

# Improving Postabortion Care: Reflections from Sri Lanka

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## ABSTRACT

Women who have experienced complications from miscarriage and unsafely induced abortions are among the most neglected of reproductive healthcare patients. In Sri Lanka and, the highest abortion rate of 67/1000 was recorded among women in the 35 to 39 years age. Long-term consequences, such as chronic pain, pelvic inflammatory disease and tubal occlusion, leading to secondary subfertility may result following abortions, and medical treatment remains a crucial component of care. Delay in seeking care, when complications occur, is an important contributory factor leading to death of these patients.

The infrastructure to make PAC services widely available usually lack in most of the developing countries. Emotional support, psychosocial counseling and provision of other reproductive services when necessary, following abortion have been shown to improve women's reproductive health and quality of their lives.

Care providers need to be supportive and should ensure the confidentiality and there is a need to strengthen the existing contraception service delivery system. PAC services should be continuously reviewed and appropriate changes should be made whenever necessary. Implementation is hindered by lack of awareness of national policies, overburdened and understaff, lack of staff skilled in counseling and supervision and poor contraceptive logistics.

Working in partnership, regular training, incorporation of PAC in preservice curricula is important to achieve universal access to sustainable high-quality PAC.

**Keywords:** Postabortion care services, Spontaneous miscarriage, Induced abortion.

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## INTRODUCTION

Women who have experienced complications from miscarriage and unsafely induced abortions are among the most neglected of reproductive healthcare patients. The World Health Organization (WHO) estimates that 10 to 50% of women who go through an unsafe abortion need medical care.<sup>1</sup>

A review of the literature indicates that although challenges remain in the implementation of postabortion care (PAC) programs, there have been significant improvements in the quality and the availability of treatment services for women suffering from abortion-related complications. A few countries have undertaken the challenge of scaling up PAC services beyond the secondary and tertiary levels of the healthcare system and Mexico and Guatemala have emerged as pioneers in the extension of PAC services to rural areas.<sup>2</sup>

The medical care that is provided to them commonly involves the use of prostaglandins or dilatation and evacuation.

In countries with poor resources, too often, scant attention is paid to other health conditions with which the patient presents (e.g. reproductive tract infections, sexually transmitted diseases and repeated miscarriages). In addition to the poor quality of medical care, interpersonal communication during postabortion treatment is found to be substandard. Counseling on the medical procedure required and the course of postoperative recuperation is usually not provided. Linkages to family planning services either by service provision during the post-abortion hospital visit or by referral to nearby family planning clinics are not a customary element of discharge procedures for most postabortion patients.<sup>3</sup>

A survey conducted in Sri Lanka in 1999 reported an estimated abortion rate of 45/1000 women in the 15 to 49 years age group. This translates into an abortion: live birth ratio of nearly 75%.<sup>4</sup> Middle-aged women with children seemed to be the most common group undergoing induced abortions in Sri Lanka and the highest estimated abortion rate of 67/1000 was recorded among women in the 35 to 39 years age group.<sup>5,6</sup> Around 10 to 13% of maternal deaths occurring in Sri Lanka results from unsafe abortions.<sup>7</sup> In many other women, long-term consequences, such as chronic pain, pelvic inflammatory disease and tubal occlusion leading to secondary subfertility may result following abortions.<sup>7</sup>

While most health institutions provide treatment for complications following abortion as part of postabortion care, the infrastructure to make these services widely available are usually lacking in most of the countries with poor resources.<sup>8</sup>

Implementing the PAC model has brought together global public health leaders, donors, technical assistance agencies and ministries of health to work with communities. Implementing the PAC package would also ensure that women having spontaneous miscarriage or induced abortion would have access to healthcare services which would manage complications, if any. They could also receive counseling, obtain contraceptive services and reproductive and other health services they need at the same time.<sup>8</sup>

## The Essential Components of a PAC Program

1. Treatment: Medical management of complications including evacuation of retained products.
2. Provision of family planning (FP) services.
3. Provision of emotional support and appropriate counseling.
4. Provision or referral for other reproductive health services, such as cancer screening.

## The Lankan Scenario

The majority (58%) of maternal deaths in Sri Lanka in 2010 were due to direct causes and septic abortion was one of the three leading direct causes.<sup>7</sup> However, the maternal mortality ratio of the country is impressively low (33/100,000 live births

in 2010) with the absolute number of women dying of unsafe abortions being less than 20 per year on average.<sup>7,9</sup> Several factors are attributed to the relatively low rates of complications following abortions. On average, 90% of abortions are carried out before 10 weeks of gestation. Most abortions are conducted by personnel with 'some form of medical training' using modern methods and antibiotics with most women having been immunized against tetanus. In addition, those with complications have access to a hospital at an early stage.<sup>4-6,10</sup>

