

The Situation of

Postabortion Care in Uganda

An Assessment and Recommendations



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Executive Summary

While abortion is illegal in Uganda except to preserve the life of the pregnant woman, abortions are common. A 1991 survey showed that over half of all 20-24 year-olds had terminated a pregnancy. Contraceptive prevalence among Ugandan women is low, contributing to the high rate of abortion. Only 7% of women aged 15-49 currently use modern contraception. Many abortions are unsafe, resulting in high rates of infection and bleeding. Complications of abortion are a major cause of morbidity and mortality in Uganda, accounting for about one-fourth of all maternal deaths. Postabortion care is a strategy to reduce death and suffering from unsafe abortion and prevent repeat abortion by providing emergency treatment for complications in combination with postabortion family planning and other reproductive health services.

This study assesses the current situation of postabortion care in Uganda to identify opportunities for future USAID program assistance through the DISH Project. In particular, information and opinions were sought on the feasibility of training nurse midwives in postabortion care in order to increase access to services in rural areas. Information was collected through key informant interviews, site visits, and review of available literature. Forty-four individuals representing 22 organizations were interviewed. These interviewees represent health care providers and trainers (doctors, nurses, midwives), government officials, NGOs, professional organizations, and donor agencies and projects.

Study results show that although the Manual Vacuum Aspiration (MVA) procedure for treatment of incomplete abortion has been demonstrated to be safe and cost-effective in Uganda, it is practiced only at selected facilities. Emergency treatment is provided by doctors only, and still consists largely of sharp curettage. For the most part, family planning services are not offered routinely at the time of emergency treatment, and links to other reproductive health care typically do not exist. Pre-service training for health personnel is inadequate, and support systems for postabortion care within the larger context of health services—support that ranges from policies and service delivery guidelines to expendable supplies for emergency treatment and family planning commodities—is lacking.

Looking to the future, interviewees support the strategy to expand postabortion care services to the grassroots level by training nurse midwives in MVA and postabortion family planning. Issues were identified about the best way to accomplish this strategy, including the need to clarify policies regarding the roles and responsibilities of nurse midwives and the importance of involving district health managers in decision making. All interviewees voiced a concern about the lack of information on postabortion care. However, many cautioned that lack of research should not forestall efforts to improve and expand services. They emphasized the need to balance research with intervention projects.

Overall, a strong interest and commitment to strengthen postabortion care services exists among the Ministry of Health, the various NGOs, implementing agencies and donors who work in reproductive health. Postabortion care is identified as a component of the National Safe Motherhood Programme. The MCH/FP strategic plan includes training in MVA and Life Saving Skills. Although current activities are few, many organizations have explicit plans for incorporating postabortion care in ongoing programs, and for linking postabortion care with current or planned activities.

Finding ways to increase access to quality services, particularly in rural areas, was identified by many interviewees as a key challenge. Proposed strategies to deploy nurse midwives for postabortion care should be viewed as part of the larger effort to strengthen the capacity of district-level administrations to manage and provide health services. While training has been the primary focus of postabortion care assistance to date, many other factors must be addressed, including policy, infrastructure and supplies, attitudes of providers and communities, IEC, management, and supervision. Aspects of postabortion care that go beyond emergency treatment to help prevent repeat abortion also deserve attention. While changes in medical procedures may move more slowly, improved postabortion family planning counseling and methods can be implemented through existing programs more quickly.

Evidence gathered during the course of this assessment indicates a need for further study of the feasibility of deploying nurse midwives for postabortion care, prior to launching a national program. Various pieces of a feasibility study are outlined in future plans, but currently MOH and the major donors have no specific plans to conduct a comprehensive study that would investigate the strategy in its entirety. There is consensus that feasibility testing and policy change should go hand-in-hand. Due to the sensitivity of the issue, many advised a "go-slow" approach to service expansion by nurse midwives, accompanied by active stakeholder involvement, particularly at the district and community levels.

The DISH Project with its multidimensional, integrated design offers a valuable opportunity to conduct a feasibility study. DISH program managers indicate that potential study activities fit well with existing activities and could be added without a major investment of additional resources. If possible, the study should be implemented in at least two districts where DISH is now working, in order to examine variability and issues of replicability. The intervention should be defined within the broader framework of the Safe Motherhood Mother Baby package, reflecting the approach that was recommended by the majority of those interviewed.

Magnitude of the Problem

Complications of unsafe abortion

Abortion in Uganda is illegal except to preserve the mental or physical health of the pregnant woman. Yet, paradoxically, abortions are common. A nationally representative survey of 4,500 young Ugandan women conducted in 1991 revealed that more than half of women aged 20-24 had terminated a pregnancy (Agyei and Epema, 1992). Many of these induced abortions have been performed by untrained persons who use a variety of unsafe procedures. Such abortions lead to high rates of infection and other complications. Many women who suffer from complications of abortion do not receive proper treatment and often die unnecessarily.

