PAC...in action

Special Issue on Postabortion Family Planning: Rights, Recommendations and Realities

Issue 10, November 2006

Emergency Contraception: A Necessary Component of Postabortion Family Planning Services

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For centuries, women have tried various home remedies, such as douching or jumping (accompanied by anxious calendar watching), to prevent pregnancy after sexual intercourse. By and large these remedies have been completely ineffectual. Today, however, there are effective contraceptive methods that can be used after sexual intercourse—"emergency contraception" or EC. The most well-known and widely available method is emergency contraceptive pills (ECPs), also known as the "morning after pill." Intrauterine devices (IUDs) can also be used to prevent pregnancy after intercourse.

Most postabortion care (PAC) clients are trying to avoid future pregnancy and are not currently using contraception; these clients benefit from being offered a range of family planning (FP) counseling and methods. EC is a unique method in that it can be used after intercourse has taken place; as such it is particularly important for women who are not using long-term contraception, may be vulnerable to sexual coercion, or who are only planning to be sexually active occasionally and therefore do not wish to start on a long-term contraceptive method. The overlap between women who may

ECPs: Frequently Asked Questions

What are ECPs?

Emergency contraceptive pills are simply a higher dose of regular birth control pills. Dedicated EC products, which are packaged and labeled specifically for EC use, are available in most countries. Most products contain one active ingredient, a progestin called levonorgestrel, which is also the hormone in minipills. Some contain both a progestin and an estrogen (similar to the hormones found in combined oral contraceptives).

In settings where dedicated EC products are difficult to access, many brands of birth control pills can be provided as EC; please see www.not-2-late.com for details of pill brands in each country that can be used for EC.

How effective are ECPs?

ECPs are not as effective as most regular methods of birth control. It is estimated that if they are used after a single act of intercourse, they will prevent about 80% of the pregnancies that would have occurred.

How do ECPs work?

There are many ways ECPs could work to prevent pregnancy. It is clear that the main way they work is by disrupting or preventing ovulation and therefore preventing an egg and a sperm from meeting.

Where are ECPs available?

ECPs are now available in more than 120 countries; they are available without a medical prescription, directly from pharmacies, in 47 countries. (For information on the availability of EC products by country, visit the International Consortium for Emergency Contraception (**ICEC**) website's searchable EC product availability database at *http://www.cecinfo.org/database/pill/pillData.php.*) However, in many settings, use is not widespread, and access may be limited for certain women, such as lower income or rural women, who either cannot afford the pills or cannot reach a pharmacy or facility that offers them.

POSTABORTION CARE PAC CONSORTIUM

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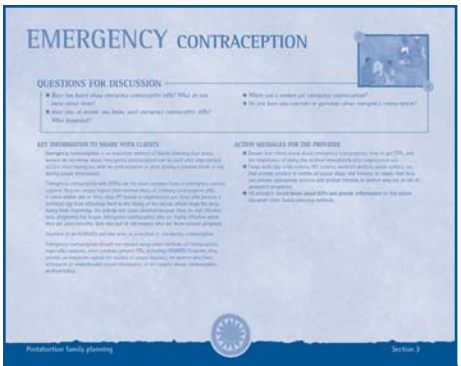
need to use EC and who are or may become postabortion clients is obviously quite large.



Family Care International's PAC flipchart for Anglophone Africa includes counseling messages about emergency contraception as well as other FP methods.

Ensuring women's access to a wide range of methods, including emergency contraception, is an effective strategy for preventing unwanted pregnancies and unsafe abortions and helping women achieve their reproductive goals. Key factors for introducing EC are (1) increasing community awareness about the method, (2) making it widely and easily accessible, and (3) promoting its appropriate uses. It is important that PAC clients, like all FP clients, are aware that EC is not as effective as an on-going method. It also is not effective against sexually transmitted diseases, the prevention of which must be a priority. However, EC is an important back-up method for condom users in case of misuse, non-use or breakage.

ECP Provision

Advance provision: Providing ECPs before they are ever needed is one option to ensure that women have timely access to emergency contraception. Studies in Bangladesh[1] and Zambia[2] have shown that women who are provided a packet of ECPs in advance of need are two to three times more likely to use it than women who receive a prescription. These women did not rely on ECPs instead of regular contraception. In Bangladesh, after EC use, 92% of the women in the study reverted to the contraceptive method they used previously or adopted a new method.

Provision through mid-level or paraprofessional providers: Studies in India[3] and Bangladesh have shown that, with training, paraprofessional and licensed physicians attained the same level of expertise in provision of ECPs. The studies demonstrated that all categories of health care providers, including NGO outreach workers, could be effectively trained to provide ECP services. The South East Asia Regional training manual[4] on emergency contraceptive pills that has been used in Bangladesh and India is available on the FRONTIERS website at *www.popcouncil.org/frontiers*.

Pharmacy or "over the counter" access: Increasingly, ECPs are available directly from pharmacies without a prescription. As of September 2006, this was the case in almost 50 countries. However, pharmacy access alone does not ensure that women who need ECPs will know about them and use them, so service providers still have a role to play in educating women about the availability of EC.

PATH has created sample client brochures in 14 languages; they can be downloaded from *http://www.cecinfo.org/publications/resources_prog.htm*

1. Khan, M.E., Sharif Mohammed Ismail Hossain, and Moshiur Rahman. 2004. "Introduction of emergency contraception in Bangladesh: Using operations research for policy decisions." *FRONTIERS Final Report*. Washington, DC: Population Council.

2. Skibiak, J.P., Y. Ahmed and M. Ketata. 1999. Testing strategies to improve access to emergency contraception pills: Prescription vs. prophylactic distribution. Africa OR/TA Project II. Nairobi: Population Council.

3. Sebastian, Mary P., Shiv Kumar, M.E. Khan, Chander Shekhar, and N.K. Gupta. 2005. "Studying the utilization of emergency contraceptive services through paramedics in India." *FRONTIERS Research Update* No. 5. New Delhi: Population Council.

4. 2006. Emergency Contraceptive Pills: A Training Manual. FRONTIERS Manual. New Delhi: Population Council.

Because of EC's unique and important role among the range of FP methods, the quality of PAC programs will be improved by the integration of EC into PAC services. However, a few cautions must be raised. As with any new service, careful thought and planning is necessary before offering EC. Like PAC, EC may be seen by community members and even health care providers as controversial or as "promoting abortion." (EC is a contraceptive method because it prevents a pregnancy from starting, but it is commonly confused with the early abortion pill, mifepristone.) Consulting and educating decision-makers, local leaders and community members is important. (See the **ICEC website** at *http://www.cecinfo.org/worldwide/introducingEC.htm* for an introduction strategy successfully used in many countries.)