Medical care that is provided to women following abortions is often limited to managing the emergency situations. Too often, little attention is paid to other components of PAC. Providing emotional support to these women with good interpersonal communication is often less than ideal in most settings. Adequate discussion on the medical procedure the patient has to undergo and the course of postoperative recuperation is usually lacking. Establishing linkages to FP services or providing other reproductive health services is not a customary component of the discharge procedure for most women.<sup>10</sup>

The knowledge on complications of both spontaneous miscarriage and induced abortions has been shown to be poor among patients.<sup>4</sup> Delay in seeking care, when complications occur, is an important contributory factor leading to death of the patients.<sup>11,12</sup> The legal concerns, stigma attached to abortion, and the negative responses from the healthcare providers in the hospitals may be responsible for the reluctance of these women to come to hospital.<sup>10</sup>

Medical treatment remains a crucial component of care. Early and aggressive medical treatment in unsafe abortions with complications becomes a life-saving measure. Even if uncomplicated on admission, they can become life-threatening if treatment is delayed. Therefore, an accurate initial assessment and prompt action taken to stabilize the patient where indicated is mandatory. Safe and effective treatment involves evacuation of the uterus, infection prevention precautions, appropriate pain management, communicating with the patient respecting her sensitivities while adhering to the guiding principles and follow-up care.<sup>13</sup>

## Family Planning

FP is important for all women, particularly to those who have experienced an unsafe abortion. It has been reported that contraceptive failure accounted for 27% and an unmet need of family planning accounted for 73% of the pregnancies that were aborted.<sup>12</sup> It is paradoxical that in a country where the female literacy rate is high (90%)<sup>14</sup> and awareness and knowledge of contraceptive methods is over 97%<sup>10</sup>, the abortion rate too is high. Lack of technically accurate knowledge which results in proliferation of myths and misconceptions about modern methods has been reported as one of the reasons.<sup>10</sup>

Women are most likely to begin using a FP method if they can obtain it at the time of their PAC rather than returning for another visit for FP counseling or being referred elsewhere to obtain it.<sup>8</sup>

If the FP component is provided in the same facility, there is an increase in the proportion of postabortion clients leaving a health facility with the contraceptive method of their choice.<sup>15</sup> The increase in contraceptive use has also been shown to result in a marked reduction of repeated unsafe abortions.<sup>16</sup> Most of health institutions in Sri Lanka that deal with abortion-related emergencies do not offer quality FP services onsite as a part of PAC.

## Emotional Support and Psychosocial Counseling

In addition to addressing subsequent fertility and contraception, postabortion care counseling consists of information provision about their medical conditions, test results, treatment and pain management options and follow-up care and emotional support in a sensitive and 'no blame no shame' manner.<sup>17</sup> This form of counseling can provide an opportunity to help women to explore their feelings about their abortion, assess their coping abilities, manage anxiety and make informed decisions.<sup>16</sup>

Some other benefits of counseling are that client-provider interactions will be more respectful, treatment will be less distressful and more effective and women's understanding and use of other health services will increase which ultimately will improve the health outcomes.<sup>16</sup>

Emotional support can be provided by staff members including nurses, midwives and medical officers. Ideally, the same individual should provide support before during and after treatment.<sup>3</sup> However, this is difficult to achieve in most of the health facilities in Sri Lanka due to limited staff and high case loads. Nevertheless, supportive and caring staff members can do much to meet the psychological and emotional needs of women seeking postabortion care.

## Other Reproductive Health Services

Additional services that may be offered or referred for during PAC, including education about the prevention, screening, diagnosis and treatment of sexually transmitted infections, including HIV, services addressing gender-based violence, education and treatment of nutritional deficiencies, screening and treatment of reproductive-related cancers.<sup>8</sup> The woman seeking PAC services in Sri Lanka is often overlooked with respect to these services due to primarily focusing on medical treatment<sup>10</sup> work overload or due to low priority given to this aspect of PAC.

## Opportunity for Change

Health education and community mobilization will encourage early access to medical care which in turn will reduce morbidity and mortality thereby improving women's reproductive health and quality of their lives.

In Sri Lanka, patients after abortion are mostly managed in specialist gynecological units. Commencement of emergency measures at primary healthcare (PHC) level is essential to maximize the chances that the woman will reach the specialist unit in a stable condition. Most of the first contact, PHC facilities

in Sri Lanka are staffed by a medical officer who should be able to diagnose and initiate management options for emergencies. Often, the care offered at this level can be improved dramatically, with a relatively small number of improvements and interventions, such as having the staff trained, and making facilities available to conduct an initial assessment, stabilize her condition and initiate emergency treatment. They also need to be able to arrange prompt and reliable transfer without delay. Therefore, they need 'in service training' focused to update their skill and knowledge on PAC services.

