



Decentralization of Postabortion Care in Senegal and Tanzania

- Complications from abortion kill at least 78,000 women every year and account for 13 percent of maternal deaths globally. Between 10 and 50 percent of women who undergo abortions need medical care for life and health-threatening complications such as infection, hemorrhage, and injury to internal organs, which occur mainly in the developing world.¹
- Postabortion care (PAC) is an important intervention for treating the health complications stemming from abortions. It also has been widely embraced as an important intervention linking women to family planning and other reproductive health programs.
- USAID places high priority on preventing abortions through the use of family planning and saving the lives of women who suffer complications arising from abortion.
- While USAID supports treatment of abortion-related complications, USAID does not support abortion as a method of family planning.

Postabortion care (PAC) is an important intervention to treat complications related to miscarriage and unsafe abortion, reduce the incidence of repeat unplanned pregnancy, and decrease the incidence of repeat abortion. To protect maternal health and avert abortions, USAID funds PAC programs that comprehensively address women's needs through three core components:

1. Emergency treatment for complications of spontaneous or induced abortion
2. Family planning (FP) counseling and services, and, depending on disease prevalence and available resources, evaluation and treatment of sexually transmitted infections (STIs) and HIV counseling and/or referral for testing
3. Community empowerment through community awareness and mobilization²

In developing countries, PAC programs are frequently available only in urban or regional health facilities, placing rural women at greater risk for mortality and morbidity from complications because they lack access to services. To improve access, USAID has worked with two focus countries, Senegal and Tanzania, to decentralize PAC activities. Required criteria for focus countries were commitment from the Ministry of Health (MOH) and matching funds from the USAID Mission to assist with scale-up and the sustainability of activities.

- In **Senegal**, Management Sciences for Health, in collaboration with the Senegal MOH and USAID/Senegal, trained more than 500 health personnel, including 104 midwives, 254 nurses, 63 regional and district-level supervisors, six doctors, and 104 counselors, from 323 facilities (23 health centers and 300 health posts) in four regions.
- In **Tanzania**, the ACQUIRE Project, in collaboration with USAID/Tanzania and the Tanzania MOH, trained 15 service providers from 11 facilities (one district hospital, seven health centers, and three dispensaries) in one district. Providers who attended training were expected to train others in their facilities through on-the-job training (OJT).

In 2007, the Frontiers Project evaluated these activities.^{3/4} The evaluation showed that PAC can be safely and successfully decentralized with services capably provided by mid-level personnel in health centers, dispensaries, and some health posts when providers are trained and supervised and equipment and supplies are available.

Decentralization of PAC services resulted in increased numbers of women using the services. In Senegal, the number of women treated with PAC services rose from 1,178 in 2003 to 2,530 in 2005. In Tanzania's Geita District, the number of facilities providing PAC services rose from two to 11, with the number of women obtaining PAC services increasing by nearly two-thirds from 593 to 972. Declines in the number of women seen at the Geita District Hospital occurred because clients sought services at health centers and dispensaries instead.

Decentralized PAC services resulted in increased contraceptive counseling and acceptance of a contraceptive method prior to discharge from the facility. In Senegal, patients receiving contraceptive counseling rose from 36 percent in 2003 to 78 percent in 2005, with 56 percent of PAC patients receiving a contraceptive method



prior to discharge from the facility. In all facilities in Tanzania, more than 95 percent of PAC clients reported receiving counseling on selected FP methods. In health centers where FP counseling and methods were provided in the PAC unit or in the same place as emergency treatment, 89 to 97 percent of clients accepted an FP method prior to discharge. In the district hospital, health centers, and dispensaries where FP counseling and methods were not provided at the same place as emergency treatment, the FP acceptance rate (41 percent) declined by more than half, with the lowest rate (14 percent) at the dispensaries.

