



Barriers and Facilitators of Access to and Use of Post-abortion Care Services: International Medical Corps-supported Sharana Hospital in Paktika Province, Afghanistan





Introduction

Three decades of conflict have contributed to Afghanistan having one of the highest maternal mortality ratios in the world as a result of neglected primary and maternal health services. While the government initiated the Basic Package of Health Services (BPHS) in 2003 to provide standardized basic health services, maternal health indicators have shown little improvement.

Safe abortion is legally permitted only to save the life of the mother or if the child will be born with a disability. In 2017, the Afghanistan Ministry of Public Health (MoPH) introduced Post Abortion Care (PAC) Clinical Service Guidelines. PAC is a lifesaving package of interventions that includes treatment of complications of spontaneous and induced abortion, counseling to identify and respond to a woman's health needs, provision of contraceptive and other sexual and reproductive health services, and community mobilization to increase awareness and address PAC-related misconceptions and stigma.

International Medical Corps supported the Sharana Provincial Hospital in Paktika province, in partnership with the MoPH, from 2004 to 2018 to provide lifesaving

emergency healthcare, including PAC services. In July 2018, International Medical Corps, in collaboration with the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative at Columbia University, conducted a mixed methods study to identify the factors that influence access to, use and provision of PAC services at Sharana Hospital.

Methodology

This study employed mixed methods, including:

- 1) a systematic PAC register review at Sharana Hospital (n=346) from July 2017 – June 2018;
- 2) a facility assessment to determine capacity to provide good quality PAC services, including an assessment of health worker PAC knowledge and attitudes;
- 3) in-depth interviews (IDIs) with 10 women who had received PAC in the previous two months;
- 4) focus group discussions (FGDs) with 80 married men and women aged 18-45 from the surrounding communities; and
- 5) key informant interviews with four community leaders.

Main Findings

Health Facility Assessment/Provider Knowledge and Attitudes

Sharana Hospital met the requirements for a functioning PAC service delivery point, although many nurses and midwives had limited training and mixed attitudes towards abortion and PAC.

- Sharana Hospital had sufficient equipment, supplies and staffing to adequately provide uterine evacuation with manual vacuum aspiration (MVA) or misoprostol and post-abortion contraception.
- While the majority of nurses/midwives provided PAC and contraceptive services, only one reported receiving in-service training to provide PAC or contraception.
- Knowledge of contraception was high, while knowledge of the clinical management of complications of incomplete abortion was low.
- Attitudes were generally favorable towards PAC and contraception, but attitudes around abortion access and induced abortion were less supportive.

PAC Register Review

The majority of PAC clients were 25-34 years of age and nearly half (48.3%) had four or more births, with a mean parity of 3.8. The majority of clients sought PAC services during the first 12 weeks of their pregnancy (68.2%), however nearly one-third of clients (31.8%) sought PAC after 12 weeks. Nearly all (98.8%) clients received treatment with Misoprostol. The registers had no data on the post-abortion contraceptive acceptance.

In-depth Interviews with PAC Clients

Clients' ages ranged from 16 to 35, all were married, had no formal education and their number of lifetime pregnancies ranged from two to 14. Just over half of pregnancies were intended. Most women experienced early term abortions (<13 weeks). All said their abortion was spontaneous; however, it is possible that due to stigma some would not admit to inducing abortion.

- **Facilitators to seeking care:**
 - Clients reported wanting to preserve her health or save the pregnancy, knowledge of Sharana, and support from husbands, in-laws or friends helped to facilitate seeking care.
- **Barriers or delays to seeking care:**
 - Clients reported experiencing little/no immediate complications, long distance to the hospital, lack of transport, lack of awareness, concern over the cost of care and negative perceptions of the hospital caused delays or barriers to seeking care.
- **Positive and negative experiences:**
 - Clients were mostly satisfied with the quality of care received at the facility, including the cleanliness of the

facility, being treated with respect, privacy, and proper pain management and treatment of complications. However, several women did not believe providers treated them respectfully and provided them with inadequate information, care or optimal environment.

- **Post-abortion contraceptive counseling:**
 - The majority of clients were interested in spacing their births; however few reported receiving counseling. For those who were offered contraception, their preference was generally not considered. Providers reportedly perpetuated misconceptions about contraceptives.

Focus Group Discussions with Married Women and Married Men

- **Spontaneous abortion (causes and response):**
 - Participants listed causes including physical labor and chores at home, underlying health issues, inadequate birth spacing, poverty leading to poor health and nutritional status during pregnancy, early marriage or household problems.
 - Response to spontaneous abortion was mixed. Negative reactions such as blame, shame, social exclusion and potentially resulting in husband's taking on a new wife were mentioned. Some groups, however, suggested that such poor treatment is in the past and almost all focus groups mentioned that spontaneous abortion could be seen as the will of God and not the women's fault.
- **Induced abortion (methods, reasons, response):**
 - Participants identified the most common methods of induced abortion as pills or injections.
 - Reasons for inducing included too many children, poverty and family discord.
 - Strong negative views emerged of women who induced abortion, something they considered a sin in the Islamic faith. These women are reportedly mistreated or taunted and face family and social exclusion.





- As the FGDs progressed, reactions became more nuanced as participants discussed the specific reasons for abortion. For example, induced abortion was not considered a sin when the woman's life was in danger. Couples may choose to induce abortion when they are too poor to care for another child.
- Despite the negative reactions, groups expressed strong support for women to seek PAC in case of complications.

Key Informant Interviews with Male Community Leaders

Results from the community leaders were largely consistent with those of the FGDs, identifying similar causes of spontaneous abortion and reasons for induced abortion. Leaders indicated varying levels of acceptability for induced abortion depending on the circumstance. They identified barriers to PAC, and believed that women should be supported in both spontaneous and induced abortion circumstances.

Key Recommendations

Policy Level

- Integrate PAC training modules, with dedicated coverage to post-abortion contraception, into Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS).

Systems Level

- Health providers and their supervisors should be knowledgeable on and have access to accurate

information on PAC and contraception, including PAC guidelines.

- Health providers, including midwives, should undergo regular supportive supervision and periodic observation in order to maintain their competence on PAC, including contraception.
- Health providers, including midwives, should undergo refresher trainings on PAC, including on pain management during PAC and post-abortion contraception, in order to keep their knowledge and skills current.
 - PAC refresher trainings should include activities and discussions to clarify values and attitudes towards abortion and PAC, promote respectful care and improve the client-provider interaction.
- Supervisors should ensure that their health providers, including midwives, have adequate supplies and equipment to provide PAC, including post-abortion contraception. This includes equipment such as specula, the products necessary for infection prevention and necessary medications, including those for pain management.
- Supervisors should ensure that their health providers, including midwives, have ample time to counsel on and provide the contraceptive method chosen by the client.
 - The PAC register should be revised to be more cohesive with the Post Abortion Care National Clinical Service Guidelines and collect data on post-abortion contraceptive acceptance and type of uterine evacuation (e.g., MVA, misoprostol) in order to better monitor progress.

Community Level

- Community mobilization in and outside of Paktika province should focus on:
 - Decreasing stigma related to spontaneous and induced abortion and women who experience abortions to ensure better and quicker access to PAC.
 - Increasing awareness of symptoms of abortion-related complications and the need to seek PAC in order to address complications, ensure future pregnancies and mitigate future costs.
 - Increasing awareness that PAC services are provided for no cost at the supported facility.
- Given the role of men as decision-makers, it is critical to actively involve men, especially influencers, such as community elders, religious leaders and community health Shura in mobilization activities.



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