

Meeting Health Care Needs of Women Experiencing Complications of Miscarriage and Unsafe Abortion: USAID's Postabortion Care Program

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Each year, an estimated 210 million women become pregnant. Worldwide, more than one fourth of these pregnancies will end in abortion or an unplanned birth. While many abortions may result from the desire to delay or avoid pregnancy, 15% to 20% of pregnancies will end in miscarriage or stillbirth with some causative agents being malaria, HIV/AIDS, and physical violence. Postabortion care (PAC) is needed to provide treatment for complications caused by incomplete or spontaneous abortion and critical family planning counseling and services to prevent future unplanned pregnancies that may result in repeat abortions. In 2003, the United States Agency for International Development (USAID) initiated a 5-year strategy wherein seven countries were provided financial funding and technical assistance. Since 2003, more than 3000 women have been seen in health centers and health posts for PAC services; more than 14,000 community members have received messages on unsafe abortion; family planning, and complications of unsafe abortion and miscarriage; and more than 600 documents were reviewed for inclusion in a global PAC resource package. This package has been used for developing Cambodia's national PAC policy and for developing patient education materials and provider job aids in Cambodia and Tanzania. These promising methodologies will be replicated in other countries. *J Midwifery Womens Health* 2007;52:368–375 © 2007 by the American College of Nurse-Midwives.

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

INTRODUCTION

Each year, an estimated 210 million women become pregnant.² Worldwide, more than one fourth of these pregnancies will end in either abortion or an unplanned birth. Women often have an abortion because of a desire to delay or avoid pregnancy.^{3,4} Fifteen to twenty percent of pregnancies will end in miscarriage or stillbirth.⁵ Some causes for spontaneous abortion include malaria, HIV/AIDS, and physical violence.^{6–9} Postabortion care

(PAC) is needed to provide treatment to women experiencing complications caused by incomplete or spontaneous abortion and to provide critical family planning counseling and services to prevent future unplanned pregnancies that may result in repeat abortions.

Postabortion Care

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

SPONTANEOUS AND INDUCED ABORTION IN DEVELOPING COUNTRIES

Spontaneous Abortion

Fifteen percent of all pregnancies end in spontaneous abortion because of either fetal or maternal causes. Fifty percent of spontaneous abortions are caused by fetal chromosomal anomalies. Maternal causes include maternal age, structural anomalies of the genital tract, infections, maternal disease, and environmental factors.

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

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

Some women presenting for PAC services may present secondary to miscarriage or spontaneous abortion caused by physical violence. Between 1996 and 1998, the World Bank conducted a study with a sample size of 765 married women. Women who experienced physical violence during pregnancy had a 10% rate of spontaneous abortion, compared to a rate of 5.7% for women who did not experience physical violence during pregnancy. For women who experienced sexual violence during pregnancy, the rate of spontaneous abortion was 5.9% percent, compared to 3.8% for women who did not report sexual violence during pregnancy.¹² Community mobilization activities in Bolivia and Kenya validate this phenomenon. In a PAC community mobilization activity involving more than 1600 men, youth, and women in Bolivia, women reported having miscarriages because of

hemorrhage caused by physical violence (catalyst consortium PAC compilation document, 2004). Domestic violence was cited as a main cause of spontaneous abortion in 18 community groups that discussed PAC in Kenya.¹³

Unmet Need and Induced Abortion

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

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

Youth presenting for PAC services may have had forced or coerced initial sexual experiences. In 13 case studies reviewed by WHO, between 5% and 15% of young females reported a forced or coerced sexual experience.¹⁴ In Tanzania, 25% of young women suffering postabortion complications were impregnated by men who were about 25 years their senior.¹⁵

Complications of Miscarriage and Unsafe Abortion

Every year, approximately 19 million unsafe abortions occur.¹⁶ Unsafe abortion as defined by WHO is a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both.¹⁸ Annually, 67,000 women die from abortion complications, which represents 13% of all pregnancy related deaths.¹⁷ Almost all (97%) abortion-related maternal deaths occur in developing countries; 3% occur in countries where abortion is legal (Table 1). Complications of unsafe abortion include incomplete abortion, hemorrhage, sepsis, uterine perforation, intra-abdominal injury, psychological trauma, and maternal death.² Women who have suffered miscarriage and/or stillbirth may experience some of these complications, thereby

