Original article

Quality of post-abortion care in public health facilities in Ethiopia

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Abstract

Background: Comprehensive quality Post Abortion Care (PAC) is one of the important strategies to save lives where access to safe abortion is restricted by Law and services are inaccessible.

Objective: The objective of the study was to assess the status of quality of PAC in health facilities of Amhara and Oromiya regional states.

Methods: The study was cross-sectional by design and was conducted from November 2002 to March 2003. Patient interview, provider interview and direct service delivery observation were utilized to capture different aspects of care. Eleven health facilities (five in Oromiya and six in Amhara Regions), 103 post-abortion patients and 87 health service providers were included in the study.

Results: although facilities were found to be prepared to manage abortion complications, some patients were delayed from receiving services because of requirement to pay before getting services, and to buy drugs and supplies from other sources. Patient-provider interaction was generally satisfactory as viewed by the respondents. Majority (88.3%) of patients felt that PAC services maintained confidentiality. Patients were not informed about the steps of each procedure. Nearly two-third of service providers informed the patients about the cause of their problem, but only 50.5% of them told the outcome of treatment. Information provision regarding important precautions and warning signs was uniformly very low in all study facilities. Only 53.4% of patients left the facilities counseled about family planning and 44.7% with contraceptives. But, 84.5% of women do not plan pregnancy within three months following the abortion. Great majority of the patients responded that they were satisfied with services they have obtained. Dissatisfaction included maltreatment by service providers, and inconvenient setup of service delivery. Patient assessment was principally based on last menstrual period and bimanual pelvic examination in most of the facilities. Service providers do not usually stick to infection prevention and universal precautions.

Conclusion: the study has shown areas of improvement for better services to respond to various needs of the post-abortion patients. [*Ethiop.J.Health Dev.* 2008;22 (1):26-33]

Introduction

Causes directly linked with pregnancy, namely severe bleeding, infection, unsafe abortion, hypertensive disorders and obstructed labor accounted for 80% of maternal deaths in developing countries (1, 2).

Due to restrictive laws, lack of access to safe abortion and lack of quality post-abortion care, millions of mothers have risked and lost their lives prematurely. Reasons for resorting to unsafe abortion after unwanted or unplanned pregnancy are well established and reflected the status of women in the society. Some of the reasons are inability to support self and family, having already enough children and being very young and being in school (3, 4, 5).

Over 40% of the total deaths due to unsafe abortion have occurred in Africa making it the leading cause of maternal mortality in the region (2). Unsafe abortion was recognized as a major public health problem at the International Conference held on Population and Development (1994) and participants called for prompt, high quality and sympathetic medical services to treat the complications of unsafe abortion. Additionally, they have called for compassionate post-abortion counseling and family planning services to promote reproductive health and prevent repeated abortions (6).

In Ethiopia, to respond to the problem in an efficient way, a comprehensive PAC approach was developed in 1991. The approach included emergency treatment of incomplete abortion and its complications, family planning counseling and services, and linking the emergency treatment along with other reproductive health services (7). Recently, the post-abortion care consortium developed an expanded and updated model which includes two more elements, i.e., providing appropriate counseling based on individual needs and community-provider partnership in prevention of unsafe abortion and care (8). These are important strategies for developing countries where access to safe abortion is restricted and knowledge and practice of family planning is low. In addition, due to severe poverty and lack of access to health care in general, PAC is one of the very few opportunities for women to seek medical services and benefit from reproductive health and family planning services.

