

Expanding Access to Postabortion Care Services in Rwanda

Final Report in Brief

Globally, 47,000 women die each year from complications due to unsafe abortion.¹ In Rwanda, maternal mortality has declined from 1,071 deaths per 100,000 live births in 2000 to 476 deaths per 100,000 live births in 2010.² However, programs to accelerate the reduction in maternal mortality are still needed, particularly to address complications of unsafe abortion and miscarriage. Approximately 47% of all pregnancies in Rwanda are unintended, and almost 30% of women who experience complications from unsafe abortion do not receive needed treatment.³ Postabortion care (PAC) is a globally endorsed intervention to treat complications due to incomplete abortion and miscarriage and to provide family planning services.

The World Health Organization (WHO) recommends misoprostol and vacuum aspiration for the treatment of incomplete abortion and miscarriage.⁴ Misoprostol is a safe, effective, heat-stable and inexpensive treatment method.^{5,6} With efficacy rates similar to those of manual vacuum aspiration (MVA), misoprostol can be administered by mid-level providers in facilities lacking MVA or other surgical capacity.⁷

In February 2012, with the support of Venture Strategies Innovations (VSI), the Rwanda Ministry of Health (MOH) launched a comprehensive PAC pilot program in four districts (Bugesera, Kicukiro, Gisagara and Nyabihu) with the aim of scaling it up nationally. All public health centers (50) and hospitals (5) in the four districts participated in the pilot program. The goals of the program were to establish comprehensive PAC services through the use of both

medical and surgical methods and to ultimately reduce maternal mortality and morbidity due to complications of unsafe abortion in Rwanda. The pilot program's main objectives were to provide evidence for introducing misoprostol into Rwanda's comprehensive PAC strategy and to demonstrate program feasibility. Additionally, the project aimed to develop and test data collection tools, a system of information flow, and service delivery indicators for

potential inclusion in the Health Management Information System (HMIS), as well as to identify logistical components and other service delivery implications for scale-up.

PILOT PROGRAM COMPONENTS

The comprehensive PAC pilot program included two components: 1) strengthening of facility-based clinical PAC services, and expansion of services to health centers through integration of medical treatment with misoprostol; and 2) a community awareness campaign.

Strengthening facility-based PAC services

Comprehensive PAC services included treatment of incomplete abortion, contraceptive counseling and services, and referral. Misoprostol, oxytocin, MVA, and dilatation and curettage (D&C) were used for the treatment of incomplete abortion and miscarriage at health facilities. All women were to receive postabortion family planning counseling and their choice of a modern contraceptive method or they were referred to secondary family planning posts for these services. Women were referred from health centers to hospitals through existing referral linkages when cases were complicated or treatment was beyond the capacity of the health center.

Community awareness campaign

A community awareness campaign was conducted to ensure that communities were aware of the newly expanded PAC services

Table 1: Incomplete abortion and miscarriage cases presenting by district (March-October 2012)

Incomplete abortion and miscarriage cases	Pilot Program Districts				Total number (%)
	Bugesera	Gisagara	Kicukiro	Nyabihu	
Treated with misoprostol	237 (85.6%)	219 (83.9%)	218 (78.1%)	94 (90.4%)	768 (83.4%)
Treated with oxytocin	21 (7.6%)	38 (14.6%)	52 (18.6%)	10 (9.6%)	121 (13.1%)
Treated with D&C	19 (6.9%)	4 (1.5%)	5 (1.8%)	0	28 (3.0%)
Treated with MVA	0	0	4 (1.4%)	0	4 (0.4%)
Total cases treated	277	261	279	104	921

available. In addition to the distribution of a brochure containing messages about the dangers of unsafe abortion and PAC service availability, districts held sensitization meetings with community leaders who then returned to their communities to sensitize women about the PAC pilot program.

QUANTITATIVE RESULTS

Between March and October 2012, 921 women were treated for incomplete abortion and miscarriage, 513 (56%) at health centers and 408 (44%) at hospitals.

