

Establishing Postabortion Care Services in Low-Resource Settings

P A P E R # 7 • O C T O B E R 1 9 9 9

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JHPIEGO Strategy Papers are designed to summarize JHPIEGO's experience in reproductive health, with a focus on education and training. The papers are intended for use by program staff of JHPIEGO, USAID and its cooperating agencies and other organizations providing or receiving technical assistance in the area of reproductive health training.

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Introduction

Complications from spontaneous and induced abortions—primarily hemorrhage, infection and injury to the cervix and uterus—remain a major cause of maternal death in many countries and contribute to the poor overall health of women in these countries. For example, in some countries abortion is the cause of up to 50 percent of pregnancy-related deaths. And, according to recent World Health Organization (WHO) estimates, up to 15 percent of maternal mortality is due to the complications of abortion. This realization has generated much discussion about how best to address this public health problem.

To reduce the risk of long-term disability or death from the complications of abortion, governments must commit to working with communities and providing easily accessible, high quality emergency services at all levels of the healthcare system. Although needed virtually everywhere, in many countries emergency treatment for incomplete abortion is:

- available only in secondary or tertiary hospitals located in major urban cities;
- performed in operating rooms by a team of specialists; and
- usually provided by sharp curettage (dilatation and curettage [D&C]), usually done under heavy sedation or general anesthesia.

Lack of transportation and prohibitive costs place these centralized services out of reach of most poor, rural women. Furthermore, the continuum of care usually ceases once the emergency situation has passed, leaving women trapped in the dangerous cycle of unwanted pregnancy and unsafe, often illegal abortion.

Although the importance of linking emergency care and family planning (FP) is obvious, until recently these two types of care rarely were offered together. Indeed, it was not until 1993 that Ipas coined the phrase “postabortion care” (PAC) to include:

- emergency treatment of incomplete abortion and potentially life-threatening complications;
- provision of family planning counseling and services; and
- links between emergency care and other reproductive health (RH) services (e.g., infertility screening, sexually transmitted disease [STD] management, cervical cancer detection or antenatal care).

Since then, much has happened. For example, as a result of the efforts of many individuals and organizations, postabortion activities supported by the United States Agency for International Development (USAID) have been launched in more than 30 countries.¹ Also, manual vacuum aspiration (MVA), an effective method of treating bleeding complications that promises increased

¹ The seven USAID-supported agencies are: AVSC International, INTRAH/PRIME, JHPIEGO Corporation, Johns Hopkins University Center for Communications Programs, Pathfinder International, the POLICY Project and the Population Council.

access to emergency care, is being promoted globally. Compared to D&C, MVA offers a number of advantages. It does not require use of heavy sedation or general anesthesia, and can be provided in an outpatient setting by nurses and midwives using inexpensive reusable instruments and equipment. Furthermore, it is easier to teach and to attain competency in MVA compared to D&C. Finally, much has been learned through operations research regarding how best to link emergency care with FP and other RH services, mobilize community support and make better use of the private sector to provide PAC services.

Significant gaps, however, still exist in implementing the overall PAC strategy. For example, at the USAID-supported PAC Cooperative Agencies meeting in January 1999, it was reported that the existing demand for services has not yet been met in any one country, nor has the full array of PAC services been provided. Moreover, key issues such as advocacy, expansion of services, institutionalization and sustainability of PAC services were yet to be addressed. As a consequence, a number of recommendations were made to address these gaps. One of these, "...the need to develop a comprehensive approach to PAC services, including the design, implementation and scale-up," provided the impetus for this paper.

In the first section, the **key elements in a PAC strategic framework** are briefly described. In subsequent sections, these elements are integrated into the major steps needed to **introduce** and **expand** PAC services in countries with limited resources. These

recommendations are based primarily on JHPIEGO's and our partners' programmatic experience of the last 5 years, as well as other lessons learned in the field.

Key Elements

The **goal** of the PAC strategy is to **improve women's health by expanding access and providing quality services at all levels of the healthcare system**. To accomplish this goal, there must be both government commitment to improve the health status of women and community acceptance of the PAC concept. Indeed, community participation is crucial to successfully integrating PAC services into a country's healthcare system, especially at the lowest level of care. Key elements of the PAC framework are advocacy, access to services, institutionalization of training and sustainability.

Advocacy

Advocacy is defined as the process of obtaining support for a cause or policy. The most effective advocacy for PAC services is country-driven, with partner agencies playing a facilitative role. Government authorities, the press and society at large must recognize that unsafe abortion takes a heavy toll on women's health and lives. The introduction of PAC must be seen as improving existing services rather than something totally new—PAC is part of the "mainstream" of healthcare services. The concept of PAC also must be understood and accepted at the community level. The steps in developing an advocacy strategy include:

- forming a network of community members;

- conducting a needs assessment;
- convening dissemination events;
- developing, implementing and evaluating an action plan; and
- using evaluation results to plan new initiatives and gain additional support.