It is especially important that PAC programs ascertain whether EC is routinely available in FP and other settings before introducing it in PAC settings. This has several benefits, including assuring an on-going supply of ECPs and guarding against EC becoming associated only with PAC, rather than being made available to all women who need it. As noted above, ECPs are now available in most countries, a major change from even a few years ago, thus these problems are likely to decrease.

To contact the **ICEC** go to *www.cecinfo.org* or e-mail *info@cecinfo.org*

Calendar

November 4-8, 2006

American Public Health Association (APHA) 134th Annual Meeting and Exposition, "Public Health and Human Rights." Boston, MA, Boston Convention and Exhibition Center.

November 5, 2006 (1-6 p.m.)

PAC Consortium Meeting at the APHA Annual Meeting, "The State of Postabortion Care Across Regions with an Eye to the Future." Boston, MA, Boston Convention and Exhibition Center, Room 208.

Monitoring and Evaluation Indicators

Inés Escandón, EngenderHealth, Co-chair of the Essential Elements Task Force

This newsletter features a new column—*Monitoring and Evaluation Indicators*. Since May 2004, the Essential Elements Task Force has put together a list of indicators (Indicators for the Essential Elements of PAC, available at *http://www.pac-consortium.org/site/DocServer/2006-05-25Indicators_for_the_Essential_Elements_of_Pos.pdf?docID=)* that programs throughout the world have used to operationalize the five elements of PAC.

The new section will feature one indicator in every issue of *PAC in Action*. The focus in this issue is on *percentage of PAC patients who receive a contraceptive method prior to departure from the health care facility*.

Experiences from the field

The CATALYST Consortium[1] reports that data on the percentage of clients who left PAC service facilities with a contraceptive method were collected through examining facility service statistics. A variety of CATALYST programs in Bolivia, Cambodia, Nepal, Peru and Romania strengthened PAC services at facilities and established two-way referral between the community and providers.

A major challenge in using this indicator was the fact that some facilities CATALYST worked with did not provide family planning (FP) methods on-site; instead, clients were referred to another department within the same facility or another facility for FP services. At some other facilities where FP methods were available, the hours for dispensing the FP methods were limited. Thus, clients discharged from these particular facilities at hours when FP methods were not dispensed did not have the option of leaving with a method, and the data for this indicator were not a true reflection of whether or not clients decided to accept methods prior to discharge. In order to collect data that were more informative of clients' decisions to begin using contraception, CATALYST supplemented this indicator with two others: (*1) percentage of clients receiving FP counseling and (2) percentage of clients referred for FP services*. Although these indicators do not measure the same information, they assisted in determining to what extent clients were empowered to seek FP methods should they have chosen to use them. By the end of the program interventions, CATALYST managed to have FP methods available on-site and for extended hours at most of the facilities that provided PAC services.

In its Malawi program, JHPIEGO also measures postabortion FP use through its indicator *percentage of PAC clients who leave a facility with a method*. Data from the sites indicate that FP acceptance varies widely between facilities. JHPIEGO staff collects registry data from sites, and then enters the data into a database. Unfortunately, sites are unable to enter the data and generate their own reports because they lack computers and person-power for this task. Regular monitoring and supervision visits carried out by the district health offices help to address challenges in time lags and missing data. The database facilitates data analysis, but triangulation of data is not possible because the program relies solely on one data source—facility registers.

To strengthen the quality of its data, JHPIEGO recently completed an evaluation that sampled a selection of PAC clients, who were followed up at home. Information from that evaluation will serve as a cross check for the service statistics data.

In collaboration with TAHSEEN/CATALYST, Population Council/FRONTIERS tested another strategy for cross-checking the postabortion FP indicator in Egypt. This strategy used client exit interviews to supplement service statistics. The program has also found it necessary to supplement the indicator with other data. Low acceptance among study participants led the researchers to explore the reasons for low FP use. Factors contributing to low FP use include the lack of FP methods available 24-hours-a-day, provider reluctance to discuss FP with women who want to become pregnant soon, and patients' desire for more children. Many women need to consult with their husbands before accepting a FP method, which is another factor that contributed to low use prior to departure from the facility. Findings from a previous study conducted in Egypt under the Population Council's Asia/Near East operations research (OR) project showed that women also have concerns about using contraception immediately postabortion.

Improving the utility of the indicator may be achieved by limiting the denominator to those who decide to begin using family planning, as opposed to all PAC clients; measuring the percentage of providers who believe that postabortion patients should be offered FP methods before discharge from the hospital; and measuring the percentage of providers who believe that primiparas should not be offered FP counseling or services. Gathering information on the availability of a range of contraceptive methods (at all times of the day) also provides further understanding of supply issues that may contribute to low levels of use.

Conclusions

In the *Indicators for the Essential Elements of PAC*, service statistics were the main source of information cited for measuring the *percentage of PAC patients who receive a contraceptive method prior to departure from the health care facility*. Use of these data carries challenges, which frequent supervision and monitoring can ameliorate. Client exit interviews and follow-up interviews can provide alternative ways of collecting information on this indicator and help verify its reliability. It is important to bear in mind that this indicator only provides part of the picture on postabortion family planning. Other indicators that look at counseling, referrals, method availability and provider attitudes might be used in order to gain a better understanding of trends in measures and also to determine the best course of action to take for improving access to FP services among PAC clients.

We would like to thank **Caroline Tran** (Extending Service Delivery Project, *ctran@esdproj.org*), **Marya Plotkin** (JHPIEGO, *mplotkin@jhpiego.net*) and **Nahla Tawab** (Population Council/FRONTIERS, *ntawab@pccairo.org*) for their contributions to this column.

For our next issue, we invite readers to send us their experiences with the following indicator: *percentage of PAC clients who receive STI/HIV/AIDS services during a given visit*. Please send them to *info@pac-consortium.org*

1. The CATALYST Consortium, which ended in 2005, was a five-year project funded by the USAID Bureau for Global Health.. The follow-on project to CATALYST is the Extending Service Delivery Project (ESD).

Scaling–Up Postabortion Care Services: Results from 23 Health Districts in Senegal

Fatim Tall Thiam, Clinical Advisor, MSH/Senegal and Siri Suh, University of Michigan Population Fellow, MSH/Senegal

Background

In Senegal, operations research (OR) has served as a major advocacy tool for postabortion care (PAC) since the late 1990s. The scale-up of PAC in Senegal began with a pilot project initiated by the Ministry of Health (MOH) of Senegal in 1997-1998 to assess the feasibility, acceptability and efficiency of implementing the original PAC model in two hospitals in Dakar and a district health center. The study showed that nearly 97% of abortion cases were treated with digital curage[1] or dilation and curettage (D&C) and only 18% of patients received information about contraception after treatment.

