

# ASSESSMENT OF PROGRESS OF THE POSTABORTION CARE INITIATIVE IN FRANCOPHONE AFRICA

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## EXECUTIVE SUMMARY

In 2002, a consortium of international and regional partners, comprising CEFOREP (Centre de Formation et de Recherche en Santé de la Reproduction/Center for Training and Research in Reproduction Health), the USAID-funded projects Advance Africa, FRONTIERS, POLICY, PRIME, and SARA, the organizations EngenderHealth, Family Care International (FCI), Ipas, Jhpiego, Population Reference Bureau, the development partners USAID and SIDA, and WHO, established the PAC Initiative for Francophone Africa Committee. The committee seeks to address the programmatic issues of increasing access to and quality of postabortion care (PAC) in Francophone Africa. The first activity of this Initiative was a four-day conference held in Dakar, Senegal, in March 2002, which had as its ultimate objective the establishment of quality, sustainable and accessible PAC services throughout the region. The conference report, “*Issues in Postabortion Care: Scaling-Up Services in Francophone Africa*” summarizes the key issues involved in expanding PAC services in Francophone West Africa.<sup>1</sup>

The Dakar conference provided an opportunity for identifying and reiterating the most appropriate and effective approaches for implementing various aspects of PAC. At a meeting of country “Focal Point” persons for PAC, held in December 2004 in Cotonou, Benin, it became apparent that Senegal, Burkina Faso and Guinea were the countries in the region where the most progress had been made in introducing and rolling out PAC services, while other West African countries were in earlier phases of advocacy or introduction. The meetings in Dakar and Cotonou also revealed that all the countries participating in the Initiative face difficulties in providing PAC, regardless of their stage of implementation.

To address this situation, a meeting was organized in March 2006 in Dakar, attended by CEFOREP, WHO, USAID, AWARE-RH, IntraHealth International, Health Policy Initiative (Futures Group), Africa’s Health in 2010, Extending Service Delivery Project, FRONTIERS, MSH and Ipas. The goal was to accelerate implementation of PAC in Francophone African countries to reduce maternal mortality. During this meeting, key strategies and numerous tools for introducing and implementing PAC programs were presented, among them information from the Global Fund, which enriched and enhanced the existing materials.

This study was initiated in response to the needs identified in this meeting by FRONTIERS and was implemented by CEFOREP in six countries: **Burkina Faso, Guinea, Mali, Niger, Senegal and Togo**. The goals of the study were to:

- Assess the national situation concerning PAC in the six countries
- Describe the process of introduction, integration and decentralization of PAC in the six countries
- Analyze the successes and obstacles in the process of introducing PAC in the countries
- Recommend key steps that all countries could follow to strengthen the introductory process

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<sup>1</sup> See the introduction of the analytic report of the Dakar Conference: *Issues in Postabortion Care: Scaling-Up Services in Francophone Africa*, Pape Gaye, IntraHealth International, PAC Consortium, USAID, 2004, pp. vi-vii.

The study used two approaches: a comprehensive review of the introduction and institutionalization of PAC in the six countries, and a situation analysis of PAC services within each country. CEFOREP, which hosted the secretariat of the initiative, undertook a documentary review of all relevant reports provided by the six countries; two staff members also visited and conducted in-depth interviews with key stakeholders in each country. Within each country, a case study approach was used to gather information and assess the PAC program in terms of its functioning, coverage and utilization. The assessment process was participatory, eliciting input from all relevant stakeholders to ensure that their perspectives were reflected. The aim was to gauge the changes made and document the lessons learned from the introductory process to inform similar efforts in the future. A total of 48 program/institution managers and 63 service providers were interviewed with the assistance of the country PAC Focal Point person and MOH staff; eight discussion groups were organized with community members.

## RESULTS

**The process of introducing PAC in Francophone African countries has followed several approaches.** The success of introducing and implementing PAC in these countries was primarily dependent on the good will and efforts of one or two key stakeholders, or “champions,” who, at times, had to overcome numerous challenges because of the sensitivity of the service. In Senegal and Burkina Faso, PAC was originally introduced through pilot Operations Research (OR) projects by the Population Council and Jhpiego, with support from USAID. These OR projects were conducted in collaboration with the Division of Reproductive Health (RH) of the Ministry of Health in each country, and with CEFOREP in Senegal and the CRESAR (Cellule de Recherche pour la Santé de la Reproduction) network in Burkina Faso.

To facilitate acceptance of this major innovation, PAC was integrated into the national Emergency Obstetric Care strategy (EmOC) in each country to avoid becoming yet another vertical program without effective links to other related services. The participatory approach of using research to introduce PAC in Senegal and Burkina Faso helped facilitate discussion within the health ministries.

Subsequently, stakeholders in other countries, such as Guinea and Niger, used the results of Senegal and Burkina Faso’s experiences to advocate with their own ministries of health. In all four countries, advocacy emphasized the importance of family planning (FP) counseling and making contraceptives immediately available after MVA (manual vacuum aspiration), thus contributing to an increase in the prevalence of postabortion contraceptive use. This was particularly true in Niger, where several broadcast debates and discussions about PAC convinced ministry authorities, parliamentarians, as well as religious leaders, about the benefits PAC could offer to the health system.

In Mali, introduction of the PAC program in 2006 within the MOH was eclipsed by initiatives by private providers who began using MVA with syringes that were purchased individually. This forced the MOH to try to regulate and standardize PAC services.

In all settings, international technical assistance/cooperating agencies have played an important role, through identifying key committed people in influential positions (ministries, parliamentarians,

universities, etc.) supporting sensitization and awareness-raising activities, as well as supporting and facilitating dialogue between stakeholders and key decision makers.

Partner organizations have supported the introductory activities in accordance with their respective mandates. For example, FRONTIERS has supported operations research that has generated information that contributed to enhancing understanding about the nature of the problem and evidence of the feasibility and effectiveness of alternative models, which helped increase interest in adopting new approaches to providing PAC. Organizations such as Jhpiego (in Burkina Faso, Senegal and Guinea), MSH (in Guinea and Senegal), FCI (in Burkina Faso and Niger), UNFPA (in Burkina Faso, Senegal and Niger), EngenderHealth (Senegal), IntraHealth (Senegal) or the regional USAID-funded AWARE-RH project (in Mali and Togo) have supported training of trainers and of service providers, reorganization of services and supplying programs with MVA equipment and contraceptive products.

In addition, there have been opportunities for organizations to work together in a country to implement the program. For example, this was the case in both Burkina Faso and Senegal, where a coalition comprised of three organizations worked together to help remove political, organizational and technical obstacles. The Yalgado Hospital in Burkina Faso lacked FP services so CRESAR requested support from UNFPA, which provided infection prevention equipment and supplies, financed the construction of, and provided equipment for, a FP Unit. In addition, it equipped the surgical unit with equipment and supplies for female sterilization, and Jhpiego, provided MVA equipment.

In both Senegal and Burkina Faso, the gynecologists from the public hospitals were the first to champion PAC in the country. Not only have they been active participants in terms of advocacy, through providing data that so poignantly illustrated the consequences of unsafe abortions, they have also contributed to demonstrating the effectiveness of an integrated approach and to its institutionalization by incorporating PAC into various training curricula.

The support of the partner organizations has been under the supervision of the Ministry of Health in all countries. For example, to facilitate collaboration between the different actors, Technical and Steering Committees were established in Niger and Mali, headed by a MOH representative. The committee members were those generally considered to be key players in the sensitization and mobilization of the authorities and service providers.

**PAC decentralization and/or scaling up:** The first countries to have introduced PAC (Burkina Faso, Senegal, Guinea and Niger) went through pilot phases to introduce the services that were implemented in national-level institutions. In Mali and Togo, where services were introduced in 2006, the approach has been to include decentralized health facilities from the beginning of the process.

Even though national leaders in RH services have expressed a desire to increase access to PAC services throughout their countries, there were no formal plans from which all the partners could define their strategies and actions. Thus the move towards scaling up PAC services has not been

made at the same speed in all countries. For example, in Senegal scaling up began at the end of a pilot project funded by UNFPA, whereas in Burkina Faso, after the initial introduction of PAC, there was a very long delay before scaling up started because of insufficient technical assistance and funding. This appears to have been due to a lack of communication among the various partners and raises the issue of who should take leadership, which according to one source, has been lacking within the ministries of health. In Senegal, given the very sensitive nature of this service, the supporters in the Division of RH decided that the first health facilities to provide PAC would be those that have highly respected medical staff and personnel with strong technical skills in their maternity units.

Two approaches have been taken in the transition to scaling up PAC services. Some countries have adopted a centralized approach, with a single contact for all stakeholders and partners, while in others the initiative for setting priorities and funding activities has been left to the local authorities. In the centralized approach, which has been the most widely used, it has been the national level of the MOH that coordinates all the activities but continues to rely heavily on assistance from donors; this approach was followed in Burkina Faso, Niger and Senegal. The decentralized approach, envisioned in Mali, has sought to empower the local authorities to develop PAC services, which offers the possibility of more quickly moving on from dependency on outside funding and to more easily involving communities. To accomplish this, however, would require the creation of a legislative framework that would allow the transfer of resources and expertise.

PAC services are now available in all the regional hospitals in Burkina Faso, Senegal and Guinea. The majority of the district health centers, and many health posts, have also been covered. Between 2003 and 2006 in Senegal, 23 health centers and 300 health posts have benefited from the support of MSH in training staff, reorganizing services, and providing treatment. These facilities were located in the regions supported by USAID: Thies, Louga, Kaolack, Fatick and Ziguinchor. By the end of the program, all health centers and 72 percent of the health posts had been covered.

All the countries have a fairly clear vision of the goals to be achieved over the next four or five years if support is provided by partners. Mali and Guinea intend to engage private health providers in the scaling-up process, which is not the case in Senegal, Niger or Togo.

**Degrees of Institutionalization of PAC:** All of the countries have documents describing a policy, norms and standards in Emergency Obstetric Care, including PAC. These documents have been, or are in the process of being, revised to include the Five-Component Model of PAC: Treatment; Counseling; Contraceptive and FP services; Reproductive and other health services; and Community and Service Provider partnership. The training module for PAC has been standardized by AWARE-RH and adapted and integrated into the in-service training curricula of certain countries.

In Burkina Faso, the emphasis is on counseling, prevention of infections, links with reproductive services and the practice of MVA. In Guinea, it has been integrated into a package of training activities carried out in a chronological order: infection prevention; contraceptive technology; preparation consultation; and then PAC. In Senegal training was developed for three types of service providers: Midwives, Head Post Nurses, and FP Counselors. In Senegal and Mali, financial support

for training has been made available to the University Public hospitals by Ipas. Integration of the PAC modules into the basic training curricula of health practitioners has not reached the same level in all countries. For example, the midwives in Burkina Faso received training that addresses, among other aspects, prevention of infections and the use of MVA, but this is not yet the case in other countries.

At the university level, this integration has not yet happened in any of the countries, although reforms are in process. This is true for Niger, where the startup is scheduled for the beginning of the academic year 2007-2008. In addition, the West Africa Health Organization (WAHO) is harmonizing these approaches so as to integrate them into the training modules for physicians. However, implementation of this policy may encounter some obstacles owing to the limited capacity of practicum sites in relation to the larger number of trainees.

In the countries where PAC has been available for some time (Burkina Faso, Guinea and Senegal), PAC services are included in the annual district plans of the MOH. In Burkina Faso and Niger, development partners support staff training and replacement of equipment at lower level facilities. In Mali, Togo and Niger, the process of introducing and scaling- up PAC services is still too recent to include them in district level plans.

**Supervision:** One of the major problems faced in the process of expanding PAC services is the inability to maintain a system of regular supervision that is appropriate for monitoring provision of PAC services. For example, after the initial follow-up visits after training, a health provider can sometimes go for as long as six months without receiving a visit from a supervisory team. Because supervisions are becoming increasingly integrated, with the expectation that all components of RH should be reviewed, supervision sessions often only scratch the surface of problems and the reports from these sessions offer only general recommendations. It should be noted that Guinea does have a regular, parallel system of supervision specific to PAC, but its sustainability remains uncertain because it depends on funding from development partners. In Senegal and Togo, regional supervisors appear not to have a clear vision of the PAC model, in contrast to the service providers. This highlights the need to involve them in the training of service providers, so that even if they do not often provide PAC they can perform quality supervision.

**Training Policy for PAC:** According to those interviewed, no written policy documents exist to guide training in PAC. The health workers targeted to be trained in PAC are generally gynecologists and midwives. However, to increase the number of providers available to provide PAC, other categories are also being trained, such as skilled doctors and nurses in Senegal, nurse-midwives in Mali, and auxiliary health workers and general practitioners in Burkina Faso.