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

Region	Annual Number of Unsafe Abortions (In Millions)	Annual Number of Deaths from Unsafe Abortion	Risk of Death from Unsafe Abortion
World total	19.0	70,000	1 in 300
Developed countries	.5	300	1 in 3700
Developing countries	18.5	69,000	1 in 250
Africa	4.2	29,800	1 in 150
Asia	10.5	34,000	1 in 250
Latin America and Caribbean	3.7	3700	1 in 800

Source: WHO, 2000

also needing emergency follow-up treatment. In women of reproductive age who have had an unsafe abortion, the prevalence rates of infertility and reproductive tract infections are estimated at 2% and 5%, respectively.¹⁸

RESPONDING TO UNSAFE ABORTION AND MATERNAL MORTALITY WITH FAMILY PLANNING PROGRAMS

The US Government and International Agency Responses

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

In June 1990, Duff Gillespie, Director of the USAID Office of Population, distinguished the components of PAC.¹⁹ At a meeting of USAID cooperating agencies in 1993, USAID Administrator Brian Atwood made a speech in which he highlighted the important role of family planning in preventing unsafe abortion and spoke of the need to work for "compassionate treatment of all women who are in such desperate circumstances that they are driven to seek an unsafe abortion" (written communication, Brian Atwood, 1993). In March 1993, the first reproductive health/family planning working group on PAC was convened by USAID.

High rates of maternal mortality and unsafe abortion became a central focus of many international meetings in the early 1990s. In the Programme of Action of the 1994 International Conference on Population and Development in Cairo, governments agreed that abortion would not be promoted as a method of family planning; that governments should deal with unsafe abortion as a major public health issue; that family planning services should be expanded and improved to help eliminate the need for abortion; and that ready access to postabortion

counseling, education, and family planning should be readily provided to help avoid repeat abortions.¹

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

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

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

US Government Statutes and Policy Requirements

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

"USAID funds may not be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortion. USAID funds may not be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations. No USAID funds may be made available to any organization or program that, as determined by the President of

Table 2. US Policy Governing USAID Family Planning Funds

Helms Amendment

“None of the funds made available under this Act may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions.”

Source: HR. 2673 Omnibus Appropriations Bill, Division D. FY 2004

Kemp–Kasten Amendment

“None of the funds made available in this Act nor any unobligated balances from prior appropriations may be available to any organization or program which, as determined by the President of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization.”

Source: HR. 2673 Omnibus Appropriations Bill, Division D. FY 2004

Method Mix (DeConcini) Amendment

“That in order to reduce reliance on abortion in developing nations, funds shall be available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services.”

“... In awarding grants for natural family planning under section 104 of the Foreign Assistance Act of 1961 no applicant shall be discriminated against because of such applicant’s religious or conscientious commitment to offer only natural family planning; and additionally all such applicants shall comply with the requirements of the previous provision.”

Source: HR. 2673 Omnibus Appropriations Bill, Division D. FY 2004

Siljander Amendment

“Provided further that none of the funds made available under this Act may be used to lobby for or against abortion.”

Source: HR. 2673 Omnibus Appropriations Bill, Division D. FY 2004

Mexico City Policy

This regulation prohibits non-US, nongovernmental organizations to which USAID provides family planning assistance funding either directly or through subawards from using their own or other, non-USAID donor funds to provide or promote abortion as a method of family planning.

Data taken from the United States Agency for International Development.⁹

the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization. No USAID funds may be used to pay for biomedical research that relates in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning. However, epidemiological or descriptive research to assess the incidence, extent, or consequences of abortion is permitted. USAID funds may not be used to lobby for or against abortion.”

THE 2001 USAID GLOBAL PAC EVALUATION

From 1994 to 2001, USAID played a critical technical leadership role in PAC in its support of organizations that implemented PAC programs in more than 40 countries. More than \$20 million supported work in the areas of policy and advocacy, operations research, training, service delivery, and health communication. In 2001, USAID conducted a global evaluation of its PAC programs. It was found that PAC programs had been embraced internationally in more than 40 countries and that PAC

services were available in both the public and private sectors and in refugee camps. Governments had developed policies, standards, and protocols to guide and support PAC services.