Complications of abortion are a major cause of morbidity and mortality in Uganda. According to Professor Mmiro, head of the Department of Obstetrics and Gynaecology at Makerere Medical School, the number of women suffering complications of unsafe abortion has increased significantly since the 1970s when there were very few cases of "criminal abortion." A study conducted at Mulago Hospital in 1993 showed that complications of abortion accounted for 25% of all maternal deaths (Bazira, 1993). A 1995 study conducted at Mulago Hospital attributed unsafely induced abortion to 85% of the deaths due to abortion complications. The remaining 15% were due to complications of spontaneous abortion, or miscarriage (Mirembe and Okong, 1995). In this study it was observed that most abortion-related deaths occurred among young (ages 15-24) and low parity (1-2 births) women. However, women of all ages and parities present with complications of abortion. In addition, Professor Mmiro reports that 90% of the infertility cases he sees are due to complications of abortion.

Unmet need for family planning services

According to the 1995 Uganda Demographic and Health Survey, more than one in five Ugandan women who indicate that they either want to space or limit childbearing are not using family planning. Contraceptive prevalence is low. Only 16% of all women in their reproductive years have ever used a modern contraceptive method. Only 7% currently use modern contraception. Contraceptive use is lower in rural, compared to urban areas, at 5% and 28% of currently married women, respectively. Modern contraceptive prevalence is lowest among those aged 15-19-- 93% of married women aged 15-19 are not using modern family planning. Limited access to quality family planning services, particularly in rural areas and among young women, contributes to the high rates of unsafe abortion and abortion complications.

Postabortion Care

Addressing the larger picture

Postabortion care (PAC) is a health intervention designed to reduce death and suffering from unsafe abortion, and to prevent repeat abortion. It focuses on women with abortion complications. Specifically, it involves strengthening the capacity of health institutions to offer and sustain three specific components:

1. Emergency treatment services for complications of spontaneous or unsafely induced abortion.

In Africa, sharp curettage is the procedure used most often for treating incomplete abortion, the primary cause of infection and bleeding. Sharp curettage is performed by doctors and requires an operating theatre and general anaesthesia. Manual Vacuum Aspiration (MVA) is a newer, safe, cost-effective, preferred procedure for treating many cases of incomplete abortion. MVA can be performed on an outpatient basis without general anesthesia. Furthermore, studies have demonstrated that lower-level cadres of trained service providers, in addition to doctors, can perform MVA safely and effectively. The procedure offers the potential to decentralize services, reducing patient loads at hospitals, and increasing access to emergency services outside urban areas.

2. Postabortion family planning counseling and services.

Most women who seek treatment for the complications of abortion were not using a family planning method prior to the pregnancy. In a study conducted at 4 health facilities in Uganda in 1995, only 9% indicated that they were using contraception at the time of their most recent pregnancy (Kinoti, et.al., 1996). The overwhelming majority of patients said that no one had talked to them about family planning services during their hospital stay. Most (75%) said that they would have liked to have had family planning information and a method offered to them. Providing counseling and services at the time of emergency treatment can help break the cycle of unwanted pregnancy and repeat abortion.

3. Links between emergency postabortion treatment services and comprehensive reproductive health care.

Particularly for young adults, emergency treatment for abortion complications is often a woman's first entree to the health care system. This presents an opportunity to evaluate a woman's overall health, educate her on the importance of healthy reproductive behavior and introduce other services, such as STD/HIV detection and treatment, prenatal care, and social services.

Unfortunately, these services are rarely offered at the time of emergency treatment.

Recognized need to expand PAC services in Uganda

Unsafe abortion is a major public health problem in both the urban and rural areas of Uganda. Unfortunately, emergency services for the treatment of abortion complications are available, typically, only at the hospital level, severely limiting access to these services, particularly for rural women. At those facilities that provide emergency services, demand is high. An estimated 64% of all gynaecological admissions at Mulago Hospital, 53% at Nsambya Hospital, and 29% at Jinja Hospital are due to cases of incomplete abortion (Kinoti, et.al., 1995). Sharp curettage is the standard treatment method for incomplete abortion at most facilities. It requires a trained physician, general anesthesia and an operating theatre.

In 1996, Mulago Hospital, with training and assistance from IPAS, began to perform the MVA procedure. An initial assessment demonstrated its safety and cost-effectiveness and led to plans to expand MVA services to other facilities. In addition to promoting the use of MVA at district hospitals, the feasibility of training nurse midwives to provide MVA services at lower-level health facilities has been discussed by members of the Department of Obstetrics and Gynaecology at Mulago Hospital, the Ministry of Health, IPAS, and several donors. At a workshop held in Kampala in April 1996, participants representing these organizations made formal recommendations to expand PAC services by training nurse midwives in MVA and postabortion family planning.

USAID and the DISH Project

Opportunity to improve and expand PAC services

USAID/Kampala, through the Delivery of Improved Services for Health Project (DISH), provides support to 10 districts in Uganda to strengthen reproductive health services. The training of nurses and midwives is an integral component of DISH. In response to the recommendations of the April 1996 workshop, USAID, through DISH and the Ministry of Health (MOH), expressed an interest to support expanded PAC services by training nurse midwives.

