

## Nurse-Midwives Expand Postabortion Care at the Community Level



### The Situation

In sub-Saharan Africa, where maternal mortality often exceeds 1000 deaths per 100,000 live births, many women die as a result of unsafe abortion. Postabortion-related deaths in Uganda account for one quarter of all maternal deaths; in Kenya the figure rises to over one third.

While the vast majority of these deaths are preventable, the standard treatment – uterine evacuation by dilation and curettage, requiring general anesthesia in a hospital setting – is often inaccessible to the poor, rural, minority, and refugee communities most in need. A fully tested, medically approved alternative procedure, manual vacuum aspiration (MVA), allows primary care providers in outpatient settings to perform safe uterine evacuation, saving the lives of many women.

### The Initiatives

The PRIME Project modeled postabortion care (PAC) initiatives in Uganda and Kenya on a successful pilot program in Ghana, where PRIME helped train nurse-midwives who demonstrated they can provide PAC services safely and effectively. What's more, their clients seek out and pay for these services.

In both Uganda and Kenya, PRIME launched pilot initiatives to expand nurse-midwives' scope of practice to include PAC. In Kenya PRIME trained nurse-midwives in selected private sector facilities, while in Uganda PRIME targeted PAC expansion at public sector facilities. The Kenya model emphasized the importance of advocacy and partnership between the private

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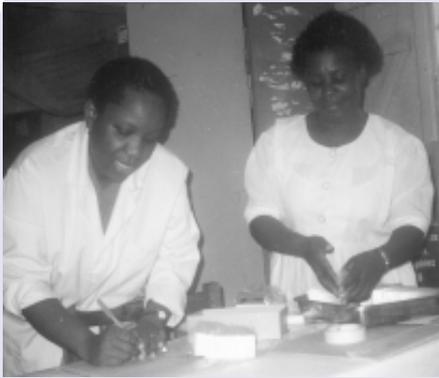
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and public sectors. The POLICY project facilitated advocacy workshops to foster support for private nurse-midwives as PAC providers.

Both projects emphasized the importance of supportive supervision. PRIME instructed supervisors from the Ministry of Health in Kenya and from the District Health Management Teams in Uganda on ways to provide technical support and effective supervision to the PAC-proficient nurse-midwives.

### The Results

The PRIME-assisted initiative in Kenya demonstrated clearly that trained nurse-midwives using MVA can provide safe, high-quality PAC services at the community level. After the training, virtually all the nurse-midwives achieved acceptable standards of performance, resulting in a rapid expansion of PAC services. Over 80% of postabortion care patients received family planning counseling and 100% of those who did not want to become pregnant accepted a contraceptive method. There were no complications related to the MVA procedure. Not surprisingly, the number of women seeking PAC services at these pilot primary care facilities increased. In fact, the availability and use of PAC services at the community level has helped reduce the number of women seeking postabortion care at referral facilities, where they often arrive with complications exacerbated by delays and difficulties in travel.



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In Uganda, the pilot PAC training improved women's access to postabortion care, and to the other reproductive health services offered in conjunction with PAC. During the course of the project, more than half of the postabortion patients seeking care presented with incomplete abortion below 12 weeks uterine size. All of them received MVA treatment, which was performed by the newly-trained midwives in three-quarters of the cases. There were no procedure-related complications. Among all the postabortion patients, 70% received a family planning method at the time of treatment, 64% received STI/HIV counseling, and 33% received appropriate nutrition counseling.



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