The Postabortion Care Family Planning (PAC-FP) Project

Project Introduction
Key Findings of PAC-FP Situation Analysis

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Strategic Approach toward Strengthening PAC FP in Tanzania

	Developing an approach	*Demonstrating a model*	*Replicating what worked*	*Going to scale*
Paradigm:	**Baseline research/ situation analysis**	**Operations research**	**Implementation Research**	**Organizational change and development**
Questions:	**What strategy might best build the capacity of the health system?**	**Does the candidate strategy work & how)?**	**What are the milestones and strategies for scaling-up?**	**Is coverage expanding? Is the system working, as planned?**
Outcomes:	**A holistic, contextually appropriate PAC-FP capacity building model.**	**Improved health outcomes, an FP-strengthened PAC model.**	**Scale up strategy**	**Coverage, operational fidelity, quality of care**

PAC-FP program development phase

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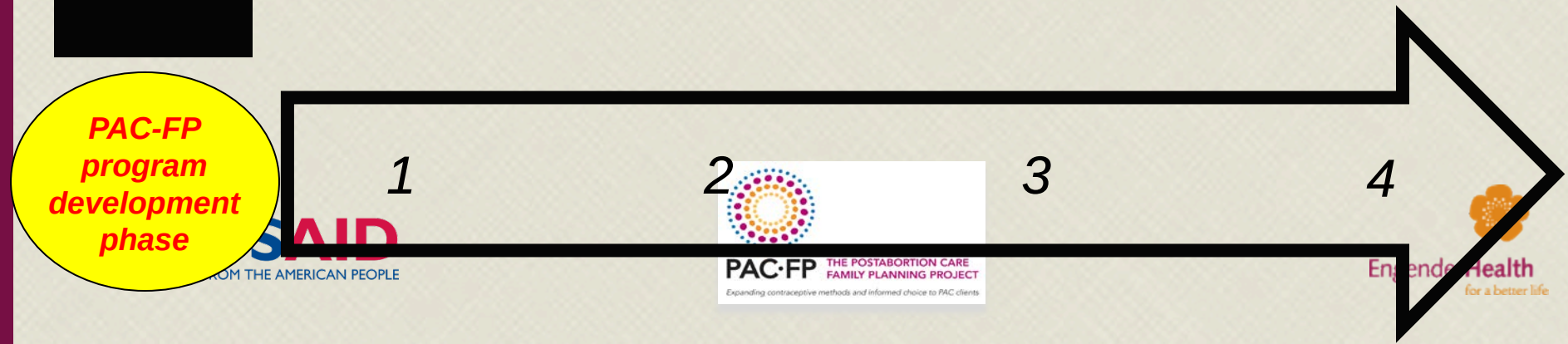

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Phase 1: Situation Analysis

Took place during April-July 2016 in 17 sites in Mwanza, Geita and 8 in Zanzibar Regions.

Objectives

To understand:

1. Factors that affect accessibility of PAC.
2. Factors that affect postabortion FP decision-making.
3. Factors that affect perceived quality of PAC services.
4. The quality of PAC service readiness and provision.
5. The factors that affect PAC provider performance.

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Data collection methods

- Analysis of PAC service delivery statistics from 120 facilities (2005-2014).
- Client exit interview (n=412)
- Client in-depth interviews (n=30)
- PAC service availability and readiness assessment (n=25)
- Provider knowledge/skills questionnaire (n=50),
- Direct observations of PAC-client provider interactions (n=30)
- Provider in depth interview (25)
- In-depth interview and focus group discussions (n=8) with community stakeholders (n=15).

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Findings we are sharing today

Client Exit Interview

Key determinants of induced abortion and postabortion FP.

Client perceptions of the quality of PAC.

In-depth Key Informant Interviews

Pathways to unsafe abortion, care seeking and postabortion FP use.

Provider perspectives on provision of quality PAC and postabortion FP.