PAC is an important, but new, activity for USAID in Africa. In 1996, the USAID Regional Economic Development Services Office for East and Southern Africa (USAID/REDSO/ESA), in collaboration with the USAID Bureau for Africa (Sustainable Development, Human Resources Division), the POLICY Project and other partners, launched a regional initiative to reduce the number and

consequences of unsafe abortion by promoting PAC services. The PAC Regional Initiative offers assistance to country Missions to assess the current magnitude of unsafe abortion and the need for PAC services, identify and plan cost-effective interventions, mobilize resources for PAC, and promote information-sharing among countries in the region. Supporting the interests of USAID/Kampala and DISH to strengthen PAC services, a PAC Regional Initiative team conducted a field assessment in Uganda during the week of 23th March 1997. This report summarizes the assessment results.

Objectives and Methods

This study was designed to assess the current situation of postabortion care in Uganda in order to identify and evaluate opportunities for future USAID program assistance. Primary objectives were to:

- Identify key stakeholders and key players
- Describe current PAC services and clarify recent major PAC activities and outcomes
- Identify issues and poll opinions regarding the expansion of PAC services through nurse midwives
- Assess government and donor interest in PAC and describe future plans
- Recommend specific actions to USAID/Kampala.

Secondary objectives were to direct the attention of key decision makers to the importance of PAC and to encourage support for PAC programs.

The assessment was conducted from 23th-29th March, 1997. Assessment team members included Dr. Florence Mirembe, Mulago Hospital, Makerere University; Tembi Matatu, DISH Project, INTRAH; Anne Otto, DISH Project, INTRAH; Michelle Folsom, USAID/REDSO; and, Susan Settergren, POLICY Project, Research Triangle Institute.

Information was collected through key informant interviews, site visits, and review of available literature. The assessment team selected an initial set of key informants; additional key informants were identified as the interview process evolved. Forty-four individuals representing 22 organizations were interviewed. These interviewees represent health care providers and trainers (doctors, nurses, midwives), government officials, NGOs, professional organizations, and donor agencies and projects. A complete list of people contacted and their organizations is provided in Annex A.

Current Status of PAC Services

Table 1 summarizes the status of PAC services at selected health facilities. This information comes from personal interviews and site visits during the assessment. One note of caution: this assessment is not meant to represent Uganda as a whole. Rather the selected facilities likely represent institutions with higher quality of care because they are located in Kampala and other urban centers. Documented information regarding the types of services offered at various health facilities throughout Uganda does not exist at the Ministry of Health or elsewhere.

Table 1. Summary of current postabortion care services

Facility	PAC Services Provided
Mulago Hospital <i>Makerere University Medical School, Kampala</i>	MVA and sharp curettage for treatment of complications of abortion in the emergency ward. Only doctors provide emergency treatment. Postabortion counseling provided; patients referred for family planning methods. A room on the ward is undergoing renovation for family planning services and counseling.
Jinja Hospital <i>Regional public hospital, Jinja</i>	Sharp curettage is the only emergency treatment method performed. Limited counseling. Patients referred to the MCH/FP clinic for family planning services.
Nsambya Hospital <i>Private Catholic hospital, Kampala</i>	Sharp curettage is the only emergency treatment method performed. Limited counseling. Patients referred for family planning services.
Marie Stopes Clinic <i>Private clinic, Kampala</i>	MVA to treat abortion complications. Procedure performed by a doctor. Nurses provide family planning counseling and a method if client receptive. STDs treated when they are detected.
Naguru Teenage Information and Health Centre <i>Private clinic, Kampala</i>	MVA, performed by a doctor, to treat abortion complications; family planning counseling and contraceptives provided.

Facility	PAC Services Provided
<i>In general:</i>	
District and regional hospitals	Sharp curettage performed by doctors is the only emergency treatment offered at public hospitals. Some private NGOs have trained their health care providers in MVA and postabortion family planning. No comprehensive information describing who they are or the coverage of these services.
Public health centres	Only one-third of health centres provide any form of care for complications of abortion. Source: <i>Reproductive Health Needs Assessment (survey of 14 of 39 districts) 1995/96.</i>

Limited use of MVA

Sharp curettage remains the most widely used treatment for incomplete abortion. The MVA procedure has not yet been introduced at most facilities; that is, staff have not been trained and equipment and supplies are not available. Mulago Hospital is the primary facility using the MVA procedure and staff there have demonstrated its feasibility and cost-effectiveness. However, even at Mulago Hospital, MVA services are not offered 24 hours a day.

The facilities that do provide MVA treatment report that the necessary equipment (e.g., MVA kits) is available. However, in each case the introduction of MVA has been supported by donor-funded project assistance and equipment is not purchased directly by the facility.

Emergency treatment by doctors only

Since sharp curettage is the most widely used procedure, emergency treatment is provided almost exclusively by doctors. Recently, several nurse midwives at Mulago Hospital were trained by Mulago doctors to provide MVA services. Their performance was closely monitored by doctors on the ward and their skills were highly rated. However, they subsequently have been transferred to other hospital wards and are no longer providing MVA services. According to the people interviewed, these nurse midwives at Mulago Hospital are the only nurse midwives in Uganda to date who have been trained in MVA.

