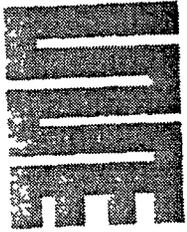
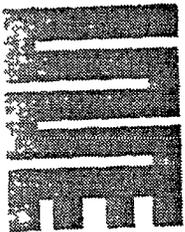


PN-ACF-363



# Training Non-Physician Providers to Improve Postabortion Care

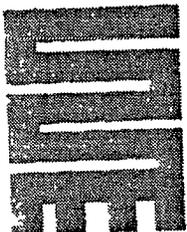
Baseline Assessment of  
Postabortion Care Services  
in Four Districts of Eastern Region, Ghana



January 1997



Ghanaian Ministry of Health  
Ghana Registered Midwives Association (GRMA)  
IPAS



The patterns portrayed on the front cover of this report are Adinkra symbols, seen throughout Ghana in daily life. *Duafe (Dua Afe)*, the wooden comb, is a symbol of feminine consideration, patience, prudence and fondness. *Ɔsrane Ne Nsormma*, the moon and stars, represents faithfulness, fondness and benevolence. The moon is often regarded as a symbol of femininity, and the moon and stars symbolize the interdependence of women and men in marriage. *Nkyinkyinmie*, twistings, stands for toughness, selfless devotion to services, and an ability to withstand difficulties. Each of these symbols work to represent the courage and commitment of those working to improve women's health throughout Ghana.

(Source *A F Quarcoo 1994 The Language of Adinkra Symbols Legon, Ghana Sebewie Ventures*)

PN-ACF-363

*MotherCare Ghana  
Operations Research Project*

# Training Non-Physician Providers to Improve Postabortion Care

Baseline Assessment of  
Postabortion Care Services  
in Four Districts of Eastern Region, Ghana

January 1997

Collaborating organizations for the  
MotherCare Ghana project include

Ghanaian Ministry of Health

Ghana Registered Midwives Association (GRMA)

IPAS



REPUBLIC OF GHANA



IPAS

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## **Executive Summary**

Unsafe abortion contributes significantly to the morbidity and mortality of reproductive age women throughout the world. Globally 13 to 14 percent of all pregnancy-related deaths (75,000 to 80,000 women) are attributable to unsafe abortion while in some countries this figure rises to as high as 60 percent. Women living in Southern countries, particularly throughout Africa, experience the greatest risk of death as well as short and long-term morbidity from unsafe abortion.

In Ghana, as in many countries, unsafe abortion contributes to high rates of maternal mortality and morbidity. Hospital-based studies report that about 22 percent of all maternal deaths are the result of unsafe abortion. The true number is certainly higher, as many women die outside health institutions.

The Ministry of Health of Ghana recognizes that unsafe abortion takes a serious toll on the health of Ghanaian women and, in its work to facilitate women's access to health care, has identified trained midwives as appropriate providers of postabortion care. To test this assumption, the Ministry of Health and the Ghana Registered Midwives Association (GRMA) and IPAS, a non-profit reproductive health organization, are working together on the MotherCare operations research project to train midwives and district hospital physicians in postabortion care. It is expected that midwives working in public health centres and private maternity homes will facilitate women's access to the emergency treatment of incomplete abortion thereby saving lives. Overall, the objectives of this project are to document the need for as well as benefits and challenges of decentralizing the treatment of incomplete abortion to community-level facilities and to demonstrate whether postabortion care provided by trained midwives actually does improve women's access to emergency care, is safe and feasible, and is acceptable to women, health care providers, community leaders, and policymakers. The project will produce a model that can be replicated in other districts throughout Ghana for building capacity at the community level to provide postabortion care services.

This report presents findings from the baseline assessment of postabortion care services in four districts of Eastern Region: East Akim and Kwahu South, which serve as the training districts in the project, and Manya Krobo and Brim South, which serve as the control districts. In-depth interviews were conducted in all four districts with women treated in district hospitals for incomplete abortion, physicians and midwives working in these same hospitals, midwives based in public health centres and private maternity homes, midwife supervisors, policymakers, and community leaders. In general, widespread support exists for the training of midwives in postabortion care.

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**I. INTRODUCTION**

Each year an estimated 585,000 women worldwide die from complications related to pregnancy and childbirth, most importantly unsafe abortion, haemorrhage, obstructed labour, sepsis, and hypertensive disorders<sup>1</sup> Ninety-nine percent of the women are from Southern or developing countries, a full 40 percent reside in African countries Millions more suffer the short and long-term consequences of such complications, including infection, infertility, and chronic pain

Unsafe abortion contributes significantly to the morbidity and mortality of reproductive age women throughout the world Globally 13 to 14 percent of all pregnancy-related deaths (75,000 to 80,000

Africa	1 in 150
Asia	1 in 250
Latin America	1 in 800
Northern countries	1 in 3700

women) are attributable to unsafe abortion while in some countries this figure rises to as high as 60 percent<sup>4</sup> Women living in Southern countries,

particularly throughout Africa, experience the greatest risk of death as well as short and long-term morbidity from unsafe abortion

*Unsafe abortion refers to “ the termination of pregnancy performed or treated by untrained or unskilled persons... Regardless of whether an abortion is spontaneous or induced, subsequent events and the care received determine whether the abortion is safe or unsafe.”<sup>3</sup>*

The provision of safe, comprehensive, and easily accessible emergency care services which women can turn to when complications arise is one key action which must be taken throughout the world so that women’s lives will be saved<sup>5</sup> This was formally recognised at the international level in 1987 with the launching of the Safe Motherhood Initiative whereby organisations and governments, with the support of the World Health Organization (WHO), the United Nations Fund for Population Activities (UNFPA), and the World Bank, made the commitment to halve maternal mortality by the year 2000 To date, however, few regional Safe Motherhood programmes have implemented specific activities to directly address the problem of unsafe abortion

**SAFE MOTHERHOOD IN GHANA**

In March 1995, the Ministry of Health (MOH) of Ghana began to implement its own Safe Motherhood Programme in an effort to reduce the unacceptably high level of maternal mortality in the country Ministry estimates place the maternal mortality ratio at 214 per 100,000 live births and the World Health Organization documents that the lifetime risk of maternal death for Ghanaian women is 1 in 18<sup>6</sup>

Ghanaian law regarding abortion allows registered medical practitioners in government hospitals or certified private hospitals and clinics to legally induce an abortion under a variety of circumstances including rape, incest, or risk to the physical or mental health of a

woman. Despite these provisions, many women throughout the country continue to suffer the consequences of unsafely induced abortion.<sup>7</sup> Hospital-based studies report that about 22 percent of all maternal deaths are the result of unsafe abortion. The true figure is certainly higher, as many women die outside health institutions.<sup>8</sup> A 1994 communique issued by the Ghana Medical Association (GMA) states that unsafe abortions are “presently the single highest contributor to our high maternal mortality rate.”<sup>9</sup>

Studies have documented a variety of techniques used to induce including insertion of a stem of the milk bush plant (‘nkrandua’) into the cervix, douching with ‘acheampong’ leaves ground with onion and laundry blue so that the mixture enters the uterus, herbal enemas, and sharp instruments, twigs, and sticks left in the cervix for many days.<sup>10</sup> Reasons for utilizing such dangerous practices may include financial barriers, social stigma, and fear experienced by women with an unwanted pregnancy. Many women are uninformed about the legal provisions available under Ghanaian law and so turn to the only options readily available to them. The general lack of providers who offer safe services also contributes to women’s use of harmful practices.

Given the prevailing situation, the Ministry of Health of Ghana recognizes unsafe abortion as one of the primary causes of pregnancy-related mortality in the country and highlights it as a major public health issue which needs to be addressed in order to improve the lives of women. Thus, the provision of postabortion care has been included by the Ministry in its 1996 National Reproductive Health Service Policy and Standards as a key component of reproductive health services which must be made more accessible to women throughout the country. In addition, Ghana’s National Safe Motherhood Task Force guidelines and activities aim to integrate postabortion care into reproductive health training and services.

*Postabortion care is an approach to reducing mortality and morbidity from unsafe abortion that involves strengthening the capacity of health institutions to offer and sustain:*

- ◊ *Emergency treatment services for incomplete abortion and other accompanying complications,*
- ◊ *Effective postabortion family planning services;*
- ◊ *Links between emergency abortion treatment services and comprehensive reproductive health care services.<sup>11</sup>*

## II. THE MOTHERCARE GHANA OPERATIONS RESEARCH PROJECT

*“Abortion care should be made available as close to people’s homes as possible and should be carried out by the least specialized personnel who are adequately trained to perform it safely and well”<sup>12</sup>*

Work undertaken by the Prevention of Maternal Mortality (PMM) Network throughout West Africa has shown that when a woman is experiencing an obstetric complication, prompt emergency care is key to her survival<sup>13</sup> In Ghana, where approximately 70 percent of the population reside in rural areas, access to emergency treatment of abortion complications has been difficult given that hospital-based physicians have been the sole providers of such care. Figures from the GMA indicate that in 1996, of the 1,713 physicians practicing in Ghana, 51 percent work in facilities located in Accra, approximately 42 percent are in urban-based teaching hospitals and medical schools throughout the country. In contrast, only 2 percent of all physicians are stationed in health centres located closer to women’s homes<sup>14</sup>

In its groundbreaking policy initiative, the Ministry of Health of Ghana has identified midwives, who currently provide a wide array of obstetric services to women, as appropriate providers of postabortion care. The operations research project, “Training Non-Physician Providers to Improve Postabortion Care,” aims to demonstrate the safety, feasibility, and acceptability of this new policy as it equips midwives with skills which they can use to treat, rather than refer, women who come to them seeking care for abortion complications.

