Developing a Supervision Instrument for Postabortion Care in Guatemala, Bolivia and Mexico

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SUMMARY

The main objective of this project was to develop and test a supervision instrument and corresponding guidelines to collect information about postabortion care (PAC) services and to provide constructive feedback to service providers and program managers. The instrument and guidelines were designed to be used by technical supervisors to monitor performance and engage providers in continuous quality improvement of PAC services.

Specific project objectives were: 1) to review, analyze and compare existing supervision practices and models of postabortion care, 2) to adapt the best practices of existing materials into one single instrument and set of guidelines that can be used by external and internal supervisors without extensive investment of staff time or changes in the data collection forms, 3) to test the improved supervision instrument, 4) to conduct a qualitative evaluation of the effectiveness of the supervision instrument in improving and maintaining quality of PAC services provided at selected hospitals, and 5) to make recommendations and suggest best practices to supervise PAC services.

As part of the project activities, existing postabortion care supervision practices were reviewed and analyzed, and, during a one-week workshop in December 2002, an international technical committee produced a first version of the instrument and guidelines. These materials were tested during a four-month period, and several limitations were identified at that time. Problems encountered in the use of the instrument were similar to those observed for other existing materials: the instrument was too long to be used during short-term supervision visits; it did not differentiate well between problems related to the overall quality of health services in general and the problems related to postabortion care services in particular; and several items did not allow unique answers or were too subjective to provide valid responses.

A group of technical advisors met in Mexico City in May 2003 to develop a second version that focused on the essential information needed to monitor quality of PAC services and use instructions for a supportive supervision process. The supervision procedure is described in Appendix 2 of this report: “Guidelines for Supervising Postabortion Care (PAC) Services: A Constructive Approach.”

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I. INTRODUCTION

Monitoring and supervision are essential to successfully implement and sustain postabortion care (PAC) programs. Although the importance of supervision is widely acknowledged, in practice supervision is rarely conducted in a systematic manner and with the technical orientation that it requires. This issue is important because without strong supervision practices, even successful interventions can weaken or be dismissed over time.

The present project aimed to address this problem by developing, testing and evaluating a supervision instrument and corresponding guidelines for use by technical supervisors of service delivery organizations. These tools assist managers to monitor performance and continuously improve the quality of service delivery processes using supportive supervision as the basis for problem detection and solution.

II. OBJECTIVES

The project objectives were the following:

1) To review, analyze and compare existing supervision practices and models of postabortion care

2) To adapt, expand and improve existing PAC supervision practices into a single integrated and easy-to-use instrument

3) To field test the improved supervision instrument

III. ACTIVITIES CONDUCTED

Staff from the Population Council's Frontiers in Reproductive Health (FRONTIERS) program conducted a review and analysis of existing postabortion care supervision practices and prepared a preliminary draft of the supervision instrument and guidelines. The members of an international technical committee reviewed these materials. During a one-week workshop held in December 2002, they discussed the goals of supervision and best supervision practices according to the literature and their own experiences. Based on these discussions, they made extensive modifications to the draft instrument and guidelines. The modified version was tested during a four-month period, and several limitations were identified at that time. Considering the recommendations that emerged from the field test, a group of technical advisors met in Mexico City in May 2003 to develop a second version of the instrument and guidelines that focused on the essential information to monitor the quality of PAC services and how to use the data gathered as part of a supportive supervision process.

The following sections describe how these activities were conducted.

Selection of Participating Hospitals and Formation of a Technical Committee

Researchers selected Bolivia, Guatemala and Mexico as the countries where the project activities would take place. Local reproductive health authorities, Cooperating Agencies, and FRONTIERS country staff selected one hospital in each country. The main criteria for selection was the agreement of the hospital and Ob/Gyn directors to conduct project activities such as participating in meetings, testing the supervision instrument, collecting data and preparing reports. Other criteria were that the hospitals had PAC programs for a minimum of three years, had an average caseload of about five postabortion care patients admitted per day, and had a reputation for providing reasonable quality of care.

The hospitals selected were the Hospital Materno-Infantil German Urquidi in Cochabamba, Bolivia, the Hospital General San Juan de Dios in Guatemala City, and the Hospital Iztapalapa in Mexico City. These hospitals are similar in size and number of postabortion cases attended to every year. Although all three units have more than three years of experience in postabortion activities, the hospitals in Bolivia and Guatemala have had a more sustained and organized program than the hospital in Mexico.

A technical committee was convened to help review and improve existing materials, test the instrument, and disseminate project results and products. The members of the technical committee included two representatives from each of the three hospitals, an international expert on postabortion issues, the project consultant and the FRONTIERS project monitor.

Review of Existing Instruments, Models and Experiences, and Development of Draft Instrument and Guidelines

FRONTIERS staff examined, analyzed and compared existing supervision practices and models of postabortion care programs. To conduct this review they used Internet resources, interviewed agency representatives, and conducted bibliographic reviews of available materials. Appendix 1 presents a detailed description of the process and results achieved in this literature search and review, and the conclusions obtained.

Reproductive health websites reviewed included the PAC Consortium Listserv, EngenderHealth, IPAS, JHPIEGO, the Safe Motherhood Initiative, and Prime II. Reproductive health search engines used included Popline, PubMed, Reproductive Health Gateway, Reproductive Health Outlook, Johns Hopkins Media/Materials Clearinghouse, and the ReproLine, Maternal & Neonatal Health section.

Key materials reviewed included EngenderHealth's "Manual to Provide PAC Services," IPAS' "Postabortion Care Checklists and Modules" and WHO's manual "Unsafe Abortion: a Practical Guide." Another instrument included in the review was "Guidelines and Instruments for Monitoring and Evaluating Postabortion Care Services," developed by the Population Council, IPAS, and the Pubcomm Group to help programs conduct a complete diagnostic study or situation analysis of postabortion care services at hospitals. Table 1 presents a summary of the main characteristics of the materials produced by six

organizations that have conducted extensive work on postabortion care that were identified in this literature search.

Table 1. Characteristics of PAC Materials Produced by Six International Reproductive Health Organizations

	Pathfinder	EngenderHealth	JHPIEGO	IPAS	Population Council	WHO/RHR
Characteristics						
Managerial or technical (medical)	Managerial	Managerial	Technical	Managerial and Technical	Managerial and Technical	Technical
Checklists	No	No	Yes	Yes	Yes	Yes
Supervision instructions	Yes	Yes	No	Yes	Yes	No
Follow-up instructions	No	No	No	Yes	Yes	No
Integrated	No	No	No	Yes	Yes	No
Best practice	Comprehensive approach	Supportive supervision	On-the-job training	MVA procedures	Integrated approach	Systems approach
Explains procedures to supervise each PAC component?						
Treatment	Source: PAC consortium	Source: PAC consortium	Yes	Yes, PAC consortium	Source: IPAS	Source: PAC consortium
Counseling	Yes	Yes	Yes	Yes	Yes	Yes
Family planning	Yes	Yes	Yes	Yes	Yes	Yes
Linkages	No	No	No	No	No	No
Community	Yes	No	No	No	No	No

Based on the materials reviewed, project staff prepared a draft of the supervision instruments and guidelines for the new expanded and updated PAC model. As such, the instrument and guidelines were the first attempt to supervise, monitor, and evaluate the five elements of the full model. The results of the literature review and of the draft of the materials were sent to the members of the technical committee for their appraisal.

Workshop to Improve First Version of the Supervision Instrument and Guidelines

FRONTIERS coordinated the first technical workshop, held in December 2002 in Guatemala City, with the National Reproductive Health Program of Guatemala and the Centro de Investigación Epidemiológica en Salud Sexual y Reproductiva (CIESAR). In addition to the members of the technical committee, workshop participants included staff of the Guatemalan National Reproductive Health Program, the Guatemalan Ministry of Public Health and Social Security (MSPAS) Hospital Services Division and the Department of Medical Sciences, the San Juan de Dios General Hospital, and CIESAR, including the coordinator of a project strengthening PAC services in 22 MSPAS hospitals. Workshop participants discussed existing PAC supervision practices in public hospitals, reviewed in

detail the draft of the instrument and use guidelines, and prepared a work plan for the implementation of the project.

The group concluded that supervision practices in PAC programs remain informal, disorganized and unsystematic. They are informal because they lack explicit norms and guidelines. They are disorganized because supervision is conducted on a discretionary basis. They are unsystematic because they are highly dependent upon the supervisor's preference at the moment of the encounter with the service provider. Other postabortion care monitoring and supervision problems that workshop participants observed were lack of adequate instruments to conduct supervision visits on an organized basis, lack of guidelines for supervisors on how to conduct supervision visits and train personnel in-service, and lack of organizational mechanisms to assign roles and responsibilities to all personnel working in wards where postabortion services are provided.