Incomplete services

For the most part, postabortion care is not provided as a complete package. Family planning services are not offered routinely at the time of emergency treatment, and links to other reproductive health care typically do not exist. Even when family

planning services are provided at the time of emergency treatment, systems for client follow-up are not in place. No official standards or guidelines for PAC service delivery have been written or adopted.

Postabortion family planning services are more highly developed at facilities that also offer MVA treatment. Mulago Hospital is currently renovating a room on the Obstetrics and Gynaecology Ward for the purpose of providing family planning services. Naguru Teenage Information and Health Centre provides family planning counselling and services to its clients following emergency treatment.

Family planning services also are provided at the Marie Stopes Clinic. Staff there indicate, however, that most clients don't accept a method at the time of treatment. Explanations offered by the staff for the low acceptance rate include: younger clients say they intend to abstain from sexual relations and therefore don't need a method; some clients prefer condoms (they are also counseled on HIV), and they generally prefer to get condoms elsewhere; some clients return at a later date for family planning services.

Insufficient PAC skills

Pre-service training in PAC for nurses, midwives and doctors is inadequate. Currently, medical students at Makerere Medical School receive a one-hour introduction to MVA and a one-hour course on family planning. Doctors who intern in Obstetrics and Gynaecology at Mulago Hospital are taught to perform MVA; however, interns at other hospitals where MVA equipment is not available (such as, Jinja, Nsambya, Rubaga, and Mengo) are not trained.

The total number of service providers trained in PAC is unknown. In-service PAC training, as well as other MCH/FP in-service training, is provided by different sources through various programs and projects. The Ministry of Health (MOH) recently made changes to the Life Saving Skills curriculum for nurses and midwives. PAC is a component of that curriculum. However, current testing of the new curriculum does not include testing the PAC component.

The largest in-service, in-country PAC training program was initiated in 1996 by Mulago Hospital and IPAS with funding from UNFPA and the Brush Foundation. In January 1996, 5 doctor-nurse midwife teams were trained. The doctors were trained in MVA and the nurse midwives were trained to assist the doctors with MVA and to provide postabortion counselling and family planning methods. All 10 also were trained as trainers.

After 4 months of practice at Mulago Hospital, MVA and sharp curettage were compared in terms of efficacy, safety and cost. MVA was found to be superior on all dimensions. Additional training was conducted in November 1996 by Mulago Hospital staff (the five doctors and a nurse trained in January). Five more doctors

and eight nurses from five hospitals (Mulago Hospital and four district hospitals in UNFPA-assisted districts) and one health centre were trained.

Inadequate support systems

Little attention has been directed to the broader context in which postabortion care services are offered. Interviewees noted that, in addition to training, other elements of PAC service delivery should be strengthened. These elements include:

- infrastructure
- policies and service delivery standards
- infection prevention practices
- logistics management of expendable supplies for emergency treatment (gloves, cotton wool, blood, disinfectant, etc.) and family planning commodities
- management and supervision
- IEC materials and strategies
- information systems for monitoring and evaluation

This neglect has limited the effectiveness of some of the training efforts. For example, it is reported that most of those trained in November 1996 by Mulago Hospital are not practicing MVA at their district hospitals because they lack expendable supplies (not necessarily MVA kits).

Expansion of PAC Services

Consensus that nurse midwives could play a larger role

All persons interviewed support the strategy to expand PAC services by training nurse midwives to perform MVA. There is unanimous agreement that this is the best strategy for expanding services to the grassroots level – where the need for services is greatest. Most agree that it would be best to begin slowly and to train first those who work in the public sector, primarily because they are more likely than private nurse midwives to serve rural areas. Some suggested that MVA training for medical assistants also should be considered.

Issues that were raised concerning the deployment of nurse midwives for PAC services included:

- How prevalent are unsafe abortions? Very little information is available.
- Demand for PAC services at the health centres is unknown. Will women go to health centres for treatment?

- District health committees and district medical officers (DMOs) have not been involved in the discussions. Are they supportive? How, and when should they be brought into the dialogue?
- How can communities facilitate the strategy? What are their opinions? Their roles?
- Provider attitudes toward clients are often negative. How can they be improved?
- What is required to ensure client safety and quality of care (esp., infection prevention)?
- What do other health cadres think about plans to train nurse midwives? Are they supportive? What are their roles?
- IEC and counseling materials and strategies are scarce. What materials are needed?
- MVA equipment can be used to induce abortions as well as treat complications. How can we ensure availability and proper use of equipment and supplies?
- Guidelines and standards for service delivery and supervision are needed.
- Spontaneous abortion, or miscarriage, often carries the stigma of induced abortion. Terminology needs clarification; service providers, clients and communities should be educated.
- Is this strategy financially sustainable? What are some options for cost sharing and cost recovery?

Confusion regarding nurse midwife policies

The assessment focused particularly on clarification of policies enabling nurse midwives to perform MVA. While all people interviewed supported the strategy promoting PAC service provision by nurse midwives, some believed that current policies limit the role of nurse midwives. Others indicated that formerly restrictive policies had been liberalized recently. Most were unfamiliar with the status of relevant policies and the process for policy revision. While no one felt that current policies explicitly restrict nurse midwives from practicing MVA, the majority expressed the importance of having supportive policies in place prior to launching a national effort.