Misoprostol quickly became the primary treatment method for incomplete abortion and miscarriage

Overall, misoprostol was used to treat 83% of all women seeking PAC (Table 1). As soon as misoprostol was introduced, providers began using it to treat the majority of incomplete abortion and miscarriage cases (90% in the first month), and misoprostol remained the predominant treatment method throughout the pilot program (Figure 1).

Enabling health centers to provide treatment with misoprostol increases the availability of PAC services and brings them closer to women

Before the pilot program, only two health centers provided PAC, and the remaining health centers had to refer women to hospitals for treatment of incomplete abortion and miscarriage. By the end of the pilot program,

health centers were treating 91% of PAC cases and referring only 9% to hospitals (Figure 2).

Complication rates were low and only a small proportion of women required referral for completion of the procedure

Less than 2% of the 921 women who were treated for incomplete abortion or miscarriage experienced complications due to treatment. Of the 345 women (67% of women treated) who returned for follow-up at a health center, approximately 13% were referred to hospitals (per comprehensive PAC treatment protocol) due to treatment failure.

Among surgical methods, D&C was more common than MVA

Use of surgical methods to treat incomplete abortion and miscarriage was low. D&C was used to treat 3% of

Figure 1: Distribution of treatment methods used for incomplete abortion and miscarriage cases over the course of the PAC pilot program (n=921)

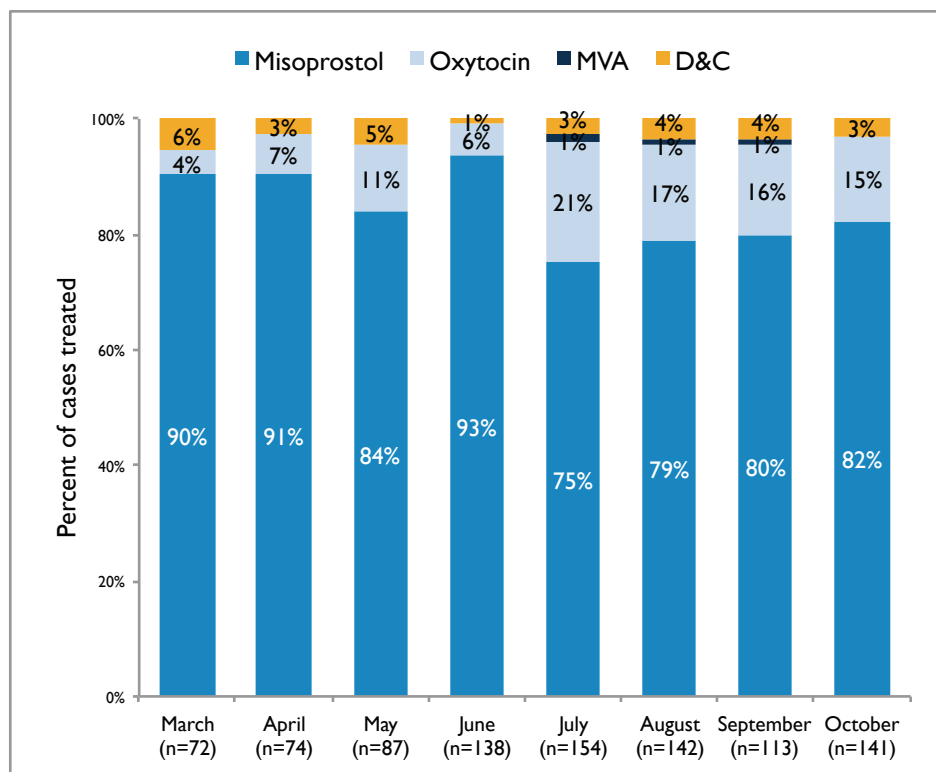
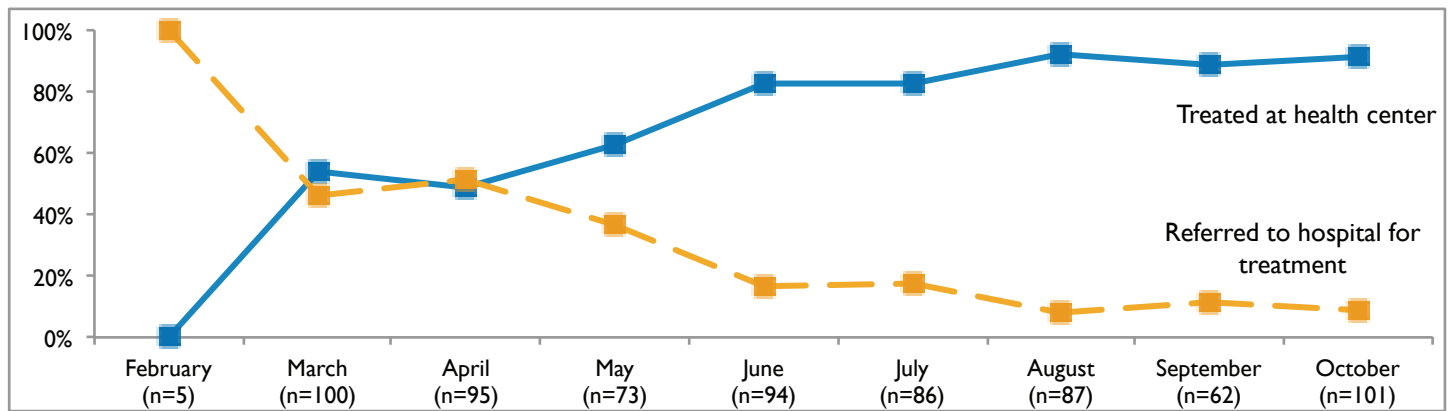