In 1999, following this national study, the United Nations Population Fund (UNFPA) supported the MOH in evaluating the capacity of regional health structures to introduce PAC. Two regional hospitals and one district health center were included in the study. Regional facilities have fewer medical specialists and less equipment than referral hospitals at the national level in Dakar; nonetheless, the regional study obtained similar results to the national study with regard to (1) the acceptability of MVA among providers; (2) a reduction in the cost and length of hospitalization; and (3) improved acceptance of family planning among abortion clients. An operations research study in 2001 conducted by EngenderHealth and supported by the Population Council's FRONTIERS Program evaluated the feasibility of introducing PAC at health centers and health posts in six health districts of two primarily rural regions. Study results indicated that quality PAC services could be offered at primary and secondary levels of the health system.

A pilot project conducted in 2002 by IntraHealth International's PRIME II project introduced PAC at the primary and community levels of the health system in one rural district. The project trained nurses, midwives, district supervisors and community health agents in PAC and reinforced referral and counter-referral systems. In addition, the project worked with communities to better identify danger signs in pregnant women and to develop linkages to health facilities for PAC and other reproductive health (RH) services. The final evaluation indicated that health post providers had improved their technical PAC skills and were increasingly managing PAC patients with digital curage. All PAC patients received FP counseling, and the proportion of patients that received a contraceptive method increased from 18% before the intervention to 62% after the intervention. Many communities established emergency funds and transportation systems to manage and refer obstetric emergencies (IntraHealth/PRIME II, 2004).

Encouraged by OR results obtained at national, regional and district levels, the MOH developed PAC norms and standards and, with the help of its partners, initiated a PAC scale-up program for all levels of the health system.

Intervention

With funds from the USAID PAC Working Group, USAID/Senegal partnered with the MOH to scale-up PAC services in health facilities in 23 of the country's 56 health districts covering approximately 60% of the population. The program, implemented by Management Sciences for Health (MSH) between November 2003 and June 2005, aimed to integrate emergency treatment for abortion complications with postabortion FP services. MSH implemented the PAC program in four steps.

Step 1. Needs Assessment: The assessment was conducted in maternity wards in 13 health centers and four hospitals to evaluate the treatment and management of abortion complications and the availability of equipment and materials. The needs assessment also served to collect baseline data and examine the feasibility of scaling-up PAC services. Results showed that, although there was a significant demand for PAC services, serious gaps existed in their quality and availability. In most facilities, *matrones* (traditional birth attendants who work in health facilities) treated abortion complications using digital curage without pain management or infection prevention measures. Furthermore, postabortion FP services were not systematically offered and the proportion of women receiving counseling and who left the facility with a contraceptive method was low. However, the needs assessment suggested that PAC services could feasibly be introduced since all providers had a background in emergency obstetric care (EmOC) and FP services.

Step 2. Provider Training: First, the program oriented 64 members of regional and district health management teams towards the problem of unsafe abortion in Senegal and shared results from PAC operations research and the recently conducted needs assessment. To encourage sustained supervision and to support providers in the implementation of PAC services at the operational levels, trainers also reviewed the concepts and technical elements of PAC with regional and district teams. Next, the program trained 523 providers (doctors, midwives, nurses and counselors) from 323 health facilities (health posts and centers) in PAC according to national norms and protocols. These norms limit the use of MVA to treat incomplete abortion to health centers. Providers in health centers (doctors, midwives and nurses) received six days of training, which included four modules: (1) initial assessment of the patient; (2) infection prevention; (3) use of MVA and PAC counseling, including psychological support before, during and after treatment; and (4) counseling for FP and other RH needs. Providers in health posts (nurses and midwives) received three days of training, which focused on evaluating and stabilizing patients with abortion-related complications, performing digital curage or referral, and FP counseling and provision. Counselors at health centers and health posts received training in PAC counseling. At the end of each training session, participants developed action plans to implement newly acquired PAC skills. All health centers received

MVA kits and all facilities received FP counseling tools for PAC.

Step 3. Data Collection: The program introduced a PAC register, developed in collaboration with the MOH and the Center for Training and Research in Reproductive Health (CEFOREP), in all intervention facilities. The PAC register is used to collect all data related to the treatment and management of patients suffering from abortion complications.

Step 4. Supportive Supervision: Supportive supervision was used to evaluate and reinforce technical performance, assess equipment and infrastructure for PAC, and to help providers identify and resolve problems encountered in providing PAC services. Supervision tools included a checklist for PAC services, interviews with PAC clients and a worksheet synthesizing performance for each facility.

Supervisors observed work environment, and the availability of PAC equipment and essential drugs, including contraceptive products. They also examined facility statistics and discussed the reorganization of services to integrate PAC with providers. At each facility, providers, district health management teams and community members used supervision results to develop action plans to improve PAC.

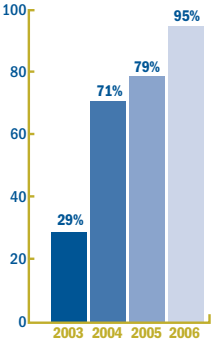
Results

Increased availability of PAC

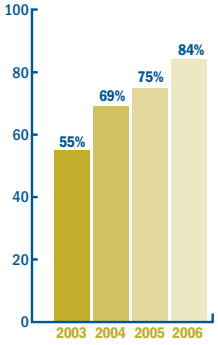
Over 500 doctors, midwives, nurses and counselors from 323 health facilities received training and refresher training. Eighty-seven percent of these providers are midwives, nurses and counselors, who are often directly in contact with PAC patients, and 69% work in health posts, the most peripheral level of the health system.

Follow-up visits with 72 midwives at health centers after training indicated that most of them (92%) had used MVA since their training. In contrast, none of the six doctors trained had used MVA. Reasons provided by midwives for not practicing MVA were the absence of space and adequate equipment and the lack of patients to apply the skills. Doctors noted a lack of time due to competing obligations in the health district as the main reason for not practicing MVA.

Graph 1. Proportion of health centers with adequate space, material and equipment for quality PAC services, 2003 - 2006



Graph 2. Proportion of health centers with services reorganized to integrate PAC, 2003 - 2006



Graph 1 illustrates the evolution in the availability of space and material for performing PAC at 23 health centers. Performance in these indicators rose from 29% in 2003 to 95% in 2006. All health centers in the intervention now have a room or a space in the delivery room reserved for MVA procedures and offer PAC services 24 hours a day, seven days a week.

Graph 2 shows the evolution in the reorganization of services at health centers to offer high-quality, integrated PAC services. The indicators used to evaluate the reorganization of services are:

- Availability of material and drugs necessary for 24/7 treatment of incomplete abortion at the treatment site;
- Availability of psychological support before, during and after treatment;
- Availability of contraception and the availability of the method selected by the patient at the facility; and
- Management or appropriate referral of other RH needs.