The duality that exists between in-service and pre-service training for RH generally also arises for PAC. In-service training is the main approach used, which is necessary to enhance the knowledge and skills of existing service providers in new therapeutic approaches. Because of this, even if PAC is included in pre-service Emergency Obstetrics Care (EmOC), specific training in PAC is still conducted. In-service training, which is usually organized as seminars and workshops, is costly and often reduces the availability of personnel to offer services during the training period, particularly in

remote areas which already suffer from a lack of staff. Dependence on donor funds for in-service training is a problem, as is the effectiveness and sustainability of this approach to building capacity of human resources.

This is felt particularly at the primary level, where three problems have significant impact on the effectiveness of an in-service training strategy: i) cost of training, which is generally supported by donors; ii) mobility of personnel, which requires repeated training whenever there are new staff; and iii) monitoring of the personnel to assure maintenance of good quality services. To this list can be added the fact that trainees often lack opportunities to practice the new skills given the low rate of attendance for PAC in facilities located in remote areas; this has been particularly noticeable in Senegal and Niger. To remedy this problem, practicing using dummy models is considered as an effective alternative training method, but these models are often lacking, as was noted in Niger.

The main challenge for some managers to provide in-service training is creating regional training teams, which could help reduce training costs, cut down the time people have to be absent from their posts to attend training, and assure more regular supervision of the services being offered. In the countries visited, training teams included doctors and midwives, the majority of which were trained at the national level. However, in the areas supported by UNFPA and the USAID-funded projects, there are training teams that also provide supervision. The training teams available are as follows: Burkina Faso (10), Senegal (19), Guinea (12), Mali (2), Niger (8), and Togo (10). The regional training teams are often subject to high staff turnover rates.

Faced with insufficient resources for organizing PAC training seminars, several facilities have initiated efforts to train their personnel using staff who have previously been trained. This approach, commonly called “cascade training,” helps reinforce the capacity of service providers at a lower cost. This approach is used in all the facilities visited, and in each, the service providers confirmed that cascade training has increased their ability to offer PAC services; in certain facilities, they are now able to offer PAC services around the clock. This approach needs to be documented, and then structured and supported by donors and the supervising institutions. In Senegal in particular, this type of training does not seem to have given the expected results—in several facilities the personnel who have undergone training by their peers have said that they felt the training was truncated.

**Health Information System:** Data on PAC services are systematically recorded in all the facilities visited. The data collection methods are standardized in Senegal, Burkina Faso and Guinea, while in the three other countries the data are recorded according to the instructions of the trainers. However, in certain facilities, compilation of data is done in the delivery rooms or surgical units where women are treated for abortion complications, which poses a problem especially for recording information on any other services provided. In several locations a codified and institutionalized system does not really exist for collecting the data, thus accurate record keeping relies on the will of a few individuals. It is also important to underscore the weakness of the referral system in all six countries; it is rare that post-treatment feedback is conducted in a systematic and institutionalized manner, and the use of cross-referenced files is practically non-existent.

**Supply of MVA Kits:** The general agreement of those interviewed is that no country has, as yet, a functioning system for supplying MVA materials. This would require, among other things, introducing norms and protocols for the technical characteristics of the types of MVA syringes that should be used. The syringes used in the facilities are generally those that have been supplied during the training of providers. Moreover, purchase of these materials is mostly funded by development partners, except in Mali where it is the MOH that purchases the syringes and gives them to trained service providers. With this initial stock, certain countries are able to offer PAC services for several years where the program has been implemented; this was the case in Burkina Faso, Senegal and Guinea. Once they are worn out, the facilities have difficulty renewing their equipment. Because none of the countries has been able to find a sustainable solution to this problem, the supply of MVA kits is still largely funded by partners.

Methods taken to ensure an adequate supply of MVA materials vary according to the country and the facilities. For example, in Senegal, MVA supply is centralized, whereas in other countries it is at the discretion of the facility head. In most countries, MVA supplies are not included in the country's national essential supply system, except Guinea. Lower-level health facilities, such as the health centers in Senegal and Burkina Faso, have developed mechanisms for self-financing their supplies of medical commodities generally, including MVA kits. Temporary solutions, such as obtaining supplies from private sources have been adopted, but this can lead to a diversity of supplies, which leads to problems of consistent use and reduces their working life.

To make PAC kits routinely available the ministries in all countries are in the process of coming up with effective solutions. This effort is sometimes in collaboration with partner organizations—but not always. In Niger, FCI joined with the MOH in an aware-raising campaign and in providing advice on how to become sustainable. In Guinea, MVA equipment is now included in the list of essential health supplies because PAC is part of the minimum health care package as an element of Basic Emergency Obstetrics Health Care.

**Provision of services:** All of the facilities visited provide continuous PAC services from Monday to Friday. In certain facilities, night-shift personnel are also providing the service. In other cases, abortion complications are treated with procedures such as D&C or flushing by untrained personnel. A lack of availability of MVA equipment during the night shift tends to encourage use of these other methods and is usually not accompanied by counseling, which sometimes leave the patients in a great deal of pain.

In contrast to after-treatment counseling in FP, counseling prior to, during, and following the evacuation treatment is not systematic. Facilities in the six countries visited provide a range of contraceptive products at the FP unit, with the exception of implants and IUDs. It should be noted that these contraceptives are not generally available in the treatment rooms or in recovery rooms, with the exception of Guinea.

Statistics show that the referral system needs to be strengthened and improved. Information about where the patient has been referred and on the patient's status is not always available. Partnership with the community calls for providing care in the patient's immediate environment. However, with

the exception of very few organizations (FCI, for example), few partners incorporate this aspect into their programs.

**Costs:** Service costs range between \$16 and \$25 (7,500 FCFA to 10,000 FCFA), which includes the contraceptive method chosen but does not include transportation costs for the client. These costs have been mentioned as financial barriers by both women and men. Some women said they decided to go to traditional midwives who charge between \$2 to \$ 4 (1,000 FCFA and 2,000 FCFA) for their services, and because they are located in the community, other costs, such as transportation, are minimized.

**Client Satisfaction:** The majority of service providers interviewed (in Burkina Faso, Mali, Guinea and Niger) said that their patients are pleased with the service received: the waiting time, pain management, and the interaction with the provider throughout the entire process. However, some problems in quality of services were noted during group discussions with community members, including inhospitality and negative attitudes of some caregivers, as well as service costs. Profiles of clients show that they have a wide range of characteristics and include adults as well as adolescents, and married and unmarried women.

## **CONCLUSIONS**

The regional conference on PAC in 2002 was an important first step for the introduction of PAC in countries of Francophone Africa. One outcome of the conference was a recommended model for the introduction of PAC services. In this model, emphasis was placed on identification of national champions, advocacy to gain support for PAC services, the need for an initially vertical program, a pilot phase using an operations research approach, and training of trainers. During this six-country assessment, these elements were highlighted as key determinants by national stakeholders. In particular, the role of an initial OR study, utilization of the findings and the leadership of university professors as facilitating factors for PAC introduction were seen as being highly influential.

Ten years later the context has changed. PAC services are widely accepted in most countries and so the challenges today are around scaling up, sustainability, supervision and re-supply of MVA equipment. Another important issue that countries are facing is the organization of services to offer FP to all clients and to link them with other relevant RH services. Partnerships with communities do not yet appear to be a crucial element for the ministries and their partners. The following recommendations will be shared with national stakeholders, USAID, CAs and other partners.

## **KEY RECOMMENDATIONS**

Based on the findings summarized in this report and in consideration of some of the essential aspects of PAC services, the following recommendations are made. They concern policymakers, stakeholders, and partners and are grouped according to the major themes addressed in this report:

## **Institutionalization and Scaling-up**

- Accompany responsibility for PAC by the national health ministries with a process of supervising trained health workers and integrating PAC into existing services to avoid making it a vertical program.
- Harmonize the health system with the norms and standards for delivery to enable an institutionalized and coherent decentralization of services.
- Establish a clear legislative/legal framework authorizing a transfer of resources and expertise from the national level towards the community level in terms of financial and administrative management.
- Promote a decentralized approach, leading local authorities to define and formulate their own PAC strategies.

## **Procurement**

- Integrate supply of MVA equipment into the National Logistics system to ensure a sustainable supply of MVA kits, which is currently lacking
- Help health facilities establish and implement supply systems that are based on effective cost-recovery mechanisms.
- Conduct advocacy within the hospitals to encourage hospital officials to start recognizing PAC as an integral component of their services rather than an external program.

## **Training**

- Evaluate and document cascade training to improve the effectiveness of the strategy.
- Support the introduction of PAC training modules in the curricula of pre-service training institutions where health professionals (doctors, nurses and midwives) receive training, and improve the capacity of these training centers.

## **Monitoring and Supervision**

- Train trainers in supervision and monitoring and increase the frequency of regional and district team supervision by a facilitator who is located within that region or district.

## **Quality and Continuity of Services**

- Bring together the obstetric and neonatal emergency care units (delivery room and surgery) for easier access to MVA equipment, packaging, and counseling materials, contraceptive commodities and data collection materials, so that they can be managed within the framework of a normal work shift.
- Develop guides and tools targeted to specific service providers, such as counseling for FP and to strengthen interactions between clients and providers before and during treatment.

- Convince those in charge of health facilities to make contraceptives available within the PAC units. The range of methods should be as wide as possible.
- Reduce barriers to access, especially the client fees—according to one client: "*C'est un peu cher, tout le monde n'a pas les moyens*" ("It's a bit expensive and not everyone has the means to pay.")

### **Links with Other Services and Programs**

- Establish close links between the PAC services and other programs, such as the malaria in pregnancy program, since malaria is the leading cause of miscarriage in Francophone Africa.

### **Community Involvement**

- Take advantage of existing community-based preventative programs (e.g., malaria) to involve the community in the development of PAC services.
- Involve communities in the development, implementation and monitoring of PAC services, which plays an important role in getting communities to support PAC services.
- Involve existing community-based women's groups to offer information on PAC.
- Increase community information and education sessions to address the lack of knowledge about issues such as FP, maternal health care and the availability of services. Find ways to get men more involved so that they can increase their knowledge and understanding about the health issues and problems that women face.
- Promote accessible transportation services that are financed by communities to help resolve the problem of emergency evacuations.

### **Research**

- Conduct operations research to help strengthen services. Depending on the country, determine the feasibility, security, acceptability and costs of the introduction of MVA in the health posts that meet the selection criteria.
- In Senegal, for example, *Misoprostol* is currently being used without guidelines, training, or complete information. It would be very important to evaluate its eventual use as an option for first-line treatment.

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# ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
ASC	Community Health Agent (Agent de Santé Communautaire)
AWARE-RH	Action for West African Region-Reproductive Health (Project)
CA	Cooperating Agency (of USAID)
CEFOREP	Center for Training and Research in Reproductive Health (Centre de Formation et de Recherche en Santé de la Reproduction)
CES	Certificate of Special Studies (Certificat d'Etudes Spéciales)
CGO	Ob-Gyn Clinic (Clinique Gynécologique et Obstétricale)
CHU	University Hospital (Centre Hospitalier Universitaire)
CIA	Clandestine Induced Abortion (unsafe abortion)
CMA	Medical Center with Surgical Facilities (Centre médical avec Antenne chirurgicale)
CMC	Community Medical Center (Centre médical communal)
CO	Cooperating agency
CRESAR	Cellule de Recherche en Santé de la Reproduction
CS	Health Center (Centre de Santé)
CSCOM	Community Health Center (Centre de Santé Communautaire)
D & C	Dilatation and Curettage
DHS	Demographic and Health Survey
DRS	Regional Health Directorate (Direction Régionale de la Santé )
DSF	Directorate of Family Health (Direction de la Santé familiale )
DSR	Directorate/Division of Reproductive Health (Direction/Division de Santé de la Reproduction)
DSVCO	Directorate of Health of the City of Conakry (Direction de la Santé de la Ville de Conakry)
EMONC	Emergency Management of Obstetric and Newborn Care
ENDSS	Ecole Nationale de Développement Sanitaire et Social
ENSP	National School of Public Health (Ecole Nationale de Santé Publique)
ESD	Extended Service Delivery Project
FCI	Family Care International
FP	Family planning
HIV	Human Immuno-deficiency Virus
HLD	High level disinfection
IEC	Information Education and Communication
INSP	National Institute of Public Health (Institut National de Santé Publique)
IP	Infection prevention
Ipas	International Project Assistance Service
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
IVG	Interruption Volontaire de grossesse (Voluntary interruption of pregnancy)
IVL	Visual inspection with lugol
Jhpiego	Jhpiego
MAP	Minimum Activity Package
MAQ	Maximizing access and quality
MIS	Management information system
MSH	Management Sciences for Health

MSPM	Ministry of Health and Prevention (Ministère de la Santé et de la Prévention médicale )
MVA	Manual Vacuum Aspiration
NGO	Non-governmental agency
OC	Oral contraceptive (Contraceptif Oral)
OOAS	Organisation Ouest Africaine pour la Santé (West African Health Organization)
OP	Operational Plan
OR	Operational Research
OR/TA	Operational Research/Technical Assistance (French: RO/AT—Recherche opérationnelle/AssistanceTechnique)
PAC	Postabortion Care (French: SAA Soins après avortement)
PADS	Program to Support Health Development (Programme d'Appui au Développement sanitaire)
PMTCT	Prevention of Mother-to-Child Transmission
PNA	National Pharmaceutical Supply (French: Pharmacie Nationale d'Approvisionnement)
PNP	Policies, Norms and Standards or Policies, Norms and Protocoles (Politique Normes et Protocoles)
PSP	Point of service provision
RH	Reproductive Health
SanFam	Family Health (NGO, French: Santé familiale)
SARA	Support for Analysis and Research in Africa (French: Soutien à l'Analyse et à la Recherche en Afrique – Project)
SOUB	Soins Obstétricaux d'Urgence de Base (English: Basic Emergency Obstetrical Care)
STI	Sexually transmitted infection
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VIA	Visual inspection with ascetic acid (French: IVA – Inspection visuelle à l'acide acétique)
WHO	World Health Organization



# INTRODUCTION

In 1997–1998, Population Council and Jhpiego collaborated with CEFOREP, the Ministry of Health in Senegal and CRESAR in Burkina Faso to introduce and test a model for the improvement of PAC.

