



# An Assessment of Health Facility and Community Readiness to Offer Postabortion Care

## Findings from a National Health Facility Survey in Rwanda



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# Abbreviations and Acronyms

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AMTSL	Active management of the third stage of labor
ANC	Antenatal care
BEmONC	Basic Emergency Obstetric and Newborn Care
CCT	Controlled cord traction
EDL	Essential drug list
EmONC	Emergency Obstetric and Newborn Care
FIGO	International Federation of Gynecology and Obstetrics
ICM	International Confederation of Midwives
IM	Intramuscular
IU	International units
IV	Intravenous
JHSPH	Johns Hopkins Bloomberg School of Public Health
MCHIP	Maternal and Child Health Integrated Program
MOH	Ministry of health
PAC	Postabortion care
PE/E	Pre-eclampsia/eclampsia
PMTCT	Prevention of mother-to-child transmission
PPH	Postpartum hemorrhage
USAID	United States Agency for International Development
WHO	World Health Organization

# 1. Background

---

Each year, more than 210 million pregnancies occur throughout the world, and 40 percent of them are unplanned. More than one-fifth of these pregnancies—including half of the unplanned pregnancies—end in induced abortion (Dailard 1999). Of the 182 million pregnancies that occur each year in developing countries, more than one-third are unintended and 19% end in induced abortion (8% are safe procedures and 11% are unsafe). The World Health Organization (WHO) estimates that 13% of all maternal deaths (67,000 women) worldwide each year are the result of untreated or poorly treated complications of abortion. Sub-Saharan Africa suffers the highest prevalence of abortion-related deaths, with an estimated rate of 650 deaths per 100,000 unsafe abortions in 2003. In addition to being a direct cause of maternal death, complications from unsafe abortions cause a loss of productivity, put an economic burden on public health systems, and cause stigma and long-term health problems such as infertility and chronic pelvic inflammatory disease (WHO 2003).

Abortion complications are one of the major reasons that women seek emergency obstetric care. The U.S. Agency for International Development (USAID) model for postabortion care (PAC) consists of three components (see Appendix 1): (1) treatment for complications related to spontaneous or induced abortions; (2) family planning counseling and, if the woman desires, the provision of family planning methods for the prevention of further mistimed or unplanned pregnancies, and where human and monetary resources exist, STI evaluation and treatment and HIV counseling and/or referral for testing; and (3) community empowerment for community mobilization and awareness of postabortion care messages.

Postabortion care has been a focus in reproductive health programming since the 1994 International Conference on Population and Development (ICPD), when more than 170 countries agreed that, “In all cases, women should have access to quality services for management of complications arising from abortion” (United Nations 2004). Global reproductive health experts have identified PAC as a critical intervention for addressing the problem of unsafe abortion, reducing maternal morbidity and mortality, and improving women’s overall reproductive health. PAC is a relatively simple, effective, and efficient way to lower maternal death rates (AED 2004).

Abortion is one of the most common gynecological experiences for women. Worldwide, women terminate about 41.6 million pregnancies every year. At least 95 percent of abortions performed in Africa and Latin America and about 60 percent in Asia (excluding Eastern Asia) are unsafe (Shah and Ahman 2009). Unsafe abortion is a critical public health, social and economic justice, and human rights issue.

In Rwanda, among 733 maternal deaths, 50% are attributable to abortion complications (Rwanda Maternal, Neonatal and Child Health Assessment 2006). Rwanda’s population is 11,700,000, and the expected number of pregnancies each year is 479,700. Forty percent of those pregnancies (191,880) are unplanned, and according to Dailard (1999), 50% of the women with unplanned pregnancies (approximately 95,940 women) will end up with complications of incomplete abortion.

Despite Rwanda’s recent success in reducing its maternal mortality ratio (MMR) from more than 1,000 per 100,000 in 2000 to approximately 750 per 100,000 live births in 2005, the country is far from reaching its Millennium Development Goal 5 target of 300 by 2015 (National Institute of Statistics, Rwanda 2005). Given the sensitivity of the subject, it is difficult to assess the number of abortions happening in-country, particularly at the community level. However, it

is estimated that complications from unsafe abortions are a major contributing factor to the high Rwanda MMR.

Postabortion care is not institutionalized in all health facilities across Rwanda, but currently it is being provided at national, provincial, and district hospitals. To assess the current availability and quality of PAC services in Rwanda, USAID/Rwanda and the Ministry of Health supported a national quality of care (QOC) study, which was conducted by the Maternal and Child Health Integrated Program (MCHIP) and focused on maternal and newborn care, including PAC. The PAC component of this assessment focused on health facilities readiness, health providers' ability to provide quality services, and community-level awareness and knowledge of unsafe abortions and PAC services.

**Figure 1.1 Map of Rwanda showing the coverage of the 29 PAC assessment districts**



Key assessment questions:

- Are key maternal health supplies, drugs, equipment and infrastructure available to address PAC needs in Rwanda?
- Are women receiving quality postabortion care services in Rwanda?
- What are the barriers to and recommendations to improve PAC services in Rwanda?
- What are the community perceptions of PAC in Rwanda?

## 2. Goal and Objectives

---

### GOAL

To assess, over a period of 30 days, health facilities' and communities' readiness to provide postabortion care services in order to reduce maternal deaths due to abortion complications and improve the quality of maternal health services using known life-saving interventions

### OBJECTIVES

- To assess quality of care in the provision of PAC services at the facility level
- To assess community knowledge of and behavior toward postabortion care
- To provide baseline estimates of PAC in Rwanda

### SPECIFIC OBJECTIVES

- To assess the quality of PAC services currently offered in health facilities, including selected hospitals and health centers
- To assess and analyze the current services available, including manual vacuum aspiration (MVA), dilatation and curettage (D&C), counseling, and linkages to other reproductive health services (such as family planning, STI, and counseling services)
- To assess health providers' knowledge of and competency to offer PAC services, including D&C, family planning, infection prevention, and post-exposure prophylaxis
- To assess health facilities' ability to meet the need for quality PAC services in terms of infrastructure and equipment as well as infection prevention
- To assess community knowledge of and behavior related to complications of incomplete abortions, including understanding of PAC services, community perception of postabortion care, and knowledge of referral systems

## 3. Methodology

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### 3.1 STUDY PARTICIPANTS

Interviews were conducted with 124 health care workers from district hospitals and health centers in 29 districts. Observations were made of 34 client cases and simulations on Zoe models, exclusively at the 27 district hospitals (see Appendix 6). The health care providers observed included providers of antenatal, labor and delivery, and postabortion care services.

### 3.2 INCLUSION CRITERIA

Health care workers on duty at the sampled facilities and women who were being attended to in the facility during the data collection period were selected as per the study protocol.

### 3.3 SAMPLING PLAN AND SAMPLE SIZE

The most valid measure of the quality of care came from observations of practice. Because we did not know how many facilities were performing PAC services or how many would be willing to participate in our survey, nor the average number of PAC procedures performed at specific health facilities, there was no predetermined sample size for the PAC study. We planned to

observe procedures and conduct simulations at as many facilities and with as many providers as we could during the assigned time at each facility. A total of 34 observations were made—18 on clients and 16 on Zoe models.

### **3.4 STUDY SAMPLE COMMUNITY**

Three focus group discussions were conducted in each of the five randomly selected districts—one with women between 15 and 24 years old, one with women 25 years old and older, and one with men 15 years old and older. A total of 15 focus group discussions were conducted. In addition, three key informant interviews were conducted in each district with key health officials, religious leaders, and community leaders. The community interview guide is included in Appendix 5.

### **3.5 QUALITATIVE DATA COLLECTION FOR PAC**

Qualitative data about PAC services were collected through focus group discussions and key informant interviews. In addition, an observation checklist was used to record responses both during simulations and with clients. Inventory checklists were used to double-check the equipment and supplies. Questionnaires were administered to assess knowledge on PAC.

No information identifying the health care workers or patients was collected. However, the names of health care facilities were recorded on the data collection forms, and facilities could be identified in the reports submitted to the Ministry of Health, given their request for this information. Reports or manuscripts generated for dissemination outside of the country do not report the names of the individual facilities.

## **4. Study Procedures**

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### **4.1 STUDY DESIGN**

This study was a cross-sectional assessment of the quality of PAC services provided to patients who presented to the facility during a prescribed period of time. It was conducted as part of the national quality of care (QOC) assessment, and the sequence and timing were the same as in the QOC study:

- Two weeks were allocated for pre-testing the data collection tools, final edits to the tools, printing, and preparation for training the data collectors.
- Physicians and midwives were hired as data collectors for the observation component of data collection, and they received refresher obstetric clinical trainings for a period of one to two weeks to update and standardize their skills.

## 4.2 DATA COLLECTION PLAN

The six-week timeline for data collection is shown in Table 4.1.

**Table 4.1 Activity timeline**

WEEK	ACTIVITY	TEAMS	TOTAL FACILITIES VISITED
Week 1	Training & pre-testing	20 participants plus trainers	N/A
Week 2	District hospitals (3 hospitals visited per team)	5 teams of 4 persons	15 district hospitals
Week 3	District hospitals (3 hospitals visited per team)	5 teams of 4 persons	15 district hospitals
Week 4	District hospitals (2 hospitals visited per team)	5 teams of 4 persons	10 district hospitals
Week 4	Break for data collectors		
Week 5	Health centers (3 health centers visited per team)	5 teams of 4 persons	15 health centers
Week 6	Health centers (3 health centers will be visited per team)	5 teams of 4 persons	15 health centers

## 4.3 TEAM COMPOSITION

Each team included one supervisor (responsible for facility inventories, record reviews, and health worker listings) and one PAC observer.

## 4.4 DAILY SCHEDULE WHEN VISITING A FACILITY

- 6:00 a.m.–2:00 p.m.: PAC observation shift
- 3:00 p.m.: Wrap up and travel to next facility
- Sundays were a day off for data collectors

## 4.5 SCHEDULE

Table 4.2 shows the overall study timeline.

**Table 4.2 Study schedule**

ACTIVITY	DATES
Data collector training workshop	August 25–31, 2010
Pre-test of tools and debrief	September 1–3, 2010
Fieldwork	September 6–October 6, 2010

## 4.4 DATA COLLECTION METHODS AND TOOLS

- Structured clinical skills observations
- Postabortion care observation checklist
- Health worker interviews (training, supervision, problems in delivering quality care)
- Knowledge questionnaires
- Facility inventory of infrastructure, supplies, and equipment (general and PAC)
- Record review for number of PAC attendances, services provided, complications, and deaths (maternal)
- Health worker interviews and knowledge tests
- PAC focus group discussion guide
- PAC key informant interview questionnaires

## 4.5 INFORMED CONSENT

A written consent form was given to the heads of facilities (hard copies obtained and submitted back to MCHIP). Appendix 4 shows the consent form used. Consent was obtained from all other participants in this assessment, including the health workers and PAC clients whose care was being observed, and next of kin for women who presented with severe hemorrhage and sepsis and were unable to provide consent themselves.

# 5. ETHICAL CLEARANCE

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The study protocol was submitted to and approved by the local National Ethics Committee and the Institutional Review Board of Johns Hopkins Bloomberg School of Public Health. The institutional review board ruled the protocol exempt from review under 45 CFR 46.101(b), Category (5). Informed written consent was obtained from all participating health providers, patients, and facility directors. When the QOC methodology was pilot-tested in Kenya, researchers realized that some women coming in with complications would be either too ill, such that they were mentally incapacitated, or unconscious and unable to give consent. Because these cases were very important in our assessment of the quality of care, we received approval to obtain consent from the next of kin in these circumstances.