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Determinants of induced vs. spontaneous abortion and postabortion FP uptake

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Socio-demographic Breakdown

Age	N	%	Mean Gravida	Mean Parity	Mean age of youngest child (months)	Married/ in union (#/%)	Education Status (#/% completed PS)	Literacy (can't read or w/ difficulty
<20	50	12.5	1.2	0.2	-	28 (56%)	37 (74%)	15 (30%)
20-24	113	28.3	2.2	1.0	10	85 (75%)	86 (76%)	24 (21%)
25-29	82	20.5	3.1	2.0	11	68 (83%)	61 (74%)	21 (26%)
30-34	70	17.5	4.4	3.0	24	62 (89%)	51 (73%)	16 (23%)
35-39	54	13.3	5.7	4.2	35	49 (91%)	31 (57%)	19 (35%)
40-46	30	7.5	7.3	5.4	40	27 (90%)	21 (70%)	12 (40%)
Missing	13	3.2	-	-	-	-	-	-
	412		**3.5**	**2.4**	**17**	**81%**	**72%**	**27%**

65% (268) have their own cell phone; 50% (206) have electricity at home.

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Postabortion Care-seeking

Facility type

- Regional referral hospital: 244 (59%)
- District hospital: 139 (34%)
- Health center: 29 (7%)

Time to facility

- 31 (7.5%) reached facility for PAC in less than 10 minutes
- 202 (49%) 10-30 minutes
- 117 (28%) 31-60 minutes
- 58 (14%) 1-2 hours
- 4 (<1%) 2 hours or more

Delay

- 110 (26.7%) aborted the day before; 98 (23.7%) aborted two days before
  99 (24.0) aborted 3-4 days before; 105 (25%) aborted 5+ days before

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Reproductive History and Intentions (I)

Gestational age and uterine evacuation methodology

- 265 received MVA, 77 sharp curettage, 35 misoprostol
- 283 (68.69%) were <=12 weeks gestational age.
  - 200 MVA (71%), 53 sharp curettage (19%), 17 misoprostol (6%)
- 65 (15.78%) were 13-18 weeks gestational age.
  - 32 MVA (49%), 11 received sharp curettage (17%), 5 misoprostol (8%)
- 64 (15.53%) were >=19 weeks gestational age
  - 31 MVA (48%), 13 received sharp curettage (20%), 11 misoprostol (17%)

Intentionality of abortion

- 52 (12.4%) report an induced the abortion, 360 (87.6%) allege it was spontaneous.

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Reproductive History and Intentions (II)

Future Pregnancy Intentions

- 337 (81.7%) reported that they want to become pregnant again in the future, 43 (10.4%) want to cease childbearing, 32 (7.8%) were undecided.
- Of those that want more children, 92 (27.3%) want to become pregnant immediately, 120 (35.6%) within 2 years, 100 (29.7%) after 2 years.

Previous abortion

- 78 (18.9%) had ever had an abortion in the past, of whom 31 (62%) once, 19 (38%) 2 or more times

Family Planning Use

- 214 (51.9%) never have used an FP method – 54 (25.2%) because of lack of knowledge, 48 (22.4%) fear of side effects.

Postabortion Care FP

Postabortion Care Counseling

- 119 (28.9%) received counseling that included discussion of FP methods, and 9 others received counseling on if and when they would like more children only.
- Of those counseled, 34 (28.6%) reported that their partner was involved.

Postabortion Care Method Provision

- 71 (17.2%) received an FP method
  - 2 received female sterilization, 17 IUD, 6 implant, 22 pills, 19 injectable, 4 condom, 1 female condom
  - 56 of FP adopters received MVA (out of 283), 11 sharp curettage (out of 77) and 4 misoprostol.

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Determinants of Abortion Type and PAC FP Uptake - Methods (I)

Analysis of data from client exit interview questionnaire.

Multi-step analysis to assess factors associated with clients' reporting:

- Induced an abortion themselves (n=52)
- Accepted a modern family planning method (n=72)

Independent variables: socio-demographic characteristics, economic status, pregnancy and birth history, fertility desires, abortion experience, spousal characteristics and clinical information on the on their experiences with PAC at the facility and interactions with providers.

Dependent variables: abortion type (induced vs. allegedly spontaneous); repeat abortion (the client had ever had an abortion vs. this was the clients first abortion); and FP-uptake (client accepted a modern FP method from PAC provider immediately before the interview vs. the client did not accept PAC FP).

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Methods (II)

Step 1: Fishers Exact tests for each independent variable in the questionnaire to assess their relationship with each outcome (i.e. dependent variables).

Step 2: Independent variables that demonstrated a significant relationship in step 1, compiled into a multivariate logistic regression model.

Step 3: Additive procedure to minimize the number of variables in each model and maximize their accuracy.