In November 1996, Parliament enacted a new *Nurses and Midwives Act*. It does not spell out roles and responsibilities of nurses and midwives, but rather identifies this as a responsibility of the Council of Nurses and Midwives. Very few people interviewed were aware of this legislation or what it covered.

The *Midwives' Handbook and Guide to Practice, authorized by the Uganda Council for Midwives and Nurses, 1993*, is the most recent document to articulate the responsibilities of nurse midwives. It does not mention duties related to PAC services. MOH (MCH/FP division) reports that this handbook currently is being revised and should be completed by mid-1997. MOH expects that this revision

will spell out authorization for nurse midwives to perform MVA. Based on information obtained from interviewees, it is not clear who has primary responsibility for drafting this handbook and what the approval process entails. However, most interviewees indicated that they would like to be kept informed of the status and outcomes of any relevant policy revisions.

Plea for better coordination

Progress has been made in the past year to improve collaboration and coordination of PAC activities among MOH, NGOs, and donors. The most notable effort is the dissemination and advocacy workshop held in Kampala in April 1996. Key plans and strategies pertaining to PAC that have been drafted since last April include:

1. *Improving Postabortion Care in Uganda: Dissemination of Progress and Planning Workshop*. Proceedings of the April 1996 workshop, the first public discussion of PAC among MOH, Mulago Hospital, and donors. Recommendations were made to expand services; specifically, to expand MVA services and to provide MVA services through trained nurse midwives.
2. *MVA and Postabortion Care in Uganda, January 1996-1999*. Prepared by Mulago Hospital and MOH to elicit donor support as follow-up to the April workshop.
3. *Uganda Safe Motherhood Programme National Plan of Action, 1996-1998*. Draft document currently is being updated. A new draft is expected April 1997.
4. *Maternal and Child Health and Family Planning: Five Year Strategic Plan (1997-2001)*. Completed March 1997.

Although the first two documents were prepared several months ago, many people interviewed had not seen them. The second two documents, MOH national plans, include PAC as key components. Both had been circulated for review, but had not been finalized at the time of the assessment.

In general, interviewees expressed concern about fragmented programming, wanted to learn more about what others are doing in PAC, and pled for better collaboration. In particular, several people expressed concern that decision makers at the district level have not been involved in the dialogue about PAC.

Balance between research and action

Reliable information to guide future programming in postabortion care is scarce. Gaps in knowledge (regarding even such basic issues as the magnitude of the demand for services and community opinions) have hindered dialogue at the policy and planning levels. Information on client needs and characteristics, as well as provider needs and attitudes, is necessary to improve quality of care. In

particular, the feasibility of expanding services through deployment of nurse midwives for postabortion care has not been tested.

All persons interviewed voiced a concern for the lack of information on postabortion care. However, many pointed out that we know enough to recognize that abortion complications are a significant, yet neglected problem and we have strategies that hold promise for addressing the problem. Many cautioned that lack of research should not forestall efforts to expand and improve services. They emphasized the need to balance research with intervention projects. With regard to launching a national effort to expand the role of nurse midwives to include MVA, there is consensus that feasibility testing and policy change should go hand-in-hand. Due to the sensitivity of the issue, many advised a "go-slow" approach to service expansion, accompanied by active stakeholder involvement, particularly at the district and community levels.

Government, NGO, and Donor Interest and Activities

Widespread support for postabortion care

The Department of Maternal and Child Health and Family Planning of the Ministry of Health identifies PAC as a priority intervention to reduce maternal mortality. Specifically, their new five-year plan states:

"Maternal mortality among women 15-49 can be substantially reduced by providing adequate pre-natal, delivery and post-partum care; family planning services; and, effective treatment of infections which result from unsafe abortions." (p.2)

MOH is committed to providing postabortion care as an integrated component of the Mother Baby Package. In its central government capacity, MOH is responsible for developing and disseminating policy guidelines, ensuring quality control, conducting research, monitoring and evaluating programs and services, and strengthening the capacity of district administrations to offer services. The Safe Motherhood Programme Action Plan, currently under revision, specifies strategies to augment PAC services within the Mother Baby package.

Overall, a strong interest and commitment to strengthen PAC services exists among the various NGOs, implementing agencies and donors who work in reproductive health. Although current activities are few, many organizations have explicit plans to undertake PAC activities in the near future. In general, organizations recognize that there are opportunities within their current programs for linking PAC with ongoing and planned reproductive health activities. Table 2 summarizes interests, along with current and planned PAC activities, among the

various key players who were interviewed for the assessment. Descriptions of their broader programs are provided in Annex B.