The convincing results that were obtained, especially in Burkina Faso and Senegal, aroused the interest of a number of countries in the question.

To initiate responses and programmatic solutions to questions about PAC, a consortium of agencies and international and projects, particularly CEFOREP, Advance Africa, FRONTIERS, POLICY, IntraHealth/PRIME, SARA, EngenderHealth, FCI, Ipas, Jhpiego, Population Reference Bureau, the Swedish Agency for International Development, USAID and WHO decided to play a catalytic role in creating a committee to implement a regional Francophone PAC initiative. The main purpose of this initiative was to promote more access and better quality of PAC services in Francophone Africa. The main activity of this initiative was a major four-day conference in Dakar, Senegal, in March 2002. The ultimate goal of the conference was to establish quality PAC services that were sustainable and accessible throughout the region. The report, *“Issues in Postabortion Care: Scaling-Up Services in Francophone Africa”* summarizes the key issues involved in expanding PAC services in Francophone West Africa.<sup>2</sup>

At the above-mentioned Dakar Conference on Postabortion Care in 2002, the 14 participating countries had developed action plans for developing PAC. Since this time, implementation of the action plans has been supported by the Francophone African Initiative to Promote Postabortion Care. This enterprise took different forms depending on the state of development of PAC activities. Indeed, the member countries of the Initiative are not at the same level of practice of PAC. The last meeting of the key leaders, which took place in December 2004, in Cotonou, showed that Senegal, Burkina Faso and Guinea are the countries most advanced in this respect; the other countries being completely in the introductory or exploratory stage. The meetings in Dakar and Cotonou, however, showed that all members of the Francophone Initiative face problems, no matter what their state of advancement.

The USAID project called Action for the West African Region (AWARE), one of whose two concerns is related to RH, initiated an important program to duplicate successful experiences in the 18 countries it covers. Replication and strengthening of PAC policy in AWARE’s area of coverage is one of its priorities interventions.

In its definition and content, the concept of PAC contributes to improving the quality of care by involving all actors in the field of maternal health. This approach is innovative in that its implementation of essential PAC elements has brought about important changes in service

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<sup>2</sup> See the introduction to the analytic report of the Dakar Conference, “Issues in PAC: Extension of services in Francophone Africa” (“Questions aux soins après avortement: extension des services en Afrique francophone,” Pape Gaye, IntraHealth International, PAC Consortium, USAID, 2004, pages vi-vii.

organization and provider behavior in countries where it has been tried.<sup>3</sup> One could mention important aspects such as improvement of interaction with patients for better pain management, strengthening service provision, provision of postabortion FP services, and strict observance of new norms of infection prevention. Studies conducted in the various countries have proven the many gains offered by this package of services.<sup>4</sup>

Nevertheless, maintaining the quality of PAC services at a high level depends on several conditions such as the availability of equipment and products in adequate quantity and quality, the availability of enough trained personnel. These questions arise especially during decentralization and also in the context of PAC sustainability, as was seen in the process of the extension of PAC in Senegal<sup>5</sup> and during the Conference in Dakar. In addition to these conditions, good organization of work and mastery of the various elements in the package of services, are other important factors for maintaining service quality.

Emphasizing the role of the community adds an extra dimension to the question of involving the final beneficiary to ensure greater effectiveness in treating abortion complications. More specifically, community involvement must take place at the primary level of the health care pyramid for early detection of signs of miscarriage but also in managing referral to an appropriate referral center.<sup>6</sup>

The role of providers and the community is just as important in treating abortion complications in vulnerable groups, especially adolescents (women younger than 20) who represent 70% of abortion cases in several African countries.<sup>7</sup> The problem of managing the reproductive health of adolescents in general and adolescent girls in particular occurs at all levels of the health pyramid in most African countries. Furthermore, in view of the magnitude of the task and limited resources of the public authorities in Africa, the private health sector must be involved in planning and in making decisions about strategies for treating abortion complications.

Evidence would seem to show that the introduction and expansion of PAC in African countries is a daily challenge, because the obstacles are so numerous. Furthermore, there is no guarantee that gains that have been made will be maintained unless suitable action is taken. It is in response to this challenge that Population Council and CEFOREP propose to conduct a study in six countries, members of the Initiative. This survey will review the scope of institutional and technical obstacles that must be overcome to succeed in popularizing PAC in Francophone Africa.

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<sup>3</sup> See the analytic report of the Dakar Conference: "Questions aux soins après avortement: extension des services en Afrique francophone", PAC Consortium, USAID, 2004, page 7.

<sup>4</sup> Pilot studies conducted in Egypt, Kenya, Ghana, Burkina Faso and Senegal showed, among other results, that PAC makes it possible to reduce the time of hospitalization, the length of treatment and cost of care and to reinforce, by means of FP, the battle against repeated abortions.

<sup>5</sup> See the report of the study "Extension of Postabortion Care (PAC) ("Extension des Soins après Avortement—PAC): Study of referral and certain aspects of PAC in the regional hospitals of Kaolack, Diourbel and in the Sokone Health Center." Ministère de la Santé, Centre de Formation et de Recherche en Santé de la Reproduction (CEFOREP), Fonds des Nations Unies pour la Population (UNFPA); 2001; 35 p.

<sup>6</sup> An experiment was conducted in Senegal in 2003 – 2004 by the Ministry of Health and IntraHealth to test the feasibility of the PAC policy in the community environment.

<sup>7</sup> See the analytic report of the Dakar Conference, "Questions aux soins après avortement: extension des services en Afrique Francophone." (Questions about postabortion care: Expansion of services in Francophone Africa ) PAC Consortium, USAID, 2004, page 64.

# OBJECTIVES

The objectives of this study are as follows:

- Evaluate the situation in six countries of the Initiative
- Describe the introduction, integration and decentralization process for PAC services
- Analyze the results and obstacles during the introduction, integration and decentralization process for PAC services
- Recommend key steps that countries could use to improve the situation

More comprehensively, the following questions will be explored

## 1. Introduction of PAC in the countries

- Was operational research (OR) undertaken before the introduction of PAC?
- Was a pilot approach conducted?
- What was the role of institutions, particularly the Ministry of Health?
- Who are the "champions" and/or leaders who motivated the PAC Initiative?

## 2. Level of PAC institutionalization

- Is PAC integrated in policy, norms and protocol documents (PNP)?
- Are the PNP available in health care centers?
- Is PAC integrated in the training curricula of pre-service education?
- Is PAC integrated in the training curricula of continuing education?
- Is PAC a part of operational planning (OP)?
- What is the system for financing PAC in the countries?
- Is there an information system that integrates PAC?
- How is PAC supervision conducted? By whom is it conducted?

## 3. Scale-up

- Is there a vision or a plan for scale-up of PAC services in the countries visited?
- What are the levels of achievement in the scale-up, according to the countries (national, regional and district hospitals and the private sector, if it is involved)?
- What was the level of financing for the scale-up, according to the countries?
- Which areas are covered or not covered by development partners in these countries?
- Has PAC been decentralized? To what extent has transfer of skills and responsibilities been achieved in these countries?

#### 4. Training

- Are tools for in-service training available? What kind of training is used by the Ministry of Health in these countries?
- Does training have both a quantitative and a qualitative component?
- What are the levels of knowledge and skills of the trainers?
- How do providers rate the quality of the training they have received?
- What is the system of formative supervision in these countries?
- Are the trained providers available at any moment?

#### 5. Equipment and Supplies

- What system for supply of MVA kits is in force in the countries?
- Is this system efficient and continuous?
- What kinds of equipment (e.g., MVA kits, sterilizers, tables, specula) are available?
- Are medications (analgesics, contraceptive products) and consumables (gloves, IP materials) available at the level of these services?

#### 6. PAC services offered

- Is there continuity in the offering of PAC services?
- What model of PAC service has been put in place in these countries?
- Does the organization of services match the model in place?
- What link exists between emergency treatment and the FP unit?
- Is there a referral and counter-referral system between health care facilities?
- Who are the providers who offer PAC services in these countries?
- What are the costs of PAC services?
- How are the data collection system and the posting of information organized at the facility level?
- What opportunities are available to allow providers to express their opinions about PAC services ?
- How do clients evaluate the services received?

#### 7. PAC and the community

- Is the community informed about the existence of PAC services?
- How is the community involved in putting PAC activities in place?
- Is there an organized system for evacuation in case of a community emergency?

- Are PAC services offered at the health center level?
- To what point can the community give its opinions and suggestions concerning access to PAC services and their quality?

# METHODOLOGY

## TYPE OF STUDY

This was a multi-centered study that used two approaches to survey PAC practices in Burkina Faso, Guinea, Mali, Niger and Togo from the time of their introduction in the respective countries. The first approach was a complete review of the process of introduction, spread and institutionalization of PAC in the health care system. The study also examined mechanisms used for ensuring supply of treatment materials as well as ways and methods used to ensure maintenance of a high level of service quality. The second approach consisted of a situation analysis whose purpose was to determine actual practice of PAC at various levels of the health care pyramid. It was completed as far as possible by a small-scale survey of clients to gather information about pain management, FP counseling and the offer of contraceptive products.

## REVIEW OF THE PROCESS

To accomplish this part, the research team decided to conduct a documentary review first, followed by interviews with key players that played an important role in the process.

## DOCUMENT REVIEW

This was a review of official documents (laws and policies, norms and protocols), supervision trip reports and research documents. This data enabled us to understand the legal and legislative environment, to measure the degree of integration of PAC in health care policies and the amount of activities related to PAC. Data was collected at the following levels: the national system in charge of PAC policy, technical institutions in charge of training providers and supervising of PAC activities, at institutions that support the Ministry of Health and also at organizations that had conducted PAC research.

## Case Study

At another time a case study was conducted in Burkina Faso, Guinea, Mali, Senegal, Niger and Togo. Its purpose was to study in depth the institutional aspects linked to decentralization, institutionalization, management, supervision, the technical level, continuity of services, quality of clinical and para-clinical practice, client satisfaction and methods of supplying MVA kits and products relating to PAC.

## Situation Analysis

The purpose of the situation analysis was to evaluate the technical level of facilities targeted by the study. Respect for norms and protocols and the quality of services were measured by an observation guide.

## **Qualitative Survey**

A qualitative survey was conducted among key persons by means of in-depth interviews designed to collect information on concrete actions that had taken place, difficulties encountered as well as mechanisms and resources used to resolve them. The key persons were:

- The head of the organization at the ministerial level in charge of the PAC question and his staff;
- Those in charge of health areas at various levels of the health pyramid;
- Heads of programs with a PAC component;
- Members of the clinical and para-clinical staff active in PAC;
- Representative community members of the population

## **DATA ANALYSIS**

Because of the different approaches suggested to study the situation of PAC in these countries, the research team used two data analysis approaches:

- Data from the survey of key persons and women who had been treated were studied by the content analysis method.
- Data from the situation analysis were analyzed by the classic method used by Jhpiego.