Workshop participants compared the first draft of the supervision instrument and use guidelines with the other instruments and best practices identified in the literature review and made extensive modifications. Collaboration among all of the participants was excellent, permitting the participants to finalize a revised version of the supervision guide for use in three hospitals beginning in January 2003.

By the end of the workshop, the following was accomplished:

1) Development of a draft instrument that could be integrated directly in the monitoring and supervision of service delivery processes used by hospitals

2) Development of a simplified instrument that allowed supervisors to better understand the needs of PAC service providers and managers

3) Beginning of a process to break down the dependence on external projects and organizations for the development and maintenance of PAC services

Testing the Instrument

After the Guatemala workshop, participants tested the usefulness and effectiveness of the instrument and guidelines in each of the three participating hospitals during a period of four months. Members of the technical committee provided verbal feedback and comments to the FRONTIERS monitor.

The main comments and observations made by the members of the technical committee conducting the fieldwork were the following:

1) The instrument was too long to be used during short-term supervision visits.

2) The instrument did not differentiate well between problems related to the quality of health services provided in general and problems related to postabortion care quality in particular.

3) Several items (marked in field test hard copies) did not permit unique answers and lent themselves to multiple interpretations (both from the point of view of the supervisor and the service providers).

4) The range of topics covered in the first version did not allow the supervisor and the health team to set priorities and concentrate on one or more areas of improvement, nor to translate the supervision visit into a clear work plan for the following supervision period.

5) It took too much time to probe all the areas included in the supervision instrument, and little time was left to discuss technical and programmatic matters with service delivery personnel.

6) The supervision instrument did not differentiate well among authority levels and thus did not lend itself to assigning roles and responsibilities for problem solving.

Second Technical Meeting and Revised Version of the Supervision Instrument

After the first four months of field-testing, it was clear to the members of the technical committee that further modifications and changes were required to make the instrument more targeted, focused and easy to use. In May 2003, five members of the technical committee met in Mexico City to review the first version of the instrument and guidelines again. During this meeting, a second version of both instrument and guidelines was developed. The purpose, objectives and contents of the supervision instruments were reviewed and clarified. Each question and section was evaluated in terms of its relevance to internal and external supervision, its language and its reliability. Questions that were addressed throughout the meeting included the following: How is this information used in the supervision process? Does this question provide answers with programmatic implications? Does it repeat or duplicate previous questions? Is this the simplest possible way of asking this question? Is a direct question the best technique to find out the actual situation? Based on this thorough review of each question, participants developed a second version of the supervision instrument and guidelines.

The second version reduced substantially the number of items to be evaluated during supervision visits, and thus made more realistic the scope of work of the supervisor. It created a clear distinction between external and internal supervision, so that the areas of responsibility of the different levels of authority were clearer. It focused on postabortion care and left aside problems related to the overall quality of health services provided by hospitals and clinics. The questions asked were clear-cut and avoided matters of opinion, so that the supervision process was based on facts and observations, rather than opinions and self-assessment made by service providers. The range of topics included enabled teams of health workers to define priority areas for improvement, which could easily be translated into work plans to be implemented during the following supervision period. The second version also made clear distinctions between levels of authority, therefore allowing program administrators and health workers to have clearly defined responsibilities.

The main advantages of the revised supervision instrument over prevalent supervision practices are that it makes supervision more focused on substantive service problems, provides a framework to analyze problems one at a time, provides guidelines to discuss each problem with the relevant staff members, allows the supervisor to develop improvement plans that are proposed by workers who will implement them and, in general, makes supervision more focused on problem-solving than problem-identification. The number of items included is substantially smaller than those in the first version and in other instruments previously developed. It also takes a more qualitative approach toward supervision, a fact that was appreciated by participating managers. Appendix 2 includes the English language version of the instrument and guidelines as developed in this meeting, the main product of this project.

IV. RECOMMENDATIONS FOR FOLLOW-UP WORK

The supervision instrument and guidelines still need to be field-tested so as to observe if they are effective in helping improve the services received by clients, as well as program management. CIESAR is currently conducting a test of the guidelines in Guatemala and will be able to provide information that will help to produce an improved version.

Beyond this, it is recommended that budget and time provisions be made to allow staff in participating hospitals to be involved in efforts to periodically evaluate service provision. Hospital staff included project were too busy to sustain participation in a time-demanding activity such as the one conducted.

APPENDIX 1

RESULTS OF THE LITERATURE SEARCH AND REVIEW

Manuals, Instruments, Guidelines and Resources Reviewed

Collaborating Agencies, such as JHPIEGO, IPAS, EngenderHealth, the International Planned Parenthood Federation (IPPF), INTRAH/PRIME, Family Care International (FCI), and the Population Council, have developed several PAC instruments, such as training manuals, counseling procedures, assessment methodologies, and cost evaluation techniques. The PopTech Project and the Center for Communication Programs (JHU/CCP) have comprehensive compilations of these instruments (available at http://poptechproject.com/library and Popline).

EngenderHealth, IPAS and JPHIEGO have developed alternative supervision strategies or approaches. Instruments such as COPE and the quality measure tool (QMT) are used in several countries. EngenderHealth has pioneered Supportive or Facilitating Supervision (FS) and has developed a Supervision Manual and a draft-training program. This approach has been successfully tested in such countries as Honduras and Colombia. EngenderHealth is interested in further conceptual and methodological refinement of this approach.

Available supervision strategies rely on widely accepted managerial principles. For example, Quality Improvement (QI) strategies, such as COPE, include expectations, motivation, environment, knowledge and supervision as factors affecting performance. Within this approach, supervision is only one of several factors, and its role is to monitor and control processes. The main role of supervision in this approach is to identify operational problems and provide feedback to administrators.

In 2000, WHO released a guide for management of complications in pregnancy and childbirth. This manual, however, does not include norms to conduct supervision of postabortion services.

There are some country-specific initiatives to improve services through supervision. For example, in Bolivia, supervision was improved through the creation of regional and facility-level PAC program coordinators. Program coordinators oversee the routine provision of PAC services, supervise providers' MVA techniques, and ensure the maintenance of the MVA equipment as well as the supply of family planning commodities. In Nepal supervisors of public health services received a one-day PAC orientation/training. By training a critical mass of supervisors, they found it was possible to conduct systematic supervision in previously unsupervised settings.

In Kenya an innovative system of public and private sector collaboration was established in which supervisors from the public sector work with private sector nurses who provide PAC services. This linkage aims to improve the quality of PAC services and to create a network of providers to exchange ideas and share resources.

Review of Contributions by CAs

The following sections describe the main or most recent contributions by CAs working in this field.

JHPIEGO

Among JHPIEGO's extensive literature on postabortion care, a key reference is "Performance Improvement: Developing a Strategy for Reproductive Health Services" by Nancy Caiola, MPH and Richard L. Sullivan, PhD, based on the manual "Postabortion Care: A Reference Manual for Improving Quality of Care." This manual developed a training system capable of producing qualified pre-service education faculty and in-service trainers. The manual is a learning package that includes service delivery guidelines to train healthcare providers. JHPIEGO's approach is to improve participants' knowledge, attitudes and skills. Also relevant for the analysis were "Essential Elements of Expanded Postabortion Care: An Expanded and Updated Model," 2002, (Postabortion Care Consortium), the "Checklist for Postabortion Care Clinical Skills," and the "Checklist for Postabortion Family Planning Counseling Skills."

One important contribution by JHPIEGO is the adaptation of learning packages to an on-the-job training (OJT) format ("JHPIEGO Adapts PAC Learning Package to Structured OJT Format," December 1999). Because postabortion care services are centered on a medical emergency that cannot be scheduled, the structured on-the-job training approach is ideal for PAC. It can be implemented effectively in a traditional OJT model, in which service providers from the OJT training site or nearby sites follow a self-paced program. This approach can also be used in a situation where service providers travel to the OJT site from more remote sites for a fixed training period. In the latter situation, the OJT package can enhance training flexibility. This model enables small numbers of participants to attend and maximizes clinical opportunities without putting an undue burden on the trainers from the training site. (This model is being used successfully in Nepal to implement a similar package for no-scalpel vasectomy training.) This important contribution has been proposed as a best practice to be recommended universally ("JHPIEGO Joins WHO and Partners in Egypt for Launch of Implementing Best Practices Consortium," March 2002). JHPIEGO's core approach to the institutionalization of PAC services is outlined in "Establishing Postabortion Care Services in Low-Resource Settings: Strategy Paper," which was recently reviewed in an inter-agency workshop in Egypt (May 1999).

Pathfinder

Among Pathfinder's most relevant materials for supervision and monitoring are the following: "A Comprehensive Training Course: Postpartum/Postabortion Contraception," "A Comprehensive Training Course: MVA for Treatment of Incomplete Abortion" and "Technical Guidance Series: Tapping Community Opinion on Postabortion Care Services." Pathfinder's training modules cover such topics as family planning methods, infection prevention, reproductive tract infections, counseling, and training of trainers. The curricula have been designed for the training of physicians, nurses, and midwives by clinical trainers who do not have an extensive training background.