While use of MVA rather than D&C should be encouraged, if it is not yet available, FP and other RH services should be linked to existing emergency services. Moreover, to gain government support for PAC services, advocacy efforts should be directed toward:

- raising awareness of the urgency needed in treating complications due to abortion;
- linking FP and other RH services to emergency services, and increasing access to and improving the quality of these services; and
- encouraging the acceptance of PAC services within the community.

Access to Services

To improve access to PAC services, those charged with developing the program must work with women in their communities as well as service providers, health facilities, and government and regulatory bodies. Issues related to quality and cost of services must be addressed as part of this effort.

Women and Communities. Working with women and their communities is crucial to improving access to PAC. Women’s networks,

traditional leaders and traditional healthcare workers should all be involved in the introduction and expansion of PAC services. Community members should be asked their opinions about the problem and potential solutions. Women who are leaders in the community will be instrumental in informing others about PAC. Determining where women go for emergency care, as well as what their views are on PAC services, can help provide the framework for introducing or expanding PAC services and integrating them into the existing healthcare system. As the community becomes involved in the introduction or subsequent expansion of these needed health services, it can be mobilized to provide transport for PAC as well as essential obstetric care (EOC).

Service Providers. A cadre-neutral approach should be supported. For many developing countries, the question is not whether doctors, nurses or midwives should be trained, but rather who is available to do the job in both the public and private sectors? Because training is only one part of the multidimensional systems approach proposed, investment must be focused on training the cadre of healthcare worker **available** at a given service delivery point (see **Attachment 1, Provision of Postabortion Care by Level of Healthcare Facility and Staff**). Frontline workers often feel helpless because they were not trained to meet the challenges of the services for which they are responsible, or are not allowed by laws and regulations to provide services in which they are competent. Often they are the first point of contact for patients suffering from complications of abortion; however, in many countries they have not been trained to manage these cases.

Increasingly, nurses, midwives and medical assistants must assume the duties that were traditionally in the domain of physicians. In Africa and most of Asia, this is typically the situation because physicians do not staff primary healthcare (PHC) services sites. Given that physicians are often located far from these sites, uncomplicated bleeding problems can become more severe and life-threatening without immediate treatment. Thus, nurses, midwives or other healthcare workers need to be trained to handle such situations.

Healthcare Facilities. PAC services should be integrated into existing maternal health, safe motherhood or EOC services, and should be offered at the lowest level facility possible. Where possible, emergency services (MVA for bleeding, antibiotics for sepsis and IVs for stabilization or referral) need to be available 24 hours a day. Appropriate logistics systems must be in place to ensure that the drugs, medical supplies and basic equipment necessary for the provision of these services are continually available. Also, because providing immediate postabortion FP has proven to be most effective, efforts should be made to provide counseling and services as close to the point of emergency care as possible.

Government and Regulatory Bodies. Existing service delivery guidelines and practices must be reviewed and issues of access to services must be discussed before starting the project. A commitment to working with appropriate authorities and providing technical support to ensure that peripheral, and not just central, health services have the capacity to deal

adequately with PAC concerns and emergency situations is needed. This commitment involves exploring newer but simpler ways of providing care where it is most needed—the community level. For example, the use of oral misoprostol, a prostaglandin, to control postpartum hemorrhage may have potential applications in preventing postabortion bleeding from progressing to more severe problems. Use of misoprostol may be especially important in rural or remote areas where medical services are limited. Before misoprostol is incorporated into PAC, however, guidelines for its use in managing postabortion bleeding need to be established.

Institutionalization of Training

To date, inservice training has been the mechanism used to train service providers in most developing countries. International donors as well as ministries of health and education personnel, however, are becoming increasingly aware that inservice training may not be the most cost-effective or efficient way of providing basic RH education and training, especially for clinical procedures. Bringing providers to an inservice course incurs financial costs (training room rental, travel, food/lodging, etc.) and disrupts service provision (providers are required to take temporary leave from their posts to participate in training). Also, providers' motivation to learn the skills being taught may be lacking. Or providers may not perceive the new procedure as an integral aspect of their job responsibilities because it was not a part of their preservice education. Furthermore, topics taught during inservice training may be perceived as

“add-on services” that are not included in a basic package of services and therefore less important.

