International Medical Corps

Barriers and Facilitators of Access to and Use of Post-abortion Care Services: International Medical Corps-supported Health Facilities in Juba Protection of Civilian Camps and Maban Refugee Camps, South Sudan

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Introduction

Several decades of conflict and instability in South Sudan have severely impacted the country's health infrastructure, inhibiting access to and use of quality sexual and reproductive health (SRH) services, and has increased exposure to gender-based violence (GBV). Health indicators are poor: the maternal mortality ratio is the fifth highest in the world at 789/100,000 live births, with unsafe abortion believed to being a major contributor. In response, the Government of South Sudan recently made a new commitment to the nation's reproductive health with its enactment of the *Reproductive Health Policy of 2019-2029 and the Reproductive Health Strategic Plan of 2019-2023.*

Safe abortion is legally permitted only to save the life of the mother. Post-abortion care (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. Despite the importance of implementing PAC as a component of a comprehensive SRH strategy, South Sudan lacks comprehensive and updated PAC guidelines.

Since 2011, International Medical Corps has worked to deliver healthcare, healthcare-related services and training through integrated interventions that strengthen the capacity of the public health system. International Medical Corps currently has active field sites in Juba, Maban, Malakal and Wau, supporting 32 health facilities to provide primary healthcare, including comprehensive SRH services, and conduct programming to improve health, nutrition and protection against GBV. In collaboration with International Medical Corps, 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 four International Medical Corps-supported facilities in two Protection of Civilian (PoC) camps in Juba and two Sudanese refugee camps in Maban.

Methodology

This study employed mixed methods, including:

1) a systematic PAC register review at four health facilities in the Juba PoCs (n=205) and Maban camps (n=177) from January 2017 – August 2018;
2) facility assessments to determine capacity to provide good quality PAC services, including an assessment of 18 health workers' PAC knowledge and attitudes;
3) in-depth interviews (IDIs) with 20 women (10 in Juba, 10 in Maban) who had received PAC during the 2-3 months preceding data collection; and
4) focus group discussions (FGDs) with 74 women and married men aged 18-45 in the Juba PoCs and Maban camps: two with women aged 18-24 (n=19), two with women aged 25-45 (n=18), two with men aged 18-29 (n=18) and two with men aged 30-45 (n=19);
5) key informant interviews with four community leaders.

Main Findings

Health Facility Assessment/Provider Knowledge and Attitudes

One Juba PoC health facility met the requirements for a functioning PAC service delivery point, defined as having sufficient equipment, supplies and staffing to provide manual vacuum aspiration (MVA) or misoprostol and post-abortion contraception. However, the other Juba PoC and the two Maban clinics did not meet the requirements. Both facilities in the Maban camps lacked supplies and training to provide MVA. Across sites, a lack of supplies and training prevented staff from providing long-acting reversible contraceptives.

While all 18 health workers provided PAC and contraception services, fewer reported receiving training to do so. Knowledge of the clinical management of complications of incomplete abortion was insufficient, which aligns with the lack of reported training. Attitudes were generally favorable related to PAC access, including provision of post-abortion contraception, except for those in Maban, who believed a husband's consent was required to access contraceptive services. Attitudes were mixed towards women who induce abortion, as well as regarding access to induced abortion under certain circumstances.

PAC Register Review

The majority of PAC clients were between 20 and 29 years old (68% in Juba PoCs and 50% in Maban camps). There were fewer younger PAC clients in Juba PoCs than in Maban camps (8% between 16-19 years old in Juba and 17% between 14-19 years old in Maban). In Juba PoCs, 22% of women reported no prior pregnancies (no data for 60% of clients) while 55%% of clients in Maban camps had four or more births (no data for 18% of clients).

While the majority (68%) of clients at Juba PoC facilities presented during the first 12 weeks of pregnancy, the majority (58%) in Maban camps presented after the first 12 weeks (no data for 62% of Juba and 42% of Maban clients). There was some variation between sites regarding the type of evacuation used: in Juba 85% of clients received MVA, followed by misoprostol (10%) while in Maban 68% of clients did not receive uterine evacuation and 32% received Misoprostol. The registers had no information on post-abortion contraceptive acceptance.

In-Depth Interviews with PAC Clients

Clients' ages ranged from 16 to 40 years, most were married, more than half had some education, and their number of lifetime pregnancies ranged from two to 10. The majority in the Juba PoCs and half in the Maban camps said their pregnancy was intended. Although all respondents stated that they had spontaneous abortions, it is possible that due to stigma some would not admit to inducing abortion.

- **Facilitators to seeking care:**
  - Some clients reported awareness of service availability, recognizing the need for PAC to address symptoms and complications, familial support and consulting with their social network.
- **Barriers or delays to seeking care:**
  - Clients, primarily in Maban, reported long distances to the facility. In addition, some clients were unaware of PAC services and concerned about the perceived costs of treatment and lack of medicines. While no women said they induced their abortion, some suggested that a woman who had induced would be hesitant to seek PAC due to stigma.
- **Positive and negative experiences:**
  - Generally, PAC clients were satisfied with the quality of care they received at supported facilities, including provider confidentiality, respect, information received, quality of medical treatment, privacy, pain management and free services. However, some women, mostly in Juba PoCs, reported that their pain management was delayed or inadequate, they did not receive adequate information about their condition or treatment, and they did not trust providers to keep information private.
- **Post-abortion contraceptive counseling:**
  - Approximately half of Maban camp clients and most Juba PoC clients reported receiving little or no contraceptive counseling while at the facility. Of those who received counseling, some highlighted stigma in their community towards contraception as a barrier to use. In several cases, the health worker insisted on a husband's permission to obtain and use contraception. Few women reported leaving with a contraceptive method.

