

# The Postabortion Care Family Planning (PAC-FP) Project

## PAC Connection Meeting

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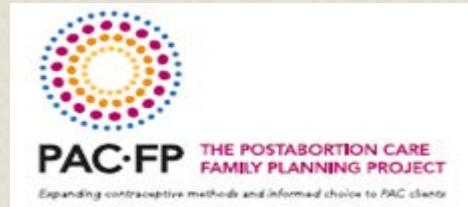
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Washington, D.C.  
September 8, 2016



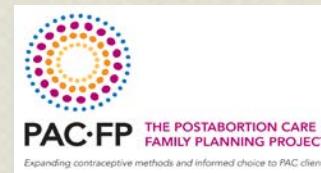
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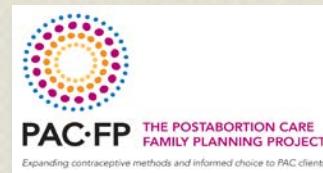
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# Overview

- Project introduction
- Background on PAC Program In Tanzania
- Preliminary results from Tanzania
- Update on Francophone Africa PAC Secretariat



# Project Introduction

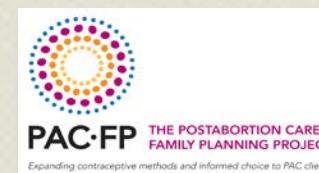


# The PAC-FP Project

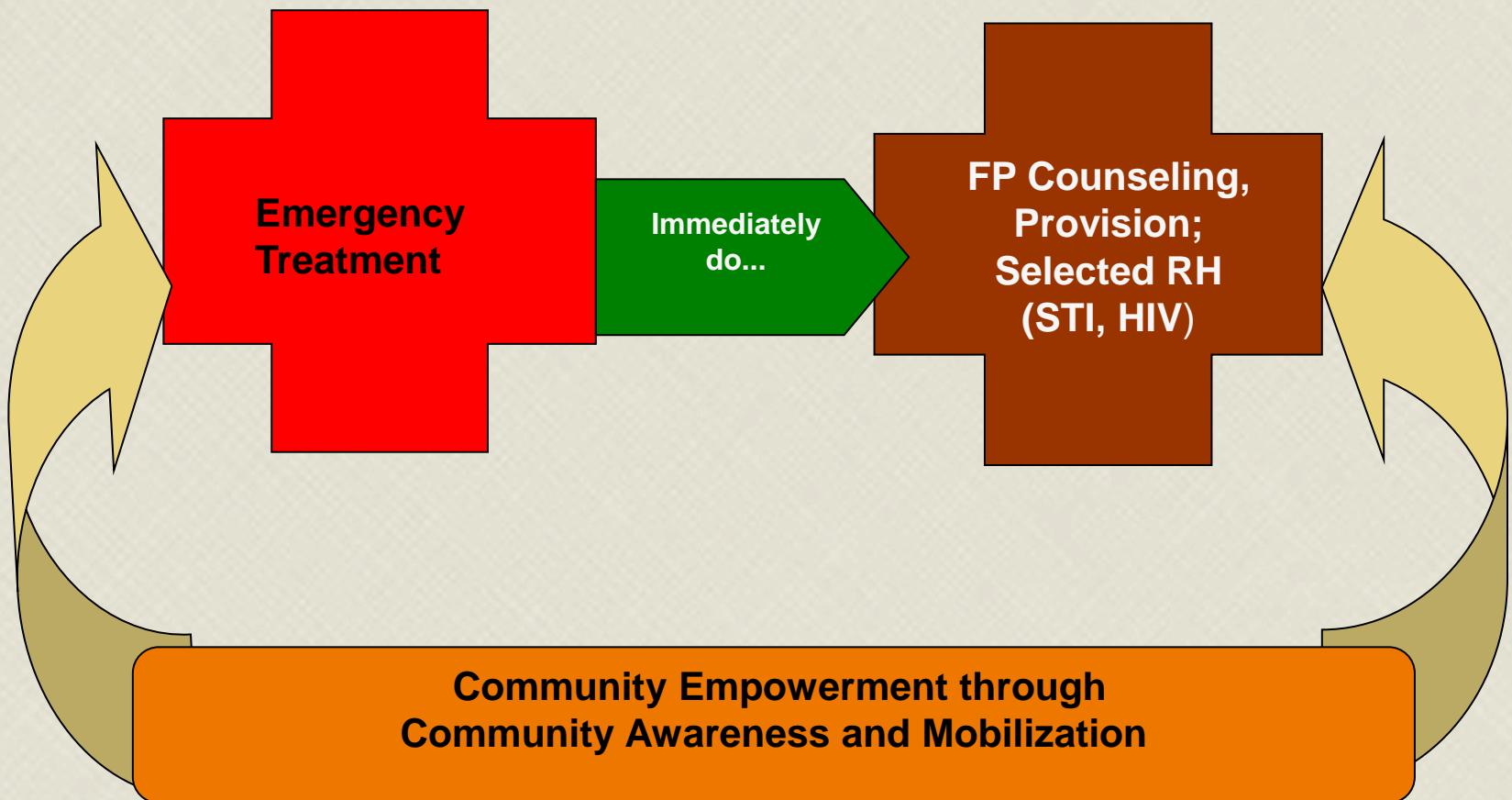
Women that receive uterine evacuation services for incomplete abortion are eligible to receive a wide variety of family planning (FP) methods.

Postabortion care FP is a high impact practice (HIP) and a model for delivering it has been developed and widely disseminated; however, in practice, a broad method mix – if any FP – is available to PAC clients in settings where they receive emergency treatment.

The Postabortion Care Family Planning Project (PAC-FP) is a five year (2014-19) seeks to expand access to a wide variety of FP methods through PAC, emphasizing the delivery long acting reversible contraceptive methods (LARC).



# The Postabortion Care Model



# Background & Goals

Builds upon previous EngenderHealth research and interventions in Tanzania as well as that of our partner, *Le Centre de Formation de Recherche et de Plaidoyer en Sante de la Reproduction* (CEFOREP) in Senegal.

## In Tanzania, Senegal and in Secretariat countries in West Africa, PAC-FP:

- Strengthen the capacity at clinical, management and policy levels to deliver a wide range of FP methods through PAC
- Promote an enabling environment and good practices for delivering high quality PAC FP services and scaling up.
- Generate evidence, strategies and tools for advancing access to contraceptive method mix to PAC clients.
- Advance scale up of PAC-FP through collaboration, sharing and improved quality of knowledge, strategies and tools.

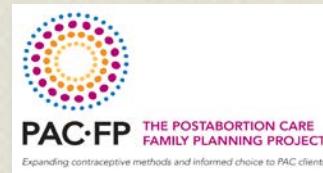
Two countries:  
Tanzania and  
Senegal; also  
sponsors a PAC  
Secretariat amongst 7  
countries (Senegal,  
Togo, Burkina Faso,  
Niger, Cote d'Ivoire  
and Benin)



# Five Programmatic Pillars

- **Research**
  - Situation analyses and operations research to drive systems strengthening, quality improvement and scaling up the delivery of FP through PAC, and dissemination.
- **Advocacy**
  - Global and country-level technical consultations and long term assistance to policymakers on how to strengthen the delivery of FP through PAC.
- **Support**
  - Training and management capacity building to providers and local health system planners and managers; planning and programmatic TA to policymakers.
- **Tools**
  - Curricula, job aids and management support kits and guidelines and technical products to guide strategy at global level.
- **Knowledge management**
  - Web-based warehousing current knowledge, tools, good practices and country experiences, participation in communities of practice, partnerships and technical manuscripts and publication.

# Background of PAC Program in Tanzania



# Tanzanian Context

Incomplete  
abortion is

Unsafe  
abortion

- Among the top 10 causes of hospital admission
- the main reasons for women seeking emergency care.

- one of the leading causes of maternal deaths
- causes 19% (DHS 2010) of all maternal deaths in Tanzania

In 2005, MOHSW and EngenderHealth Tanzania, began to decentralize PAC services to lower-level health facilities to increase the availability of PAC services throughout the country.

