

RESEARCH

• RESULTS

***Postabortion Care  
for Adolescents:***

***Results from  
Research in the  
Dominican Republic and  
Malawi***



**ENGENDERHEALTH**

*Improving Women's Health Worldwide*

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## Introduction

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It is estimated that 2 million to 4.4 million adolescents\* have unsafe abortions (either induced or spontaneous) each year, accounting for an estimated 14% of the unsafe abortions that are performed in all developing countries (Olukoya et al., 2001; WHO, 2004). Adolescents are more likely than older women to face significant obstacles to obtaining a safe abortion (Olukoya et al., 2001), and 38% to 68% of women admitted to a hospital for abortion complications in countries where abortion is legally restricted are under age 20 (Bankole, Singh, & Haas, 1999).

Adolescents who choose abortion are more likely than adult women to delay seeking services once they know they are pregnant. They also are more likely to resort to unskilled providers and dangerous methods. When complications result from an abortion, adolescents tend to delay seeking treatment and, consequently, often present at health facilities with serious and life-threatening complications (Olukoya et al., 2001).

What is the experience of young women who have abortions and then seek treatment for complications? What happens in cultures where unmarried young women face social, familial, and educational ostracism for being pregnant; where teens often are physically too immature to carry a pregnancy to term and give birth safely without significant clinical intervention; where they are uneducated, and unable to afford a child; where abortion is legally restricted and socially unacceptable? What kind of treatment do young women seeking postabortion care (PAC) services receive from health care providers, and what care and information do they need? And once adolescents have received PAC services, do they know how to prevent unwanted pregnancies in the future?

There is still much to learn about how best to provide PAC services to adolescents. To this end, EngenderHealth conducted studies in the Dominican Republic and Malawi in 2002 and 2003, respectively, to determine how hospitals can better meet adolescents' needs for PAC (EngenderHealth and Centro de Estudios Sociales y Demográficos, 2002; EngenderHealth, 2004).

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\* For the purposes of this research, an adolescent is defined as a person aged 13 to 19.

## Components of Postabortion Care

Over the past decade, efforts have been made around the world to ensure that high-quality PAC is available wherever and whenever a woman seeks treatment for complications of abortion. The concept of PAC encompasses five primary components (Postabortion Care Consortium Community Task Force, 2002):

1. Community and service-provider partnerships, to prevent unwanted pregnancy and unsafe abortion, mobilize resources, and ensure that health services meet community expectations and needs
2. Comprehensive counseling, to respond to women's emotional and physical needs and other concerns
3. Treatment of incomplete and unsafe abortion and potentially life-threatening complications
4. Contraceptive and family planning counseling and services, to help women prevent unwanted pregnancies or practice birth spacing
5. Provision of reproductive health and other health services (either on-site or via referrals to other facilities)

An underlying principle of PAC is that services are offered within the context of a supportive, caring environment.

## Research Methodology

The research examined the reasons adolescents in the Dominican Republic and Malawi seek PAC services, and sought answers to the following questions:

- What problems do adolescents face in obtaining PAC?
- What are their perceptions of the care they receive?
- How can PAC for adolescents be improved?
- What information and services do adolescent PAC clients want and need?

This qualitative research was conducted at two hospitals in the Dominican Republic (in Santo Domingo) and at four hospitals in Malawi (in Blantyre, Kasungu, Lilongwe, and Machinga). Semi-structured, in-depth interviews were conducted with adolescent clients who arrived at the study sites seeking treatment for abortion complications. Interviews also were conducted with obstetrician-gynecologists, nurses, clinical officers, residents, and administrators who work in the wards where abortion complications are treated at each hospital.

Approval of the study design and permission to conduct the research were obtained from each institution's administrators and research and ethics committees. During recruitment, potential participants were informed of their right to refuse to be interviewed, and were assured that refusal would in no way affect their ability to give or receive proper health care at the facility. To guarantee anonymity, written consent was not requested; however, verbal consent was required.