Results after all three steps: abortion-type (I)

Variables	Multivariate Analysis	
	Adjusted OR (95% CI)	P-value
Marital Status		
Single	1.00	
Married/in-union	0.44 (0.21-0.93)	0.032*
Age		
Under 27 (mean age of PAC clients)	1.00	
Over 27	0.55 (0.27-1.12)	0.10
Religion		
Muslim	1.00	
Christian	1.75 (0.85-3.61)	0.124
Occupation		
Gainful employment	1.00	
Non-gainful employment	0.40 (0.20-0.79)	0.009**

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Results after all three steps: abortion-type (II)

Variables	Multivariate Analysis	
	Adjusted OR (95% CI)	P-value
Family Planning Use		
Never used a modern method	1.00	
Had ever used a short-acting method	0.47 (0.22-1.00)	0.049*
Had ever used a long or shorting acting method (inc. PM)	0.25 (0.06-0.97)	0.045*
Gestational Age		
After 12 weeks into pregnancy	1.00	
12 weeks or less into pregnancy	3.17 (1.34-7.51)	0.009**
Desire for future pregnancy		
No intention	1.00	
Wants to become pregnant now	0.21 (0.04-1.15)	0.072
Wants next child within two years	1.65 (0.53-5.11)	0.385
Wants next child after two years	1.21 (0.37-3.88)	0.835
Wants to cease childbearing	2.90 (0.83-10.09)	0.094

Results after all three steps: postabortion FP uptake (I)

Variables	Multivariate Analysis	
	Adjusted OR (95% CI)	P-value
Education		
Didn't complete primary school	1.00	
Completed primary school	2.83(1.01-6.[illegible]5)	0.024
Religion		
Muslim	1.00	
Christian	1.55 (0.78-2.91)	0.187
Family Planning Use		
Never used a modern method	1.00	
Had ever used a short-acting method only	2.15 (1.19-4.[illegible]71)	0.023
Had used long and short acting methods	1.36 (0.52-3.83)	0.532

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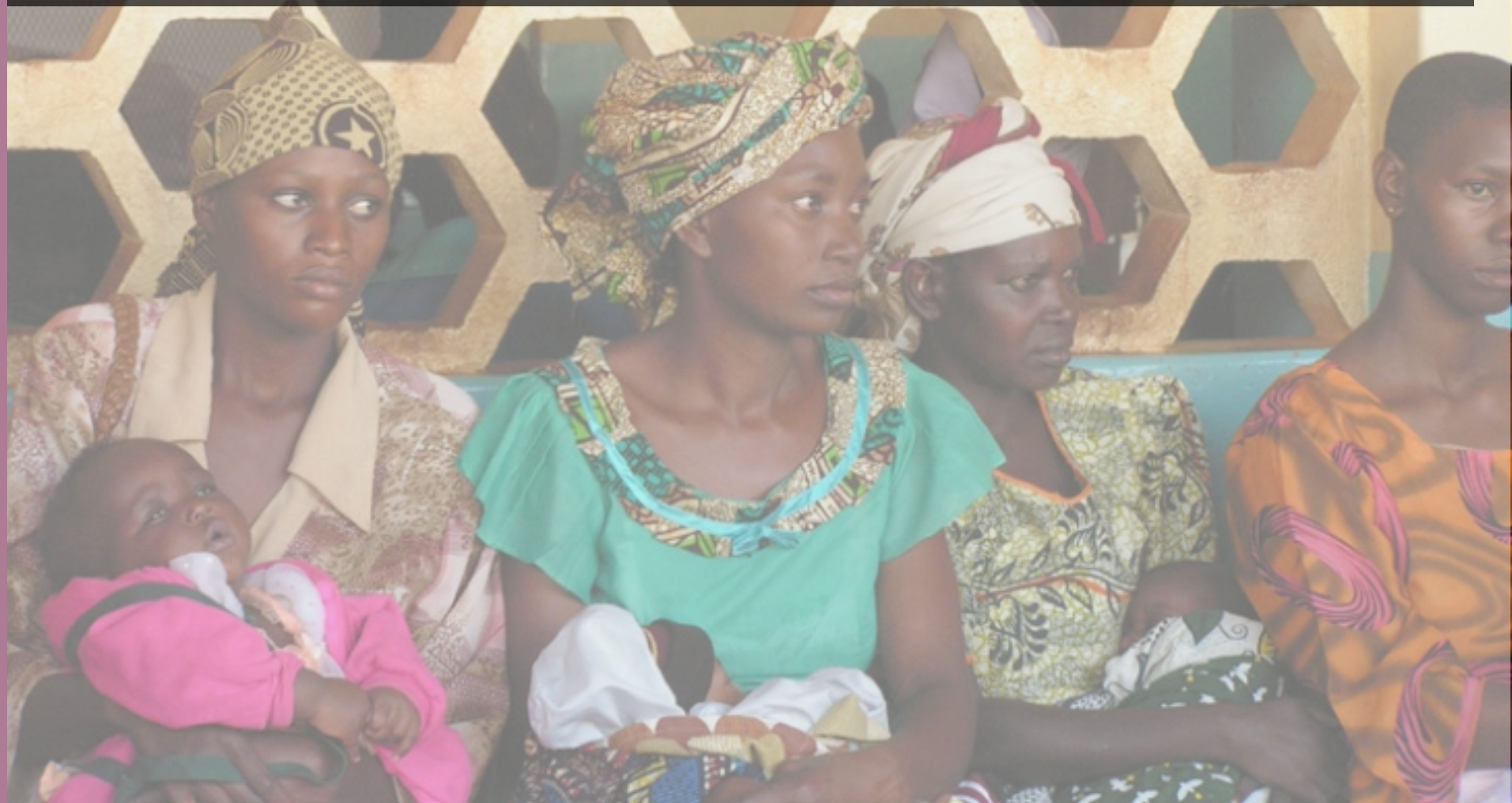
Results after all three steps: postabortion FP uptake (II)