Over 6,000 midwives practice throughout Ghana, the majority located in health centres or private maternity homes in or near the communities where most women reside. They are often community members themselves and are trusted by women to provide them with gynaecological and obstetric care. Thus it is expected that by training midwives in postabortion care, women will be less likely to

- 1) delay their decision to seek care,
- 2) experience delays in actually reaching a facility, and
- 3) experience yet another delay in receiving care upon arrival at the facility<sup>15</sup>

Few health programs provide training to or even authorize midwives to manage a whole range of obstetric complications, even when shown that they can do so safely. In a recent article authored by Hord and Delano, they note that, “A summary of safe motherhood strategies (by Otsea 1992) adopted by countries throughout the world consistently mentions unsafe abortion as a major contributor to maternal death and illness, but only a

few countries have targeted training for midwives in abortion care as an appropriate intervention for addressing this problem directly”<sup>16</sup> Ghana is one of those few countries

The Ghanaian Ministry of Health has defined concrete actions to be taken over the coming years. These include

- To directly manage women with abortion complications at all levels within the health system. Appropriate actions include stabilization, referral, uterine evacuation in cases of incomplete abortion, and treatment of other complications depending on the skills and training of the provider,
- To refer women with abortion complications to higher levels of the health system when necessary,
  - To prevent unwanted pregnancies through the provision of family planning counselling and services, including after treatment for abortion complications,
  - To educate women about the signs and symptoms of abortion complications so that they will seek appropriate care,
  - To create general public awareness about the dangers of unsafe abortion

Trained midwives, along with nurses, physicians, and obstetricians, have been identified as key providers of such services at sub-district, district, regional, and national levels throughout the country. Manual vacuum aspiration (MVA) is indicated as the most appropriate technique to be used in the treatment of incomplete abortion, particularly given that it is safer than and equally as effective as sharp curettage (SC) during the first trimester.<sup>17</sup> In general, MVA is a low-cost technology which does not depend on the availability of electricity or operating room facilities, thus making it accessible to providers working in lower-resource, primary care settings. In fact, the WHO has recommended that vacuum aspiration be available at this very level within the health care system as part of comprehensive care to reduce maternal mortality.<sup>18,19</sup>

### *OBJECTIVES OF THE OPERATIONS RESEARCH PROJECT*

The objectives of this operations research project are to

Document the need for as well as the benefits and challenges of decentralizing the treatment of incomplete abortion to subdistrict-level facilities where many trained midwives practice,

Demonstrate whether postabortion care provided by trained midwives in such subdistrict-level facilities

- a) improves access to emergency life-saving care,
- b) is safe and feasible within the Ghanaian context given the existing health infrastructure,
- c) is acceptable to women, health care providers, community leaders and policymakers, and

- d) **improves linkages** between the emergency treatment of incomplete abortion and the provision of postabortion family planning This includes the development of systematic referral and counter-referral of patients between midwives and the district hospital providers

The key components of this operations research project include

**Baseline assessment of existing postabortion care services in four districts of Eastern Region**

2 Training Districts East Akim and Kwahu South  
2 Control Districts Manya Krobo and Birim South

*January - June 1996*



**Intensive training of midwives and doctors in comprehensive postabortion care services**

Including the treatment of incomplete abortion with MVA in East Akim and Kwahu South Training is accompanied by general improvements in service delivery The majority of midwives selected to participate in this project currently practice in private maternity homes or community health centres, while some work at the district hospitals The physicians trained are working at the district hospitals where most complicated incomplete abortion cases are referred for treatment

*Four trainings held in May, July, August 1996*

**Community education** efforts began during this phase of the project in order to increase general awareness about how to avoid unsafe abortion, the signs and symptoms of abortion complications, as well as where to go for help when such complications arise



**Post-training assessment and evaluation of services**

*February - June 1997*

Analysis will include comparisons between training and control districts as well as pre- and post-intervention results

Overall, the project will produce a model for building capacity at the community/sub-district level to provide postabortion care services and for more effectively linking community-based services to services at other levels within the health care system

### III. BASELINE ASSESSMENT OF POSTABORTION CARE SERVICES

#### *METHODS*

The baseline assessment of existing postabortion care services was carried out in four districts of Eastern Region

#### Training Districts

*East Akim  
Kwahu South*

#### Control Districts

*Manya Krobo  
Birim South*

All of these districts have comparable health service resources and are generally similar in terms of their religious, ethnic, and economic profiles. Given that we did not want training information and skills to be easily transmitted to providers working in the control districts during the course of this project, the lack of a common border was one important criterion for the selection of training and control districts.

Six interviewers, all health workers who have extensive experience at both the district and sub-district levels, participated in a one-week interviewer training course in January 1996. During this time all of the research instruments described below were reviewed, role-played, pre-tested in Central Hospital and Pat's Maternity Home in Koforidua, and finalized prior to the start of the field period. Interviews were then conducted in both the training and control districts during February through June 1996.

#### *Description of Interviews Conducted*

##### ◆ **Women treated for incomplete abortion in district hospitals**

For two consecutive weeks data collectors conducted structured interviews with virtually all women who arrived at the six district hospitals for treatment of incomplete abortion (See Table 1). Women were interviewed immediately prior to their departure from the hospital after receiving all available services and after recovering from any anaesthesia which might have been administered. The goals of conducting this interview were to

- Generate a demographic profile of women seeking services from the district hospitals,
- Chart their pattern of care-seeking, including documentation of whether they sought care from a midwife before arriving at the hospital,
- Document their perceptions of access to services,
- Document their evaluation of services received at the hospital,
- Document their use of family planning methods prior to their abortion and their experience with postabortion family planning services at the hospital

It should be emphasized that the women interviewed are those who actually arrived at the district hospital for services. Yet research conducted across numerous countries has shown that many women, particularly those living in rural areas, may never reach a health facility for care. Reasons for this inability to access care include their low status within the family and community, distance from the district hospital, availability and cost of transport, and inadequacy of the referral system<sup>20</sup>. Ghanaian women are no exception to this pattern. Thus, women included in this sample represent a specific subgroup of all women experiencing incomplete abortion in the study districts.

Given the difficulties of entering communities within a short timeframe to interview a representative sample of women who have experienced abortion complications, we opted instead to speak directly with women who were being treated for such complications in first referral district hospitals<sup>21</sup>.

**Table 1 Number of Interviews with Women Treated in District Hospitals**

<i>Training Districts and Hospitals</i>	
<b>Kwahu South</b>	
Kwahu Government Hospital at Atibie	5
<b>East Akim</b>	
Tafo Government Hospital	3
Kibi Government Hospital	4
<i>Control Districts and Hospitals</i>	
<b>Birim South</b>	
Akim Oda Government Hospital	9
<b>Manya Krobo</b>	
Akuse Government Hospital	4
Atua Government Hospital	4
<b>TOTAL</b>	<b>29</b>

Interviews were conducted with a total of 29 women in six district hospitals in Eastern Region. This is close to the expected sample size of 35 for a 2-week period of time<sup>22</sup>.

Table 2 illustrates the overall profile of the women included in the sample as well as a profile of women in both the training and control districts. Approximately one-quarter of all women interviewed were between the ages of 16 - 19, while the mean age was 26 or 27. A higher percentage of women in the control districts have not had any schooling while a greater proportion of women in the training districts have attained post-secondary education. More than one-half of all women earn income, mostly from farming and trading. In the control districts, almost one-half of all women interviewed are single while a significantly smaller percentage of women in the training districts are single. Religious affiliation and ethnicity vary slightly between the training and control districts, with most women practicing some type of Christianity and identifying themselves as Akan. In the control districts, 47 percent of all women stated that the pregnancy/abortion for which she is currently hospitalized was her first. Note that this is approximately the same percentage

of women who are single in this sub-sample. Almost one-quarter of all women who had been pregnant at a previous time have had at least one other abortion or stillbirth.