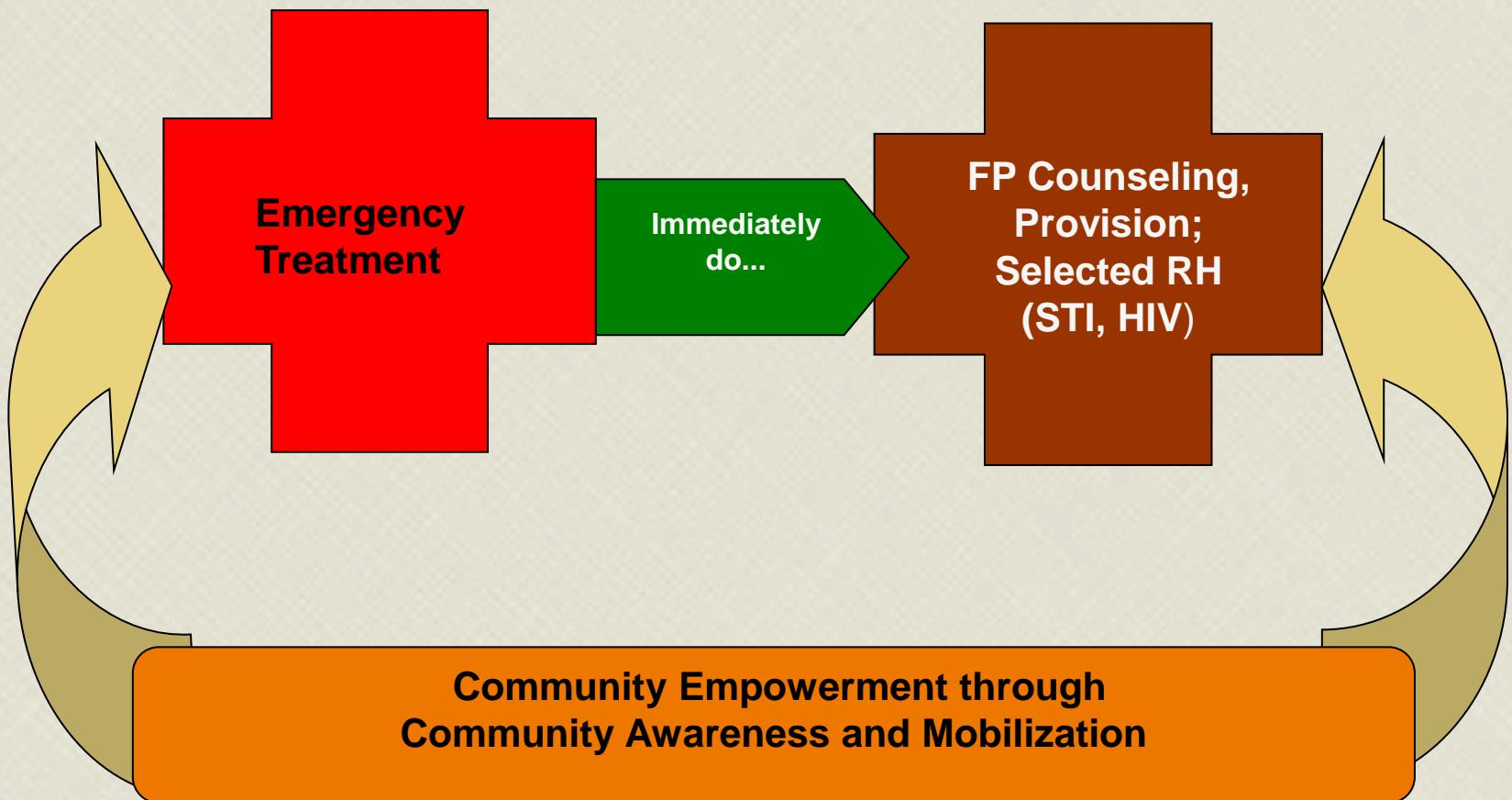


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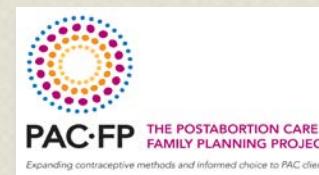
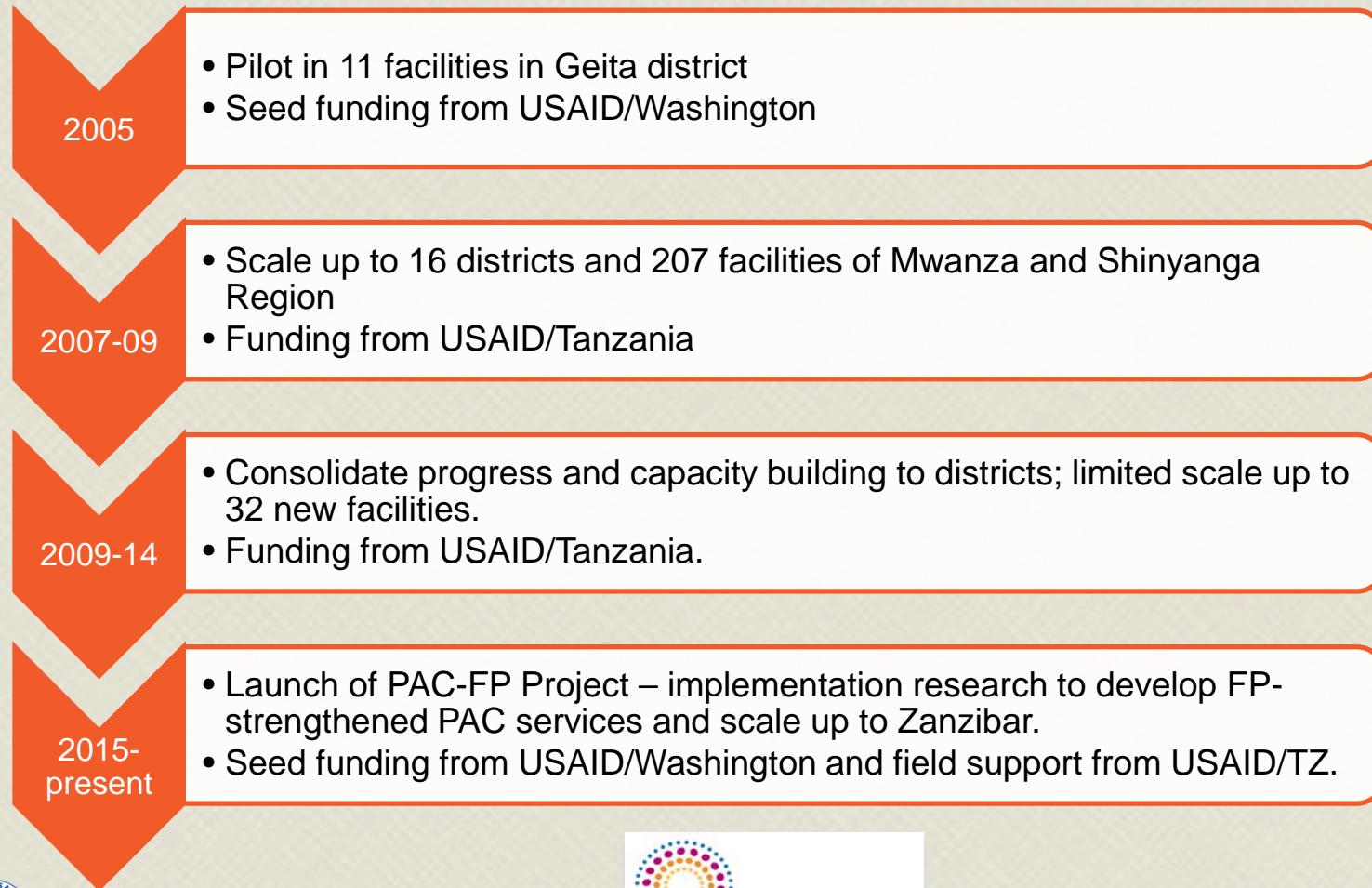


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# The Postabortion Care Model



# The Decentralization Process



# Program Interventions to pilot PAC services

## Facility Improvements & Provider Training:

- Pilot district -Assessed to establish facility preparedness in 15 HF<sup>s</sup> to provide PAC.
- Minor renovations to address infrastructure gaps
- Trained 32 TOTs and 952 service providers on PAC and the use of manual vacuum aspiration (MVA), including FP counseling.
- Conducted whole-site orientation to involve all staff in the introduction of PAC services

## Program Monitoring & Community Engagement

- Upgraded PAC procedure logbooks with common categories across all facilities.
- Providers and supervisors trained in completion and routine use of log books for program monitoring.
- Created community partnerships and fostered local “champions” to create community awareness and acceptance of services.
- COMPACC Model.



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# Achievements of the Pilot

**Policy change**

**Developed national documents**

Nurse midwives to provide MVA

MVA kits included in the essential drugs/supplies list

PAC guidelines

PAC curriculum and training materials



# Scale Up Strategy through District Decentralization

## Organizational Capacity Assessment & Selection of Sites

- Council Health Management Teams (CHMT) form scale up teams and evaluate their facilities for:
  - Infrastructural capacity
  - Availability of trainable staff
  - Gaps in supply chain management
  - Frequency of supervisions and quality assurance activities within facilities.
  - Feasibility of re-organizing PAC and FP services
  - Referral and service utilization patterns.
- Select and prioritize intermediate and primary-level sites for 'scaling down' PAC .