Although initially it may be necessary to introduce PAC services via inservice training, it is desirable that training quickly be incorporated into the preservice setting. Training in PAC should be considered an essential part of the basic skills package being taught in medical, nursing and midwifery schools. Each time the RH component of the preservice curriculum is revised, PAC training should be added or, if necessary, improved. Preservice training provides a greater opportunity to influence provider attitudes and standardize skills. As with other clinical skills, preservice PAC training will be most effective when it occurs toward the end of the educational program, close to the time when the student will be working independently in the clinical setting (e.g., internship or clinical preceptorship).

Targeting teaching hospitals for the introduction of PAC services lays the groundwork for medical, nursing and midwifery students to be trained in PAC. All students should understand the concept of PAC and the importance of being prepared for emergencies. Developing teaching hospitals and satellite clinics as model service, and then training, sites is important to ensure that students have adequate opportunities for clinical practice. It is equally important for students to have the opportunity to observe and work with a well functioning team of providers offering PAC services.

Preservice education and training efforts should address provider attitudes and sensitize those

being trained to the complex issues surrounding PAC. Furthermore, it is essential that the service delivery system be able to support what students learn in the preservice setting. Model clinical sites used for PAC training, where different cadres can be trained together as a team, play an important role in the institutionalization of training and the expansion of PAC services.

With either inservice or preservice training, competency-based learning packages are required. With each country, a decision needs to be made about whether existing training materials can be adapted or new ones developed specifically for the program. Experience has demonstrated that these packages should include learning guides, algorithms, protocols and use of anatomic models for initial practice.

Another issue to be addressed is how service providers will maintain their skills after training. A **critical mass** of healthcare providers needs to receive initial training, and then have the opportunity to maintain their skills, so that there are enough competent professionals available to provide 24-hour service at health facilities. If caseloads are small, these individuals should be trained in small groups (three to five individuals) in order to get sufficient clinical experience with patients.

Sustainability

Sustainability is defined as the ability of countries to carry on their own programs without outside support. Efforts to foster sustainability of PAC services should address political will, management and financial systems, supervision

and service provision. Availability of and access to PAC are limited not only by financial and human resources but also by support from the host government. Commitment must be translated into action that ensures host governments accept responsibility for the continued availability and wider access to PAC. For example, elements of PAC should be made available at the smallest health units of the healthcare system to serve as the entry point for women in need of services. Linking them to polyclinics or district hospitals that either provide emergency care (MVA) or serve as the gateway for stabilization of critically ill women prior to referral will further support the integration of PAC into the healthcare system. For PAC services to be sustainable, they must be built on a solid base of quality service provision.

The community also plays an important role in ensuring sustainability of any PAC program. Mobilizing community resources and support for PAC services is a key factor. For example, in countries where patients are accustomed to paying for care, reasonable fees may be charged to those who can afford to pay for the services. Clients are generally willing to pay if the services provided are of good quality. In coming years, involvement of the private sector is expected to increase availability of and access to PAC services because private sector providers already supply a substantial portion of these services in many countries.

Introduction of PAC Services

Introducing PAC services is different from introducing an elective service or a new contraceptive. Providers and trainers must be

prepared to provide a range of treatments—from performing an uncomplicated MVA to treating life-threatening emergencies. While elective procedures can be scheduled, patients presenting with incomplete abortion are often quite sick and may require stabilization prior to MVA. Also, training is only one aspect that needs to be considered in establishing high quality, comprehensive PAC services in a particular country. Advocacy and consensus building efforts, overall management of services (including infection prevention [IP] and patient flow) and service delivery issues need to be considered at the start of the project to ensure its success. A sound introduction strategy can lay the groundwork for future expansion efforts.

Soliciting support and commitment from key stakeholders is crucial. Much advocacy work has to be done prior to the start of project activities. Stakeholders may have questions or concerns about potential misuse of equipment or management of the overall PAC services, for example. These questions need to be reviewed in detail in order to gain their support. These stakeholders can then serve as spokespersons for the project and become advocates for raising awareness of the need to provide quality care to women suffering from complications of incomplete abortion. Finally, once this support has been obtained, it is recommended that the activities described below be reviewed and adapted as appropriate in order to introduce services in a particular country.

Needs Assessment

The community—including its key stakeholders and leaders—should be involved, and findings

from the needs assessment should be incorporated into the PAC service delivery strategy. Visits should be made to potential sites to observe service delivery practices and determine client and provider needs for PAC services. The communities served by these sites also should be assessed to learn about community needs and perspectives. The assessment of service provision should address the capacity to deal with emergencies and treat complications; IP practices; FP service provision; linkages between PAC services and other hospital and community services; and suitability of a clinic's location as a future training site (i.e., connection to a medical, nursing or midwifery school). Data collection should include:

- observation of service delivery practices in the clinic or hospital;
- interviews with providers, government officials and administrators to determine management issues; and
- review of logbooks to examine recorded caseloads and case fatality rates as well as what information is currently collected on a regular basis.