### Challenges to Adolescents' Ability to Prevent Pregnancy

- Ambivalence toward sexuality and fertility
- Difficulty in negotiating the terms of a sexual relationship
- Vulnerability to gender-based violence
- Insufficient knowledge of contraception
- Lack of access to contraceptive counseling and services
- Fear of providers' attitudes or judgments about adolescent sexuality
- Presumed lack of confidentiality when seeking family planning and other reproductive health services

## Research Findings

### The Dominican Republic

According to the 2002 Demographic and Health Survey, more than 3% of adolescent women in the Dominican Republic have their first child by age 15, almost one-quarter by age 18, and up to 45% by age 20 (Centro de Estudios Sociales y Demográficos et al., 2003). The maternal mortality ratio is 178 per 100,000 live births. Approximately 25% of women aged 15 to 19 who either are married or are unmarried and sexually active have used a modern contraceptive method. In addition, 70% of women in this age group know someone who is living with or has died from AIDS, but approximately 44% have no information or knowledge about sexually transmitted infections (STIs.)

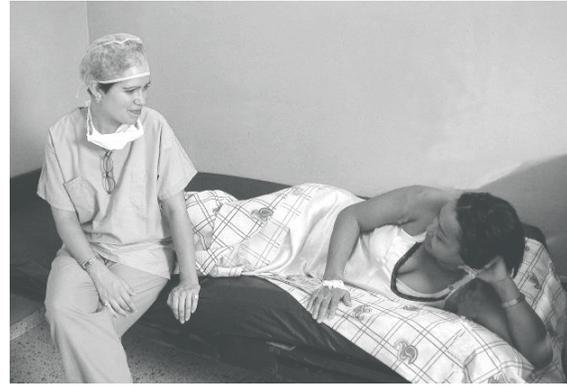
In this country, where abortion is highly restricted, a large number of adolescents seek PAC services. Records from one hospital selected for this research indicate that 41% of the PAC clients seen there are under age 20. Despite efforts to increase providers' skills in working with young people, many providers say they need more information and training to better serve adolescent PAC clients.

### Adolescents' Perspectives

Forty clients were interviewed at two hospitals in Santo Domingo. Most of the clients had only primary-level education, and more than 50% had left school because they became pregnant or had gotten married. All hoped to return to school. Nearly half of the young women were either married or in a consensual union. Thirty-eight percent (15) had at least one child already, and more than half were daughters of women who had been adolescent mothers.

The young women interviewed for this study largely reported that they had not planned to become pregnant, but that in many cases, and for a variety of reasons, they were not taking measures to prevent pregnancy. Six clients (15%) had planned their pregnancy, and expressed happi-

ness about it, either because they would be a young mother, because it would please their husband, or because pregnancy defined them as a woman. "A child is a gift from God," one client explained.



Most of the women who knew they were pregnant told their boyfriends or husbands and, often, their mothers. Most (78%) told some family member, and a few told a friend. In many cases, relations with a boyfriend or husband improved after announcement of the pregnancy: The partner provided increased affection and care, and there was some reduction in domestic violence. In other cases, the relationship ended, with the man denying paternity, abandoning the pregnant woman, or encouraging her to have an abortion. The clients' mothers, on the other hand, generally gave advice about how to continue and care for the pregnancy.

Forty percent of the adolescents interviewed reported a delay of several days in receiving care because of visits and referrals to multiple health care facilities. Most of the women arrived at the hospital where they were treated in intense pain and with an abortion in process. At one of the facilities, several of the clients arrived seeking care for bleeding and pain, but didn't know they were pregnant until a provider told them.

Some of the young women had experienced a spontaneous abortion, or miscarriage, while others may have induced an abortion. At the time of the interview, nearly all of the clients were

upset—some were in tears—and as a result, many of the interviews were not completed, to allow the women the time and privacy they needed. All expressed sadness and fear of sterility, and all had experienced physical pain. The women who either admitted to having or were assumed to have had an induced abortion tended to express guilt and fear of rejection from family members or partners.