Variables	Multivariate Analysis	
	Adjusted OR (95% CI)	P-value
Type of Facility		
Regional Referral Hospital	1.00	
Hospital	5.17 (2.59-10.38)	0.000
Health Centers	5.58 (1.68-18.49)	0.005
Waiting time after arrival to facility		
Received care immediately	1.00	
Waited	0.70 (0.36-1.38)	0.305
Male involvement		
Male partner accompanies client and partakes in FP counseling	1.00	
Male partner accompanies only	0.46 (0.16-1.30)	0.143
Neither	0.53 (0.20-1.42)	0.210
Perceived quality of counseling		
Counseling clear and client could ask questions	1.00	
Counseling not clear and/or client could not ask questions	0.11 (0.05-0.22)	0.000

Client Perceptions of PAC Quality



Client Perceptions of PAC Quality - Methods

Assemble the data: The exit interview collected data on clients' perceptions of the quality of PAC vis-à-vis the following six dimensions:

1. Client-provider interaction
2. Counseling and information provision
3. Technical competence of the provider
4. Postabortion contraceptive services
5. Accessibility of postabortion care
6. Facility Environment

Construct the dependent variable: A four-point scale representing clients' **overall evaluation of PAC quality** was constructed using data from **12 questions – all four-point Likert scales –** each representing at least one dimension of quality. A Cronbach's alpha coefficient was calculated to validate the scale (α=0.9003). Each point on the scale represents participant classification within percentile of the inter-quartile range (1=0-25%, 2=26-50%, 3=51-75%, 4=76-100%)

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Methods (cont.)

Identify independent variables: Based on empirical knowledge from the literature on what factors influence attitudes on RH service quality:

- *Socio-economic factors:* age, parity, literacy, employment status, religion.
- *Reproductive health factors:* intentionality of the pregnancy and abortion, ever use of family planning, ever had an abortion previously, gestational age at abortion.
- *PAC visit characteristics:* accompanied to the facility, facility type, waiting time at facility, uterine evacuation treatment received, content of counseling recalled, respectful treatment from staff and provider, receipt of pain management, cleanliness and organization of the service environment.

Conduct statistical tests: We used ordinal logistic regression analysis to identify independent variables relevant to PAC clients' overall evaluation of quality. First, we estimated bivariate models to determine associations and those that were significant (at $p<0.10$) were then used in multivariate models (same as steps 1-3 used earlier).