These data will contribute to defining the needed training activities as well as the efforts necessary to strengthen the sites in preparation for provision of quality PAC services. Moreover, sharing the results of the needs assessment is an important part of the advocacy work because it sensitizes key stakeholders to relevant issues and proposed solutions and provides an opportunity to solicit their feedback.

Policies and Service Delivery Guidelines

One of the most important activities relevant to program planning and soliciting interest and support will be the process of developing national policies and service delivery standards for PAC. Guidelines are essential to ensure high quality service delivery, training, supervision and management practices. The guidelines development process facilitates discussions while providing an official record of consensus among appropriate stakeholders.

If current policies and guidelines do not include appropriate information relative to PAC, these documents must be updated. Policies should highlight all aspects of PAC services (treatment of emergencies, counseling and provision of FP, and linkages to other RH services) and should include information on case management, relationship with other RH services, management of PAC instruments and a list of necessary equipment and supplies. The guidelines provide the details of how and by whom the services are to be managed and delivered. As mentioned earlier, a cadre-neutral approach as well as a commitment to maximize access to PAC services in the country is needed. If nurses and other nonphysician healthcare workers will be providing PAC services at remote sites, national policy must reflect this, and protocols detailing their role and responsibility should be clearly articulated.

Key stakeholders from both the private and public sectors must be involved in this process.

Development of relevant PAC guidelines not only encourages close study of reference materials, but also results in a better understanding of the subject matter and prompts discussions regarding how best to integrate PAC services into the healthcare system. In addition, this process provides an opportunity to discuss logistics and management issues before the start of services. Implicitly included in this process is an analysis of the availability and cost implications of essential drugs, medical supplies and basic equipment for PAC services. To facilitate this process, a majority of the individuals working to develop or update policies, protocols and guidelines for PAC should have attended the Infection Prevention and Management of PAC Services Workshop (see below). The greatest challenge, however, remains dissemination of guidelines and monitoring their use once they have been approved.

Infection Prevention and Management of PAC Services Workshop

Sensitization activities should not be limited to service providers but should include (to the extent possible) all clinic or hospital clinical, administrative and management staff. Strengthening IP practices at sites where PAC will be integrated is an important first step. In fact, the introduction of PAC services provides a good opportunity to assess and strengthen the quality of recommended IP practices throughout the facility. Typically this involves training staff from the teaching hospital (maternity service) and nearby ambulatory sites. Given that IP practices are fundamental to all services offered by the sites, introducing simple and practical IP

concepts and recommended practices early in the project can encourage providers to think about how to strengthen overall management of clinical services at a particular site. Training should include not only those staff responsible for provision and management of services but also the individuals responsible for processing supplies and equipment (instruments, gloves, drapes, etc.) as well as those administrators and managers responsible for ordering and managing supplies needed for IP. Training content should cover management issues related to emergency preparedness as well as skills related to implementation of recommended IP practices, and provide adequate opportunity to practice the newly acquired knowledge and skills. Finally, overall management of the site must be considered to ensure appropriate integration of PAC.

It is recommended that PAC experts with appropriate experience in IP visit the sites selected for introduction of PAC prior to the workshop to determine present practices. They should also visit the sites 2–3 days following the workshop to assist participants with implementing the recommended practices and with solving problems. Participants in the workshop will be considered the core team for improving practices and will spearhead improved practices at service sites. Regular followup to monitor progress in introducing recommended practices by local or regional PAC experts should be built into the introduction activities.

Using sensitization to management issues and IP training as a first step in improving the quality of services (e.g., maternity care) provides a

noncontroversial introduction to the sensitive subject of PAC and can gather momentum for the project. In addition, by doing this, PAC is presented not as an “add-on” service but rather as an essential element to be integrated into existing services, all of which require attention to quality.

Contraceptive Technology Update (CTU)

Data from the needs assessment will provide information regarding the FP knowledge and skills of providers. In most cases, it will be necessary to update service providers’ knowledge about contraceptive methods, especially as they relate to the needs of postabortion women. Also, this update provides an opportunity to stress the benefits of immediate on-site provision of FP counseling and services as part of the comprehensive package of PAC services.

In some cases, a FP skills standardization workshop may be required to strengthen providers’ clinical skills as well as their knowledge. In most countries, national FP training efforts are traditionally focused on PHC or Maternal and Child Health (MCH)/FP centers, resulting in the exclusion of teaching hospitals from these efforts. As a consequence, faculty and clinical preceptors working in teaching hospitals often have little or no training in FP and may require considerable technical assistance in this area.