**Table 2. Profile of Women Treated for Incomplete Abortion at District Hospitals: Total Sample, Women in East Akim and Kwahu South (training), and Women in Manya Krobo and Birim South (control)**

	% Total Sample (N=29)	% Training Districts (n=12)	% Control Districts (n=17)
<b>AGE</b>			
<i>Mean</i>	16-40 years 26 years	16-38 years 26 years	16-38 years 27 years
<i>Age 16-19 (%)</i>	24	25	24
<b>EDUCATION</b>			
<i>No schooling</i>	17	8	24
<i>Primary</i>	17	8	24
<i>Middle</i>	38	58	24
<i>Secondary</i>	17	8	24
<i>Secondary+</i>	11	17	4
<b>EARN INCOME</b>	65	75	59
<b>MARITAL STATUS</b>			
<i>Married/Co-hab</i>	59	66	53
<i>Single</i>	35	17	47
<i>Divorced/widowed</i>	6	16	—
<b>ETHNICITY</b>			
<i>Akan</i>	59	75	47
<i>Ga-Adangbe</i>	17	—	29
<i>Ewe</i>	14	8	18
<i>Other</i>	10	17	6
<b>RELIGION</b>			
<i>Catholic</i>	21	17	24
<i>Protestant</i>	21	8	29
<i>Pentecostal</i>	52	67	41
<i>Muslim</i>	3	8	—
<i>None</i>	3	—	6
<b>PREGNANCY LOSS</b>			
<i>Current abortion was first pregnancy</i>	34	17	47
<i>Had at least one other stillbirth or abortion (spont. or induced)</i>	24	25	24

◆ **Physicians based in District Hospitals**

Physicians who regularly *manage* women who arrive with abortion complications were interviewed at each of the six district hospitals in Kwahu South, East Akim, Birim South, and Manya Krobo (See Table 3) Structured interviews were conducted in order to

- Document current postabortion care practices at these first referral-level sites,
  - Assess the attitudes of physicians regarding the training of midwives in postabortion care,
  - Document the roles physicians regard as suitable for midwives in the provision of postabortion care,
  - Document current postabortion family planning services available at the district hospitals, and
  - Document physicians' evaluation of patient-provider interactions
- 'Manage' refers to any of the following performing or assisting in the uterine evacuation procedure, counselling about the procedure and general treatment, nursing care, and family planning services*

**Table 3 Number of Interviews with Physicians in District Hospitals**

<i>Training Districts and Hospitals</i>	
<b>Kwahu South</b>	
Kwahu Government Hospital at Atubie	2
<b>East Akim</b>	
Tafo Government Hospital	2
Kibi Government Hospital	2
<i>Control Districts and Hospitals</i>	
<b>Birim South</b>	
Akim Oda Government Hospital	2
<b>Manya Krobo</b>	
Akuse Government Hospital	2
Atua Government Hospital	1
<b>TOTAL</b>	<b>11</b>

Interviews were conducted with a total of 11 physicians in six district hospitals in Eastern Region All identified themselves as general practitioners

Physicians included in this sample who manage women experiencing incomplete abortion have been practicing from 5 to 16 years, with an average of 11 years of practice Time spent working at the district hospital where they were interviewed ranged from 3 months to 11 years, with a mean of 5 years Most (91 percent) of all physicians interviewed were male The sub-samples of training and control districts were comparable in terms of years of practice and years spent in the district hospital

◆ **Midwives based in District Hospitals**

While many midwives practice at the sub-district or community level, working in private maternity homes and/or public health centres, many are also employed in the district hospitals where some *manage* women who arrive with abortion complications. Structured interviews with these midwives were conducted in order to

- Document their current roles in postabortion care practices at the hospital,
- Document their views toward the training of midwives in postabortion care, including uterine evacuation using MVA, and
- Document the roles they regard as suitable for midwives in the provision of postabortion care

**Table 4 Number of Interviews with Midwives in District Hospitals**

<i>Training Districts and Hospitals</i>	
<b>Kwahu South</b>	
Kwahu Government Hospital at Atobie	5
<b>East Akim</b>	
Tafo Government Hospital	3
Kibi Government Hospital	4
<i>Control Districts and Hospitals</i>	
<b>Birim South</b>	
Akim Oda Government Hospital	11
<b>Manya Krobo</b>	
Akuse Government Hospital	4
Atua Government Hospital	4
<b>TOTAL</b>	<b>31</b>

Interviews were conducted with a total of 31 midwives in six district hospitals in Eastern Region

A profile of the hospital-based midwives is presented in Table 6 along with a descriptive profile of midwives based in public health centres and private maternity homes

◆ **Midwives based in Private Maternity Homes and Public Health Centres**

Structured interviews with midwives working at both of these sub-district/community level locales in the four study districts were conducted. The overall goals were to

- Document the current postabortion care practices which these midwives provide, particularly regarding the treatment, stabilization, and referral of women who arrive with incomplete abortion as well as other abortion complications,
- Document their views toward the training of midwives in postabortion care, including uterine evacuation using MVA, and
- Document the roles they regard as suitable for midwives in the provision of postabortion care

A list of midwives to be included in this study was generated and approved by the Ministry of Health and the GRMA prior to interviewing Midwives in East Akim and Kwahu South were subsequently trained in postabortion care during May, July and August, 1996 by two in-country IPAS trainers It is expected that the midwives in Manya Krobo and Birim South who participated in the study will be trained after the close of this operations research project

**Table 5. Number of Interviews with Midwives in Public Health Centres and Private Maternity Homes**

<i>Training Districts and Hospitals</i>	
<b>Kwahu South</b>	12
<b>East Akim</b>	17
<i>Control Districts and Hospitals</i>	
<b>Birim South</b>	10
<b>Manya Krobo</b>	11
<b>TOTAL</b>	50

Interviews were conducted with a total of 50 midwives practicing at the sub-district/community level in four districts in Eastern Region

**Table 6 Profile of Midwives Based in District Hospitals and Midwives Based in Public Health Centres/Private Maternity Homes (Sub-district Level)**

	<b>Mws in District Hospital (n=31)</b>	<b>Mws at Sub-district Level (n=50)</b>
<i>MEAN AGE</i>	47 years	50 years
<i>NUMBER OF YEARS PRACTICING AS A MIDWIFE</i> <i>Mean</i>	1-34 years 18 years	2-42 years 18 years
<i>MIDWIFERY TRAINING NUMBER OF MONTHS</i> <i>Mean</i>	12-30 months 24 months	12-36 months 24 months
<i>TRAINING IN LIFE-SAVING SKILLS (LSS)* (% YES)</i>	35	42
<i>TRAINING IN FAMILY PLANNING COUNSELLING AND METHOD PROVISION (% YES)</i> <i>IUD INSERTION/REMOVAL</i>	15 50	81 40
<i>MEMBER OF GRMA (% YES)</i>	16	70

\* Life-Saving Skills (LSS) A program developed by the American College of Nurse Midwives (ACNM) to train midwives in emergency obstetric care including manual removal of placenta, vacuum extraction, and partograph In Ghana this program is offered to both private and public midwives

Midwives practicing in district hospitals and those in private maternity homes and public health centres have comparable years of experience as well as years of midwifery training. However, significantly more midwives working at the subdistrict level have received training in family planning counselling and method provision (80% vs 15%), perhaps in part due to their membership in the GRMA which has sponsored such sessions over the years.

Tables 7 and 8 present the same profile information for midwives but compare the similarities and differences between those located in the training vs control districts for midwives based in district hospitals and those based in public health centres and private maternity homes.

**Table 7 Profile of Midwives Based in District Hospitals in East Akim and Kwahu South (Training) and Manya Krobo and Birim South (Control)**

	Mws in Training Districts (n=10)	Mws in Control Districts (n= 21)
<i>MEAN AGE</i>	43 years	45 years
<i>NUMBER OF YEARS PRACTICING AS A MIDWIFE</i> <i>Mean</i>	9-30 years 20 years	1-36 years 16 years
<i>MIDWIFERY TRAINING</i> <i>NUMBER OF MONTHS</i> <i>Mean</i>	12-30 months 24 months	12-36 months 24 months
<i>TRAINING IN LIFE-SAVING SKILLS (LSS) (% YES)</i>	63	22
<i>TRAINING IN FAMILY PLANNING COUNSELLING AND METHOD PROVISION (% YES)</i> <i>IUD INSERTION/REMOVAL</i>	12 0	17 67
<i>MEMBER OF GRMA (% YES)</i>	43	6

Midwives based in district hospitals in both the training and control districts are comparable in terms of age, mean number of years practicing as a midwife, their number of months of midwifery training as well as the percentage who have received family planning service training. Significantly more midwives in the sample from East Akim and Kwahu South have received LSS training than those working in Manya Krobo and Birim South. Almost one-half (43%) of all midwives based in the training districts are GRMA members while only 6 percent of those in the control districts belong to the organisation.

**Table 8 Profile of Midwives Based in Public Health Centres and Private Maternity Homes in East Akim and Kwahu South (Training) and Manya Krobo and Birim South (Control)**

	Mws in Training Districts (n=29)	Mws in Control Districts (n=21)
<i>MEAN AGE</i>	48 years	50 years
<i>NUMBER OF YEARS PRACTICING AS A MIDWIFE</i> <i>Mean</i>	2-42 years 16 years	9-30 years 20 years
<i>MIDWIFERY TRAINING NUMBER OF MONTHS</i> <i>Mean</i>	24-36 months 24 months	12-36 months 24 months
<i>TRAINING IN LIFE-SAVING SKILLS (LSS) (% YES)</i>	43	43
<i>TRAINING IN FAMILY PLANNING COUNSELLING AND METHOD PROVISION (% YES)</i> <i>IUD INSERTION/REMOVAL</i>	81 44	81 35
<i>MEMBER OF GRMA (% YES)</i>	78	58

Overall, midwives based at sub-district/ community-level facilities are comparable in the training and control districts. While 81 percent of all the midwives included in this sample have received training in family planning services, a greater proportion of midwives in the training districts as compared to those in the control districts can insert and remove IUDs. A greater percentage of midwives in East Akim and Kwahu South than in Manya Krobo and Birim South are members of GRMA.