Ethiopia is one of the developing countries with the highest maternal mortality ratio in the world which is

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estimated at 871 per 100,000 live births (9). Although researches have documented that abortion is the leading cause of maternal mortality access to safe abortion is extremely limited in the country (10). A nationwide study on abortion complications indicated that abortion is not only the problem of the urban and referral facilities, but also for rural and lower-level facilities where 85% of the total population is living (11,12). Gebreselasse & Fetters found in their study that only around half of the facilities in Amhara, Oromiya and Addis Ababa regional states provide one kind of uterine evacuation (13). This study has further documented that practice of MVA a safer and more effective procedure to evacuate the uterus was quite low compared to sharp metallic curettage. It also revealed that post-abortion family planning services were very minimal. Similarly, a survey focusing on quality of PAC, which was conducted in Addis Ababa, has shown that family planning counseling and services were provided for only 20% and 3%, respectively. The study has shown that there is demand for contraception by significant proportion of the patients. Provision of important information and linkage of the emergency service along with other reproductive health care system were also areas requiring attention (14). The fact that 34.0% of married women need family planning for both spacing and limiting pregnancies while only 14.0% of Ethiopians use modern contraceptives show lack of access to quality services and appropriate knowledge (9).

As quality of health care has multiple dimensions, one should look from the side of all involved including the patients. The client's or the patient's perspective is very important because satisfied clients are more likely to comply with treatment and to continue to use health services which is very relevant in the case of PAC (15). It is expected that patients seeking post-abortion services face misjudgment and maltreatment not only in the community, but also in the health care system.

All these facts call for concerted and intensive effort to save lives and suffering of women due to abortion complications. The aim of this study is, therefore, to look at the status of PAC services in selected public health facilities in Amhara and Oromiya regions using different measurements of quality of services. The study focused mainly in the areas of patient satisfaction, technical competence of the providers and appropriateness of setup of the facilities to provide quality PAC. The findings are believed to provide important information on clients' expectation of services and how to design better and sensitive services to the needs of both the patients and the service providers.

Methods

This study was a facility based cross-sectional descriptive analysis on PAC focusing mainly on quality of service delivery. It was conducted from November 2002 to March 2003 in the public facilities implementing PAC services in the Amhara and Oromiya regional states. The two regions are where around 61% of the total populations of the country reside and where major proportions of different levels of health facilities are located.

The facilities were selected purposively with the main criteria of presence of PAC related support to a given facility and presence of active PAC service during data collection period. Accordingly, eleven health facilities providing PAC, 5 from Oromiya Region (1 hospital and 4 health centers) and 6 from Amhara Region (2 hospitals and 4 health centers) were studied for a month to get enough cases for exit interviews and observations. The duration of data collection was designed for one month and all cases treated for abortion complications at the selected facilities during the survey period were included. The total study period was extended from November 2002 to March 2003 and the duration for data collection at a given facility was allotted one month. Therefore sample size was not calculated for this study and all patients who came during the one month period were included in the study. Direct service delivery observation is an intrusive procedure and time consuming, so it was decided to conduct only for 25.0% of the cases who came to seek care during the study period.. Multiple approaches were utilized to capture the varied aspects of care, which included interview with patients, interview with service providers, direct observation of service delivery, walkthrough observation and inventory of relevant equipment and supplies.

Client exit interview was conducted at a point where the patients were ready to be discharged. The attending physician or a nurse who attended at the time of the survey approved the physical and psychological readiness of the patients before interview commenced. In the questionnaire socio-demographic aspects, access to services, information provision, patient-provider interaction, family planning information and method provision and overall satisfaction were addressed. Twelve grade completed non-health professional females were selected from the areas of each facility and were given intensive three days training on how to approach patients and on the basic principles of data collection. Verbal consent was obtained from each respondent and privacy and confidentiality was ensured.

To minimize bias, direct service delivery observation was undertaken by two health officers who received training in comprehensive PAC earlier. They were given a one-day orientation on observation checklist and methodology of observation. The checklist had six major sections (*statistical information and record keeping system, registration and examination, counseling, procedure, post-procedure and, instrument processing).* Providers and patients were informed about the objective of the study and their consent was obtained. Patients

unable to give consent, for instance those in critical condition and those who were unconscious, were excluded. Observers were in white coat and remained inconspicuous not to interfere with routine service provision.