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Results after all three steps: perceived quality (I)

Measure	Odds Ratio (95% CI)	P-value
Parity		
No children	Reference	
>=1 child	1.67 (1.08-2.60)	0.021
Time to facility		
<= 30 minutes	Reference	
> 30 minutes	1.03 (0.69-1.53)	0.884
Facility type		
Referral Hospital	Reference	
Hospital	2.51 (1.58-3.99)	0.001
Health Center	2.71 (0.87-8.38)	0.084
Time waited at the facility prior to seeing a provider		
<= 30 minutes	Reference	
30-60 minutes	0.77 (0.47-1.27)	0.320
> 60 minutes	0.50 (0.30-0.86)	0.011
Uterine Evacuation Method		
Manual Vacuum Aspiration	Reference	
Sharp curettage	0.67 (0.41-1.01)	0.048
Misoprostol	0.49 (0.24-1.00)	0.050

Results after all three steps: perceived quality (II)

Measure	Odds Ratio (95% CI)	P-value
Recalls counseling on uterine evacuation method		
No	1.00	
Yes	1.01 (0.67-1.50)	0.979
Recalls counseling on danger signs		
No	1.00	
Yes	1.66 (1.44-1.96)	0.032
Recalls counseling on fertility intentions		
No	1.00	
Yes	1.48 (0.82-2.67)	0.189
Recalls counseling on contraceptive methods		
No	1.00	
Yes	1.05 (0.67-1.65)	0.805

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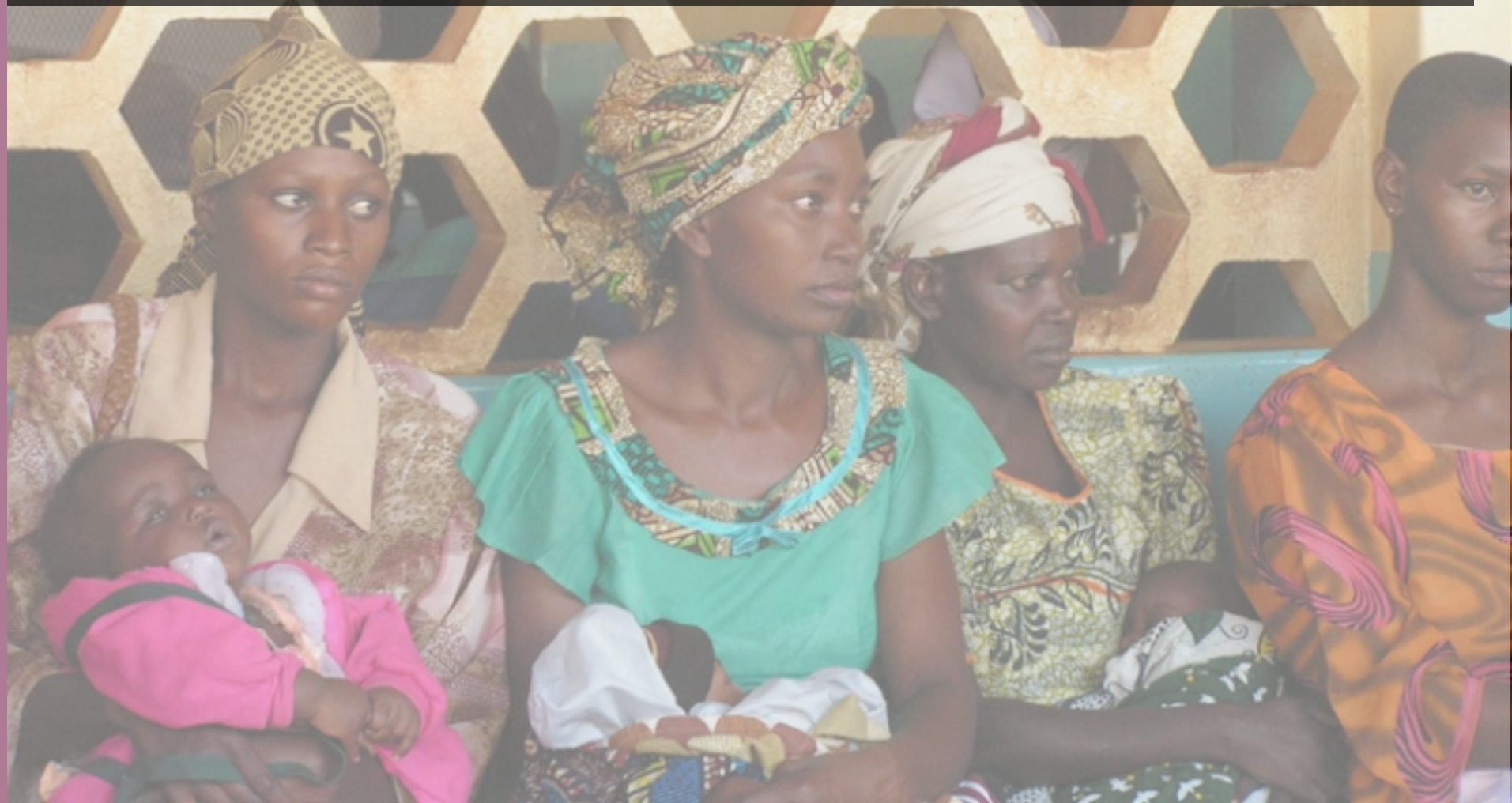
Pathways to unsafe abortion and care seeking and perceptions of service quality