Focus Group Discussions with Women and Married Men

- **Spontaneous abortion (causes and response):**
  - Participants listed causes including physical labor and chores at home, underlying health issues, poverty (e.g., inability to afford good nutrition to support pregnancy), medication side effects, environmental setting and daily instability, marriage/pregnancy at an early age, having too many children already, and problems with a partner.
  - While a few groups mentioned negative responses to spontaneous abortion, such as blame, discrimination, social exclusion and stigmatization, others, especially those in Juba PoCs, stated that a spontaneous abortion was beyond a woman's control and instead due to God's will.
  - The general consensus in the Juba PoCs and Maban camps was that women who had a spontaneous abortion should be supported in seeking and receiving PAC.
- **Induced abortion (methods, reasons, response):**
  - Participants identified the most common methods of induced abortion as pills or injections, although a few in Maban camps stated that some use traditional methods, such as a blue powder called Zahar.
  - Reasons women or couples may decide to induce an abortion include young age, a partner lacking funds or livestock for a dowry, having too many children, poverty, family problems, instability due to conflict (e.g., women and girls trade sex for financial support or safety in the camps), and pregnancy as a result of extramarital sex or rape.
  - Some participants expressed negative views toward women that induce abortion, associating it with criminality and murder, and going against religion and culture. They explained that such women could be mistreated and abused, banished from home, excluded from the community, and have reduced marital prospects or be divorced by their husband.
  - Despite the initial negative reactions towards women who induce abortion, participants in nearly all groups further described actions and responses to induced abortion that were more nuanced than the initial statements of rejection by some participants. For example, in the Juba PoCs, participants described circumstances under which induced abortion was more understandable, including to preserve the woman's health, if the woman was seemingly too young to have a child, or if the woman did not have the means to support a child.
- **Care-seeking for PAC (reasons and barriers):**
  - The most commonly cited reason to seek care was to treat complications and allow for recovery.
  - The most frequently cited barriers to seeking care were embarrassment and shame, largely due to the negative perceptions of abortion, male providers at the facilities, the often negative perceptions of extramarital sex, distance to the facility and lack of transport, perceived lack of medicine and perceived lack of equipment and supplies necessary to support PAC.
  - Participants largely agreed that a woman who experienced complications after an induced abortion should seek care at a health facility to prevent long-term physical consequences, such as infertility or death, and many would support them to do so.

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. Despite the negative responses towards abortion, some community leaders described how it was their role to help women who induce abortion, mediating with their families and helping them to seek PAC. One community leader recommended the development of more facilities that provide PAC in the Juba PoCs, explaining that some women travel long distances to reach facilities and risk their health and wellbeing in the process.

Key Recommendations

Systems Level

- The MOH should develop and implement national PAC guidelines based on WHO guidance, which would include recommended indicators for monitoring PAC.
  - The MOH and SRH partners should ensure that WHO-recommended PAC indicators are integrated into national HMIS.
- The MOH and SRH partners should revise existing registers to better collect important monitoring data on PAC, including data on post-abortion contraceptive acceptance and type of uterine evacuation (e.g., MVA, misoprostol).

  - Registers should be printed and providers trained on how to complete them.
  - The MOH and SRH partners should monitor that the registers are consistently and correctly completed at the time of service provision.
- The MOH and SRH partners should develop PAC training materials and provide training and/or refresher training to midwives and other providers of PAC to keep their knowledge and skills current, including on post-abortion contraception.
  - PAC trainings should include activities and discussions to clarify values on abortion and PAC, promote respectful care, and improve the client-provider interaction. Trainings should cover how provider attitudes can affect quality of care and that contraception can be provided to women without the consent of their husbands.
  - The MOH should work to ensure that PAC is integrated into relevant pre-service training curriculums (e.g., midwifery and nursing schools).
  - Health providers, including midwives, should undergo regular supportive supervision and periodic observation in order to maintain their competencies on PAC.
  - Health providers and their supervisors should be knowledgeable on and have access to accurate information on PAC and contraception, including PAC guidelines.
  - A pool of trained PAC trainers should be established throughout the country.
- The MOH and SRH partners 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, infection prevention supplies 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 MOH and SRH partners should ensure that PAC, as an important lifesaving intervention, is provided free of charge to all women and girls.
- The MOH and SRH partners should ensure that PAC is provided at all primary health care centers and higher level facilities.

Health Worker Level

Health workers should:

- Understand the importance of post-abortion care to reduce maternal mortality and morbidity;
- Share information during antenatal care on the symptoms of abortion, the need for treatment, and the availability and utility of PAC services;
- Acknowledge the ways in which their personal attitudes and biases can affect the quality of care that they provide;
- Offer post-abortion contraception to all PAC clients; and
- Consistently and correctly complete registers with client information at time of service delivery to ensure appropriate monitoring, and use the data to improve services.

Community Level

SRH partners should strengthen community mobilization activities in order to:

- Decrease stigma related to abortion to ensure better and quicker access to PAC;
  - Engage with men to support women to seek PAC as well as with women and adolescents
- Increase education on and awareness of the symptoms of abortion, the need for treatment, and the availability and utility of PAC services;
  - Engage community leaders and local authorities on the importance of PAC and PAC service availability
- Acknowledge a woman's right to seek PAC and adopt contraception without their husbands' permission; and
- Educate the community on the benefits of contraceptive use, including health benefits for both the mother and children, and reframe contraception as birth spacing rather than as limiting.

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International Medical Corps

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