## Systems Strengthening and Provision of Essential Backstopping

- Cascade training (ToT at regional level → centralized training for supervisory and high level staff → on the job training for additional cadres).
- Facilitative supervision (whole site training, COPE®, quarterly visits to scale up facilities).
- Data quality assurance (reviewing, compiling and reporting records from facilities' PAC logbooks)
- Facilitating procurement and logistics.



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# Achievements of Decentralization (cont.)

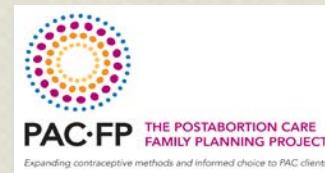
Introduced PAC in 239 sites;

- 15 of hospitals
- 67 health centers
- 157 dispensaries

Increased access for PAC services at lower level facilities;

- Decongested hospitals
- Increased FP counseling and uptake for PAC clients

# Findings from Tanzania



**Identify health systems problems**

Service delivery limitations and constraints

Manpower limitations

Information utilization & decision-making gaps

Stock-outs and logistics problems

Policy, planning, management and leadership constraints

Inadequate participation of communities

**Design health system strengthening interventions**

#1 Improved integration and organization of PAC-FP services

#2 Strengthened PAC-FP workforce & training

#3 Enhanced Information for decision-making

#4 Reliable provision of PAC-FP supplies

#5 Appropriate leadership and governance

#6 Mobilization and engagement of communities

**Measure health system strengthening outputs**

Increased access to post abortion FP

Extended range FP methods available during PAC.

Improved quality of PAC-FP

Improved management and efficiency of PAC-FP services delivery

Enabling and supportive environment

**Country-level Postabortion Care Family Planning Project Theory of Change**

**Evaluate health system strengthening outcomes**

Enhanced Utilization of FP among PAC clients

Increased met need for FP

**(Contribute to) reduced preventable child and maternal deaths**

**Global learning about what works and how to do it.**

**Evaluation, documentation, sharing, tool development, advocacy**

# Strategic Approach toward an FP-strengthened PAC Program

	Developing an strategy	Demonstrating what works	Replicating what worked	Going to scale: from pilot to program
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 strategy.	Improved health outcomes, an FP-strengthened PAC model.	Scale up strategy	Coverage, operational fidelity, quality of care

PAC-FP  
program  
development  
phase



1



PAC-FP THE POSTABORTION CARE FAMILY PLANNING PROJECT  
Expanding contraceptive methods and informed choice to PAC clients

3

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# Phase 1: Baseline Research

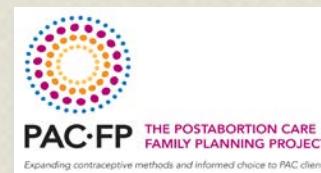
- Took place during March-July 2016 in 25 sites in Mwanza, Geita and Zanzibar Regions of Tanzania.

## Objectives

- To explain contraceptive utilization behaviors and trends in the context of PAC.
- To assess the strength of PAC implementation and explain how this is managed as an integrated health systems program.

## Methods

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



# Preliminary Findings

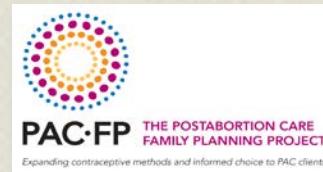
*Results of PAC  
decentralization (2005-  
2014)*

*Who are PAC clients,  
what are their FP  
preferences, decisions,  
behaviors?*

*Barriers and  
opportunities to  
strengthen that PAC FP  
method mix and quality  
of care?*



# Results of Decentralization – Analysis of PAC Service Statistics



# Data from 120 facilities in Geita and Mwanza Regions

Age	N	%	Gestational Age (weeks)	N	%	
<20	2,337	12.5	<=12	14,491	77.6	
20-24	5,047	27	13-18	2,604	13.9	
25-29	4,405	23.6	>=19	1,125	8.5	
30-34	3,449	18.5	Missing	468	2.5	
>=35	3,256	17.4	<b>Uterine Evacuation Technology</b>			
missing	194	1	MVA/EVA	14,362	76.9	
<b>Parity</b>			Sharp curettage	3,903	20.9	
0	1,877	10	Missing	423	2.3	
1	2,424	13	<b>Facility Type</b>			
2	3,017	16	Hospital	9,094	48.7	
3	3,026	16	Health Center	6,256	33.5	
4	2,382	13	Dispensary	3,338	17.9	
>=5	5,253	28	Missing	0	0	
missing	709	4				
<b>TOTAL</b>			<b>N = 18,688</b>			

# Who are the PAC Clients?



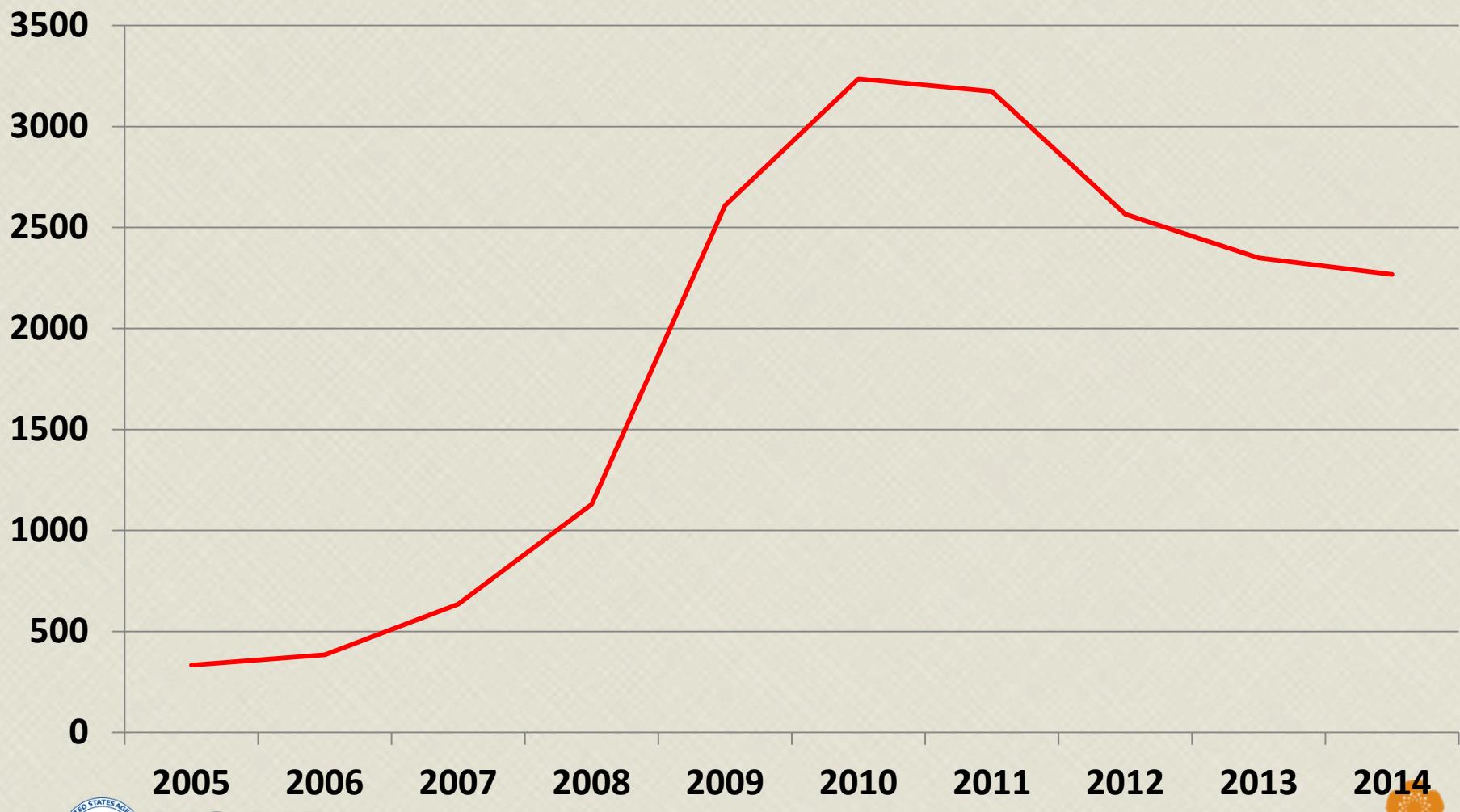
Mean age: 27, but 60% are between 15-29 years of age