**Forty percent of the adolescents interviewed in the Dominican Republic reported a delay of several days in receiving care because of visits and referrals to multiple health care facilities.**

Most of the adolescents, upon entering the hospital prior to receiving treatment, were worried about what would take place. Nearly half reported eventually feeling satisfied with the way the staff had alleviated their concerns, by offering reassurance, explaining what was occurring, and providing overall help. Those whose concerns were not eased described rude and limited communication by the providers: “...They did not tell me anything”; “They did not explain the procedure, speak about anything; they only asked when I was born.” Some of the young women felt they had not been treated humanely because the staff assumed they had induced their abortion.

Many clients complained that they received no medication for managing the pain they experienced during uterine evacuation, and they identified the lack of analgesia to be a major problem. Interviewees also said there was a need for better hygiene and infection prevention at the hospital where they were treated. For example, they objected to the fact that they had had to share a bed with other clients and that bloody floors were not cleaned between procedures.

### ***Providers’ Perspectives***

Twenty-one providers were interviewed at the two hospitals. Most had between two and 10 years’ experience working in the ward where PAC services were offered. The providers had

been trained in family planning, sex education, use of manual vacuum aspiration (MVA), and client-provider relations. None of those interviewed had received any training in comprehensive PAC or in adolescent care.

Generally, these providers believed that adolescent pregnancy is a growing problem resulting from several factors, including lack of sex education and family tensions (such as

economic hardship and domestic violence), which contribute to poor communication and lack of trust between parents and daughters. They also blamed adolescents for succumbing to the influences of peer pressure and external factors such as the media. Some of the providers felt that adolescents who seek abortion are irresponsible, and others felt pity for the young women because their circumstances involved significant social, economic, and family challenges.

The providers generally felt they behave compassionately toward their adolescent PAC clients but that the clients communicate little to them and provide little feedback about their abortions. The providers noted that adolescent clients arrive at the hospital alone, anxious and eager to be attended immediately, so they can return to their routine activities without drawing attention to themselves.

Several of the providers said that adolescents should receive more humane treatment, both in terms of clinical services (such as pain medication and respect for privacy) and personal interaction (including general dialogue, counseling, and the quality of information provided). Doctors felt nurses should improve their relations with clients; nurses felt this was the doctors’ responsibility. Most of the providers felt the lack of space, beds, MVA equipment, and contraceptive methods were the primary obstacles to offering good-quality PAC services.

## Malawi

In Malawi, where abortion is illegal, unsafe abortion accounts for 60% of all hospital admissions for acute gynecological problems and is responsible for 30% of maternal deaths (Kinoti et al., 1995; Lema et al., 1997). According to the 2000 Demographic and Health Survey, about one-quarter of women aged 15 to 19 have borne at least one child, and another 8% are pregnant with their first child; 63% of women in Malawi give birth before age 20 (National Statistical Office [Malawi] and ORC Macro, 2001). The maternal mortality ratio is 1,120 per 100,000 live births—more than double that of a decade ago. Though 96% of married women aged 15 to 19 are estimated to be knowledgeable about modern contraceptive methods, only 13.5% of those who are married or are unmarried and sexually active have used a modern method. In addition, nearly 70% of women aged 15 to 19 know someone who is living with or has died from AIDS. And, according to the DHS data, while 98.3% of women in this age group have heard of HIV or AIDS, nearly twice as many women as men either have no knowledge of or know of only one of the primary methods for preventing infection with HIV.

### *Adolescents' Perspectives*

Forty-two clients presenting for PAC services at two urban and two rural hospitals in Malawi were interviewed for this study. All but four of the clients were in their first trimester of pregnancy; the remainder were in their second trimester. Twenty-six percent of the young women had attended school through primary level (fourth grade), and 54% had received an upper-primary education (grades 5 to 8). The vast majority of clients were not in school at the time of the study; 63% reported that they could not attend school for economic reasons, and 25% couldn't because they were pregnant. More than 76% of the clients were married, and 33% of the total had at least one child. Roughly 40% of those interviewed had planned their current pregnancy.