# 6. CONSTRAINTS

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This assessment was conducted in a context with the following constraints:

- The subject of PAC itself is still a taboo for many providers, and there was some confusion between performing postabortion care and performing an induced abortion. This confusion resulted in some providers declining to participate in the assessment.
- Some hospitals did not participate due to long administrative procedures.
- Due to the sensitivity of the subject matter, it was difficult to find clients, both in the facility and in the community.

- Simulation of the procedure was another constraint due not only to a lack of training but also to the lack of needed equipment such as the Zoë model and MVA kits.

## 7. Facility-Level Results

### 7.1 HEALTH FACILITY INVENTORY RESULTS

#### General Infrastructure and Supplies

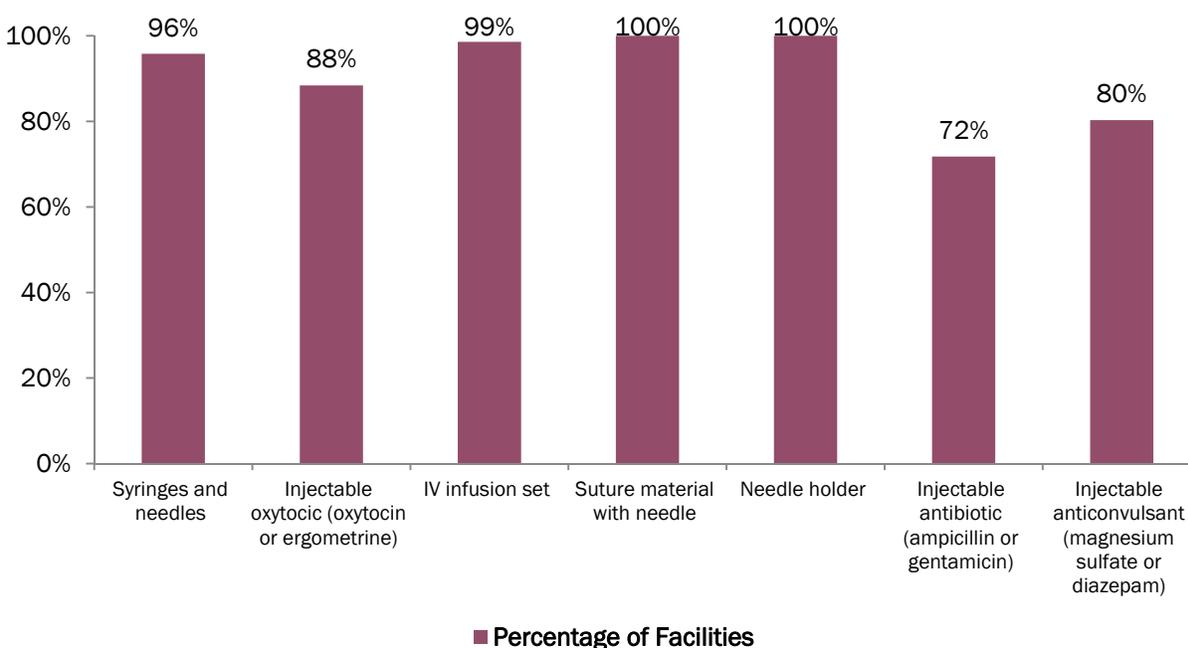
Table 7.1 shows the availability of general infrastructure of the facilities assessed. Water supply, toilet facilities, room for communication, and emergency transport all affect PAC services. Having a safe water source within 500 meters is essential. Approximately two-thirds of the health facilities (65%) had an appropriate water supply. Forty-nine percent of the facilities had functional improved-type toilets.

**Table 7.1 Availability of infrastructure (n=69 facilities)**

INDICATOR	PERCENTAGE OF FACILITIES
Electric power (grid or functioning generator with fuel)	93%
Safe water source within 500 meters of facility	65%
Patient room with auditory and visual privacy	93%
Functional improved-type toilet	49%
Communication equipment	69%
Emergency transport	66%

Figure 7.1 shows the availability, in or near the delivery room, of drugs that can be used in emergency situations such as severe bleeding and resuscitation of hypovolemic shock or sepsis. Oxytocin or ergometrine was available at 88% of the facilities, while injectable antibiotics were available at 72%.

**Figure 7.1 Essential supplies and drugs for PAC emergencies**



## Infection Prevention Supplies

**Table 7.2 Availability of infection control items**

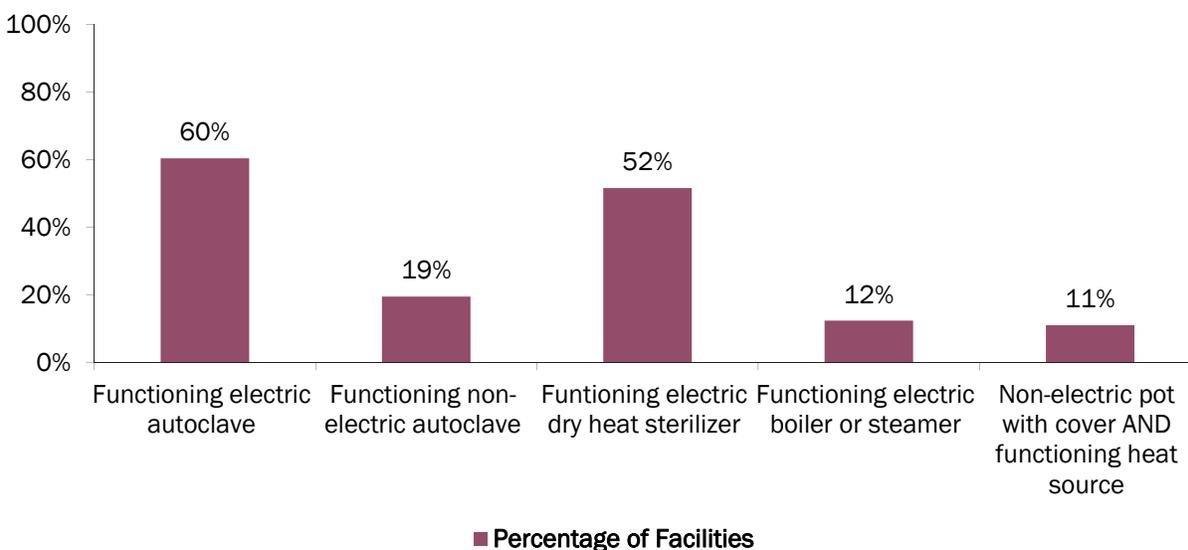
INFECTION CONTROL ITEM	PERCENTAGE OF FACILITIES
Soap for hand washing	77%
Piped water or bucket with tap	91%
Soap and safe water (piped or bucket with tap)	71%
Sharps container	97%
Decontaminating solution	99%
Clean (or sterile) gloves	87%
Mean score for infection control*	88%

\*Soap and piped water/bucket with tap, sharps container, decontaminating solution, and clean or sterile gloves

Table 7.2 shows the availability (in or near the delivery room) of infection prevention supplies and equipment for processing instruments, which reflects site preparedness for PAC provision in an infection-free environment. Seventy-seven percent of the facilities had soap available for hand washing, 91% had an appropriate water source, 97% had a sharps container for disposal of needles and others sharps, 99% had decontaminating solution (0.5%), and 87% had clean (or sterile) gloves.

Figure 7.2 shows the availability of functional sterilizing equipment for processing surgical instruments in postabortion care.

**Figure 7.2 Availability of functional sterilizing equipment**



## Provision of PAC Services in the Facilities (n=69 facilities)

Facility in-charges were asked whether their facility performed removal of retained products of conception. Sixty-one percent reported offering the service (42 of 69), but less than half (30 of 69) reported performing removal during the past three months.

## D&C and MVA Kits in Facilities Performing Removal (n=42 facilities)

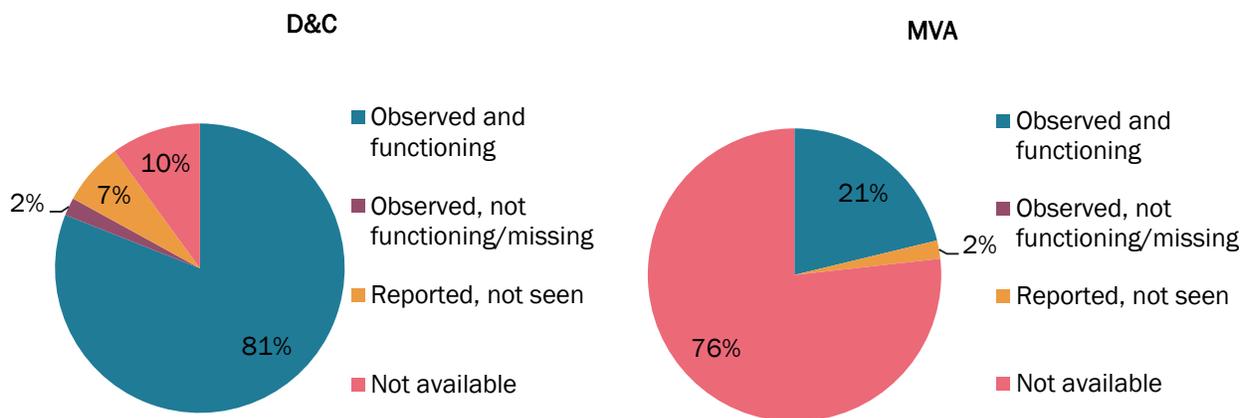
In the 42 facilities providing removal of retained products of conception, dilatation and curettage (D&C) kits were available at the majority of facilities, and 81% had confirmed functioning D&C kits in the delivery room or an adjacent room, where they would be easily available in an emergency. Manual vacuum aspirators, however, were available at only 21% of facilities (Figure 7.3).

### MVA versus D&C

MVA is a very safe way to remove retained products of conception:

- It is easy for health care providers to use compared to D&C.
- Evidence shows that patients are highly satisfied with MVA compared to D&C.
- Pain management with MVA is simpler and more affordable.

Figure 7.3 Availability of kits in facilities performing D&C and MVA (n=42 facilities)

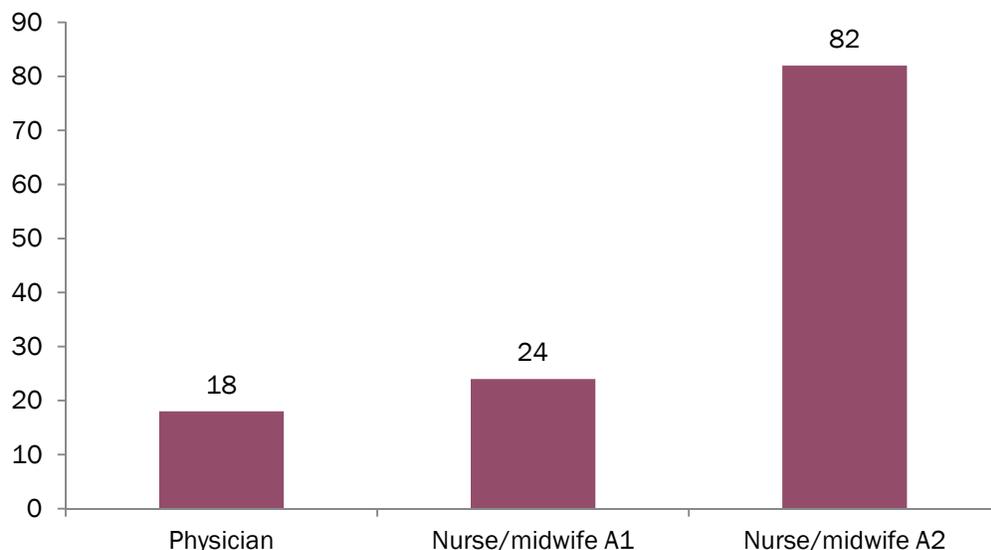


## 7.2 PAC HEALTH CARE PROVIDER INTERVIEWS

### Health Providers Interviewed, by Profession (n=124)

As shown in Figure 7.4, 82 of the 124 health care providers who participated in this study were A2 nurse/midwives and 24 were A1 nurse/midwives. A1s are similar to registered nurse/midwives, while A2s are considered auxiliary nurses/midwives. Only 18 general physicians participated in the interviews, and no obstetricians were interviewed.