By 2006, 84% of health centers had reorganized and adapted their services to offer PAC services compared with 55% in 2003. According to providers, the main obstacles to reorganization of services are inadequate management of other RH needs and lapses in the availability of contraceptive methods at the treatment site, particularly the IUD and Norplant. The lack of availability of contraceptive methods is related to the separation between the FP department and the emergency room. Since the intervention, the availability of PAC services—defined as the presence of at least one provider trained in PAC and the existence of PAC services—has improved in both health centers and health posts. The proportion of health centers with PAC services increased from 39% (9/23) in 2003 to 100% in 2005. In health posts, the proportion increased from 0% to 72% (216/300 health posts) in 2006.

Increased utilization of PAC

A fundamental aspect of offering quality PAC services involves strengthening providers' competence in the three elements of the original PAC Consortium PAC model.[2] Follow-up visits in 23 health centers were used to obtain important data on the management of abortion complications by providers since training. These data also provide insight into the utilization of PAC services by clients.

The number of patients who sought services for abortion complications more than doubled between 2003 and 2005 (from 1178 to 2530). Certainly, the availability of PAC services in the 23 health centers may account for the significant increase in patients received in certain facilities between 2003 and 2004. However, there are other factors that may have contributed to this increase. For example, the implementation of a PAC register may have permitted providers to improve the registration of patients with abortion complications and the management of data related to these cases. The training of chief nurses in health posts in PAC may have increased the number of patients referred to health centers for MVA. In addition, the integration of PAC-related topics into facilities' information, education and communication (IEC) activities may also have contributed to this increase.

With the scale-up of PAC services, MVA has emerged as the preferred technique for uterine evacuation. Training providers in PAC has thus improved the emergency treatment of patients consulting for abortion complications. The percentage of patients treated with MVA in 23 health centers more than doubled between 2003 (27%) and 2005 (57%). These findings are consistent with studies in other countries.

The provision of FP counseling for PAC patients has increased in the 23 health centers. The proportion of PAC patients who received counseling before leaving the facility increased from 36% in 2003 and 2004 to 82% in 2005. Gaps in the completion of newly introduced PAC registers observed at health facilities may explain the stagnation of results at 36% in 2004. Although providers were registering PAC patients and the type of treatment they received, supervisors noted that counseling, when conducted, was not consistently reported in the register. To address this problem, providers received on-the-spot orientation in record keeping during subsequent follow-up visits.

The patient's ability to make an informed choice about contraception and the availability of her desired method are also critical elements of quality PAC services. The proportion of patients who received counseling and who left the facility with a FP method rose from 15% in 2003 to 28% in 2004 and again in 2005 to 51%. These results are consistent with findings in other countries that suggest that providing PAC patients with essential information regarding their health, such as the benefits of birth spacing, the rapid return of fertility after abortion and the availability of safe and efficient contraceptive methods that can be used immediately can improve the acceptance of contraception.

Achievements

Before the scale-up in Senegal, PAC services were available only in national hospitals. Treatment of incomplete abortion was performed in health centers with digital curage by matrones or, with referral, in regional hospitals with operating rooms, by specialized physicians and anesthesiologists. Treatment at hospitals was more or less limited to an evacuation of the products of conception from the uterine cavity by D&C or electric vacuum aspiration under general anesthesia. Patients with abortion complications rarely received information related to their health, the treatment they received or family planning; even fewer women left the facility having made an informed decision about family planning.

Since the scale-up, the treatment and management of women suffering from abortion complications in intervention zones has improved. Providers have been trained to offer emergency treatment (including MVA by providers at hospitals and health centers). As a result, the proportion of PAC patients treated with MVA has increased. Through supportive supervision, facilities have reorganized their services to ensure the patients' rights to privacy and confidentiality and the integration of FP services at the site of emergency treatment. Counseling has become more systematic, and more PAC patients are leaving facilities with a contraceptive method. The training of paramedical staff in MVA has empowered midwives and nurses to effectively treat and manage abortion complications, thereby reducing the number of patients treated by matrones under unsafe conditions. In addition, training has improved the clinical examination of patients and the development of appropriate diagnoses and treatment for PAC patients according to the gestational age.

However, several challenges remain in the scaling up of PAC services:

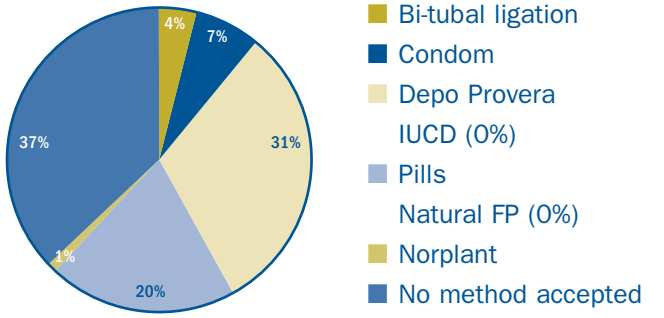
1. Scaling-up: At health posts, a certain laxity has been observed among nurses with regard to treating and managing abortion complications. Although nurses at health posts have been trained in digital curage, they systematically refer patients to health centers where MVA is available. Another challenge is linking PAC to other RH services. Testing and treatment for sexually transmitted infections (STIs), counseling and

Family planning after PAC for selected clients in Malawi

Marya Plotkin, JHPIEGO, Prisca Masepuka, JHPIEGO/Malawi, and George Vilili, JHPIEGO/Malawi

In Malawi, complications arising from incomplete abortions and miscarriages are a significant public health problem. JHPIEGO has been working to improve PAC in Malawi since 2001. One of the specific improvements is integrating FP services into PAC service provision in 55 health facilities. To date, over 17,000 PAC clients have been seen in these facilities.

FP acceptance and method mix among PAC clients in Malawi



JHPIEGO monitors PAC service provision in 36 of these facilities using a client-centered database, which provides up-to-date information on FP acceptance rates and method mix choices aggregated by health facility. The graph (left) shows method mix for the clients included in the database. Among the PAC clients for these 36 sites, 64% of clients accepted an FP method after PAC; of all methods, the most commonly chosen method (31% of clients) was Depo Provera.

