THINKING BIG ABOUT POSTABORTION CARE

Improving postabortion care and postabortion family planning through identification, prioritization, and enabling critical behaviors.

MOMENTUM Country and Global Leadership

USAID FROM THE AMERICAN PEOPLE

MOMENTUM A Global Partnership for Health and Resilience

SEPTEMBER 2021

MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

This report is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID) under the terms of the Cooperative Agreement #7200AA20CA00002, led by Jhpiego and partners. The contents are the responsibility of MOMENTUM Country and Global Leadership and do not necessarily reflect the views of USAID or the United States Government.

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Suggested Citation

Wakefield, Christina, and Hooks, Carol. 2021. *Thinking BIG About Postabortion Care: Improving postabortion care and postabortion family planning through identification, prioritization, and enabling critical behaviors*. Washington, DC: USAID MOMENTUM.

ACKNOWLEDGEMENTS

MOMENTUM Country and Global Leadership is part of a suite of innovative awards funded by the U.S. Agency for International Development (USAID) to holistically improve voluntary family planning and maternal and child health in partner countries around the world. The project focuses on technical and capacity development assistance to ministries of health and other country partners to improve outcomes.

The family planning and reproductive health team of MOMENTUM Country and Global Leadership gratefully acknowledges the contributions of many individuals in the preparation of this guidance. Our technical advisory group included Blami Dao, Ricky Lu, Saumya RamaRao, Tsigue Pleah, Levent Cagatay, Japheth Ominde Achola, Bethany Arnold and Elizabeth Arlotti-Parish. Context-specific expertise and feedback was provided by the following MOMENTUM Country and Global Leadership staff: Anne Pfitzer, Bethany Arnold, Elizabeth Arlotti-Parish, Myra Betron, Meghan Gallagher, and Callie Simon. The Postabortion Care Connection provided input on the idea and near-final product at two of its meetings. The team would also like to thank USAID colleagues for their technical review: Erin Mielke, Gyasi Gomez, Patricia MacDonald, Meridith Mikulich, and Mary Ellen Stanton. Editorial support was provided by additional partners: Elizabeth Thompson from Jhpiego and Brian Hatcher, Hatcher Design Office.

BACKGROUND

The United States Agency for International Development (USAID) and its partners have been investing resources in improving the access to and quality of postabortion care (PAC) for three decades. In that span, numerous technical resources, research papers, and reports have been produced on both access and quality. In addition, managing complications of bleeding in pregnancy is recognized as a key emergency obstetric care signal function and part of quality PAC. USAID has worked with numerous other donors and with the International Federation of Gynecology and Obstetrics, International Confederation of Midwives, and International Council of Nurses to issue a consensus statement on postabortion family planning (PAFP) as a key component of PAC. In many countries, USAID is supporting efforts to improve and streamline voluntary PAFP. Even with these efforts, few countries offer high-quality, stigma-free PAC at scale, inclusive of a full range of voluntary contraceptive options for clients who seek care.

This guidance leverages lessons learned from global efforts to-date to pinpoint and prioritize the key actions and actors at different levels required to transform global PAC, including supporting countries to identify and resolve their own, context-specific challenges and opportunities. For each priority action, the guidance then offers pathways to change designed to enable and sustain that action. These pathways map barriers, motivators, and supporting actors for each action or behavior and conclude with suggested strategies. All profiles are summarized and presented in a comprehensive results framework describing who needs to do what to achieve the goal and how to support those efforts. This guidance is offered as a template for customization and adaptation within specific country contexts. Although developed during the global COVID-19 pandemic, the research upon which they were built does not specifically include barriers or changes related to service delivery during COVID-19, such as an increase in telehealth or promotion of self-care behaviors, such as multi-scripting. As such, this guidance serves as a starting point for leveraging behavioral thinking to make progress in an area often left behind.

FIGURE 1: STEPS IN CREATING AND IMPLEMENTING A BEHAVIOR-FOCUSED STRATEGY

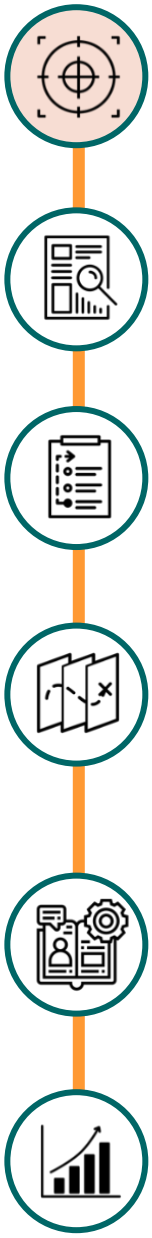


Figure 1 describes the specific steps[1] in this process, which include:

- Identifying a clear goal
- Identifying impediments to reaching the goal
- Prioritizing the most important, proximal behaviors required to achieve the goal
- Creating behavior profiles defining logical pathways from desired results (framed as priority behaviors), through the factors inhibiting or motivating practice of those behaviors, to the key supporting actors required to sustain change and ultimately arriving at the interventions most likely to achieve behavior change
- Identifying commonalities across different behaviors and outcomes and creating opportunities for efficiencies in programming
- Developing program-wide strategies and project-specific action plans
- Establishing and measuring behavioral and factor-level indicators
- Applying the principles of adaptive management

GOAL

REDUCE REPEATED UNINTENDED PREGNANCY POSTABORTION

Worldwide, both miscarriages and induced abortion are extremely common. Decades of data from around the world indicate that between 10% and 20% of all recognized pregnancies end in spontaneous abortion or miscarriage in the first trimester.[1] Further, between 2015 and 2019, more than 121 million women experienced an unintended pregnancy, and 61% of those women voluntarily terminated the pregnancy.[2-4] Planned pregnancy may also end in termination (to save the life of the mother, for non-viability of the fetus, or for other reasons). Because there are significant restrictions on abortion and PAC in many countries, both induced and spontaneous abortions increase the risk of mortality or morbidity for women, with some studies estimating that for every 150 abortions in Africa, at least one woman dies.[5] These figures are even more significant for young women: 41% of unsafe abortions in developing regions were among young women ages 15 to 24 years.[6]

Research presented in the most recent High-Impact Practices Brief on Postabortion Family Planning[7] notes that, on average, nearly 20% of postabortion clients report having had a previous induced abortion, that a substantial portion of those postabortion clients expressed interest in contraception, and that, ultimately, just over a quarter of clients left a facility with a method.[8] This gap is critical as a woman's fertility returns as soon as one week after an abortion, putting women at risk of a subsequent unintended pregnancy almost immediately.

Numerous studies indicate that when contraception is offered at the moment of emergency treatment, women are significantly less likely to have an unplanned pregnancy in the year following the abortion.

The need to support women in avoiding repeat unintended pregnancies is clear, but how to achieve this is often less explicitly defined. As such, this document serves to provide an actionable roadmap toward progress by more intensively focusing a lens on the human beings facilitating or participating in the drive for progress and the complex contexts in which they live, work, and deliver or access health care. The document describes specific, critical behaviors for actors at various levels, and it maps pathways to enable, facilitate, and measure those behaviors.

[1] Detailed guidance on each of these steps is available at: https://thinkbigonline.org/index.

IMPEDIMENTS ANALYSIS

To identify the specific behaviors and actors required to achieve the goal of reducing repeat unintended pregnancies postabortion, we start with an analysis of the current context. A high-level global review of evidence demonstrated the following categories as current significant impediments to progress.

ENABLING ENVIRONMENT AND PROVIDER CAPACITY

First and foremost, many countries maintain inadequate or restrictive policies, laws, and guidelines governing PAC and contraception, and PAC is often conflated with termination of pregnancy. In some cases, there are no or unclear guidelines on PAC, including level and type of provider (e.g., midwives) authorized to provide it.[9,10] In other cases, there are explicit legal barriers and restrictions, or a lack of clarity about what laws allow or prohibit, such as when a woman presents with an incomplete abortion or when adolescents seek PAC.[11,12] In some cases, although PAC encompasses a broad set of interventions from emergency care to counseling and postabortion contraception, providers are not always fully trained to deliver all elements of PAC, or are even prevented from such delivery. [13–16] Those who are trained are not on call at all times, and often referral to a specialized gynecologist required for certain levels of care is not feasible due to distance between facilities, transfer costs, and lack of transportation or ambulances.[17-22] The lack of access to skilled providers is even more acute for youth.[23] These considerations both inhibit providing contraception as a component of care and limit the overall number of women seeking PAC.