A walkthrough assessment was done by the principal investigator to look at the organization of service delivery system with regard to PAC. It included the assessment of integration of post-abortion family planning and reproductive health services with the emergency treatment of abortion and its complications.

Service providers were interviewed using a self-administered questionnaire regarding their qualification, relevant post basic trainings, opinion on unsafe abortion, attitude towards patients' post-abortion and the referral system. Only providers who were directly involved in PAC were interviewed.

The quantitative data were analyzed using SPSS version 11 statistical package. The results were presented using descriptive statistics including frequencies, percentages, tables and graphs. The data from observation were extracted from the checklist, organized and presented under different themes.

Results

Client Exit Interview: A total of 103 postabortion patients were identified and interviewed. Sixty-four (62.1%) were from Jimma Zone in Oromiya Region and 39 (37.9%) were from west Gojam and Bahir Dar especial Zone in Amhara Region. Age of respondents ranged from 16 to 48 years, and the age group 18-30 years constituted 68.0%. Majority, 76 (73.7%) of them were married and 73 (70.8%) were housewives. Significant proportion 44 (42.7%) were illiterate, while 47 (45.6%) attended formal education varying from elementary school to college level (Table 1).

The travel time from patient's residence to the last facility (place of interview) was less than two hours for 58 (56.3%) of the cases. Of the total patients only 10 (9.7%) traveled for more than 12 hours. Thirty eight percent used rented car or taxi to reach the facilities, followed by walking or being on men's back (including make shift stretcher carried by men) in 25.0% (Fig. 1). Fifty-seven (55.3%) reached the health facilities where they have obtained treatment for complications of abortion after visiting at least one other health facility. Upon arrival, 81(78.6%) patients did not have difficulty to identify services, while five (4.8%) encountered difficulty in searching PAC services. On the other hand, seven (6.7%) of the participants were turned away because of not having enough money for the services. Eighteen (17.5%) of the study subjects commented that the time range from admission to the actual treatment was very long.

Fifteen (14.5%) patients paid nothing to the facilities as they were free patients. The fee for service in the health facilities ranged from 9.70 to 201.5 Birr. Nearly a quarter 75 (72.8%) of the respondents additionally paid for drugs and supplies, which were not available in the facilities. Maximum payment for drugs and supplies was 500 birr. Fifty-three (51.4%) of the participants reported other expenses for food, drinks and hotel. Overall, 48 (46.6%) of them commented that the cost incurred for services was too low, while 25 (24.2%) reported it was too high.

Sixty-nine (67.0%) cases responded that the providers were calling them by their name and 31 (30.1%) of the participants were treated with respect and dignity. The respondents had been informed about the cause and condition of their illness upon arrival in 67 (65.0%) of the cases. Similarly, 66 (64.0%) of the unit of analysis were told about the treatment or procedure to be undergone, while only 52 (50.5%) were informed about the final outcome of their illness and the procedure.

Table 1: **Socio-demographic characteristics of post-abortion patients, public health facilities in Amhara and Oromiya, November 2002 to March 2003**

Variable	No. (%)
Age	
14-17	2(1.9)
18-24	38(36.9)
25-30	32(31.1)
31-34	3(2.9)
35-40	20(19.4)
41+	3(2.9)
No response	5(4.9)
Occupation	
Employed	8(7.8)
House wife	73(70.9)
House maid	5(4.9)
Private business	5(4.9)
Student	5(4.9)
Unemployed	3(2.9)
No response	4(3.9)
Marital status	
Never married	18(17.5)
Married	76(73.8)
Cohabiting	2(1.9)
Widowed	5(4.9)
No response	2(1.9)
Education	
Illiterate	44(42.7)
Read and write	9(8.7)
1-6 grade	17(16.5)
7-8 grade	12(11.7)
9-12 grade	10(9.7)
12+	8(7.8)
No response	3(2.9)

