



## Postabortion Care: Midwives Expand Service Availability in Sub-Saharan Africa

### The Problem of Unsafe Abortion

Unsafe abortion<sup>1</sup> accounts for high levels of maternal mortality throughout the world. In Africa, women experience the greatest risk of death from unsafe abortion (1 death from 150 unsafe abortions, versus 1 in 260 in Asia, 1 in 800 in Latin America and 1 in 1800 in Europe)<sup>2</sup> as well as short and long-term health problems that include infection, chronic pain and infertility. Although only 1 in 10 of the world's women live in sub-Saharan Africa, the region accounts for 40 percent of all

pregnancy-related deaths worldwide<sup>3</sup> and an estimated 30 percent of all maternal deaths in sub-Saharan Africa are due to complications of unsafe abortion.<sup>4</sup> The high rate of unsafe abortions in Africa is linked in part to the lack of access to contraception. Despite increases in the last decade, modern contraceptive use in Africa remains low. Approximately 26 percent of married women of childbearing age in Africa want to delay or avoid another pregnancy, but are not using contraception. This measure of unmet need for family planning is higher in sub-Saharan Africa than in any other region of the world, and would be a higher percentage if it included sexually active but unmarried women and adolescent girls of reproductive age. Programs that seek to reduce the numbers and minimize the consequences of unsafe abortion are clearly a necessity.

### Midwives Can Expand the Availability of Postabortion Care Services

Midwives are well-positioned to be one of the first referral

points for the majority of obstetrical emergency patients and to play a critical role in reducing maternal morbidity and mortality due to unsafe abortion. Midwives are widely distributed throughout health service delivery systems in many countries and frequently care for women experiencing obstetric emergencies.

Yet in much of the world, physicians working in urban-based teaching and referral hospitals are the only providers authorized, trained and equipped to treat abortion complications. Midwives have been trained alongside physicians in some countries, but their role is often limited to assisting physicians to perform manual vacuum aspiration (MVA) and providing postabortion family planning. However, in some countries, such as Nigeria, trained midwives are providing MVA services. The focus on hospitals and physicians as sites and providers of postabortion care services severely limits access to safe emergency care for women experiencing abortion complications. The WHO, UNICEF and the International Confederation of Midwives (ICM)<sup>5</sup> have all issued

*Unsafe abortion is defined by the World Health Organization as...a procedure for termination of an unwanted pregnancy carried out either by persons lacking the necessary skills or in an environment lacking the minimal medical stan-*



*Postabortion care (PAC) is an approach for reducing mortality and morbidity from unsafe abortion and for meeting the reproductive health needs of women treated for complications of unsafe abortion. It involves strengthening the capacity of health systems to offer and sustain a set of integrated reproductive health services that include:*

- *emergency treatment for complications of abortion*
- *postabortion family planning counseling and services*
- *links between emergency treatment and other reproductive health services*

statements that call for the increased participation of midwives in the provision of PAC services.<sup>6</sup>

There is significant potential for midwives to provide comprehensive PAC services, including emergency treatment for complications of abortion, postabortion family planning counseling and services, and links with other reproductive health services. Midwives should also have a key role in preventing unwanted pregnancies by providing family planning services and educating communities about the problems and consequences of unsafe abortion.

### **PRIME's PAC Initiatives**

Acting on the potential of midwives providing PAC services, 3 countries in Sub-Saharan Africa—Ghana, Kenya and Uganda—are undertaking collaborative projects with PRIME to design, implement and evaluate approaches to expand the availability of PAC services at primary level facilities. Project results are expected to contribute to PAC expansion strategies in the 3 countries, to other countries in sub-Saharan Africa, and elsewhere in the world. PRIME also expects that results will contribute to further under-

standing and documentation of the pivotal role of midwives in expanding the availability of high quality PAC services.

### **Ghana, Kenya and Uganda: Approaches, Policies, Partnerships and Service Integration**

In Ghana, Kenya and Uganda, approaches to expand the availability of PAC services depend on each country's experience with unsafe abortion and postabortion care, and the priority accorded postabortion care in each country's reproductive health policy and service delivery strategies and plans.

#### **Ghana: Institutionalizing PAC Services**

The Ghana Ministry of Health (MOH) is considered to be a leader in officially sanctioning midwives to provide PAC services, including MVA. From 1995-1998, with support from the MotherCare Project and Ipas, the MOH and the Ghana Registered Midwives Association (GRMA) undertook an operations research (OR) project to determine the feasibility and acceptability of midwives providing PAC services.<sup>7</sup> In 1996, with pre-

liminary results from the PAC OR project in hand, the MOH officially sanctioned trained midwives to provide PAC services by adopting the 1996 National Reproductive Health Service Policy and Standards, which identified PAC as a key reproductive health service and service decentralization as a priority for improving women's access to emergency care and postabortion family planning services.<sup>8</sup>

This supportive policy environment enabled the MOH and GRMA, with PRIME assistance, to launch a program in 1998 to institutionalize PAC services by strengthening the integration of PAC into the National Safe Motherhood Program and by decentralizing the training and support supervision systems to the regional level.<sup>9</sup> In 3 of Ghana's 10 regions, this initiative is strengthening existing regional resource teams, including clinical trainers and service supervisors, to train and support midwives in providing integrated safe motherhood services, including life saving skills (LSS)<sup>10</sup> and PAC, in public and private sector primary level facilities. The initiative is also strengthening the referral system between primary level facilities and district hospitals, and between midwives and physicians. In recognition of the critical role midwives and other primary providers can play in educating communities about unsafe abortion and the new services offered, PRIME also supported the MOH to continue development of PAC educational materials for use in facilities and community outreach work.<sup>11</sup> The MOH is interested in expanding the integrated LSS and PAC training and support program to the remaining 7 regions and to continue promoting family planning as a means to prevent unwanted



pregnancies.