SUB-OPTIMALLY ORGANIZED SERVICES

Similarly, while PAFP is a critical component of PAC, in many countries, significant administrative barriers exist in linking contraceptive services to broader PAC, including logistical difficulties in ensuring that contraceptive commodities are routinely available in the postabortion treatment area.[24-30] Likewise, given the sensitivity of PAC and frequent stigmatization, inadequate time for counseling, patient flow disruptions and overcrowding, space limitations, and lack of privacy are often obstacles in the provision of effective counseling on postabortion contraception, resulting in premature patient discharge and missed opportunities.[31-34] Additionally, the lack of standard inclusion of a wide range of contraceptive methods limits women's and their partners' choices and subsequent adherence.[35-39]

COST

In some locations, direct and indirect costs prevent women from seeking PAC, including accessing PAFP. These costs include required advance payment for PAC, transportation costs, oft-required supplies like toiletries and bath basins, opportunity costs in terms of disclosure to family or community that an abortion has occurred, time, and in some contexts, access to digital payment methods, such as mobile money.[40-42] In certain places, costs also affect method choice, as not all methods are free or widely available[43] and not all PAC providers are trained on all methods, especially longer-acting ones.

SUPPORTIVE CULTURAL CONTEXT

At times, even in locations where great progress has been made in general provision of contraception, providers working with a woman postabortion are often unsupportive, discriminatory, and stigmatizing of women. There are reports of extreme levels of action where providers withheld pain killers, perpetuated sexual abuse, or threatened to have police come to the facility to arrest the client.[44-48] This is particularly complex for women who take misoprostol at home and therefore are unlikely to receive comprehensive counseling and support.[49-51] Additionally, in areas where PAC is provided by a physician, especially a surgeon or highly specialized physician, some providers believe that contraceptive provision is not a physician's task,

which can result in a missed opportunity through referral to or non-mention of FP services.[52] On the other side, many providers who provide PAC face or fear public discrimination, harassment, arrest, or abuse, even where they do not provide abortion itself.[53,54] Clients themselves are often stigmatized or carry their own shame, embarrassment, and fears of legal repercussions and public disclosure after seeking care.[55-62] Once care is sought, women face similar challenges when accessing contraceptive services, including concerns of subsequent infertility, fear of repercussions from a male partner, widespread lack of understanding that fertility returns almost immediately following abortion, and—especially for adolescents and unmarried women—fear or shame in admitting sexual activity and corresponding need for contraception.[63-66]

PRIORITY BEHAVIORS

Against this context, achievement of a set of specific actions, or behaviors, is critical to address these issues and, ultimately, attain the goal of reducing repeated unintended pregnancy postabortion. To extract the specific behaviors, we ask the question, *to address these impediments and achieve our goal*, *who needs to do what?* The "who" becomes the primary actor, and the "who" and "what" together become the behavior. While the potential list is long, the following four behaviors were selected based on their potential impact on the identified impediments and current insufficient global uptake of PAFP (Table 1).

TABLE 1. FOUR PRIORITY PAC BEHAVIORS

Women and adolescents seek care for bleeding in (early) pregnancy and associated complications or following an incomplete abortion	
STEPS	1. Recognize the need for professional PAC, in all cases, but especially when symptoms or complications occur.
	2. Learn where to receive PAC and support, including non-facility options like hotlines or online platforms for initial screening and information.
	3. Obtain care, including organizing transport and shifting of household duties like childcare if necessary.
	4. Discuss options with provider for emotional support and return to fertility and contraception to prevent any future unintended pregnancy, as desired.
	5. Seek immediate help from provider if symptoms persist or other warning signs occur.
Women and adolescents voluntarily adopt a modern contraceptive method immediately after treatment for abortion complications	
STEPS	1. Seek professional counseling or care within 48 hours following any induced or spontaneous pregnancy loss or immediately in cases of severe bleeding or fever.
	2. Know about return to fertility postabortion.
	3. Discuss contraceptive method options with a qualified provider, if desired.
	4. Share questions and concerns with a qualified provider, if desired, including discussion of experience, fears, and emotions relating to abortion or pregnancy loss.
	5. Make an informed choice about contraception, including whether or not to use any and, if yes, which method to use.
	6. Adhere to the instructions of the provider.
	7. Manage side effects, including consulting a health provider if indicated.
	8. Consult a provider to select another method if not satisfied with the current method.

Service providers proactively offer comprehensive, compassionate, client-centered counseling and voluntary modern contraceptive services at the same time and location where women receive postabortion care	
STEPS	1. Maintain adequate contraceptive method mix, supplies, and equipment at point of care.
	2. Sharpen contraceptive and client-centered counseling knowledge and skills.
	3. Treat all clients respectfully and with compassion, regardless of age, parity, or marital status.
	4. Respect client privacy and confidentiality.
	5. Strive to understand the client's fertility desires from her perspective.
	6. Conduct screening for gender-based violence if the client presents with signs of such, providing first-line support as needed.
	7. Ask the client if she would like her male partner or companion to participate in her care and counseling session, or be informed about her condition, treatment, follow-up care, and contraceptive method.
	8. Include client's partner/companion in contraceptive counseling and ongoing consultation if the client would like them involved.
	9. Counsel each client according to guidelines and client's situation.
	10. Offer voluntary contraceptive services to each client postabortion regardless of the type of evacuation procedure.
	11. Refer to qualified provider if the method of choice is not available (e.g., due to level of service or being out of stock), offering a bridge method for interim use.
Policymakers establish clear national policies and guidelines that promote comprehensive postabortion care	
STEPS	1. Review sample/exemplar PAC policies.
	2. Assess current PAC policy.
	3. Review other laws, policies, and guidelines (e.g., FP service delivery, law enforcement) that potentially impact access to, use of, or delivery of PAC.
	4. Draft or revise policies and guidelines as appropriate.
	5. Establish indicators for measuring policy implementation and quality of care.
	6. Follow the required approval processes.
	7. Disseminate the new/updated policies and guidelines at all health system levels and to the public.
	8. Monitor implementation of the new/updated policies and guidelines.

Analysis of these behaviors revealed supporting actors and potential strategies needed to enable the behaviors individually. Supporting actors are the key people needed to support the practice of a behavior and typically fall into the categories of institutional, community, and household-level actors (Figure 2). While service providers and policymakers—health systems actors—feature here as primary actors, each also appears as a supporting actor in at least two analyses. Key supporting actors such as community members or community-based organizations are often the primary stakeholder for interventions to enable the primary actor's action, but are not themselves the primary actor.

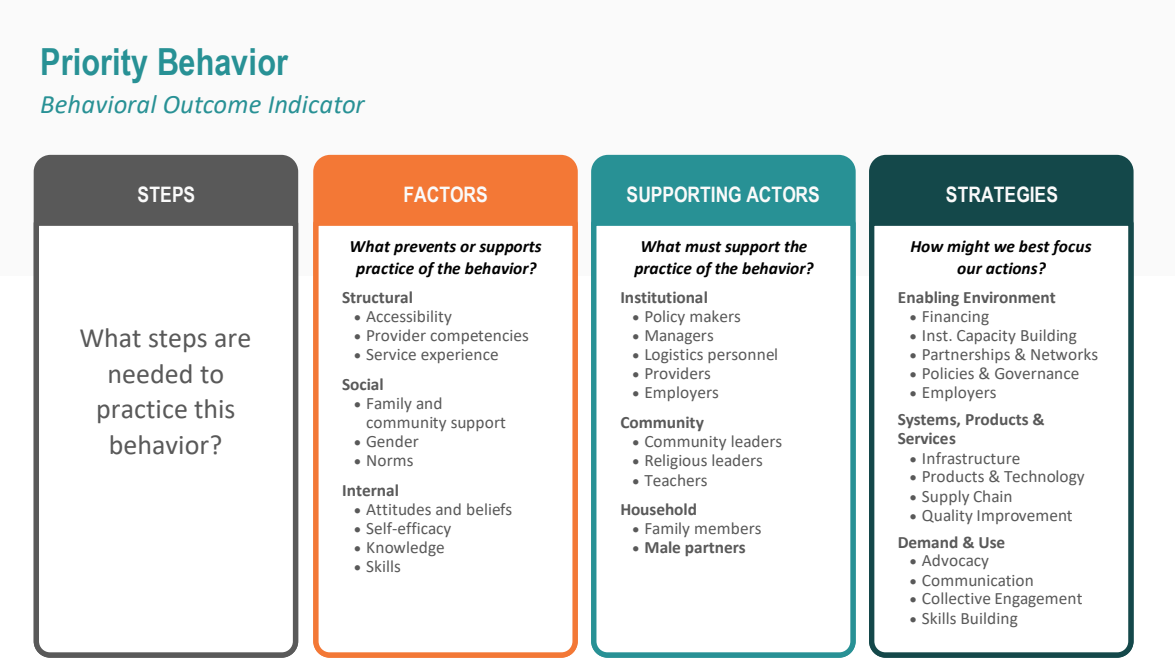
Countries that want to use these analyses will need to assess, customize, and adapt them to their context. The specific critical factors, supporting actors, and strategies identified for each priority behavior could differ based on context. Countries also might want or need to prioritize different behaviors or additional behaviors not listed here.