80% are married or in union

41% are parity 4 or greater

78% gestations age <=12 weeks; 9% >=19 weeks

## Figures 3: PAC Utilization during Scale Up (2005-2014)

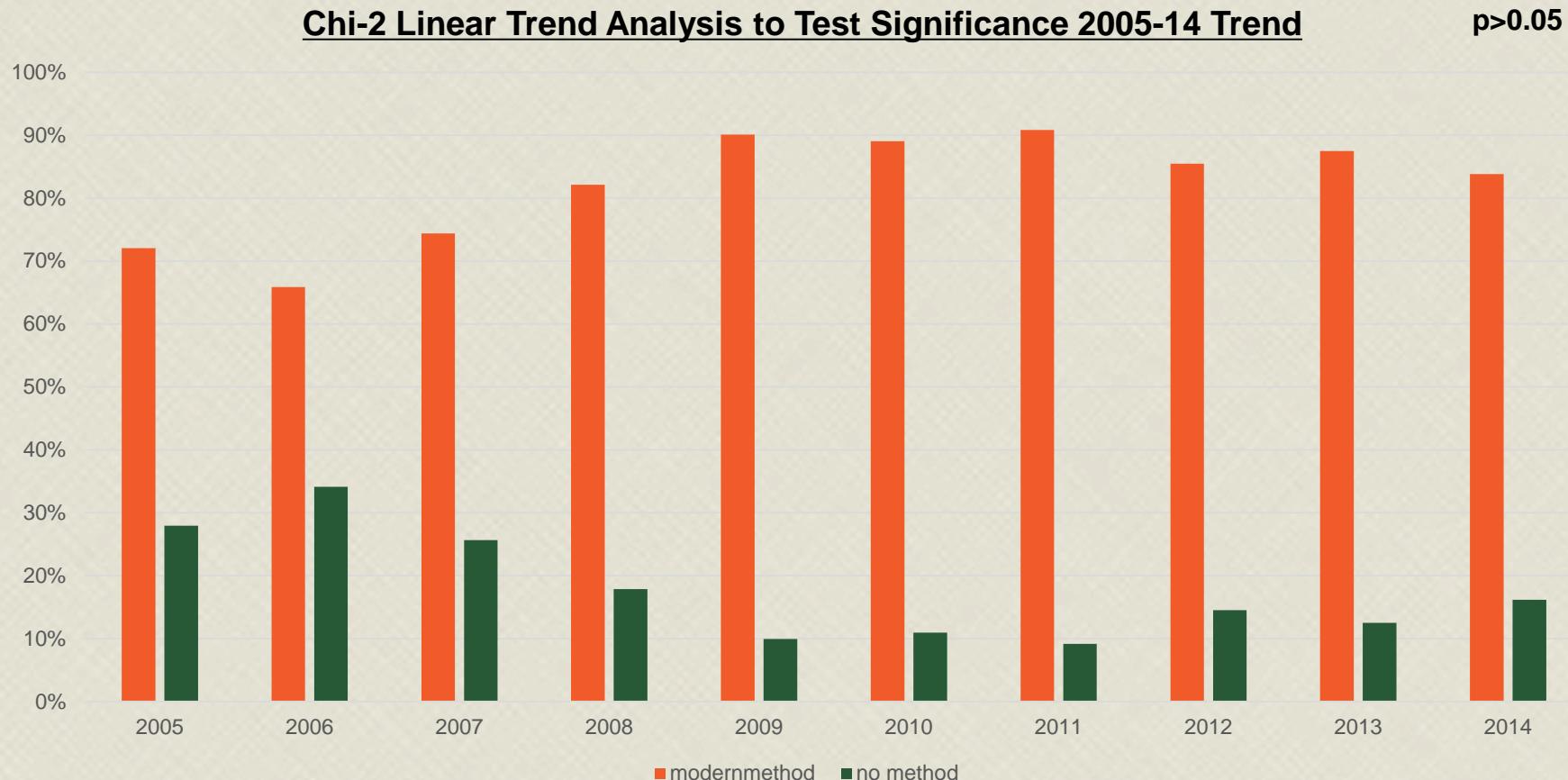


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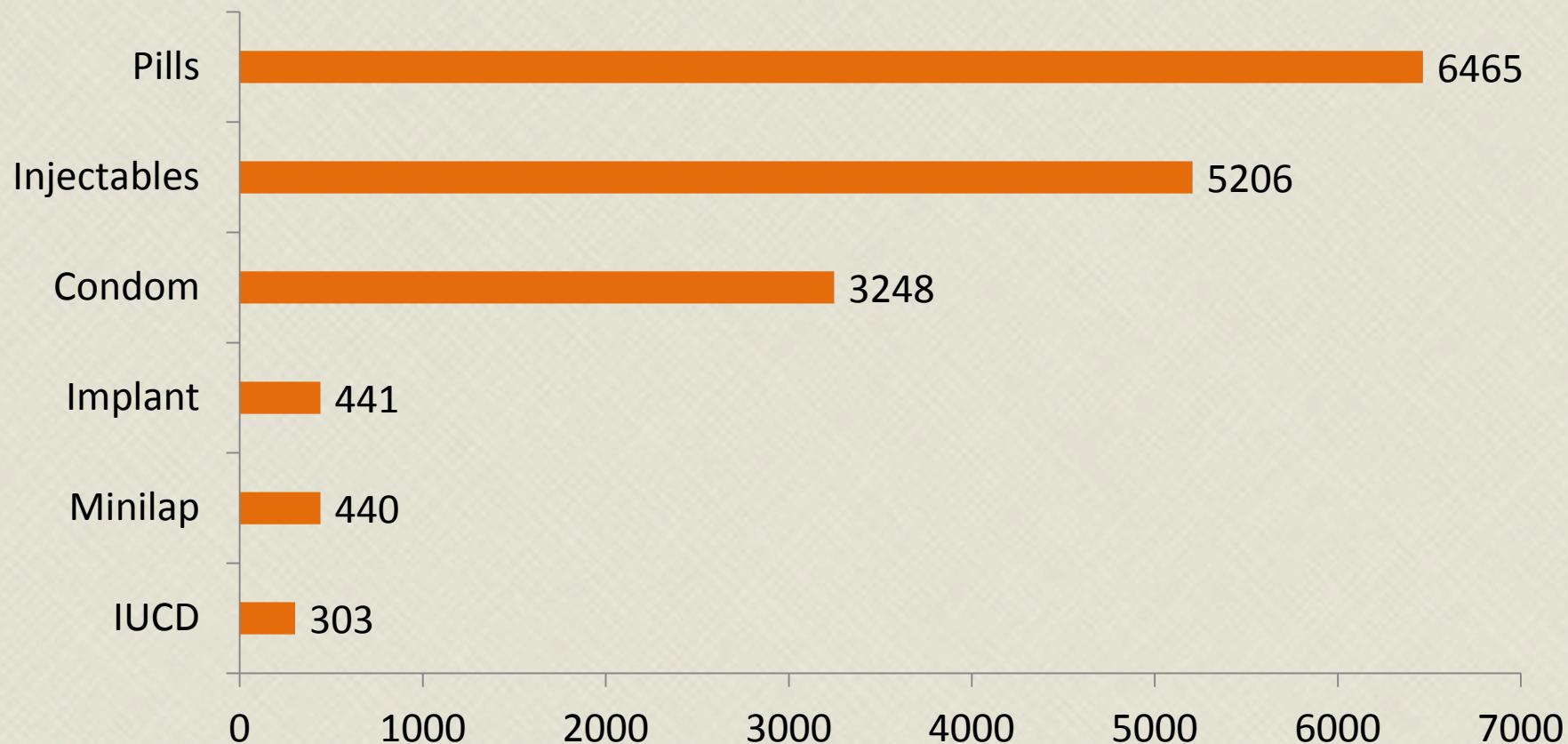
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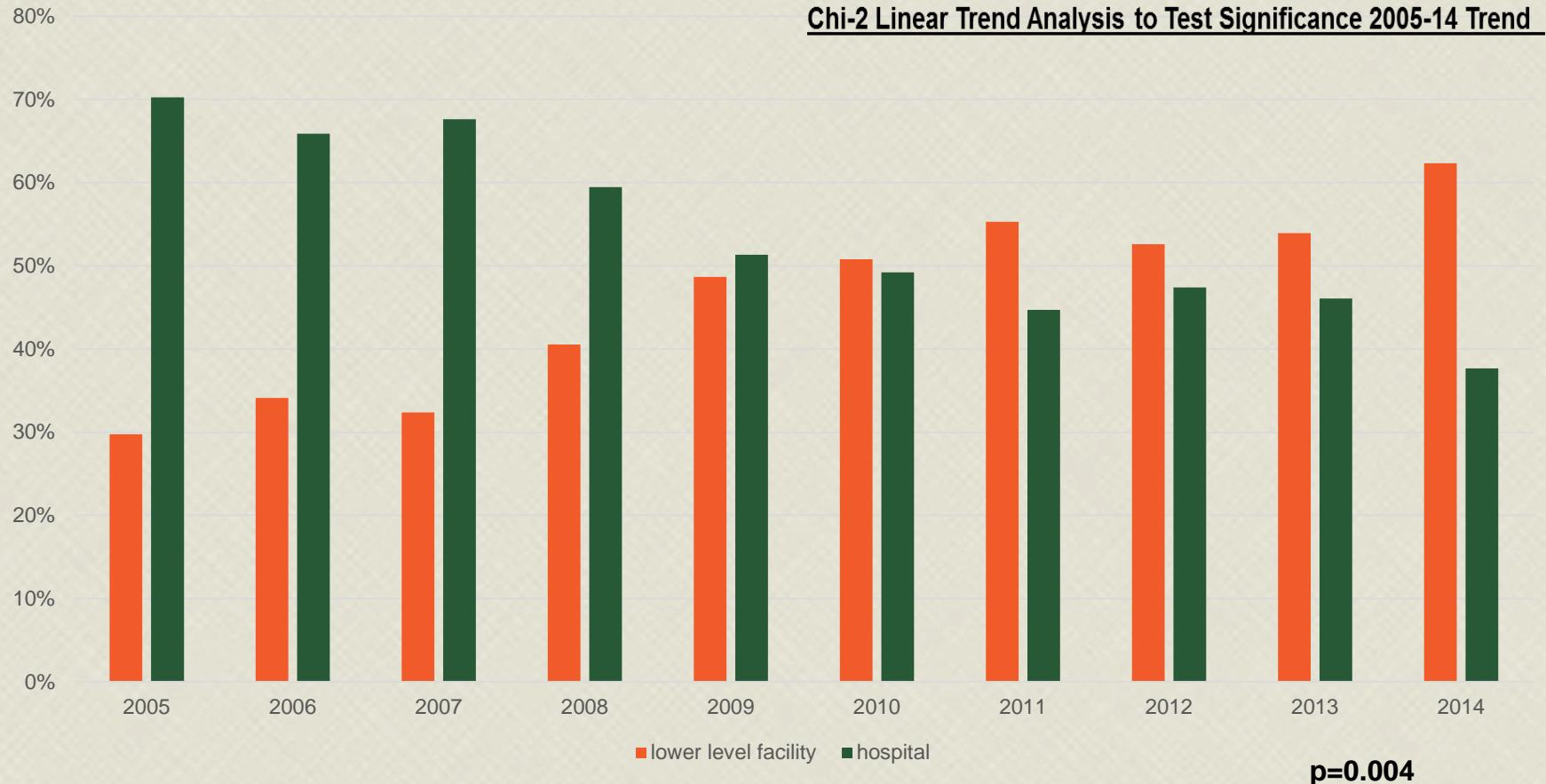
# Modern FP Method Adoption by PAC Clients