In an effort to make the analysis more consistent with the outline suggested at the Dakar Conference, the commentary will be made according to the following plan:

- Policy and institutional aspects
- Scale-up including decentralization
- Sustainability/institutionalization

## **PROBLEMS ENCOUNTERED**

For data collection, we had planned to spend five working days in each country—except Senegal, where USAID had hoped to have larger scale study with a more solid data collection team. These circumstances, along with the quite large number of directors and providers to be interviewed, meant that the investigators had fewer possibilities of substitutions if some of the target audiences were unavailable.

This unavailability of some targeted audiences was another one of the difficulties with which the investigators were sometimes faced. In some cases it was possible to find replacements.

Furthermore, it was not always possible to have complete data about the PAC activities of sites visited. Usually only overall data describing the volume of fairly recent PAC activities were available.

## LIMITATIONS OF THE STUDY

The data of this evaluation were collected in six countries selected in a logical way. Therefore, in our opinion, even if these countries represent all the situations that occurred, they should not be considered generally applicable to all the other countries in the sub-region.

Furthermore, information collected was limited to the capital cities, with the exception of Senegal. This did not give enough information on PAC experiences in decentralized settings.

It was not possible to organize focus groups with clients in every country. Only Senegal had benefitted from having an adequate budget for this part of the study.

## EVALUATION OF DATA COLLECTION

**Table 1: Synthesis of data collection**

Country	Target Program Directors and Staff from Institutions	Providers	Focus Group Discussions	Health Care Facilities Visited
<b>Burkina Faso</b>	<ul style="list-style-type: none"> <li>Director of Studies of National Institute of Public Health</li> </ul>			
	<ul style="list-style-type: none"> <li>Chief physician, CMA Maternity</li> </ul>			
	<ul style="list-style-type: none"> <li>WHO Advisor</li> <li>Director: head of Family Health</li> <li>Coordinator of FCI</li> <li>Person In charge of FCI project in one district</li> <li>Assistant physician of the CHU maternity point person for PAC</li> <li>Former president of CRESAR</li> <li>UNFPA program director</li> </ul>	<ul style="list-style-type: none"> <li>2 MDs (CHU) + 2 Midwives</li> <li>2 MDs (CMA) + 2 Midwives</li> </ul>	2	
<b>Mali</b>	<ul style="list-style-type: none"> <li>Director of RH</li> <li>PAC point person</li> <li>Chief physician of CHU Maternity</li> <li>Chief physician of referral center</li> <li>Training director, MOH Guinea</li> </ul>	<ul style="list-style-type: none"> <li>2 MDs (CHU) + 2 midwives</li> <li>2 MDs from (Referral Center) + 2 midwives</li> </ul>	0	1 CHU 1 Health care center
<b>Guinée</b>	<ul style="list-style-type: none"> <li>Training Director, MS Guinea</li> <li>Program Director, EngenderHealth</li> <li>Chief of RH section</li> <li>Chief of Conakry Community Center</li> <li>Faculty member, Fac. of Medicine, PAC point person in Guinea</li> </ul>	<ul style="list-style-type: none"> <li>3 MDs (CHU) + 2 Midwives</li> <li>2 MDs (Health Center) + 2 midwives</li> </ul>	1	1 CHU 1 Health care center
<b>Togo</b>	<ul style="list-style-type: none"> <li>Chief physician Maternité CHU</li> <li>Director, Chief of DSF</li> <li>Program Director, Togo Association for Family Wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>2 MDs (CHU) 2 Midwives</li> <li>2 Medical assistants</li> </ul>	0	1 CHU 1 Urban hospital

Country	Target Program Directors and Staff from Institutions	Providers	Focus Group Discussions	Health Care Facilities Visited
<b>Niger</b>	<ul style="list-style-type: none"> <li>• FCI Administrator</li> <li>• Chief physician, Maternity</li> </ul>	<ul style="list-style-type: none"> <li>• 1 auxiliary MD (Maternity) 2 Midwives</li> <li>• 2 Midwives from Health Centers</li> </ul>	0	1 CHU 1 Health care center
<b>Senegal</b>	<ul style="list-style-type: none"> <li>• 25 stakeholders and partners: IntraHealth, WHO, UNFPA, MSH (2) Engender Health, ENDSS, CGO, CEFOPREP, Centre de santé Roi Baudoin, DSR, USAID (2) PNA. Medical Regions Ziguinchor (2) Thiès ( 2) Kaolack (2), Sokone District (2) Presidents of Health Committee (2)</li> </ul>	<ul style="list-style-type: none"> <li>• Providers, midwives and counselors (27)</li> </ul>	5	2 Regional hospitals 7 Health care centers 2 Health care posts
<b>TOTAL</b>	<b>48</b>	<b>63</b>	<b>8</b>	<b>21</b>

## CHARACTERISTICS OF PERSONS INTERVIEWED

Under the evaluation of PAC practices, we interviewed several heads of clinical services or programs in which PAC was included. The directors of clinical services were employed in hospital settings as well as in referral hospitals whereas others worked in health centers—either with or without surgical units. Among the program directors, there were directors of MOH services employed in PAC implementation or their representatives and program managers. Among the NGOs were those of the UN system that have PAC components. However, in Burkina Faso, we met resource persons who had played a key role in the introduction of PAC but who are no longer employed.

As part of this same exercise, the research team interviewed several service providers. They were physicians, gynecologists and midwives, all of whom were involved in treating women presenting with abortion complications. These providers were also employed in referral hospital settings as well as in other facilities ranked as health centers with or without surgical capability. Usually in each of these facilities two physicians and two midwives were interviewed.

The level of responsibility of people interviewed depended on the type of institution. At the university hospital level, physicians interviewed were the ones involved in providing PAC treatment, but who also acted as trainers, supervisors and directors in this area. The midwives were respectively head of PAC units and providers assigned to the PAC units. In the health centers as well, providers interviewed were all engaged in clinical and administrative work. Nevertheless, we chose to ask them questions according to their main activity in their facility and in PAC.

# RESULTS

## PROCESS OF INTRODUCING PAC

Introducing PAC in Francophone Africa took several approaches. If some countries were first required to perform OR for the PAC initiative, other countries later benefitted from experiments that had already been conducted. The private sector sometimes was ahead of the health administration, which later contributed elements of strategy and normalization.

## VARIOUS APPROACHES TO THE INTRODUCTION OF PAC

*Operational research approach:* In Senegal and Burkina Faso, PAC was introduced in the form of OR by the Projet de Recherche Opérationnelle et d'Assistance Technique en Afrique II (OR/TA II) in collaboration with Jhpiego. This OR was conducted with the Ministries of Health of the two countries and with CEFOREP in Senegal and CRESAR in Burkina Faso.

This research was all the more acceptable because the question of unsafe abortion and its consequences was a subject that troubled health authorities in these countries. Hospital statistics revealed a fairly high rate of maternal deaths due to abortion (18% to 20%). *"...therefore it was clear that the problem could be addressed as a means of seeing how to provide quality care to women who were victims of abortion complications before thinking of offering them a contraceptive method that could help them to avoid an unwanted pregnancy."* (Program Director, Burkina Faso)

The legal and socio-cultural context, however, made raising questions concerning abortion extremely sensitive. In fact, from the legal point of view, laws concerning this subject strictly forbade interruption of pregnancy. Revision of the French law of 1920 and adoption of the Code of Public Health in Burkina allowed them to consider FP as a question of public health but still forbade recourse to abortion. In addition to the legal aspect, the strong influence of religious leaders on the attitudes and beliefs of the people was another considerable obstacle to starting a fruitful debate about the question.

The participative measures adopted by the precursors of the research in Senegal and Burkina facilitated broadening discussions at the Ministry of Health and with some program directors. *"Even if the books and laws formally forbid any recourse to voluntary interruption of pregnancy (except if the mother's life is in danger), the latter declared the necessity to prevent maternal mortality."* (Burkina Program Director). This opening was used by promoters of PAC, who stressed the importance of the counseling element and arrangements made to offer a contraceptive method immediately.

Results of the OR in two hospitals and one health center in Senegal and two hospitals in Burkina finally convinced the skeptics of the feasibility of: introducing PAC, reducing hospital costs and cost per client as well as a growing use of contraceptives provided strong arguments. Research also revealed the quality of services offered to patients suffering from abortion complications, especially those suspected to have been caused by voluntary interruptions of pregnancy. These are difficult cases which still preoccupy medical ethics experts.

**Using the experience of others.** In 1998, after the Mauritius Conference where the OR results were shared, the Guinean delegation, composed of technicians, sought the support of the Ministry of Health to undertake the introduction process. Jhpiego's support of this step was a plus.

Advocacy with local political, administrative, customary and religious authorities consisted of showing the possible risks of D&C, which was responsible for considerable morbidity and mortality in Guinea. If such problems were to occur with MVA, the risk of complications would be less. In addition, routine offer of FP aroused interest. *"This is because the MOH was already sensitized to the effect of family planning and everyone was asking what to do to increase the prevalence of contraception. Therefore, this was immediately seen as a way to increase contraceptive prevalence"* (a university member from Guinea)

In Guinea the consequence of capitalizing on the results of OR in Burkina and Senegal was that PAC was introduced in two hospitals. The first training courses were given in these two countries. *"It was not really an operational study like operations research but it was a means of seeing how a test phase might be put in place logistically and organizationally."* (Guinean University staff member)

**Private initiatives then standardized by the Ministry.** In Mali, PAC introduction was fostered by a political commitment at the highest government level in large initiatives to reduce maternal mortality, such as the Vision 2010 movement. High ministerial authorities, after regional meetings, during which the questions was broached, also reminded the Division of RH of the need to introduce this new approach. The DSR had already taken some steps after 2003 with the AWARE-RH Project and the local USAID mission to establish this program.

Several providers who replied to a survey, mostly gynecologists, said they were already using MVA syringes and had procured them individually during regional conferences. Therefore the Ministry should standardize the treatment of abortion complications by training more staff to use the activities package, reorganizing services to improve access and quality of care and making the system for managing the equipment and information (systematic case notification) stricter and more logical. With funds from the Aware-RH Project and technical assistance from CEFORP it was possible to accomplish this in 2006.

**Pioneering initiative:** The idea of introducing PAC in Niger dates from the Maximizing Access and Quality (MAQ) Conference in Dakar (1998), during which a team from Ghana gave a PAC presentation. As a result, a conference on Emergency Obstetrical Care (EMOC) took place in Tawa, Niger (1999) with the Division of RH, FCI and UNFPA. During this conference, many questions were asked about the potential link between PAC and voluntary interruption of pregnancy. The idea of introducing PAC in Niger had been expressed by the head physician of Maternity I. Gazobi at the time of this meeting. This suggestion met with many objections and pressure on the part of some medical colleagues. However, many exchanges—enhanced by radio and television debates and demonstrations of the method—convinced the ministerial authorities and parliamentarians as well as religious leaders of the benefits that PAC could bring to the health care system. PAC introduction was achieved by developing policies, norms and protocols in 2002.

## **ROLES OF ORGANIZATIONS AND STAKEHOLDERS**

### **Cooperating agencies (CA) and UNFPA**

PAC introduction in the countries was initiated by the CAs supported; however, the effort was supported by identifying key agents at the Ministry of Health or within the university. Sometimes these were members of parliament. The concept of PAC was explained to these people with a view toward creating awareness of the importance of the question and the value of taking action. With the assistance of this first group, advocacy with decision makers was undertaken.

The CAs provided financial and technical support by facilitating dialog among the various decision makers, by organizing OR as well as information and sensitization meetings. For this purpose, their expertise in the process of using research results was a determining factor. Once the idea of introducing PAC was accepted by decision makers, the CAs and UNFPA continued their actions by providing technical support as well as material and financial assistance for planning the process, establishing program activities and also evaluating them.

In all the countries visited, these organizations continued to play a vital role in the continuity of PAC activities. Thanks to these groups, facilities were supported not only to train providers and provide MVA equipment, but also in matters of institutionalization and standardization of PAC policies, norms and protocols.

It should, nevertheless, be said that partner organizations intervened within the framework of their mandate. Thus Population Council, by means of OR, contributed important information, making it possible to understand the magnitude of the problem and the value of adopting the new approach to treat abortion complications. Institutions such as Jhpiego (Burkina Faso, Senegal, Guinea), MSH (Guinea and Senegal), FCI (Burkina Faso and Niger), UNFPA (Burkina Faso, Senegal, Niger), Engender Health (Senegal), IntrahHealth (Senegal) or the regional project AWARE-RH (Mali, Togo) contributed to the training of trainers and providers, the reorganization of services, as well as furnishing MVA equipment and contraceptive products. These actions were limited to each organization's areas of intervention in a particular country. Furthermore, it occurred that several institutions worked together in a country to put the program in place. This was the case in Burkina Faso and Senegal where the coalition among three institutions enabled each of the two countries to overcome several political, organizational and technical obstacles. In Burkina Faso, because the maternity of CHU Yalgado did not have a FP unit, CRESAR appealed to UNFPA, which provided infection prevention products, financed the construction of a FP unit, equipped the FP unit and provided the maternity's operating suite with materials to practice voluntary surgical contraception. Jhpiego provided MVA materials.

