OR SUMMARIES

Bolivia/Mexico Postabortion Care

System-Wide Planning is Needed for Decentralized Postabortion Care

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Sharp curettage and manual vacuum aspiration, the most common treatments for incomplete abortion in developing countries, are equally safe and effective and can be provided on an outpatient basis. Integrating clinical treatment with family planning counseling and services increased clients' knowledge and contraceptive use. However, integrated postabortion care requires a strategic approach that examines system-wide requirements for care.

Background

Governments in developing countries recognize the need for appropriate technology for the treatment of emergencies from incomplete abortion or miscarriage. Numerous studies have investigated the appropriateness of an integrated model of postabortion care (PAC) that includes three essential elements: emergency treatment for spontaneous or induced abortion; counseling and family planning services; and links to other reproductive health services. Many integrated PAC services include replacement of the conventional clinical treatment, sharp curettage (SC), with manual vacuum aspiration (MVA).

In 1997 and 1999 the Population Council supported intervention studies in Mexico and Bolivia, respectively, to assess PAC programs in terms of safety, effectiveness, quality of care, cost, and subsequent contraceptive use by clients. Ipas conducted the studies in collaboration with the Mexican Institute for Social Security and the Bolivian Ministry of Health.

Both interventions introduced integrated PAC services and compared the outcomes of MVA and SC use in large secondary- or tertiary-level public hospitals. Approximately 75 providers in each study received training and refresher courses on clinical emergency obstetric care and on postabortion counseling and family planning services. To assess changes in service quality and costs, researchers analyzed clinical records and interviewed clients (803 in Mexico and 931 in Bolivia) and providers before and after the interventions.

Findings

◆ MVA and SC are equally safe and effective in completing uterine evacuation in these settings. Complication rates during or after the procedure, using both MVA and SC, were below 5 percent in the two studies. Uterine evacuation was complete for all women treated with MVA and SC in Mexico (100% and 99%, respectively) and in Bolivia (99% and 96%).

◆ Providers interviewed following the Mexico intervention generally found MVA and SC equally safe, effective, and easy to use. They noted that MVA increased interaction with clients, as the procedure uses a local, rather than general, anesthetic. However, they also noted barriers to MVA use, including problems with pain management, insufficient staff training in MVA, and loss of trained personnel due to frequent staff turnover.

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◆ The main determinants of service costs were length of stay and organization of services. The type of procedure made little difference in the length of stay (five to 10 hours) when PAC was provided as an outpatient service (in all the Mexican hospitals and one of the Bolivian hospitals). When PAC was provided as a non-ambulatory service, recovery time was the main determinant in length of stay (between 20 and 45 hours).

◆ Pain control needs improvement irrespective of the type of procedure performed. Clients in both countries said they felt pain before and after treatment with either method (see Table). In the Mexico study, women described their pain levels as moderate or higher (between 4 and 7 on a 10-point scale) throughout the procedure. Bolivian providers noted that women wished to be fully sedated for either treatment method.

Proportion of clients reporting pain before and after uterine evacuation at intervention sites

	Pre-procedure (%)	Post-procedure (%)
Bolivia MVA (n=228)	72	29
Bolivia SC (n=339)	75	30
Mexico MVA (n=251)	60	41
Mexico SC (n=270)	58	23

Source: women interviewed following treatment for incomplete abortion

◆ Integration of clinical care and family planning counseling and services occurred in Mexico but not in Bolivia, where rapid staff turnover, limited supervision, and the low number of trained personnel impeded integration. However, women in both countries were still insufficiently informed about many aspects of their treatment and recovery, return to fertility, and warning signs following discharge.

Policy Implications

◆ Findings from these studies suggest avenues for policy and research on decentralized health care. PAC can be safely provided on an outpatient basis regardless of the method of uterine evacuation. Providing such services may require reorganization of clinic space and logistical strengthening to ensure that treatment areas, supplies, and medications are available in decentralized settings.

◆ For long-term sustainability, postabortion care requires commitment from facility managers and in many cases, restructuring of procedures for admission, discharge, payment, and insurance. Institutionalizing PAC in a decentralized system requires routine pre-service, in-service, and refresher training for all personnel involved in treatment and counseling. Additionally, links to other reproductive health services need to be enhanced.

◆ Training and clinic reorganization should address pain management through all stages of treatment, from admission to recovery.

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Sources: Billings, Deborah L., Eliana Del Pozo, and Hugo Arévalo. 2003. "Testing a Model for the Delivery of Emergency Obstetric Care and Family Planning Services in the Bolivian Public Health System," *FRONTIERS Final Report*. Washington, DC: Population Council. Available on our website at www.popcouncil.org/frontiers/frontiersfinalrpts.html or by e-mail: frontiers@pcdc.org.

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