

**MALAWI MINISTRY OF HEALTH AND POPULATION
REPRODUCTIVE HEALTH UNIT**

NATIONAL POSTABORTION CARE STRATEGY

Mission

The Ministry of Health and Population (MOHP) recognizes that access to sexual and reproductive health (SRH) services is a fundamental human right and therefore strives to expand and provide voluntary, high quality, affordable, accessible and acceptable SRH information and services to all women, men and young people who need them.

Vision

No woman should suffer or die from complications of abortion in Malawi

Goals

1. Contribute to the reduction of maternal mortality and morbidity related to complications of incomplete abortion
2. Break the cycle of repeat abortion, through the provision of postabortion family planning (FP), thus improving the health and wellbeing of women in Malawi

Objectives of National Postabortion Care Program

1. To raise awareness of the magnitude of the problem of incomplete abortion and its complications and the availability of postabortion care services (PAC)
2. Increase accessibility of PAC services in an integrated SRH program
3. Provide quality PAC services
4. Establish a sustainable system for providing PAC services

Specific Objectives

1. To raise awareness of the magnitude of the problem of incomplete abortion and its complications and the availability of PAC services

Establish task force to manage and coordinate PAC programme strategy development, programme design and implementation

Develop an IEC programme for PAC messages – aimed at policy-makers, general community and targeted groups (men, youth, etc.)

- Develop and disseminate a comprehensive PAC policy as one component of the national SRH policy
- Increase PAC knowledge/awareness of all cadres of staff working in sites where PAC services are offered
- Ensure involvement of community in design, development and delivery of PAC services

2. Increase accessibility of PAC services in an integrated SRH program

- Increase the number of service providers
- Expand the types of cadres allowed to provide comprehensive PAC services
- Increase the number of sites where PAC services are provided
- Increase the number of PAC trainers
- Improve the availability of equipment, supplies and drugs necessary for PAC services
- Ensure PAC services are delivered in the most timely manner possible at the service delivery point

3. Provide quality PAC services

- Provide comprehensive PAC services at all levels of the health care system, from the hospital out to the health centre
- Ensure that PAC services are offered by trained and competent service providers
- Establish and maintain a safe environment for delivery of PAC services
- Ensure that the appropriate technology is used in delivery of PAC services
- Ensure linkages are made to other SRH services
- Monitor provider performance through existing supervision systems to ensure continued quality of care

4. Establish sustainable system for providing PAC services

- Strengthen PAC component of preservice education in Colleges of Medicine, Nursing and Health Sciences
- Implement cost-recovery schemes for PAC services (in the context of the planned national MOHP cost-recovery schemes)
- Ensure necessary equipment and supplies for PAC services are incorporated into national- and district-level procurement/requisition systems (e.g., Reproductive Health Logistics Management Information System)

I. Background

Complications from spontaneous and induced abortions – primarily hemorrhage, infection and injury to the genital tract – remain a serious threat to the health of women in Malawi. These complications account for as much as 60% of acute gynaecological admissions into both public and private health facilities in Malawi (Kinoti et al, 1995). As well, an estimated 30% of maternal mortality in Malawi is due to complications of abortion (Mtimavalye, 1996). Cognisant of the WHO estimate that for every case of maternal mortality there are 10-15 women who sustain serious morbidities, and the high national maternal mortality rate of 1,120/100,000 live births (The National Statistical Office, *The Demographic and Health Survey – 2000*), it is clear that abortion complications significantly contribute to maternal morbidity and mortality in Malawi.

Adolescents comprise a large percentage of those women presenting with complications from unsafe abortion; fully 50% of cases treated at Queen Elizabeth Central Hospital in 1998 were adolescents (*MOHP/JHPIEGO RH training needs assessment*, 1999). Similarly, in 1999, 60% of cases treated at Rumphi District Hospital were adolescents, 60% at Nkhata Bay

District Hospital and 50% at Kasungu District Hospital (*MOHP/JHPIEGO PAC district needs assessment*, 2000). These adolescents represent a key group to target under a national PAC programme in order to improve their access to and acceptance of FP services.

In most health facilities in Malawi there is only one operating theatre that is often utilised for various surgical emergencies, including caesarian section, ectopic pregnancy, trauma and other surgical emergencies. These emergencies receive priority over women who present with abortion complications, which delays management and augments the risk of complications, including death. There is also an acute shortage of the necessary surgical equipment, instruments and supplies required to provide safe and high quality PAC services. Even when there is more than one theatre, and equipment and supplies are in sufficient quantity, there is a tremendous lack of competent clinical personnel to provide quality comprehensive postabortion care. All of these factors stand in the way of Malawian women and young girls being able to access quality postabortion care services.