The findings regarding PAC elements were that clients receiving sharp curettage for emergency treatment because of gestational age, severe hemorrhage, infection, or abdominal injury were not receiving the same level of family planning counseling and services as were women who had MVA for emergency treatment. More attention was needed to ensure that family planning counseling and services were provided to all clients regardless of the method used for emergency treatment (MVA or sharp curettage). The emphasis on high-quality family planning was not as strong as the emphasis on high-quality emergency treatment. This was apparent in training for family planning counseling, the lack of patient education materials and provider job aids, and the lack of contraceptive supplies that would support method mix and contraceptive choice. Linking emergency care to other reproductive health services had not been well-defined and was a very weak component in the PAC model. This component was almost nonexistent in most public sector settings.²²

THE 2003 USAID PAC STRATEGY

Acting upon recommendations of the 2001 USAID global evaluation, a 5-year strategic plan was developed. USAID revised its model for PAC in 2003 to include community mobilization, an evaluation strategy (results framework), and global and country benchmarks (indicators) to measure progress and successful outcomes for PAC programs. The three core components of the revised USAID PAC model are: 1) emergency treatment for complications of spontaneous or induced abortion; 2) family planning counseling and service provision, sexually transmitted infection evaluation and treatment, and HIV counseling and/or referral for HIV testing (optional services are optional depending on disease prevalence and human resources); and 3) community empowerment through community awareness and mobilization²³ (Appendices A and B). Proposed activities of the 5-year PAC strategy include the standardization of training materials, guidelines, and benchmarks; expansion and institutionalization of PAC at the country level; identification of successful models; leadership in identifying further research, compilation of research findings; and monitoring and evaluation of activities.

Focus Countries Chosen

In 2003, seven focus countries were chosen to receive a small amount of funding to expand and institutionalize PAC. These countries were selected because of their high maternal mortality and induced abortion rates; low prevalence of contraceptive use; and total fertility rate. To

help assure sustainable PAC programs, commitment from the Ministry of Health and matching funds from local USAID offices were required. The selected countries were Bolivia, Cambodia, Haiti, Kenya, Nepal, Senegal, and Tanzania.

Compilation of Standardized Tools in the Global PAC Resource Package

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

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

Community Mobilization

The development of community and service delivery partnerships were also promoted. Community and service delivery partnerships can: 1) provide education about obstetric emergencies, appropriate care-seeking behaviors, and contraceptive methods; 2) allow community members to participate in decisions about availability, accessibility, and cost of services; and 3) mobilize community resources to ensure that women experiencing obstetric emergencies receive timely care.²⁴

The USAID PAC working group funded a PAC community mobilization model in Bolivia that reached more than 1600 community residents. Pre- and posttest findings in Bolivia (n = 1217) found a significant increase in knowledge of types of contraceptive methods (from 88% to 94%) and use of family planning in last sexual intercourse (from 46% to 54%). In 2006, the PAC community mobilization model from Bolivia was replicated in Kenya and reached 412 men, women, and youth in 16 community groups in an effort to educate and involve men in family planning activities. The causes of

unplanned pregnancy and unsafe abortion identified by community members included the lack of knowledge and misconceptions about pregnancy; bleeding during pregnancy; family planning; peer pressure; and poor couple and interfamily communication. Pre- and posttests showed a dramatic increase in knowledge regarding vaginal bleeding as a danger sign of pregnancy (from 66% to 90.5%), the causes of maternal death (vaginal bleeding from 41% to 64%; violence against women 24% in posttest); and delays in seeking care (96% posttest). Condoms were cited by 77% of respondents as having dual protection against HIV and pregnancy. The development of action plans helped with identifying and prioritizing problems, problem-solving, and identifying community resources for pregnancy, family planning, and PAC, and was seen to be applicable to other problems, such as drug use and abuse, alcoholism, deviant behavior, and water and sanitation.¹³

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

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

Decentralization of PAC Services to Primary and Secondary Levels

The decentralization of PAC services allows services to be extended from the tertiary hospital down to district and community levels. Training nurses, midwives, and chief medical officers to provide PAC services is crucial in the decentralization process. Since 2003, more than 3000 women have received PAC services in health centers and health posts in Nepal, Tanzania, and Senegal through the decentralization of PAC services. In Nepal, the establishment of PAC services at two regional health centers has brought these services 30 and 80 miles closer to women, respectively. Of the 147 PAC cases performed, only one had to be referred to the hospital. In the Geita district hospital, in Tanzania, the PAC caseload decreased by 64% from June 2005 to June 2006 after

PAC services were decentralized to regional health centers and health posts. An average of 73% of clients accepted a postabortion family planning method (51% in Senegal, 80% in Tanzania, and 91% in Nepal). A cost analysis performed in Tanzania showed that just more than \$2000 USD per hospital and \$700 USD per health center is needed to introduce PAC services (PAC activities implemented, July 2004 to June 2005, annual report to USAID).