To supplement the information in the PAC database, an assessment was conducted in Malawi from November 2005 to January 2006, looking at FP use among selected PAC clients. One hundred and eighty clients were interviewed on their discharge from PAC services; among these, 125 were followed up in their homes one to three months later. In this cohort, 78% of clients accepted an FP method at discharge and 56% of clients were using a method one to three months after PAC services. Approximately 22% of clients discontinued their contraceptive method in the three-month period following services. The most frequent reason for discontinuing FP usage was "husband disap-

voluntary testing and treatment for HIV/AIDS and prenatal care must be routinely available for PAC patients but is rarely offered at the facility level. Although the PAC program introduced PAC registers to all facilities, analysis and utilization of data remain limited at the local level—in health facilities, districts and regions. These data can be used to develop local strategies for improving PAC and other RH services.

2. Linking providers to the community: A continuing challenge to the extension of PAC is the development of links between communities and providers to reinforce availability and increase utilization of PAC services. To address this issue, MSH recently supported the MOH in its revision of sexual and RH policy, norms and protocols to integrate the community element. Additionally, in 2006, MSH collaborated with the MOH to initiate community-based PAC activities in three districts in the southern region of Ziguinchor. A community-based survey to assess knowledge, attitudes and behavior regarding unsafe abortion and PAC was carried out, and results were disseminated to stakeholders in the community and within the health system. The PAC program also sponsored a theater competition among various youth groups to explore PAC-related themes such as sexuality, unwanted pregnancy, unsafe abortion, the community, and the role of the health system and providers. In response to these activities, health providers and educational and cultural professionals developed partnerships that helped sensitize nearly 900 young people about the risks and prevention of unwanted pregnancy and unsafe abortion. Results from this experience are encouraging, but efforts must be continued to involve communities in PAC and form links with the health system.

3. Legal issues: Since the 1950s, many developed countries have adopted less restrictive abortion legislation in order to reduce mortality and morbidity related to unsafe abortion; more recently, some developing countries have also done this. Abortion legislation in Senegal is heavily influenced by religion, and prohibits induced abortion except to save a woman's life. Health personnel who provide abortions risk fines, imprisonment and temporary or permanent suspension of their license to practice. Advocacy efforts to liberalize abortion laws to include cases of rape or incest can refer to Guinea and Mali as regional examples of predominantly Muslim countries where abortion laws have been liberalized.

Nonetheless, legislative changes alone cannot reduce the incidence of unwanted pregnancy or unsafe abortion; evidence suggests that the availability and effective use of modern contraceptive methods is critical to reducing these public health problems. It is therefore essential that efforts to reduce unwanted pregnancy and unsafe abortion in Senegal concentrate on improving access to and utilization of quality PAC services. All PAC patients, whether they are treated with MVA, digital curage or D&C, and whether they are treated in public or private facilities, must receive FP counseling and services in order to prevent additional unwanted pregnancy and unsafe abortion.

For more information about the Senegal PAC program, or for a longer version of this paper with complete references, please contact **Fatim Tall Thiam** at *timataal@yahoo.fr*

1. Digital curage is the use of the forefingers to evacuate uterine contents
2. This model was developed in the early 1990s and its three elements include: (1) emergency treatment for complications of spontaneous or unsafely induced abortion; (2) postabortion family planning counseling and services; and (3) links between these services and other elements of comprehensive reproductive health care. In 2002, the PAC Consortium revised this model to include five essential elements. See the September 2002 "PAC in Action" supplement, available at www.pac-consortium.org, for more information.

proved," followed by "unfamiliar with or uncomfortable using method." The results of this assessment demonstrated a clear need for contraceptive services for PAC clients, highlighting the need for continuing expansion of services and maintenance of quality of services.

The PAC clients in this assessment, while clearly needing access to FP methods, had very little experience using contraceptives. Just under half of the PAC clients indicated that they had ever used a modern method of contraception. Only 5% of clients indicated that they had ever used a condom. Although condoms were provided to clients after their service, the use dropped off dramatically in the months following the service.

Despite the fact that 14% of PAC clients indicated that they never want to get pregnant again, and 48% of clients would like to delay pregnancy for two or more years, relatively few clients obtained a permanent or long-term method of contraception. One of the most effective long-term FP methods, the intrauterine contraceptive device (IUCD), has become all but obsolete in Malawi. JHPIEGO and USAID are working with the MOH to invigorate use of the IUCD through the public health sector.

Given that a high percentage of PAC clients state a desire to prevent or delay pregnancy, have little experience using contraception, and may experience negative consequences if they immediately become pregnant again (i.e., immediate pregnancy is medically contraindicated), the importance of integrating family planning into PAC services cannot be overemphasized. Recommendations include the following: improving FP counseling, expanding client access to permanent and long-term FP methods, and providing follow-up and outreach to PAC clients to improve utilization of family planning after services.

For more information on this evaluation, please contact **Marya Plotkin** at *mplotkin@jhpiego.net*

PROGRAMMATIC UPDATES

Linking family planning with postabortion services in Egypt: Testing two models of integration

A collaborative activity between the FRONTIERS program of the Population Council, the TAHSEEN/CATALYST Project and the Ministry of Health and Population (MOHP) in Egypt was undertaken to test feasibility, acceptability, and effectiveness of two models of linking family planning with postabortion services in the Ob/Gyn ward. The first model (model I) includes FP counseling with referral to a FP clinic near the client's residence while the second model (model II) includes FP counseling and provision of FP methods on the ward for clients who decide to use a method immediately.

The intervention included offsite training of physicians and nurses in six MOHP hospitals on improved PAC services and FP counseling and service provision. Training was followed by three months of monitoring through biweekly visits by trainers. A brochure with information about care after discharge from the hospital and appropriate FP methods for the postabortion period was developed and given to postabortion clients. For model II, services were reorganized and FP commodities were put on the Ob/Gyn ward.

The study used a pretest–posttest design with separate pretest and posttest samples. In each of the six hospitals, the models were implemented consecutively—starting with model I—for a period of six months each. Both models were assessed through exit interviews with postabortion clients, home interviews with these same clients three months after discharge and interviews with providers. In-depth interviews with seven supervisors (e.g., hospital director, FP director) were also conducted at the end of the study. Table 1 shows the sample sizes of providers and clients for each model.

Participants	Model I (n)	Model II (n)
Providers	*159*	*135*
Postabortion clients	*320*	*296*

Table 1

Study results showed that more clients received FP counseling under model II than model I (85% versus 77%), and more clients under model II were told that fertility returns within two weeks (86% versus 78%). More providers under model II believed that a postabortion client can use a FP method immediately after treatment, and more of them believed that a postabortion client needs to postpone her next pregnancy even if she wants more children (82% versus 67%).

Although both providers and supervisors indicated that model II was feasible to implement, fewer than half of providers (45%) reported that they were competent enough to provide FP services to clients. Additionally, only 13% of clients under model II said that they would have liked to receive a FP method before discharge, and an even smaller proportion of clients (3%) actually received a method before discharge. Significantly more clients under model II agreed to the statement "Getting a method from the hospital would upset my husband" as compared to clients under model I (88% versus 32%).