Manual vacuum aspiration (MVA) can be successfully provided in health centers, dispensaries, and health posts as treatment for women with complications from miscarriage or unsafe abortion. When personnel are trained and supervised and equipment and supplies are available, MVA can be successfully provided in health centers and dispensaries to treat women experiencing complications of miscarriage or unsafe abortion. When established criteria are met, PAC services can be provided in health posts. However, when supervision and equipment are not available, personnel may lose confidence in performing emergency treatment and will refer clients to the next level of service. MVA equipment for treating complications needs to be available through the medical supply chain, and personnel must be aware that the equipment can be ordered with other supplies.

Training needs to be strengthened for decentralized PAC services. To fully integrate PAC into lower-level facilities, enough trained and competent staff are needed. In Tanzania, trained personnel were expected to train others in their facilities through OJT. Supportive supervision and OJT need to be strengthened as providers reported a lack of confidence in their training abilities. Supervisors and trained staff need to function as preceptors for trainees. Establishing comprehensive PAC training in preservice professional schools and at regional training centers is recommended, as well as OJT by trained trainers in sites that have sufficient caseloads to allow trainees to practice.

Provider bias and client experiences indicate the need for strengthened FP counseling. In Senegal, provider bias toward hormonal methods existed, and the intrauterine device (IUD) was seen as inappropriate. There was very little knowledge of fertility awareness methods, and few providers mentioned the appropriateness of condom use. While most clients were told about pills, injectables, and implants, none of the providers mentioned condoms or IUDs. The process for obtaining a contraceptive before discharge was not client-friendly. In Tanzania, most clients interviewed (11 out of 16) stated that FP counseling did not include information on possible side effects. Most (12 out of 16) also felt that they did not get enough information about contraception.

Multiple barriers exist that can reduce access to PAC services. User fees, poor geographic access, and punitive attitudes by providers in facilities posed barriers to accessing PAC services. The emergency nature of PAC results in many clients seeking services after regular clinic hours or when pharmacies are not open. When contraceptives are not available as part of the PAC service, clients who are stressed by the emergency treatment may be unable to get access to an FP method because they do not have the required fees for contraceptives or lack transportation to the pharmacy.

Referral procedures need to be strengthened. Referrals for FP, STIs, HIV/AIDS, and other services need to be strengthened. Systems for tracking referrals need to be established for follow-up of contraceptive use and treatment of STIs, HIV/AIDS, and other conditions.

Costs to decentralize PAC services are reasonable. The Tanzanian MOH estimates that expansion to 89 hospitals and 296 facilities for countrywide coverage will cost \$406,000, with 67 to 82 percent as up-front costs. This amounts to \$2,143 per district hospital and \$762 per health center. Expenses are higher for hospitals than health centers and dispensaries because larger numbers of personnel are trained and more equipment is needed. Recurrent costs in Tanzania are estimated to be 18 to 33 percent, depending on the facility. Senegal spent \$675,000 to implement decentralized PAC services in 23 health centers and 300 health posts in four regions, for a per site expenditure of \$2,190.

Resources: (1) WHO. Unsafe abortion: Global and regional estimates of incidence of a mortality due to unsafe abortion with a listing of available country data, Third edition, 1997. (2) United States Agency for International Development. USAID Postabortion care strategy. Washington, DC. United States Agency for International Development. 2004. (3) RamaRao, S, Ottolenghi, E, Faye, Y, Diop, N, Dieng, T. Assessment of the Extension of Postabortion Care Services in Senegal The Population Council.; Washington, DC July 2007. (4) Wanjiru, M, Askew, I Nunguti, N, Homan, R, Ramarao, S, Kahando, R. Assessing the feasibility, acceptability and cost of introducing comprehensive Post Abortion Care in health centres and dispensaries in rural Tanzania. The Population Council.; Washington, DC July 2007.

Where to get more information: www.maqweb.org

Designed and produced by: The INFO Project at the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs. Published with support from the United States Agency for International Development (USAID), Global, GH/POP/PEC, under the terms of Grant No. GPH-A-00-02-00003-00.



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