### **Role of the University Professors**

In countries such as Senegal and Burkina Faso it was the professors of gynecology of the teaching hospitals who were the first "PAC champions." Not only did they participate in advocacy by providing OR and eloquent figures on the consequences of badly treated abortions to demonstrate the efficacy of the new approach—but they also helped with institutionalization by inserting the teaching of PAC in some curricula.

## The Ministry of Health

Support of the CAs always took place under the guidance of the Ministry of Health, particularly the department of maternal health. In order to facilitate collaboration among the various actors, a technical committee or pilot committee was put in place. It was directed by an officer of the ministry. Those who filled these positions were usually considered key players in the process of sensitizing and mobilizing authorities and service providers.

## Private Initiatives and NGOs

Investments in the project were made by hospitals (Hôpital Principal de Dakar – a private institution) or NGOs (SanFam) for organizing services and purchasing materials. Organizations such as CEFOREP and CRESAR played an active role in OR and later in the institutionalization, training and extension of PAC.

## SCALE-UP OF PAC

### Vision and Plan

The first countries to introduce PAC (Burkina Faso and Senegal) had to go through the pilot experience in referral hospitals at the national level, such as university and national hospitals. Sites for OR in Burkina were the two university hospitals, CHU Ouagadougou and CHU Bobo Dioulasso. Senegal had integrated in its first OR a CHU, a national private hospital, and a health center situated in a semi-urban setting—but which had a volume of Ob/Gyn activity comparable to that of the national hospitals. For Niger and Guinea, although the promoters profited from the experience of the first two countries, activities had to be started in the big hospital centers before they could consider extending them to peripheral facilities. Lastly, in countries such as Mali and Togo, the logic of the pilot experience to extend to other sites has not influenced their action. National referral sites as well as others in decentralized areas have been included in the introductory phase. Procedures used by the various countries are shown by the following.

**In Burkina Faso**, according to respondents who participated in establishing PAC in these countries, the decision to extend PAC to other sites if the pilot experiment to be conducted at the Ouagadougou and Bobo Dioulasso teaching hospitals proved successful, was made right from the start: "*...we had planned right from the beginning to do the experiment and, if it went well we would expand it to other centers.*" Another respondent added: "*Our intent was to actually cover Burkina with an offering of PAC services. Another intention was that these were not to be vertical services but were to be integrated with all types of care in general.*" The determining results obtained by OR, made it easier to convince the authorities to adhere to the idea of integrating PAC in other institutions. Nevertheless, given the sensitive nature of any question relating to abortion, it was necessary to repeat the same dialog for sensitization and advocacy in order to bring the general population and other local authorities to not consider the initiative an inappropriate way to "*... liberalize abortion so that young girls could abort more easily. . . .*" Many meetings and much action in decentralized settings brought about the support of the general population, the authorities and health professionals. The work of sensitizing and advocacy was carried out by CRESAR and the Department of Family Health (DSR). Technical activities, however, were performed by CRESAR: "*...it was a lot of work because there were*

*meetings to gain consensus. We had to go to sites to look at the existing needs and to do what was needed to equip these maternities for infection prevention, because they were really the foundation for treatment.*"(a member of CRESAR, Burkina Faso).

The total effort consisted of beginning the process at the highest level of the health pyramid, then reaching out to regional hospitals and peripheral sites. For the staff, CHU trainers trained staff members at peripheral sites in PAC and charged them with training other staff members: "...we trained people from different rural health centers and then charged them with training providers at their sites."

Nevertheless, the CHU, given its status, was not able to extend its actions to the heart of the communities. *"At the beginning there were the three elements, and then later, the list was increased to five. Thus this phase could not be considered as part of the beginning of the program."*

Projections made by the promoters at the time did not find the same degree of support for PAC as that found in Burkina Faso. There was a relatively long period before the first scale-up activities were begun. A CRESAR university staff member, however, said: *"We had made a decentralization plan but we had no financial follow-up. This is what led us to interrupt the process."*

On the other hand, one respondent, a member of one of the partner institutions, said one could not speak of a temporary plan for scale-up of PAC. In his opinion: *"There is no temporary plan. Our objective is to cover all health care facilities in our area with emergency obstetrical care, taking into account postabortion care."* No member of the staff of the Department of Family Care interviewed about the question confirmed this fact. That showed a lack of communication among the various actors and took the matter back to the question of leadership, which, according to a respondent, was lacking.

**In Senegal**, the Ministry of Health had already decided on scale-up right after publication of the results of the OR. Actually, the PAC expansion plan had already been developed at the time of the PAC PNP development workshop in 1998, with support from Population Council and Jhpiego. At the time, they had decided to introduce PAC in a certain number of health care facilities in decentralized areas at different levels of the health care pyramid, by defining the role and prerogatives of each. Officially, it was a matter of introducing PAC in regional hospitals, district health centers and health care posts in a community setting. Nevertheless, use of MVA had been accepted only in hospitals and health centers. At health posts staff training was proposed—for nurses and occasionally for midwives or health care agents—to detect signs of miscarriage or complications of abortion, to provide FP counseling and to take emergency actions in preparation for referral and digital curettage.

Introduction of PAC in a community setting had been planned but only as an experiment, because of a lack of data about feasibility and effectiveness. Willingness to generalize use of the new PAC model on a national scale was tempered by the fact that financial means, coming exclusively from partner organizations, could only be invested in a certain number of regions or districts. Moreover, given the sensitive nature of the subject, promoters under leadership of the Division of RH (DSR)

were concerned about avoiding any action that would threaten the future of the program. Thus it was decided to select the first facilities to receive PAC based on the presumed qualities of their directors and other maternity staff with the necessary technical potential.

The first phase of the scale-up pertained to five health care sites, situated in five of the ten regions in the country, with support from Jhpiego. There were four regional hospitals, (Diourbel, Saint-Louis, Kaolack, Ziguinchor) and one health center in a region where the hospital was still not functioning (Sokone District in the Fatick Region). Satisfactory results obtained, particularly from the Sokone health center, encouraged the authorities to pursue the initiative at the operational level. Thus, with support from EngenderHealth, introduction proceeded at the health care centers and health care posts in two regions where the model had already been used (Kaolack et Fatick). Subsequently, always under the leadership of the DSR, Intrah Prime tried out the PAC model in a community setting, in the Sokone health care district.

This scale-up had been documented by research activities which made it possible to provide decision makers with the information needed for the initiative to succeed. The research—in which the stakeholders were the DSR, Population Council, CEFOPREP, UNFPA, EngenderHealth and Intrah Prime—showed the efficiency and adaptability of the PAC model because it had been demonstrated that it could be adapted with several advantages, at all levels of the health care pyramid, all the while keeping its consistency as a whole.

After these first phases of expansion, Jhpiego addressed two new regions (Thiès et Louga), but only in the regional hospitals. MSH picked up the torch by introducing PAC in 23 health care centers and 300 health care posts in five targeted regions (Thiès, Louga, Ziguinchor, Fatick, Kaolack). During the same period, UNFPA introduced PAC in two regions in the south and southeast regions of the country (Kolda and Tambacounda).

**In Guinea**, according to a director at the MOH, the intent of the scale-up was to bring services closer to the people. Guinea's approach was that, after having introduced PAC in the national hospitals, PAC should be integrated into regional and prefectural hospitals and then turn in health centers, said a participant in PAC introduction in this country. He said that in fact this step was necessary so as to avoid the risks which would be very great if a massive scale-up had been conducted. *"...we said to ourselves that channels to the hospitals should be used before going to the health centers..."* He continued: *"...according to the integration plan in the strategic reproductive health care plan, integration in all the hospitals should be covered first before going to the health care centers."* The temporary plan had been defined by the MOH in collaboration with the donors within the framework of the strategic RH plan of 2000–2015.

According to a trainer, a director at the MOH, after adoption of the strategy, the first unit was installed at Donka National Hospital. A year later (2003), an evaluation enabled them to install a second unit at Niassa Hospital. Then, with support from PRISM and Jhpiego, expansion toward other sites became possible. Within this framework, there was an exchange of experts among Guinea, Senegal and Burkina for the follow-up visits. These exchanges were done in very close collaboration.

Another agent of the MOH noted, however, that the whole country has been not covered but all the regional hospitals have been. From now until 2010, all prefectural hospitals will be covered; the health centers will be covered by 2015. From the present, 2008, PAC will be integrated in two large private clinics in Conakry.

The need to train hospital personnel first was justified by the concern for consistency in administration of the process within the regions. Thus, the hospital staff who had been trained must then supervise health center staff. This desire for consistency was coupled with a concern for offering a less costly approach. To do this, research was initiated to evaluate action already conducted. This enabled implementers to take stock of the situation at every step of the way so they could make corrections before continuing the expansion.

**In Mali**, according to a health care facility director, the vision sustaining expansion of the PAC strategy is to introduce effective solutions for women's pain "*...our vision is really to ease women's suffering*" he said. In practice, this would mean to train national and regional trainers (two per region), and then to train providers in the regions.

The Ministry intends to play a leading role in every region in defining its own priorities and the ways in which they will be achieved—while integrating training, supply and supervision activities in the operational plans of local authorities. This work would be done under the guidance of regional RH directors.

Still according to this respondent, decentralization would expand down as far as community health centers (CSCOM). He added: "*At the moment the plan is for the regional hospitals and referral centers, because in Bamako we can go as far as community centers, which are maintained by physicians and midwives as referral centers. At present, however, they do not perform any surgical procedures, but initially there is no question of going beyond community health centers; it stops at the referral level.*" Indeed, the scale-up is accompanied by full empowerment of local facilities. Actually, according to a director of the Division of RH: "*...if we first train trainers (two per region), afterward with decentralization [...], it is up to the regions to train their trainers and also to expand at their level. We, at the national level, will expand, but to the regional level. The regions will then expand to these centers, always keeping in mind the donation of kits in the operational plans [OPs], while integrating training in the OP.*"

The decision to give preference to local initiatives, particularly to the regions, may stem from the lack of clear commitments on the subject of scale-up in Mali. Indeed, the chief authorities interviewed stated that it would be up to the regions and the facilities in their jurisdictions to find ways and means to ensure implantation of PAC activities. The question is whether with this approach, the Division of RH can persuade the local authorities to make a significant investment in the development of PAC activities.

The private sector has not been forgotten in the development of RH. According to a director at the DSR: "*...we involve the private organizations. They are organized as associations. We ask these associations, for example, to send representatives from two facilities for this kind of training, [...] they come, or they don't. But they are nevertheless involved officially in all continuing (in-service) training.*" (A

director at the Mali MOH). As for PAC, however, the private clinics have not yet been involved in training activities. The directors interviewed said that these facilities would be involved later. A University representative in Mali, however, had some reservations as to the capacity of the private health sector to develop a PAC policy. In his opinion: “...*I do not think that the private sector is structured overall in a meaningful way for a sufficiently effective PAC policy.*” The community aspect has not yet been planned in the scale-up process.

**In Niger**, after the training of the first group of trainers, all of whom came from the Maternité Issaka Gazobi, PAC activities began immediately in this facility.

The need was felt to expand the practice of PAC to the interior of the country, following the plans made by the NGO FCI in several regions. This is how, with considerable material and financial assistance from this partner organization, the team at Maternité Issaka Gazobi began to train service providers in the health care facilities of the Zinder region. Subsequently, the Agadez region received training from the team.

A temporary plan for PAC expansion was developed with partner health organizations of which the Belgian Cooperation (Peace Corps) is the leader. Furthermore, thanks to advocacy led by the chief physician of the Maternité Issaka Gazobi and the DSR, there will be UNFPA coverage of the PAC expansion process in the Niamey and Thilabéry regions, while the World Bank will cover the Dosso and Tawa regions.

### **Achievement of Levels of Decentralization and Scale-up**

All the countries visited had exceeded the introductory step of PAC, although Mali and Togo launched their activities only recently. In these two countries the introductory strategy included, besides the national referral sites, some regional sites. It may be considered that for these countries, it was more a matter of decentralization of PAC.