Training supervision includes simulation skills practice, case studies, role-playing, discussions, clinical practices, on-site observation, specific measurable objectives,

knowledge, attitudes and skills checklists, and exercises for the development of action plans.

Module 11 of this series, titled "MVA for Treatment of Incomplete Abortion," aims to prepare health workers to counsel women who come to a facility for treatment of an incomplete or septic abortion and to assess and manage the complications. It includes information on preparation of MVA equipment, infection prevention procedures, processing MVA equipment for reuse, pain control, the MVA procedure, management of complications of the MVA procedure, and the introduction of comprehensive PAC services in a clinical setting.

The Pathfinder approach ("Addressing the Consequences of Unsafe Abortion: Insights from Pathfinder Program Experience") has been tested in Peru ("Improving the Treatment of Incomplete Abortion and Postabortion Family Planning Services in Peru" and "Support to the Postabortion Care Program in Peru"), Bolivia ("Support to the Reproductive Health Program in Selected Areas of the Ministry of Health in Bolivia"), Ecuador ("Comprehensive Treatment of Incomplete Abortion in Public Sector Hospitals of Guayaquil, Ecuador"), Haiti ("Postabortion Care in Four Haitian Hospitals") and Egypt (Population/Family Planning Project IV in Egypt).

EngenderHealth

EngenderHealth trains program staff to monitor and evaluate PAC programs, to ensure long-term supplies of equipment, to provide client counseling, to use on-the-job learning principles, and to control costs. According to EngenderHealth sources, they have created or redesigned PAC services at more than 100 sites in 10 countries—Colombia, the Dominican Republic, Egypt, Indonesia, Kenya, Myanmar, the Philippines, Senegal, Tanzania, and Uganda.

In the Philippines, EngenderHealth collaborated with the Department of Health to foster support for a national program to introduce postabortion care services. This opened the door for the first-ever nationwide PAC training in the Philippines for doctors and nurses in clinical skills, counseling, family planning, and infection prevention. In Turkey and Vietnam they developed PAC family planning programs, and in India they are addressing community-level PAC needs.

In February 2003 EngenderHealth released a new training guide for counseling postabortion clients: "Counseling the Postabortion Client: A Training Curriculum," which includes supervision practices and recommended practices. The trainer's curriculum was designed to make counseling an integral part of comprehensive postabortion care (PAC) services. The new curriculum was developed based on a needs assessment and review of existing postabortion counseling literature and models conducted by EngenderHealth. The guide was field tested in several countries. The resulting research concluded that traditional postabortion counseling tends to focus primarily on the provision of family planning information and methods and lacks emphasis on emotional support and communication. In response, the training guide was designed to expand the realm of traditional PAC services by teaching crucial skills needed to improve communication between providers and clients. The guide teaches providers how to create a comfortable environment for discussion and when to ask open-ended questions in order to explore clients' opinions and feelings. It also

teaches providers how to assess and acknowledge clients' concerns and needs by using improved listening skills.

Ipas

IPAS has a three-volume series available on Technical Resources for Postabortion Volume 1, "Implementing Postabortion Care" by Traci L. Baird, M. Virginia Chambers and Charlotte E. Hord (supplement: "Postabortion Care: A Reference Manual for Improving Quality of Care"), shows how to assess the need for postabortion care, plan changes in training and service delivery, implement and monitor new services, and conduct periodic evaluation. Each chapter reviews a different topic, provides a checklist of steps involved, and describes at least one example of a health care situation compiled from Ipas projects. The manual refers readers to additional resources on topics that may require more in-depth information, including how to conduct research on abortion and how to manage serious clinical complications.

Volume 2, "Training Postabortion Care Providers," compiled by José David Ortiz Mariscal and Judith Winkler, includes instructional materials for training health professionals in all elements of postabortion care. The manual consists of nine modules that can be used individually to meet specific training needs or as a complete course. Volume 3, "Monitoring Postabortion Care," by Karen Otsea, Janie Benson, Diana Measham, Margaret V. Thorley and Rosalinda Lidh, reviews monitoring postabortion care services norms and procedures, and includes model-monitoring forms. A computer diskette is included to allow users to customize the forms for specific situations.

IPAS' core reference material is "Postabortion Care: A Reference Manual for Improving Quality of Care," edited by Judith Winkler, Elizabeth Oliveras and Noel McIntosh. This manual outlines the range of activities needed to provide appropriate, high-quality postabortion care, including family planning and referral to health-care services needed after emergency treatment.

IPAS has also available documentation on scaling-up postabortion care services to a national scale. IPAS experiences are documented in a series named *Dialogue*. For example, the issue of *Dialogue* titled "Scaling-Up Postabortion Care: Lessons from a Decade of Experience in Mexico" (Vol. 5, No. 2), reviews work being done in Mexico to scale-up postabortion care services. Also, the issue "Postabortion Care Services: An Update from PRIME" (Vol. 1, No. 2), contains contributions by the PRIME Postabortion Care Theme Team and staff which include: Postabortion Care Services: An Update from PRIME; Quality of Postabortion Care; Integrating PAC Services; PAC Services to Integrate by Levels of the Service Delivery System; PAC Activities Report; and Management Steps to Integrate PAC at the Primary Care Level.

"Preventing Unwanted Pregnancy: Management Strategies to Improve Postabortion Care" (Vol. 5, No.1), by Janie Benson, Robert Gringle and Judith Winkler, presents management-based strategies for solutions to the problem of repeat unwanted pregnancies, focusing on providing quality postabortion care through a medical care services system.

More recently, IPAS developed a PAC information and evaluation system, including data collection forms, user's manual and software to process and report information. The

INFOAPA and EVALAPA system provide a comprehensive and rapid assessment of postabortion services. The system aims to collect information and evaluate quality of services during pre-intervention, intervention and post-intervention of postabortion clients. EVALAPA evaluates six components of quality of care at each intervention stage:

1) Technical competence
2) Appropriate technologies
3) Supplies, instruments and equipment
4) Information and counseling
5) Client-provider interaction
6) Access to PAC services

The data collection instrument includes 108 items that are rated on a Yes/No basis. Items are grouped into 18 sets (six components times three intervention stages) and the software provides a rapid assessment of the state of each component/stage on a 0 to 100 point scale. The evaluation thus consists of a quantitative appraisal that enables supervisors to assess what components and stages need attention.

The EVALAPA and INFOAPA system may be used in several hospitals or medical units. Results may be compared across medical units, for example in a health region. EVALAPA and INFOAPA represent a major advance in PAC supervision procedures. The system is comprehensive, easy to use and low cost. It has been used with success in Perú and may be readily applicable to other countries.

Population Council

The Population Council, in collaboration with IPAS and the Pubcomm Group, Inc., developed an assessment tool utilizing materials from IPAS Postabortion Care Checklists and Modules and the WHO manual "Unsafe Abortion: A Practical Guide" (WHO/RHT/MSM/96.25).

The instrument, titled "Guidelines and Instruments for Monitoring and Evaluating Postabortion Care Service" by Santana Felipe, Nancy L. Sloan, Rafaella Schiavon, Deborah Billings, Timothy King, Bernard Pobiak, and Ana Langer, is a situation analysis that provides a baseline diagnostic exploration of postabortion care. It was designed to guide program design for improving services and postabortion care based on knowledge of:

1) Equipment
2) Supplies
3) Infrastructure
4) Service provider procedures including provider-patient interaction

The system helps hospitals determine the requirements for upgrading facilities and for training to improve the provision of postabortion care. The tool may also be used to evaluate the change in postabortion care services (equipment, supplies, infrastructure and procedures) before and after program implementation to improve postabortion care.

These guidelines were developed using methodology similar to the situation analysis of family planning developed by the Population Council to obtain detailed data on the service-

delivery environment for family planning and to describe the availability, functioning and quality of family planning services for clients at the grassroots level (Robert Miller, Andrew Fisher, Kate Miller, et al 1997; Mensch, 1994).

The instrument contains information on comfort, privacy, hygiene, equipment, medications and supplies, infection prevention, human and laboratory resources, and reference, counseling/educational materials on the following areas:

1) Infrastructure

   a. General facility
   b. Waiting room
   c. Examination room
   d. Operating room
   e. Recovery room
   f. Diagnostic area
   g. Postabortion contraception
   h. Supplies and sterilization

2) Norms and procedures

   a. Managing staff
   b. Administrative procedures
   c. Registration and statistics
   d. Statistics on 20 patients
   e. PAC training needs

World Health Organization
WHO's strategy in this area is to generate evidence to assist in the development of programs and policies. This includes the compilation of data on the incidence of unsafe abortion and abortion-related mortality and morbidity. It also conducts research on priority issues regarding the determinants of abortion and, especially, unsafe abortion. In addition, WHO sponsors biomedical research to develop improved methods of abortion as well as epidemiological research to investigate the obstetric sequelae of non-surgical abortion and the link between induced abortion and subsequent pregnancy outcomes. WHO has developed a number of practical guidelines on management of abortion complications and on abortion and postabortion care and has also prepared training modules on incomplete abortion management for midwives and a guide for midwives and doctors on managing complications of pregnancy, including those due to abortion.