At three months, the proportion of clients who were using a FP method was almost equal under the two models—30% under model I and 25.3% under model II. It is noteworthy that of the eight clients who received a FP method prior to discharge from the hospital, only three clients were using the same method at three months.

Study findings support the conclusion that placing FP methods on the Ob/Gyn ward may have a synergistic effect on the quality of FP services. Nonetheless, the data show that three months after discharge, there were almost no differences in the proportion of clients who were using a FP method under the two models. This demonstrates a clear need for follow-up in the postabortion period.

Successful implementation of model II should involve more than training of providers and placing the methods on the ward. Administrative changes at the hospital level are needed to encourage curative care providers to offer FP services, which they may not see as their primary responsibility. Sociocultural barriers to accepting a FP method immediately postabortion should be overcome. Adequate training of providers should help them gain more confidence in providing counseling services. Community awareness interventions should be reinforced in order to overcome some of the misconceptions about the effects of FP methods and to solicit husband support for postabortion use of contraception. Finally, some changes in hospital admission procedures may be needed to enable clients to discuss contraceptive options with their husbands and for the latter to seek advice from the treating physician/nurse.

For more information about this study, please contact **Nahla Tawab** at *ntawab@pccairo.org*

Source: Youssef, Hala, Nahla Abdel-Tawab, Ton van der Velden, Mohamed Abou Gabal. *Forthcoming*. "Linking family planning with postabortion services in Egypt: Testing feasibility, acceptability and effectiveness of two models of integration." *FRONTIERS Final Report*. Cairo: Population Council.

Evaluation of the quality of postabortion care in Tucumán, Argentina from a rights perspective: Supporting public health systems to respect human rights

Unsafe abortion is both a major public health and human rights problem in Argentina. Implementation of a woman-centered PAC model is one strategy to improve the situation. The quality of PAC services was measured in three public hospitals in Tucumán, a province with high levels of poverty and maternal mortality due to unsafe abortion. The evaluation was conducted using EvalAPA, a tool developed by Ipas that assesses the quality of care during three stages of care: (1) prior to the uterine evacuation (UE) procedure, (2) during the UE procedure, and (3) post-UE. Qualitative methods were also used to evaluate the quality of PAC services.

Overall, quality was found to be poor. In particular, postabortion contraceptive services were virtually non-existent. Two of the hospitals scored at a level that indicated that services needed to

be greatly improved through a controlled intervention and one hospital scored at the lowest "alert" level, denoting that links between clinical care and contraceptive services needed to be initiated. Without such changes, women's basic needs during their care are not met, thereby compromising their full access to multiple rights.

Women cared for in the main public hospitals in Tucumán, Argentina do not receive services in a manner that respects their human rights. This includes their rights to health and health care, information and the benefits of scientific progress. Findings from the evaluation are being used to develop collaborative NGO/hospital/policymaker efforts to improve PAC services.

For more information, please contact **Rodolfo Gomez** at *gomezr@ipas.org*

Source: Gómez Ponce de León R., D. Billings and K. Barrionuevo. 2006. "Woman-centered post-abortion care in public hospitals in Tucumán, Argentina: Assessing quality of care and its link to human rights." *Health and Human Rights* 9(1):2-29.

Poor quality postabortion family planning in a Thai hospital: Means and methods

Refugees and migrant workers from Burma (Union of Myanmar) are among the most marginalized people in Thailand, and therefore face the greatest health risks. In 2005, Dr. Suzanne Belton, a research fellow at the Graduate School for Health Practice Institute for Advanced Studies at Charles Darwin University in Australia, completed her doctoral thesis on Burmese women's experiences of unwanted pregnancy and induced abortion.[1-3] She interviewed 43 women with early pregnancy loss who were admitted to either a Thai- or Burmese-led health facility in one border province of Thailand. These women, their partners, their abortion providers and other health workers provided valuable information to describe the physical, social and political causes and consequences of a lack of reproductive rights that manifested in a large amount of maternal morbidity and mortality. Dr. Belton lived in the Burmese community for 10 months, and had a strong relationship with that community because she had previously worked for one year as a health educator on a maternal and child health project.

Her research methods included a mix of public health and anthropological approaches to generate both quantitative and qualitative data. These included: (1) a retrospective medical record review of one year's visits to the outpatient department, recalling any woman with a diagnosis of early pregnancy loss, any type of abortion, perforated uterus or intestines or other pelvic injury; (2) a review of casenotes in the same year for all women who were referred to a higher level of care with a complicated abortion or pelvic injury; (3) semi-structured interviews with women admitted to two health facilities with the same diagnosis as stated; (4) semi-structured interviews with the women's partners with consent from the women; (5) semi-structured interviews with health workers and abortion providers; (6) participant–observation of PAC and the community; and 7) free lists and group discussions with women of reproductive age in the community. This triangulation produced rich data and Dr. Belton used iterative processes with Burmese women and key informants to ensure validity and rigor. There were some limitations to the methodology. It was time consuming and also focused only on two health facilities in one province of Thailand; thus, findings are not generalizable.

The study found that Burmese women confront a variety of problems when they experience an unwanted pregnancy, and often attempt to end the pregnancy. They face pressure to abort by husbands, employers and poverty, and also may become victims of domestic violence. The general insecurity of the area and restrictions on travel exacerbate the problems. The inaccessibility or low quality of RH services available to women mean that they are often unable to find a positive health outcome. Furthermore, the differences in language and culture erect barriers to understanding and trust between health workers and women. Women resort to their own traditional or local knowledge, which is not always effective and sometimes very dangerous.

There is little reproductive security for Burmese women in Thailand, and the legal sanctions against ending an unwanted pregnancy cause women to seek out dangerous methods and unqualified abortion providers.

Modern FP methods are acceptable to Burmese women if offered at the time of need and in culturally-appropriate ways. The Mae Tao Clinic is a unique model of refugee-led primary health care, with mostly informally trained staff, which provides good quality PAC to refugee-migrant workers from Burma. This improved after a PAC training supported by the Women's Commission for Refugee Women and Children, a U.S.-based NGO. The Thai-led public hospital did not participate in the PAC training but was staffed by qualified doctors and nurses.