Methods

Qualitative, in-depth interviews with PAC clients (n=30, 15 between 18 and 30 and 15 over 30 years of age).

Purpose: obtain descriptive information on clients' decisions concerning abortion and use of family planning, recognition of complications, care seeking, experiences and reactions to receiving PAC.

Three-stage process to review data and determine frameworks and themes for the analysis (below) and reach explanatory findings.

	Framework	Themes
1.	**Factors that influenced clients' abortion.**	Postpartum/current breastfeeding, method failure (traditional), method failure (modern), method switching, marital tension, partner absence, family pressure, desire to space/rest, desire to long-term-space, fear of contraception/side effects.
2.	**Recognition of complications and care seeking**	Insider help, incomplete first line treatment, over-reliance on drug shop or primary-level sites, 'expected' versus 'excessive' bleeding, delay and referral at lower level sites, transportation delay.
3.	**Perceptions of quality at the point of care.**	Escort and insider-support, delayed admission, confusing cost, poor pre-treatment counseling (miso), staff turnover, pain, kind staff, exclude family, awareness of rights, recall of counseling, buy supplies.

Factors influencing unintended pregnancy and abortion (I)

Four types of PAC clients:

(1) Young, recently married women with 1-2 children, never used modern contraception and unsuccessfully rely on traditional methods to space childbearing during the postpartum period;

(2) Older, married women with 3+ children that have used multiple methods and have experienced difficulty switching methods, intending to space indefinitely;

(3) Young, unmarried women with no children motivated to abort by social and familial pressure or perceived lack of social support from sexual partner and family;

(4) Partnered women of any age that face pressure from partners because of general discord in the relationship or economic-related tensions specifically.

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Recognition of complications and care seeking (I)

Four themes on PAC clients:

(1) Lived near hospitals and had resources to reach the facility independently and/or had a friend or relative that worked at the facility and could get them in without delay;

(2) Mistakenly relied on advice and support from pharmacists at drug shops or at dispensaries who advised them to take medication and manage complications at home;

(3) Stayed at home for too long because they struggled into recognize danger signs; feared telling friends, family and neighbors about condition;

(4) Faced delays owing to lack or cost of transportation, inefficient referrals.

Perceptions of service quality (I)

Clients lack a shared definition of quality or a sense of entitlement to a certain standard of care.

Generally, clients reported discomfort, disorientation, lack of comprehension/poor recall of counseling messages; yet, they praise and show gratitude for their providers.

Systems in place at referral-level facilities to quickly triage clients that are experiencing severe complications upon arrival; otherwise, clients face long queues.

Clients reported interruptions in the pre-procedure sequence of events – there is delay in between triage, examination, counseling and uterine evacuation and different providers conduct these steps.

Perceptions of service quality (II)

Clients that receive misoprostol for uterine evacuation report long stays at the facility with infrequent contact with providers, confusion about how the medication is supposed to work.

Pain medication is used rarely and often clients are required to pay for it; often clients initially admitted for PAC would have to leave, buy pain relievers from pharmacy and then return to receive treatment.

Clients do not believe that they are entitled to a “pain free” service; it is treated like a bonus and clients accept this.

Providers are considered kind and helpful, with few cases of rude treatment reported; however, counseling is weak, casual and impersonal.