The product listing that follows was compiled by WHO following two consultations and a series of discussions to identify priority needs. A meeting titled "Priorities and Needs in the Area of Unsafe Abortion" was held in August 2000. It reviewed state-of-the-art information on technologies and the latest evidence on the situation of abortion in Africa, Asia, Latin America and the Caribbean, and in Eastern Europe and Central Asia. The second meeting was a WHO Technical Consultation on "Safe Abortion: Technical and Policy Guidance for Health Systems," held in September 2000. The two meetings identified a range of research topics of high relevance and importance in the area of safe and unsafe abortion. These

topics were then reviewed for duplication of work by other agencies, relevance to developing countries, feasibility, potential for impact, and WHO's comparative advantage. This process yielded a selection of priority products for work by WHO's program over the next few years.

ID	Project	Milestones for 2002	Milestones for 2003
145	Systematic reviews of abortion techniques and care	Three reviews completed and some updated	Three additional reviews completed and some updated
146	Abortion-related morbidity and mortality	Analysis of results from earlier studies completed. Systematic review and protocol for additional studies finished	Studies under way in three-five countries
147	Improved technology for first-trimester medical abortion	'Four-arm' study continued. Misoprostol-alone study in first trimester completed. Misoprostol versus vacuum aspiration study started	'Four-arm' study completed. Phase II clinical trial of mifepristone plus iNOS started
148	Improved technology for pregnancy termination in second trimester	Completion of misoprostol alone study	
149	Improvement of safety of surgical abortion	Study of routine priming with misoprostol continued. Study to compare vacuum aspiration versus sharp curettage initiated	Study of routine priming with misoprostol alone completed. Study to compare vacuum aspiration versus sharp curettage continuing
150	Optimal misoprostol regimens for abortion	Studies under way in selected countries	Evidence of refined regimen accumulated
151	Comparative safety, efficacy and acceptability of medical abortion regimens	Studies under way in selected countries	Results available on the comparative safety, efficacy and acceptability
152	Medical abortion methods for 10-13 weeks of gestation	Studies under way in selected countries	Evidence on the safety and efficacy of medical method for abortion at 10-13 weeks of gestation
153	Vacuum aspiration versus misoprostol for incomplete abortion	Studies under way in selected countries	Studies ongoing in selected countries
154	Prophylactic doxycycline in incomplete abortion	Studies under way in selected countries	Evidence on the potential benefits of prophylactic doxycycline for incomplete abortion available
155	Men's knowledge, perceptions and attitudes regarding abortion and their roles	An overview paper produced identifying knowledge gaps, strategies and priorities. Protocols developed and studies planned in selected countries	Studies under way in three - five countries
156	Quality of care in abortion services	One-two studies launched	An additional two-three studies launched
158	Provision of abortion services by non-physicians	Studies under way in two countries	Studies under way in two additional countries

ID	Project	Milestones for 2002	Milestones for 2003
161	Strategic approach to introducing medical abortion	Assessments completed and research launched in one country	Research completed in one country and scaling-up activities planned. Research ongoing in second country
162	Role of counseling on postabortion contraceptive use among young unmarried women	An overview paper with gaps in knowledge, strategies and priorities completed. A protocol developed and countries identified	Studies under way in two countries with high incidence of repeat abortion among unmarried young women
163	Exploring unwanted pregnancy, abortion and decision-making pathways among young unmarried women [Priority 1 HRP B1]	Assessment of the situation, strategies and priorities completed. Two-three research projects (of two-three years' duration) developed and supported	Continuation of support to two-three projects implemented in 2002. Dissemination of programmatic findings initiated
164	Gender, sexuality, violence and abortion	Overview paper completed about what is known, knowledge gaps, strategies and priorities. A protocol developed	Four-five studies launched
165	Translation, reprinting and dissemination of existing HRP technical materials relating to preventing unsafe abortion	Translation, reprinting and dissemination of existing materials carried out	Translation, reprinting and dissemination of existing materials carried out

Source: http://www.who.int/reproductive-health/hrp/plan_of_work/Unsafe_abortion_product.en.html

FRONTIERS
IN REPRODUCTIVE HEALTH

APPENDIX 2

Guidelines for Supervising Postabortion Care (PAC) Services: A Constructive Approach

Draft for discussion: October, 2003

I. WHAT IS POSTABORTION CARE (PAC)?

Postabortion care is:

- An approach for reducing morbidity and mortality from complications of unsafe and spontaneous abortion
- Improving women's sexual and reproductive health and lives

The World Health Organization (WHO) defined unsafe abortion as "any procedure for terminating an unwanted pregnancy (carried out) either by persons lacking the necessary skills or in an environment lacking minimal medical standards, or both…" Spontaneous abortion is defined as "the loss of a fetus during pregnancy due to natural causes…before fetal development has reached 20 weeks…The term spontaneous abortion refers to naturally occurring events, not elective or therapeutic abortion procedures." (Department of OB/Gyn at University of Pennsylvania Medical Center; MAQ Exchange)

According to the WHO, in 1995 there were approximately 20 million unsafe abortions, leading to approximately 70,000 deaths (Ahmand and Iqbal, 2002; WHO, 1997; IPPF, 2002). The estimated global proportion of maternal deaths due to complications of abortion is 13 percent, but in Latin America is as high as 21 percent (WHO, 1998). In countries like Bolivia, Guatemala and Honduras, complications of abortion are the leading cause of maternal mortality, especially among indigenous and rural populations (WHO, 2000). Between 38 and 68 percent of deaths occur among women less than 20 years of age. For every woman who dies from unsafe abortion, 10 women suffer morbidity.

II. WHY IS PAC AN IMPORTANT INTERVENTION?

PAC is essentially an emergency care service:

- Timely PAC saves women's lives
- Increases use of family planning
- Prevents repeat abortion

The social, economic and public health consequences of unsafe abortion have been documented in countries like Peru (Colombo et al, 2001), Bolivia (MPSSP, 1989, Cobb et al. 2001), and Mexico (Ellerston et al, 2000). These studies show that complications of abortion represent between 30 and 50 percent of hospital occupancies and up to 70 percent of resources invested in obstetrical care.

An underlining source of unsafe abortion is the unmet need for contraception to delay, space or limit pregnancies. High unmet need for methods to prevent sexually transmitted infections (STIs) including HIV further complicates the problem of unsafe abortion.

III. HOW IS PAC DEFINED?

Postabortion care is a term now widely used and understood to include the following elements:

Element	Service	Objective
Treatment	Emergency treatment	Treat incomplete and unsafe abortions and potentially life-threatening complications
Counseling	Inform women about their medical condition	Identify and respond to women's emotional and physical health needs and other concerns
Contraceptive and family planning services	Postabortion family planning counseling and services	Help women prevent an unwanted pregnancy or practice birth spacing
Reproductive and other health services	Linkages between emergency care and other reproductive health services, such as management of STIs	Provide RH services on-site or via referrals to other accessible facilities in providers' networks
Community and service provider partnerships	Community participation and education	Prevent unwanted pregnancies and unsafe abortion. Mobilize resources to help women receive appropriate and timely care for complications from abortion. Ensure that health services reflect and meet community expectations and needs

Source: Postabortion Care Consortium Task Force, Essential Elements of Postabortion Care: An Expanded and Update Model, PAC in Action 2, Special Supplement.

A conceptual framework developed by PRIME (Ghosh et al, 1999) postulates that the quality of care of the above components can be assessed in terms of:

1) Information and counseling
2) Interactions between women and providers/staff
3) Equipment, supplies and medication
4) Appropriate technologies for the treatment of complications
5) Technical performance

IV. MONITORING AND SUPERVISION

- **Monitoring** is the analysis and follow-up of a program's main indicators. The objective of conducting monitoring activities is to evaluate the performance of a PAC program and its components.
- **Supervision** is the utilization of monitoring results to 1) identify a program's areas of improvement, 2) determine the origin or cause of problems or deficiencies, 3) find possible solutions, and 4) establish guidelines to solve problems. For supervision to be efficient, it should include participation at all organizational levels, from top management to operations staff.

- **External supervision**, regional or national, is a process through which health regulatory authorities collaborate with the operations staff of a medical unit (i.e. hospital, clinic, health center or post) to determine the extent to which quality norms and standards are being complied with. This process allows a health facility to conduct a self-evaluation, determine the quality of available data, learn about current quality standards, and identify areas of opportunity and the most effective strategies to maintain quality standards.
- **Internal supervision** consists in a self-evaluation or peer-supervision conducted by post-abortion service providers to assess performance, service quality, and determine what resources are needed to maintain quality standards.