#### ◆ Midwife Supervisors

Structured interviews were conducted with the following supervisors

- 1) public sector supervisors who are the Senior and Principal Nursing Officers (SNO and PNO) in charges,
- 2) GRMA supervisors working in the four study districts, and
- 3) the Deputy Director for Nursing Services (DDNS) for the district hospitals in Eastern Region

A total of 13 supervisors working in both the training and control districts were interviewed in order to

- Document the kinds of supervisory activities they undertake,
- Document their views toward the training of midwives in postabortion care, including uterine evacuation using MVA, and
- Document the roles they regard as suitable for midwives in the provision of postabortion care

Of all the supervisors interviewed, 1 works as the Deputy Director of Nursing Services (DDNS), 3 are Principal Nursing Officers (PNOs), 4 hold the post of Senior Nursing Officers (SNOs), and 5 work as GRMA supervisors. All have been supervising midwives on average for 11 years, with a range of 2 to 23 years

#### ◆ **Policymakers**

Nine semi-structured tape recorded interviews were conducted with nine policymakers in Accra and Eastern Region in an effort to better understand existing policy support as well as barriers to decentralizing postabortion care. All interviews were later transcribed for review and general coding.

Policymakers included a representative from each of the following organisations/institutions

- ◇ Ghana Medical Association (GMA)
- ◇ Christian Health Association of Ghana (CHAG)
- ◇ Ghana Registered Midwives Association (GRMA)
- ◇ Ghana Registered Nurses Association (GRNA)
- ◇ Association of Obstetricians and Gynaecologists
- ◇ Nurses and Midwives Council
- ◇ Ministry of Health, Headquarters
- ◇ Human Resources Development Unit, Ministry of Health
- ◇ Police Hospital in Eastern Region

#### ◆ **Community Leaders**

In-depth, semi-structured interviews were conducted with 20 community leaders in the four study districts. Five interviews were conducted in each district, most often in the language of that community, all were tape recorded and later transcribed. Leaders were identified after nurses in each of the main district hospitals were asked to list individuals whose opinions were highly regarded in health matters. In each district at least one religious leader and one traditional or civil leader was interviewed. Each list also contained at least one woman who is a leader in the area surrounding the district hospitals.

The objectives of conducting interviews with community leaders were to

- Identify the extent to which abortion complications are considered to be a problem among opinion leaders who are not health workers,
- Determine the different options that community leaders would consider in efforts to reduce and prevent the incidence of unsafe abortion,
- Document their views toward the training of midwives in postabortion care, including uterine evacuation using MVA,
- Document the roles they regard as suitable for midwives in the provision of postabortion care, and
- Collect and document local terminologies for describing abortion, incomplete abortion, and other abortion-related complications in order to design appropriate community education materials

Table 9 illustrates the general profile of all community leaders included in the sample. Note that almost one-half (45%) of all leaders interviewed were women.

**Table 9 General Profile of Selected Community Leaders in East Akim, Kwahu South, Manya Krobo, and Birim South**

	<b>% Community Leaders (n=20)</b>
<b>SEX</b>	
<i>Male</i>	55
<i>Female</i>	45
<b>AGE</b>	
<i>Mean</i>	38-74 years 56 years
<b>LENGTH OF RESIDENCE IN COMMUNITY (YRS)</b>	
<i>Mean</i>	2.5-74 years 22 years
<b>OCCUPATION</b>	
<i>Civil/public servant</i>	20
<i>Religious leader</i>	20
<i>Trader</i>	15
<i>Traditional leader</i>	15
<i>Farmer</i>	15
<i>Pensioner</i>	15
<b>RELIGION</b>	
<i>Christian</i>	90
<i>Methodist</i>	39
<i>Presbyterian</i>	39
<i>Anglican</i>	11
<i>Assemblies of God</i>	11
<i>Muslim</i>	10

## BASELINE RESEARCH FINDINGS

### ◆ Women treated for incomplete abortion in district hospitals (N=29)

#### Uterine Size in Number of Weeks LMP

6 to 12	71%
13 to 14	11%
18 to 20	18%

Women arrived at the hospital with a uterine size of 6 to 20 weeks, with a mean of 12 weeks. According to their hospital records, approximately one-third (31%) of the women had no other complications accompanying the incomplete abortion while over one-half (52%) experienced haemorrhaging. The remaining women (5 cases) showed signs of shock, sepsis or other complications when they arrived at the hospital for treatment of

incomplete abortion

When asked what health problems made them seek treatment at the hospital, 79 percent of the women indicated vaginal bleeding and 76 percent identified abdominal cramping and pain as the main reasons for seeking care. Less frequently mentioned were fever/chills (7%) and a foul-smelling discharge (10%). Almost one-half (48%) of the women began to experience these problems at least 5 days before arriving to the hospital, indicating a delay in seeking care.

*Vaginal bleeding and abdominal cramping and pain were mentioned most frequently as reasons for seeking care*

While we did not ask a direct question about whether the abortion had been induced or spontaneous (having little confidence in the validity of the response to such a question), the interviewers did ask women what they thought might have been the cause of their health problems. Almost one-half (45%) of the women noted that they did not know, for those who did give some reason, the cause most frequently mentioned was "stress due to hard work". Only a few women stated that they had inserted herbs to induce the abortion and one woman stated that her problems were caused by trauma due to assault.

#### *Patterns of Care-Seeking, Access, Referral to Services*

Before arriving at the hospital, 45 percent of all women interviewed sought help from someone else (discussed below), while 55 percent did not. Those who came directly to the hospital indicated either that there was no other provider available or that they were facing an emergency situation.

*Approximately 45 percent of all women sought care before coming to the district hospital while 55 percent came directly to the hospital for services*

As expected, all but 1 (who came from Accra) of the patients came from the district hospital catchment area. That is, women are using the hospital facilities located within the district in which they live rather than crossing district boundaries. In general, the incomplete abortion patients who were interviewed live within easy access to the hospitals, thus this sample of women does not represent those who live in areas further from the hospitals where access to transportation is more difficult. A full 83 percent of all

the women in the sample reached the hospital by bus or rented vehicle which, in general, cost 1,000-5,000 cedis (\$US 0.62 - 3.13 at the time of the study). Sixty-two percent stated that it took them one hour or less to reach the hospital and 81 percent said that access was very or somewhat easy.

### *Seeking Care before Arriving at District Hospital*

Forty-five percent of all women interviewed did seek help from someone before coming to the hospital for care. Of these women, 38 percent sought help from a traditional birth attendant and/or 38 percent from a midwife (since some women listed multiple sources of help). When asked, "Who provided you with the most important help?", 38 percent of women stated 'midwives', while only 15 percent noted 'TBAs'.

*Midwives and Traditional Birth Attendants (TBAs) were most commonly consulted for help before women arrived to the hospital for care.*

In general, the person from whom women sought help before travelling to the hospital was someone located within their community (69 percent of cases), and thus for most women travel time to the facility was less than one hour (75 percent of cases). In most cases this provider either gave the woman some sort of medication or herbal preparation or referred the woman to the district hospital. Overall, 54 percent of all women who did not go directly to the hospital were told to go to that hospital for further help but only 25 percent of the women were actually accompanied to the hospital by that caregiver.

### *Seeking Care Directly at the District Hospital*

Of the 55 percent of women who went directly to the hospital for care, most noted that theirs was an emergency situation or that, in general, they preferred to see a doctor. Of these women, 62 percent stated that there was a midwife in their community but most (70 percent) would not have gone to see her even if she could have treated her problem. Their comments reflect their awareness that midwives currently cannot treat abortion complications. One woman's statement reflects her concern with anonymity, preferring to seek care at the hospital where it is less likely that someone will recognize her.

- *I don't think that she would be able to take good care of me, all of the facilities needed are there at the hospital,*
  - *I don't want anyone to see me,*
  - *I don't think I can receive the kind of services I'm getting here from the midwife,*
  - *I want to be seen by a doctor so that when there is any problem I can be well looked after, In the course of treating my problem if there arises any complication she would refer me to the hospital so it is better to come to the hospital where I am sure to have the best,*
- By all means I will be referred to the hospital*

The remaining 30 percent of women who sought care directly from the hospital noted that would have preferred to stay with the midwife for care if she had been able to treat their problem

- . *It would be nearer and I know that if I don't receive immediate help I may die,*
- . *I could die on the way, travelling to the hospital,*  
*If she is trained to take care of me I would prefer her because she is closer to us,*
- . *Because she lives in the same community with me, I wouldn't have paid money on transport, my relatives would have been around to assist me,*  
*Cost is reduced, especially for transport and my people would be around me,*  
*Because I would be seen earlier considering how I was suffering and I would not pay money on transport,*  
*Because it happened in the night and she would have been nearer and she could save me from dying*

#### *Care Received at the Hospital*

Sixty-two percent of the women interviewed stated that they waited only a 'short time' to be examined after they entered the hospital, 28 percent noted a 'long time' and 10 percent stated it was 'just right, like I expected'. Waiting time ranged from 2 minutes to 12 hours, with a mean time of 79 minutes, according to women's estimates. Waiting time from examination to procedure was longer than from entry to examination, with a mean waiting time of 2 hours and 40 minutes according to women's estimates.