Postabortion care is:

- emergency treatment of incomplete abortion (uterine evacuation) and potentially life-threatening complications;
- provision of FP counselling and services; and
- links between emergency care and other RH services (e.g., infertility screening, sexually transmitted Infection (STI) management, cervical cancer detection or antenatal care).

Malawi has committed itself to the ideals and goals of the Global Safe Motherhood Initiative (SMI), which seeks to reduce unnecessary deaths and illnesses that result from pregnancy or childbirth. Since unsafe abortion is one of the leading causes of morbidity and mortality, the SMI has stated that safe and humane services for the management and prevention of abortion complications should be given priority within the health systems. In addition, the Consensus Statement of the 1994 Cairo ICPD, to which Malawi has subscribed, recommended that all women with abortion complications should have access to quality services for their management (United Nations, 1995). It goes on to state that postabortion FP counselling, education and service should be offered promptly, thus minimizing the chances of repeat abortion.

II. Policy

The Ministry of Health and Population would like to improve and expand postabortion care services in the country. To assist in the implementation of PAC services a specific policy statement on PAC has been developed and is incorporated into the sexual and reproductive health policy document which is under development.

✓ Policy

The sexual and reproductive health policy emphasizes that all SRH services should be implemented, monitored and evaluated in accordance with the Malawi National Reproductive Health Service Delivery Guidelines, of which PAC is a part and which outlines where PAC services can be provided and by which cadre of provider. Wide dissemination of and adherence to these guidelines by all involved parties will assist with a uniform delivery of high quality PAC services throughout the country. Dissemination will also assist in updating the sexual and reproductive health knowledge (including MVA, family planning and

infection prevention) of all service providers through update workshops as well as provision of guidelines as a reference document to all health facilities.

Furthermore, these *Service Delivery Guidelines* will guide the development of national PAC training guidelines and a standardised national PAC training curriculum. All institutions and cooperating agencies of the Government of Malawi (GoM) would then be expected to follow these guidelines and adhere to that curriculum for the training of PAC providers. Once this PAC curriculum is institutionalised, there should be a rapid movement of the content of this curriculum into the preservice education of appropriate health workers.

The National SRH Policy should support expanded access to quality PAC services at all public and private hospitals, even to the level of health centers. Provision of PAC services at the health center level would move the service closer to women and make it available to them at the time that they need it. Policy should allow for PAC services to be provided by a variety of appropriate clinical personnel, including specialists in obs/gynae, medical officers, clinical officers and registered nurse/midwives.

All collaborating partners should be oriented to the SRH policy, including PAC policy and guidelines, to ensure that services are standard and of high quality. Communication among these partners will be facilitated through the Reproductive Health Coordinating Committee (RHCC), which meets quarterly, and the Programme Management Group (PMG), which meets on a monthly basis. At the district level, the district health management teams will ensure coordination among the various partners working in PAC.

It is the responsibility of the Reproductive Health Unit of the MOHP to review the PAC policy and guidelines when the need arises.

III. Advocacy

The Government of Malawi has demonstrated the strong political will necessary for the successful implementation of a comprehensive PAC program. Furthering the objectives of the program may necessitate meetings with various policy makers and concerned individuals to educate them on the severity of the problem and the nature of the solution. A small pamphlet that contains key pieces of evidence regarding the magnitude of the problem and the benefits of PAC services may be a useful mechanism for conveying specific information.

Donors and multilateral agencies will need to be informed regarding the national PAC program. Those who are able to offer assistance to the program should be guided to provide assistance that is complementary and critical. There should be avoidance of duplication of effort or establishment of parallel systems.

Before PAC services are introduced into facilities, there should be orientation sessions for service providers, administration and staff of the facility, as well as members of the community that the facility serves. This orientation is meant to involve all the key parties in the process of establishing services. It is crucial that the community and the facility staff understand that PAC services are interventions to help address a medical problem. Helping all clinical and nonclinical cadres of staff within a facility, to understand the importance of PAC is key to the successful introduction of services at the facility. Staff should be encouraged to ask questions and discuss their views in order to encourage open discussion

and dispel any misconceptions regarding the objective of PAC services. It is important also to include mobile health clinic staff, HSAs, TBAs, CBDAs and other community health workers in orientation sessions to enable them to take on an advocacy role in the communities they serve.