Figure 2: Treatment vs. referral of incomplete abortion and miscarriage cases presenting at health centers (n=703)*



*Preparatory phase baseline data that were collected prior to the start of implementation are included in this figure.

cases treated at hospitals. MVA use was reported only in Kicukiro District, where it was used to treat 1% of cases of incomplete abortion or miscarriage (Table 1).

Contraceptive uptake was moderate and varied by district

Overall, 59% of women received a contraceptive method. Contraceptive uptake varied by district, ranging from 35% in Nyabihu to 84% in Bugesera (Figure 3). Many mission facilities did not offer modern family planning services; thus, women who received PAC services at these facilities were referred to secondary family planning posts.

QUALITATIVE RESULTS

In addition to quantitative results, informal discussions with providers and project staff revealed key program strengths and areas for improvement.

Monitoring and evaluation: Service delivery indicators provided data that were essential to monitoring the PAC program. Other indicators were useful for pilot program monitoring but will not need to be included in the HMIS for scale-up.

Provider training: During the first few months of implementation, some providers deviated from the protocol and made errors in data collection, which supervisors then corrected. Providers emphasized the need to train more providers at each health facility due to gaps in PAC service availability when trained providers were absent from facilities or occupied with other patients.

Community awareness: During implementation meetings and monitoring visits, providers and supervisors expressed concern that communities lacked awareness about the PAC program, potentially

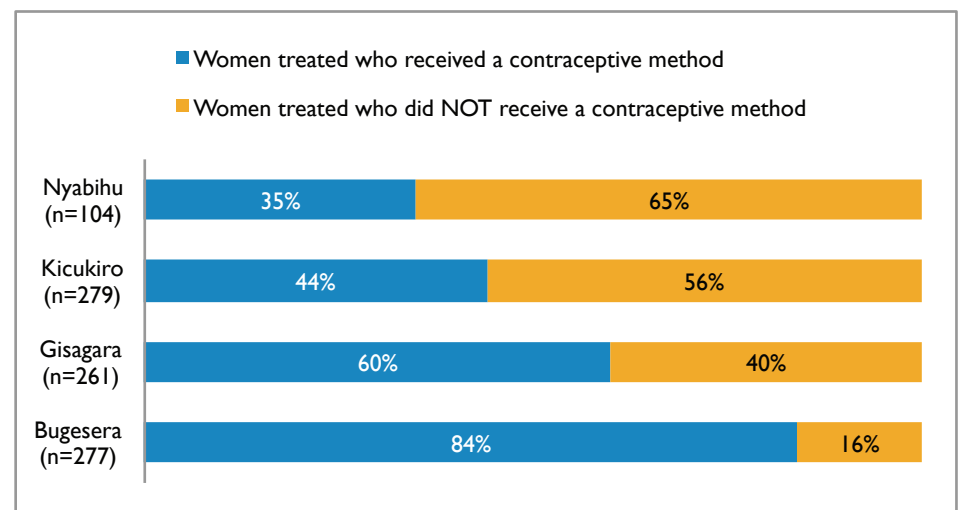
preventing some women from seeking PAC.