Perceptions of service quality (III)

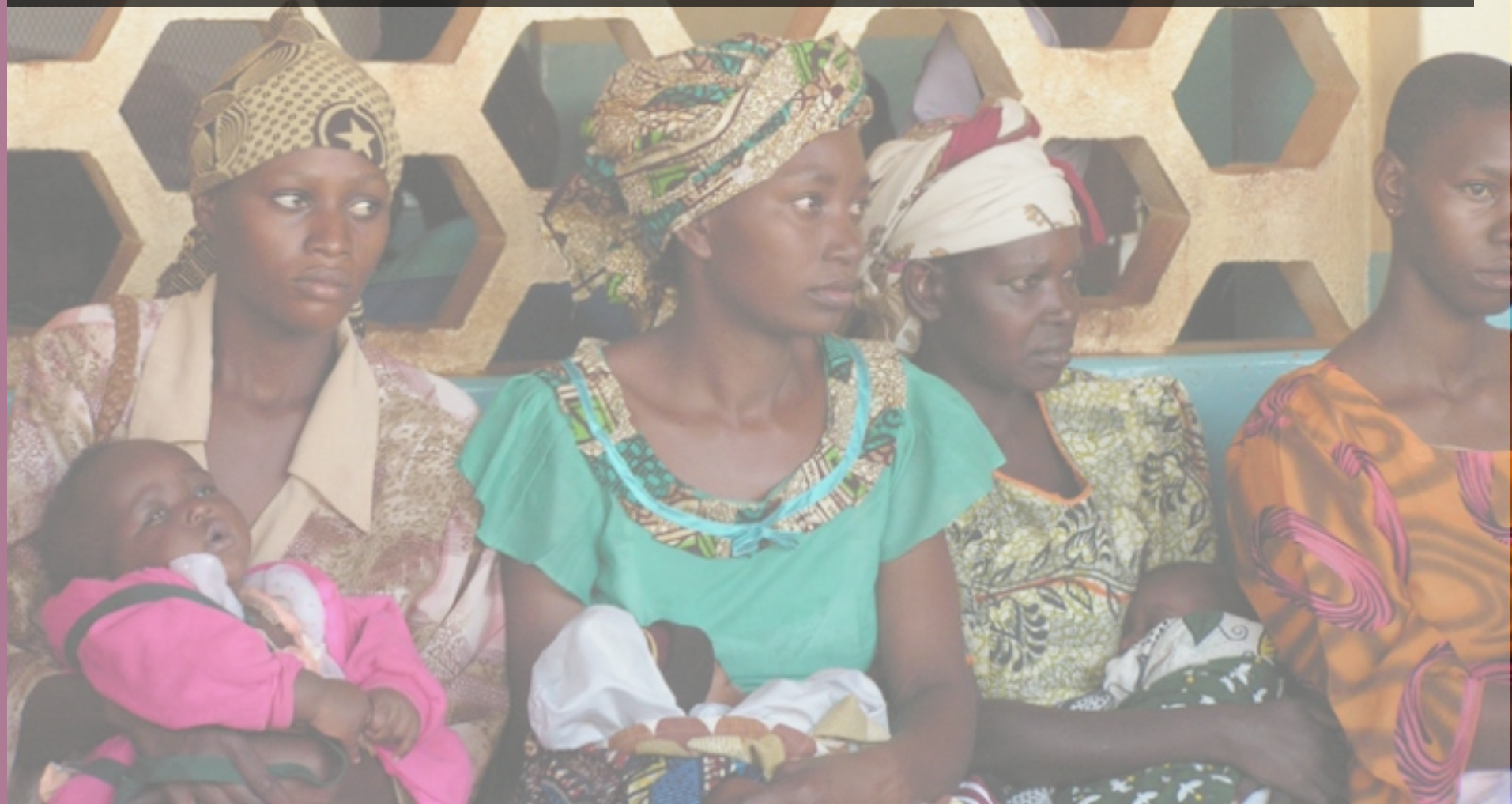
Counseling is conducted in very brief window of time immediately after emergency treatment in the PAC setting before the client goes to recovery room.

Family planning counseling – not based on clients' history of FP use and pregnancy intentions; lack of detail on different FP methods.

Clients report that their partners joined them to the facility but were not permitted by staff to join the client in the procedure room, even for counseling.

Clients do not demonstrate understanding of when their fertility will return.

PAC Clients' fertility preferences and postabortion care FP uptake.