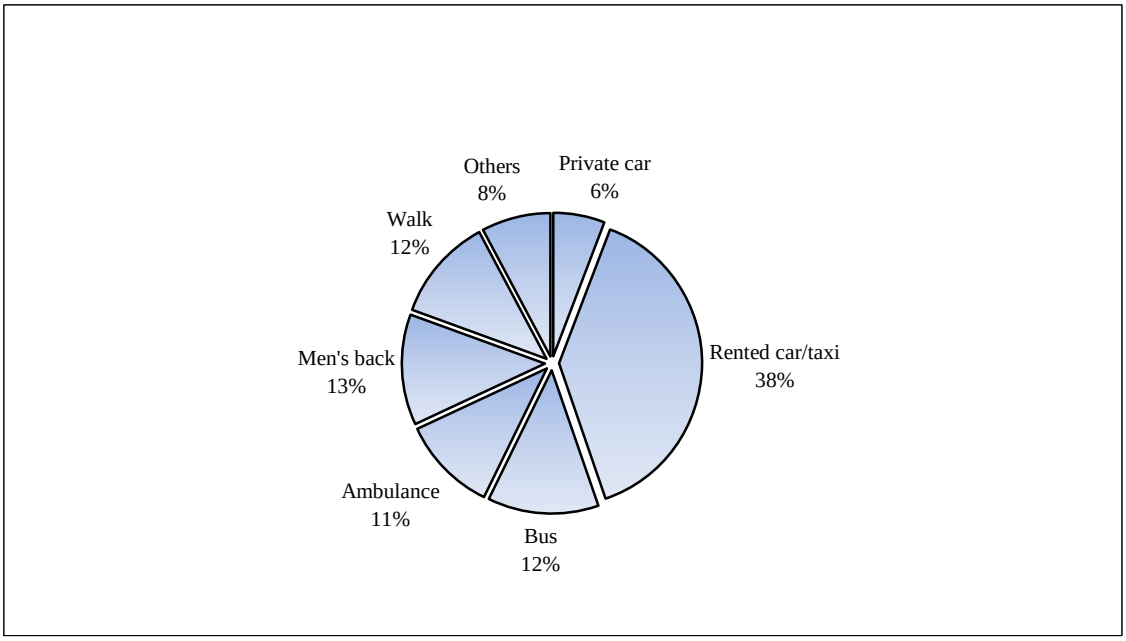

Figure 1: **Mode of transportation used by post-abortion patients to reach facilities where they have received PAC, public health facilities in Amhara and Oromiya, November 2002 to March 2003**

Of the 92 respondents who reported pain while waiting for surgical procedure, only 51 (49.5%) were given medications for pain control. Similarly, out of the 89 respondents who reported feeling pain during procedure, 51 (57.3%) were given medication for pain. On the other hand, 72 (84.7%) of the 85 patients reported feeling pain after the procedure has been completed.

Forty-two (40.8%) patients did not have plans to become pregnant in the near future and only 11 (10.7%) had intentions to get pregnant within three months (Fig. 2). The remaining 45 (43.7%) of the participants preferred to wait for more than three months. However, only 23 (22.3%) of the respondents asked for contraceptives and providers offered contraceptive related information to 55 (53.4%) patients (Table-2). Forty-six (44.7%) went home with contraceptive methods while 9 (8.7%) were appointed to come later.

Eighty-two patients (79.6%) expressed their satisfaction with the services they received and 91(88.3%) reported that the services were delivered in a confidential way. Though only 7 (6.7%) of them expressed their dissatisfaction clearly, when asked to give any opinion on general service delivery 22 (21.3%) asserted their dissatisfaction; 10 (45.5%) in the manner they were handled by providers, 7 (31.8%) were not being given pain treatment, and 5 (22.7%) complained absence of relevant education and facilities such as toilet.