PATHWAYS TO CHANGE

The following pages present a behavior profile for each of the four prioritized PAC behaviors. A behavior profile is an at-a-glance map of pathways to change a particular behavior. The profiles for the four priority PAC behaviors are based on a consensus discussion among technical experts and a review of selected global evidence (Appendix A). They do not represent a fully exhaustive literature review, nor were they developed with a particular country or context in mind. Additionally, while the factors presented appear often in the studies cited, they do not reflect an exhaustive list of potential factors that might exist in a particular context. Instead, these profiles attempt to capture and frame the steps, critical factors, programmatic considerations known to be important for improving PAC, proven strategies, and innovative strategies that look promising. They present this information in an actionable, measurable way that country stakeholders can and should use as a guide. Specifically, country programs can use these global behavior profiles for:

- **ORIENTATION:** These profiles can help orient global and local program staff to a holistic way of thinking about PAC, including indicating the kinds of factors, supporting actors, and strategies that might be relevant for a given context.
- **A STARTING POINT:** In some cases, the local team might not have the time or resources to develop a completely new behavior profile. In those cases, the team can use this global work to prompt thinking on what might or might not be locally relevant and important, adding or deleting information from the sample profile as applicable. Similarly, if little local research on critical factors and supporting actors is available, these global pathways contain research that programs can use as proxy information until they can learn more about the local context.
- **DEFINING A RESEARCH AGENDA:** As individual countries adapt these behavior profiles, they will notice where data exist and where gaps in understanding and knowledge persist—both around which factors are most critical to address or leverage and around the strategies and interventions appropriate, acceptable, and effective to change those factors. These gaps can help programs structure formative and operational research questions at the local level.

FIGURE 2: BEHAVIORAL ANALYSIS—DEVELOPING INTENTIONAL PATHWAYS TO CHANGE



Creating a behavior profile can be done online or off, using the Think| BIG Behavior Profile tool (https://thinkbigonline.org/tools). It entails answering four key questions, reflected in Figure 2.

1. **What steps are needed to practice this behavior?**
   Answering this question provides an opportunity to tease apart the behavioral outcome itself into smaller steps that can guide further analysis or refinement of focus for a particular context. Not necessarily sequential, these steps, when completed, constitute practice of the behavior. For some behaviors, steps are quite clear and based on a logical model. In other cases, identifying the steps can be a source of discussion, debate, and consultation with stakeholders.

2. **What factors prevent or support practice of the behavior?**
   Answering this question requires a full understanding of the ecosystem in which a human being exists and in which the behavior in question is or is not practiced. Loosely based on the socio-ecological model, this question entails examining the potential impact that various structural, social, and internal factors might have on a given behavior and then prioritizing which of those factors are most critical to address in a particular setting. This analysis always requires a review of existing literature, and it can require and include new research for areas in which little is known or understood. Various tools can also be used to unpack different factors. For example, a tool such as USAID's Social Norms Exploration Tool (SNET) can be used to flesh out the "social norms" category, while an Applied Political Economy Analysis https://usaidlearninglab.org/library/applied-political-economy-analysis-pea-reference-materials might be appropriate to better understand the interplay between structural factors affecting system-level actors. Further, each category can be positive (a source of motivation) or negative (a source of limitation) to the behavior. Once analysis is completed, this column in the behavior profile describes ***why*** people do what they do (as distinct from knowing *what* people do) and points to what is required to affect change.

3. **Who must support practice of the behavior?**
   The next question entails, for each factor identified, understanding the individuals or groups of individuals who have a direct impact on changing or leveraging the identified factors and therefore on

whether or not the primary actor can practice the behavior (or specific steps of the behavior). As noted above, often, these actors become primary stakeholders in development activities, as their actions are a key step in the pathway.

4. **How might we best focus our actions?**
   Answering this final question is often the place where development starts—what activities should be implemented? What best practice or innovation is required? Placing the question, instead, at the very end of the pathway, ensures that the answer to this question is tailored exactly to the context in which it is being asked and that it explicitly responds to the factors and the supporting actors deemed important enough to include in the profile. Ideas on activities can be drawn from the literature, generated by stakeholders, or framed as challenges as a way to elicit suggestions on what might work best to complete the pathways.

BEHAVIOR PROFILES

1. WOMEN SEEK POSTABORTION CARE

Goal	Reduce repeated unintended pregnancy postabortion
Behavior	Women and adolescents seek care for bleeding in (early) pregnancy or any complications from a miscarriage, incomplete abortion, or induced abortion
Indicator	Percent of women who have lost a pregnancy, either induced or spontaneously, who report having consulted a provider in the 48 hours afterwards
Online Version	https://thinkbigonline.org/share/E947498B86D54EF08B119CE8363CD7EA

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
What steps are required to practice this behavior?	What factors may prevent or support practice of the behavior?	Who must support practice of this behavior, and what actions must they take?	What interventions will best focus our efforts, based on this analysis?
1. Recognize the need for professional care following an abortion, in all cases, but especially when symptoms or complications occur 2. Learn where to receive PAC and support, including non-facility options like hotlines or online platforms for initial screening and information 3. Obtain care, including organizing transport and shifting of household duties like childcare if necessary	**STRUCTURAL** **Accessibility:** Care is not always available, especially in rural areas, and at times providers, even when trained, refuse to provide care relating to abortion for any reason, including spontaneous abortion or miscarriage. **Accessibility:** Legal framework for PAC services is often confusing for providers and clients alike. **Accessibility:** Cost, distance, and service hours make accessing care particularly hard for some groups of women, such as adolescents and youth. **Accessibility:** Minors are not always allowed to seek care without family permission, often in writing. **Service Provider Competencies:** Providers are not always trained on how to offer compassionate, emotional support and counseling for women and adolescents on the emotional complexity of a spontaneous or induced abortion.	**INSTITUTIONAL** **Policymakers:** Institutionalize provider behavior change content for postabortion providers at all stages of training and professional development **Policymakers:** Include easy to understand language on the right and need for PAC, including clarity on what the law allows providers to offer, in health-related policies and community governing documents **Managers:** Include competencies related to psychological and emotional support in supportive supervision and mentorship **Managers**: Ensure privacy for client consultations to facilitate confidentiality	**ENABLING ENVIRONMENT** **Partnerships and Networks:** Support engagement with private sector, pharmacies, CHWs to expand availability, including use of telehealth to "prescribe" medical methods for women far from a health facility **Policies and Governance:** Update, clarify, and effectively disseminate policies and legal framework ensuring explicit access to PAC for all women **Policies and Governance:** Ensure that policies and protocols for PAC standards of care include privacy, mental health care and counseling, and follow-up **SYSTEMS, PRODUCTS, AND SERVICES** **Infrastructure:** Prioritize budget line for facility renovations to ensure audio and visual privacy and establish minimum standards of privacy for facilities **Products and Technology:** Support expansion of PAC as part of primary health care, including the use of