Postabortion FP Uptake

Qualitative, in-depth interviews with PAC clients (n=30).

Purpose: to understand the factors that influence clients' preferences on future childbearing and decision to uptake modern family planning before discharge from PAC.

Three-stage process to review data and determine frameworks and themes for the analysis (below) and reach explanatory findings.

	Framework	Themes
1.	**Individual, cognitive influences**	Family formation/reproductive volitions (weak/strong), 'no autonomy'/fatalism, fear of side effects/misconceptions, lack of knowledge/misunderstanding, health perceptions, past use of FP, life-stage.
2.	**Spousal/partner influences**	Relationship status, husband's prerogative, spousal conflict, delay to discuss, husband's method preference (traditional).
3.	**The health services environment**	Escort and insider-support, delayed admission, confusing cost, poor pre-treatment counseling (miso), staff turnover, pain, kind staff, exclude family, awareness of rights, recall of counseling, buy supplies.
4.	**Societal and cultural context**	Religion, social cost/stigma, pro-natalist norms.

Individual cognitive influences

PAC clients reported future pregnancy intentions, however, these did not translate to a demand for postabortion contraception.

- Sense of autonomy over reproduction is low and, often, do not feel comfortable determining or indicating preferences.
- View of reproductive in fatalistic terms.
- Misconceptions about side effects and consequences on future fertility, particularly after an abortion.
- Lack of understanding of when they can become pregnant again.
- Older women with experience demonstrate more confidence in terms of asserting a demand for contraception; young women do not.
- Uptake is linked with reported experiences women have had previously with a specific method, especially among women that got pregnant because of challenges related to method switching.

Spousal/partner influences

Women believe that, after God, decision on when to have children or whether to use FP belong to their husband.

Women that were not married feared that use of postabortion FP would interfere with their future fertility and prevent them from getting pregnant again after they marry.

Fear of spousal discord motivated women to decline postabortion FP and return again after discussing it at home.

Pressure to demonstrate fertility to their husbands following the abortion complications.

The Health Services Environment

Over half reported that they did not recall receiving any counseling on postabortion FP. When recalled counseling was rushed and de-linked from pre-procedure discussion on fertility and FP history.

Providers sometimes discuss different methods, but they do not base their counseling on information provided by clients on their backgrounds and preferences.

Clients recall providers telling them that they cannot get pregnant again until 6 months after their abortion.

Clients remark that they have questions on FP methods, but do not feel like they can ask their provider.

FP methods are often not available in the PAC room; if client says they want a method they are referred to another department.

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Societal and cultural context

Religious influences generally averse to adoption of FP.

Legal context of abortion affects how openly clients feel they can discuss their reproductive behaviors, generally.

Experiencing a complication from early termination of pregnancy – even according to those who admit to inducing abortion – is perceived as less stigmatizing than open use of an FP method.

Pro-natalist social norms – large family size.

So What?

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Strategic Approach toward Strengthening PAC FP in Tanzania

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Paradigm:	**Baseline research/ situation analysis**	**Operations research**	**Implement Resear**
Questions:	**What strategy might best build the capacity of the health system?**	**Does the candidate strategy work & how)?**	**W t are n tone**
Outcomes:	**A holistic, contextually appropriate PAC-FP capacity building model.**	**Improved health outcomes, an FP-strengthened PAC model.**	**Sca up st**

Training based on technical gaps observed

COPE for PAC to address management and systems problems.

M&E Framework that documents inputs and reflects outputs and outcomes.

Updated service delivery guidelines.

Process benchmarking and build capacity for 'data for decision making' – inform continuous QI with practical application of M&E findings.

PAC-FP program development phase

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Strategic Approach toward Strengthening PAC FP in Tanzania

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Paradigm:	Bas situ	rations earch	Implementation Research	Organizational change and development
Questions:	W mi the he	e candidate gy w &	What are the milestones and strategies for scaling-up?	Is coverage expanding? Is the system working, as planned?
Outcomes:	c app bu	es, nene PAC odel.	Scale up strategy	Coverage, operational fidelity, quality of care

Make the training scalable (OJT, integrated with MNH trainings.

Peer exchanges to replicate site-based QI teams.

Strengthening routine HIS to incorporate indicators on quality and process.

Scale up planning.

PAC-FP program development phase

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Asante! Thank you!

Maswali? Questions?