The role of supervision in PAC is to help maintain quality on the front line (MAQ, 2003).

How supervision works:

1) Identifies problems and priorities
2) Organizes work to be done
3) Establishes quality standards
4) Delegates tasks
5) Develops work plans to solve problems identified
6) Monitors performance towards the solution of problems
7) Links staff with the larger organization

The qualities of an effective supervisor are the following:

1) Creates trust and develops a system of two-way communication
2) Respects others and values their input
3) Promotes gender equity among staff
4) Holds staff accountable and rewards excellence
5) Motivates and challenges staff without being punitive

V. AN ASSESSMENT OF CURRENT SUPERVISION PRACTICES

Frequently, supervision consists of inspection visits, with a strong administrative or social component, aiming to review the number of services provided over a given period. Rarely do supervisors review processes, teamwork, problems encountered or solutions proposed. Supervision is generally episodic problem solving lacking follow-up and continuity.

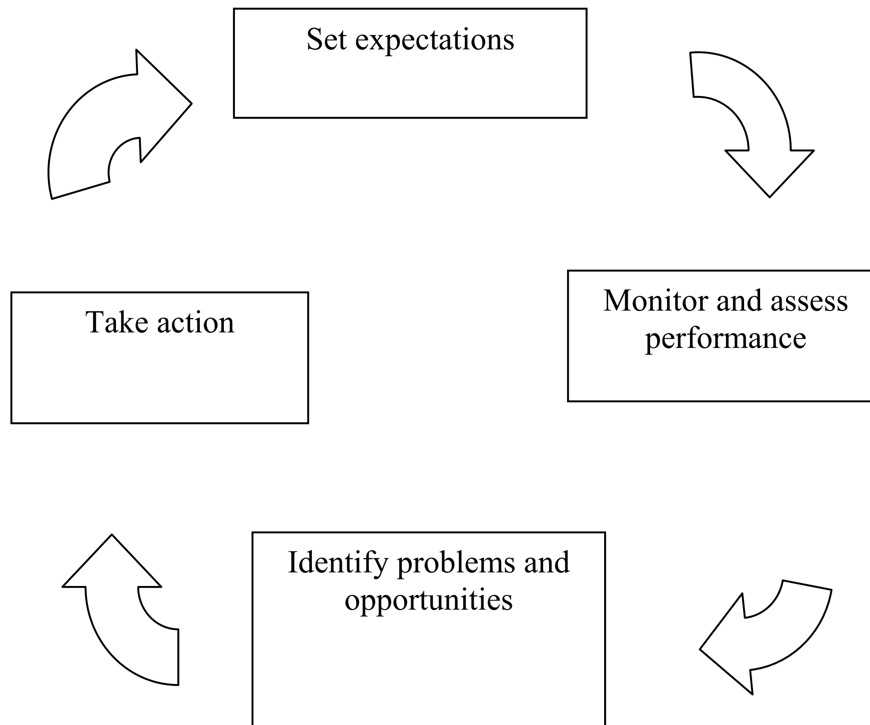
Hospital-based monitoring and supervision of postabortion services is plagued by several problems, such as the following:

1) Lack of adequate instruments to conduct supervision visits on an organized basis
2) Lack of procedures that inform supervisors how to conduct supervision visits and train personnel in-service
3) Lack of organizational procedures that assign roles and responsibilities to all personnel working in wards where postabortion services are provided

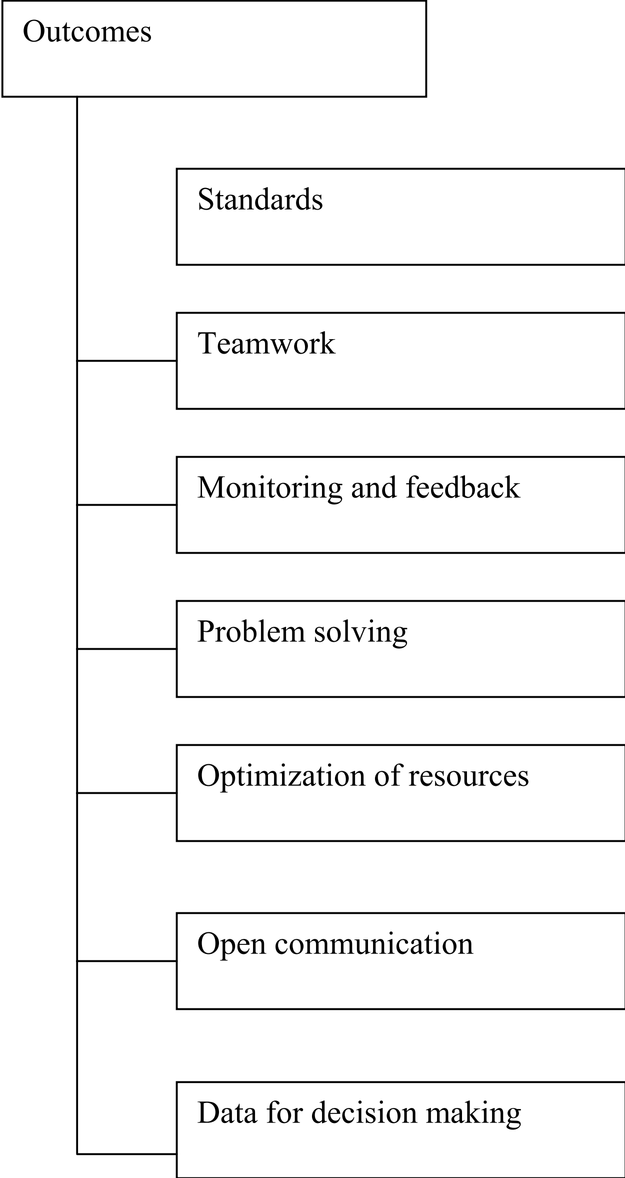
Supervision practices in PAC programs are often informal, disorganized and unsystematic. They are informal because they lack explicit norms and guidelines. They are disorganized because supervision is conducted on a discretionary basis. They are unsystematic, because they are highly dependent upon the supervisor's preference at the moment of the encounter with the service provider.

VI. A NEW VISION OF SUPERVISION

A new vision of supervision is focused on outcomes, ideas and strategies for moving forward (MAQ Exchange, 2003). Under this view, supervision is an ongoing process, not an event.



Supervision reinforces quality of outcomes at all service levels.



Supervision is the unifying element in quality control, as it offers operational personnel the direction and support they need to apply directives to their daily activities.

Supervision has undergone interesting changes in the way it is conceptualized. It used to be a synonym for courtesy or inspection visits and for the assessment of findings. Supervision was understood as a means for superiors to control and exercise power, and tended to be directed more toward the supervision and control of personnel and less toward improving teamwork and processes. It was a way to solve problems periodically and was characterized by its lack of continuity.

Now supervision is understood as a technical administrative practice that is carried out as processes develop. It is defined as a procedure for research and analysis that has as its objectives the integral development of personnel, facilitating decision-making and improving the quality of services. Both the supervisor and supervisee should be permanently immersed in a teaching-learning relationship, and it should be oriented toward achieving good results.

These new ways of looking at supervision have increased and improved the role of the supervisor in quality management. Traditionally the supervisor takes on the role of inspector and uses verification lists to evaluate the performance of personnel. These verification lists now focus more on questions of quality; they help the supervisor identify specific areas of weakness and allow him or her to provide immediate feedback to personnel.

The current function of the supervisor goes beyond inspection and includes support and orientation for operative personnel. Supervisors can diminish the fears of supervised personnel and develop more trusting relationships. They can also help personnel resolve problems; they can train and motivate employees, provide a link to higher-ranking managers, and act as facilitators or intermediaries, for example by helping obtain training programs, improving infrastructures or providing necessities. When health personnel are seen as internal clients, supervisors provide a more productive focus on supervision.

The concepts of "facilitating supervision" and "team supervision" put in practice these new focuses on supervision. Both link the periodic visits of a supervisor with continual self-improvement efforts on behalf of clinic personnel. These focuses require supervision visits that last days instead of hours, but the additional time offers supervisors the possibility of improving the quality of attention, rather than simply grading it. In places where a shortage of resources hinders this sort of external supervision, one of the members of the personnel in the unit could take on supervisory functions.

During the visit to a unit, the supervisor not only carries out monitoring tasks such as reviewing records, visiting the unit, observing check-ups and surgical procedures for uterine evacuation (MVA/D&C), interviewing users and so forth. Rather, he or she also has to organize and hold meetings with personnel to talk about areas that need improvement, and establish recommendations and duties in writing with managing and operative personnel in the unit to specify who will correct problems and when actions will be taken. Supervisors need the full backing of the highest-ranking directors in order to help them take on more supportive roles. Organizations have to find a way to reward internal supervisors

who take their quality improvement responsibilities seriously. Training is crucial in teaching supervisors the necessary abilities to solve problems, listen, counsel and train.