Once services are established, referral facilities and personnel that refer to the facility should be informed about the new service. Clients who present to dispensaries or peripheral health workers with vaginal bleeding in early pregnancy can then be appropriately referred to the facility for PAC. Ultimately, all health centres will offer PAC services as well. Until that point is reached, some health centres as well will need to be informed of the availability of PAC services at their referral hospital and encouraged to refer clients.

Specific attention may need to be directed to certain subsections of the community, including youth, refugees (internally displaced persons), religious groups or men. Advocating for PAC services among these groups can be particularly important given their marginalised status or role as key decision makers.

IV. Community Participation

As noted above, community participation is essential in the establishment and success of PAC services at all levels, from the hospital level out to the health center level. Key ✓ community representatives should actively participate with the management teams of various facilities to help ensure quality services that address the needs of the community. This process should be ongoing so providers have a mechanism in place to identify barriers to the provision of services. Communities should work with facilities to create a positive and safe environment in which women can receive PAC services.

Community-based abortion care (COBAC) is a strategy for involving the community in the prevention of unsafe abortion. The objectives of COBAC are to:

- Reduce the prevalence of unsafe abortion
- Modify community perceptions and attitudes toward unwanted pregnancies and toward women with unwanted pregnancies
- Modify community perceptions and attitudes toward abortion
- Establish continuity of care for women with complications of abortion, from the community to the referral centers and back to the community

Additionally, providers should work with the community to identify solutions to problems of access to care, such as lack of transport, lack of funds or difficulties in making the decision to seek care. The community will be able to identify other felt needs that impact the ability of individuals to obtain quality services. They will be well suited to the development of local strategies to resolve these problems.

These initiatives can be accomplished by creating local linkages with social welfare organisations or the District Executive Committee. In addition, TBAs, CBDAs and other community health workers can play instrumental roles in advocacy and orienting women to available postabortion care services and in ensuring that women suffering complications from incomplete abortion are quickly identified and referred for service.

V. Service Delivery

Ultimately, PAC services should be available throughout the whole of Malawi. Along the road to achieving this, certain sites will be selected for initial establishment of these services. These sites should include facilities associated with the national clinical training centres and clinical faculties Establishing PAC services at these sites prepares them for eventual use as inservice and/or preservice training centres, among other sites as may be identified by the MOHP/RHU.

Initially PAC sites should be hospitals or health centres that have demonstrated some commitment to the provision of care for women with complications of abortion. PAC programs are implemented most smoothly when the facility staff itself has identified complications of abortion as a problem to be addressed. The administration should be supportive in the implementation of the service and there should be a management system ✓ that will facilitate the new service. Ideally, sites should have an adequate caseload which will allow the providers at the site to maintain their clinical skill, as determined by supervisory mechanisms.

*Other requirements for the provision of PAC services include:

- availability of the procedure on a daily basis and, if possible, 24 hours per day.
- personnel who are competent in providing comprehensive PAC services, including the ability to respond to complications and emergencies
- a clean and equipped procedure room that is dedicated to minor surgeries or procedures and has adequate space for privacy and confidentiality while counselling, history taking and performing the MVA procedure
- ability to provide a range of postabortion FP methods in the same place where the uterine evacuation is done. Otherwise, FP (and other RH services) should be in close proximity to the site where uterine evacuation is performed.
- staff and space available for post-procedure recovery and to provide post-procedure instructions, warning signs, and referral information

It is preferable that the site be able to provide emergency care and surgical backup. If surgical backup is not available, the PAC service site must have written referral protocols and ready access to pre-arranged referral sites.

Expansion of services to additional health facilities will need to take the above requirements into account during site selection.

The key components of PAC services include:

- client assessment, including assessment of other causes of bleeding in early pregnancy
- uterine evacuation, preferably by MVA
- counselling and provision of FP services to both sexes (pre-procedure, intra-procedure and post-procedure (males should be included in counselling whenever possible))
- management of emergencies and complications
appropriate infection prevention
- referral to other health services

- counselling and health education related to SRH

Training is focused on preparing providers to manage all of these components of PAC service.

Stakeholders at various levels should be involved in planning of establishment of postabortion care services at health facilities. It is crucial to include senior site managers (district health officers, matrons, directors) as well as service providers at the site in all decision-making related to introduction of PAC, as well as key community representatives (women, men and youth leaders, traditional leaders, traditional birth attendants, political leaders).

Introduction of PAC services will require an initial needs assessment to determine if the site meets the criteria as outlined above. Staff will then need to be oriented and sensitized on postabortion care, followed by training in comprehensive PAC services (manual vacuum aspiration, postabortion family planning, infection prevention). In addition, key service providers may also need training in training and supervisory skills. Support staff will also need to be oriented/trained in infection prevention procedures.

