the contraceptive counselling they received during their care;
- evidence of appropriate referrals for follow-up from the site of the emergency care to family planning services;
- women's understanding of the range of options available and information on the specific use of the method chosen.

The Technical Working Group concurred that follow-up of women at home after treatment of abortion complications for the purpose of documenting their care raises questions of confidentiality. Also, the effort involved in locating women who may not

have used a correct name or address can be tremendous and, in this instance, not cost-effective. Because of this difficulty, process indicators were judged to be important to assessing progress rather than relying solely on impact indicators.

In some instances, a point-of-contact interview may be most useful in assessing women's perceptions of their care, the information they received, and their intentions for future actions. While point-of-contact information is often different from information obtained at some later date, the Group did not feel that this makes point-of-contact information invalid. However, it is necessary to consider the "courtesy factor" in assessing women's report of the quality of care they received, i.e. women may be reluctant to criticize the provider of care immediately after having received that care.

9. CONCLUSION AND FOLLOW-UP ACTIONS

On the basis of the results of the Technical Working Group's meeting the WHO Maternal Health and Safe Motherhood Programme should undertake the following actions:

- publish the report of the meeting;
- publish a discussion of the meeting in the Safe Motherhood Newsletter;
- produce the clinical guidelines on the management of emergency abortion care, with accompanying managerial guidelines and decision trees;
- produce guidelines on provision of post-abortion contraception;
- develop and evaluate a protocol to test the impact of the guidelines;
- collaborate with other agencies globally to implement and test the suggested improvements in service delivery.

The Technical Working Group commended WHO on its attention to this important public health problem.

The causes of unsafe abortion are rooted in a complex set of circumstances which are not easily solved. Nevertheless, practical strategies are available to us now to prevent much of the maternal mortality which results from unsafe abortion. Clinical treatment protocols, appropriate technologies, and management systems can be combined and tested to find the most effective solutions for any health system. Assessing women's preferences in the design of family planning services, including information and services following treatment of abortion complications, will identify mechanisms that more effectively meet women's needs. This step can correct failures in existing programmes, preventing many unwanted pregnancies.

To accomplish these changes, however, will require a renewed commitment of resources, energy, and time by policy makers, health care providers, managers and donor agencies.

ANNEX 1

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ANNEX 2

MEETING OF THE TECHNICAL WORKING GROUP ON UNSAFE ABORTION
Geneva, 13-15 April 1992

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ANNEX 3

**MEETING OF THE TECHNICAL WORKING GROUP ON UNSAFE ABORTION
Geneva, 13-15 April 1992****Agenda**13 April 1992

- 09.00 Opening of the meeting
 - Appointment of Chairperson and Rapporteur
 - Adoption of agenda
- 10.00 Overview of contribution of unsafe abortion to maternal mortality
- 10.50 Discussion of draft guidelines for the clinical management of complications of unsafe abortion
- 14.00 Modifications to draft guidelines
- 15.50 Modifications to draft guidelines

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- 09.00 Discussion of need for additional clinical research in management of complications of unsafe abortion
- 09.45 Discussion of need for additional operations research in management of complications of unsafe abortion
- 11.00 Discussion of indicators of progress in management of unsafe abortion
- 14.00 Discussion of background paper on provision of immediate postabortion contraception
- 15.50 Discussion of background paper on provision of immediate postabortion contraception

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- 09.00 Modifications to recommendations in background paper
- 10.50 Discussion of need for additional clinical research in provision of immediate postabortion contraception
- 14.00 Discussion of need for additional operations research in provision of immediate postabortion contraception
- 15.50 Discussion of indicators of progress in provision of postabortion contraception and prevention of repeat unsafe abortions
- 17.00 Any other business

Close of the meeting

ANNEX 4

MEETING OF THE TECHNICAL WORKING GROUP ON UNSAFE ABORTION
Geneva, 13-15 April 1992**Terms of Reference**

The objectives of the meeting are to:

1. Review draft guidelines on the clinical management of unsafe abortion and modify them as necessary,
2. Review the background paper on provision of immediate postabortion (i.e. before discharge from hospital) contraception, and modify as necessary. (Guidelines will be developed from this.)
3. Review the need for additional clinical research in the two areas above.
4. Review the need for operations research to evaluate the impact of adoption of the guidelines.
5. Suggest appropriate indicators for monitoring progress made.

Several aspects of unsafe abortion are not covered by these objectives but may be covered by future meetings of the Technical Working Group.

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