Staff Orientation Meetings

One-day orientation meetings for hospital and clinic staff who have not been an integral part of the preparations for the introduction of PAC, as well as for staff from neighboring clinic sites, should be held. The purpose of these meetings is to elicit staff interest and involvement in the PAC activities and discuss how staff can incorporate them into their work (e.g., more timely referrals from surrounding sites, prompt evaluation of PAC patients, better referral of PAC patients for FP, etc.). The meeting will provide staff with an opportunity to review important information regarding the problem of incomplete abortion, the elements of PAC, and information about MVA and how PAC services will function at the facility. A presentation of the proposed PAC service delivery plan should also be reviewed to gain consensus and help in finalizing the plan.

For hospital sites, orientation meetings should include staff at all levels from admitting to labor and delivery, as well as those from hospital administration. Key health workers who may refer women from surrounding areas should be invited so that they are aware of the availability of PAC services and make timely referrals. Faculty from various preservice institutions also should be invited.

These orientation meetings can serve as an important advocacy tool. Not only do the meetings provide an opportunity to disseminate

information, but those who give presentations can articulate their views and become more vocal advocates for the issue of managing complications of abortion. PAC clinical trainers, representatives from the Ministry of Health (MOH) and other stakeholders should be encouraged to make presentations in order to demonstrate their commitment to PAC, address questions and dispel rumors.

Technical Assistance to Set Up Clinic Sites

Development of PAC services requires careful planning and coordination. A number of policy decisions (e.g., management of equipment and materials, rotation schedules and responsibilities) and program planning steps have to be completed before the initiation of training and delivery of services at a particular site. A PAC expert should be available to work with project staff to assist with preparing the sites to offer services. Patient flow, organization of emergency services, case management, IP, record keeping, FP counseling and FP referrals should all be reviewed. A team approach to service delivery, in which different cadres work together to provide PAC services, should be fostered. Also, a system for collecting the information needed for routine monitoring of PAC services should be established.

Consideration should be given to the data needed to adequately evaluate the introduction and later the expansion of PAC services as well.

Training

Once the above activities have been successfully accomplished, PAC training can be carried out.

Caring for the total needs of the patient—not just the medical emergency—should be stressed as an important element of the training strategy. Participants should learn to:

- accurately diagnose incomplete abortion and other causes of vaginal bleeding;
- talk with patients before MVA and counsel them after the procedure about FP and other RH care, as appropriate; and
- manage uncomplicated cases as well as life-threatening emergencies.

This training activity should provide an overview of PAC, focus on training providers in how to talk to the patient during the MVA procedure and use recommended IP practices. Team training involving both physicians and nurses or midwives is recommended.

Monitoring Activities

When possible, the PAC expert who helped develop the program and conduct the training, together with local representatives, should conduct the initial followup visits to the PAC service delivery sites to ensure the provision of comprehensive services. In the absence of patients, “clinical drills” on how the provider might manage hemorrhage or sepsis should be conducted, or clinical demonstrations using models can be done. During these visits, the post-training knowledge and skills of the new providers and other members of the PAC team should be assessed, and management issues that may hinder provision of PAC services should be addressed. Meetings with representatives from the hospital administration or supervisory

staff from the clinic should be held to ensure their continued support of the project and to discuss how to maintain services.

Summary of Steps Needed to Introduce PAC

The goal of PAC services is improved women's healthcare at all levels of the healthcare system. To accomplish this requires a multidimensional approach that must be conducted within a favorable policy environment. The **key steps** needed to successfully introduce PAC services are summarized in **Figure 1**.