For PAC pioneer countries (Burkina Faso and Senegal), scale-up enabled them to cover all the regional referral institutions (the equivalent of the regional hospitals.). In Burkina Faso, there are 13 regions, whereas in Senegal there are 11. Nevertheless, a certain number of health districts do not offer PAC. The division of health districts corresponds entirely to the areas of intervention of the partner organizations. In Senegal, for instance, between 2003 and 2006, 23 health care centers and 300 health care posts benefitted from Management Sciences for Health (MSH) support to train their staff, reorganize their services and treat women suffering from complications of abortion. These facilities were in regions traditionally targeted by USAID: Thiès, Louga, Kaolack, Fatick and Ziguinchor. At the conclusion of the program all the health centers and 72% of the health care posts had been reached by the interventions. This support was achieved within the framework of the bilateral agreement between the Government of Senegal and USAID. During the same period UNFPA was conducting interventions in the regional hospitals of the Kolda and Tambacounda regions and the eight district health care centers as well as in a good number of health care sites. In Guinea, on the other hand, not all the prefectural hospitals are covered as yet. According to a respondent, there are still about ten to be reached.

As for the private sector, whereas Mali intends to become officially involved in the scale-up process, the situation is not the same in the other countries—Guinea, Burkina Faso, Senegal, Niger and Togo.

**Text Box 1: PAC Scale-up activities performed by MSH in Senegal**

<ul style="list-style-type: none"> <li>The Division of RH is very much in favor of the introduction of quality PAC services in first level facilities.</li> </ul>	<ul style="list-style-type: none"> <li>Because of the lack of funding for PAC services at rural health care centers, most patients are referred immediately to a higher level institution, without receiving any care.</li> </ul>
<ul style="list-style-type: none"> <li>The number of patients treated for postabortion complications has risen from 1178 in 2003 to 2530 in 2005. Of this number, 53% were treated by MVA.</li> </ul>	<ul style="list-style-type: none"> <li>Lack of referral to other RH services to meet women's needs</li> </ul>
<ul style="list-style-type: none"> <li>The percentage of patients having received FP counseling after treatment has risen from 36 in 2003 to 78% in 2005.</li> </ul>	<ul style="list-style-type: none"> <li>Lack of contact with community services</li> </ul>
<ul style="list-style-type: none"> <li>Of patients who received counseling, 56% returned home with a contraceptive method.</li> </ul>	<ul style="list-style-type: none"> <li>PAC logs inadequately completed</li> </ul>
<ul style="list-style-type: none"> <li>Thanks to supervision, services were reorganized in 23 health care centers</li> </ul>	<ul style="list-style-type: none"> <li>FP methods lacking at sites where emergency services are offered</li> </ul>
	<ul style="list-style-type: none"> <li>Ministry of Health provides no supervision in 20 of the 23 districts after MSH activities were reduced. External transportation assistance was needed for good organization and supervision.</li> </ul>
	<ul style="list-style-type: none"> <li>Regional hospitals have not participated in this phase and this was not well received by providers at these health care facilities</li> </ul>

**Source:** Special document #5, 2006

**AREAS NOT COVERED BY DONORS**

Like most health care programs, PAC is dependant on the support that countries or partner institutions grant them. The donors, however, limit their interventions to a few regions and districts. For this reason, some areas that are not covered remain untouched by any major activity. This is the case in all the countries, particularly in those that were first to introduce PAC (Burkina Faso, Senegal, Guinea and Niger).

Faced with this problem, countries such as Burkina Faso and Senegal, for instance, have signed a partnership agreement with Ipas for the training health care staff in some regions not yet covered and supplying MVA kits for these institutions. In Senegal, this collaboration has become established with the training of midwives in the Dakar area and of trainers from the National School of Health

and Social Development from which midwives are graduated. Burkina Faso is planning to construct referral hospitals in the two regions that do not yet have one. According to a counselor at the local WHO office, this country plans to expand PAC to all qualified hospitals (i.e. ,hospitals and medical centers with surgical facilities) in the framework of an overall program which is supposed to mobilize all partners. In Guinea, according to a respondent, coverage of the ten remaining prefectural hospitals will certainly be a priority in the National Program for Health Care Development (PNDS), financed by the World Bank, because of their distance and isolation.

## **INSTITUTIONALIZATION OF PAC**

### **Development, Implementation and Update of PAC Policies, Norms and Standards**

Between 1998 and 2005, in all the countries visited, PAC has been integrated in the PNP documents. At present, in some countries they have been revised with a five-component model (Senegal, Burkina Faso, Guinea). In other countries (Togo, Niger), they are still using the three-component model. The revision process is supposed to start very soon. In Mali, where integration was delayed (2005), the five-component model was introduced directly. These documents are the outcome of the standardization process initiated by AWARE-RH.

### **Integration of PAC in Continuing Education Curricula**

The PAC training module that came from the standardization process initiated by AWARE- RH, has been integrated in the continuing education curricula of the countries visited. It was introduced by CEFOREP in the sub-region during the training of service providers or trainers. Depending on the training needs and the setting of each country, this basic module was adapted by the Ministry of Health and national trainers. Thus, in Burkina Faso, counseling, infection prevention, links with RH services and MVA were emphasized. In Guinea the module was integrated in a package of activities carried out in chronological order, training in: infection prevention, contraceptive technology, the preparatory visit, then training in actual PAC skills. In Senegal it was adapted to three types of service providers (midwives, health care post chief nurses and FP counselors)

In Mali, Togo and Niger, within the framework of AWARE-RH activities and during the scale-up process, the model introduced by CEFOREP was the one used.

Furthermore, it should be mentioned that in Mali there was a different training tool, which had been put at the disposal of the teaching hospital by Ipas for the training that this organization is financing.

### **Integration of PAC in Pre-service Training**

The degree of PAC integration in the pre-service training varies, depending on the country and the type of student taught.

At the university level, for fifth and seventh year medical students (Niger), initiatives are in the process of preparation as the medical school programs are being reformed. In most of the countries, PAC is not taught in a modular form. In actuality the instruction is more of an introduction than

real training for acquisition of skills, because of the number of students (case of Burkina, Senegal or Mali). The training is given during clinical rotations at the hospital (as in the case of Guinea and Senegal).

In the paramedical schools the student midwives are the most involved. Student nurses also have the benefit of PAC training in Burkina Faso. Here too integration means only the theoretical aspects. Objectives of practical clinical training are more difficult to attain there also because of the numbers of students to be trained (Burkina, Guinea and Togo). In Niger, practical training is planned for the academic year 2007-2008. In Senegal the process has not yet been undertaken.

### **Integration of PAC in Operational Planning**

Regarding PAC institutionalization, there are two groups of countries. In the first, in which PAC was established fairly long ago (Burkina Faso, Guinea and Senegal), PAC is taken into consideration in annual district planning. In Burkina and Niger, for example, the partners in development support decentralized facilities in training and replenishment of materials. In Senegal, on the other hand, it is the districts that buy replacement MVA kits with their own funds. In Guinea, PAC is integrated in the Feuille de Route (official equipment list) and are therefore included in the annual planning of every health care institution.

In the second group of countries (Mali, Togo and Niger), the process of PAC establishment and scale-up of PAC is still too recent to allow for their integration in the plans of decentralized institutions.

### **Health Information System**

PAC data are systematically recorded in all the sites visited. In countries where PAC has been established for almost ten years, standardized and printed logbooks—reserved exclusively for PAC activities—are used (Senegal, Burkina and Guinea). In the other three countries, logbooks are designed according to the instructions of the trainers. For example, at the Issaka Gazobi Maternity in Niamey, logbooks were suggested by trainers from the CHU Yalgado in Burkina Faso, whereas in Mali and Togo the logbooks are modeled after those suggested by CEFORP. In addition to these logbooks, the teaching hospitals have individual files for the patients. The logbook gives an overall view of the development of PAC activities. This information provides a data base for research because, after analyzing them, they are often used by students for their doctoral theses (Burkina Faso, Mali, Senegal). At certain sites, however, compilation of data provided by different units where women are treated for abortion complications cause problems, particularly for after-hour teams. Either compilation of data is not done systematically—or it is not done at all. There is always the problem that at several sites there is no real system for collecting, codifying and institutionalizing data. Reliability of the system depends on the will of one or a few people. For example, the director of the PAC unit of a maternity in Niamey claimed that she takes a tour of the labor and delivery room every morning in order to note cases of abortion complication treated by the most recent overnight team. She records them in the PAC logbook. Even if this is a good idea, one cannot but wonder about its sustainability and the level of detail collected in the labor and delivery room.

The weakness of the referral and counter-referral system in the six countries should also be mentioned. Retro-information after treatment is rarely recorded and institutionalized systematically. The use of counter-referral forms is practically non-existent.

## **Supervision**

One of the major problems faced by countries during PAC expansion is their inability to ensure a supervision system that is regular and thorough enough to deal with issues that related PAC practices. This appeared in the proposals of all the respondents, regardless of their country. Difficulties at the origin of this problem are linked to a lack of human resources competent in this area. Usually pools of trainers, who in addition to their daily work, must find the time to supervise agents who have been trained, realizing that formative supervision is often talked about. The other difficulty relates to the spacing of supervisory visits. After the follow-up visits post-training, providers can go for six months or more without a visit from a supervisory team. Furthermore, supervisory visits are integrated with visits for other services. There is not automatically specific supervision for PAC; all facets of RH are reviewed. In certain situations, RH is only a part of the supervision. In the latter scenario, as often happens, supervision is conducted because of a particular circumstance. Thus it might occur that a supervisory visit is conducted only because of a case of meningitis. The consequence is often that supervision only skims over a problem and the reports of the visit provide only general recommendations. A respondent in Burkina Faso said “...*at the national level we recommend integrated supervision; that means that when teams go out to the field, they must observe all kinds of services, and sometimes this does not support quality, particularly in some areas.*”. He continued, “...*one becomes aware of the fact that one has been able to take an interest in aspects of RH, perhaps at most, once a year, and one wonders in what way?*”

It must be emphasized that Guinea has a regular system of supervision, parallel and specifically for PAC, but its sustainability remains tied to financing by partners in development.

Furthermore, in Senegal as in Togo, regional supervisors, contrary to the situation of the service providers, do not have a clear vision of the PAC model. This raises the problem of their involvement in the training of providers (formative supervision) when they do not often perform PAC or, when it is necessary, to give them guidance so that they can do their job of facilitative supervision.

## **TRAINING OF SERVICE PROVIDERS**

### **Training Policy**

This subject is a key aspect of PAC development. It is usually difficult, however, for directors to speak of PAC training policy in a formal way when, in their opinion, there is no written document on the subject. Although the apparent goal is to train the maximum number of service providers, training activities are, in fact, most often planned and conducted according to programs suggested by partner organizations.

Certain directors consider the duality between in-service and pre-service training as a problem of balance. In-service training is necessary because of the need to update the knowledge and skills of providers in their work when new therapeutic approaches are developed.”...*we are obliged to provide*

*in-service training, but it is important that in-service training does not overwhelm pre-service training.”*  
(Program director of the DSF, Burkina Faso)

A partner organization has suggested to Burkina Faso a policy of which one of the objectives is to train providers in 13 regions of the country. This policy consists of forming a team of trainers at the central level. This team would take on the assignment of establishing and supervising teams of regional trainers who would develop the skills of providers in their respective jurisdictions. Similar policies are already being applied in Guinea and will also be applied in Mali, according to some respondents.

It should be specified that in Guinea the question of existence of a PAC human resources training policy is not understood in the same way by all respondents. For some the system exists with national and regional trainers, whereas for others, whatever is done relates rather to personal initiatives, without any real correspondence among the various actors. In any case, those who think there is a general training policy that integrates PAC, insist that revision of this policy is in process. Training of providers applies to those who work in national and regional hospitals and prefectural health care centers.

In Mali and Togo, training activities are just beginning. A respondent in Mali said that PAC scale-up will affect the entire health pyramid from the national referral level down to community health care centers (CSCOM) that have a physician. Until now, only physicians and midwives have had the benefit of PAC training. According to this respondent, the group of nurse-birth attendants should be included if we want to expand scale-up to the community level. At the present time, this training policy is being planned at the national level, managed by the DSR.

## **IN-SERVICE TRAINING**

### **Training Workshops**

From 1997 to the present time, workshops have been the chief method for training PAC service providers. The principal reason for this situation is related to the fact that training courses are most often initiated in the framework of programs that—in order to achieve their objectives within several years—are obliged to integrate, in their activities, the training of providers already in service. This reasoning, which could have been justified during the first PAC introduction initiatives, the main objectives of which were to demonstrate the efficacy of the new approach, does not seem to fit the current situation. Furthermore, PAC is more and more considered as a part of more comprehensive programs, such as emergency obstetric care, even though training specifically for PAC is still conducted. According to several respondents, in-service training in seminars and workshops are costly. And, the availability of personnel to provide services during a training session is often reduced, particularly in outlying areas that suffer from a shortage of staff.