#### **The Examination**

Prior to the procedure 83 percent were examined by a doctor and 17 percent by a nurse/midwife. Only 52 percent of women received any information about her health or physical condition at the time of this initial examination and only 28 percent were told what would happen during the evacuation procedure. In addition, 97 percent noted that they were not given the opportunity to ask questions about the procedure.

In 65 percent of all cases the person examining the woman was a male health worker. When asked whether she preferred to be examined by a male or female provider, 79 percent stated that it did not matter while 17 percent stated she would have preferred a female since

- . *I would not feel shy about my condition,*
- . *Because she is also a woman like me,*
- . *I feel shy of male doctors*

Only one woman said that she preferred being examined by a male provider.

In most cases, numerous people are present in the room while a woman is being examined. Ninety percent of all women noted that in addition to the person examining them someone else was also present in the examination room, in most cases this was another health worker. Eighty-five percent of all women said that they "did not feel anything" about this

### **The Uterine Evacuation Procedure**

According to women's hospital records, 23 were treated with SC and four with MVA, in two cases the technique used was not recorded on the interview schedule. All procedures were performed by physicians. In three of the four MVA cases the woman was not under general anaesthesia during the procedure while only four of 23 women treated with SC were not fully sedated during the procedure.

In the seven cases in which women were fully awake, only one noted that the doctor explained to her what was happening during the procedure, in five cases the doctor did not talk with her during the procedure to make her feel comfortable. All of the women who were awake for the procedure felt pain, three noting that it was 'extreme,' two stating that it was 'moderate' and two stating it was 'minimal.' For three of the women the pain was 'more than what she expected,' three noted it was 'less' and one noted it was 'what she expected.' Four of the seven women received medication to ease the pain.

### **Information Received by Women**

In general, women do not receive vital information regarding their health care subsequent to being treated at the district hospitals. After the procedure was over and before leaving the hospital, 93 percent of all women interviewed stated that they were not told of any specific problems for which they might have to return to the health facility. Such potential problems include heavy bleeding or bleeding lasting more than two weeks, fever, chills, abdominal cramping lasting for more than three days, severe or increased pain, and fainting. Eighty-six percent of all women were not informed before leaving the hospital that they are capable of becoming pregnant as soon as resuming sexual relations. When asked how soon after losing a pregnancy a woman can once again become pregnant, women stated anywhere from 1 to 52 weeks. This misinformation, combined with the lack of postabortion family planning services puts them at risk for yet another pregnancy.

### **Postabortion Family Planning**

In general postabortion family planning services are not being offered at any of the district hospitals included in this study. When asked whether anyone on the hospital staff had spoken with her personally about family planning, 90 percent of all women in the sample stated 'no', 97 percent of all women in the sample were not told where to obtain family planning methods in her community, and no women interviewed actually chose a family planning method before leaving the hospital.

Nonetheless, 90 percent of all women thought that, in general, women who come to the hospital with abortion complications would like to *receive family planning information* before leaving the hospital, 93 percent thought that their partners should also *receive this information*. Eighty-three percent also noted that they thought that women with abortion complications would actually like to *receive a method* before leaving the hospital. The provision of family planning counselling and methods was the most frequently mentioned comment offered by women regarding ways to improve their hospital care.

### Overall Cost of Services to the Patient

On average, women paid 38,000 cedis (\$US23 75) for services at the hospital. Almost all (86 percent) were being assisted by someone, most often their partner (77 percent of cases). Seventy-five percent of all women noted that this amount was too much for them.

#### ◆ Physicians and midwives in district hospitals (N=42)

All of the providers stated that they manage incomplete abortion patients who seek care at the hospital, all but one midwife had seen at least one woman in the last six months. Seventy-nine percent had seen an incomplete abortion patient within one month of the interview.

Physicians and midwives generally play different roles in the care of incomplete abortion patients (see Table 10).

**Table 10 Roles Played by Physicians and Midwives in District Hospitals in the Management of Incomplete Abortion Patients**

<i>Role</i>	<i>% Physicians (n=11)</i>	<i>% Midwives<sup>23</sup> (n=31)</i>
Initial Assessment/ examination of patient	91	74
Stabilization of patient	64	87
Counselling about procedure	9	40
Uterine evacuation	91	0
Post-procedure family planning counselling	36	20
Post-procedure provision of contraceptives	0	0

Midwives are more active than are physicians in counselling women about the uterine evacuation procedure, although still less than one-half provide this information to women. Uterine evacuation is currently conducted by physicians and almost one-half (40 percent) responded that they use SC for uterine evacuation while 50 percent noted that they use both SC and MVA. One provider also noted the practice of manual removal for evacuations. Of those who did not mention MVA as a method they use, all stated that they were at least familiar with MVA.

As highlighted in the interviews with women, few providers are engaged in postabortion contraceptive counselling and none actually provide women with a method prior to their departure from the hospital.

Providers indicated that when women arrive with complications in addition to incomplete abortion, they most often see haemorrhage, septicaemia, and localized infection (see Table 11). A significant proportion of providers also noted that women often arrive at the hospital with uterine perforation.

**Table 11. Complications Seen Most Often by Hospital Providers**

<i>Complication</i>	<i>Estimated Percentage of Cases</i>
Haemorrhage	90
Septicaemia	50
Localized infection	76
Uterine perforation	31
Cervical injury	19

*Potential Role of Midwives in Postabortion Care According to Physicians and Midwives in District Hospitals*

When asked which complications midwives in general, if trained, could safely treat, 69 percent of the providers interviewed noted haemorrhage and 50 percent noted localized infection. Thirty seven percent of the providers interviewed thought that midwives could safely treat septicaemia and only 12 percent noted that they could safely treat cervical injury. All of the providers agreed that midwives could not safely treat uterine perforation. In fact, haemorrhage, septicaemia, and localized infection are among the most common complications seen by midwives based in public health centres and private maternity homes (see discussion below).

Other roles that midwives, both in the hospitals and at the community level, can play in the treatment of women with abortion complications are numerous according to hospital-based providers. Table 12 illustrates the percent of hospital providers who agree that midwives in both locales can play the following roles.

**Table 12. Percent of Hospital-Based Providers (Physicians and Midwives) Who Agree that Midwives in Hospitals and in Community Facilities Can Safely Render the Indicated Service to Women Experiencing Incomplete Abortion.**

<i>Role</i>	<i>LOCATION OF MIDWIFE</i>	
	<i>Midwives in Hospitals</i>	<i>Midwives in Community</i>
IV infusion	38	19
Check vital signs	31	51
Stabilize women	25	44
Administer oxytocics	0	19
Resuscitation	19	0
First aid	0	25
Administer antibiotics	0	0
Assess patient	13	0
Administer pain killer	0	0
Refer to hospital	0	56
Evacuation of uterus	0	6

It is interesting to contrast the roles which hospital-based providers assess as suitable for midwives in the community to provide to women with the information in Table 13 (see next section) which outlines the services that community-based midwives already provide to women arriving at their maternity homes and clinics for care. Overall, midwives included in this study are already providing most of the services listed in Table 12, except uterine evacuation.

While few providers spontaneously named uterine evacuation as one role of community-based midwives, 67 percent responded "yes", that if community-based midwives were trained they too could safely perform the procedure. Comments such as the following illustrate why some providers feel that it would be important for midwives in public health centres and private maternity homes to provide this service to women. Overall, providers' comments reflect that training midwives in the community will facilitate women's access to services.

- *Some of the hospitals are quite far from the health centres and sometimes when transferring patients anything can happen,*
- *Some of the patients come from far away so if the midwife in her community can do it, it saves lives, money, and prevents complications,*
- *If the midwife is properly trained she can go ahead and do the evacuation,*
- *Patients will not have to travel to receive care and money will be saved on transport*

Some providers, on the other hand, indicated that community-based midwives should not perform uterine evacuations.

- *It takes a long time and a lot of work under supervision to prevent complications,*
- *It is not easy and they can perforate the uterus. They would not use an aseptic technique*

And some providers had reservations such as the following.

- *They can do it but with limitations. They must be under the supervision of a doctor and there must be sanctions [if they go beyond their limits]*

It should be noted that supervision and monitoring is a key component of the MotherCare project. Infection prevention protocols for the re-use of MVA instruments are highlighted in the training of all health personnel, including midwives involved in this project.