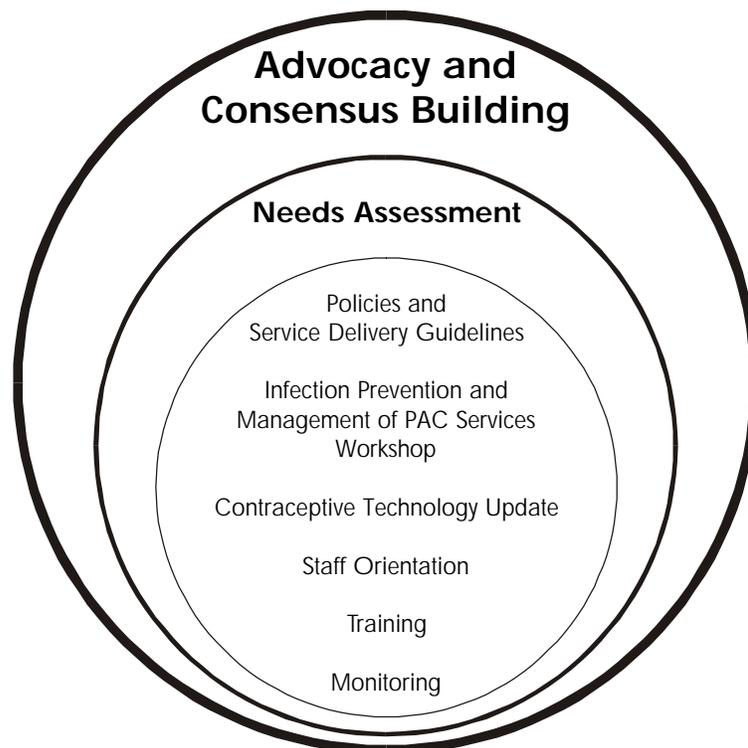
Expansion of Services

Initiation of comprehensive PAC services is a major step toward reducing maternal mortality and morbidity due to complications of abortion.

Further reduction calls for expanding PAC services to additional service delivery sites and progressively into more remote areas. It is at this stage that the private sector may begin to play a bigger role. For example, in Kenya more than 40 percent of PAC services are provided by private practitioners.

Compared to introduction of PAC services, there is less experience with and therefore less available information about expansion of services. Therefore, the following sections present a brief review of the factors that should be considered before expanding PAC services. These factors are based largely on the lessons learned in introducing services. It is anticipated, however, that most of them will need to be addressed by country programs when considering expansion.

Figure 1. Introduction of PAC Services



National Strategy Meetings

Key stakeholders should review the national policies, protocols and guidelines developed during the introduction phase and adapt them as necessary in order to develop a country-level expansion strategy. The PAC Consortium reference manual, *Postabortion Care: A Reference Manual for Improving Quality of Care*, provides recommendations that can be adapted for each country. The review by key stakeholders should focus on policies and protocols that will empower both healthcare workers and traditional healthcare providers at the community level to become part of expansion programs. This includes considering the level of care they will be allowed to provide and the guidelines that will allow them greater access to higher referral levels. The national strategy meetings should also include opportunities to discuss issues related to community participation and social mobilization. In addition, orientation meetings should be held with regional policymakers and program managers. The meetings should focus on the importance of expanding PAC services throughout the country and what is needed to accomplish the expansion.

Once in place, the national strategy will guide where, when and how PAC activities will be expanded. The strategy will elaborate:

- selection criteria for expansion sites,
- which level of service providers will be trained, and
- the best way to transfer the knowledge and clinical skills needed to provide quality services.

For most countries, the first level of expansion will most likely be to district-level maternity hospitals or maternities in the capital which are not yet providing PAC services. Subsequent expansion should include district hospitals and polyclinics located further from the capital or large cities.

Questions regarding sustainability should be discussed at these meetings as well. For example, in most countries, women pay for maternity services. Therefore, the cost of providing PAC services should be determined, and a payment scale developed so that women using the services can contribute to their sustainability.

Developing Criteria for Selection of Expansion Sites

Assessment criteria for proposed expansion sites should be drawn from the following factors:

- current management of women presenting with postabortion complications,
- referral acceptance capability,
- use of recommended IP practices,
- FP counseling and services,
- provision of other RH services,

- stability of personnel, and
- availability of equipment and supplies.

It is most important that proposed sites have **projected** caseloads such that trained providers will be able to retain their competency.

Needs Assessment

A team composed of representatives of the MOH and providers involved in the PAC introduction phase should assess proposed expansion sites to determine if they meet the agreed-upon selection criteria. The most likely sites for the first level of expansion services are district level maternity hospitals and large polyclinics. During the needs assessment, staff will be told about the expansion strategy, and their interest in integrating PAC into their existing RH services will be determined. Priority should be given to clinics and hospitals willing to allocate some of their human and financial resources and whose sites meet the selection criteria.

Training

Selected service providers and faculty involved in the introduction phase will be identified as members of the expansion training teams and trained as clinical trainers. The training will emphasize essentials of adult learning principles, including participatory learning techniques and a focus on skill building. Learning materials will be reviewed, and adapted if necessary, to ensure that they meet the training needs for the expansion strategy.

Developing teaching hospitals and their satellite clinics as model training sites during the introduction phase lays the groundwork for improved preservice training in PAC because medical, nursing and midwifery students use these facilities for clinical training. Therefore, by the start of the expansion phase, preservice PAC training should have been institutionalized. In Kenya and Nepal, preservice training has been institutionalized and all medical graduates now receive PAC training. In Burkina Faso, both medical and nurse midwifery students soon will be receiving this training as well.

