Expanding Access to Postabortion Care Services in Angola with the Introduction of Misoprostol

Final Report in Brief

Globally, 47,000 women die each year from complications due to unsafe abortion.\(^1\) Angola, a country with stark health disparities between its rural and urban populations, has a maternal mortality ratio of 610 maternal deaths per 100,000 live births.\(^2\) Complications resulting from unsafe abortion contribute significantly to maternal morbidity and mortality and abortion-related deaths are the leading cause of preventable maternal mortality in Angola. Postabortion care (PAC) is a globally endorsed intervention to treat complications due to incomplete abortion or miscarriage and provide family planning services. The World Health Organization (WHO) recommends misoprostol and manual vacuum aspiration (MVA) for the treatment of incomplete abortion and miscarriage.\(^3\) Misoprostol is a safe, effective, heat-stable and inexpensive treatment method,\(^4,5\) with efficacy rates similar to those of MVA.\(^6,7\) It can be administered by mid-level providers in facilities lacking MVA or other surgical capacity.\(^8\)

In June 2012, the Angola National Directorate of Public Health and the Ministry of Health, with support from Venture Strategies Innovations (VSI), initiated a pilot project in Luanda with the aim of increasing access to PAC and to ultimately help reduce maternal mortality and morbidity due to complications of unsafe abortion. Ten health centers in three municipalities in Luanda Province implemented the project: Samba and Kinanga in Samba municipality; Katambor, Kassequel, Alegría and Rocha Pinto in Maianga municipality; and Ana Paula, Viana II, KM12 and Bita Sapu in Viana municipality (Figure 1).

The primary goal of this project was to expand access to PAC by introducing misoprostol for treatment of incomplete abortion at all levels of the health care system. The project’s main objective was to evaluate the feasibility, safety and effectiveness of misoprostol administration by nurses and midwives, including elementary midwives in health centers. The results of this project will serve as a basis for the revision of guidelines for the treatment of incomplete abortion in Angola.

PILOT PROGRAM COMPONENTS

The PAC pilot included three activities: 1) strengthening of facility-based PAC services, and expansion of services to health centers through integration of medical treatment with misoprostol; 2) an exit interview to assess women’s satisfaction with the misoprostol for PAC services; and 3) a provider survey to assess provider perspectives and acceptability of using misoprostol for PAC.

Facility-based PAC protocol

PAC services included treatment of incomplete abortion and miscarriage,
Samba and Kinanga in Samba Province implemented the project: three municipalities in Luanda morbidity due to complications of reduce maternal mortality and access to PAC and to ultimately help (VSI), initiated a pilot project in June 2012, the Angola National introducing misoprostol for PAC services included treatment of miscarriage and no maternal deaths were reported symptoms, the most had no symptoms after taking another facility due to treatment another facility by training all centers and hospitals by training all providers on the use of misoprostol graduated access to PAC by building the capacity of nurses and midwives not previously trained in MVA to treat incomplete abortion. Of the 402 women treated for incomplete abortion and miscarriage, 375 (93%) were treated with misoprostol (Table 2). Safe and high-quality PAC services were provided at all levels No adverse events due to treatment and no maternal deaths were recorded during the pilot. Of the 231 women who returned for follow-up, 94% had a complete procedure with a single dose of misoprostol. Only nine women who returned for a follow-up visit required additional contraceptive counseling and methods provision, and referral services to higher-level facilities. Misoprostol and MVA were used for the treatment of incomplete abortion and miscarriage at health facilities. Misoprostol for treatment of incomplete abortion was introduced as a first-line treatment option for women presenting with a uterine size equivalent to 12 weeks or less without signs of complications. MVA was reserved for more complicated cases, greater uterine size, or as a back-up method if treatment with misoprostol was unsuccessful. All women were to receive postabortion family planning counseling and their choice of a modern contraceptive. 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.

In total, 49 providers were trained at the ten participating health centers, ensuring that every health center had at least two trained providers.

**RESULTS**

Between June and September 2012, 402 women presented at health centers for treatment of incomplete abortion or miscarriage (Table 1). Of these women, over half (59%) completed an exit interview. In addition, thirty-three providers completed a provider survey.