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
4. Discuss options for emotional support and return to fertility and contraception to prevent any future unintended pregnancy, as desired, with provider 5. Seek immediate help from provider for any further symptoms or complications from the abortion	**Service Provider Competencies:** Providers are often unable to provide care impartially, without judgement on what the woman should or should not have done, resulting in some cases, even, in explicit abuse of the woman. This is even more pronounced for adolescents and youth. **Service Experience:** Construct of "safe" and necessary care from a clinical perspective often differs from the needs of PAC clients, who often cite their top priority as supportive counseling, compassion, and privacy. **Service Experience:** Women are unable to find privacy either because facilities are not designed to provide it or because staff do not respect it. **SOCIAL** **Family and Community Support:** Advice from a trusted support person is often most critical factor in where, when, and what kind of care is sought for complications from abortion (either induced or spontaneous). **Family and Community Support:** Concerns of public disclosure and privacy, along with fear of repercussions should the community find out, are often paramount for women, especially adolescents and youth, in considering care-seeking. **Family and Community Support:** Intense community stigma, including lack of broad support for anything related to abortion, including PAC, and active discrimination, shaming, marginalization, and even violence often exist. **Family and Community Support:** Adolescents seldom feel comfortable discussing pregnancy with family members and therefore often lack options for support for an unintended pregnancy.	**Providers**: Practice client-centered care, remove from service delivery all personal bias and judgement on reasons for care-seeking and follow-up recommendations **Providers**: Maintain and reassure clients of strict confidentiality **COMMUNITY** **Community Leaders**: Normalize postabortion care-seeking and publicly praise the standard of supporting women and families to seek necessary medical care for any and all reasons **Community Leaders**: Guide communities to adapt attitudes around the role and value of women in society **Religious Leaders:** Discuss the importance of seeking health care for any reason without judgement or shame **Religious Leaders**: Reinforce women's value and dignity as human beings and the importance of compassion over judgement **Teachers:** Provide young people with complete and correct information about PAC **School Staff:** Let students know that they are available to listen and provide emotional support without judgement	medical methods for emergency treatment of incomplete abortion and availability of PAFP methods **Products and Technology:** Explore establishing or expanding telehealth options to provide initial level of care or screening for those women and adolescents unable or uninterested in care in a brick-and-mortar facility **Quality Improvement:** Incorporate technical training and values clarification activities for providers into pre-service, in-service, and continuing professional training **Quality Improvement:** Adapt and roll out values clarification and attitudes transformation activities for health managers (district and national levels), health providers, community leaders, even school educators **Quality Improvement:** Integrate role playing for emotional support and adolescent-responsive care into trainings and mentorship **Quality Improvement:** Collect and use data on delivery of comprehensive PAC (emphasizing PAFP and counseling) to hold facilities accountable for adhering to established policies and protocols **DEMAND AND USE** **Communication:** Expand outreach and public communication around bleeding in pregnancy, available services, where to access, etc., so women experiencing a miscarriage know the danger signs and are able to access care in a timely manner **Communication:** Train providers in how to help couples/families develop emergency plans for medical care (including finances, transport, shifting of household tasks) **Communication:** Create communications to reduce stigma around common pregnancy complications, including bleeding, and the importance of the client's mental health during and after adverse events

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
	Gender: Fear of disclosure to partner (due to risk of intimate partner violence or just not wanting partner to know) discourages early care-seeking. **Gender:** Complex notions of femininity and motherhood inhibit prompt care-seeking, including ideas of who controls a woman's body at different age-stages, prevent women from seeking care for fear of public judgement in addition to private shame, including ideals that define a woman as a body that should produce children, or an adolescent as a body that is pure and should not have sexual relations. **Norms:** Public community and religious norms often marginalize women who have experienced abortion or pregnancy loss as immoral or having failed in their role as a woman or as an adolescent. **Norms:** Public norms provoke feelings of guilt, shame, and embarrassment for women. **Norms:** In some cases, private opinions differ from public norms, with many community members supportive of women who experience spontaneous abortion or abort in cases of rape or incest. **INTERNAL** **Attitudes and Beliefs:** For many women, abortion (both spontaneous and induced) carries with it psychological trauma, interlaced with feelings of guilt, shame, denial, grief, and other internal cognitive and non-cognitive experiences that often result in "emotional paralysis," which can inhibit or delay medical care following the experience and interest in contraception. **Knowledge:** Women do not always know they should seek follow-up care, especially in cases of early spontaneous abortion or medical abortion using misoprostol or other methods.	**HOUSEHOLD** **Family Members:** Reinforce, without judgement, the importance of skilled care for all maternal health concerns including abnormal bleeding, cramping, or other conditions **Family Members:** Be open and supportive of the decisions of other women, including adolescents and youth, ensure they receive appropriate care when they are asked for support **Family Members:** Tangibly and emotionally, without judgement, support women who have gone through an abortion of any kind (taking tasks, allowing for extra rest, providing space for discussion) **Male Partners:** Support wife/partner to receive appropriate medical care as needed for any reason without question or judgement **Male Partners:** Actively participate with wives/partners in reproductive decision-making	**Communication:** Create or enhance crisis hotline, textline, or internet platform for women and adolescents to receive automated information on crises during pregnancy, including screening and referral to in-person care and/or counseling as necessary or desired **Communication:** Integrate messages on fertility awareness, including after pregnancy loss, into adolescent sexuality curricula and broader maternal health discussions and communications **Collective Engagement:** Support CHWs to encourage women to access care for any reason, including postabortion or bleeding in pregnancy, and to provide emotional and mental health support to women who have experienced pregnancy loss for whatever reason **Collective Engagement:** Integrate messaging on maternal care, including the importance of seeking prompt care for bleeding during or after pregnancy, into speeches, sermons, and community events **Collective Engagement:** Use the Social Norms Exploration Tool (SNET) to engage communities around untangling and changing harmful norms around pregnancy loss **Skills Building:** Develop job aids and other tools for providers to guide the provision of client-centered care with a focus on the particular trauma associated with pregnancy loss or abortion.

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
	Knowledge: Women do not always know they are entitled to PAC nor where to seek it, especially in cases where the legality of abortion is unclear or uncertain **Knowledge:** Women, especially young women and adolescents, do not always know that fertility can return quickly after pregnancy and/or abortion, making a decision to prevent future unintended pregnancy urgent.		

2. WOMEN VOLUNTARILY ADOPT POSTABORTION FAMILY PLANNING

Goal	Reduce repeated unintended pregnancy postabortion
Behavior	Women and adolescents voluntarily adopt a modern contraceptive method immediately after treatment for abortion complications
Indicator	Percent of PAC clients who left the facility with a contraceptive method
Online Version	https://thinkbigonline.org/share/1837D1E5BBD5416DBEF11733C823AA45

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
What steps are required to practice this behavior?	What factors may prevent or support practice of the behavior?	Who must support practice of this behavior, and what actions must they take?	What interventions will best focus our efforts, based on this analysis?
1. Seek professional counseling or care within 48 hours following any induced or spontaneous pregnancy loss, or immediately in cases of severe bleeding or fever	**STRUCTURAL** **Accessibility**: Women and adolescents do not use contraception following treatment for abortion complications because of the unavailability of a sufficiently wide range of contraceptives in emergency/maternity units, including long-acting reversible contraceptives (LARCs).	**INSTITUTIONAL** **Policymakers**: Include client-centered FP counseling and delivery of all methods in guidelines for routine PAC for clients of all ages and marital status **Policymakers**: Ensure policy	**ENABLING ENVIRONMENT** **Policies and Governance**: Monitor client satisfaction and reward facilities commensurately, including whether or not clients were inappropriately charged, received all services included in comprehensive PAC, and felt respected and protected within the facility