### **Postabortion Family Planning Services in the District Hospitals**

When asked whether the women who enter the hospital with incomplete abortions were using some form of family planning when they became pregnant, 38 percent of providers stated that "none are," 56 percent of providers stated that "some are", of these 78 percent said that women are using pills and injectables, 67 percent say that women are using condoms, and 57 percent state that women are using the IUD. All providers thought that

women became pregnant despite their use of a method because they were not using the method correctly, mostly due to lack of knowledge on the part of the woman, 44 percent of the providers also pointed to method failure as a reason for pregnancy

Interviews with women treated for incomplete abortion showed that only ten percent of women in the sample were using a method of family planning at the time they became pregnant. Of those who were not using a method, 25 percent noted that they wanted to become pregnant, 21 percent feared the side effects, 11 percent were not having sexual relations on a regular basis, and 11 percent faced opposition from their husbands, family, or religion.

Postabortion family planning, including counselling and provision of methods, is not a routine part of postabortion care in the hospitals included in this study. Thirty-seven percent of all providers stated that incomplete abortion patients always receive family planning counselling, 37 percent stated that these patients only sometimes receive such counselling, and 25 percent stated that patients did not receive family planning counselling during their stay at the hospital. A general review of hospital services indicates that women are not routinely receiving family planning counselling after treatment for abortion complications. Yet virtually all providers (94 percent) interviewed agreed that it is important that incomplete abortion patients receive family planning counselling, and all agreed that women are interested, at least sometimes, in receiving such counselling.

Actual provision of a method to women after treatment for abortion complications and before their discharge from the hospital is also rare. A full 88 percent of providers noted that this was not done in their site. Reasons cited include:

- *This is not part of the delivery setup in the ward (40%),*
- *Women actually want to get pregnant (13%), and*
- *Shortage of family planning staff (7%)*

Thirteen percent of hospital providers could not cite a reason why family planning methods were not routinely offered to women after being treated for incomplete abortion. The MotherCare project is working to improve postabortion care services within the hospitals such that counselling and methods will be available on ward where MVA services are provided. Shortage of family planning staff will be addressed as hospital-based midwives receive, as part of the overall postabortion care training, information on postabortion family planning services.

Overall, 63 percent of the hospital-based providers thought that methods should be offered, at least sometimes, while 37 percent thought that they should not be offered. Virtually all providers (94%) thought that women would be interested in receiving some method, at least sometimes.

Provision of postabortion family planning counselling and methods was cited by providers as one area in which midwives in both the hospitals and community-based sites could play

important roles. Follow-up family planning services was mentioned by one-quarter of all physicians and hospital-based midwives as a specific service which community-based midwives could provide to women following their treatment in the hospital.

◆ **Midwives in private maternity homes and public health centres (N=50)**

Twenty-three of the interviews were conducted in public health centres and 27 in private maternity homes, 80 percent of all these sites are located in rural areas. Ninety percent of the clinics and health centres are open to women seven days a week, while five clinics are open only five days. Forty-five of the 50 sites are accessible to women 24 hours a day.

*Community-Based Midwives Current Services to Women Experiencing Abortion Complications*

All of the midwives interviewed stated that during their years in practice, women with incomplete abortions have come to them for care.

Sixty-two percent of the midwives have cared for women with incomplete abortion within the last 6 months. Forty-five percent noted that women arrive to their homes/clinics in stable condition, while 50 percent noted that women arrive in both stable and critical condition, only 5 percent (1 midwife) stated that women arrive in critical condition.

*Care was defined as any or all of the following medical treatment, uterine evacuation, referral, accompaniment, transport, and general advice.*

Midwives see women experiencing a variety of abortion complications, most commonly haemorrhage (90%), localized infection (60%), and septicaemia (30%). Cervical injury and uterine perforation are rarely seen by community-based midwives, suggesting that women experiencing these complications are traveling directly to the hospitals for care (Note Table 11 above).

Midwives take various courses of action with women who arrive at their facilities seeking care, including performing pelvic exams, diagnosing the stage of abortion, and generally stabilizing and referring women to other health facilities for uterine evacuation.

**Safety and Efficiency of Services: Necessary Infrastructural Support for Actions**

The safety of services provided by community-based midwives to women experiencing abortion complications is one key focus of the MotherCare project. Given that this is not a clinical study and we are not able to record changes in complication rates, we use “infrastructural support” as one indicator of whether a midwife can safely provide services. Table 13 outlines a variety of actions which midwives currently take with women who arrive at their clinics and maternity homes with abortion complications. The percentage of midwives who currently have the infrastructural support necessary to provide such care is also indicated. In general, community-based midwives seem to be well-equipped for providing services. Subsequent to their training and certification in

postabortion care, midwives received MVA kits, including syringe and cannulae, which they previously did not have in stock

**Table 13 Courses of Action Midwives Take with Women Who Come to Them with Abortion Complications and Infrastructural Support for Such Actions**

<i>Action Taken</i>	<i>Percentage of Midwives Who Have Taken Such Action</i>	<i>Notes on Infrastructural Support</i>
Perform a pelvic exam	44	64 percent have a strong light source, 68 percent have a speculum, 98 percent have examination gloves
Diagnose stage of abortion	66	-----
Perform haematocrit/haemoglobin testing	42	90 percent regularly have a hematocrit testing system
Provide antibiotics	72	46-58 percent regularly have amoxicillin and ampicillin.
Administer IV fluids	60	74 percent regularly have IV infusion equipment, 86 percent regularly have IV infusion fluids
Administer oxytocics	70	70-90 percent regularly have oxytocin, as well as ergometrine in tablet and injectable form
Administer pain meds	82	6-10 percent regularly have pethidine IM and pentasozine (Sosegon)
Administer anxiolytics	Not asked	74-88 percent regularly have diazepam oral and IM as well as promethazine
Evacuate uterus	2	40 percent have a tenaculum, 68 percent have a speculum.
Refer to another provider	86	-----
Arrange transport to referral centre	66	-----
Provide transport to referral facility	10	-----
Accompany woman to referral facility	46	-----

### Stabilization and Referral

When asked how care for women with incomplete abortion would be affected if midwives like themselves were trained to better stabilize and refer women, 80 percent noted that

women would receive more prompt care, 80 percent stated that further complications would be avoided and 60 percent said that transportation costs for women would be reduced. Only 12 percent stated that women would then receive follow-up care. In general, midwives emphasized that women's lives would be saved.

Forty seven of the 50 midwives (94%) are interested in receiving training in stabilization and referral of incomplete abortion patients.

All midwives agreed that if they were trained to better stabilize and refer women with incomplete abortion and its complications that these women would seek care directly from the midwives more often than they now do. Reasons include:

- *Patients feel more comfortable with the midwives,*
- *Some people are shy to confide in people they are not familiar with, the midwife lives in their community and therefore the patients will confide in her,*
- *Transportation costs will be reduced. The inconvenience of leaving family and travelling out will be reduced,*
- *Some people prefer midwives to the big hospitals, they feel more at home,*
- *We are very free with them so they will come to us,*
- *They would be encouraged to know that now midwives can help,*
- *She will be capable of providing all of the services and she is nearer [to where women live]. People will have more trust in the midwife since they already know her,*
- *Confidentiality is assured, and*
- *Because they [women] know you [the midwife] better and can easily tell you their problems*

Most midwives could think of no barriers which would impede them from receiving training in stabilization and referral of incomplete abortion patients. A few mentioned that doctors themselves might actually create barriers since they may think that midwives are taking their patients from them.

### **Uterine Evacuation in Cases of Incomplete Abortion**

If midwives were actually trained to perform uterine evacuations in cases of incomplete abortion unaccompanied by other complications, 78 percent of the midwives noted that women's lives would be saved. Seventy percent thought that women would receive care more promptly and 70 percent thought that further complications would be avoided. Other positive effects included, saving women time and money since transportation costs and overall costs of care would be lower.

On the negative side, 50 percent thought that some midwives will use the MVA equipment to actually induce abortion, and 52 percent noted that some will not recognize their limits and will attempt to evacuate complicated cases. Other negative effects included the possibilities for actually adding complications. Specifically mentioned were infection and uterine perforation.

Again, all of the midwives concurred that if midwives like themselves were trained to perform uterine evacuations in cases of incomplete abortion then women would come to their clinics and homes more often for care. Their reasons mirrored those outlined above as they note

- *Patients prefer going to the nearest centre than travelling,*
- *There is privacy and the cost would be less,*
- *It will save time and transport costs,*
- *They will know that she is competent and lives will be saved,*
- *Treatment would be given promptly,*
- *They are familiar with the midwife and it's convenient for the client,*
- *Service will be more accessible and affordable,*
- *Because she is nearer they will have trust in her and it will be economically better,*
- *Some people prefer the midwife to a big hospital because midwives have time for them, and*
- *They [women] would now know that the government has given permission for them [midwives] to do it [uterine evacuations for incomplete abortion] so they would come*

Forty-six of the 50 midwives (92%) are interested in receiving MVA training, although only 58 percent had ever heard of MVA even after being shown a photo of the kit. Seventy-five percent thought that there would be no barriers to such a training while 10 percent noted that doctors will not be happy and may put obstacles in the way, another 5 percent cited possible financial/resource constraints.