Provider interview: A total of 87 (35 [40.2%] from Oromiya and 52 [59.8%] from Amhara) health service providers directly involved in the provision of PAC were interviewed (Fig 3). Over 60% of the providers from Oromiya were between 18 and 29 years, of which just over 70.0% were males and twenty-five (71.4%), were unmarried. Significant number of (54.3%) providers were followers of Orthodox Christianity followed by Muslim 7 (20.0%). Twenty one (60.0%) worked in the current facility for less than one year and 13 (37.1%) have completed their basic education more than one year ago while 3 (8.6%) completed their basic education and worked for more than five years. Almost 60% of the providers from Amhara Region were aged between 25-34 years; 27(52.0%) were females and thirty-six (69.0%) were married.

Table2: **Family planning service following post-abortion care, at public health facilities in Amhara and Oromiya regions, November 2002 to March 2003.**

Variables	No. (%)
Patients asked for contraceptives	
Yes	23(22.3)
No	77(74.7)
No response	3(2.9)
Patients given information on FP	
Yes	55(53.4)
No	44(42.7)
No response	4(3.9)
Patients given contraceptives	
Yes	46(44.7)
No	54(52.4)
No response	3(2.9)

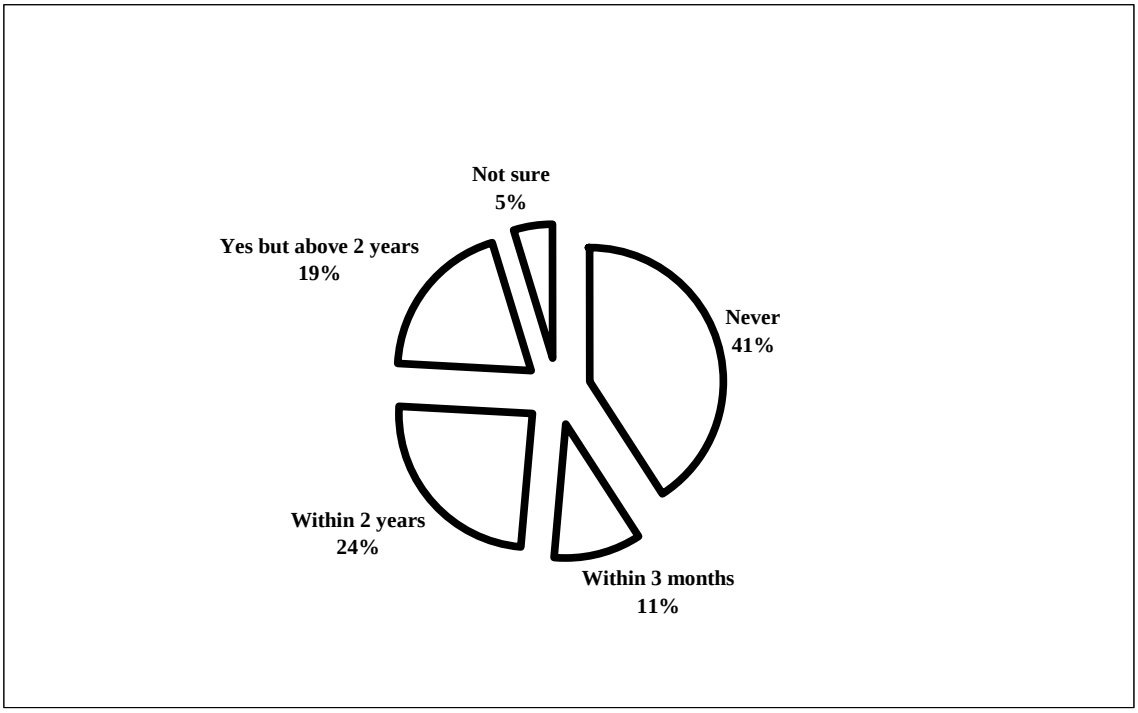

Figure 2: **Future pregnancy plan of post-abortion patients, public health facilities in Amhara and Oromiya, November 2002 to March 2003**

Most of the providers were Orthodox Christians by religion 46 (88.5%) followed by Protestant 4 (7.7%). The majority were general nurses 29 (55.8%) followed by general practitioners 6 (11.5%). Forty-four (84.6%) worked in the facilities of the study for more than one year and 47 (90.4%) completed their basic education more than one year ago.