# PAC FP Uptake – Method Mix



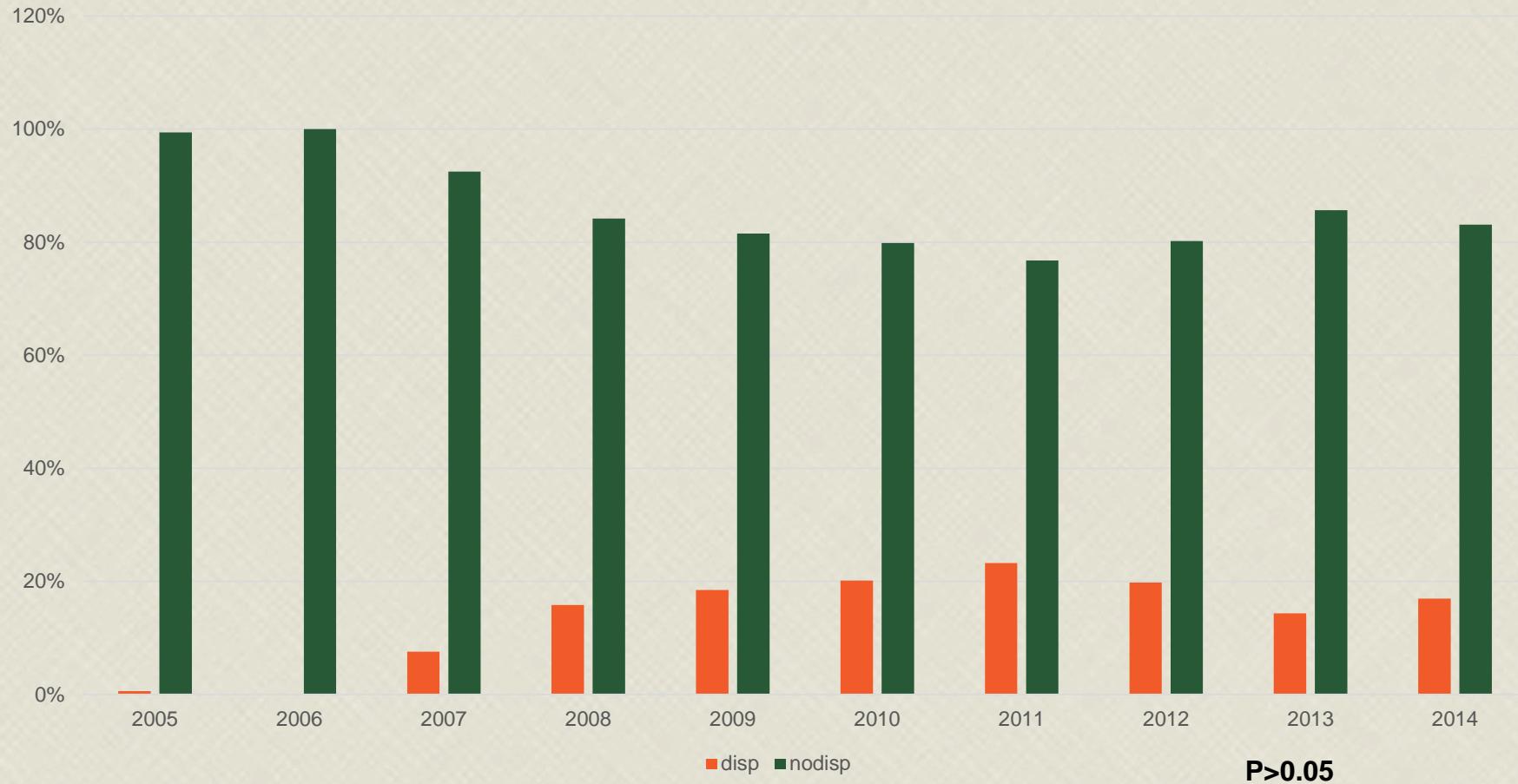
# PAC utilization by Facility Type – Lower level Facility v. Hospital



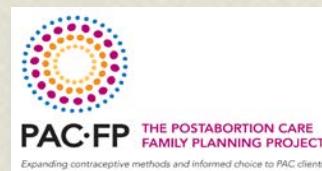
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# PAC Utilization by Facility Type – Hospital v. dispensary



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# Analysis of associations between PAC FP Uptake (any modern method) and variables of interest.

- Using chi sq tests, significant ( $p<0.001$ ) associations were detected between PAC-FP uptake and following independent variables:
  - Client age
  - Facility type
  - Uterine evacuation technology
  - Gestational age
- Logistic regression analysis to assess the associations between PAC-FP uptake and different sub-groups within the above independent variables.
  - Age 35 age above (OR 0.80,  $p<0.05$ , ref. age<20)
  - PAC utilization at health center (OR 1.39,  $p<0.001$ , ref. hospital), and dispensary (OR 1.43,  $p<0.001$ , ref. hospital).
  - Uterine evacuation technology is MVA/EVA (OR 1.84, ref. other).
  - Gestational age at time of PAC 13-18 weeks (OR 0.75, ref. gest. Age  $\leq$  12 weeks).

# Analysis of associations between PAC FP Uptake (LAPM only) and variables of interest.

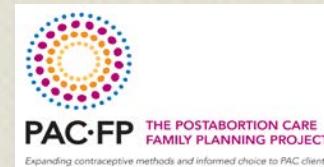
- Using chi sq tests, significant ( $p<0.001$ ) associations were detected between PAC-LAPM uptake and following independent variables:
  - Client age
  - Facility type
  - Uterine evacuation technology
  - Gestational age
- Logistic regression analysis to assess the associations between PAC-LAPM uptake and different sub-groups within the above independent variables.
  - Age 20-24 (OR 1.73), 25-29 (OR 2.54), 30-34 (3.40), 35+ (6.71), (all  $p<0.001$ ).
  - PAC utilization at a health center (0.75,  $p<0.001$ ).
  - UE Technology was MVA/EVA (1.62,  $p<0.001$ ).
  - Gestational age at time of PAC is 13-18 weeks (0.73,  $p<0.001$ ) and 19+ weeks (0.68,  $p<0.001$ ).