Supervision of PAC services should be performed by a clinician with PAC skills. Supervision should be coordinated out of the MOHP/RHU and be part of an integrated supervisory system. To that end, PAC should be included in the RH supervisory checklist. Supervision of clinical services should be an ongoing, continuous process and should be supportive or facilitative in nature. It should be an opportunity to seek solutions to problems or barriers to high quality PAC services, rather than an effort to assign blame or only identify problems. It is recommended that the district level supervise health centers monthly and when the need arises and the central level supervise the districts on a quarterly basis.

Quality assurance is also an important part of maintaining PAC services. Service providers, SRH coordinators and site-based quality assurance teams should take responsibility for ensuring quality service delivery.

The MOHP will seek assistance from international NGOs and technical assistance agencies to establish PAC services in the country.

It will be important to ensure that PAC services are also available in the private sector. This sector should follow all SRH policies, guidelines and procedures set by the MOHP and therefore complement government efforts. The private sector should fund training for their own service providers but should have access to government trainers to ensure standardized training content. Quality of PAC services in the private sector will be monitored through the RHU, the regulatory bodies and the district health management teams.

The PAC guidelines should be widely disseminated and a national workshop for stakeholders should be organized in order to sensitize them to availability of these services. A copy of the PAC guidelines should be made available at each PAC service delivery site.

VI. Training

To promote sustainability of PAC services, training must include both preservice education and inservice training. The basic skills of client assessment, uterine evacuation and FP provision should be developed in conjunction with other RH skills. In order to teach these skills, the faculty and clinical instructors and clinical preceptors in the nation's Colleges of Medicine, Nursing and Health Sciences must possess these skills as well. In addition, inservice coordinators at the teaching hospitals should be considered as potential trainers. Initially, therefore, an investment in inservice training must be made.

Participants in inservice training courses must be medical officers, clinical officers and registered nurse/midwives who have satisfied their basic education requirements (i.e., are fully qualified health professionals). In addition, they should have experience in providing RH services (preferably FP) and have demonstrated a commitment and interest to provide PAC services.

Trainers, in turn, must be proficient PAC service providers who have good communication/facilitation skills. They must have learned the skills necessary to be a competency-based trainer and have an ongoing interest in being a trainer. Development of a proficient cadre of clinical trainers is a key component of the National PAC Strategy, and a necessary step toward program sustainability. Service providers are first certified and then supported through supportive supervision visits to provide PAC services. In the same way, trainers should be certified as qualified trainers and supported while they conduct a PAC course as a training practicum to reinforce their training skills.

Training will be conducted using a national standardised PAC curriculum. Existing national and international materials from a variety of sources will be adapted to develop the training curriculum. The basic training package will contain:

- reference manual with essential clinical information
- participant's handbook with case studies and skill learning guides
- trainer's notebook with knowledge and skill assessment tools
- audiovisual materials, such as infection prevention and procedure videos
- anatomic models to assist with skill acquisition.

Based on course objectives and with the above training package, a standard course schedule for a competency-based course will be developed. It is anticipated to be a course of approximately 6 days, based on client flow. As with all competency-based training, however, duration of the course is dependent upon achieving competency in the desired clinical skills.

Faculty members at the appropriate preservice institutions will be trained and supported to become proficient PAC service providers and trainers. A process of curricular review will allow the knowledge and skills for PAC to be moved into the preservice curriculum. For medical officers and clinical officers, skill acquisition may be accomplished during the internship phase of training. For nurse/midwives, however, it is recognised that sufficient clinical practice opportunities may not exist in the preservice years. Therefore, some provision for clinical skill acquisition may need to be made in the inservice arena.

VII. Behaviour Change Communication (BCC)

Appropriate mechanisms for alerting the community regarding the availability of PAC services will need to be determined. Focus group research may be needed to understand which messages are best able to increase people's awareness of the services without causing confusion. Service delivery points must be ready to respond to a potential increase in demand for services and help educate women on the symptoms of abortion for which they should seek attention.

PAC messages may be included in other SRH BCC campaigns. These can include, but are not limited to, such media as wall posters, print and electronic media.