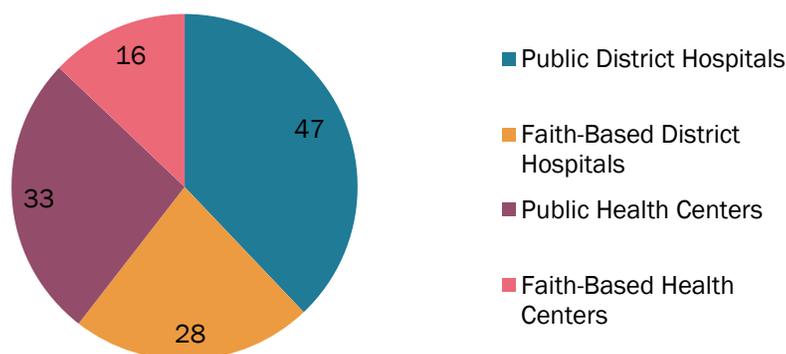
Figure 7.4 Health care providers, by profession



### Provenance of Providers Interviewed

All 124 providers participated in the assessment of providers' knowledge of PAC; among them, 92 were women and 32 were men. As shown in Figure 7.5, they represented four types of faith-based and public hospitals and health centers: 16 were from faith-based health centers; 33 were from public health centers; 28 were from faith-based district hospitals; and 47 were from public district hospitals.

Figure 7.5 Providers interviewed, by facility type and status

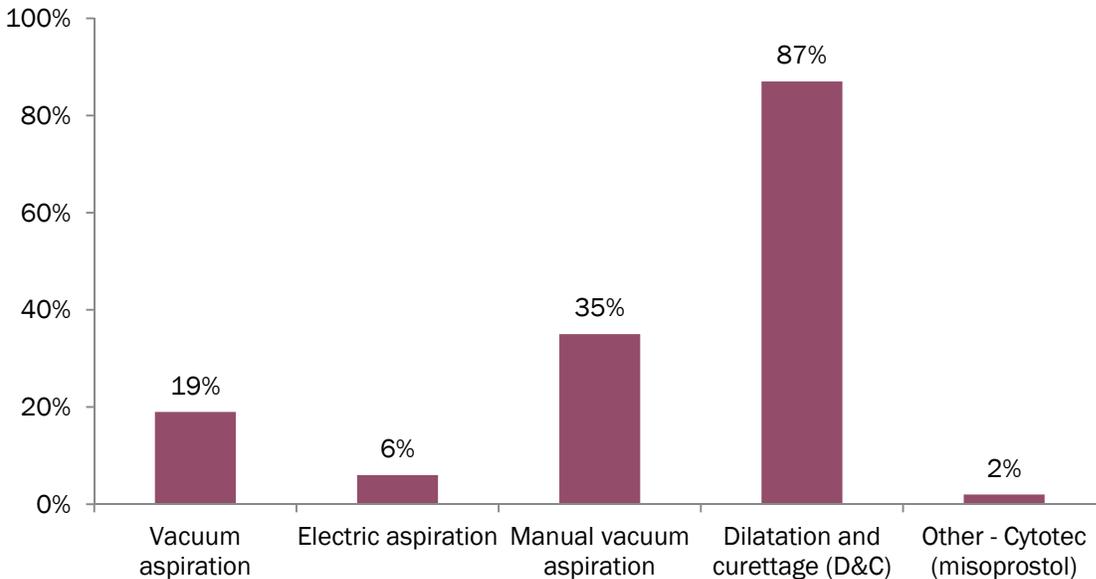


## 7.3 HEALTH WORKER KNOWLEDGE ASSESSMENT

### Knowledge of PAC

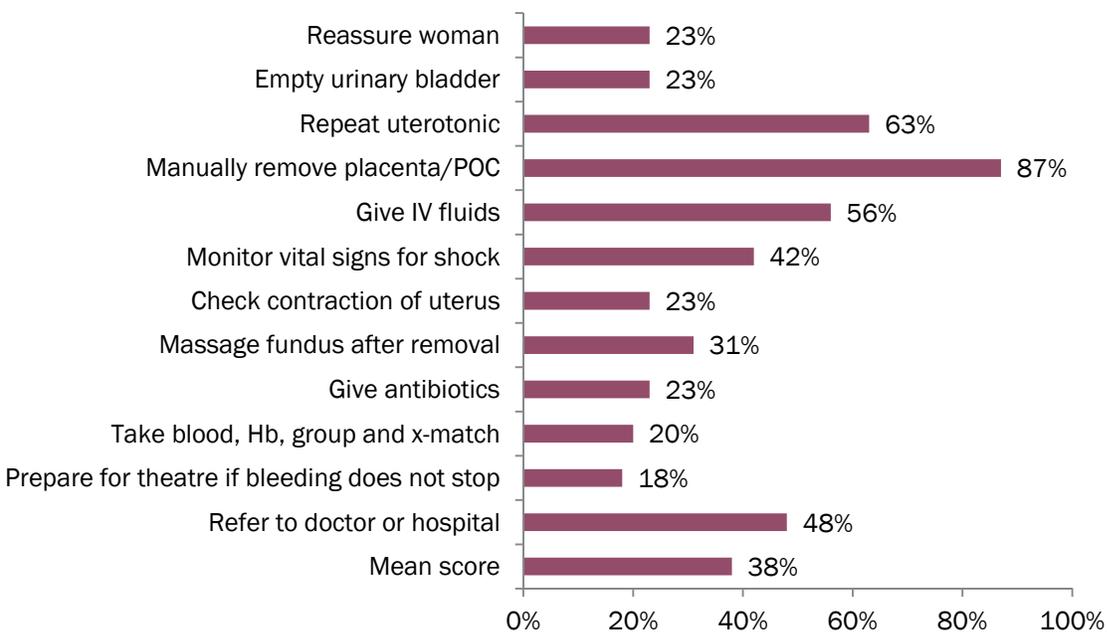
About 60% (74/124) of the participating health providers identified emergency treatment as a component of postabortion care; only 12% identified strengthening community capacity as a component. The other elements, family planning and provision of selected reproductive health services, were identified by 44% and 28% of providers, respectively. The mean score for these four correct answers was 36%. The fact that 22% of providers could not list any components of PAC is cause for concern.

**Figure 7.6 Treatment methods for incomplete abortion (n=124)**



Most providers (87%) correctly identified D&C as a treatment method for incomplete abortion, and 35% identified MVA (Figure 7.6). Providers were given the option of writing in other answers, and a small number (two physicians and two nurse/midwives) suggested misoprostol as another method for treating incomplete abortion. Only one provider could not provide any answers. Providers' ability to correctly understand differences between MVA and D&C treatments for first trimester incomplete abortion was mixed; 65% knew that MVA was as effective as D&C, but less than half (42%) knew that MVA results in less bleeding seven days after a procedure. More than 20% of providers could not answer the questions about differences between MVA and D&C.

**Figure 7.7 Actions to take for a woman with retained placenta/products of conception (n=124)**



The most commonly identified correct actions to take for a woman with retained products of conception were administration of a uterotonic, manual removal of the placenta, and administration of intravenous (IV) fluids (Figure 7.7). The other seven steps were each selected by less than one-third of providers. The mean score for providers across all steps was 38%.

Knowledge of elements of postabortion resuscitation and emergency transfer/referral was high, except for control of pain, which was identified by only 28% of providers. Intravenous fluid replacement was identified by 85% of providers and control of bleeding by 64%. The mean score for all three elements was 59%. Seven percent of providers (9 out of 124) could not identify any correct answers.

## Knowledge of Postabortion Family Planning

About two-thirds of health workers (79 of 124) knew that family planning methods could be provided immediately following treatment for incomplete abortion or before discharge. The survey did not gather data on knowledge of the types of methods that can be provided. Only 25% of health providers (31 of 124) knew that fertility returns two to three weeks after a first-trimester abortion. Close to 40% of those surveyed believed that women would not be fertile until one month or more after a first-trimester abortion, and several believed that it would take six months or more. Notably, one provider thought that fertility would not return for a year. One-fifth of providers did not know the answer to this question.

Among the elements that should be considered when providing postabortion contraception, health workers most commonly identified effectiveness of method and reproductive risk (56% and 57%, respectively), followed by patient preference (34%) and availability of a wide range of options (16%). An additional 10% of providers did not respond. The mean score for all four factors was 47%. During visits to the participating facilities, it appeared that most hospitals were not providing family planning, although a few were starting to provide intrauterine devices, tubal ligation, and vasectomy. At health centers, all family planning options other than long-term methods were offered.

## 7.4 PAC HEALTH CARE PROVIDER OBSERVATIONS

### PAC Observations (n=34)

A total of 34 PAC providers were observed, 18 with clients and 16 with a Zoë model. As mentioned previously, difficulty finding PAC cases during the period of the assessment was one of the study constraints.

### Case Studies of PAC Client Observations

Two cases of postabortion care were observed:

**Case 1** was a D&C performed by a female physician at a public district hospital. The health provider completed 65% of the specific actions prescribed in the D&C checklist correctly (see Appendix 2). During preparation for the procedure, the provider failed to perform a bimanual pelvic exam to confirm uterine size, position, and degree of cervical dilation. The exam is important because the diagnosis of incomplete abortion is an open cervix. After the contents of the uterus were evacuated, the provider did not check the size and firmness of the uterus with a bimanual exam, did not check for bleeding using a speculum, and made no check of cramping and bleeding before discharging the patient.

Three out of four infection prevention steps were correctly performed, including the use of antiseptic solution applied to the cervix and vagina prior to the procedure and proper disposal/disinfection of waste materials, gloves, and instruments. The provider failed to wash her hands after the procedure. Communication tasks such as explaining the procedure to the

client were not performed at all, but the provider did refrain from giving inaccurate assurances (e.g., saying “this won’t hurt”). No instructions on postabortion care were provided.

**Case 2** was a D&C performed under general anesthesia by a female physician at a public district hospital. Seventy-one percent of the technical actions were performed correctly during the procedure. The health provider failed to correctly position the tenaculum or vulsellum forceps, and after evacuation she did not perform a bimanual exam to check the size and firmness of uterus. The provider did not check for a decrease in the amount of bleeding and/or cramping before discharge, but since the client was under anesthesia and transferred to a health center after the procedure, this check may have occurred outside of the observation period. Infection prevention steps were properly performed, except for disinfection of gloves and removal of the gloves by turning them inside out.