# Qualitative findings to explain results

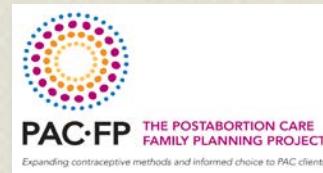
- Health system challenges undermine sustainability at dispensary level.
  - Frequent staff turnover, inadequate supervision, frequent stock outs, case mix varies tremendously and few PAC clients makes it difficult to retain PAC skills.
  - Case load absorbed by dispensaries is negligible and equipped health centers have capacity to take this on.
- Weak FP component of PAC training and follow ups undermines method mix available.
  - Provider biased against utilization of LARCs because of time requirements for counseling and services delivery
  - PAC training modalities lack emphasis on FP services delivery, don't include LARC.
  - Majority of PAC providers only receive on-the-job training, no formal OJT training regimen and FP often not included in OJT.
- Partner involvement – a challenge to PAC FP counseling.
  - Clients may wish to accept a method but cannot decide without consulting partner.
  - Many accept a short acting method in the meantime.

# Lessons Learned - highlights

- PAC clients are mostly non-adolescents (25 and older) and married; however, youth were 40% of clientele.
- The majority are well-into childbearing (3+ children); parity for those above 25 was 4.6 children and those above 30 years was 5.4.
- Decentralization expanded access to PAC and age (actual and gestational) and parity trends remained constant over time.
- Scaling up a FP-strong PAC model is possible, but LARC component remained weak.
- Scaling down to health centers decongested hospitals, but introduction of PAC to frontline dispensaries had no effect.
- Poor delivery of FP through PAC/SC services.



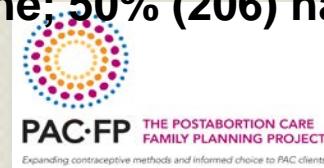
# Client Exit Interview



# 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	-	-	-	-	-	-
	<b>412</b>		<b>3.5</b>	<b>2.4</b>	<b>17</b>	<b>81%</b>	<b>72%</b>	<b>27%</b>

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



# Postabortion Care-seeking

## Facility type

- 370 (89.9% ) hospital, 42 (10.1%) health center

## 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

## Accompaniment

- 367 (89%) were accompanied of whom 185 (51%) by husband/ partner.

## 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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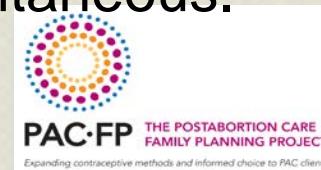
# Reproductive History and Intentions (I)

## Gestational age and uterine evacuation methodology

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

## Intentionality of abortion

- 45 (10.9%) report that they induced the abortion themselves, 183 (44.4%) allege it was spontaneous.



# Reproductive History and Intentions (II)

## Pregnancy Intentions

- 236 (57.28%) report to have wanted the pregnancy (for which they received PAC) when they conceived; 165 (40.1%) report that it was unintended.
  - 123 of unintended were mistimed (client wished to has delayed it)
  - 28 were unwanted (client did not ever want to get pregnant again)
- 54 (13%) of all clients reported that they were using a modern FP method when they conceived.
- Of those that had a *prior pregnancy* (317), 118 (37.2%) reported that it was unintended – 84 (71%) mistimed, 21/118 (17.7% unwanted).



# Reproductive History and Intentions (III)

## 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 and use of PAC

- 51 (12.4%) had ever received PAC before of whom 31 (62%) received it once, 19 (38%) 2 or more times.
- 32 had aborted in the past but did not use PAC, 21 only once.

## 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, 43 (20.1%) because of wanting to get pregnant, 14 (6.5%) partner opposition, 8 (3.7%) religion.

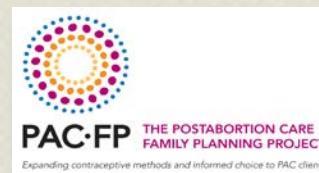
# Postabortion Care FP

## Postabortion Care Counseling

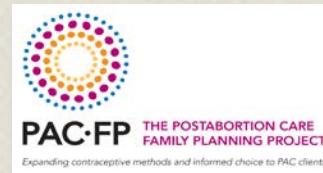
- 119 (28.9%) received counseling that included discussion of FP methods, and 9 others received counseling on if and when they would like more children only.
- Of those counseled, 34 (28.6%) reported that their partner was involved.

## 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, 11 sharp curettage and 4 misoprostol.



# Service Availability and Readiness Assessment



# Site Readiness (n=25) for FP Delivery through PAC (I)

- 18 facilities can provide sharp curettage, of which:
  - 6 deliver FP to SC clients in the room where SC is performed.
  - 5 deliver FP to SC clients, but in a different location.
  - 7 do not deliver FP to SC clients.
- 25 sites perform MVA of which:
  - 18 deliver FP to MVA clients where PAC is delivered.
  - 7 deliver FP to MVA clients but in a different location.
- 10 sites perform PAC through misoprostol of which:
  - 5 deliver FP to misoprostol clients.



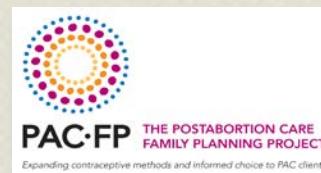
# Site Readiness for FP Delivery through PAC (II)

## Human Resource

- Out of 130 providers trained in PAC at hospitals, 92 can also deliver IUD or implants.
- Out of the 69 providers trained in PAC at health centers, 31 can also provide IUD or implant.

## Supplies

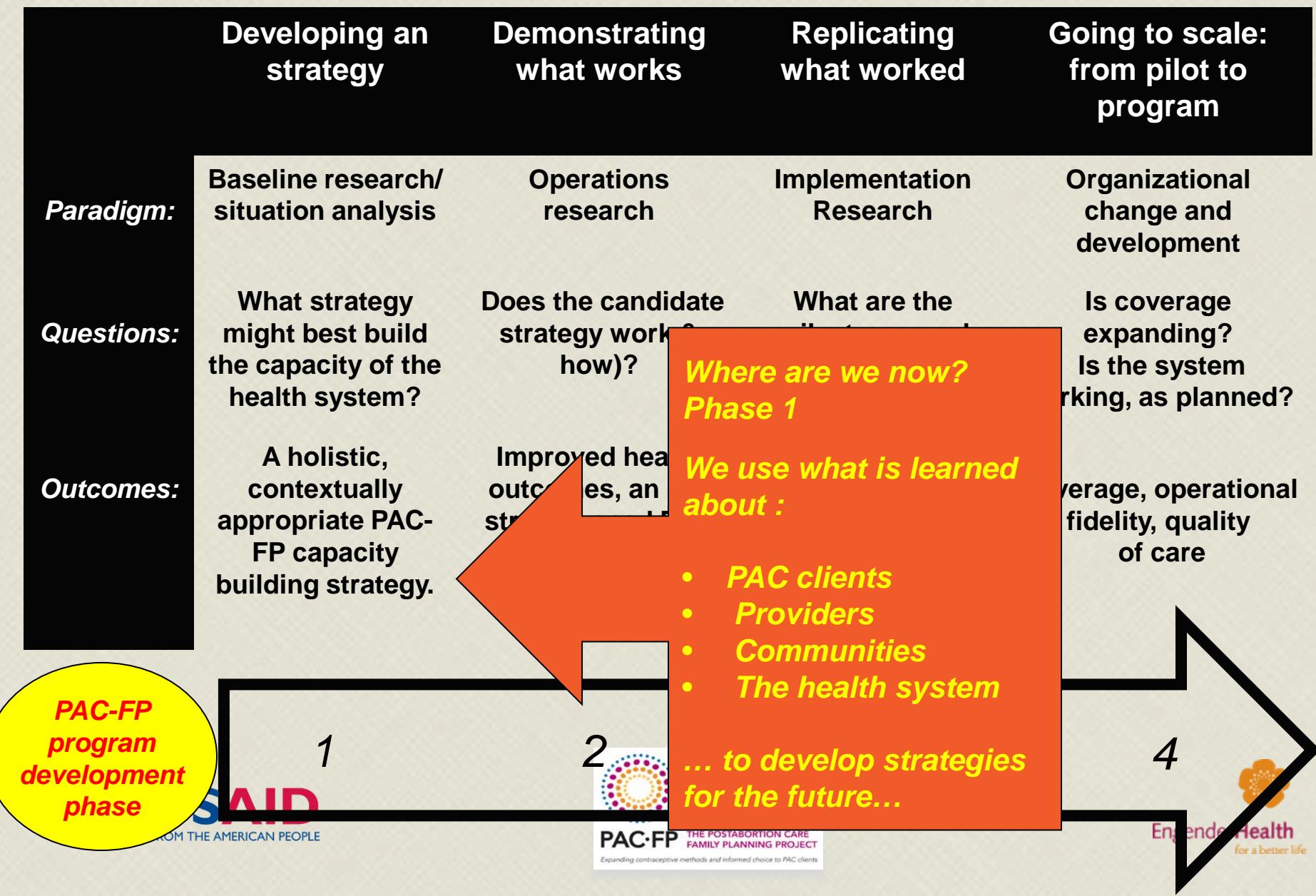
- 6 sites had  $\geq 50\%$  of necessary supplies, equipment and drugs in area where MVA is provided
- 11 sites, 25-49.9%
- 8 sites, 3.4-24.9%