Table 2. Current and planned postabortion care activities

Organization	Activities
Ministry of Health, Department of Maternal and Child Health and Family Planning	<ul style="list-style-type: none"> • PAC is identified as a component of the Mother Baby package within the Safe Motherhood Programme. • MCH/FP strategic plan includes Life Saving Skills and MVA training. • Other specific actions are identified in the <i>Safe Motherhood Programme Action Plan</i>. • MOH has collected information on management of incomplete abortion at the district-level as part of the <i>Reproductive Health Needs Assessment Survey 1995/96</i>. Further analysis of the data is needed.
Department of Obstetrics and Gynaecology, Mulago Hospital, Makerere Medical School	<ul style="list-style-type: none"> • Provide services and train medical personnel in PAC/MVA; conduct operations research and provide technical assistance in PAC. • Expanding postabortion family planning services on the Obs-Gynae ward.
Institute of Public Health, Makerere University	<ul style="list-style-type: none"> • Provide field-based training linked to district health teams for graduate students in public health. • Supportive of addressing problems of unsafe abortion and conducting/facilitating operations research through the graduate training program.
IPAS	<ul style="list-style-type: none"> • At Mulago Hospital, provided staff training and equipment for MVA and postabortion family planning; technical assistance to assess safety and efficacy of MVA. • Provided technical assistance for dissemination workshop in April 1996. • Working with the MOH to develop a national strategic plan for MVA training. • Planning MVA training for 18 district hospitals.
USAID/Uganda	<ul style="list-style-type: none"> • Implements an integrated reproductive health project (DISH) in 10 districts with emphasis on service delivery, training, IEC, and social marketing of contraceptives and STI treatment packages. • Exploring options for adding PAC activities to the service delivery, training and IEC components. See Recommendations below.
INTRAH	<ul style="list-style-type: none"> • Pre-testing the Life-Saving Skills curriculum with the MOH.

Organization	Activities
UNFPA	<ul style="list-style-type: none"> • Funded procurement of MVA equipment, two postabortion care training sessions at Mulago Hospital, and the dissemination workshop which reported findings of a study comparing MVA to sharp curettage (with IPAS). • Country Plan includes training of 2 doctor-midwife teams in each of its 26 districts; procurement of MVA equipment. • Supports development of the Safe Motherhood Life Saving Skills Curriculum and Training materials. • Supports the Naguru Teenage Information and Health Centre.
ODA and CARE	<ul style="list-style-type: none"> • ODA supports the Mother Baby package in its three districts. • CARE implements most of ODA's district-level activities with an emphasis on raising awareness of health needs at the community level and developing community health action plans. • Rehabilitating 83 health units with equipment and staff training, including emergency obstetric care, provision of essential referral services, IEC and family planning. • Committed to PAC training; plan to train in the next funding cycle.
Association of Uganda Women Medical Doctors	<ul style="list-style-type: none"> • 1996/99 workplan includes: <ul style="list-style-type: none"> – research on unsafe abortion in 10 urban and 10 rural hospitals; – film on consequences of early sex with special reference to teenage pregnancy and abortion; – sensitization workshops on safe motherhood (with emphasis on abortion); – training of health workers in PAC/MVA.
JHPIEGO	<ul style="list-style-type: none"> • Train faculty at nursing and para-medical schools in family planning and STIs; develop curricula. • Currently have no specific PAC component, but train midwives in family planning for postabortion women. • Committed to including postabortion family planning and MVA in pre-service curricula.
Pathfinder International	<ul style="list-style-type: none"> • Funding renovation of a room on the Obs-Gynae ward at Mulago Hospital for provision of reproductive health services. • Provided training in postabortion family planning and reproductive health services at Mulago Hospital.
AVSC	<ul style="list-style-type: none"> • Developed and tested postabortion family planning IEC materials. • Planning MVA training at 4 sites.

Conclusions

District-level participation is important

Clearly, unsafe abortion is recognized as a public health problem within the health community in Uganda. Postabortion care is supported as an intervention to help reduce maternal mortality and morbidity. Successful efforts have been initiated at Mulago Hospital and other urban health facilities to improve the treatment of abortion complications. The current challenge is to expand such services to lower levels of the health care system, particularly in rural areas. The issues and problems associated with PAC expansion resemble those associated with the decentralization of many health services, especially emergency services. The cast of stakeholders and actors has broadened, decision making is dispersed, roles and responsibilities are changing. In the case of postabortion care, nurse midwives who provide services at health centers are being considered as one solution to expanding services.

The proposed changes have implications for the entire health system. For example, if health centers acquire the capacity to manage even selected cases of incomplete abortion, the demand for staff time and resources at higher-level facilities is potentially decreased. Responsibilities among various personnel within a facility also would shift creating an impact on the whole facility. The strategy to deploy nurse midwives for PAC should not be viewed as isolated from related, ongoing efforts to strengthen the capacity of district-level administrations to manage and provide health services. In particular, district-level opinion leaders, service providers, and management need to be brought into the dialogue on policies, strategies and implementation.

Few district-level stakeholders were interviewed as part of this assessment, so information on their participation to date in dialogue on postabortion care is partial and mostly second-hand. This limited information, however, suggests that perspectives, ideas and support at the district-level are critical to the success of expanding postabortion care services.