Dependence on non-state donors is still considered to be a burden on funds because of anxiety about the effectiveness and sustainability of the strategy to strengthen human resource capacity by means of in-service training.

## Pool of Trainers

In the first countries to introduce PAC, a pool of national trainers was put in place at the beginning. Members of these teams were usually gynecologists serving at the sites where the pilot experiments were conducted. This was the case in Burkina Faso, Senegal and Guinea, as well as in Niger. Countries that joined in the second period (such as Chad, Mali, Cape-Verde, Guinea Bissau and Togo) created at the very outset of their program a team of trainers at the referral hospital level but also included health care workers from decentralized facilities. With some directors the chief concern for in-service training is to create teams of trainers in each region. They say that this will help to reduce the costs of training, time of staff absences from work for training and also ensure more regular supervision of service provision. In countries visited during the study, pools of trainers comprised physicians as well as midwives. In most cases they were trainers at the national level. The Burkina Faso team comprised ten trainers, the Guinea team had 12 (of whom seven were from the regions), and Niger had eight. In Senegal, since the introduction of PAC, several training teams have been created, particularly in regions where USAID and UNFPA are invested. In these areas, it is usually members of the district team who go on to train and supervise service providers in their area. In Togo, there were three teams of trainers, two of which came from secondary towns. Opinions seemed to be divided in Mali on the subject of a pool of trainers. Some thought there were 12 trainers; others believed that only the two providers who had been trained by trainers from Dakar were trainers—the others who were learning under a buddy system were not, properly speaking, real trainers.

**Table 2: Number of PAC trainers in the six countries evaluated**

Country	Number of Trainers
Burkina Faso	10
Senegal	19
Guinea	12
Mali	2
Niger	8
Togo	10

Teams of regional trainers were often subject to considerable losses. This was the case with the FCI training team in Burkina Faso—two of the three team members left the intervention area. UNFPA complained of the same problem and was seeking to renew the training teams to cover the loss of personnel at this level.

*“...there is a loss of trainers ; some go to work in public health; some leave and go into other specialties; So we lose a great many. Only the gynecologists stay because they have already been trained in their specialty and we can use them as trainers.”*(a facility director in Burkina Faso).

Teams in Guinea comprise physicians and midwives. It is in the latter group that losses are the greatest because of their heavy work load.

## Service Providers to Be Trained

Providers targeted for PAC training are usually physician-gynecologists and midwives. Choice of these two categories of personnel is logical because of their Ob/Gyn skills. Putting them in charge reduces training time and ensures that complications can be avoided or foreseen early and treated if necessary. In the scale-up context, a shortage of staff with these qualifications might persuade the authorities to broaden the possibilities by including nurses and physicians with some skill in emergency obstetrical care. This is the case in Senegal, where physicians called “skilled in EMOC”

and nurses have been trained in PAC. In some regions, head nurses of health care posts have been trained in all the elements of the PAC package of services with the exception of use of the MVA syringe, which so far has been limited in the hospitals and health care centers (in Senegal, only facilities with physicians are allowed to practice MVA). These nurses can detect signs of the complications of abortion, provide counseling, perform digital curettage if conditions are right, offer a method of contraception and refer more severe complications to referral centers. In Mali, the DSR plans to provide PAC training to nurse-birth attendants to work at community centers that have a physician—but do not plan to include ordinary nurses in this training.

### **Efficacy and Sustainability of In-service Training**

The question of efficacy and sustainability of the current in-service training model arises more in the context of decentralization/scale-up. Indeed, at the peripheral level we can identify three problems that have a noticeable effect on the efficacy of the in-service training strategy of service providers: costs of the training, which are usually borne by the donors; mobility of staff, which obliges us to repeat the training every time there are new staff members; and follow-up of staff to ensure a high level of service quality.

Other problems very often arise in decentralized training settings. According to these respondents, trainees often do not have the opportunity to practice enough cases because the peripheral facilities are poorly attended. This fact was found chiefly in Senegal and Niger. To mitigate this deficiency, practice on models is considered a fairly effective alternative. These tools, however, are also lacking—most often in decentralized settings—as was clear in Niger.

### **Peer Training**

Faced with inadequate resources to conduct PAC training courses, several facilities tried to train their staff with the help of their own personnel who had already been trained. This approach, however, had not been tried by our respondents at the central level or by donors. It was mentioned only by directors of health care facilities and service providers. Their attitude showed that their programs and strategies did not take into account the potential this type of training could have, and its possible effect on the quality of services.

Some respondents said that this approach, commonly called “cascade training” makes it possible to strengthen providers’ skills at less cost. This type of training targets in-service midwives as well as specially trained obstetrician/gynecologists (CES), and it is given by physician trainers but also by chief midwives in charge of PAC units. Training on the job or non-formal training can take several forms. In Burkina, some providers, particularly the specially trained obstetrician/gynecologists (CES), have been integrated into formal training sessions led by their teachers, thus providing benefits to the staff of other facilities. They were able to benefit from all the theoretical and practical training given during PAC workshops. In this way, at CHU Yalgado in Ouagadougou, according to a PAC service provider, about 60 health care workers were formally trained by benefitting from training sessions intended for other staff. Beside this type of training, other providers were introduced to PAC in the framework of their regular activities. This type of training is given by providers already trained, whether or not they had reached the status of trainers in this area.

Usually providers seeking skills observe their colleagues performing a certain number of cases. They then practice directly on patients admitted for complications of abortion. Service providers state that in this way they have trained more than 140 providers at CHU Yalgado, Ouagadougou, about 1,000 health care workers and medical students at the Sector CMA 30 in the same city, since 2003. In this institution, outside of the initial team of midwives trained at the CHU, all the others were introduced “on the job.” This training was conducted in the following way: The candidates were recruited among midwives who worked at the level of post-delivery care. Every month, one of them would work in the PAC unit with the head midwife. She would review all aspects of treatment and counseling. The option of participating in this training was free. Nevertheless, in time there were fewer and fewer candidates, according to the chief physician of the maternity.

According to several providers, peer training produced positive results in that it provided a more numerous skilled staff, particularly for teams of the night staff. At most of the facilities visited, providers stated that the informal training given had increased the offering of PAC services and that 24/24 service could be given, thanks to this approach. “...we no longer see patients wandering around with referral slips looking for service,” said a provider in Burkina Faso. This opinion was confirmed at the CHU Yalgado by a PAC service provider who stressed the fact that there were no longer “...cases waiting for MVA because all women who come are treated by staff on site. It is not like before; waiting time is shorter for the patients.”

In Senegal, however, this type of training does not seem to have had the expected results. In several facilities, workers who were coached by their peers felt that their training had been truncated. For this reason, they often refuse to participate in care of women admitted for complications of incomplete abortion, and prefer to call on the services of a colleague who has been fully trained.

The problems posed by the lack of motivation noted in some locations in Senegal and Burkina Faso are exacerbated by inadequate facilities. PAC units are sometimes reduced to only one room, which poses major problems for teaching—not to mention the problems posed by the lack of teaching materials. This situation often reduces non-formal training to the practice of MVA, even if other components are mentioned, though only orally. It is therefore urgent that state cooperating institutions pay closer attention to this type of training, which would enable them to evaluate and suggest improvements that would ensure greater results.

One of the actions recommended to make in-service training more effective is summed up by WHO in the term “Accompaniment.” One respondent said, this word implies a scenario for training staff in service at the national level, accompanied by all elements necessary for complete functioning of services. The whole scenario is accomplished according to a carefully mastered plan. For human resource capacity development, training a core of national trainers is the first step. Training teams of regional trainers is the second step. Thus, in the end, national level trainers will play the role of trainers and supervisors of regional trainers. Central level authorities would therefore establish a system for the regions and districts launching PAC strategies. This action, said the respondent, would bring about tangible results more rapidly.

## Pre-service Training

Ministry leaders and directors of support programs working to make a large number of staff members competent in PAC have encountered difficulties. These difficulties have led these players to think and act with the aim of integrating PAC into the curricula of institutions for training health care workers specializing in ob/gyn.

This question has been raised for some time, particularly at the Francophone African Conference on PAC in 2002. At that time, many players had stressed the urgency of seeing health care providers acquire—during their medical school training—the skills needed to practice PAC. Heads of these institutions, however, had reminded everyone of the steps necessary to attain this objective. According to an analytical report of this meeting, the following remarks were made concerning introduction of PAC into the curricula of pre-service training institutions. "*Given that this process of reinforcement requires time, in-service training is used to develop provider skills, improve performance and develop clinical training sites. As the students leave these basic training institutions and are added to the national pool of providers, the need for in-service training will decrease.*" This report then emphasized the gains in effectiveness that could come about by combining in-service training with pre-service training.

The success achieved in applying the 2002 Conference recommendations varied by country. For training health care providers, with the exception of the university hospitals, which had already begun training ob/gyn specialists and interns in PAC practice, in Burkina Faso, Senegal, Guinea and Niger, the medical schools as well as midwifery schools had not achieved the same level of advancement in integrating PAC into their training curricula from one country to another. Though student midwives and nurses at the National School of Public Health (ENSP) in Burkina benefit from a PAC module, it is not the same in Senegal, Guinea, Mali, Niger and Togo where this project is more or less advanced. Some countries intended to launch the new PAC model beginning with the 2007-2008 academic year. It should be noted that in fact, PAC was taught in the midwifery training schools and for students specializing in gynecology—but not in its present form. Only digital curettage and D&C were taught. Infection prevention and counseling were not included in the instruction. Furthermore, these institutions did not yet have trainers in their midst. They called on the trainers from the university hospitals.

Nevertheless enthusiasm shown by department heads at the Burkina Faso National School of Public Health (ENSP) for the quality of instruction in PAC, was not always shared by some trainers based at the CHU. The latter brought out two important problems. The first related to the quality of clinical training which, in their view, was not satisfactory, given the large number of students and the limited capacity of the clinical training facilities. This caused many students to pass PAC without having practiced PAC services. The second problem is related to the evaluation system. There is, in fact, no evaluation that applies specifically to PAC. Evaluations deal with gynecology and obstetrics, and it can happen that not a single question is related to PAC. As for the medical schools, the integration process seemed even longer and never really advanced in the countries.

It is to solve this problem completely and definitively that the West Africa Health Organization (WAHO) initiated action with the university authorities of the sub-region to harmonize the

curricula in Emergency Obstetric and Neonatal Care and introduce them in the curricula of medical, midwifery and nursing schools.

## **SUPPLY OF EQUIPMENT AND MATERIALS FOR MVA**

### **Supply Mechanism**

According to all the directors and service providers interviewed, supply of MVA kits is a constant problem in efforts to generalize PAC and make it sustainable. Indeed, until the present time, most of the MVA syringes are provided by partner institutions of the countries. Usually, the first supplies are given as part of the activities to train providers. After each workshop, an MVA kit, including a complete syringe and cannulae of various sizes, is given to each provider trained. Institutions have benefitted from this initial contribution to launch their PAC activities and continued to offer services with the same materials. Some countries have thus been able to offer PAC for several years in facilities where the program was put in place. This was the case in Burkina Faso, Senegal and Guinea. It should, however, be noted that in Mali it is the Ministry of Health that bought the first orders of MVA syringes and gave them to facilities whose personnel had been trained. According to a PAC trainer, the director of a health care institution: “...*it is the national authority that bought on order. They paid for quite a large stock because, as far as I know, they even have the equipment in stock that is needed in the regions.*” This was, according to the respondent, while waiting for health care institutions and local groups to pick up the burden.

The problem of MVA kit supply arose with the first requests for renewal. During the first years of the introduction of PAC in Francophone Africa, problems occurred because the first supply of syringes quickly wore out (only 100 aspirations can be performed with one syringe), while the partner organizations had not foreseen the need to supply MVA equipment after the training. And, the countries had not yet included the idea of putting systems in place to supply PAC products. In addition, the main concern of government leaders was to avoid any risk of failure of the supply system. They therefore always expressed the hope to have control of the whole chain of ordering and distribution of this material, a matter considered very sensitive. However, solutions were slow to become concrete.

Confronted with this situation which was about to come to an impasse, various stakeholders made provisional decisions to ensure supply of the institutions from which requests for care kept increasing. Approaches used differed by country and by institution. In some countries, such as Senegal, for example, supply was centralized whereas in others, it was more or less left open to the interpretation of the heads of health care institutions. In the general view of people interviewed, none of the countries yet had a sufficiently authentic system of supply for MVA materials, which showed, among other criteria, the need for introduction of norms and standards for the types of MVA syringes that should be used. In any case, partner organizations have had to continue to furnish materials and, at the present time, they are furnishing most of the equipment.