**Misoprostol was the primary treatment method used for incomplete abortion and miscarriage**

The introduction of misoprostol expanded access to PAC by building the capacity of nurses and midwives not previously trained in MVA to treat incomplete abortion. Of the 402 women treated for incomplete abortion and miscarriage, 375 (93%) were treated with misoprostol (Table 2).

<table>
<thead>
<tr>
<th>Table 1: Data for analysis, by municipality (June – September 2012)</th>
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<tbody>
<tr>
<td>Women presenting for treatment of incomplete abortion and miscarriage</td>
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<tr>
<td>160 (39.8%)</td>
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<td>Exit Interviews with women</td>
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<td>Provider Surveys</td>
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<tr>
<th>Table 2: Incomplete abortion and miscarriage cases presenting by municipality (June-September 2012) (n=402)</th>
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<tr>
<td>Treatment at initial visit</td>
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<tr>
<td>Treatment of incomplete abortion</td>
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<tr>
<td>Other/unspecified</td>
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<tr>
<td>Method at baseline</td>
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<tr>
<td>MVA</td>
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<tr>
<td>Misoprostol</td>
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<tr>
<td>Other</td>
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<tr>
<td>Result of initial treatment at follow-up visit</td>
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<tr>
<td>Successful treatment (out of all women treated)</td>
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<tr>
<td>Received additional treatment</td>
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<tr>
<td>Transferred to another facility</td>
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<tr>
<td>Did not return for a follow-up</td>
</tr>
<tr>
<td>Other/unspecified</td>
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<td>Successful treatment (out of women who returned for follow up)</td>
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interventions for completion, and only one woman was transferred to another facility due to treatment failure. In addition, all participating providers administered the correct dose of misoprostol (a single dose of 600 mcg) orally. Most women (78%) had no symptoms after taking misoprostol. Among those who reported symptoms, the most commonly reported were vaginal bleeding (20%), followed by abdominal pain (15%) and chills (8%).

Contraceptive uptake varied by district
An important component of PAC services is the counseling and provision of contraceptive methods after treatment. In total, the majority of women (71%) received a contraceptive method and of those, 64% received a method at their initial consultation (Table 3). Contraceptive uptake varied by district, ranging from 68% in Maianga and Viana to 84% in Samba. The most common contraceptive methods given to women were injectable contraceptives (20%) and oral contraceptive pills (18%).

Nearly two-thirds (65%) of women reported not using contraceptives before requiring PAC services (Figure 2). Of the 35% of women who reported not using contraceptives, 18% did not use the method regularly, and the remaining 18% used the method regularly, but cited method failure as the reason for pregnancy. This further emphasizes the importance of strengthening access to family planning services.

Providers felt confident in using misoprostol for postabortion care
A total of 33 health providers participated in provider surveys, representing all participating health facilities. All agreed or strongly agreed that it was easy to learn how to use misoprostol to treat incomplete abortion; that they felt comfortable using misoprostol to treat incomplete abortion; and that the training they had received made them confident in using misoprostol for treatment of incomplete abortion.

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. The introduction of misoprostol increased access to PAC by training nurses, midwives and elementary midwives on using misoprostol for the treatment of incomplete abortion and miscarriage. The project demonstrated that misoprostol is a safe, effective and feasible treatment method for incomplete abortion at all levels of the health system, including those facilities that do not have the capacity for MVA.

Recommendations
Expand PAC services to all health centers and hospitals by training all providers on the use of misoprostol for the treatment of incomplete abortion.
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Update technical guidelines to
include misoprostol for the treatment
of incomplete abortion and
miscarriage and disseminate the
revised guidelines to all major
stakeholders and PAC health
providers.
Engage providers and other
municipality health staff 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.

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Provider perspectives
“Let the PAC services be integrated permanently in all health centers, because the patients are already accustomed. There have been fewer cases of transfers to hospitals. Let the supply of misoprostol continue.”

“I like the approach of PAC services. Misoprostol is easy and effective administration.”