More than training is needed

Training has been the primary focus of assistance in efforts to strengthen postabortion care services. While it is an important first step, training alone will not prove sufficient. Many issues raised in the interviews surrounding the training of nurse midwives reflect the fact that insufficient attention has been directed to

the broader context within which trained personnel perform. In order to ensure quality and safety of services, many factors must be addressed simultaneously. Those mentioned most often in the interviews include: policy guidelines and service delivery standards, infrastructure and supplies, attitudes of providers and the community, management and supervision. Technical assistance to strengthen these components should accompany and coordinate with training efforts.

Postabortion family planning warrants attention

By definition, postabortion care is an integrated package of services. In Uganda, however, postabortion care has focused on emergency treatment of abortion complications. Priority has been placed on this first component of postabortion care, replacing sharp curettage with MVA. Family planning services for women who present with complications have been strengthened only at facilities where MVA has been introduced.

The capacity to offer MVA services is very important because it has a direct and immediate impact on saving women's lives. Postabortion family planning, which aims to prevent repeat abortion, also deserves attention. Improvements to postabortion family planning services may be feasible at facilities that still rely on sharp curettage for emergency treatment. For example, while it may require considerable time and effort to introduce MVA to district hospitals, it may be quite manageable to improve postabortion family planning counseling and methods in the meantime.

The three PAC components do not need to be programmed simultaneously or sequentially. Consideration of postabortion care as an integrated component of the Mother Baby package, as recommended by the Safe Motherhood Programme, should help to highlight opportunities for parallel activities, which in turn will strengthen all components of postabortion care.

Consensus and leadership have built a strong foundation

Postabortion care should be part and parcel of the decentralization and integration of health care services. As such, it both benefits and suffers from the issues and challenges that surround these larger efforts. Progress feels slow because key players have increased in number and diversity. Setting priorities becomes problematic when, by definition, services are interdependent.

Partly because of the sensitive nature of postabortion care, the stakeholders interviewed for the assessment recognize the importance of building a strong base of support. They also expressed concern that postabortion care not be approached

as a stand-alone program, although some are concerned that it could become buried within the bigger maternal health framework. Experience suggests that while these perspectives are key to the success of any integration and decentralization effort, often they are not shared. Consensus on the approach to strengthening postabortion care services, combined with the leadership of a growing number of champions, suggests that a strong foundation for success has been laid.

Recommendations to USAID/Kampala

Evidence gathered in the course of this assessment indicates a need for further study of the feasibility of deploying nurse midwives for postabortion care, prior to launching a national program. Various pieces of a feasibility study are outlined in future plans, but currently MOH and the major donors have no specific plans to conduct a comprehensive study that would investigate the strategy in its entirety.

The DISH Project with its multidimensional, integrated design offers a valuable opportunity to conduct a comprehensive study. DISH program managers indicate that potential study activities fit well with existing activities and could be added without a major investment of additional resources. Other implementing agencies now working in Uganda (e.g., AVSC, IPAS, etc.) and other donors should be invited to collaborate.

If possible, the study should be implemented in at least two districts where DISH is now working, in order to examine variability and issues of replicability. The intervention should be defined within the broader framework of the Safe Motherhood Mother Baby package, reflecting the approach that was recommended by the majority of those interviewed. In order to move forward with this recommendation, all the policies that pertain to the responsibilities of nurse midwives must be clarified and disseminated.

Preliminary ideas for this feasibility study are outlined below.

Objective:

To test the feasibility of expanding postabortion care services to the level of health centers through service provision by nurse midwives.

Expected outcomes:

- Determination of the impact and cost-effectiveness of the introduction of services at selected sites
- Elaboration of the issues, constraints, and opportunities
- Recommendations for further expansion of PAC services.

Options for specific activities (from among those discussed during the assessment):

- Develop/test the PAC component of the new Life Saving Skills curriculum
- Assist to develop service delivery standards and guidelines
- Conduct in-service PAC training, including training in MVA, family planning methods, and counseling
- Improve supervision and management skills, including attention to provider attitudes
- Develop IEC materials and strategies:
 - community education and sensitization
 - postabortion family planning and other reproductive health services
 - health provider education and sensitization
- Build commitment among district service providers and managers, (e.g., using COPE and INREACH techniques)
- Facilitate policy development and dialogue at national and district levels
- Strengthen district capacity to manage and sustain services:
 - strategic planning
 - resource allocation
 - monitoring and evaluation
- Document and disseminate pilot study results.

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Annex A

Persons interviewed, 23rd - 29th March, 1997

Donors

Jay Anderson, USAID
Rose Cooper, ODA
Francois Farah, UNFPA

Ministry of Health, Entebbe

Professor Emmanuel M. Kaijuka, Commissioner for Health Services (MCH/FP)
Dr. Olive Sentumbwe-Mugisa, WHO- Safe Motherhood
Lorna Tumwebaze, Population Secretariat
Dr. Bazirake, National Expert, UNFPA
Dr. A. K. Mbonye, Research Director
Regina Ssendi, MCH/FP Trainer

Mulago Hospital, Makerere University

Dr. Mmiro, Head OB/GYN
Dr. Fred Kinene, Director of Postabortion Care
Dr. Charles Kiggundu, OB/GYN
Ms. Nakirija, In Charge, Gynae Emergency