Of the 43 women who agreed to be interviewed, 18 disclosed inducing their abortion. Virtually all were married, only eight women were childless, and a quarter had experienced five or more pregnancies already. They were predominantly Buddhist, but five were Muslim, one was Christian and one Animist. They were largely undocumented factory or farm workers with little education, and six women disclosed surviving domestic violence. Of the 43 women, 26 were admitted as inpatients to the Burmese-led health facility, where they received FP education and counseling in their own language (Karen or Burman) and were offered free contraceptive supplies for two to three months before they left the facility. These women accepted a variety of modern methods of contraception: nine chose a tubal ligation, seven chose to take condoms home, seven accepted Depo Provera injections, two declined any method and one took nothing. In contrast, the group of 17 women admitted to the Thai-led health facility received no education or counseling on family planning and language differences made communication difficult. Thirteen women received nothing, three women accepted a tubal ligation, and one woman declined any contraception. The Thai obstetrician responsible for these women's PAC justified this by offering women an outpatient appointment six

weeks after discharge from the health facility. He was unable to report how many women attended this type of appointment after returning home.

These results reflect the findings in the literature; in many cases, women struggle to manage their fertility in harsh environments with few resources. The findings also show the positive impact of specialized PAC training for health workers, even those who are informally trained. The Burmese health workers who had attended the PAC training were able to offer postabortion contraception appropriately. The retrospective medical casenote review of 185 women who presented to the outpatient clinic of the Mae Tao Clinic with early pregnancy loss and complicated abortions, which was conducted prior to the training intervention, showed that only 20 out of 50 women with an induced abortion received any method of contraception. These findings only focus on postabortion family planning from a quantitative perspective but women and men also voiced their opinions during exit interviews. The qualitative results suggested themes of relief, surprise, lack of knowledge, coercion, skepticism and worry about using a modern method of contraception. Women, men and abortion providers were willing to speak about their most intimate problems when offered privacy, sensitivity and gender-appropriate interviewers.

For more information, please contact **Suzanne Belton** at *suzanne.belton@cdu.edu.au*

References

1. Belton S. 2005. Borders of Fertility: Unwanted Pregnancy and Fertility Management by Burmese Women in Thailand [Doctoral thesis]. University of Melbourne.
2. Belton S. and C. Maung. 2004. "Fertility and abortion: Burmese women's health on the Thai-Burma border." *Forced Migration Review - Reproductive Health for Displaced People Investing in the Future.* http://www.fmreview.org/FMRpdfs/FMR19/FMR1917.pdf:36-37.
3. Belton S. *Forthcoming.* "Borders of Fertility: Unplanned pregnancy and unsafe abortion in Burmese women migrating to Thailand." *Health Care for Women International.*

WORKING GROUP UPDATES

PAC Consortium Chair

The Chair organization rotates every two years. Organizations active in the PAC Consortium who are interested in the Chair may volunteer for this role. Prior to serving as the Chair, organizations must serve on the advisory group. As of July 2006, the new Chair organization is the Population Council. PAC Consortium Co-Chairs are **Johannes van Dam**, *jvandam@popcouncil.org* and **Laura Raney**, *lraney@pcdc.org*. Thank you to Maureen Corbett of IntraHealth, and her team, for their dedicated leadership over the past two years. Thank you also to the Packard Foundation for awarding a grant that supports the PAC Consortium website and the newsletter.

Advisory Group

With leadership from the PAC Consortium Chair, the Advisory Group participates in the process of strategy development for the PAC Consortium. The strategy expresses the vision for the Consortium, and what the Consortium expects to accomplish over the next 1-2 years. Members of the Advisory Group are: **Barbara Crane**, Ipas; **Maureen Corbett**, IntraHealth International; **Lorelei Goodyear**, PATH; **Ron Magarick**, JHPIEGO; and **Cathy Solter**, Pathfinder.

Communications Task Force

Co-Chairs: **David Nelson**, IntraHealth, *dnelson@intrahealth.org* and **Laura Raney**, Population Council, *LRaney@pcdc.org*

The Communications Task Force (CTF) is responsible for the website and the newsletter. At the May 2006 meeting, the CTF discussed the need to increase awareness and use of the listserv by providing information about how to join the listserv and how to reply to a message on both the newsletter and the website. Additionally, they discussed the possibility of sharing information on the newsletter on a monthly basis. The CTF recently redesigned the PAC Consortium (PACC) website to make it easier to navigate (check out the new design at *www.pac-consortium.org*!). The group also discussed the need for photos for the newsletter and the importance of photo consent. PACC-affiliated organizations are encouraged to submit photos, and should use the PACC photo consent form (request from *info@pac-consortium.org*). Among other topics, the CTF discussed the inclusion of an M&E column in the PACC newsletter; the first M&E column is included on page 3 of this issue.

Essential Elements Task Force

Co-Chairs: **Inés Escandón**, EngenderHealth/ACQUIRE Project, *iescandon@engenderhealth.org* and **Kiyomi Tsuyuki,** *ktsuyuki@gmail.com*

The Essential Elements Task Force (EETF) discussion at the May 2006 meeting focused on three items: (1) a review of an indicator list designed to help operationalize the five elements of PAC; (2) an introduction to the Implementing Best Practices' (IBP's) Electronic Communications System (ECS); and, (3) a discussion of the future of the task force. For the past several years, the EETF has been working on compiling a list of monitoring and evaluation (M&E) indicators that can be used to evaluate PAC programs within the context of the Essential Elements model, i.e., the extent to which the program meets the criteria/guidelines of the model. The finalized indicator list is available on the PAC Consortium website at *pac-consortium.org/site/DocServer/2006-05-25_Indicators_for_the_Essential_Elements_of_Pos.pdf?docID=261*, and next steps include collecting information from the field about experiences, tools and challenges in measuring these indicators (the Monitoring and Evaluation Indicators column on page 3 in this issue represents an effort to this end). The ECS is a tool that IBP members use to exchange information on best practices. The EETF has set up a community on the essential elements of PAC. Individuals interested in joining this community should contact **Inés Escandón** at *iescandon@engenderhealth.org.* The TF is interested in hearing about challenges related to method choice, time for individual counseling, commodity supplies, spousal consent issues and data collection. Turnout for EETF meetings has been very low at the last two PAC Consortium meetings, and, given that the TF has completed the indicator list, there may no longer be a mandate for a separate TF. The co-chairs will reexamine the role of the EETF after the November 2006 PAC Consortium meeting at APHA.

PAC Technologies Task Force

Co-Chairs: **Nancy Harris**, John Snow International, *nharris@jsi.com* and **Sheila Raghavan**, Gynuity Health Projects, *sraghavan@gynuity.org*

At the recent PAC Technologies Task Force (PTTT) meeting, Gynuity Health Projects presented an update on their misoprostol research in the context of PAC, including ongoing studies in Moldova and Madagascar that compare oral vs. sublingual treatment for incomplete abortion. Venture Strategies for Health and Development (VSHD) provided an update on the use of misoprostol for postpartum hemorrhage (PPH); in early 2006 Nigeria and Ethiopia became the first countries to approve misoprostol for this indication. Ipas shared information about the manual vacuum aspiration (MVA) drawdown account (DDA); between FY02-06, MVA kits were donated to over 28 countries.