### Family Planning Services Offered by Midwives

Ninety-four percent of the midwives interviewed provide family planning counselling and 68 percent actually provide methods to their clients. This is not limited to women with incomplete abortion. A breakdown of counselling and method provision by type of method is provided in Table 14.

**Table 14 Percentage of Community-Based Midwives Who Provide Counselling and Methods by Type of Contraceptive**

Method	% Counsel about Method	% Actually Provide Method
FOAMING TABLETS	89	94
CONDOMS	94	91
FAMPLAN/DEPO	94	97
IUD	83	44
COMBINED ORAL CONTRACEPTIVES	68	94
PROGESTIN-ONLY ORAL CONTRACEPTIVES	57	73
DIAPHRAGM	6	2
FEMALE STERILIZATION	51	--
MALE STERILIZATION	34	--
RHYTHM	26	--
WITHDRAWAL	13	6

## **Midwives' Role in Community Education**

After receiving training in stabilization, referral, and evacuation procedures, 70 percent of all midwives noted that giving talks and lectures in public places would be a good way to inform members of her community that women can and should seek care from her when they are experiencing incomplete abortion. Twenty-five percent thought that talks at clinics and outreach programmes would also be effective.

### **◆ Midwife Supervisors (N=13)**

Seventy-seven percent of all supervisors supervise 11 or more midwives, with 39 percent supervising 21 or more midwives. Twenty-three percent stated that they make daily supervisory visits while most others make quarterly (23%) or bi-annual (23%) visits to the midwives that they supervise.

All supervisors interviewed agreed that midwives currently provide antenatal, labour and delivery, and postnatal services to women. Most supervisors also noted that midwives provide general curative medical care (69%), family planning counselling (62%), family planning method provision (54%), as well as other services (61%) such as providing immunizations and conducting educational talks on lactation/breastfeeding and nutrition. Thus, midwives are currently practicing a variety of skills in their care of women.

### **Perceptions of Midwife Supervisors of Training Provided to Midwives**

Most midwives attend in-service training programmes to upgrade their knowledge and skills. Most prevalent are Life-Saving Skills workshops and trainings in general family planning. Overall, all of the midwife supervisors felt that training changed midwives' practices in some way (none stated that there was no observed change after training). Most (72%) stated that training made midwives more efficient and that training enabled midwives to acquire the specific skills in question (64%). They also stated that training in general makes midwives more confident of their skills.

### **Care Provided by Midwives to Women Experiencing Abortion Complications**

All supervisors stated that the midwives they supervise provide care to women with incomplete abortion but that none actually perform uterine evacuations (note, however, that in Table 13 one midwife did indicate that she has done uterine evacuation). Midwives do, however, provide medical treatment, and refer, accompany, and at times transport women to the appropriate health facilities.

Table 15 illustrates which complications of incomplete abortion midwife supervisors say that their midwives currently see most often and which they feel midwives can currently manage in a safe manner.

**Table 15 Complications which Midwife Supervisors State Midwives Currently See and Complications They Could Manage Safely**

<i>Complication</i>	<i>Currently See (%)</i>	<i>Can Manage Safely (%)</i>
Localized infection	85	54
Septicaemia	62	15
Haemorrhage	100	100
Uterine perforation	8	0
Cervical injury	15	8
Other e.g. PID, anaemia, retained placenta	38	23

In order to better manage the complications of incomplete abortion, midwife supervisors suggested that more midwives receive training in Life-Saving Skills (69%) and administering antibiotics (61%). Thirty-nine percent mentioned uterine evacuation as essential to any training which better equips midwives to treat women with abortion complications.

With such training, midwife supervisors noted that further complications would be avoided (69%), women would receive care more promptly (61%), and transportation costs for women would be reduced (54%). Other supervisors mentioned that mortality rates would decrease or, more directly, "women's lives would be saved."

Thirty-eight percent of the supervisors mentioned negative effects which might result from training midwives to better manage women with abortion complications, including they may misuse their knowledge and "go after intact pregnancies," and patients may die if the training is not done properly.

### **MVA Training for Midwives**

Most (77%) supervisors were not familiar with manual vacuum aspiration for uterine evacuation and have never received training in postabortion care. Of those who were familiar with MVA, 75 percent thought that it would be appropriate for the midwives they supervise to learn to use the instruments for uterine evacuation in cases of incomplete abortion. Their reasons included:

- *It will help the patient toward early recovery,*
- *Patients in remote areas will receive immediate care which will prevent death*
- *Lives will be saved especially in communities and villages where women will utilize the health centers and will not have to travel to the hospital. This will also reduce transportation costs,*
- *The burden on the doctors will be relieved,*
- *Complications and death due to delay will be prevented,*
- *It will arrest haemorrhage and eliminate unnecessary pain, and*
- *Self-induced cases will feel more comfortable with the midwife with her status as a social worker in the community*

The remaining 25 percent of supervisors familiar with MVA felt that training in uterine evacuation would be appropriate sometimes, because it will save the lives of patients where there is no doctor available but that midwives could potentially misuse the technology to induce abortions. No supervisors stated that training in MVA would be completely inappropriate. The only barriers mentioned which would impede such training include religious barriers, fears of uterine perforation, clients' preference for doctors, and the potential for misunderstanding between doctors and midwives.

All concurred that training midwives to provide postabortion family planning will improve services to incomplete abortion patients. Reasons cited by supervisors include

- *Those who feel shy to go to Family Planning units will get their method from the midwife and more women will be covered, and*
- *Midwives live in the community and can best relate with them [the women] thus making women patronize the services more than before*

Some supervisors did note that because midwives are already trained in family planning counselling and provision of methods that they do not need further training specifically for postabortion patients. This ignores the specific needs and concerns that women experiencing incomplete abortion have regarding family planning.

### **Suggestions for Monitoring and Supervision of Midwives Trained in MVA**

Midwife supervisors listed a variety of suggestions for ongoing monitoring and supervision of midwives' skills and practices, most importantly

- 1) Monitor the midwives using a standardized checklist,
- 2) Document all cases of incomplete abortion, including the condition of the woman upon arrival at the facility and any care provided to the woman, and
- 3) Sanction midwives who misuse the MVA instruments

#### **◆ Policymakers**

Policymakers who were interviewed expressed serious recognition of unsafe abortion as a major health issue facing Ghanaian women. Some noted

- *It [abortion] is a very serious health problem. I do not have the figures readily available but I think that it is one of the most serious problems of women in the child-bearing ages,*
- *Abortion poses a great threat to the health of the majority of women, especially adolescents, and*
- *I think it [abortion] is a problem in Ghana because it is causing infertility problems*

Policymakers were in general agreement that decentralizing emergency care for abortion complications is an important step forward and that other cadres of health care providers, in addition to physicians, be trained and empowered to provide treatment for incomplete abortion without coming into conflict with the law on abortion. Some noted

- *It is important that emergency treatment be given to these women at the source and at the spot where they live. Doctors are not around for people to get emergency treatment while there are enough midwives who could have assisted if these patients were aware that they could go to them for help. There should be education of the public so that they know where to go when they have such problems. Sometimes doctors are overworked in the rural areas and may not be in the position to deal with such problems when it comes to emergencies,*
- *The policies which need to be made include making simple equipment and drugs to deal with incomplete abortion available in the rural areas, and*
- *There are some places where the doctors are far away from the community but the midwife is within the community. If they are trained, they can do it [care for women with incomplete abortion]*

Few policymakers explicitly mentioned the Ministry of Health's National Reproductive Health Service Policy and Standards as an official advancement towards these goals.

Overall, policymakers agreed that the Ministry of Health has embarked on a long-term project to decentralize emergency obstetric services to women through the Safe Motherhood Initiative. Barriers to be expected include resistance from some religious groups as well as from health care workers themselves who may view midwives' new skills and practices as a threat to their livelihood. When asked whether hospital providers will be supportive of the new directions the Ministry is taking, one policymaker succinctly stated

*"They might not but I do not think it is their responsibility [to be supportive]. The critical question is, 'what will save lives?' Right now they can not cope with the caseload [of women arriving with abortion complications]."*

Like the midwife supervisors, policymakers emphasized the importance of monitoring and supervision of midwives as they practice their new skills. In addition, the creation of a strong support network that provides MVA kits, necessary drugs, regular refresher training, and helps to develop a referral and community transport system to be used when necessary were defined as critical to the success of the decentralization of services to women experiencing abortion complications.