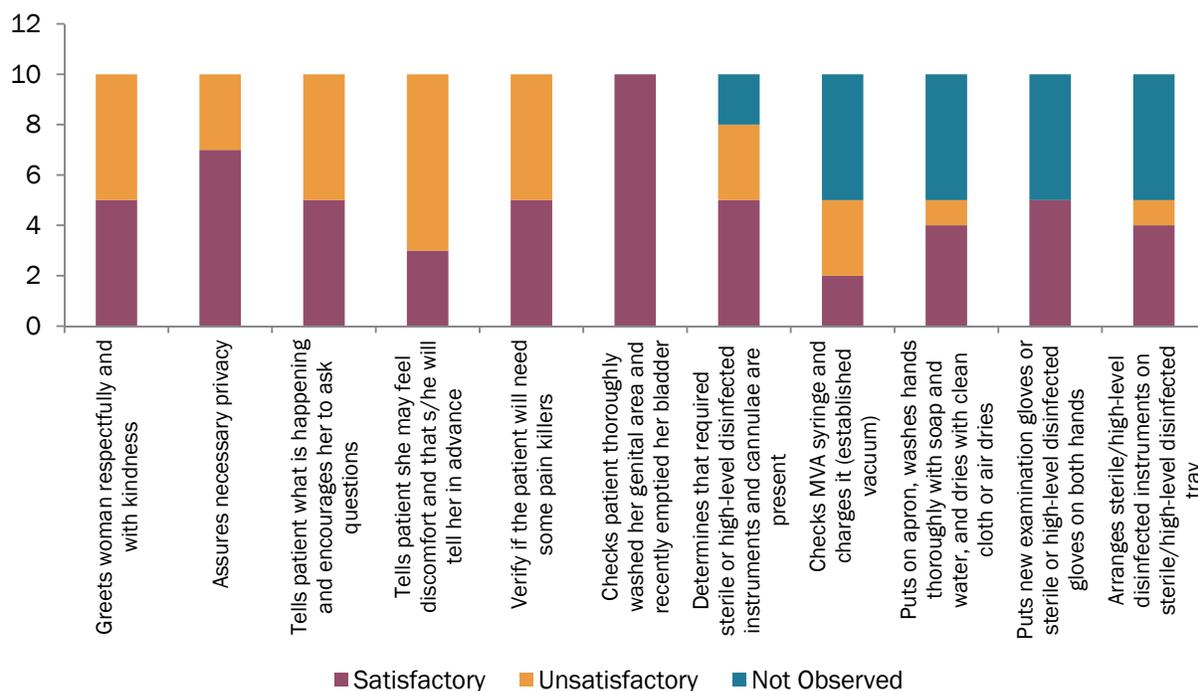
### MVA Client Procedure Observation

Five MVA procedures were observed. Because the pre-MVA checklist items were sometimes filled in for other procedures—specifically, two D&Cs, two patients receiving Cytotec, and one other patient for whom it was unclear whether any procedure was performed—these data were included in the pre-MVA sample. Thus, the pre-MVA sample is 10 and the sample for the MVA procedure is five.

### Provider pre-procedure readiness

The results of the pre-procedure observations were mixed (Figure 7.8). All patients were questioned about emptying the bladder and washing the genitals, and most patients were assured of their privacy. Infection prevention procedures—washing hands, wearing gloves, and preparing sterile instruments—were satisfactory for the most part. However, few providers talked in advance about discomfort or checked the functioning of equipment in advance. The patient was greeted appropriately and encouraged to ask questions in only half of the cases.

**Figure 7.8 Observations of providers’ pre-procedure readiness (n=10)**



## MVA procedures

Steps in the MVA procedure that were frequently observed included applying antiseptic twice, doing the procedure slowly, evacuating the contents of the uterus by rotating and moving the cannula gently back and forth, and checking for bleeding before withdrawing the instrument (Figure 7.9). However, steps for interpersonal communication between provider and patient—such as explaining the procedure, asking about pain, making sure the patient is ready before each step, asking the patient to breathe deeply during pain—were not well performed in many cases.

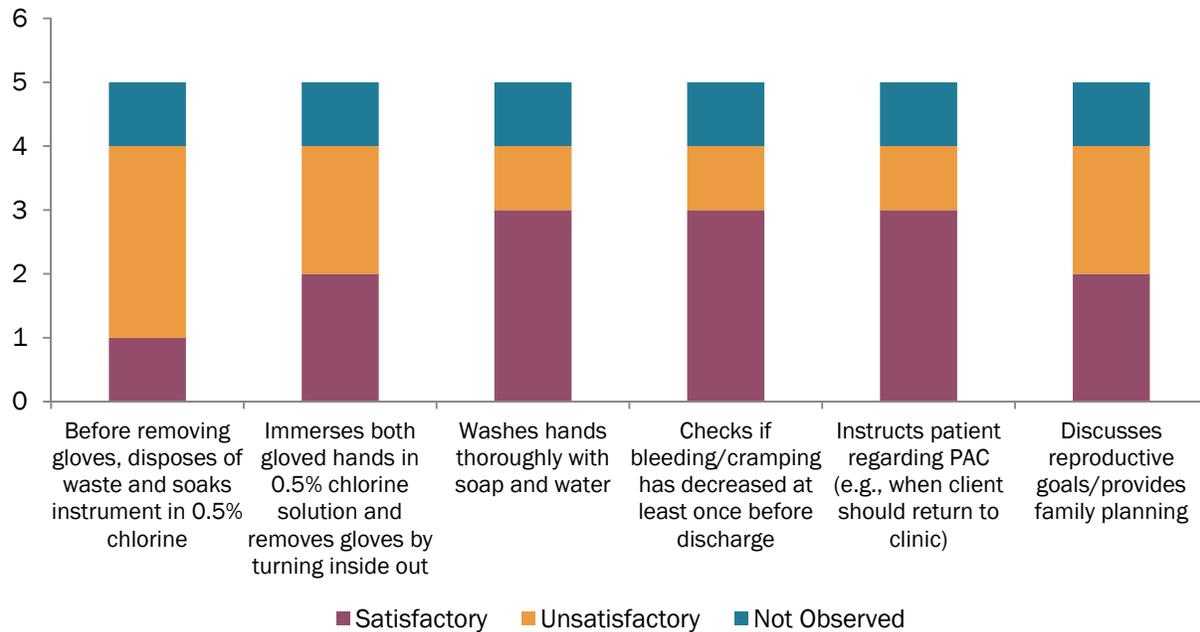
Figure 7.9 Steps observed during MVA surgical procedure (n=5)



## Post-MVA procedures

Figure 7.10 shows that the providers observed during post-MVA procedures needed to improve their practice of disposing of waste materials, soaking instruments and MVA items for decontamination, and immersing both gloved hands in 0.5% chlorine solution before removing their gloves by turning them inside out. Most providers were observed washing their hands thoroughly with soap and water, checking the amount of bleeding, checking whether cramping had decreased at least once before discharge, and explaining postabortion care instructions to the client (e.g., when client should return to clinic).

Figure 7.10 Post-MVA steps observed (n=5)



## D&C Procedure Observation

The majority of PAC observations (26 of 34) were observations of D&C procedures.

### D&C procedure

Many of the steps in the D&C procedure were performed accurately by providers, especially the surgical steps for the D&C itself (Figure 7.11). However, a few steps were less satisfactory than expected. These included steps such as asking the patient to breathe deeply during pain, talking to the patient during the procedure, asking about the patient's pain, and making sure the patient was ready for each step. Results for correct bimanual pelvic exams before and after the procedure were also low.

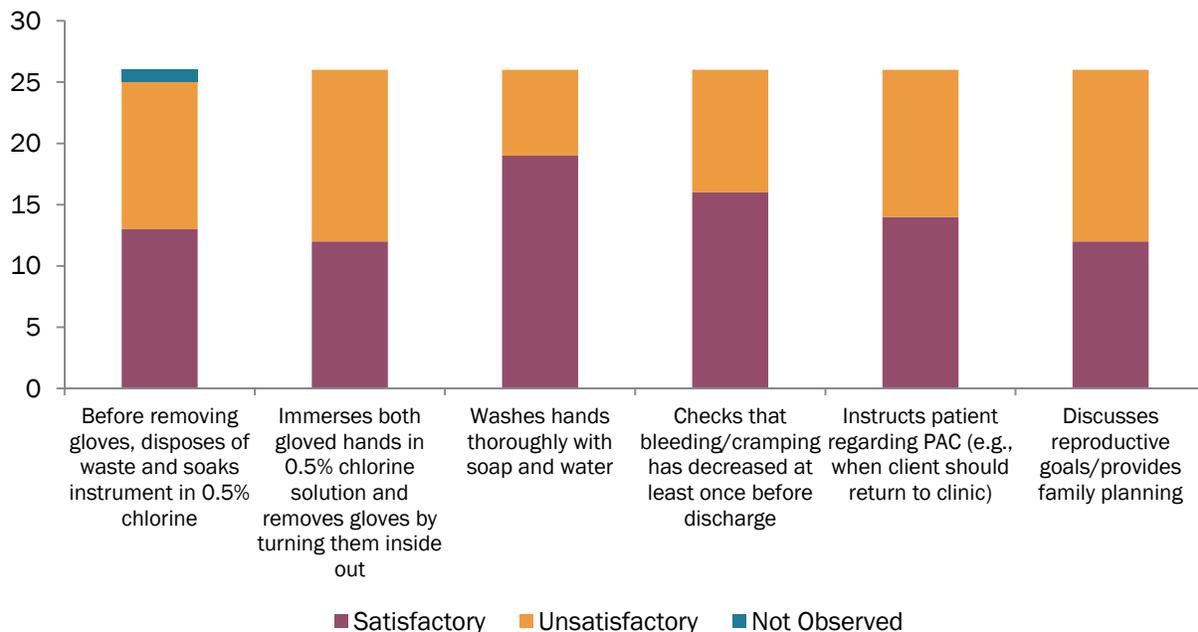
Figure 7.11 Steps observed in D&C procedure (n=26)



### Post-D&C procedure

Post-D&C steps were performed satisfactorily in only about half of the observations (Figure 7.12). Providers scored somewhat better for washing their hands after the procedure and checking on bleeding and cramping.

Figure 7.12 Steps observed post-D&C procedure (n=26)



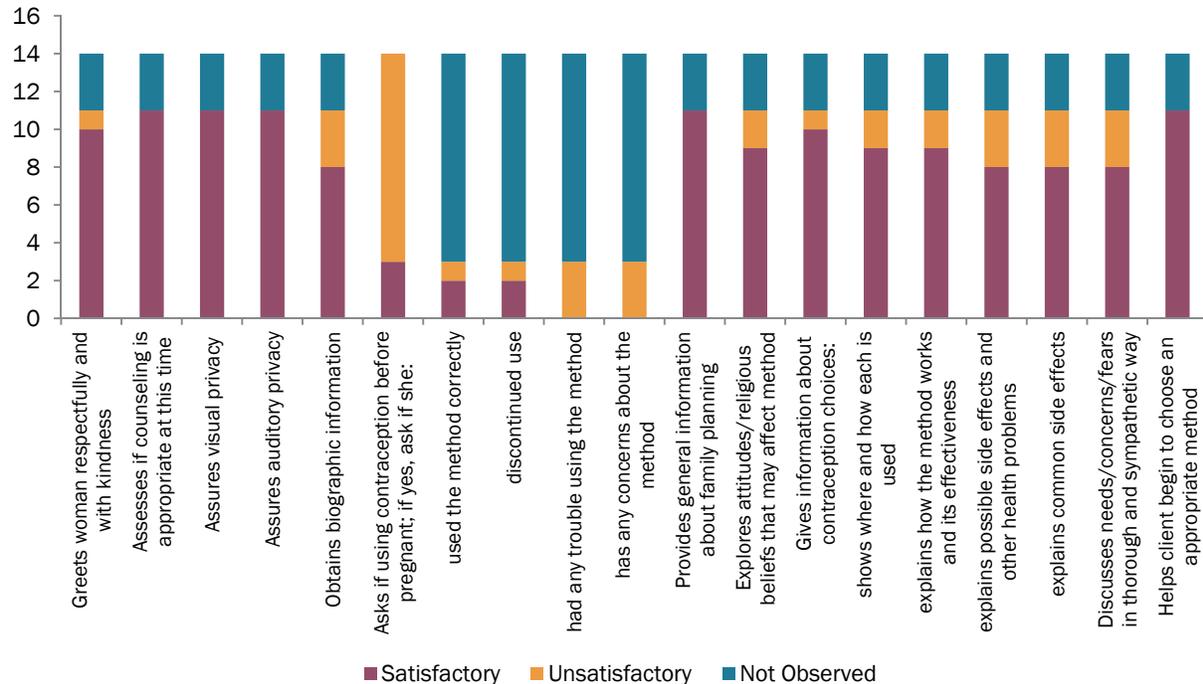
## FP Consultation Observation

Family planning consultations following PAC procedures were observed in 14 cases.