Once the women began to seek help for bleeding and abdominal pain, most (93%) experienced a lengthy referral process from one provider to another before reaching the hospital where PAC services were provided. This referral process often resulted in a long delay before the client received the critical medical care she needed; some clients, for example, had to wait up to eight days for uterine evacuation. In addition, the young women had already delayed seeking medical care from the time of the onset of symptoms because in all cases, clients had had to wait for a senior relative or neighbor for permission to seek care either from a traditional healer or at the hospital.



The majority of clients (93%) reported that their pregnancy strengthened their relationship with their partner, but some relationships ended as a result of the pregnancy. Most of the clients did not tell friends, and a few told female relatives. In general, those who had not planned their pregnancy reported that their family members were unhappy or were disappointed with them, and two of the young women were abandoned by their parents.

Most of the women who had planned their pregnancy were very disappointed to have had a miscarriage. The women who had not planned their pregnancy reported feeling neither sad nor happy, and one felt relieved. Most also expressed concern about not knowing enough about their condition or about what would happen in the unfamiliar hospital setting, and most expressed fear of dying. Of those who expressed their concerns, only five were given reassurance by a provider, had their symptoms and the procedures explained to them, and were given adequate pain medication. Ten clients said that the providers did not give them any reassurance, and several noted that the providers exhibited negative attitudes, which the women felt may have been the reason for the extensive delays in receiving treatment. The other women said they had no concerns once they were in the hospital, as they felt they were in the right place to deal with their condition.

### Barriers to Quality Postabortion Care Services for Adolescents

- Insufficient knowledge of PAC services
- Inadequate access to PAC services or linkages with other reproductive health services
- Poor knowledge on the part of providers (inability to diagnose and/or treat abortion complications)
- Fear of providers' attitudes or judgments
- Presumed lack of privacy and confidentiality during service provision
- Unsatisfactory infection prevention practices
- Few or no pain management options
- Lack of space, beds, and MVA equipment

The majority of clients were told they would experience pain during uterine evacuation and that they must “endure it.” Few received pain medication. None of the interviewees had been

informed about what to expect after uterine evacuation, including possible postprocedure complications. The women told the study team that they had received either limited or no information about family planning; a few women received a contraceptive method. None of the clients were counseled on HIV/AIDS or other STIs during their visit. Despite the problems they described, most of the clients reported feeling satisfied with the services they received, as they perceived their physical situation had improved.

### Providers' Perspectives

Forty providers were interviewed at the four hospitals in Malawi, including physicians, nurses, midwives, clinical officers, medical assistants, administrators, and other clinic staff. Overall, the providers considered PAC to consist of clinical management of abortion complications, and some added provision of family planning education as a component of PAC. Clinical providers at all four study sites stated that no formal guidelines or written protocols exist, though their descriptions of how to care for PAC clients were generally similar. They interpreted the lack of a protocol for pain management to mean that minimal pain management was indicated. Hospital administrators at some sites, however, cited written PAC guidelines and reported that all PAC clients were offered family planning and STI/HIV/AIDS services.

The providers offered several reasons why young women become pregnant, revealing their attitudes toward adolescents who present for PAC. The reasons cited include peer pressure to engage in sex; lack of information; poverty, leading to the exchange of money for sex; alcohol consumption; and irresponsibility. Most of the providers interviewed were under the impression that abortion among adolescents is very common and that this is why so many young women seek PAC services. Negative provider attitudes were commonly observed during the interviews, and the majority of the interviewees reported that negative

attitudes generally prevail over positive ones. Some of the negativity was interspersed with possible concern for the young women: “Why did she not use condoms, especially in this era of HIV/AIDS?”

Most of the providers agreed that adolescents face many barriers when seeking PAC services, including negative provider attitudes, fear that their abortion will be discussed among the community at large, and hesitation about seeking services for so stigmatized a situation.