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
2. Know about return to fertility postabortion 3. Discuss contraceptive method options with a qualified provider, if desired 4. Share questions and concerns with a qualified provider, if desired, including discussion of experience, fears, and emotions relating to abortion or pregnancy loss 5. Make an informed choice about contraception, including whether or not to use any and, if yes, which method to use 6. Adhere to the instructions of the provider 7. Manage side effects, including consulting a health care provider if indicated 8. Consult a provider to select another method if not satisfied with the current method	**Accessibility**: Although "comprehensive postabortion care" includes FP counseling, in practice, such counseling is not always delivered, which may be due to a physical separation of emergency/maternity units and FP units and/or different personnel required or authorized to provide care or services. **Accessibility**: Women and adolescents do not adopt modern contraception following treatment for an abortion because of a lack of clearly articulated policies specifying legality of various components of comprehensive PAC. **Accessibility**: Women who had an uncomplicated abortion outside of a facility, especially a medical abortion, often do not have immediate access to a provider to discuss FP or preventing a subsequent unintended pregnancy. **Service Provider Competencies**: Quality of counseling, especially at what is sometimes a tender, raw moment in a woman's life, is often extremely poor and primarily focused on sharing information, rather than fostering discussions between the client and provider based on the client's needs, including emotional readiness, fear of stigma, and shame relating to the abortion itself, as well as broader support for contraception, and future family plans. **Service Provider Competencies**: Providers often bring their own attitudes and beliefs to counseling FP clients, including ideas of abortion in general, what a woman should/should not do following an abortion, contraceptive methods they should adopt, and even if they should be using contraception at all. This is exacerbated for adolescents. **Service Experience**: Women and adolescents do not choose to engage in discussion on contraception postabortion because of a lack of	guaranteeing free PAFP is being followed and services are not being charged on the side **Policymakers**: Strengthen referral networks between lower-level facilities and tertiary facilities that offer long acting and permanent methods **Managers**: Facilitate creation of space within facilities, especially at lower levels, where privacy can be had for counseling and discussions on contraception **Managers**: Strengthen referral networks in communities for FP providers who can do home follow-up for clients **Providers**: Offer client-centered, complete and correct contraceptive counseling to every PAC client, regardless of age, parity, or marital status, including offering information for consideration and a follow-up time for women who need more time **Supervisors**: Include competencies related to comprehensive PAC and psychological and emotional support in supportive supervision and mentorship **COMMUNITY** **Community Leaders**: Promote and explain the link between abortion and maternal mortality and the importance of contraception in solving the challenge **Community Leaders**: Incorporate discussions about gender norms and	**Policies and Governance**: Update, clarify, and effectively disseminate policies and legal framework ensuring explicit access to PAC for all women **SYSTEMS, PRODUCTS AND SERVICES** **Infrastructure**: Prioritize budget line for facility renovations to ensure audio and visual privacy and establish minimum standards of privacy for facilities **Products and Technology**: Create or expand technology platforms to reach women with contraceptive counseling and prescriptions without the need for in-person services (See example at https://tinyurl.com/yzdggfas) **Supply Chain**: Procure complete method mix of commodities for facilities that provide PAC and ensure availability in same space as service provision site **Supply Chain**: Better link women to community or private sector providers of contraceptive products to ensure continuous access **Quality Improvement**: Incorporate contraceptive training, inclusive of LARCs into clinical PAC training for all levels of provider **Quality Improvement**: Incorporate technical training and values clarification and attitude transformation activities, for providers at all levels of PAC, into pre-service, in-service, and continuing professional training **Quality Improvement**: Improve overall quality of contraceptive counseling for all women, including considering supporting a dedicated FP counselor at facilities, so that women are more aware of their options prior to needing to access PAC **Quality Improvement**: Include mental health counseling and support services for women post pregnancy loss or abortion and provide ongoing follow-up

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
	privacy at health facilities and a fear of accidental disclosure. **Service Experience**: If a procedure requires recovery time, women often prefer to wait to discuss contraception until the immediate issue has resolved, but then may not return. **Service Experience**: Poor linkages/referrals between contraceptive service providers in communities and PAC providers sometimes inhibit continuance of a method. **SOCIAL** **Family and Community Support**: Even when support for contraception in general is present, the stigma related to both spontaneous and induced abortion is frequently so strong, decision-making during the postabortion period is often shrouded in shame and guilt. **Gender**: Women do not adopt modern contraception following an abortion because of a refusal of spouse or lack of autonomy over decisions relating to her body. **Norms**: Adolescents do not always access contraception counseling because of norms that create shame and stigma for adolescents, especially girls, who are sexually active. This is often only heightened after an abortion, when girls frequently fear disclosure. **INTERNAL** **Attitudes and Beliefs**: Fear of side effects (infertility among others) inhibits use of contraception postabortion in the same way it inhibits contraception during other moments of a woman's life.	women's rights (including the right to make decisions about her own body) into larger health promotions and discussions **Community Leaders**: Support families, including adolescents, to access voluntary contraceptive services to delay, space, or limit pregnancies **HOUSEHOLD** **Family Members**: Talk openly with youth about contraception from early adolescence to normalize decision-making **Male Partners**: Actively participate with wives/partners in joint reproductive decision-making	**DEMAND AND USE** **Advocacy**: Promote inclusion of comprehensive sexuality education in schools so adolescents better understand fertility, modern contraception, etc. and are comfortable talking about traditionally "taboo" subjects **Communication**: Utilize social media platforms or collaborative gaming to engage adolescents in reproductive health topics like fertility, contraception, pregnancy loss, and PAC ahead of needing those services **Collective Engagement**: Use/adapt values clarification and attitude transformation for use among community leaders/members to support women accessing care **Collective Engagement**: Create hotlines or other anonymous avenues for women to access information on types of care available, emotional support, and counseling during pregnancy and following an induced or spontaneous abortion

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
	Attitudes and Beliefs: Some clients fear that if they adopt a contraceptive method, they will be shamed for terminating a pregnancy, even if the abortion was spontaneous. **Self-Efficacy**: Some clients are embarrassed to discuss contraception after a spontaneous or induced abortion for fear that a provider will judge their decision because they are young women continuing to have sex, or married women whom providers believe should try to get pregnant again, among other reasons. **Self-Efficacy**: The immediate period postabortion is potentially a gateway moment in a woman's life where a fundamental shift has happened, often leaving a woman more empowered, willing, and motivated to consider adopting new practices.		

3. PROVIDERS OFFER VOLUNTARY POSTABORTION FAMILY PLANNING

Goal	Reduce repeated unintended pregnancy postabortion
Behavior	Service providers proactively offer comprehensive, compassionate, client-centered counseling and voluntary modern contraceptive services at the same time and location where women receive any PAC
Indicator	Percent of PAC clients counseled on modern contraception during PAC visit
Online Version	https://thinkbigonline.org/share/E1DF3B26D8A54F62B9A18904B19262DF

BEHAVIOR ANALYSIS			**STRATEGY**
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
What steps are required to practice this behavior?	What factors may prevent or support practice of the behavior?	Who must support practice of this behavior, and what actions must they take?	What interventions will best focus our efforts, based on this analysis?
1. Maintain adequate contraceptive method mix, supplies, and equipment at point of care 2. Sharpen FP and client-centered counseling knowledge and skills 3. Treat all clients respectfully and with compassion, regardless of age, parity, or marital status 4. Respect client privacy and confidentiality 5. Strive to understand the	**STRUCTURAL** **Accessibility**: Providers cannot offer contraception at the same time and location that they provide emergency care because they lack adequate time due to competing priorities, including having many clients at one time **Accessibility**: Providers cannot offer contraception at the same time and location as emergency care because of a lack of dedicated space for counseling, especially when caseloads are high **Service Experience**: Providers can offer contraception at the same time and location as emergency care due to on-site availability of contraceptive supplies and equipment **Service Experience**: Providers do not offer contraception at the same time and location as emergency care because they are not held accountable for doing so	**INSTITUTIONAL** **Policymakers**: Develop and disseminate clear policies and guidelines to support the implementation of PAC **Policymakers**: Make the right and need for PAFP explicit for all medical providers AND the community at large and incorporate adequate PAC training for providers at all levels into pre-service, in-service, and continuing professional training **Policymakers**: Authorize use of misoprostol for emergency medical management of complications of incomplete abortion **Policymakers**: Develop performance indicators to measure PAC delivery and quality	**ENABLING ENVIRONMENT** **Institutional Capacity Building:** Collaborate with medical, nursing, and pharmacy schools (and the government agencies that regulate them) to integrate comprehensive adult- and adolescent-friendly PAC into educational curricula of nurses, midwives, pharmacists, and physicians **Institutional Capacity Building:** Design, test, and implement on-the-job PAC training and mentorship for all current and incoming maternal and reproductive health staff, appropriate to their service level **Partnerships and Networks:** Involve the private sector (e.g., pharmacies, private clinics, their associations) in providing comprehensive PAC **Policies and Governance:** Revise FP guidance for all levels of providers to include information on PAFP counseling and service provision **Policies and Governance:** Draft, clarify, revise, and actively disseminate comprehensive PAC policies and guidelines—including the credentialing of mid-level health care providers, pharmacists, and pharmacies—for approval and dissemination