### Kenya: A Private and Public Sector Partnership

In Kenya, the National Reproductive Health/Family Planning Policy Guidelines and Standards for Service Providers supports the provision of PAC services at the first available opportunity.<sup>12</sup> Private nurse-midwives registered with the Nursing Council of Kenya (NCK) requested PRIME assistance to include PAC in the range of preventive and curative maternal and child health services they offer. These private nurse-midwives have their own clinics, offer services in areas traditionally under-served by physicians (e.g. urban slums and rural market places), and frequently care for women experiencing obstetric emergencies.

In late 1998, in partnership with the National Nurses Association of Kenya (NNAK) and with support and sanctioning from the NCK and the Primary Health Care Division of the Kenya Ministry of Health, a PRIME-assisted pilot project was launched in 3 provinces.<sup>13</sup> Eighty nurse-midwives from 40 privately owned facilities are being trained and provided with support supervision to expand the array of services to include PAC. Expansion plans are underway to other districts and provinces.

To ensure that the new PAC service network is effective and can be sustained, the private nurse-midwives are linked to the public sector for referral, supervision and advocacy. Public sector public health nurses provide supervisory support to the private nurse-midwives who offer PAC services. A referral system for managing postabortion complications is being established between the private nurse-midwives and public sector physicians and clinical officers trained in PAC and working

at public sector hospitals. Public sector officials, including service directors, managers and supervisors, and representatives from the NNAK and NCK, participated in PAC advocacy workshops and are carrying out activities to increase support for PAC in the public and private sectors at the central, provincial and district levels.

Preliminary findings indicate that high quality PAC services are being provided by trained nurse-midwives including MVA, postabortion counseling and family planning, and other services such as STI and HIV counseling and prevention education. An exciting prospect is a recent recommendation by the NCK that the basic nurse-midwifery curriculum include PAC as a core competency by the year 2000.

### Uganda: Public Sector Integration of PAC Services

The Uganda MOH views integration of PAC into public sector midwifery service provision as a significant step toward improving PAC service access and quality. An important feature of the PRIME-assisted MOH project in Uganda responds to the MOH interest in determining the type of facilities at which trained midwives should offer PAC services: referral hospitals where there are ob/gyn specialists; district hospitals where there are medical officers; and, health centers where there are no medical officers. The MOH plans to use results of the project to finalize the national reproductive health service policy that would permit trained midwives to provide comprehensive PAC services, and to formulate PAC guidelines for service delivery and training, and PAC service, quality assurance, supervision

and training expansion strategies.

The Uganda health service system has several years experience in the provision of PAC services. Ugandan midwives based in hospitals and other health care units were trained in 1996 to assist physicians during MVA and to provide postabortion family planning. In 1998, the MOH and the Department of Obstetrics and Gynecology at Makerere University Medical School, in collaboration with PRIME and the USAID/Uganda-supported Delivery of Improved Services for Health (DISH) Project, initiated a pilot project in 9 districts to demonstrate that trained midwives, provided with on-site support supervision, can provide safe, high quality PAC services, including MVA.<sup>14</sup> The pilot project involves training 24 midwives in hospitals and health centers to provide emergency treatment of incomplete abortion, as well as providing postabortion counseling and family planning, and other services such as STI and HIV counseling and prevention education, and to incorporate information about unsafe abortion and family planning in their community activities. Special attention is paid to the referral system for managing complications, and 11 hospital-based ob/gyns and medical officers were trained and prepared to manage complications.

### Conclusions

The PRIME-assisted projects in Ghana, Kenya and Uganda—although not yet completely evaluated—are clearly demonstrating the potential of 3 approaches to expand the availability of PAC services at primary level facilities. PRIME and host-country organizations will be completing these projects



and formulating lessons learned and recommendations during the summer of 1999. In each country, data are being collected to determine the extent of achievement of project objectives and expected outcomes, including impact on a selected number of indicators including:

- Number of primary level facilities where trained midwives are providing comprehensive PAC services, including MVA
- Number of emergency postabortion patients treated by trained midwives using MVA
- Number of postabortion patients who wanted to prevent or delay a subsequent pregnancy and received a family planning method, by type of method
- Number of postabortion patients referred for or provided with other reproductive health services, by type of service

PRIME expects that project results will contribute to further understanding and documentation of the pivotal role of midwives at the primary service level in expanding the availability of high quality PAC services. More specifically, results will be used to answer program design and strategy questions:

- What are the advantages and benefits of training midwives to provide PAC services, using MVA?
- What are the barriers and facilitating factors to integrating PAC with other services provided by midwives?
- What are the minimum conditions and requirements needed for trained midwives to safely provide PAC services, using MVA, at different levels of health service delivery systems?

## References

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- <sup>10</sup> Life-saving skills (LSS) is a competency-based training program developed by ACNM. See Marshall MA, Buffington S. *Life-Saving Skills Manual for Midwives, 3<sup>rd</sup> Edition*. Washington, D.C.: American College of Nurse Midwives, 1998.
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