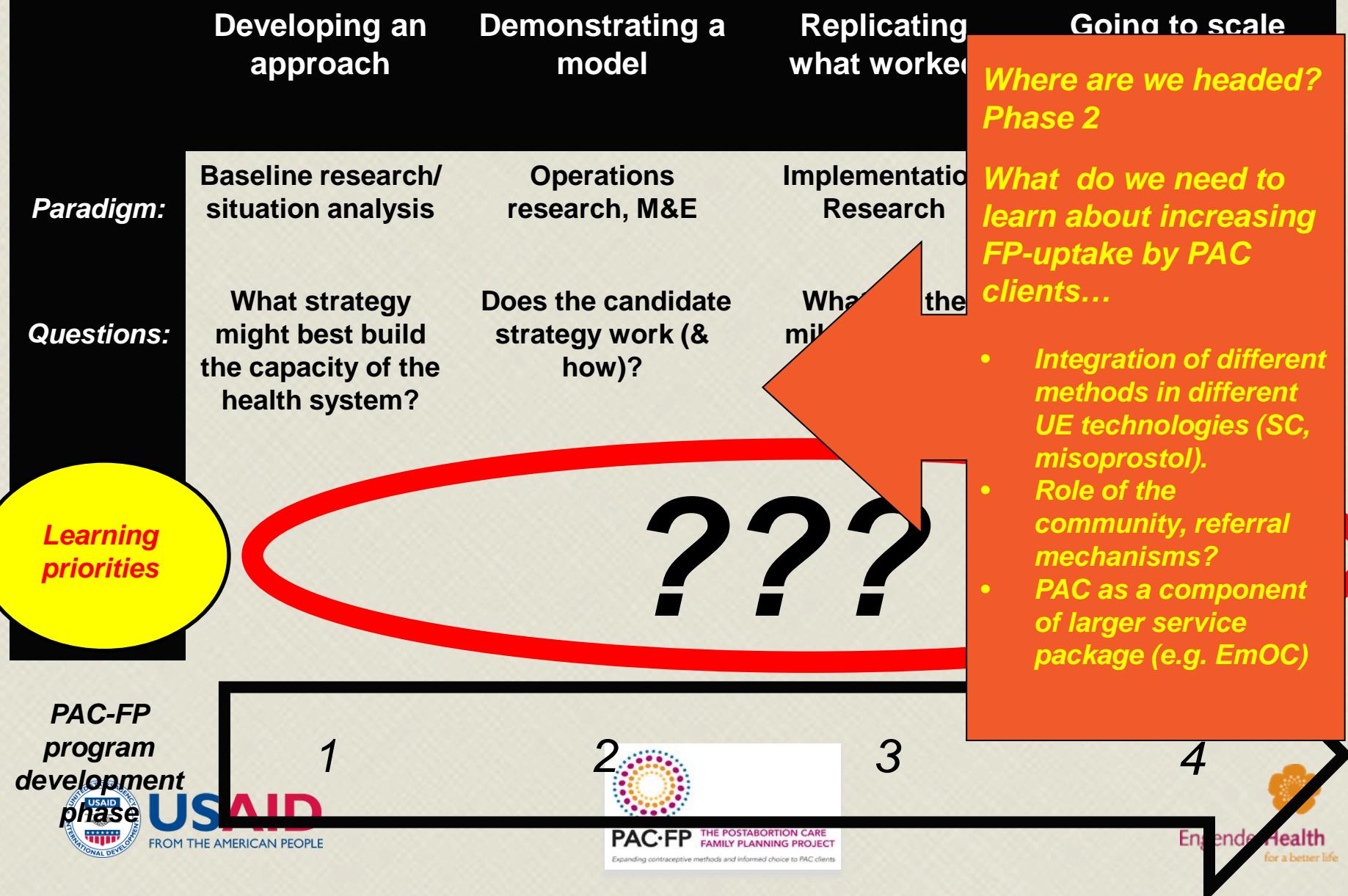
# So What?



# Strategic Approach toward an FP-strengthened PAC Program



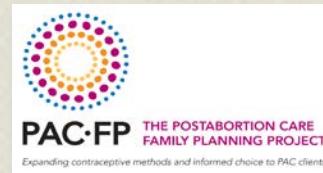
# Learning in Phases



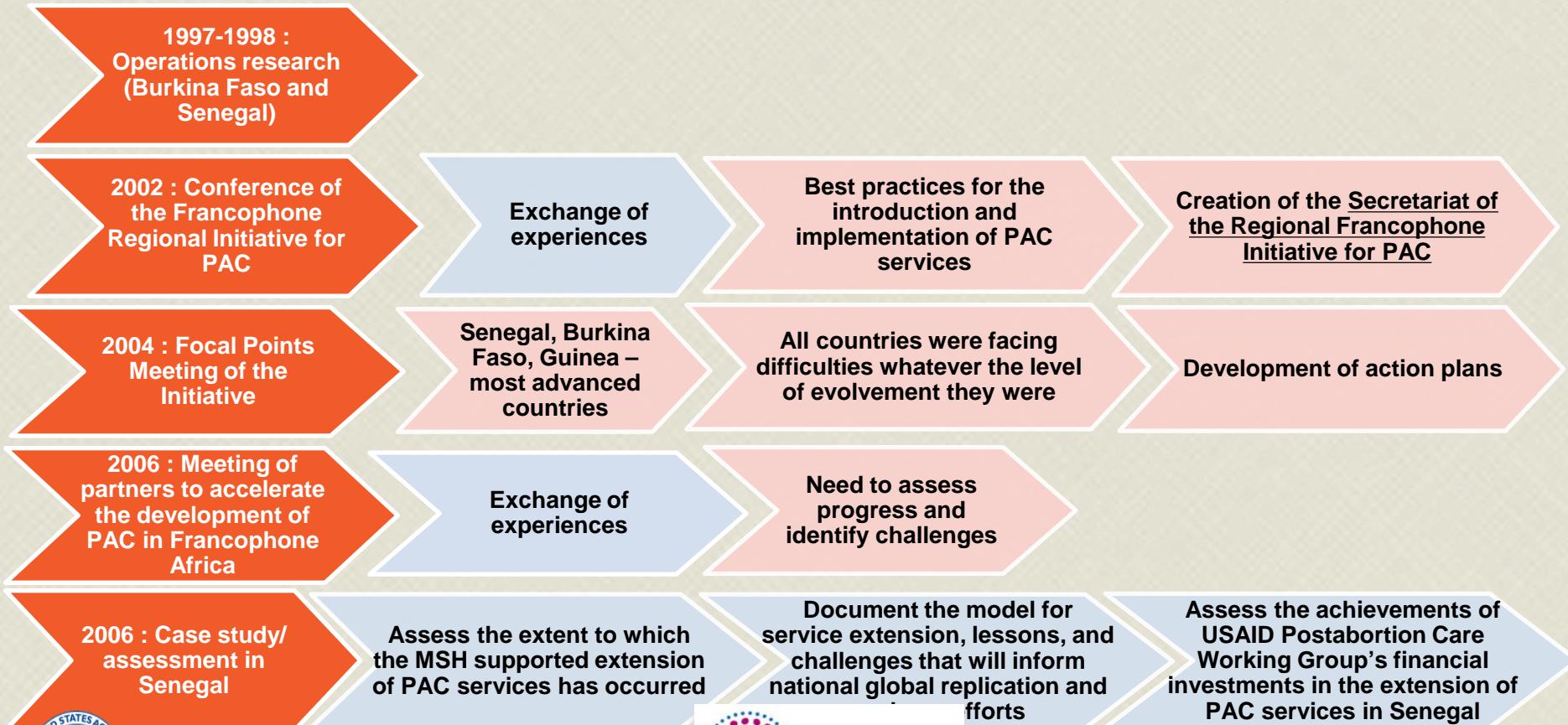
# For Discussion – a PAC Learning Agenda

- What are key lessons learned from the past or current generation of PAC projects?
- What are the gaps in programming that needs to be addressed through future projects, and what good practices have been documented that may address them?
- What are the research questions and/or learning priorities that should guide the development of the next generation of PAC projects?