Key messages could include the following:

- Unwanted pregnancy is a major problem and can be avoided.
- Seek medical help immediately once an abortion has occurred.
- Avoid judgmental attitudes towards women with unwanted pregnancies and abortions.
- Support a woman with an abortion.
- Women who have had an abortion should seek family planning methods immediately to avoid unwanted pregnancies.
- Postabortion care is **not** abortion – postabortion care addresses a medical problem.
- Complications from incomplete abortion contribute greatly to maternal mortality.

It is important also to solicit feedback from the community on the type and quality of services offered to ensure that the community's needs are met.

VIII. Logistics/Management

To support the decentralisation of PAC services all necessary PAC supplies and equipment should be included on the essential drug/equipment list and the National Reproductive Health Logistics Management Information System (RHL MIS). This will help to establish an appropriate procurement/distribution system for supplies and equipment. Infection prevention supplies (e.g., chlorine, Cidex, gloves and hand rub materials) should also be included in the RHL MIS. In addition, there should be proper record-keeping of equipment/supplies, especially MVA syringes and cannulae.

There is a need to develop equipment inventory, supply list and drug list forms for monthly compilation at PAC services sites. In addition, the PAC service provider at the site should liaise with the SRH coordinator to ensure sufficient supply of STI drugs (also to be used in PAC services).

Training in PAC should include instruction in proper care and maintenance of MVA equipment, and guidance on when syringes or cannula should be replaced. An effort should be made to look for various distributors of MVA syringe and even establish local procurement or marketing of the MVA syringe for private sector and eventually government.

IX. Monitoring/Evaluation

Standardised tools and instruments for monitoring of PAC services should be developed based on appropriate indicators. This monitoring must link with and be integrated into the existing National Health Management Information System (HMIS). Information should be sent from the health center to the district health office and then on to the Reproductive Health Unit, who will then ensure that data is passed to the National HMIS. Feedback on the data should follow the same system.

Monitoring is facilitated by appropriate record-keeping. Records should be kept with the following information, although, not limited solely to this information:

- number of cases
- complications including:
 - genital tract trauma
 - uterine perforation or intra abdominal injury
 - hemorrhage
 - infection
 - shock
 - death
- type of procedure (MVA vs. sharp curettage)
- acceptance of FP method, and what method accepted
- demographics (age, parity, if FP method used at time of conception)

Where possible, data should also be collected on availability of staff, in provider attitude (capture through exit interviews, among other strategies), infection prevention practices, availability and maintenance of equipment and supply/drug stock.

✓ Staging
data

It is suggested that PAC service sites maintain a separate log book in the site where PAC services are provided to document information on the cases they manage.

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While this data should be made available to the central level through the existing reporting system, it is important that staff be taught how to gather, interpret and use their own data. Local use of data has a powerful impact on staff to help them identify areas of strength in service delivery and areas that may need improvement, as well as helping to identify client groups that may be in need of targeted messages or education. Based on the reported data the peripheral facilities should be given feedback on their individual performance and how it compares to other programs.

Prior to the implementation of services some baseline data should be collected. This will allow the staff and supervisors to identify certain population trends from year to year. Ultimately, collation of this data on a national scale may reveal a decrease in the morbidity and mortality related to complications of abortion.

X. Sustainability

As the PAC program is an integral government program, district health offices should begin to include their needs for PAC services as a budget line item when requesting annual funding

(for supplies, ongoing training, replacement equipment, etc.). This will allow districts to receive equipment, supplies and medications from central medical stores.

In the context of the national health program in which it may become necessary to charge for clinical services, appropriate charges for PAC and related FP services may need to be established. Using that revenue will contribute to the financial sustainability of the program. Additionally, local fund raising may become an important mechanism for ensuring that some funds are available to help those who cannot afford to pay for services. *PPFS* ✓
group study

As the availability of PAC services become more widely known there will need to be a steady supply of PAC providers. By including PAC clinical skills in the preservice curriculum of nurses, clinical officers and medical officers, there will always be an expanding group of providers able to offer PAC services.

XI. Research

The overall success of the program may be facilitated by the production of some research data and information demonstrating the strengths and limitations of the PAC program. Potential areas for research may include:

- baseline information needed at each new service delivery point on status and types of abortion complications
- collecting data on complications of abortion as part of the DHS or other surveys
- determination of appropriate IEC messages about PAC
- a review of available/current documents to assess the extent to which PAC is adequately represented or included
- qualitative research on PAC policies or general attitudes related to PAC.

Any one of these or other areas of investigation may lead to additional topics for further investigation.

XII. Summary

It is the vision of the national postabortion care program that no woman will suffer or die from complications related to abortion. By implementing a broad national program according to this strategy it is hoped that high quality PAC services will be widely available and women will access them easily.

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