### Initial Interview

As shown in Figure 7.13, most consultations satisfactorily met the standard for the initial interview observation checklist. However, areas of improvement included asking about prior contraceptive use and experience with that method, and fully explaining about contraceptive choices.

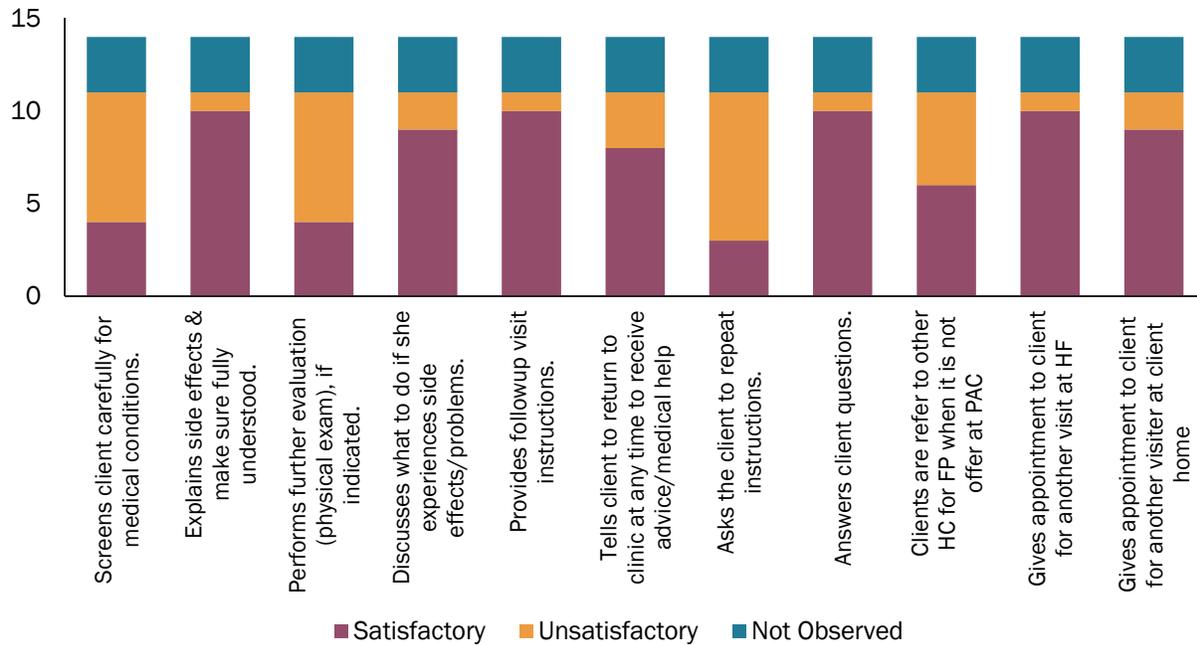
Figure 7.13 Steps observed during initial interview on PAC FP (n= 14)



### Client screening and PAC FP provision

Providers observed during the client screening portion of postabortion family planning performed well at explaining potential side effects of the procedures and what to do if these side effects occurred (Figure 7.14). They also answered client questions and set up appointments for facility and home visits. However, they did not perform well on screening the client for medical problems, performing physical exams, or requesting that clients repeat their instructions.

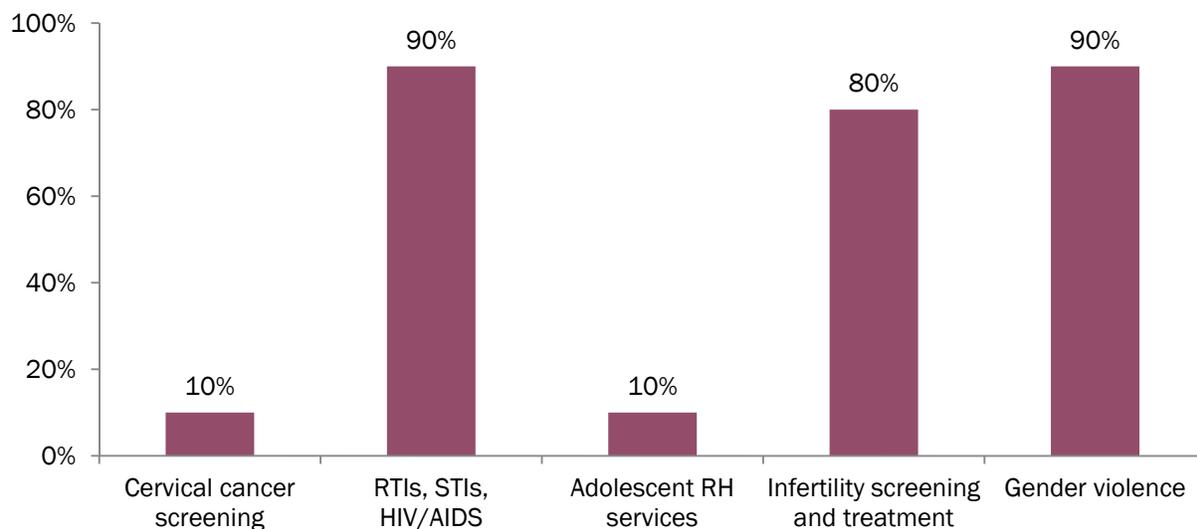
**Figure 7.14: Client screening steps observed on PAC FP (n=14)**



### Linkages to RH services

Providers observed during FP consultations were asked about linkages to RH services at their facilities (10 providers from 10 facilities responded). Most providers reported that services for HIV/AIDs and other STIs, infertility management, and gender-based violence were available on site (Figure 7.15). Cervical cancer services and adolescent reproductive health services were not available at most facilities.

**Figure 7.15 Availability of other RH services (n=10 facilities)**



## 8. Community-Level Results

### 8.1 COMMUNITY HEALTH WORKER INTERVIEWS

Maternal community health workers such as *animatrices du sant  maternelles* (ASMs) were interviewed as part of the study. Interviewers noted that these are the first contact personnel for women seeking PAC services at the community level. Most of the ASMs lacked key knowledge on PAC services. The community health worker interview and knowledge test is included in Appendix 7.

### 8.2 FOCUS GROUP DISCUSSIONS

At the end of the data collection, 15 focus groups were conducted with participants from five district hospital catchment areas. Table 8.1 shows the composition of the focus groups.

**Table 8.1 Characteristics of participants and provenance represented in 15 focus groups**

N <sup>o</sup>	FOCUS GROUP CHARACTERISTICS	DISTRICT HOSPITAL NAME
1	Men	Rutongo
2	Women < 24 years (15-24)	Rutongo
3	Women > 24 years	Rutongo
4	Men (spouse) of women who have had an abortion	Nyanza
5	Women < 24 years (15-24)	Nyanza
6	Women > 24 years	Nyanza
7	Men	Muhima
8	Women < 24 years (15-24) who have had an abortion	Muhima
9	Women > 24 years	Muhima
10	Men	Kabaya
11	Women < 24 years	Kabaya
12	Women > 24 years	Kabaya
13	Men	Kibungo
14	Women < 24 years (14-24)	Kibungo
15	Women > 24 years	Kibungo
<b>TOTAL</b>	<b>15 Focus Groups</b>	<b>5 hospitals</b>

#### Availability of PAC services

Focus group participants indicated that PAC services are important in order to identify the cause of the abortions and prevent similar occurrences in the future. The group discussions recognized that PAC services were available both at the community level and at the health facility level. At the community level, women seeking PAC services typically were provided information on where to go or were escorted to facilities by community health workers. Community health workers not only advised pregnant women to use health services but also escorted women with pregnancy complications to the health facility. Support for partners was mentioned as a service that is important in preventing abortions.

At the health facility level, participants talked about blood transfusion, curettage, ambulance availability to allow transfer from a health center to a district hospital, use of drugs to facilitate the placenta expulsion, family planning services, and counseling services for pregnant women seeking an abortion.

A participant from Nyanza Hospital said:

*I have got the abortion on the way to the health center and I continued. Once at the health center, providers gave me medicines to allow the placenta expulsion, they stayed with me, telling me that everything going to be fine. Once at home, my neighbors advised me to eat a complete meal and they helped me in domestic tasks at home.*

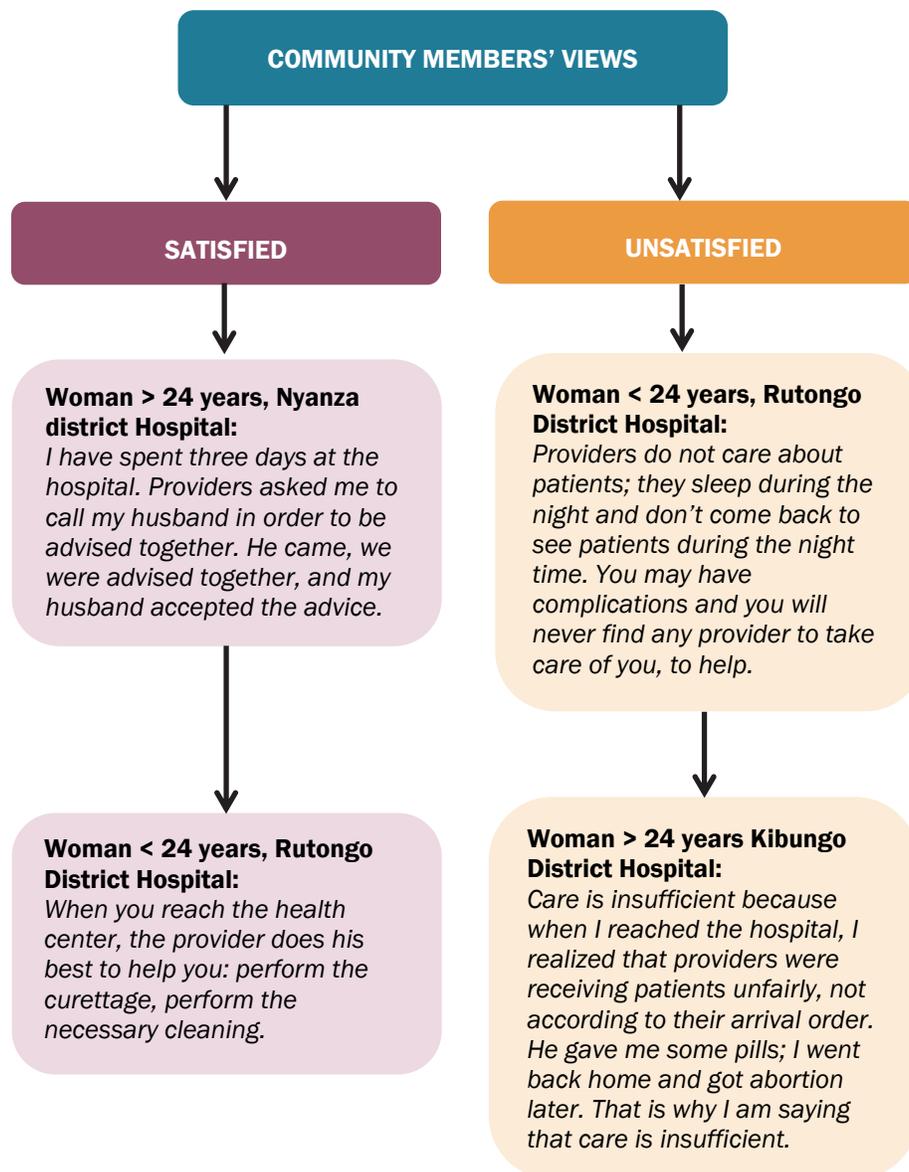
A participant from Muhima Hospital said:

*When I aborted, it was my third time; they told me that I should become pregnant after 6 months. That is what I consider as a support to a woman after abortion.*

## Community appreciation of PAC services

Some participants were satisfied with PAC services, but others were not, as shown in the Figure 8.1.