Use of misoprostol can completely evacuate the uterus in early pregnancy failure (delayed miscarriage or early fetal demise) and incomplete miscarriage in 50 to 96% of the time if given orally or vaginally, thus avoiding unnecessary surgical intervention.<sup>18,19</sup>

It is the responsibility of all providers, including specialists, medical officers, nurses and family health workers, to provide accurate and updated information in a simple manner about natural/traditional methods, modern methods and emergency contraception highlighting areas responsible for contraceptive failure. This will help the PAC clients to recognize their need for contraception, overcome possible misconceptions and fears regarding contraceptive method and to gain confidence and trust in the healthcare system.<sup>10</sup>

There is a need to strengthen the existing contraception service delivery system in the field and hospital setting. This includes ensuring the availability of a wider choice of methods, minimizing any short fall in supplies, ensuring accessibility, enhancing the counseling and service provision skills of the service providers to enable them, to motivate and encourage the women to make an informed choice.<sup>10</sup>

Even though it may be difficult to avoid all unplanned pregnancies, good FP services with high level of contraception use could lead to a lower abortion rate. Failure to provide quality FP services to all segments of Lankan society will naturally push the current abortion rate to higher levels.<sup>4</sup>

As Sri Lanka has a strict law on abortion, women are unlikely to divulge information on interventions done to procure an abortion. Concerns about the possibility of unsafe abortion/septic abortion should be made but in a very sensitive manner, particularly because it is going to critically influence the management and not merely fulfil a legal responsibility.

Ensuring the confidentiality and respect will encourage women to give the information and it is important to take measures to create such an atmosphere. Sadly, this is an area often neglected in care provision in Sri Lanka. The involvement of the husband in the decision-making process is important. With the client's consent, counseling the husband/partner separately results in an increase in the acceptance of FP by women who receive PAC.<sup>20</sup> Which ever approach is preferred by the couple should be supported and implemented.

Care providers need to be supportive and nonpunitive and should take extra care to express openness and compassion with regard to adolescents because they may not have the support of their partners or parents and are more likely to experience isolation and emotional stress. Adolescents may also find it difficult to understand and use FP methods consistently and correctly.<sup>21</sup>

PAC services should be continuously reviewed and appropriate changes made at national level with the collaboration of relevant stakeholders with the leadership of Family Health Bureau (FHB) and Sri Lanka College of Obstetrician and Gynaecologists (SLCOG). Monitoring may include direct observation of staff at work, use of checklists (e.g., to evaluate critical skills), examination of clinic records, and discussions with patients, staff and the community.<sup>22</sup> This should be followed by identifying challenges faced in providing care and provide feedback to staff, and instituting appropriate interventions to correct any problems identified.

### *Anticipated Challenges in providing Comprehensive PAC Service*

Ensuring that every woman who has a miscarriage or an induced abortion receives comprehensive PAC and counseling services is a challenge in a health system already overburdened and understaffed. Although many models on how FP services can be integrated with PAC services have been described effective implementation under the prevailing conditions remains a weakness of all. At the health system level, implementation is hindered by poor contraceptive logistics and lack of awareness of national policies and guidelines on integrated services at the facility level, disruptions in contraceptive supplies and Inability of providing FP services at the same location as PAC services.

Lack of staff skilled in counseling and lack of supervisory support to overcome service challenges will be another constraint.<sup>23-25</sup> Ensuring quality of PAC services is another challenge. Regular training strategies are required for the overall quality and sustainability of a PAC service program.<sup>3,26</sup> Incorporating theoretical and practical training on PAC in pre-service curricula in medical and nursing schools will strengthen health providers to provide PAC when they start practising. In-service training then needs take the form of refresher training.

## **CONCLUSION**

Postabortion care (PAC) is internationally recognized as an integral part of reproductive health services provided to women. In order to reduce the risk of long-term illness or disability and death to women presenting with an incomplete spontaneous miscarriage or an induced abortion, healthcare system needs to provide easily accessible, high quality comprehensive PAC at all service levels.

Few countries have undertaken the challenge of scaling up PAC services beyond the secondary and tertiary levels of the health care system. A National Guideline on postabortion PAC has already been developed by the SLCOG and is awaiting publication.<sup>17</sup> The purpose of this guideline is to provide health-care personnel with essential information and guidance on the management of women presenting with an abortion, in order to provide comprehensive high quality PAC services, conforming to international standards.

There is a necessity to improve both skills and capacity of care providers to provide effective, comprehensive, holistic PAC, within the existing legal framework to women of Sri



Lanka. To achieve universal access to sustainable high-quality PAC, institutional care providers, field health staff, community healthcare professionals and advocacy groups, ministry of health and other stakeholders interested in women's health must work in partnership.

It is our hope that this report may be relevant and helpful to other countries in South Asia who wish to design appropriate strategies to overcome the complex issues and challenges surrounding the provision of PAC.

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