# Update on the Francophone PAC Secretariat



# Historical Process

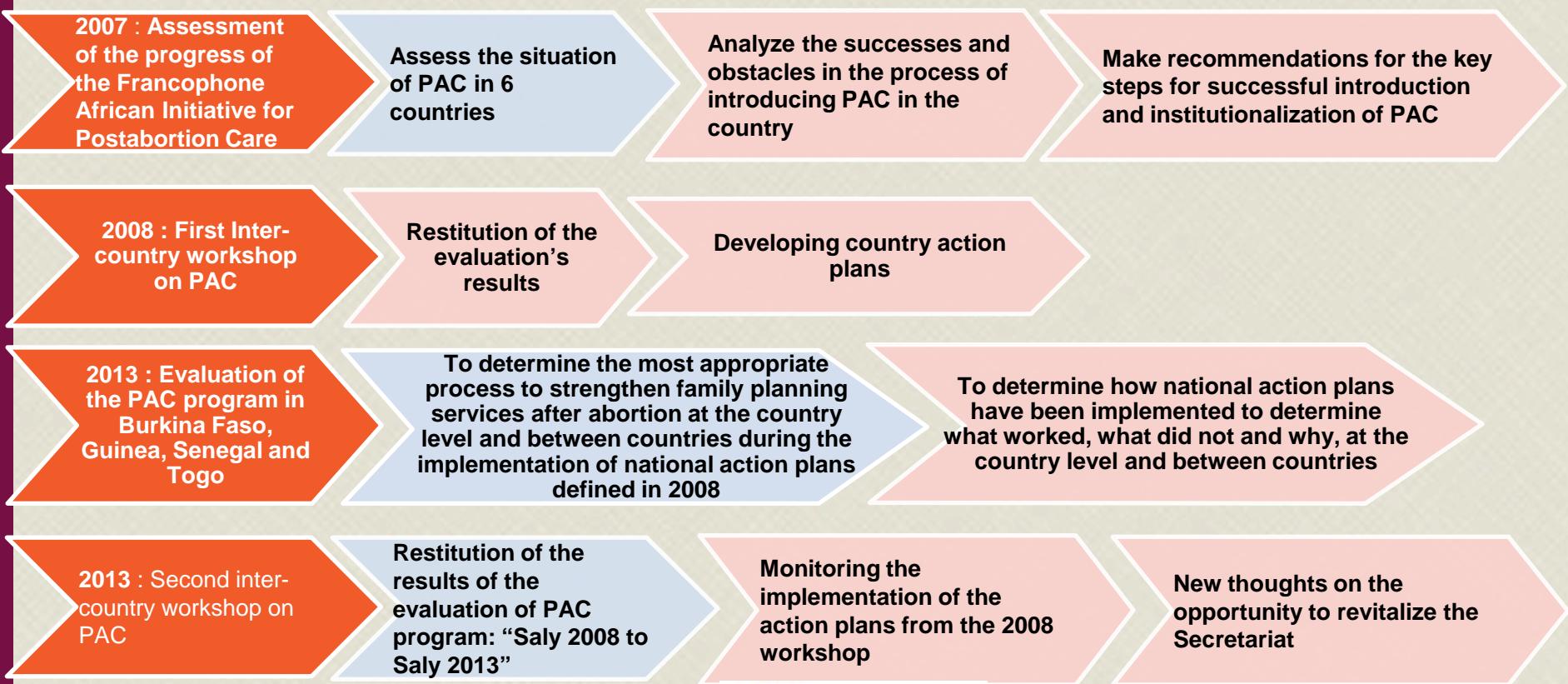


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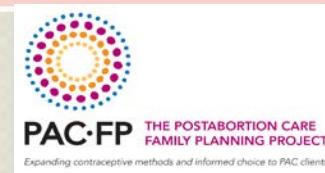


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# Historical Process



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# Why strengthen Postabortion FP in Francophone Africa?

Comprehensive  
PAC services  
imply FP  
counseling



**Situation in 2008 :**  
Sénégal (56%), Niger (83%), Mali (61%), Burkina Faso (51%), Guinée (46%), Togo (39%)



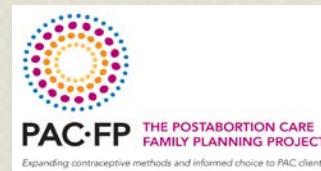
**Pilot studies (1997-1998):**  
counseling for more than 90% of PAC patients →  
83% accepted in Burkina Faso while 76% in Sénégal



**Current situation (2013) : Sénégal : 47,6%**



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# Why strengthen Postabortion FP in Francophone Africa?

**Potential causes of low  
use of family planning  
in PAC in Francophone  
Africa**

- Lack of human resources?
- Disorganisation of services?
- Deficiencies in counseling and provision of contraceptive methods?
- Lack of adapted policies?
- Sociocultural considerations?
- Financial obstacles?
- Geographic barriers?

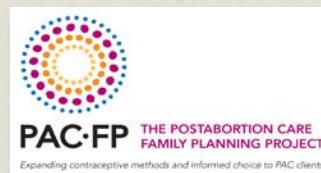
# Why strengthen postabortion FP in Francophone Africa?



Experiences in Egypt and Kenya have shown that the best PAC-FP integration model was to put contraceptives in the treatment rooms



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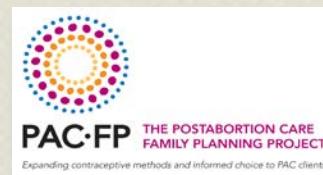
# What solution?

Create a sub-regional framework for promoting the use of family planning in PAC, particularly long-acting methods

Revitalize the Secretariat, with basically the same mission, but with a new format



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# Current goal of the Secretariat (under the PAC-FP Project)

Improve the environment at the national and regional levels for scaling up high quality of Post-Abortion Care Services in the seven countries, by focusing on strengthening the family planning component



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# Structure of the Secretariat

## Advisory Committee

### Includes

Institutions such as WAHO, WHO, USAID, UNFPA, the Ouagadougou Partnership, Multi-country or Regional Projects (EngenderHealth-Agir PF, JHPIEGO, IntrahHealth), etc.

### Role and objectives

- Advice and assistance to the orientation of the actions of the Secretariat
- Relay with partner institutions in the country
- Support for resource identification

## Technical Committee

### Includes

Members from research and clinical training institutions as well as gynecologists and midwives professional societies

### Role and objectives

- Make recommendations for a harmonized and efficient practice of PAC in the subregion
- Promote research and the collection of evidence to improve the quality of services
- Support advocacy to enhance the accessibility and quality of services

## Policies and Funding Committee

### Includes

Representatives of the Ministries of Health of the member countries

### Role and objectives

- Support initiatives to improve the quality and coverage of PAC in the subregion
- Support initiatives to improve the quality and coverage of PAC in the subregion
- Promote good practices in the scaling up strategies of PAC
- Propose approaches to increase funding for PAC services
- Support advocacy to enhance the accessibility and quality of services



# Operating Model



# Secretariat relay at country level

## Existing national committees which promote maternal health

Support the development of appropriate standards and protocols

Encourage the integration of PAC in national policies and strategies for Maternal Health

Capitalize the opportunities offered by the political, legal and administrative environment, as well as other strategies

Advocate for improving the policy, legal and financial environment for PAC and FP

Advocate for scaling up PAC quality

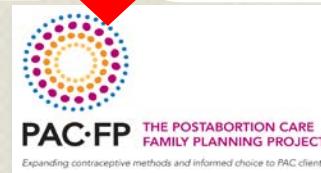
Promote PAC as a lever for the use of family planning



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# Target countries



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# Activities already done

Several meetings with: WAHO, WHO, ICM, Ouagadougou Partnership, MOH and USAID in Senegal, IBP

Participation to the first follow up visit after the 1<sup>st</sup> ECOWAS Forum on Best Practices in Health, organized by WAHO and IBP

Participation to the biannual FIGO regional workshop on PAC

Rapid assessment in some countries

First workshop for revitalizing the Secretariat



# Next steps

Conduct a situational analysis in the seven priority countries

Return the results in each country

Organize the second workshop of the Secretariat

Analyze data

Propose action plan drafts for each country

Finalize national action plans

Validation of the action plans of the Committees Secretariat

Pre restitution and discussion of the results of the situational analysis

Extending concepts of promoting change and scaling up



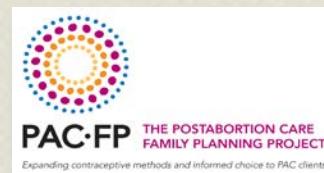
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# Next steps

**Follow up and support the implementation of sub-regional and national action plans**

**Conduct a study on improving the accessibility of contraceptives in PAC services (Senegal)**



Merci! Asante! Thank you!

Des questions? Maswali? Questions?