#### ◆ Community leaders (N=20)

Like policymakers, community leaders interviewed for this project agreed that abortion and abortion complications pose major health problems to women in their communities. Women experiencing such problems are seen as "a burden on their husbands and family

because they can not work ” In addition, community time and money is spent on their transportation and care, thus incurring costs to those outside of their immediate family Thirty-percent of all community leaders linked abortion complications with the incidence of infertility and 60 percent accurately noted its linkage with women’s morbidity and mortality

Training midwives to better care for women with incomplete abortion was generally viewed as a viable and worthwhile activity Midwives were identified as the appropriate providers of such services since, in the words of one leader, “It is the job of a midwife to take care of pregnant women, so if a pregnant woman has a problem she has to go to the midwife ”

Their reservations mirror those expressed by providers, policymakers, and supervisors, particularly that midwives may use their skills to induce abortion rather than solely treat cases of incomplete abortion They also emphasized that equipment must be made available if the new services are to be offered safely, consistently, and effectively

#### **IV CONCLUSIONS AND NEXT STEPS**

The baseline assessment of existing postabortion care services has documented general agreement on the part of providers, policymakers, and community leaders that unsafe abortion poses a significant health problem to Ghanaian women. Overall, support exists for midwives, particularly those based in health centres and private maternity homes, to be trained in the provision of comprehensive postabortion care, including uterine evacuation with MVA in the treatment of incomplete abortion and the provision of postabortion family planning. As all who were interviewed indicated, emergency treatment needs to be available as close as possible to where women live so that delays in seeking and garnering care can be reduced. In this way, women's lives will be saved. Additionally, midwives will be able to provide personalized follow-up care to women in their own communities both to ensure that women are not experiencing any further complications subsequent to treatment and that women are satisfied with the decision they have made regarding contraceptive use and future pregnancy.

Stabilization and referral of women experiencing complications, such as uterine perforation or uterine size beyond 12 weeks LMP, will be key to the success of care midwives provide to women. As such, strong links need to be made with district hospitals and other referral sites to ensure that women arrive safely and are treated promptly.

Education of community members regarding the dangers of unsafe abortion as well as the signs and symptoms of abortion complications will be a central activity undertaken by midwives and other health workers after postabortion care training has been completed. Such efforts will also serve to inform community members in the training districts of the availability of these new services.

Lastly, supervision and monitoring of midwives skills and practices subsequent to their training in postabortion care will be necessary to ensure that midwives are providing quality services to their clients. These activities will be undertaken by a doctor-midwife team who will visit midwives where they practice.

Post-training research is scheduled to begin in February 1997 and will document the effects of the overall project on the provision of postabortion care services throughout Eastern Region.

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**ENDNOTES**

- <sup>1</sup> The figure 585,000 is the newly revised estimate for 1990, derived by the World Health Organization and the United Nations Children's Fund (UNICEF) World Health Organization 1996 *Revised 1990 Estimates of Maternal Mortality A New Approach by WHO and UNICEF* World Health Organization, Geneva
- <sup>2</sup> World Health Organization 1994 *Abortion Tabulation of Available Data on the Frequency and Mortality of Unsafe Abortion, 2nd Ed* World Health Organization, Geneva.
- <sup>3</sup> World Health Organization 1995 *Complications of Abortion Technical and Managerial Guidelines for Prevention and Treatment* World Health Organization, Geneva
- <sup>4</sup> *Abortion Tabulation of Available Data on the Frequency and Mortality of Unsafe Abortion, 2nd Ed*, Tinker, A and Koblinsky, M A 1993 *Making Motherhood Safe* World Bank Discussion Papers, 202, Washington, D C, World Health Organization, Carla AbouZahr, personal communication, 1996
- <sup>5</sup> Thaddeus, S and Maine, D 1990 *Too Far to Walk Maternal Mortality in Context* Prevention of Maternal Mortality Program, Center for Population and Family Health, Columbia University
- <sup>6</sup> The maternal mortality ratio is defined as the number of maternal deaths per 100,000 live births Note that in the United States the maternal mortality ratio stands at 12 and the lifetime risk of maternal death is 1 in 3500 Ministry of Health, Republic of Ghana. 1996 *National Reproductive Health Service Policy and Standards; Revised 1990 Estimates of Maternal Mortality A New Approach by WHO and UNICEF*
- <sup>7</sup> See *Criminal Code (Amendment) Law, 1985* P N D C L 102, The Gazette Ghana Publishing Corporation, Accra-Tema
- <sup>8</sup> Deganus-Amorin, S 1993 "Unsafe Abortion and the Safe Motherhood Initiative in Sub-Saharan Africa" Presented at the Medical Women's International Association Congress, Nairobi, Kenya
- <sup>9</sup> Ghana Medical Association Communiqué 1994 Resolved at the 36th Annual General Conference, Koforidua.
- <sup>10</sup> See Taylor, J and Ablordey, M 1994 "The Dimensions of Abortion in Ghana An Exploratory Study of Kwahu South District." IPPF, unpublished
- <sup>11</sup> Greenslade, F C, McKay, H., Wolf, M, and McLaurin, K 1994 *Post-Abortion Care A Women's Health Initiative to Combat Unsafe Abortion* Advances in Abortion Care, 4(1) IPAS, North Carolina.
- <sup>12</sup> World Health Organization 1995 *Complications of Abortion Technical and Managerial Guidelines for Prevention and Treatment* World Health Organization, Geneva.
- <sup>13</sup> Prevention of Maternal Mortality Network 1996 *PMM Results Conference Abstracts* Columbia University, Center for Population and Family Health, School of Public Health, New York. Note that the full proceedings will be published in 1997 as a supplement to the *International Journal of Gynecology and Obstetrics*
- <sup>14</sup> Ghana Medical Association (GMA) 1996 *38th Annual General and Scientific Meeting Programme* Accra, Ghana

<sup>15</sup> Thaddeus, S and Maine, D *Too Far to Walk Maternal Mortality in Context* Columbia University, Center for Population and Family Health, School of Public Health, New York These three delays have been identified as key to determining whether a woman will receive prompt, life-saving services

<sup>16</sup> Otsea, K 1992 *Progress and Prospects The Safe Motherhood Initiative 1987-1992* Background Document for the Meeting of Partners for Safe Motherhood, The World Bank, Washington, DC, Starrs, A 1987 *Preventing the Tragedy of Maternal Deaths* A Report on the International Safe Motherhood Conference The World Bank, Washington, DC, White, S M., Thorpe, R.G , and Maine, D 1987 "Emergency Obstetric Surgery Performed by Nurses in Zaire," *Lancet* 2(8559) 612-613., Hord, C E and Delano, G 1995 "Reducing Maternal Mortality from Abortion The Midwife's Role in Abortion Care" In Murray, S F (ed ), *Midwives and Safer Motherhood* Mosby, London

<sup>17</sup> Baird, T L , Gringle, R.E , Greenslade, F C 1995 *MVA in the Treatment of Incomplete Abortion Clinical and Programmatic Experience* IPAS, North Carolina Safety is measured by the complication rates of the technique while effectiveness is measured by the need for a repeat evacuation to resolve the incomplete abortion

<sup>18</sup> World Health Organization 1995 *Complications of Abortion Technical and Managerial Guidelines for Prevention and Treatment* World Health Organization, Geneva

<sup>19</sup> World Health Organization 1991 *Essential Elements of Obstetric Care at First Referral Level* WHO, Geneva.

<sup>20</sup> *Too Far to Walk Maternal Mortality in Context* Thaddeus, S and Maine D Prevention of Maternal Mortality Program, Center for Population and Family Health, Columbia University, 1990

<sup>21</sup> In his work in southern Ghana, Bleek (1987) demonstrated a great deal of underreporting of abortion when women were asked directly about having had one Based on participant observation of women in a lineage, Bleek concluded that 53 percent had induced an abortion (n=19), while only 4 percent of women interviewed by Ghanaian nurses in a child-welfare clinic (n=179) admitted to having induced an abortion See Bleek, Wolf 1987 "Lying Informants A Fieldwork Experience from Ghana " *Population and Development Review*, 13(2) 314-322

<sup>22</sup> Logbooks dated January through November 1995 at each of the district hospitals were reviewed prior to the field period All cases recorded as the following were included as part of the total caseload criminal/incomplete abortion (N=455), threatened abortion (N=239), retained product or tissues (N=58), uterine perforation (N=2) Based on these categorizations, district hospitals recorded the following number of cases for 1995 Kwahu Government Hospital at Atobie, 157, Tafo Government Hospital, 152, Kibi Government Hospital, 24, Akim Oda Government Hospital, 235, Akuse Government Hospital, 107, Atua Government Hospital, 79 Assuming an equal distribution of cases over this 11-month period, providers at each hospital should see the following number of cases Kwahu Government Hospital at Atobie, 7, Tafo Government Hospital, 7, Kibi Government Hospital, 1, Akim Oda Government Hospital, 11, Akuse Government Hospital, 5, Atua Government Hospital, 4

<sup>23</sup> During the initial fieldwork period, midwives were interviewed using the same instrument as was used with physicians in the hospitals During the extended period of fieldwork, midwives in district hospitals were interviewed with the instrument designed for community-based midwives Thus the following categories are a compilation of specific actions outlined in the community-midwife instrument

*Physician and Midwife in Hospital Instrument*

- 1) Initial assessment/ examination of patient
- 2) Stabilization

*Community Midwife Instrument*

- 1) Perform a pelvic exam, diagnose stage of abortion
- 2) Haemoglobin testing, provide antibiotics, IV fluids, oxytocics, basic pain medication