One concern of the TF is the fact that a number of countries continue to rely on DDA donations, rather than developing a sustainable supply for MVA kits. The group made the following recommendation: Include training and policy activities prior to any initiation of new PAC activities. Additionally, TF members suggested a number of follow-up activities that would support MVA procurement in multiple countries, including conducting advocacy work with the RH Supplies coalition to include MVA as a lifesaving technology and verifying that the UNFPA/WHO commodity list includes MVA. The TF continued to discuss the development of PAC country profiles for priority countries; these country profiles will allow the TF to follow progress in PAC over time in those countries. The group shared an illustrative outline, and plans to develop one to two page profiles for six priority countries/regions by November 2006. Finally, the TF seeks broader participation in terms of partners and geographic representation. Anyone interested in participating in this group should contact the co-chairs.

PAC and Safe Motherhood Task Force

Co-Chairs: **Koki Agarwal**, JHPIEGO, *kagarwal@jhpiego.net* and **Elizabeth Westley**, Family Care International, *ewestley@familycareintl.org*

Over the past several years, the Safe Motherhood Task Force (SMTF) has found it challenging to identify concrete activities to implement; nonetheless, participants at the May 2006 meeting agreed that the TF is an important vehicle and forum for focusing on PAC as a safe motherhood/maternal health issue. They agreed that the TF could develop documents or tools that would help PAC Consortium-affiliated organizations address PAC as a maternal health issue, for example, by developing a training guide that outlines how to integrate PAC into Safe Motherhood. Anyone interested in participating in this TF should contact the co-chairs.

Youth-Friendly PAC Working Group

Chair: **Gwyn Hainsworth**, Pathfinder International, *ghainsworth@pathfind.org*

The "Youth-friendly Technical Guidance for PAC Services," developed by this working group, was unanimously adopted by the PAC Consortium at the May 2006 Consortium meeting at the Global Health Council Conference. These guidelines are organized according to the PAC Consortium's Essential Elements of PAC model. They do not suggest the creation of stand-alone PAC services for adolescents but rather focus on improving the overall quality of existing PAC services bearing in mind the special needs of young people. The finalized Guidance is available on the PAC Consortium website at *http://www.pacconsortium.org/site/PageServer?pagename=PAC_Resources*, along with other resources on adolescents and PAC. Next steps for the Working Group include integrating the Guidance within existing partner PAC programs (where applicable) and documenting the results.

MVA Drawdown Account

The Manual Vacuum Aspiration (MVA) Drawdown Account (DDA), which is managed by Ipas, was established in 1998 with funding from the Packard Foundation. The DDA supports the donation of MVA instruments to ensure continuing global access to MVA instruments through sustainable access at the local level. Thanks to the generosity of the Packard Foundation, another one-year grant that supports the provision of MVA instruments was awarded to Ipas as of October 1. Instruments provided through the DDA are intended to: (1) serve as an interim supply to generate interest in MVA; (2) facilitate access to MVA instruments for providers who could not otherwise obtain them; (3) encourage agencies to undertake programming that supports the use of MVA instruments in quality improvement efforts; (4) where appropriate, function as a bridging mechanism while long-term sustainable means for instrument supply are developed locally; and (5) serve as a mechanism to meet the need for instruments for humanitarian relief purposes, such as in natural disasters and conflict situations.

The DDA supplies MVA instruments to organizations that are directly engaged in clinical training and/or service delivery in developing countries, and should be used only when other funds cannot be secured. Multiyear requests for MVA instruments are discouraged. MVA instruments provided through the DDA should not be stocked or sold. Whenever possible, the delivery of donated instruments is managed through the local Ipas product distributor so that future orders for instruments can be placed directly through that local distributor.

There are three significant changes with the new grant:

1. More specific guidelines and criteria designed to encourage sustainability will be used by Ipas and the DDA Selection Group to assess the request.

2. Ipas will contact requesting and beneficiary organizations to learn about the use of the donations and the steps taken to establish sustainable supplies, such as conducting advocacy with local ministries and other donors.

3. Funds are available through Ipas to provide technical assistance (TA) in establishing a sustainable supply of MVA. The TA will be focused in countries with repeated requests for large donations and that have significant PAC programs with local presence.

If you have questions or would like to receive a form to submit a request for donated MVA instruments, send an email of inquiry to **Beverly Tucker** at *tuckerb@ipas.org*

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PAC-CONSORTIUM-request@lists.ibiblio.org

RESOURCES

Unless otherwise indicated, resources are available only in English.

- Warriner, Ina K. and Iqbal H. Shah, eds. 2006. Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action. New York: Guttmacher Institute. Available on the Guttmacher Institute website at: *www.guttmacher.org/pubs/2006/07/10/PreventingUnsafeAbortion.pdf*

Unsafe abortion is a significant yet preventable cause of maternal mortality and morbidity in developing countries. This report contains the papers submitted to an interdisciplinary consultation convened by the World Health Organization to assess the problem of unsafe abortion globally and to identify a research agenda aimed at reducing unintended pregnancy, unsafe abortion, and the resultant burden on women, their families, and public health systems. Experts at the consultation reviewed the available evidence on unsafe abortion, examined the factors that perpetuate the problem, and identified both opportunities for preventing unsafe abortion and constraints on prevention. Participants addressed the theoretical and medical issues relating to research on unsafe abortion and outlined regional priorities for the prevention of unsafe abortion. Both longstanding and emerging issues relating to research on unsafe abortion were discussed.

- Two fact sheets from the White Ribbon Alliance for Safe Motherhood:
  - Safe Motherhood Fact Sheet
  - General Information on Safe Motherhood

available at *http://www.whiteribbonalliance.org/Resources/default.cfm?a0=Facts*

- Tesfaye, Solomon, Tamara Fetters, Kathryn Anderson Clark and Heathe Luz McNaughton. 2006. Expanding our Reach: An Evaluation of the Availability and Quality of Postabortion Care Services in Three Regions in Ethiopia between 2000 and 2004. Chapel Hill, NC: Ipas.

This report evaluates the successes and challenges of expanding postabortion care (PAC) in Ethiopia, where unsafe abortion may account for up to a quarter or more of maternal deaths. The extensive study covers four years of collaboration between Ipas/Ethiopia and the Ethiopian Regional Health Bureaus, and details improvements in the availability and overall quality of PAC. It also documents the continuing need for comprehensive reproductive health care, training for health care providers, and adequate supplies of medical instruments and contraceptives. To order, please send an e-mail to *ipas_publications@ipas.org*. Also available online at *http://www.ipas.org/publications/en/EXPETH_E06_en.pdf*