Training background: Twenty (23.0%) of the providers received training in PAC and thirty-four (39.0 %) have also been trained in one or more reproductive health related issues.

Provider's attitude: Majority (70.1%) responded that women suffering from unsafe abortion should not be denied of services (Table 3), while 16 (18.4%) would like services to be denied. Similarly, 74 (85.1%) believed that women suffering from unsafe abortion deserve equal attention to other women seeking medical services. Three (8.6%) of the participants believed that the women should not deserve equal attention. More than half (53.4%) of health providers were comfortable in dealing with cases of unsafe abortion. Interestingly, 31(35.6%) admitted that they are not comfortable. Forty-eight (55.2%) of the respondents believed that all women including married, unmarried and adolescents deserve equal attention while 31(35.6%) do not believe so. Those who feel uncomfortable did more often with adolescents 22 (71.0%) followed by unmarried women 10 (32.3%). Fifty two (59.8%) of the service providers believed that unsafe abortion is a problem of the community at large; however 9 (10.3%) of them reported it is the problem of the women only.

Table 3: **Attitude of health service providers towards women seeking PAC, public health facilities in Amhara and Oromiya, November 2002 to March 2003.**

Variables	No. (%)
Women with unsafe abortion should be denied services	
Yes	16(18.4%)
No	61(70.1%)
Don't know	2(2.3%)
No comment	4(4.6%)
No response	4(4.6%)
Women with unsafe abortion do not deserve equal attention	
Yes	12(13.8%)
No	69(79.3%)
No comment	4(4.6%)
No response	2(2.3%)
Comfortable to deal with cases of unsafe abortion	
Yes	46(52.9%)
No	31(35.6%)
No comment	6(6.9%)
No response	4(4.6%)
Married women, unmarried and adolescent girls should be treated equally	
Yes	44(50.6%)
No	35(40.2%)
No comment	7(8.0%)
No response	1(1.1%)

Referral system: Significant proportion (83.9%) of the facilities received cases of unsafe abortion as referral from other facilities. The referring facilities included government clinics/health posts (31.0%), private clinics (23.0%) and health centers (13.8%). The referred cases did not present with formal referral slips according to 64(73.6%) of the respondents. Forty (46.0%) of the providers have referred cases to other level facilities of which majority were towards hospitals 36 (90.0%) and almost the same proportion provided referral slips.

Measure of providers' technical competence and communication skills: A total of 35 observations were made, of which five were excluded to avoid duplication of observations where one provider appeared in more than one procedure. Accordingly, 30 providers, of which 2 were specialists, 9 general practitioners, 8 interns, 4 health officers, 6 midwives and 1 nurse, were observed while providing care.