Nsambya Hospital, Kampala

Dr. Pius Okong, OB/GYN
Dr. Kiiza, Medical Superintendent

Jinja Regional Hospital, Jinja

Dr. Benon, Medical Superintendent
Dr. P. Nsiimwe, Head OB/GYN

Nurse and Midwifery Training School, Jinja

James Balikagala, Senior Nursing Tutor
Margaret Chota, Midwifery Tutor in Charge

Marie Stopes Clinic, Kampala

Dr. Godwin Turyasingura, OB/GYN,

Naguru Teenage Information and Health Center, Kampala

Dr. Sarah Naikoba, Medical Officer
Edith Mukasa, Administrator/Social Scientist

Institute of Public Health, Makerere University

Dr. Fred Wabire-Mangeni, Head

DISH Project

Jean Karambizi, Pathfinder
Tembi Matatu, INTRAH
Anne Otto, INTRAH
Cheryl Lettenmeir, JHU/CCP/PCS

CARE

Dr. Carol Abeja

JHPIEGO

Alice Nkangi
Dr. Byamugisha

AVSC

Dr. Henry Kakande

Nurses Council

Mrs. Nalubega

IPAS

Christine Achurobwe, Midwife trainer

YWCA

Mrs. Alice Mungerera

Association of Uganda Women Medical Doctors

Dr. Olive Sentumbwe-Mugisa
Dr. Esther Aceng
Dr. Janet Kayita
Dr. Elizabeth Ekochu
Dr. Zainob Akol
Dr. Christine Biryabareme

FIDA, The Uganda Association of Women Lawyers

Jacqueline Asimwe
Pauline Popina
Matilda Makata
Winnie Agabo

Donor and NGO Assistance in Reproductive Health (among those interviewed)*

Organization	Program Activities
UNFPA	<p>Working in 26 districts and at the central government level. UNFPA portfolio includes: RESCUER (Rural Extended Services and Care for Ultimate Emergency Relief) program, a new, innovative referral system; PEARL (Programme for Enhancing Adolescent Reproductive Life); development of the Safe Motherhood Life Saving Skills Curriculum and Training Materials; training CHWs as CBDs; support to NGOs, such as FIDA ,who play advocacy roles in mobilizing women; support for the formulation of the national population policy; and, development of capacity in the formal and non-formal sectors. UNFPA will support research on maternal mortality.</p>
USAID	<p>Assistance is implemented in 10 districts through the DISH Project, an integrated reproductive and child health project. Provide contraceptives, health worker training including midwives and TBAs on Safe Motherhood Life Saving Skills. DISH Project implementers and activities include:</p> <p><u>PATHFINDER</u>: Service delivery</p> <p>Developing integrated health services including the expansion of CBD agents, HMIS, health financing and cost sharing activities.</p> <p><u>INTRAH</u>: Training</p> <ul style="list-style-type: none"> - Comprehensive Midwife Training: Family planning, maternal health, STI syndromic management - Tailored Midwife Training: Family planning update - Lifesaving Skills: EOC - based on WHO Mother Baby package <p><u>IHU/CCP/PCS</u>: IEC</p> <p>Focus on family planning and youth HIV messages, moving into maternal health, using mass media, theatre; produced a training video on integration called "Caring Completely"</p> <p><u>SOMARC</u>: Social Marketing</p> <p>Social Marketing: Protector condom and pills, Depo at private clinics, STI treatment package.</p>

* GTZ is a major donor in reproductive health. Their information is not included in this report because they were not interviewed during the assessment due to scheduling conflicts.

Organization	Program Activities
ODA	Working in 3 districts in: Health Sector Reform (health financing schemes and hospital autonomy in the Health Planning Unit); reproductive health, supplying Depo and STI drugs; HIV (a palliative care and treatment center for those living with HIV and by supporting NGOs; and, immunizations (by supporting UNICEF). CARE implements ODA activities at the district level, in the primary health units and at the community level.
CARE	Supports reproductive health care in Kabale, Rukungiri and Kaponworwa districts. Trains health workers in family planning and emergency obstetric care using Safe Motherhood Lifesaving skills.
IPAS	Manufactures and distributes MVA equipment. Advocates for improved postabortion care, conducts research, and trains health care providers in MVA and family planning.
JHPIEGO	Currently doing pre-service training of nurses and medical assistants, phasing in curriculum for doctors.
AVSC	Expanding access to high quality, clinic-based permanent and long-term contraception. Currently focusing on integration, decentralization of supply depot, training, supervision of on-the-job training in surgical and counseling skills and management using COPE, TA for site supervision, and " Men as Partners."
Association of Uganda Women Medical Doctors	Advocates for the reproductive rights of women. Activities include research, speaking engagements and training.
YWCA	Works to improve the quality of life for rural women, particularly young women. They have a health clinic at headquarters in Kampala and in two districts they run a Health Improvement Project which includes a large CBD program.
FIDA- Uganda Association of Women Lawyers	FIDA promotes legal reform and educates women and men on women's legal social rights. FIDA has established legal aid clinics and works at the community level on civil rights and operations.