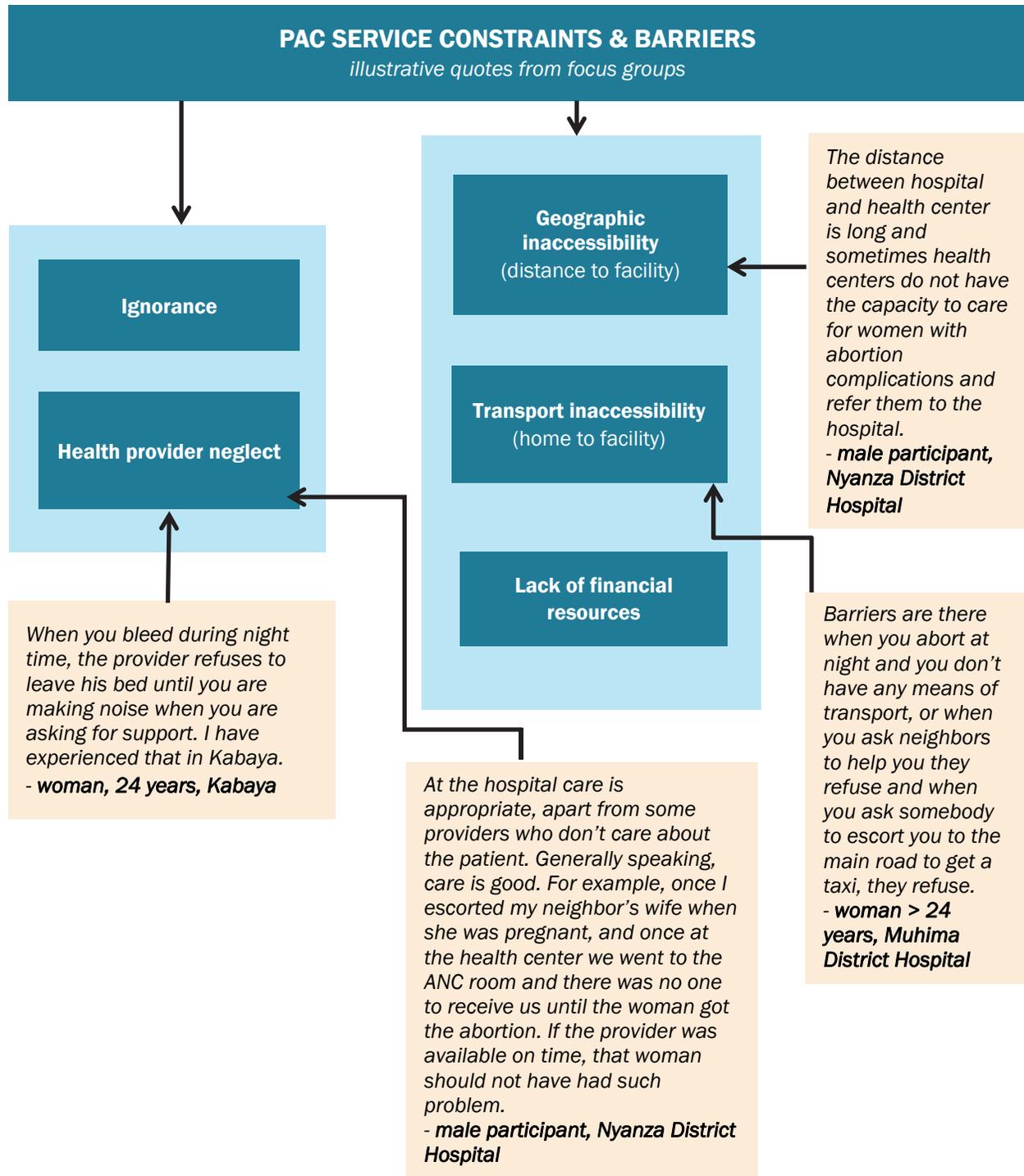
Figure 8.1 Community views of PAC services



### 8.3 CONSTRAINTS TO ACCESSING PAC SERVICES

The focus group discussions also highlighted the constraints to access to PAC services. Figure 8.2 shows the barriers and constraints identified by focus group participants.

Figure 8.2 Constraints to accessing PAC services



## Skill Level of Providers Offering PAC Services

Most participants mentioned that there was a difference in skills when comparing community staff (CHWs and traditional birth attendants) and health facility providers involved in PAC services. According to the participants, health facility providers are more competent than community staff in care for postabortion cases. CHWs and TBAs do not provide PAC; however, they are the link to the services and play a role in referring women. Referral facilities vary in the services available, with district hospitals providing the most comprehensive PAC services, and health centers offering more limited provider training and equipment.

Some providers from both hospitals and health centers were viewed as neglecting pregnant women or receiving them only after a long waiting time, especially in hospitals. At the community level, some participants said that even if CHWs are knowledgeable of health issues, they don't have enough skills to take care of postabortion cases. But they recognized that CHWs play an important role in escorting women to health facilities and advocating for appropriate care. Participants said "traditional doctors" do not have skills to take care of postabortion cases, but people seek help from them because they are near the community.

A participant from Muhima Hospital:

*Medical services receive you and give you the required treatment. When I aborted, it was midnight. I arrived at the hospital, and they received me and gave me appropriate care.*

A participant from Nyanza Hospital:

*Nowadays, we have CHWs who sensitize the community to avoid going to traditional doctors because they do not have required knowledge and skills. In health centers or hospitals, we have competent providers.*

## Key Players Implementing PAC Services

Participants reported that when an abortion occurs, community members go either to a CHW, to seek support, or to a provider at a health facility (health center or hospital).

According to a participant (> 24 years) from Kibungo District Hospital:

*Go to the community health worker because they escort women after abortion to the hospital.*

Another participant (> 24 years) from Nyanza District Hospital:

*We have at the community level the CHWs who advise to go to the health center. They even escort patients, especially pregnant women in labor.*

Participants who preferred to go to a health facility did so because they recognized that it is the best place for the management of abortion complications. They emphasized hospitals in particular because hospitals could identify the causes of abortion.

One participant (> 24 years) from Nyanza District Hospital said:

*Health centers have appropriate materials to take care of women after abortion while at home you may die. They have drugs, equipment, and qualified staff to take care of you.*

Several groups confirmed that women sometimes choose to go to traditional doctors because they are more accessible financially (for those who cannot afford health services when there is an abortion) and geographically (being the nearest place in the community). The following participant statements illustrate this point.

A woman (< 24 years) from Muhima District Hospital said:

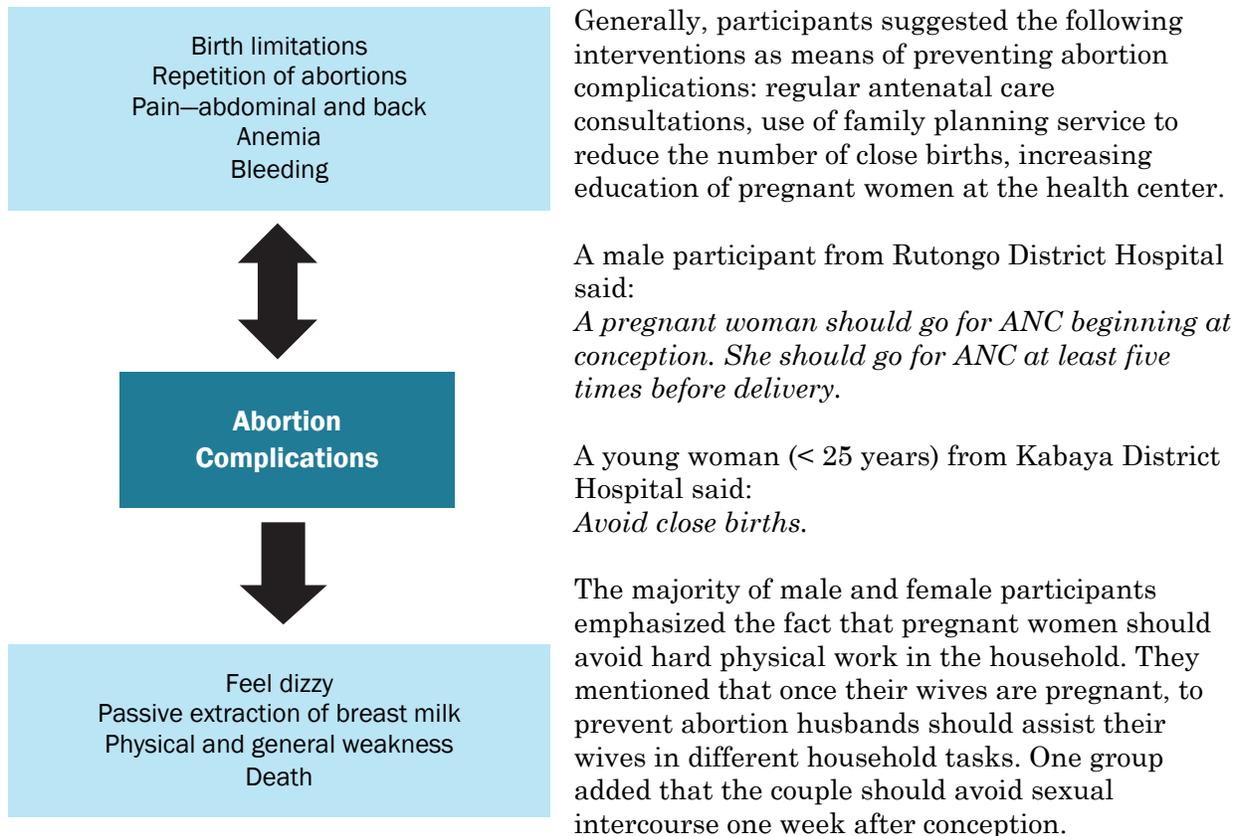
*When I was pregnant, I had abortion signs, and a lady came and prepared traditional medicine for me. I took that treatment and once at the hospital, they told me that my baby was no longer*

alive. I started to ask myself if that was due to the traditional treatment taken or if the labor had started.

A male participant from Kibungo District Hospital said:  
*Sometimes in our community we take traditional treatment because we live far from the health center. Sometimes pregnant women prefer to go for traditional treatment because traditional healers are near families.*

Figure 8.3 shows some of the issues perceived as related to abortion complications:

**Figure 8.3 Factors related to abortion complications**



A woman (> 24 years) from Muhima District Hospital said:  
*When I aborted, I didn't know that I was pregnant, I went to the hospital, and they told me I had an abortion. I asked them the cause of that abortion and they told me that it was because I had worked hard. I told them that I did nothing. I suspected that it was due to my last cesarean delivery. They advised me to avoid working hard once pregnant. Therefore, any pregnant woman should avoid too much physical work.*

## 9. Recommendations

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Based on the USAID PAC model (see Appendix 3) and our findings of gaps at different levels of PAC service provision, the assessment team has made the following recommendations for improving PAC services in Rwanda:

### *Recommendations for the Ministry of Health*

- Reorganize services at facilities so that all three components of the PAC model can be used, including emergency treatment, immediate provision of FP counseling and RH linkages, and community empowerment through community awareness and mobilization.
- In order for health facilities to be ready to provide services, the following actions need to be taken:
  - Develop/update national guidelines for PAC services.
  - Transition from D&C to MVA for first-trimester PAC cases.
  - Ensure the availability of PAC kits and ensure commodity and supplies security.
  - Ensure the availability of a wide mix of contraceptive methods.
  - Strengthen health care providers' capacity to offer comprehensive PAC services.
  - Improve community awareness of PAC and strengthen linkages with health facilities.
  - Develop behavior change communication/information, education, and communication materials.
- Improve the monitoring and evaluation (M&E) of PAC activities by identifying indicators for PAC services, and integrate tools for data collection and decision-making into the existing M&E system.
- Develop and disseminate job aids and training packages on the key PAC practices.
- Promote task shifting for PAC services to increase access to care.
- Conduct supportive supervision at all levels of care and enable a sound quality improvement approach or system to ensure that PAC services are having a positive impact on the population.