Supervision has several stages:

1) Planning. In this stage, expectations for visits are defined. Areas and persons to be supervised are determined, and supervisors set the length of the process and work schedules. They obtain contacts at health units and for key people who should be supervised, establish work rules, and define their internal support and operational logistics.

2) Implementation. In this stage, operative areas are visited, alone or in the company of internal supervisors or chiefs of service to observe attention processes. Techniques and instruments that have been previously selected are applied. Interviews and meetings are carried out with personnel involved directly in the attention process of post-abortion care in order to collect information, listen to complaints, make suggestions for change, identify whether there is enough support, and offer constant feedback and counseling.

3) Evaluation. In this stage, the data and information gathered is analyzed, findings and results are organized and preferably graphed, and recommendations are written. It is convenient to give managing and operative personnel the results of the supervision and the recommendations during a formal evaluation meeting, which allows for the following:

    a. To appreciate the progress achieved in goals and objectives
    b. To rate providers
    c. To rate the methods used by the supervisor
    d. To reorient the development of the PAC program
    e. To sustain the planning and execution of recommendation and follow-up activities
    f. To establish and define duties

Supervision and Interpersonal Relations

When personnel from the same unit are supervising, it is possible that interpersonal problems may emerge. In order to avoid this, it is recommended that the supervisor should:

1) Have frequent meetings with the members of different departments and sections that intervene in the provision of PAC services
2) Allow people to express their opinions openly
3) Describe functions and responsibilities in a detailed and clear way and preferably write them out for each department (protocols)
4) Establish well-defined procedures (guidelines)
5) Distribute tasks in an equal form
6) Share the success of objectives that have been accomplished

Aspects that should be taken into account during the supervision process are:

1) Application of administrative process on behalf of the supervisor
2) Application of technical PAC norms
3) Strengthening of interpersonal relationships between the health team and the community
4) Training of personnel

Parts that a general supervision plan should include:

1) Health conditions
2) Objectives
3) Area
4) Date and duration
5) Activities
6) Resources
7) Techniques and instruments
8) Chronogram of activities
9) Budget

Characteristics of a good supervisor

In order for the PAC supervision process to be carried out adequately and to obtain the expected results, it is convenient for the person that supervises to have these personal characteristics and follow some of these recommendations:

1) **Legitimacy.** The person or persons that supervise post-abortion care services should have not only theoretical but also operational experience. This will provide an adequate dimension to findings. It isn't always easy to find a person with in-depth knowledge of the PAC model who has also observed its use or experienced it in a health unit. When the supervisor lacks some of this experience, it is recommended that they have support from another member of the health personnel experienced in the area that he or she is supervising (e.g. community, technique, counseling).

2) **Objectivity.** From the beginning of the supervision process there should be a fixed plan, valid instruments and a focus on problem solving, not on finding out who is responsible or who is to blame. Supervision should be seen as an opportunity for growth, improvement, and should be based on real and trustworthy information in order to avoid subjectivity as much as possible. If, by chance, the supervisor has an interpersonal conflict with a member of the health personnel, it is advisable that he or she ask for the support of another member of the supervising team or be very precise in his or her observation, as well as careful in registering findings.

3) **Respect.** The person who supervises should be respectful of the culture, traditions, politics and religion of the area where the unit to be supervised is located. It is advisable to avoid discussions on polemical themes with the supervised personnel and service users, unless it is vital, and the supervisor considers this will benefit

them. Treatment of local authorities and members of health personnel should always be respectful.

4) **Integrity.** The supervisor must be regarded by others as a person with integrity, with a high sense of responsibility, incorruptible and unbreakable when faced by external or internal pressures.

5) **Firmness.** Before emitting a judgment or qualifying a result, the supervisor must be sure of what he or she will say or do, as he or she will have to be firm in order to gain everyone else's respect.

6) **Adaptability.** The supervisor must be adaptable to changing work conditions, climate, transportation, logistical aspects, and so forth. On occasion it is necessary to improvise, postpone, set back or even suspend the activity and find a better moment in the future. A dose of good humor also helps.

7) **Flexibility.** During the supervision process a flexible attitude must be shown, an adequate mixture of compliance and firmness.

8) **Participative**. It is recommended that during the visit s the supervisor be accompanied by one of the unit's authorities. This will back him or her up whenever he or she points something out or gives an opinion to operative personnel. It is recommended that they comment on some of the findings, particularly on the negative ones, and find out opinions and listen to explanations. At the same time, when positive situations are found, the managers must also be involved, as this will motivate them and make them more involved in quality processes. Before final results are given to directors, it is recommended that they carry out several formal and informal meetings with PAC personnel in which findings and results are taken into consideration and rated.

9) **Open to change**. The supervisor must have, as one of his or her objectives to propose changes that emerge from findings, to improve quality of attention to users and working conditions for health personnel. He or she should also express his or her satisfaction for the work accomplished.

10) **Non-punitive**. Supervision as a means of punishment, revenge or reprisal should be avoided as much as possible.

11) **Timely**. This does not mean superficiality in the supervision process, but rather that the supervision will allow for the main problems to be identified, providing feedback in order to reorient processes at the least possible cost and in the shortest possible time-frame, and proposing the best solutions.

12) **Motivational**. Supervision processes can occasionally be painful, be it for the supervisor or the supervisee, due to the negative results that are at times found. Even in these cases, however, it is feasible to find ways of transforming these results into a source of motivation in order to reach improved levels. This implies recognizing other people's efforts in a fair manner.

13) **Regular**. Supervision must be carried out with the necessary periodicity to improve the structure, processes and results in order to impact the health of the population that uses PAC services.

VII. PAC SUPERVISON PROCEDURE

The supervision procedure consists of a sequence of information sharing, reporting, evaluating and planning steps involving external and internal supervisors, as well as medical unit directors, administrators and service providers at all levels.

The process is initiated by an external supervisor, who is a national or regional officer responsible for providing quality PAC services. At least one month in advance of the supervision visit, the external supervisor requests key information from the hospital or clinic. This information includes: number of abortion cases attended, treatment used, number and proportion of women provided PAC who received family planning counseling, contraceptive prevalence rate upon hospital discharge, opinions of women about the care they received, and any problems encountered in service provision.

Key PAC indicators include the following:

A. Treatment
   1) Trend and number of abortions
      a. By maternal age
      b. By gestational age
   2) Trend and number of cases treated with MVA and D&C
   3) Trend and number of complicated abortions
   4) Trend and number of post-abortion complications
   5) Evaluation of provider technical competence
   6) Training needs by type of provider:
      a. MVA
      b. Family planning
      c. Eligibility criteria
      d. Female VSC
      e. Male VSC
      f. IUD
      g. Emergency contraception
B. Family planning counseling and services
   1) Number and proportion of women receiving family planning counseling
   2) Number and proportion of women receiving a method upon hospital discharge
   3) Number and proportion of women receiving appointments
   4) Method mix
C. Women informed about postabortion care, medical conditions, alternative medical procedures available, and pain management
D. Number and proportion of women referred or treated for other RH needs
E. Number, proportion and significance of community-oriented activities related to abortion prevention
   1) Meetings and activities conducted

2) Cases attended or effectively referred for preventive treatment

The following sections of this manual describe the data collection forms and instructions that may be used to request the relevant information on these indicators. Often, hospital directors do not provide most of the information requested. This creates an opportunity to discuss the need to establish a postabortion care improvement program involving personnel at all levels.

With the information provided by the hospital, the external supervisor will prepare a one or two day supervision visit. Because the external supervisor has national or regional responsibility, it is unlikely that he or she will have more time to devote to each hospital or clinic.

During the one or two-day supervision visit, the external supervisor will interview the:

1) Hospital or clinic director
2) Internal supervisor in charge of PAC services or staff responsible for OB/Gyn or emergency services
3) Service providers who have contact with postabortion patients

To conduct these interviews, the external supervisor will use the semi-structured questionnaires included in this manual. The purpose of these questionnaires is to guide the interviews towards the identification of potential problems affecting PAC services and possible solutions. Questionnaires are not designed to be analyzed statistically, but to conduct a qualitative appraisal. The relevant outcome of such questionnaires is the identification of problems and solutions.

Upon identification of problems and possible solutions, the role of the external supervisor is to help develop work plans to implement the solutions proposed. Different methodologies may be used to develop such work plans and it is a matter of managerial approach to translate the solutions proposed into realistic work plans.