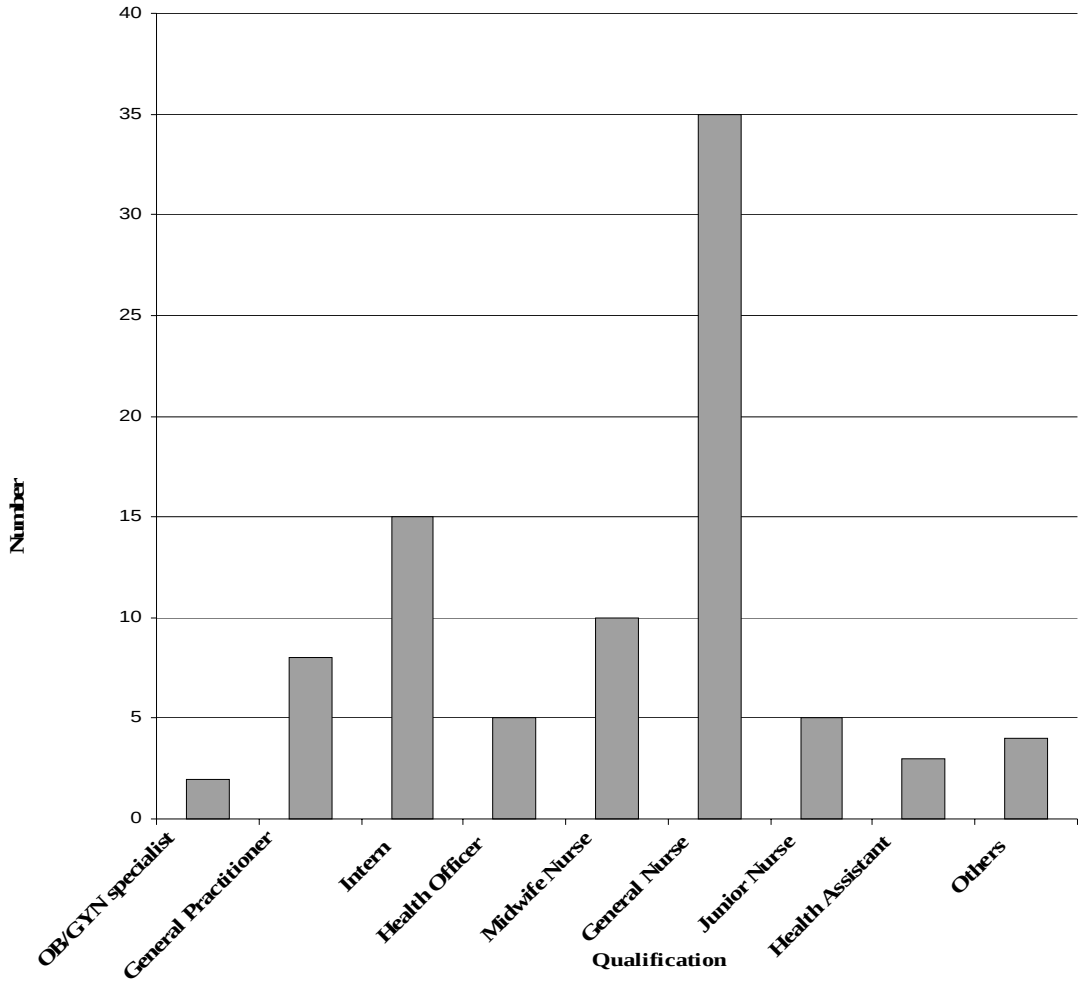

Figure 3: **Profile of Health Service Providers Involved in PAC, public health facilities in Amhara and Oromiya, November 2002 to March 2003**

Communication: During the initial contact, only 4 of the 30 providers (13.3%) introduced themselves to the client prior to the procedure. Eighteen (60%) of the providers gave verbal support. Although 22 (73.3%) were attentive and respectful, 25 (83.3%) of the providers did not give patients the opportunity to pose questions and concerns. Fifteen (50%) of the providers explained how to do self care to their patients and the possibility of occurrence of pregnancy immediately after the current abortion. Seventeen (56.7%) of them provided counseling on contraceptive methods. Twenty-one (70%) explained about-prescribed medicines but only 16 (53.3%) provided emergency contact information while only seven (23.3%) provided follow up information.

Infection prevention/Universal precaution: Only two of the providers wore goggles during procedure. Although all wore sterile gloves only 7 (23.3%) washed hands before gloving. Sixteen (53.3%) of the participants changed gloves after vaginal examination before proceeding to evacuate the uterus. None of the providers wore protective boots.