### Recommendations for Improving Postabortion Care Services for Adolescents

The young women interviewed in the Dominican Republic and Malawi provided many suggestions for what would constitute good PAC services for adolescents. Their descriptions form the basis for recommendations for adolescent PAC clients regardless of location, and include the following:

- **Faster service.** For many reasons, adolescents are more likely than older women to delay seeking an abortion and to delay seeking treatment for abortion complications should they occur. As a result, by the time they present at a treatment facility, these clients may already have complex and serious complications. Because of this potential for delay and its implications, adolescents presenting with abortion complications should be considered an emergency until proven otherwise (Olukoya et al., 2001).

To this end, PAC services can and should be made available at as many health facilities as possible throughout a country. Basic PAC can be provided at all levels of the health care system and should be available whenever a health facility is open and an appropriate provider is available. Training of more providers may be necessary to make PAC services available wherever they are needed.

- **The use of analgesics for pain management.** Women in many countries who have had uterine evacuation for treatment of abortion complications have repeatedly called for improved pain relief. Providers and health systems would do well to heed this call for adequate pain management.
- **Nonjudgmental provider attitudes toward adolescent clients.** Both the clients and the providers interviewed in these studies cited the need for more respectful, more humane, and less judgmental treatment of adolescent PAC clients. Training of providers in how to understand, counsel, and work more effectively with adolescents is clearly necessary.
- **Separate recovery areas.** Abortion can be a complicated and difficult physical and emotional experience for any woman, regardless of whether her abortion was spontaneous or induced. Recovery areas for women who have been treated for abortion complications should provide privacy and should clearly be separate from the maternity ward.
- **Better hygiene and use of infection prevention practices.** Providers and clients alike are aware of the implications of unclean clinic facilities and crowded conditions. Creative use of space and resources is needed to avoid having hospitalized clients share beds. Increased training in infection prevention is also needed.
- **More information (offered voluntarily by providers) about pregnancy, abortion risks, uterine evacuation, post-procedure care, family planning, STIs/HIV/AIDS, and future fertility.** Women must have access to information in order to make sound decisions about their health and their lives. Health care providers, who are highly educated in their fields and have ongoing access to health information, need to share their knowledge and effectively guide women to other sources of information about the topics they seek to understand, including pregnancy, abortion risks, uterine evacuation procedures, family plan-

ning options, and future fertility. Postprocedure information and a thorough discussion of potential complications, as well as how to address them, is an integral component of PAC. In addition, information about preventing HIV/AIDS and other STIs is absolutely crucial to discuss during every client-provider interaction.

It is important to keep in mind that all health care clients should be invited and encouraged to ask questions about their health. Even when clients do not ask, pertinent information should be provided voluntarily, as clients (of any age) don't always know that there is more to be learned.

The findings of this research point to two additional recommendations for good PAC services for adolescents:

- **Improved linkages and referrals to other health services.** Ensuring that PAC clients who desire a family planning method actually receive it is vital to preventing unplanned and unwanted pregnancies and repeat abortions. Those who need information or services for other health needs, including sexuality or STIs/HIV/AIDS, need to be effectively referred to, directed to, and encouraged to use such services.
- **Written practice guidelines.** Formal written and accepted practice guidelines or protocols help to ensure that specific health services, such as PAC, are provided throughout a health care system, and they outline the service-delivery standards required to address clients' needs. In the case of PAC for adolescents, the guidelines also should reflect that for many adolescents, postabortion treatment may be the first time they have had a gynecological exam.

## Conclusion

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As PAC is further established as a basic health service around the world, the circumstances of the adolescent PAC client must be kept in mind. While the basic components of PAC remain the same for all clients, the circumstances of adolescent life call for paying particular attention to young PAC clients. Though true for all PAC clients, for adolescent PAC clients rapid, respectful, and thorough services and information are vital to saving lives, averting long-lasting morbidity, and furthering the likelihood that future pregnancies will be wanted and planned.

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