A key to successful supervision is to discuss different sorts of problems and solutions with the relevant level of authority within the medical unit, as follows:

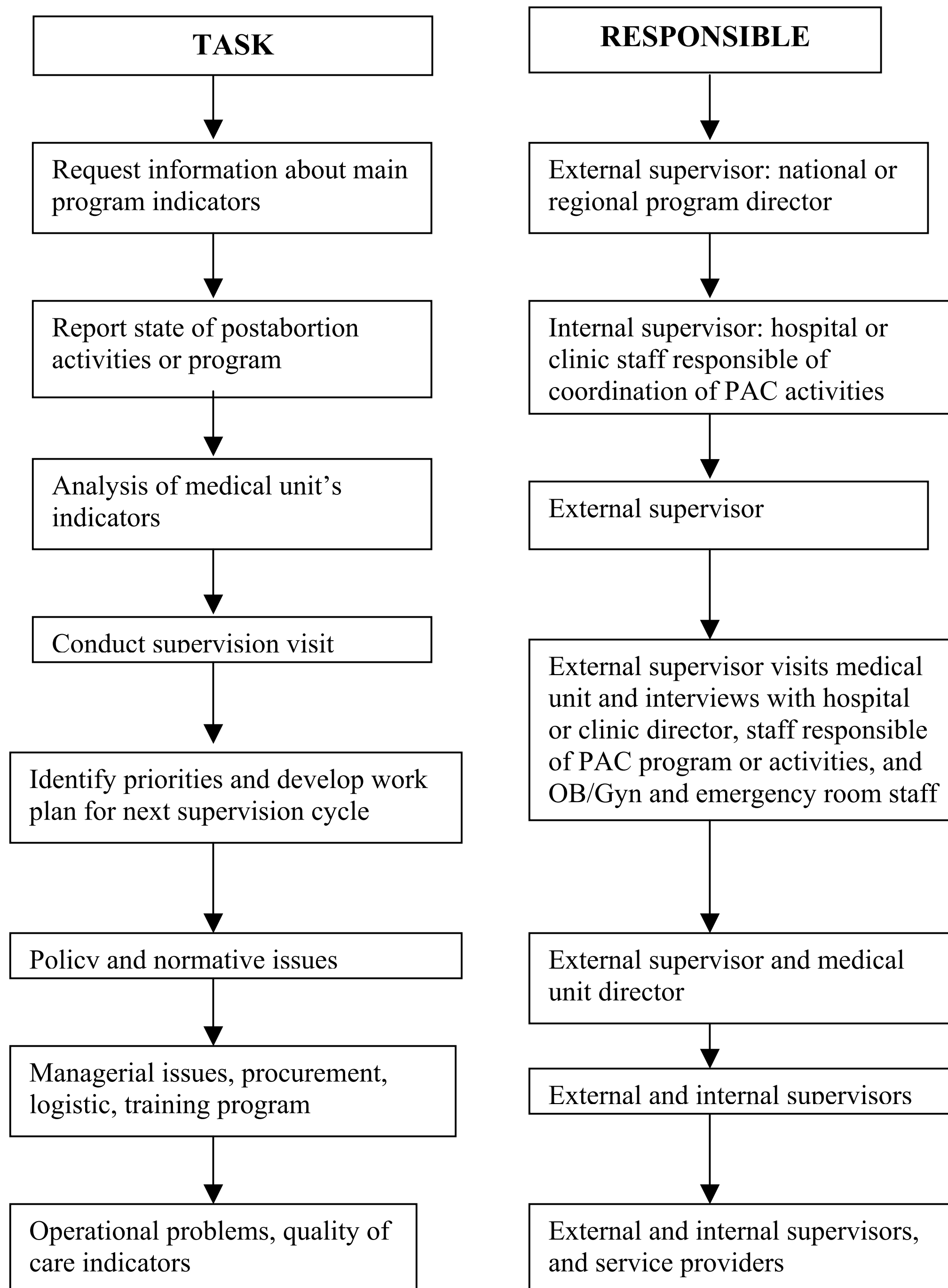
1) **Hospital or clinic policy and norms**. For example, whether or not there are community-oriented activities aiming to prevent abortion, or whether or not postabortion care is a priority at the hospital. These topics should be discussed with hospital directors or administrators.

2) **Organizational issues**. Financial support, procurement, availability and accessibility of rooms, space use within medical unit, and training needs. These issues may be discussed with the internal supervisor or staff responsible for OB/Gyn services or a designee.

3) **Operational problems**: Logistic issues, training needs, attitudinal problems, technical competence, problems and deficiencies in patient care. These issues may be discussed with service providers who have direct contact with patients.

Of course, all service levels have relevant opinions about each of the above topics. However, a time-efficient approach to supervision requires that supervisors target their time to identify relevant problems, propose feasible solutions, develop adequate work plans to implement solutions and, finally, set goals and a time frame to put those solutions in place.

Graphically, the supervision process is the following:



The PAC program's supervision activities include the following steps:

1) Request information about the main program indicators
2) Conduct an analysis of the unit's indicators
3) Conduct supervision visit
4) Meet with operational staff (physicians, nurses, social workers, and educators)
5) Identify priorities and operational action plan for next supervision period
6) Meet with top management (unit director, head of services, program manager)
7) Identify priorities and management action plan for next supervision period

STEP 1: PREPARING FOR THE SUPERVISION VISIT

Information about the main PAC indicators should be requested at least a month before conducting an external supervision visit. Such information includes:

Indicator	Information Source	Instrument
MEDICAL TREATMENT		
Trend and number of abortions By maternal age By gestational age	Log	SUP1 Form
Trend and number of MVA and D&C	Log	SUP1 Form
Trend and number of complicated abortions	Log	SUP1 Form
Trend and number of post-abortion complications	Log	SUP1 Form
Provider technical competence	Observation of service provision Summary of observation results	CHKLST 1 SUP2 Form
Training needs by type of provider: MVA Family planning 1. Eligibility criteria 2. Female VSC 3. Male VSC 4. IUD 5. Emergency contraception 6. Family planning counseling PA counseling Other RH services	Diagnosis by director or head of Ob-Gyn service	SUP3 Form
COUNSELING		
Information received by patients and service quality	User interviews	QUEST 1 SUP4 Form
FAMILY PLANNING		
Prevalence of contraceptive use	Log	SUP5 Form
Method mix	Log	SUP5 Form
LINKS TO OTHER REPRODUCTIVE HEALTH SERVICES		
Service statistics on other RH pathologies or problems and referrals	Log	SUP6 Form

DISCUSSION AND SUPERVISION GUIDES

FRONTIERS
IN REPRODUCTIVE HEALTH

Interview with Hospital Director

(To be filled in by supervisor)

Name of Interviewee ____________________ **Hospital/Health Unit** ________________________

Position ______________________________________ **Date** ______________________________________

MANAGERIAL COMPONENT			**COMMENTS**
1. Are abortion-related maternal deaths in the facility's area of influence routinely examined?	Yes	No	
2. Does the facility provide post-abortion care 24 hours a day?	Yes	No	
3. Are PAC services free?	Yes	No	Cost?
4. Are companions of PAC patients allowed access to the facility?	Yes	No	
5. Is this hospital treating abortion patients that live outside its area of influence?	Yes	No	How many cases per month?
6. Have some of these cases been referred/refused admission to the hospital?	Yes	No	How often?
7. Are there any other cases that must be refused/referred to other units?	Yes	No	
8. Is the hospital conducting outreach activities to prevent unwanted pregnancies?	Yes	No	
9. Is the hospital conducting outreach activities to prevent unsafe abortion?	Yes	No	
10. Are there official coordination mechanisms between the hospital and its health centers and posts to prevent abortion and to provide comprehensive care to women who have received an abortion?	Yes	No	If **Yes**, give an example: ____________ ____________
11. Does the hospital participate in reproductive health outreach activities?	Yes	No	If **Yes**, give an example: ____________ ____________
12. Does the hospital produce and distribute information materials on abortion?	Yes	No	

TREATMENT			
13. What specific actions have you undertaken to support the Post-Abortion Care program?			
14. Does the hospital have providers trained in Manual Vacuum Aspiration (MVA)?	Yes	No	
15. Does the hospital have providers trained in MVA in the three shifts?			
Morning	Yes	No	
Afternoon	Yes	No	
Night	Yes	No	
16. Can a PAC patient be discharged at any time of day?	Yes	No	
FAMILY PLANNING			
17. Does the hospital officially offer family planning services in the immediate post-abortion period as part of its comprehensive PAC services?	Yes	No	
18. Does the hospital have copies of the official norms on family planning issued by the Ministry of Public Health and Social Assistance? Are they available?	Yes	No	(If **Yes**, request a copy)
19. Does the hospital offer post-abortion family planning methods?	Yes	No	
20. Are the following indicators recorded?			
a) Prevalence of contraceptive use	Yes	No	
b) Method mix	Yes	No	
c) Trend and number of MVA and D&C	Yes	No	
d) Trend and number of abortions	Yes	No	
1. By maternal age	Yes	No	
2. By gestational age	Yes	No	
e) Trend and number of complicated abortions (fever, uterine perforation, vaginal laceration, unstable vital signs, etc.)	Yes	No	
f) Trend and number of post-procedure complications, by type of procedure	Yes	No	
g) Statistics on other reproductive health problems	Yes	No	