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
client's fertility desires from her perspective 6. Conduct screening for gender-based violence if the client presents with signs of such, providing first-line support as needed 7. Ask the client if she would like her male partner or companion to participate in her care and counseling session, or be informed about her condition, treatment, follow-up care, and FP method 8. If the client would like her male partner or companion to be involved, include the partner/person in FP counseling and ongoing consultation 9. Counsel each client according to guidelines and the client's situation	**Service Experience**: Providers do not offer contraception at the same time and location as emergency care because of a lack of clear, active policy support (i.e., regulations, guidelines, performance indicators) for PAC, especially regarding adolescents **Service Experience**: Providers cannot offer contraception at the same time and location as emergency care because health systems and health facilities have not ensured that contraceptive services are available on maternity and emergency wards **SOCIAL** **Norms**: Providers do not offer contraception at the same time and location as emergency care because they work in a social and cultural context that is averse to PAC and to contraception in general, especially for unmarried adolescents **INTERNAL** **Attitudes and Beliefs**: Providers offer contraception at the same time and location as emergency care because they believe providing contraceptive counseling and services to prevent repeat unintended pregnancy is important and one of their key roles **Attitudes and Beliefs**: Providers do not counsel each client according to guidelines and the client's situation because they prefer certain methods for PAFP or particular types of clients (e.g.,	**Policymakers**: Allocate budget for training providers in client-centered PAFP counseling, service provision, and referral **Managers**: Section off or otherwise provide private space (aural and visual) for PAFP counseling where PAC is provided **Managers**: Add contraceptive counseling, uptake, and supplies to PAC record-keeping systems **Managers**: Organize/reorganize services and physical space (to improve client flow and engagement) **Managers**: Provide job aids to assist staff (medical eligibility criteria and other checklists, protocols, etc.) **Managers**: Collect, analyze, and use data to assess method choice, etc., and address issues **Managers**: Implement quality improvement measures based on a PAC quality of care assessment **Managers**: Provide supportive supervision—including problem solving, constructive feedback, and positive feedback on what they are doing well—to PAC providers **Logistics Personnel**: Consistently procure adequate contraceptive supplies for the department providing PAC	**SYSTEMS, PRODUCTS AND SERVICES** **Infrastructure:** Provide architectural design services, facility-based problem solving, and other needed support to add or section off space to create private counseling areas(s) **Quality Improvement:** Assist health facilities to apply job and client flow analysis tools to identify ways to reduce time and space pressures and ensure appropriate skill sets **Quality Improvement:** Integrate values clarification and attitude transformation and role playing related to adult- and adolescent-friendly PAFP into pre- and in-service training curricula for providers of emergency, maternal, and reproductive health care **Quality Improvement:** Conduct exit interviews to assess extent to which PAFP counseling and method provision is taking place and the quality of those services, including method choice **Quality Improvement:** Link (or provide technical assistance to link) PAC and FP data management systems **Quality Improvement:** Integrate at least one PAC indicator into country HMIS **Quality Improvement:** Develop provider training for client-centered comprehensive PAC **Quality Improvement:** Deploy trained field representatives to meet with providers monthly to address individual and structural barriers constraining PAFP **Quality Improvement:** Facilitate integration of contraceptive methods including LARCs within PAC into quality improvement and supervision tools and performance standards **Quality Improvement:** Work with managers to habituate asking at daily labor and delivery unit staff meetings for number of clients receiving PAFP or PPFP **DEMAND AND USE** **Advocacy:** Advocate for expanding indicators used to monitor and assess PAC

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
10. Offer voluntary FP services to each client postabortion regardless of the type of evacuation procedure 11. Refer to qualified provider if the method of choice is not available (e.g., due to level of service or being out of stock), offering a bridge method for interim use	only condoms for adolescents, no LARCs if client has one child) **Knowledge**: Providers do not counsel each client according to guidelines and the client's situation because they lack knowledge about return to fertility and indications for contraceptive methods after surgical or medical evacuation, especially for adolescents **Knowledge**: Providers do not counsel each client according to guidelines and the client's situation because they lack awareness of the link between sexual and gender-based violence, age of consent, and PAC for adolescent clients **Skills**: Providers do not offer contraception, especially to adolescents, at the same time and location as emergency care because they lack skills in providing contraception and adolescent-responsive care	**Supervisors**: Ensure all staff receive comprehensive PAC training, including on how to reduce own biases and avoid judgement in service delivery **Managers and Policymakers**: Operationalize task-shifting to ensure adequate coverage (including optimizing roles of all levels of providers) **Managers and District Health Officials**: Participate in values clarification and other training to support providers **Medical, Nursing, and Pharmacy Schools**: Incorporate client-friendly PAC into pre-service training for all students	**Advocacy:** Advocate with policymakers, logistics managers, reproductive health departments, facility managers, district health teams, and others, as needed, to improve the onsite availability of modern contraceptive methods (including LARCs), related equipment, and space for counseling **Advocacy:** Train champions within and outside the MOH to advocate for comprehensive, adult- and adolescent-friendly PAC and to leverage donor resources **Communication:** Organize facilitated, short, multi-session workshops designed to give providers opportunities to reflect over time upon the rewards and burdens of providing PAC, including stigma (see: https://sites.google.com/umich.edu/providershareworkshop/about) **Collective Engagement:** Organize community exploration of the reasons for and importance of PAFP, as well as the non-contraceptive benefits of some methods (e.g., lighter periods, reduced PMS, treatment of acne, decreased cancer risk) **Skills Building:** Conduct PAC training for providers, managers, and supervisors that adequately emphasizes adolescent- and adult-friendly counseling, comprehensive values clarification and attitude transformation exercises, data collection and use, and supplies management and, particularly for adolescents, non-contraceptive benefits of certain methods (e.g., lighter periods, reduced PMS, treatment of acne, decreased cancer risk) **Skills Building:** Implement modularized onsite peer-learning approaches that emphasize continuous quality improvement vis-à-vis clinical guidelines, values clarification exercises, the practical realities of operationalizing quality, and choice during PAC **Skills Building:** Provide or support the MOH and facilities to provide long-term, need-based post-training support to providers

4. POLICYMAKERS ESTABLISH CLEAR POSTABORTION CARE POLICIES

Goal	Reduce repeated unintended pregnancy postabortion
Behavior	Policymakers establish clear national policies and guidelines that promote and support comprehensive PAC
Indicator	Existence of/number of policies and guidelines that promote access to comprehensive PAC
Online Version	https://thinkbigonline.org/share/408D4EBCAB5B46AA8646428D027248F8

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
What steps are required to practice this behavior?	What factors may prevent or support practice of the behavior?	Who must support practice of this behavior, and what actions must they take?	What interventions will best focus our efforts, based on this analysis?
1. Review sample/ exemplar PAC policies 2. Assess current PAC policy 3. Review other laws, policies, and guidelines (e.g., FP service delivery, law enforcement) that potentially impact access to, use of, or delivery of PAC 4. Draft or revise policies and guidelines as appropriate 5. Establish indicators for measuring policy implementation and quality of care	**STRUCTURAL** **Accessibility**: Policymakers are more likely to establish PAC policies and guidelines when there is sufficient funding and health system capacity to implement them **Service Experience**: Policymakers can more easily establish clear policies and guidelines when the need and urgency for them are (broadly) felt in the national and policymaking arena **SOCIAL** **Norms:** Policymakers sometimes establish PAC policies because they know that they will have to present their country's progress in front of their peers from other countries **Norms:** Policymakers do not establish policies and guidelines that promote comprehensive PAC because of socio-cultural norms and religious and moral beliefs that reject PAC because of its association with abortion	**INSTITUTIONAL** **Managers**: Advocate for clear policies and guidelines and their implementation through district health offices **Development Partners**: Advocate/support advocacy for adequate funding and policy/guideline development capacity and for close monitoring of policy implementation **Development Partners**: Convene action-oriented fora for countries to share PAC progress and learning, including as it pertains to adolescents **Development Partners**: Provide funding and technical assistance for PAC policy and guideline review, revision, implementation, and monitoring	**ENABLING ENVIRONMENT** **Financing**: Provide financial and technical support for policy, guideline, and indicator development, review, revision, and introduction **Partnerships and Networks**: Create alliances with powerful groups such as unions and professional associations based on shared values or interests **Partnerships and Networks**: Foster collaboration between policymakers and health professional associations (national and international) on the design, shepherding through the policy process, and implementation of PAC-promoting policies and guidelines **Partnerships and Networks**: Partner with groups advocating for gender equity and youth engagement in politics to include supportive PAC policy and increased access to quality PAC in their policy and advocacy agendas **Policies and Governance**: Organize regional fora where health ministers and others discuss and commit to developing, implementing, monitoring, and continuously

