IPPF

From choice, a world of possibilities

Increasing access to Post abortion care

Integration of PAC into other sexual and reproductive health services

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Introducing PAC services

- All women have the right to quality post-abortion care regardless of legal context and abortions rates are not decreased in highly restrictive settings.
- As SRH service providers, we have an obligation to provide comprehensive services including PAC and safe abortion where possible

Example: Burkina Faso - Association Burkinabé pour le Bien-Etre Familial (ABBEF)

- ABBEF was established by a group of community members and health professionals in 1985
- Their scope of services expanded over the years to include a broad range of SRH services
- PAC services were limited and provided by D&C
- Legal situation in Burkina Faso: abortion is permitted to preserve the physical health of the woman and in cases of rape/incest/fetal impairment
- Abortion rate estimated 40/1000 women aged 15-44 (nearly all clandestine)
- 71% of abortion-related admissions to the Centre Hospitalier National Yalgado Ouédraogo (CHNYO) are due to unsafe abortions.

Introducing PAC services

- In order to scale up PAC services:
  - Training of providers on MVA – D&C had been provided only by physicians – MVA training included nurses and midwives
  - Review clinic lay out to ensure confidentiality and optimum infection prevention – an OPPORTUNITY to improve overall quality of clinical services
  - Procure necessary equipment – MVA and emergency equipment
  - Counsellors were given additional training on discussing abortion related issues – after care and post-abortion contraception
  - 24 hour services have not been necessary
  - Good referral systems

Opportunities/Challenges

- Very little additional equipment or training is needed to provide PAC where comprehesive SRH services are provided *(If you can insert an IUD, you can perform MVA)*
- Providing PAC services within a centre with a strong family planning programme is an ideal opportunity to increase post-abortion contraception
- Referral systems and overall quality of care are improved when adding PAC and/or CAC to services
- Reluctance on the part of providers/clinic staff to be part of 'abortion' services
- MVA equipment is expensive and can be difficult to import

Misoprostol

- Use of misoprostol for PAC has the potential to reach settings where MVA is not feasible
- Also avoids the 'stigma' of MVA which some providers are not willing to learn for fear of being associated with abortion
- Within 6 months of introducing combination regimen for safe abortion services in Family Guidance Association of Ethiopia, 26% of all abortion services were medication abortion.
- Where misoprostol is registered for PPH it is easily accessible and available in our clinics which provide maternity services and can be used off-label for PAC
- Integration of pre- and post- abortion care as part of the Harm Reduction Model in Latin America

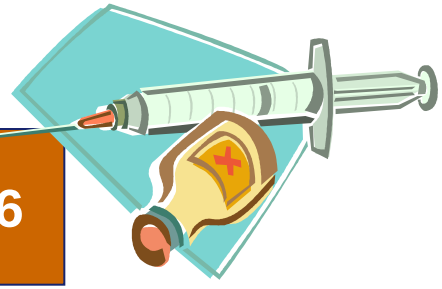
Emergency Obstetric Care

Table 4. Signal functions used to identify basic and comprehensive emergency obstetric care services

Basic services	Comprehensive services
(1) Administer parenteral[1] antibiotics	Perform signal functions 1–7, plus:
(2) Administer uterotonic drugs (i.e., parenteral oxytocin[2])	(8) Perform surgery (e.g., caesarean section)
(3) Administer parenteral anticonvulsants for pre-eclampsia and eclampsia (i.e., magnesium sulfate).	(9) Perform blood transfusion
(4) Manually remove the placenta	
(5) Remove retained products (e.g. manual vacuum extraction, dilation and curettage)	
6) Perform assisted vaginal delivery (e.g. vacuum extraction, forceps delivery)	
(7) Perform basic neonatal resuscitation (e.g., with bag and mask)	
A basic emergency obstetric care facility is one in which all functions 1–7 are performed. A comprehensive emergency obstetric care facility is one in which all functions 1–9 are performed.	

Basic Emergency Obstetric Care (BEmOC)

At health centers (1 per 30,000 people)



Provided by midwives and nurses

1. Administer parenteral antibiotics
2. Administer parenteral uterotonic drugs (oxytocin)
3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia (magnesium sulfate – MgSO4)

4. Perform manual removal of placenta
5. Perform removal of retained products of conception (MVA - manual vacuum aspiration, D&C dilatation & curettage)
6. Perform assisted vaginal delivery, e.g. vacuum

Kit 9

Kit 10

RH in Crisis Settings

- UNFPA estimates that 25-50% of maternal deaths in refugee settings may be related to unsafe abortion. Settings with restrictive abortion laws have higher rates of maternal mortality due to unsafe abortion. This is even further magnified in crises.
- Contraceptive failure as a result of disrupted use during flight, interruption of health services, rape and sexual violence place refugee women and adolescent girls at particular risk of unintended pregnancy and unsafe abortion.
- UNFPA RH Kit 8 – Management of miscarriage *and complications of abortion*.

Minimum Initial Service Package (MISP) for Reproductive Health

Objective 1

Ensure health cluster/sector identifies agency to LEAD implementation of MISP

- RH Officer in place
- Meetings to discuss RH implementation held
- RH Officer reports back to health cluster/sector
- RH kits and supplies available & used

RH Kit 0

Objective 5

Plan for COMPREHENSIVE RH services, integrated into primary health care

- Background data collected
- Sites identified for future delivery of comprehensive RH
- Staff capacity assessed and trainings planned
- RH equipment and supplies ordered

RH Kit 4 | RH Kit 5 | RH Kit 7

Objective 2

Prevent SEXUAL VIOLENCE & assist survivors

- Protection system in place especially for women & girls
- Medical services & psychosocial support available for survivors
- Community aware of services

RH Kit 3 | RH Kit 9

GOAL

Decrease mortality, morbidity & disability in crisis-affected populations (refugees/IDPs or populations hosting them)

Objective 4

Prevent excess MATERNAL & NEWBORN morbidity & mortality

- Emergency obstetric and newborn care services available
- 24/7 referral system established
- Clean delivery kits provided to birth attendants and visibly pregnant women
- Community aware of services

RH Kit 12

RH Kit 2 | RH Kit 6 | RH Kit 8 | RH Kit 9 | RH Kit 10 | RH Kit 11

Objective 3

Reduce transmission of HIV

- Safe and rational blood transfusion in place
- Standard precautions practiced
- Free condoms available

RH Kit 1 | Standard precautions through kits 1-12 | RH Kit 12

Summary

- PAC is an essential part of comprehensive sexual and reproductive healthcare and not to provide the service where it can be provided is unethical
- The skills for PAC are easily translatable into CAC
- There is not an extensive amount of additional training or equipment required to integrate PAC into existing SRH services but integrating PAC and/or CAC can be an opportunity to improve services
- PAC is an essential component of EmOC and SRH care in crisis situation and equipment and training must be available

Thank you!