### *Recommendations for Health Facilities*

- Prepare sites for emergency care by ensuring the availability of space or rooms for PAC activities, including surgical procedures. This may require renovation or building of new infrastructure.
- Build capacity for providers to offer the full model of PAC services through on-the-job training, mentorship, and group training.
- Ensure that PAC services are covered in the antenatal care package; include postabortion and postpartum family planning as free services.

### *Recommendations for the Community Health Worker in Charge*

- Sensitize community members, including leaders and households, to the importance of PAC services.
- Orient CHWs on the dangers of postabortion complications and enable an effective, practical system of referral of suspected cases.

- Develop and disseminate BCC activities and IEC messages about PAC and target them to women and families.
- Improve data collection and monitoring of PAC activities in communities.

#### *Recommendations for Rwanda Development Partners*

- Prioritize PAC as a key area of support to the government of Rwanda.
- Support the procurement of equipment such as MVA kits and supplies.
- Support strengthening the capacity of health care providers and the community members.
- Mobilize more resources to support PAC programs at all levels.

## 10. Conclusion

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This report provides an assessment of the current status of PAC services in Rwanda. While some PAC services are available, the practices are not adequate to provide quality care in postabortion management for the majority of clients. To address this gap, it is necessary to provide support for improved quality of PAC services and to ensure that supplies are available and ready for emergencies. The subject of postabortion care itself is still a taboo for many providers, who may not make a distinction between inducing abortion and performing postabortion care for abortion complications. This confusion caused some providers to decline to participate in this assessment, despite the research team's efforts to sensitize providers to this distinction.

At both the facility and the community level, the sensitivity of the subject matter made finding clients difficult. Simulation of the procedure created another constraint, due not only to the lack of trained providers but also to the lack of simulation equipment such as Zoë models and MVA kits.

Our discussions with providers at facilities indicated that PAC services currently offered in Rwanda are limited and consist mainly of the removal of retained products of conception by D&C. While our conclusions are not generalizable due to the sampling procedure used for data collection, there was strong anecdotal evidence to support the limitations around current PAC services. Most of the essential supplies for PAC are available, but MVA kits are needed. Infection prevention equipment and prevention practices need to be strengthened. Health facilities need to be adequately equipped to manage quality PAC services.

At the community level, the focus groups elicited many different perceptions about postabortion care. There is a need to strengthen community health workers (e.g., ASMs) in the quick recognition of danger signs of postabortion complications. Awareness of danger signs should be integrated into the linkage between families, CHWs, and health facilities to ensure prompt attention and interventions in order to avert maternal deaths. Community members seem to have a good understanding of abortion consequences and where to seek services, but they lack key life-saving messages on what to do to prevent complications from abortions. CHWs/ASMs are playing an important role as the first contact for clients who are seeking PAC services, but they are not well trained to educate women on how to prevent complications.

Barriers to accessing quality PAC also persist at the facility level. The barriers include the following:

- Lack of knowledge of PAC services
- Exposure to high surgical risks with D&C as main mode of uterine evacuation used by physicians
- Lack of postabortion FP services
- Poor adherence to infection prevention practices
- Poor interpersonal communication with clients
- Lack of adequate and functional PAC equipment and supplies

Evidence-based solutions to these barriers have been well documented and recommended for implementation in Rwanda. Comprehensive PAC services play a major role in averting preventable maternal deaths, a priority for both the government and its partners in health programming.

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# Appendix 1: Three Core Components of Postabortion Care

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## Appendix 2: Postabortion Care Clinical Assessment Checklists

Find the provider who is responsible for postabortion care. If he or she is a new provider, obtain signed consent. Once you have the provider’s consent, move on to obtain the signed consent of the client.

Before observing the consultation, make sure you have the consent and/or assent of the provider and client, and that the provider understands that you are not a specialist/expert to ask for advice during the consultation.

Note on the checklist whether the provider performs the steps/tasks listed. (Some of the steps/tasks may happen before others, or they may be performed simultaneously by several service providers).

**Type of observation (circle one):** Simulation    Client

**Type of consultation (circle one):** MVA                  D&C                  FP

CHECKLIST FOR POSTABORTION CARE OBSERVATION	
MVA CLINICAL SKILLS	
Time at start of MVA section (24-hour clock): _____	
STEP/TASK	Result
<b>Getting Ready Before MVA</b>	
1. Greets woman respectfully and with kindness	
2. Ensures the necessary privacy and confidentiality	
3. Tells patient what is going to be done and encourages her to ask questions	
4. Tells patient she may feel discomfort during some of the steps and the provider will tell her in advance	
5. Assesses need for pain management medication	
6. Checks that patient has thoroughly washed her perineal area and has recently emptied her bladder	
7. Determines that all required sterile or high-level-disinfected instruments and cannulae are present	
8. Checks MVA syringe and charges it (establishes vacuum)	
9. Puts on apron, washes hands thoroughly with soap and water, and dries with clean, dry cloth, or air dries	
10. Puts new examination or sterile or high-level-disinfected gloves on both hands using aseptic “no touch” technique	
11. Arranges sterile or high-level-disinfected instruments on sterile tray or in high-level-disinfected container using aseptic “no touch” technique	
<b>MVA Procedure</b>	
12. Explains each step of the procedure prior to performing it	
13. Asks the patient throughout the procedure if she is experiencing any pain	
14. After performing each step or task, waits for patient to prepare for the next one	
15. Moves slowly, without jerky or quick motions	

CHECKLIST FOR POSTABORTION CARE OBSERVATION	
MVA CLINICAL SKILLS	
16. Asks the patient to take deep breaths in and out during the procedure if there is some pain	
17. Uses instruments with confidence	
18. Avoids saying things such as “this won’t hurt,” if it will hurt, or “I’m almost done,” if it isn’t true	
19. Talks with the patient throughout the procedure	
20. Performs bimanual pelvic examination to confirm uterine size, position, and degree of cervical dilation	
21. Checks the vagina and cervix for tissue fragments and removes them	
22. Applies antiseptic solution two times to the cervix (particularly the os) and vagina	
23. Puts tenaculum or vulsellum forceps on anterior or posterior lip of cervix	
24. Correctly administers paracervical block (if necessary)	
25. Dilates the cervix (if needed)	
26. While holding the cervix steady, inserts the cannula gently through the cervix into the uterine cavity.	
27. Attaches the prepared syringe to the cannula by holding the end of the cannula in one hand and the syringe in the other	
28. Evacuates contents of the uterus by rotating the cannula and syringe and moving the cannula gently and slowly back and forth within the uterine cavity	
29. Inspects tissue removed from uterus for quantity and presence of products of conception and to ensure complete evacuation	
30. When the signs of a complete procedure are present, withdraws the cannula and MVA syringe and removes forceps or tenaculum and speculum (the speculum should not be removed until the cervix has been observed)	
31. Performs bimanual examination to check size and firmness of uterus	
32. Inserts speculum and checks for bleeding	
33. If uterus is still soft or if bleeding persists, gives Ergometrine and/or repeats some of steps 4–11 where necessary	
<b>Post-MVA Tasks</b>	
34. Before removing gloves, disposes of waste materials and soaks instruments and MVA items in 0.5% chlorine solution for 10 minutes to decontaminate them	
35. Immerses both gloved hands in 0.5% chlorine solution and removes gloves by turning them inside out: <ul style="list-style-type: none"> <li>- If disposing of gloves, places them in a leakproof container or plastic bag</li> <li>- If reusing surgical gloves, submerges them in 0.5% chlorine solution for 10 minutes to decontaminate them</li> </ul>	
36. Washes hands thoroughly with soap and water and dries with clean, dry cloth, or air dries	
37. Checks for amount of bleeding and whether cramping has decreased at least once before discharge	
38. Instructs patient regarding postabortion care (e.g., when patient should return to clinic)	
39. Discusses reproductive goals and, as appropriate, provides family planning	
Time at end of MVA section (24-hour clock): _____	

Comments:

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If same health worker provides postabortion family planning counseling, then continue to observe. Otherwise, the observation ends (skip to FP section).

CHECKLIST FOR POSTABORTION CARE OBSERVATION	
D&C CLINICAL SKILLS	
Time at start of D&C section (24-hour clock): _____	
STEP/TASK	Result
<b>D&amp;C Procedure</b>	
1. Explains each step of the procedure prior to performing it (if not using general anesthesia)	
2. Asks the patient throughout the procedure if she is experiencing any pain (if not using general anesthesia)	
3. Waits after performing each step or task for patient to prepare for the next one (if not using general anesthesia)	
4. Moves slowly, without jerky or quick motions	
5. Asks the patient to take deep breaths in and out during the procedure if there is some pain (if not using general anesthesia)	
6. Uses instruments with confidence	
7. Avoids saying things such as “this won’t hurt,” if it will hurt, or “I’m almost done,” if it’s not true (if not using general anesthesia).	
8. Talks with the patient throughout the procedure (if not using general anesthesia)	
9. Performs bimanual pelvic examination to confirm uterine size, position, and degree of cervical dilation	
10. Checks the vagina and cervix for tissue fragments and removes them	
11. Applies antiseptic solution two times to the cervix (particularly the os) and vagina	
12. Gives sedatives, analgesic, or anesthetic	
13. If using local anesthetic, waits 3–5 mins. before beginning	
14. Puts tenaculum or vulsellum forceps on anterior or posterior lip of cervix	
15. Dilates the cervix (if needed)	
16. Measures the uterine cavity	
17. While holding the cervix steady, inserts the curette gently through the cervix into the uterine cavity	
18. Scrapes carefully to evacuate contents of the uterus, moving the curette gently and slowly back and forth within the uterine cavity	
19. Inspects tissue removed from uterus for quantity and presence of POC and to assure complete evacuation	
20. When the signs of a complete procedure are present, withdraws the curette and removes forceps or tenaculum and speculum (the speculum should not be removed till the cervix has been observed so that step 14 will not be necessary)	
21. Performs bimanual examination to check size and firmness of uterus	
22. Inserts speculum and checks for bleeding (not necessary if 13 above is done as suggested)	
23. If uterus is still soft or if bleeding persists, gives uterotonic (type? dose? route?) and/or repeats some of steps 4–11 where necessary	
24. Initiates antibiotherapy	
<b>Post-D&amp;C Tasks</b>	
25. Before removing gloves, disposes of waste materials and soaks instruments in 0.5% chlorine solution for 10 minutes to decontaminate them	

CHECKLIST FOR POSTABORTION CARE OBSERVATION	
D&C CLINICAL SKILLS	
26. Immerses both gloved hands in 0.5% chlorine solution and removes gloves by turning them inside out: <ul style="list-style-type: none"> <li>- If disposing of gloves, places them in a leakproof container or plastic bag</li> <li>- If reusing surgical gloves, submerges them in 0.5% chlorine solution for 10 minutes to decontaminate them</li> </ul>	
27. Washes hands thoroughly with soap and water and dries them with clean, dry cloth, or air dries	
28. Checks for amount of bleeding and whether cramping has decreased at least once before discharge	
29. Instructs patient regarding postabortion care (e.g., when patient should return to clinic)	
30. Discusses reproductive goals and, as appropriate, provides family planning	
Time at end of D&C section (24-hour clock): _____	

Comments:

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If the same health worker provides postabortion family planning counseling, continue to observe him or her. Otherwise, the observation ends (skip to FP section).