Training in PAC should take advantage of other appropriate training activities already in place. For example, in some teaching hospitals, general practitioners come to the maternity for a 6-month rotation to learn new surgical techniques. This is a perfect opportunity to introduce PAC and maximize the physicians' training time. Moreover, having improved knowledge and skills in IP, in how to talk to patients and in counseling will improve the quality of care for any surgical procedure, not just PAC.

Under the expansion phase of the project, only limited inservice training should be needed. This should take place at model sites established during introduction of services. Rollout of activities to the district level and beyond will require the same level of knowledge and skills as was necessary to introduce PAC in the teaching hospitals. As the expansion strategy evolves, a form of structured on-the-job training may be the most effective and efficient way for

service providers to attain competency, especially in health facilities where the population base is smaller and fewer women come for PAC services on a daily basis.

Information, Education and Communication (IEC)

Informing people about the increased availability of PAC services should be a key component of all community health education activities. Because PAC is an integral part of maternal health, it should be discussed in community meetings as one of the many services available. These meetings provide the opportunity to highlight improvements in client management and IP. They also provide healthcare staff an opportunity to solicit client perspectives—an essential element in providing quality services—and give people the opportunity to ask questions, present their views and get accurate information about PAC services.

Information about the availability of other RH services, such as fertility screening, STD management or cervical cancer testing, should be provided at these meetings. Finally, visual or audio aids should be made available to augment the limited time providers have for this purpose and to help women better understand the services being offered.

Management and Logistics Systems

With an increased number of service delivery points, it is even more important that effective

systems be in place to ensure adequate supplies and accurate reporting of services. For example, clinic materials (e.g., gloves, tenacula, specula, MVA equipment) should be available at sites with trained PAC providers. (In some countries, hospital staff have established emergency kits that contain all the essential supplies to treat a woman coming to the maternity with an emergency.) It may be most efficient for PAC supplies to be integrated into the emergency obstetric care supplies in a hospital's central supply department.

A number of MOHs have instituted logistics management systems at both central and district levels, some of which are computer-assisted. These systems should be modified to incorporate PAC logistics. For example, line items should be added to the procurement form for easy resupply of MVA materials. Also, the MOH should have the addresses of distributors of the MVA kits for resupply.

Data for monitoring PAC services will have to be collected on a much larger scale. The systems developed during the introduction phase should be reviewed and revisited. Again, the essential data needed to adequately monitor PAC services should be reassessed. In addition, a system should be set up to track providers trained and where they are assigned. Having this information will enable the MOH to better decide where PAC can be offered and ensure that the necessary equipment and supplies are at the new site. Ideally, monitoring of PAC services should be integrated into existing efforts by the MOH.

Summary

Program achievements in several counties indicate that where there is a favorable policy environment, PAC services can be integrated into the existing primary healthcare system.

Introduction of services usually requires 1 to 2 years of major donor support for technical assistance, policy and guidelines support, materials and model service site development, training and other startup activities. Also, this is the time when the groundwork for creating sustainable PAC services must be fostered. For example, before implementing PAC services it is essential to gain endorsement by the government and commitment to support expansion of services. Targeting teaching hospitals and their satellite clinics as clinical training sites during the introduction phase helps ensure that medical, nursing and midwifery graduates perceive PAC as a basic, rather than “add-on,” service.

Expansion of PAC services usually takes an additional 2 to 3 years and centers on strengthening preservice education and linking clinical training to PAC service delivery sites. Establishing PAC training at model service sites where different cadres can be trained together and work together is strongly recommended. The integration of PAC into preservice education will help drive its expansion. For example, as healthcare graduates are deployed not only to PAC clinical sites but also to other healthcare posts in both the public and private sectors, they

will establish services at new sites throughout the country. As a consequence, governments will be leveraged to assume greater responsibility for expanding services because trained healthcare workers will need some support to continue to provide PAC services. In this scenario, donor resource needs for long-term expansion efforts will be reduced significantly and should be limited to technical assistance, with the host country assuming responsibility for the equipment, supplies and management as well as staffing needs.

While the private sector may not play an active role in the introduction of PAC services, it will definitely have an impact on the expansion of these services. For example, private practitioners may directly offer PAC services or make appropriate and timely referrals to the public sector. In any case, the way they practice must conform to national standards and guidelines. Ensuring their support can be most effectively accomplished by their inclusion from the early stages of advocacy onward.

Finally, to be successful, a strategy for introducing and expanding PAC services should be country-driven and address issues of advocacy, access, institutionalization of training and sustainability. The involvement of the community and consideration of its members' needs and perspectives are critical to establishing a successful PAC program. (Specific introduction activities and recommended expansion efforts are summarized in **Table 1**.)