LINKS						
21. What reproductive health services does the hospital offer and refer to?			**Refers**			
a) External reproductive health services, care for victims of domestic and/or sexual violence	Yes	No		Yes	No	
b) STI (sexually transmitted infections) services	Yes	No		Yes	No	
c) Early detection of cervical cancer	Yes	No		Yes	No	
d) Breast cancer detection	Yes	No		Yes	No	
e) Programs for social risk detection in regards to abortion	Yes	No		Yes	No	
f) Youth program	Yes	No		Yes	No	
g) Infertility service	Yes	No		Yes	No	
h) Psychology services	Yes	No		Yes	No	
i) Other (specify):	Yes	No		Yes	No	

TRAINING NEEDS				
22. What are the main training needs in regards to post-abortion care?				
	Physicians	**Nurses**	**Social Workers**	**Other**
MVA				
Family Planning				
Eligibility Criteria				
Male and Female VSC				
IUD Insertion				
Emergency Contraception				

Counseling				
Other reproductive health services				

23. How is training evaluated?

24. How is PAC service quality evaluated?

25. Checklist:

Interview with Head of Ob-Gyn Service

Name of Interviewee ____________________ **Hospital/Health Unit** _________________________

Position _____________________________________ **Date** ______________________________________

TREATMENT			
A. TRAINING			
			COMMENTS
26. Does the service have competent providers to perform Manual Vacuum Aspiration (MVA) at any time of day?	Yes	No	
27. Is there a formal theoretical and practical PAC course of at least 20 hours for health providers?	Yes	No	
28. Is there a formal practical course in which physicians must treat at least five patients using MVA under supervision?	Yes	No	(Evaluate checklist)
B. PRODUCTIVITY			
Show and discuss the treatment tables included in attached interview form			
29. Monthly trend and number of abortion patients admitted during the last six months			
30. Monthly trend and number of MVA and D&C performed in the last six months			

C. PERFORMANCE				
31. Did patients with incomplete, non-complicated abortions receive pain medication BEFORE the procedure (MVA/D&C), when not contraindicated?		Yes	No	
32. Did patients with incomplete, non-complicated abortions receive pain medication AFTER the procedure (MVA/D&C), when not contraindicated?		Yes	No	
33. Type of anesthesia	MVA	D&C		
Paracervical				
General				
Sedation				
34. What is the average hospital stay?				hours
35. According to official hospital reports, what is the rate of complications and reevacuation with D&C?				%
36. According to official hospital reports, what is the rate of complications and reevacuation with MVA?				%
37. Do providers that staff the procedure room comply with biosafety standards when processing MVA instruments (initial decontamination, cleansing, high-level disinfection or sterilization, and residue disposal)?		Yes	No	
D. EQUIPMENT				
38. Is MVA equipment available and accessible at any time of day, 365 days a year?		Yes	No	
39. Does the service have the necessary instruments (indispensable plastic and metallic devices) to provide MVA?		Yes	No	
40. What is the condition of MVA instruments? *(Mark only one)*				
Excellent / Good				
Average				

Bad			
There are no instruments			
E. INFRASTRUCTURE			
41. Is there an adequate area (clean, well lit, private, and equipped with the basic elements needed to ensure the patient's safety) available to perform uterine evacuation and separate from the operating room?	Yes	No	
42. Is the operating room equipped to provide timely emergency care to both incomplete abortion patients with complications and labor/C-section patients?	Yes	No	
43. Is there a log in which to record uterine evacuation procedures?	Yes	No	
If **Yes**, does it include the following basic data?	Includes		
Name or initials of patient/user	Yes	No	
Date and time of procedure	Yes	No	
Age	Yes	No	
Previous pregnancies, births, C-sections, abortions	Yes	No	
Date of last menstruation (DLM)	Yes	No	
Uterine size before procedure	Yes	No	
Analgesia/anesthesia techniques used	Yes	No	
Trans-surgery complications	Yes	No	
Referral to other reproductive health services	Yes	No	
Date and time patient left procedure room	Yes	No	
44. Type of procedure performed MVA	D&C		
F. RESULTS			
45. Present and analyze situation analysis data	Presented and discussed?		

Trends and rates of hospital abortion	Yes	No	
Age groups	Yes	No	
Place of origin	Yes	No	
Average hospital stay	Yes	No	
Trends and rates of post-procedure complications	Yes	No	
Statistics or data on pain management	Yes	No	
Gestational age and uterine size by surgical uterine evacuation technique	Yes	No	
COUNSELING			
46. How many PAC counseling sessions did the following staff provide last month?			
Staff	**Total**		
Ob-Gyns			
Nurses			
Social workers			
General practitioners			
Residents			
Interns			
Medical students			
Other			
47. Are exit interviews conducted upon discharge to determine the patient's degree of satisfaction with the counseling service?	Yes	No	
48. Is the institution using the data thus obtained?	Yes	No	Give example

49. What are the staff's needs in regards to training/counseling inputs?			
CONTRACEPTION AND FAMILY PLANNING			
A. TRAINING			
50. Does the hospital have providers that need training in family planning?	Yes	No	Actions undertaken
51. Does the hospital have providers that need training in eligibility criteria?	Yes	No	Actions undertaken
B. PRODUCTIVITY			
52. Percentage of women that leave the hospital with an effective family planning method	%		

Method	**Percentage**
Pills	%
IUD	%
Condom	%
Vaginal	%
Diaphragm	%

Injectables	%		
Implants	%		
Emergency contraception	%		
Other	%		
Total	%		
C. COVERAGE AND TYPE OF METHOD BY AGE GROUP			
53. Is informed consent requested prior to post-abortion surgical sterilization?	Yes	No	(See that document is included in clinical file)
54. Is informed consent requested prior to IUD insertion?	Yes	No	(See that document is included in clinical file)
D. INPUTS			
55. Does the unit have a wide range of temporary contraceptive methods readily available to PAC providers? Specify.			
Pills	Yes	No	
IUD	Yes	No	
Condom	Yes	No	
Vaginal	Yes	No	
Diaphragm	Yes	No	
Injectables	Yes	No	
Implants	Yes	No	
Emergency contraception	Yes	No	
Other (specify)	Yes	No	
56. Have there been instances when one of the following methods has not been available or supplied for 24 hours?			
Pills	Yes	No	
IUD	Yes	No	

Condom	Yes	No	
Vaginal	Yes	No	
Diaphragm	Yes	No	
Injectables	Yes	No	
Implants	Yes	No	
Emergency contraception	Yes	No	
Other (specify)	Yes	No	
Actions undertaken: ______________________________			
57. Do PAC providers have IEC materials on contraceptive methods?	Yes	No	Actions undertaken ______________ ______________

E. INPUTS			
58. Does the hospital have logistics, equipment or infrastructure problems to perform surgical sterilization or insert IUDs?	Yes	No	Actions undertaken
59. Is there enough privacy in the PAC area to provide family planning methods?	Yes	No	
60. Does the PAC area have problems to store family planning inputs?	Yes	No	
61. Is the hospital as a whole experiencing problems in regards to availability of family planning methods?	Yes	No	
62. Is the hospital as a whole experiencing problems in regards to offering family planning methods?	Yes	No	
CONTRACEPTION AND FAMILY PLANNING			
63. Do health providers know about other reproductive health services to which they can refer patients?	Yes	No	(Interview with health staff)
64. Number and type of reproductive health problems identified among post-abortion patients			
65. What mechanisms do you use to evaluate PAC service quality? (Check clinical file)			

Exit Interview with Users after Hospital Discharge

NAME_______________________________**DATE**_____________________________

EXIT INTERVIEW WITH USERS AFTER HOSPITAL DISCHARGE

QUESTION			COMMENTS
66. Did you receive support during your hospital stay?	Yes	No	
67. Were you informed about your health problem?	Yes	No	
68. Were you informed about the two possible treatments for your abortion?	Yes	No	
69. Were you able to choose between the two treatments?	Yes	No	
70. Do you know what kind of anesthesia you received?	Yes	No	Type of anesthesia:
71. Did you feel pain during the procedure?	Much		
	Little		
	None		
72. Were you informed about post-procedure precautions and danger signs that could be indicative of complications and of the need to seek care again?	Yes	No	
73. Were you informed that having several abortions constitutes a life-threatening risk?	Yes	No	
74. Were you informed about the likelihood of immediate pregnancy if you have unprotected sex within the next 15 days?	Yes	No	
75. Were you asked if you wanted to get pregnant any time soon?	Yes	No	
76. Did you receive information about family planning methods?	Yes	No	

77. Did you receive printed materials on family planning to take home with you?	Yes	No	
78. Did you receive information about other services offered by this hospital that can improve women's health?	Yes	No	
79. During your stay in hospital, did you suffer maltreatment?	Yes	No	
80. Write down any additional comments:			