Checklist for Postabortion Care Observation	
FAMILY PLANNING COUNSELING SKILLS	
Time at start of FP section (24-hour clock): _____	
STEP/TASK	Result
<b>Initial Interview</b>	
1. Greets woman respectfully and with kindness	
2. Assesses whether counseling is appropriate at this time (if not, arranges for her to be counseled at another time)	
3. Ensures visual privacy	
4. Ensures auditory privacy	
5. Obtains biographic information (name, address, etc.).	
6. Asks if she was using contraception before she became pregnant. If she was, finds out if she: <ul style="list-style-type: none"> <li>- Used the method correctly</li> <li>- Discontinued use</li> <li>- Had any trouble using the method</li> <li>- Has any concerns about the method</li> </ul>	
7. Provides general information about family planning	
8. Explores any attitudes or religious beliefs that either favor or rule out one or more methods	
9. Gives the woman information about the contraceptive choices available and the risks and benefits of each: <ul style="list-style-type: none"> <li>- Shows where and how each is used</li> <li>- Explains how the method works and its effectiveness</li> <li>- Explains possible side effects and other health problems</li> <li>- Explains the common side effects</li> </ul>	
10. Discusses patient's needs, concerns, and fears in a thorough and sympathetic manner	
11. Helps patient begin to choose an appropriate method	
<b>Patient Screening</b>	
12. Screens patient carefully to make sure there is no medical condition that would be a problem for specific contraceptive methods (completes Patient Screening Checklist)	
13. Explains potential side effects of the various contraceptive methods and makes sure that each is fully understood	
14. Performs further evaluation (physical examination), if indicated (non-medical counselors must refer patient for further evaluation)	
15. Discusses what to do if the patient experiences any side effects or problems from contraceptive methods	
16. Provides follow-up visit instructions	
17. Assures patient she can return to the same clinic at any time to receive advice or medical attention	
18. Asks the patient to repeat instructions	
19. Answers patient's questions	
20. Refers client to other health care facility for FP services if they are not available at the treatment center	
21. Fixes an appointment for the client to revisit the health facility	
22. Fixes an appointment with the client for follow-up visit at her home, if applicable	
Time at end of FP section (24-hour clock): _____	

Comments:

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**Reproductive Health Linkages**

Ask the provider: Are the services for these other RH needs available onsite and/or by referral?

SERVICES/REFERRAL	YES	NO
Cervical cancer screening		
RTIs, STIs, HIV/AIDS		
Adolescent RH services		
Infertility screening and treatment		
Gender violence		

# Appendix 3: PAC Community Assessment: Focus Group Guide

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Thank you for being available to participate in this focus group discussion today. I'm {person name and title}. I'll be your moderator for this session; {person name and title} will be taking notes. Before starting the discussion, I'll ask each of you to introduce yourself.

The purpose of this group discussion session is to provide the MOH with information that will help improve its PAC policy and guidelines, as well as quality PAC services.

## Process

The principles of this session are that, as participants, you are free to express yourself, and there are no right or wrong answers. Everyone's thoughts are important to share. The entire session will be tape-recorded to ensure that all thoughts are captured and considered in writing up our report, which won't include your names. In addition, the information you'll If you have any concerns or opinions you'd feel more comfortable discussing with someone else, please let us know. We'll be delighted to refer you to the right person.

## Ground Rules

In order to ensure that the notes tape recordings are clear, it is important you speak up and talk **one** at a time.

For any question asked, there is no single answer or type of answers. Instead we are expecting that a wide range of thoughts and ideas are brought up. Also, feel free to give your opinion if you don't agree with a given idea or if you agree with an idea and want to reinforce it. Whenever you want to express yourself, please do. The flow is always open.

We believe that the opinions we'll be collecting from you through this group discussion session will surely help improve PAC services.

## Guide for Questions

- Introduction:
  - Do you think that availability of quality PAC Services is a serious issue?
  - Why or why not?
- Going more in-depth:
  - How are the complications of abortions handled in your community?
  - How do you think that the prevention of complications of abortions can be conducted and improved?
- Closing:
  - What expectations do you have about PAC services?

## Appendix 4: Consent Form

### Consent from the Stakeholder

Find stakeholders in the catchment area of randomly selected health centers, such as local government officials, community opinions leaders, and grassroots organization leaders. Read the following to the respondents:

Hello. I'm [Name of the Interviewer]. I am representing the Ministry of Health of Rwanda and its partner Jhpiego. We are conducting a study to assess the quality of postabortion care services. This is part of a broader study which has the goal of finding ways to improve delivery services, particularly for women and newborn babies. Understanding health needs pertaining to postabortion care in your community is a very important first step. For that reason, we are conducting interviews with key community leaders. The opinions that will emerge from all of our interviews will be considered in the study report as well as in designing policies, guidelines, strategies, and programs to improve service delivery, particularly postabortion care. However, the interviews will be strictly confidential and opinions expressed will not be tied to the names of interviewees. The interview will take about 40 minutes. We hope that you could avail yourself for the interview. Do you agree? Is this a good time for you? If not, could we schedule another time for the interview?

---

Interviewee's signature  
(Indicates respondent's willingness to participate)

Date

RECORD WHETHER PERMISSION WAS RECEIVED FROM THE HEALTH WORKER.  
YES /  / NO /  → END

## Appendix 5: Community Interview Guide

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1. Let's start with you telling me about yourself and your organization.

- How long have you been living/working in this community?
- What is your mission?
- What are the issues you work on?
- How do you define your organization/community?

### Health Issues

2. What are the major health issues you see in your community?

- Health may include things that are not strictly medical, like gender violence prevention, AIDS education, etc.
- Access to health facilities is important for many reasons: financial, geographical, and cultural. Are there also others?

3. What do you know about complications of pregnancy in your community?

- What are the sources of knowledge: reports from health facilities, MOH, district, CHWs, and others stakeholders?

4. Are complications of abortions a health issue in your community?

- Why? / Why not?
- Is there information from CHWs, health facilities, and others?
- Are maternal death audits conducted in the community?

5. Where do people go for care in case of complications of abortions? Why?

- Community healers, CHWs, etc.?
- Health facilities?
- Accessibility?
- Quality of care?

6. How is your community organized to deal with emergency care needs?

- Is emergency transportation available?
- How is it organized?
- Is it affordable? Who pays?
- What needs to be improved?

7. How is the community-based health insurance (CBHI or *mutuelle de santé*) role for emergency care (i.e., postabortion care in your community)?
  - What is the coverage?
  - Is emergency care included? Is access improved?
  - How is the community coping with people without *CBHI*?

#### Advocacy and Behavior Change Communication (A&BCC)

8. What types of community groups are available for A&BCC?
9. How are the A&BCC groups working in your community?
  - Working in the same/different health issues?
  - Working separately? Together?
  - Who drives their agenda?
  - Who coordinates? Who supports?
10. What are A&BCC groups' motivations?
  - Are they volunteers?
  - Are there themes they are mostly involved with? Why?
  - Are there barriers to more involvement in emergency care such as postabortion care?
  - Do they have needed human resources, knowledge, and skills?
11. Do you have additional thoughts you want to share about improving postabortion care?
12. Are there other stakeholders in your community you would recommend that we interview?

#### *Close:*

Thank you very much for your time and the invaluable contribution you made through this interview. If you wish to be updated on the outcome of this study, we'll certainly be delighted to keep you informed of when it will be completed. Again, thanks a lot!

## Appendix 6: Hospitals Visited, Number of Observations, and Hospital Status, by District

DISTRICT	HOSPITAL NAME	NUMBER OF OBSERVATIONS	HOSPITAL STATUS
Bugesera	Nyamata DH	1	Faith-based
Burera	Butaro DH	1	Public
Gatsibo	Ngarama DH	1	Public
	Kiziguro DH	1	Faith-based
Huye	Kabutare DH	4	Public
	CHUB	1	Teaching
Kamonyi	Remera-Rukoma DH	1	Faith-based
Karongi	Mugonero DH	1	Faith-based
Kayonza	Gahini DH	2	Faith-based
	Rwinkwavu DH	1	Faith-based
Kicukiro	Kanombe MH	1	Military
Kirehe	Kirehe DH	1	Faith-based
Muhanga	Kabgayi DH	2	Faith-based
Ngoma	Kibungo DH	1	Public
Ngororero	Kabaya DH	1	Public
	Muhororo DH	1	Public
Nyagatare	Nyagatare	1	Public
Nyamasheke	Kibogora DH	1	Faith-based
	Bushenge DH	1	Public
Nyarugenge	Muhima DH	1	Public
	CHK/CHUK	2	Teaching
Nyaruguru	Munini DH	1	Public
Rubavu	Gisenyi DH	1	Public
Ruhango	Gitwe DH	1	Faith-based
Rusizi	Mibilizi DH	1	Faith-based
	Gihundwe DH	1	Public
Rwamangan	Rwamagana DH	2	Public
<b>Total</b>	<b>27</b>	<b>34</b>	

NUMBER OF HOSPITALS, BY HOSPITAL STATUS				
Faith-based	Teaching	Public	Military	Total
11	2	13	1	27

## Appendix 7: Rwanda Health Worker Interview and PAC Knowledge Test

NO.	QUESTIONS	CODING	
Please answer the following questions to the best of your knowledge. Most of the questions I will be asking you will require multiple responses from you. Please provide all responses that come to mind. I will probe sometimes to help you remember some more information.			
705	What are the components of PAC?  CIRCLE ALL CORRECT ANSWERS	Emergency treatment Family planning counseling and service delivery Provision of selected reproductive health services (STI evaluation and treatment; and HIV counseling and/or referral for HIV testing) Strengthening community capacity Awareness and community mobilization Don't know	A B C  D E Z
706	Please tell me what the treatment methods of incomplete abortion are.  CIRCLE ALL CORRECT ANSWERS	Vacuum aspiration Electric aspiration Manual vacuum aspiration Sharp curettage/Dilatation and Curettage (D&C) Other _____ (specify) Don't know	A B C D X Z
707	What are the elements of postabortion emergency resuscitation/preparation for referral and transport?  CIRCLE ALL CORRECT ANSWERS	Management of the airway and respiration Control of bleeding Intravenous fluid replacement Control of pain Other _____ (specify) Don't know	A B C D X Z
708	Please tell me when return to fertility is following a first trimester abortion.	2-3 weeks after the abortion 30 days after the abortion Following the first menstruation after the abortion All of the above None of the above Other _____ (specify) Don't know	A B C D E X Z
Please tell me whether the following statements are True or False.			
709	MVA is not as effective as sharp curettage for treatment of first trimester incomplete abortion.	TRUE FALSE	1 2
710	Women undergoing MVA procedures had significantly decreased bleeding seven days post evacuation than women undergoing sharp curettage.	TRUE FALSE	1 2
711	A woman's chosen family planning method may be provided immediately following treatment of incomplete abortion or before discharge.	TRUE FALSE	1 2
712	What are aspects that must be taken into account to provide information on contraception for postabortion patients?  CIRCLE ALL CORRECT ANSWERS	Reproductive risk Effectiveness of method Patient preference for a particular method Availability of a wide range of contraceptive options Other _____ (specify) Don't know	A B C D X Z