Table 1. Summary of PAC Introduction Activities and Expansion Efforts

	INTRODUCTION ACTIVITIES	EXPANSION EFFORTS
Policy/Advocacy	<ul style="list-style-type: none"> • Preliminary meetings to raise the awareness of government officials and key stakeholders about the importance of effective PAC services in improving maternal health; gain consensus and commitment to PAC initiative • Needs assessment • Development of policies and standards for PAC services • Orientation meetings • Followup visits 	<ul style="list-style-type: none"> • Review with key stakeholders the progress made at the pilot sites • Reach a consensus on a strategy for the appropriate approach to expand the delivery of quality PAC services • Assess potential expansion sites according to agreed upon selection criteria • Assure that PAC policies, norms and service delivery guidelines are appropriate for expanded services • Develop an appropriate system for formative supervision of expanded PAC services and train supervisors
Training	<ul style="list-style-type: none"> • Needs assessment • Sensitization to management of PAC services and training using recommended IP practices • CTU Workshop/FP skills standardization workshop • PAC training • Followup visits 	<ul style="list-style-type: none"> • Develop appropriate learning materials which can be used for preservice training • Develop appropriate learning materials which can be used for decentralized training • Strengthen clinical training sites • Work with providers trained during the introduction phase to train preservice trainers and additional providers from expansion sites
Service Delivery	<ul style="list-style-type: none"> • Needs assessment • Development of policies and standards for PAC services • Technical assistance visits to set up PAC services (reinforce use of recommended management and IP practices, links to other RH services, use of service delivery guidelines, availability of necessary equipment and supplies) • Followup visits 	<ul style="list-style-type: none"> • Assess potential expansion sites according to agreed upon selection criteria • Strengthen IP knowledge and practices among hospital staff at PAC expansion sites and ensure good IP practice at the sites • Set up a system to respond to women's expressed needs and desires for RH services, including FP counseling and services or counseling and services for infertility • Provide technical assistance to expansion sites to develop case management protocols • Develop an appropriate system for formative supervision of expanded PAC services and train supervisors • Integrate necessary PAC equipment and supplies into the current logistics and management systems to ensure the institutionalization of quality PAC services

ATTACHMENT 1

PROVISION OF POSTABORTION CARE BY LEVEL OF HEALTHCARE FACILITY AND STAFF

LEVEL	STAFF MAY INCLUDE	EMERGENCY POSTABORTION CARE PROVIDED	FAMILY PLANNING & OTHER REPRODUCTIVE HEALTH SERVICES
Community	Community residents with basic health training, Traditional birth attendants, Traditional healers	Recognition of signs and symptoms of abortion and serious postabortion complications Referral to facilities where treatment is available	Provision of pills, condoms, diaphragms and spermicides Referral and followup for FP as well as other RH services
Primary (Primary health clinics, FP clinics or polyclinics)	Health workers, Nurses, Trained midwives	All primary care facilities. Above activities, plus: <ul style="list-style-type: none"> • Diagnosis based on brief medical assessment, including pelvic examination • Resuscitation/stabilization (e.g., IVs) prior to transfer • Hematocrit/hemoglobin testing (optional) 	Provision of above methods plus IUDs, injectables and Norplant® implants Referral for voluntary sterilization
		If trained staff and appropriate equipment are available, above activities, plus: <ul style="list-style-type: none"> • Initiation of emergency treatments <ul style="list-style-type: none"> – antibiotic therapy – IV fluid replacement – oxytocics or misoprostol • MVA during first trimester for uncomplicated cases of incomplete abortion • Pain management <ul style="list-style-type: none"> – oral analgesics and sedation – local anesthesia (paracervical block) • Referral for treatment of complications 	Screening and treatment for STDs Infertility screening Antenatal counseling and services Cervical cancer testing
First Referral Level (District hospital)	Nurses, Trained midwives, General practitioners	Above activities, plus: <ul style="list-style-type: none"> • Emergency uterine evacuation through second trimester • Treatment of most postabortion complications • Local and general anesthesia • Referral for treatment of severe complications (septicemia, peritonitis, renal failure) • Laparotomy and indicated surgery (including for ectopic pregnancy) • Blood cross match and transfusion 	Provision of above methods plus voluntary sterilization Followup Simple testing (rapid plasma reagin, postcoital tests) Simple infertility treatment (clomiphene) Medical treatment
Secondary and Tertiary Level (Regional or referral hospital)	Nurses, Trained midwives, General practitioners, Ob/Gyn specialists	Above activities, plus: <ul style="list-style-type: none"> • Uterine evacuation as indicated for all incomplete abortions • Treatment of severe complications (including bowel injury, severe sepsis, renal failure) • Treatment of bleeding/clotting disorders 	All above activities plus advanced treatment

Adapted from: WHO 1994.

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