Family planning: Providers explained that in addition to the distance that some women must travel if they are referred for family planning services, religious and cultural beliefs and misinformation are also barriers to contraceptive uptake.

CONCLUSIONS

Enabling health centers to provide PAC through the integration of misoprostol as a treatment method increases the availability of PAC services and brings them closer to women. Mid-level providers at health

Figure 3: Percent of women who received a contraceptive method at the initial visit or at follow-up by district



Provider perspectives

"It is good for everyone that they can now receive care at the health centers. It is good for the women, it is good for families, it is good for the health system."

PAC District Supervisor, Gisagara District

"It is not only the hospitals. The health centers now also have the capacity to take care of women. The number of women referred has decreased. Only a few women are being referred, only those with complications."

Doctor, Bugesera Hospital, Bugesera District

centers were able to successfully provide PAC services, including follow-up during this pilot program, with follow-up rates higher among women who received treatment at health centers (67%) compared to hospitals (33%). The results demonstrate that PAC treatment was safe and effective. The system of data collection and monitoring was successfully implemented, and key service delivery indicators are suitable for integration into the HMIS.

Recommendations

Expand PAC services to all health centers and hospitals by training all providers of reproductive health services in comprehensive PAC and ensuring the supply of PAC commodities.

Family planning: Strengthen the referral system at all levels, particularly between mission health

facilities and secondary family planning posts to ensure that women who are referred receive family planning services. Train health workers at the community level to sensitize women to the importance of family planning and train providers at the facility level on counseling to increase family planning uptake.

Community awareness: Engage providers, community health workers, district health staff and community leaders in community sensitization activities to raise awareness of unwanted pregnancy, the consequences of unsafe abortion, availability of PAC services, and the importance of follow-up.

Provider training: In addition to training on misoprostol, train providers on the use of MVA and provide MVA supplies to ensure that the program is comprehensive and

uses all methods of uterine evacuation. The MOH has already developed plans to strengthen provider skills in MVA provision and provide MVA kits in order to phase out D&C.

Provide refresher trainings and reference materials for trained providers to address any errors in reporting or deviations from the protocol, and to improve PAC counseling, family planning counseling, and management of complicated cases.

Monitoring and evaluation: Integrate all service delivery indicators into the HMIS to allow for effective PAC monitoring at the national level.

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¹ World Health Organization (WHO). Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Third Edition. Geneva: WHO, 2011.

² National Institute of Statistics of Rwanda (NISR) [Rwanda], Ministry of Health (MOH) [Rwanda], and ICF International. Rwanda Demographic and Health Survey 2010. Calverton, Maryland, USA: NISR, MOH and ICF International, 2012.

³ Basinga P, Moore AM, Singh SD, et al. Abortion Incidence and Postabortion Care in Rwanda. *Studies in Family Planning* 2012;**43** (1): 11-20.

⁴ WHO. Technical and Policy Guidance on Safe Abortion. Second Edition. Geneva: WHO, 2012.

⁵ el-Refaey H, O'Brien P, Morafa W, et al. Use of oral misoprostol in the prevention of postpartum hemorrhage. *British Journal of Obstetrics and Gynaecology* 1997;**104**:336-39.

⁶ Blum J, Winikoff B, Gemzell-Danielsson K, et al. Treatment of incomplete abortion and miscarriage with misoprostol. *International Journal of Gynecology & Obstetrics* 2007;**99**:S186-89.

⁷ Sahin Hodoglugil N, Graves A, Prata N. The role of misoprostol in scaling up postabortion care. *International Perspectives on Sexual and Reproductive Health* 2011;**37** (3).