CONCLUSIONS

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

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

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Appendix A. USAID Postabortion Care Strategy: Provision of Care by Level of Health Care Facility and Staff

Level/Staffing	Component One Emergency Treatment	Component Two Postabortion Family Planning
Community Level Staffing may include community residents with basic health training, traditional birth attendants, traditional healers	<ol style="list-style-type: none"> 1. Recognition of signs and symptoms of abortion and postabortion complications 2. Referral to facilities where treatment is available 	<ol style="list-style-type: none"> 1. Provision of pills, condoms, diaphragms, and spermicides 2. Referral and follow up for these and other methods
Primary Level – Primary health clinics, family planning clinics, or polyclinics Staffing may include health workers, nurses, trained midwives, general practitioners	<p>All Activities above AND:</p> <ol style="list-style-type: none"> 3. Diagnosis based on medical history; physical examination and pelvic examination 4. Resuscitation/preparation for treatment or transfer 5. Tetanus vaccination 6. Referral, if needed <p>If Trained Staff and Appropriate Equipment Available: all activities above AND:</p> <ol style="list-style-type: none"> 7. Counseling regarding treatments/emotional support 8. Hematocrit/hemoglobin testing 9. STI evaluation and treatment 10. Initiation of emergency treatments: antibiotic therapy, intravenous fluid replacement, oxytocics 11. Uterine evacuation during first trimester for uncomplicated cases 12. Appropriate pain control: simple analgesia and sedation and/or local anesthesia (paracervical block) 	<p>All Activities above AND:</p> <ol style="list-style-type: none"> 3. IUDs, injectable contraceptives, Norplant implants, and standard days method 4. Referral for voluntary sterilization 5. Family planning follow up and referral to primary and community level for long-term FP follow up 6. HIV counseling 7. F/U appt or referral for HIV counseling and testing (as program dictates) 8. Referral to primary/secondary/tertiary sites as appropriate for gender-based violence, psychological/emotional needs; HIV counseling and testing
First Referral Level – District Hospitals Staffing may include nurses, trained midwives, general practitioners, obstetrician/gynecologists, specialists	<p>Activities above AND:</p> <ol style="list-style-type: none"> 13. Emergency evacuation for fetal death through second trimester 14. Treatment of most postabortion complications 15. Local and general anesthesia 16. Diagnosis and referral for severe complications (septicemia, peritonitis, renal failure) 17. Laparotomy and indicated surgery (including for ectopic pregnancy) 18. Blood crossmatch and transfusion 	<p>All Activities above AND:</p> <ol style="list-style-type: none"> 9. Voluntary sterilization
Secondary and Tertiary Level – Regional or Referral Hospitals Staffing may include nurses, trained midwives, general practitioners, obstetrician/gynecologists, specialists	<p>Activities above AND:</p> <ol style="list-style-type: none"> 19. Uterine evacuation as indicated for all cases 20. Treatment of severe complications (including bowel injury, severe sepsis, renal failure) 21. Treatment of bleeding/clotting disorders 	All Activities above

IUD = intrauterine device; STI = sexually transmitted infection.

Adapted from: World Health Organization. Clinical management of abortion complications: A practical guide. Available from: www.who.int/reproductive-health/publications/clinical_mngt_abortion_complications/index.html [Accessed March 22, 2007].

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

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

Core Component 3: Community Empowerment Through Community Awareness and Mobilization

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

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

IUD = Intrauterine device; STI = sexually transmitted infection; VCT = voluntary counseling and testing for HIV.

Depo-Provera is manufactured by Pfizer Pharmaceuticals, New York, NY; Norplant is manufactured by Wyeth-Ayerst Laboratories, Collegeville, PA.