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
6. Follow the required approval processes for establishing policies and guidelines 7. Disseminate the new/updated policies and guidelines at all health system levels and to the public 8. Monitor implementation of the new/updated policies and guidelines	**INTERNAL** **Attitudes and Beliefs**: Policymakers do not establish clear policies and guidelines that promote PAC because of abortion-related stigma **Attitudes and Beliefs**: Policymakers are guided by political considerations (such as opposition to contraception and abortion) rather than by evidence of what works to reduce maternal mortality **Attitudes and Beliefs**: Policymakers do not establish clear policies and guidelines because they perceive the issue as relatively less urgent or important than other issues **Self-Efficacy**: Policymakers do not establish clear policies and guidelines because they lack confidence in their ability to drive a big policy push in this area **Knowledge**: Policymakers establish clear policies and guidelines because of evidence that PAC can be feasibly and safely provided at lower-level facilities by midlevel providers **Knowledge**: Policymakers do not establish clear policies and guidelines because they themselves are not clear about current laws and policies about or that impact PAC	**NGOs**: Speak with communities about the critical need for PAC **Medical, Nursing, and Pharmacy Associations**: Generate broad support among members for policy advocacy and community-level support **Medical, Nursing, and Pharmacy Associations**: Actively disseminate PAC policies and guidelines to members and non-members, engaging them in discussions, problem-solving, identification of training and advocacy needed, etc., about the policies and guidelines and their implementation and monitoring **Medical, Nursing, and Pharmacy Associations**: Organize members to meet with policymakers and opinion leaders about the ethical imperative of providing quality PAC to women and adolescents, challenges faced, effective solutions (e.g., task-shifting), and policymakers' role in enabling such solutions **Medical, Nursing, and Pharmacy Associations**: Participate in analysis of relevant policies, laws, and guidance and how they impact PAC, including adolescent access to quality, affordable care **COMMUNITY** **Community Leaders**: Advocate strongly for clear PAC guidelines and policies, full funding of PAC at all service levels, and accountability	improving PAC policies, guidelines, and programs as an essential part of achieving SDG 3—reducing maternal mortality **Policies and Governance**: Undertake a review of all laws, policies, and guidelines that impact PAC, especially for adolescents **Norm Shifting**: Undertake efforts to make comprehensive PAC a routine part of maternal and reproductive health care and seen by communities, providers, and policymakers as such **DEMAND AND USE** **Advocacy**: Provide financial and technical support to professional association and local/national NGO advocacy efforts on the urgent need for PAC policy, guidelines (task-shifting, provider performance guidelines, monitoring, etc.), and legal reform needed to promote provision and use of quality PAC **Advocacy**: Identify policy champions (from within and outside the health sector) and messages to position PAC as a cost-effective, compassionate, ethical, lifesaving response to women and adolescents in difficult circumstances and an essential part of reducing maternal mortality **Advocacy**: Focus PAC advocacy at local or regional levels as possible and necessary to avoid polarization by party elites and other powerful influencers **Communication**: Use events and mass media to build empathy for and destigmatize PAC for women and adolescents, e.g., highlighting the experiences of women and adolescents who did not have access to quality PAC **Communication**: Bring together partners who are committed to increasing access to quality PAC through the design and testing of new interventions that carefully research and prioritize key actors, including policymakers, community and religious leaders,

BEHAVIOR ANALYSIS			STRATEGY
Steps	**Critical Factors**	**Supporting Actor Actions**	**Possible Interventions**
		through regular monitoring and reporting **Religious Leaders**: Share with congregants information about the role of PAC in saving lives and reducing demand for abortion	communities, and others in order to influence social norms **Communication**: Draft sample policies and guidelines that include the evidence base for private-sector PAC through pharmacies and private clinics **Communication**: Create fora (online and in-person) for South-to-South policymaker sharing of progress and problem-solving around stigma reduction, policy design, task-shifting, quality improvement, adolescent-friendly care, financing, agenda-setting, and other key PAC topics (or include in existing fora) **Collective Engagement**: Support local NGOs to organize community engagement around the need to demand quality PAC for all who need it, including adolescents **Collective Engagement**: Implement the *WHO Strategic Approach to strengthening sexual and reproductive health policies and programmes* to develop consensus and take action on improving PAC policy (https://tinyurl.com/hnh26pth) **Skills Building**: Provide PAC advocacy training to health ministers and other potential champions within ministries of health, finance, women, youth, and justice **Research**: Provide the evidence base for comprehensive PAC for women and adolescents (e.g., through data analysis, demonstration programs)

APPLY AND MANAGE: GLOBAL RESULTS FRAMEWORK

To turn the very information-rich behavior profiles into a manageable program strategy, we identified synergies, commonalities, and important differences across the four profiles by looking across each of the profiles using the Think | BIG Behavior Summary tool (https://thinkbigonline.org/tools). This step maintains the intentional pathways from the desired behaviors to potential strategies for achieving them, but takes what is often a large amount of data and condenses it into a manageable size, ensuring efficiencies are identified while critical elements are not lost. We translated this summary into a strategic framework for action (Figure 3). In this framework, each behavior became an intermediate result (IR). Then, we translated the summarized critical factors into sub-IRs; and the summarized strategies became outputs. When interventions (outputs) are implemented, they result in a change in critical factors (sub-IRs), which in turn enable a change in priority behaviors (IRs) and lead to the goal of reducing repeated unintended pregnancy postabortion.

In looking at this results framework, it is important to note that nearly all identified critical factors are cross-cutting. This means that achieving the goal of reducing repeat unintended pregnancy will require a comprehensive strategy that engages and supports all the primary actors toward change. In addition, although the factors driving care-seeking for PAC and subsequent use of PAFP are entirely cross-cutting, it is important to maintain those two behaviors as distinct outcomes to focus programming efforts not only on what happens once women do seek services, but also on ensuring they are able to access those services in the first place.