Procedure: All providers respected patients' audiovisual privacy in procedure room. Only eight (26.7%) gave anesthesia, while 18 (60%) provided verbal support during the procedure. Six (20%) of the providers conducted bimanual examination to determine uterine size and position. Eight (26.7%) forgot/ignored to decontaminate the cervix and vagina before procedure. Twenty of twenty-two checked the aspirator for maintaining the negative pressure immediately before the procedure. Twelve providers measured uterine size before starting to evacuate uterine contents. Twenty-eight (93.3%) of the providers correctly recognized signs of complete evacuation. Twenty-five (83.3%) appropriately followed no touch technique. Seventeen participants checked the evacuated tissue. Twenty-six assisted the client to recovery area. A large proportion (86.4%) performed the procedure well.

Instrument reuse: Twenty-six (86.7%) of the providers soaked used instruments in decontamination solution, but only half drew the decontamination solution through the cannulae. Twenty-seven cleaned procedure table after client left. Eleven properly disposed medical waste.

Post procedure: No IEC/BCC material on post-abortion self care and on contraceptive methods was available in any of the institutions. None of the providers have introduced themselves in the post procedure room. Pulse and blood pressure (BP) monitored only in 2/3rd of the cases. Twenty-two participants gave information on warning signs.

Discussion

Given the nature of abortion and its complications, health facilities should respond to it irrespective of financial status of the women. Although majority of the patients had no difficulty in getting prompt services, some were delayed due to lack of adequate money. The other limiting factor in getting immediate service was requirement to buy drugs and supplies from other sources.

The existing patient-provider interaction should be improved through training. Provision of in service training for providers and introducing appropriate protocols have been proven effective in improving quality of PAC (17). To be effective in providing knowledge on proper care and prevention, there is a need to develop and distribute appropriate materials. This includes posters to be put at important places and leaflets that patients can take home and read. It was clearly shown that provision of important life saving information was overlooked universally. These information materials are as equally important as other components of care. Hence, future refresher training should focus on these areas. Posting the information on the walls for the providers could also be reminding.

Post-abortion family planning counseling and method provision is very encouraging compared to similar study conducted earlier which could be attributed to the active support by MOH & Ipas-Ethiopia that is going on the study facilities (16). Nevertheless, looking at the number of women leaving the facilities without information (43.8% from Oromiya and 41.0% from Amhara) one can see the missed opportunities that call for more attention. The fact that majority of the respondents have intention to delay next pregnancy indicates critical demand for the service. The practice of giving anti-pain medication at all the stages of patient care seems to be very low.

Great majority of the patients have expressed their satisfaction with services they have been offered. This significant proportion of participants dropped during an open-ended question asking for their general opinion. Though the findings are encouraging, the discrepancy signifies the need for qualitative research in the future on selected patients to get their full insights.

Although lower in proportion, the negative attitude towards cases of unsafe abortion in general and adolescents in particular deserve immense attention. It should be focused on future refresher and basic PAC trainings. There is some kind of two-way referral system between different level facilities. There needs more to be done to strengthen the system with regard to supporting with referral slips and sharing of findings and results through feedbacks. Some of the facilities lack important instruments and supplies. Responsible parties shall provide this missing instruments and supplies in order to provide quality of PAC services. All institutions did not follow proper procedure to examine evacuated products for floating villi. This might at that time leads to the wrong diagnosis that may threaten the life of the woman. It should be one of the focuses during refresher and basic training. Appropriate IEC materials should be designed and made available to the facilities and to the patients. The fact that the providers are not sticking to appropriate steps of infection prevention and instrument processing routinely calls for a short refresher course or on the job follow-on supervision.

In conclusion, the study has identified key areas that need improvement to make PAC better in the study facilities. Attention should be given to making drugs related to PAC available in the health facilities. IEC effort and the existing client-provider interaction need to improve. Provider training should emphasize on how to deal with more at risk groups such as the adolescents.

Acknowledgements

We would like to thank Ipas-Ethiopia for funding the study. We are very grateful to the Amhara and Oromiya Regional Health Bureaus for facilitation of the study process.

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