SUPPORTING ACTORS

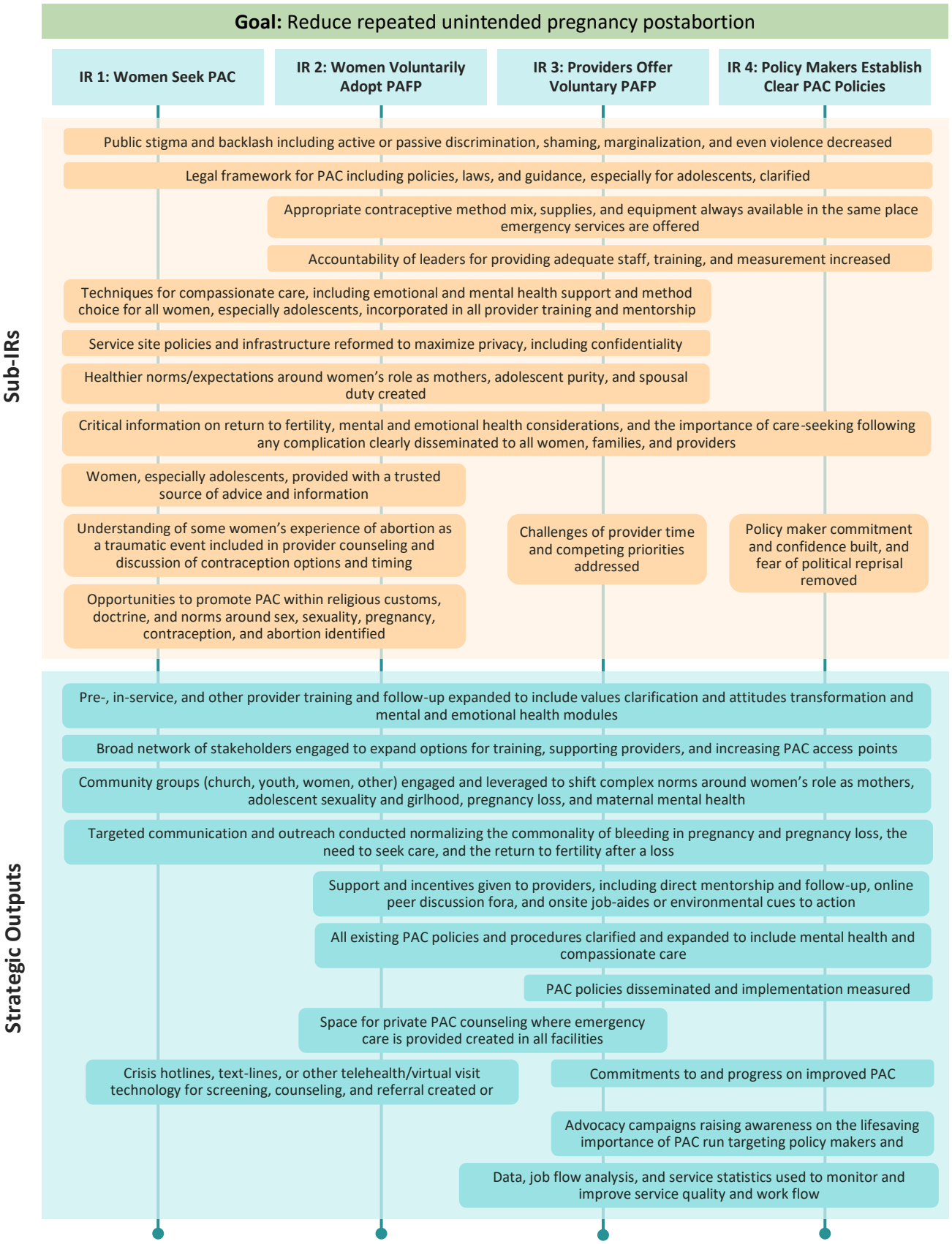
As part of the behavior profile creation process, supporting actors were identified as those key people required to support the practice of a behavior. These actors include institutional, community, and household actors and are critical stakeholders to engage in program interventions. As noted above, policymakers and providers are supporting actors for other PAC behaviors.

The PAC Behavior Profiles and Summary identified the following supporting actors:

- **Institutional:** development partners; national, regional, and district health officials; logistics personnel; managers; medical, nursing, midwifery, and pharmacy associations; medical, nursing, midwifery, and pharmacy schools; nongovernmental organizations; policymakers; providers; supervisors
- **Community:** friends/peers, community leaders, faith-based organizations, religious leaders, teachers and school staff
- **Household:** family members, male partners

Their actions are incorporated into the sub-IRs and strategic outputs levels of the results framework. Appendix B presents an at-a-glance picture of this variety of stakeholders who will likely need to be engaged to achieve the goal along with their key actions.

FIGURE 3. STRATEGIC FRAMEWORK FOR ACTION



TRACK AND ADAPT: BEHAVIORAL METRICS

Thinking BIG requires some reorientation of how programs monitor, evaluate, and learn. In addition to measuring outputs, Think | BIG expands the measurement focus to the behaviors of the primary actors, as tracked through behavioral outcome indicators. The selected PAC behavioral outcome indicators are shown in Table 2.

TABLE 2. PAC BEHAVIORS AND INDICATORS

Policymakers Establish Clear PAC Policies

Policymakers establish clear national policies and guidelines that promote comprehensive PAC

Existence of/number of policies and guidelines that promote access to comprehensive PAC

Providers Offer Voluntary PAFP

Service providers proactively offer comprehensive, compassionate, client-centered counseling and voluntary contraceptive services at the same time and location where women receive any PAC

Percent of PAC clients counseled on modern contraception during PAC visit

Women Seek PAC

Women and adolescents seek care for bleeding in (early) pregnancy or any complications from a miscarriage, incomplete abortion, or induced abortion

Percent of women who have lost a pregnancy, either induced or spontaneously, who report having consulted a provider in the 48 hours afterwards

Women Voluntarily Adopt PAFP

Women and adolescents voluntarily adopt a modern contraceptive method immediately after treatment for abortion complications

Percent of PAC clients who left the facility with a contraceptive method

In addition, to assess progress and adapt programming as necessary, it will be important to track change in at least some of the factors, including for example, assessing change in perceived and real levels of stigma for both providers and clients, or measuring progress in policy dissemination or incorporation of compassionate care into provider training and mentorship. The specific indicator and methodology used to obtain data for each will depend on country context, available data sources, and resource availability. At the global level, harmonizing these kinds of indicators and ensuring cohesive tracking above-country-level should follow the dissemination of this guidance.

Output indicators are also measured and contribute to learning. Programs can use the combination of indicator types to assess progress toward achieving a goal and determine whether and when to make adaptations. In reading and interpreting the data collected through regular monitoring and occasional evaluation, programs can ask the following questions and adapt program elements as needed, based on the answers:

- Priority Behaviors: Is uptake moving in the right direction?
- Pathways to Change: Do factor-level changes support your theory of change?
- Quality Indicators: Are you getting what you need?
- Targets: Are you meeting them?
- Subgroups: Are there differences sub-nationally or across other subgroups?

More detailed adaptive management guidance can be found in Think | BIG Adaptive Management Guidance and Tools.

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APPENDIX A. BEHAVIOR PROFILE BIBLIOGRAPHIES

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APPENDIX B: SUMMARIZED SUPPORTING ACTORS AND ACTIONS

Supporting Actors and their Actions	
Institutional Actors and Actions	
Development Partners	Provide advocacy, funding, convening power, and technical support for clear and comprehensive PAC policy development, revision, sharing, implementation, and monitoring
Logistics Personnel	Provide a consistent supply of PAC commodities and equipment, including a full complement of contraceptives, where emergency care is provided
Managers	Organize emergency services such that treatment of abortion complications, private counseling, and contraceptives are offered/provided to all women and adolescents seeking PAC
	Improve PAC using data, quality assessment, job aids, and competency-based supportive supervision (including problem solving, psychological and emotional support, and positive and constructive feedback)
	Advocate through district health offices for clear PAC policies and guidelines and their implementation
Managers and District Health Officials	Participate in values clarification and other PAC training
Managers and Policymakers	Operationalize task-shifting for PAC, including optimizing roles of all levels of personnel
Medical, Nursing, Midwifery, and Pharmacy Associations	Advocate with members, policymakers, and communities for clear and comprehensive PAC policies and guidelines and affordable, high-quality services that support all women, including adolescents
Medical, Nursing, Midwifery, and Pharmacy Schools	Incorporate client-friendly PAC into pre-service training for all students
Nongovernmental and Civil Society Organizations	Discuss the critical need for PAC with communities and other stakeholders; participate in training and advocacy efforts
Policymakers	Develop, disseminate, and monitor clear, supportive policies and guidelines for client-friendly PAC for all women and adolescents who need it
	Mandate and fund comprehensive, client-centered pre-service and in-service PAC training, service provision, and follow-up
	Authorize use of misoprostol for emergency medical management of complications of incomplete abortion
Supervisors	Provide in-service PAC training, including values clarification; support providers following training to practice and improve skills, problem solve, and share learning with peers

Supporting Actors and their Actions	
Community Supporting Actors and Actions	
Community Leaders	Normalize PAC seeking and provision by advocating for and publicly praising the roles and values of women, clear and supportive PAC policies and guidelines, full funding of PAC at all levels of care, accountability, and the rights and expectation of women and adolescent girls to seek needed care
Faith-based Organizations	Voice strong support for inclusion of contraceptive choice for PAC, including adequate commodity and equipment supply
Religious Leaders	Discuss with congregants and others the impact of PAC on reducing maternal mortality, women's value and dignity, the importance of compassion, and the right and expectation of women and adolescent girls to seek needed care
Teachers and School Staff	Provide young people with nonjudgmental emotional support and complete and correct information about PAC
Friends and Peers	Support pregnant women to make the best choice for her; provide supportive, nonjudgmental listening, and direct women who need services to the appropriate facility
Household Supporting Actors and Actions	
Family Members	Provide emotional and practical support to women and adolescents needing or having experienced PAC, including reinforcing the need for skilled care, providing space for discussion, avoiding judgment, and temporarily taking on tasks as needed
Male Partners	Actively support partner in reproductive health decision-making including the decision to seek PAC and contraceptive choice

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