The lack of an effective and sustainable supply system inevitably causes more or less extended interruptions of services and favors a multiplicity of sources of supply—and results in a great diversity of MVA materials. In Burkina Faso, for example, the supply system has not yet been

standardized. Sources of MVA kits are not all the same; it depends on the partner organizations. Organizations such as WHO and UNFPA get their supplies from abroad, from their respective headquarters, whereas the NGO FCI gets its supplies from Ipas, which has placed a representative in the country. WHO launched its MVA kit supply initiative in 2006. It relies on strengthening its program to provide emergency obstetrical care kits, conducted with the European Union in nine of the country's 13 regions. It also has its own provider. On their part, health care facilities try to obtain supplies from another local source. This is the case with the CMA of Sector 30 in Ouagadougou, whose chief physician once obtained supplies from GEFCOM, a supplier of medical equipment in the capital.

In Niger, since the introduction of PAC, the country has greatly benefitted from substantial FCI support to provide MVA equipment. Requests to FCI were made by the Issaka Gazobi Maternity. In its intervention areas, FCI sends the syringes directly to the facility. The equipment is bought from Ipas from its headquarters in New York. In addition to this institution, UNFPA provides considerable support for MVA equipment in two regions.

Given the difficulties of obtaining supplies faced by the facilities, border countries are looking for solutions. Meanwhile, members of the staff take opportunities to move about the countries of the sub-region to purchase a few kits and are reimbursed by the central administration of their facility.

The diversity of supply sources has brought about many differences among the products. For this reason there are often problems related to lack of understanding of proper use of the equipment. Such problems significantly reduce the useful life of the syringes. Furthermore, some of the products do not fit economic conditions of the health care system of African countries. For instance, CHU Yalgado once received single-use MVA syringes, according to one of the directors of this institution's maternity hospital.

To halt the problems, one of the respondents suggested centralizing orders at the National Pharmacy to ensure uniform products and a sustainable supply system under the supervision of the Ministry of Health. The ministry would then be expected to carry out regular supervisory visits to maintain an acceptable level of service quality.

In Niger, FCI ensures resupply for a certain number of years after PAC activities have begun. Some providers, however, think that support to their institution is dwindling to such an extent that the syringe used at the time of the interview at the PAC unit of Maternité Issaka Gazobi had been bought by one of the midwives when she was passing through Dakar. She was later reimbursed by the facility. For the moment, the solution planned is to send someone to buy MVA kits in one of the neighboring countries.

In countries that are trying to centralize the MVA equipment supply system, the ministerial system is assigned the MVA program that gathers requests from health care facilities. It sends requests to the partners and organizes the redistribution of equipment obtained. In some countries, the ministry has a budget for purchasing medical supplies, in which they can include MVA kits. Nevertheless, the fact that the requests are sent to various partners that purchase the products from their own providers

and deliver them to the ministry poses the same problem of multiple sources and diversity of types of syringes and cannulae.

In Senegal, the Roi Baudouin Health Center has been buying and stocking MVA kits since June 2006. This has been a special arrangement, initiated because of the lack of a formal system. It was facilitated by the choice of this institution by Ipas and the presence of a PAC promoter, the chief physician, who is a PAC trainer. Nevertheless, this system has raised some misunderstandings and negative reactions from other health care center directors. They believe that the Roi Baudouin Health Center, having the monopoly of supply and sale of MVA equipment, generates income for itself.

Furthermore, the present MVA equipment ordering process is awkward and requires several steps: one has to have the authorization signed by the Ministry of Health and settle the payment before going to the Roi Baudouin Health Center to get the supplies. Program directors and administrators of the other health care centers think there should be greater transparency in the MVA equipment supply process. Specifically, they know very little about the origin and identity of the MVA equipment supplier and the wholesale price. Currently the price of an MVA kit varies from 25,000 to 28,000 FCFA (about \$50 to \$55), after checking with the supplier. Communication among the various stakeholders seems to be needed to dissipate misunderstandings that appear to be hampering the system.

Assistance for supply provided by the partners cannot be sustainable and cannot continue to support the ministries endlessly. According to a respondent in Burkina Faso, “... *given that we don't have even 50% autonomy, I don't think sustainability is guaranteed.*” Another respondent said that PAC materials should therefore be integrated with procurement plan for RH products.

## **Solutions that Work**

Solutions have been implemented to ensure the supply of PAC kits but they apply chiefly to peripheral facilities. Some of these centers have developed mechanisms for cost recovery and sharing resources that enable them to replenish their MVA equipment. These are the Sector 30 Medical Centers with surgical facilities (CMA) in Ouagadougou, the Roi Baudouin Health Center in Dakar and the Community Medical Center La Minière in Conakry. At the Sector 30 center, the chief physician of the maternity gets his own supplies from a private source. Having himself created the PAC unit in the facility, he guaranteed a first supply at the time of the SAGO Congress in Bamako (January 2003). Subsequently, a local supplier specializing in medical equipment named GEFCOM, enabled him to endow the PAC unit with MVA kits. This source of supply is not known to all the providers interviewed at this level; one of the midwives knows only that it is done by the chief physician, who buys from a private supplier. At Roi Baudouin Health Center in Dakar, the Health Care Committee provides financial resources and manages the stock of products with help of the manager. Supply is handled directly with Ipas. Other health care centers throughout Senegal obtain supplies through the Roi Baudouin Health Center, thanks to resources generated by their activities. Finally, La Minière Community Medical Center in Conakry has put a cost-recovery mechanism in place. It also ensures procurement of supplies by devoting 35% of its monthly receipts to the purchase of medications and treatment materials, including MVA kits.

## Planned Solutions

Faced with increasingly heavy demand from facilities offering PAC but also with the challenge to all of the countries to spread PAC practice throughout the whole territory, ministry directors are in the process of thinking of effective and sustainable solutions. Most respondents think as does the following program director: “...*I believe that we must manage to integrate these costs in our purchases, such as, for instance medications that we buy on the national budget... and that actually the partners are not an factor in the implementation of these programs, but only the backers.*” (a director of the DSR, Burkina Faso)

This effort is sometimes accompanied and supported by partner organizations, but not always. The work done by FCI in Niger is an example of action that provides advice and motivation to lead the ministries of health and institutions to develop a supply system that can ensure them some autonomy. As mentioned above, FCI has supported the PAC policy in Niger for several years. It has been trying for some time to urge the Niger RH administration, particularly the maternities, to develop initiatives that help to make them autonomous. It goes about this effort by sensitization and by advising ways and means for attaining autonomy in this area, accompanied by reducing the number of orders for routine supplies. Over time these orders will cease. Elsewhere, in a partner institution based in Burkina Faso, the solution seems to lie in the pursuit of support for routine supply even though there has been an expression of the need to organize a sustainable system. The RH program director said: “*Theoretically the purchase of MVA kits is linked to our programs but I don't see how we can stop as long as we are in Burkina and as long as abortions are performed.*”

In Guinea, MVA equipment is now listed with essential supplies because PAC services are part of the minimum activity package, having been integrated as an element of basic emergency obstetrical care. “*It was therefore introduced in the plan for RH product security at the national pharmacy and laboratory directorate level.*” (a university trainer, Guinea). This decision has not yet been carried out, according to one of the respondents.

In the other countries PAC equipment is not currently on the national supply system list of equipment and logistic supplies. Discussions are going on in Senegal among the various units within the Ministry of Health (DSR, National Pharmaceutical Supply – PNA) and partners in development with a view to including PAC equipment in the list of essential drugs. The PNA would take charge of stocking supplies and supplying them to the regions and districts as needed.

## PAC SERVICES OFFERED

In the framework of this study, several types of facilities were visited: hospitals, health care centers, national referral centers, peripheral facilities with a client load equivalent to that of a health care center, and health care posts. Analyses of services offered in these facilities apply only to maternities and related units such as FP centers. In each facility, the research teams visited the PAC units and FP clinics, if they were separate from the PAC units.

## Organization and Continuity of Services

All the facilities visited university hospitals, CMA (medical centers with surgical facilities), regional hospitals, health care posts and health care centers) particularly in Burkina, Guinea, Mali and Togo, provide PAC service continuously. PAC units are open Monday through Friday. After working hours the night teams have in certain facilities at least one member trained in PAC to ensure continuous service, as in the Maternité Issaka Gazobi in Niamey.

For instance, Maternité Issaka Gazobi is open from Monday to Thursday from 8:00 am to 4:30 pm and Friday from 8:00 am to 1:00 pm because of the Muslim hours of prayer which are observed by the majority in the country. It sometimes occurs, however, that providers work until 6:00 pm, according to the wealth of the clients. Outside of the working hours of the PAC ward, patients are treated in the labor and delivery room. In these circumstances, incomplete abortion complications are often treated using other procedures such as D&C or digital curettage by the night staff.

In Senegal, the research team found out that night-time PAC services are not always available in some health facilities, where the patients are treated by digital curettage or sent away till the next day for PAC by MVA.

In Mali, according to a health care provider, patients received by the night shift are sent to other facilities: “*Outside of the regular schedule the patient must be evacuated at the referral facility in Bamako.*” (Malian provider). This is due to the absence of trained providers on the night team.

In the facilities visited in Guinea, arrangements have been made so that care is offered at any time. But some respondents think that the equipment is not available 24 hours a day at the Health Center Minière because not all the members of the night team have been trained. “*The room is closed after regular hours. If PAC patients are not bleeding heavily, they have to wait until the next morning to be treated.*”(Guinean provider)

Another reason related to unavailability of MVA equipment during the night is that it is sometimes locked up and only the PAC director has access to it. Some providers justify this situation, saying that guarding the equipment is a precaution to keep it from being used for other purposes.<sup>8</sup> In a Bamako referral facility, the following solution is used to ensure continuous PAC services, while protecting the security of use of the equipment: “. . . *at present in the gynecology department and at the same time our service, the equipment is taken to the operating suite for MVA to keep it from becoming something very secret when someone comes to open the gynecology room, just because it is very far away. The equipment must be opened by the night team in full sight of everyone [and] recorded.*”(a director of the Bamako maternity). In Togo, at an outlying center, the MVA equipment has deteriorated and has become unusable. The PAC team has been dispersed and service provision has been interrupted for several months.

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<sup>8</sup> The team did not attempt to find out whether or not the use of PAC equipment for other purposes was a reality or not.

Unavailability of PAC equipment during night hours revives the practice of digital curettage and D&C, which are often not accompanied by counseling and which sometimes cause the patients pain.

The staff emphasized problems that have an important effect on the patients. In these situations, the number of syringes (usually not more than two per facility) and the time needed to disinfect or sterilize them often force the staff to use other methods of uterine evacuation. *“Sometimes when the case load is very heavy, some providers are obliged to use other uterine evacuation methods because of the urgency of the situation, and they have to wait until the equipment is in usable condition.”* (according to a Burkina service provider).

### **PAC Services Offered**

At the 2002 PAC Conference a five-component model was introduced to replace one with three components, which was in force at the time of the first experiments. The five essential components are:

- Treatment of incomplete abortion
- Counseling
- Offer of contraceptives and FP services
- Links to other services
- Partnership with the community

Analysis of the PAC services offered will be conducted according to these five components.

### **Treatment of Incomplete Abortion**

Most abortion complications presenting in the facilities visited were treated with MVA. This equipment and its packaging made it much easier to treat patients. MVA made it possible to involve midwives and sometimes nurses fully and give them responsibility for handling emergencies. Because this category of personnel was more numerous in the health centers, it was possible to shorten the time between admission and actual treatment. In all the institutions we visited, autonomy of the areas reserved for PAC gave patients direct access to care and avoided competition with other types of gynecological or obstetrical complications that are often considered priorities.

Nevertheless, in some facilities, there is still no space reserved for PAC because of logistic constraints which still exist. This is the case in a health care facility in Bamako where the treatment of abortion complications is performed in the operating room, when it is available, or in the emergency treatment room of the maternity. A situation like this poses a problem of efficient management of the equipment and continuity in the full package of model PAC services. The pace of use of an operating theater does not give enough time to conduct good pre-, per- and especially post-MVA counseling.

The emergency room varies in size and generally has several beds. It does not provide the confidentiality necessary to handle questions about abortion.

This situation is found in all facilities visited, particularly night facilities when the PAC unit is closed. In these cases abortion complications are treated in the labor and delivery room or the surgical suite. All of the providers interviewed seem to find this solution acceptable—but the question is whether this solution contributes effectively to the quality of PAC. There is also the question of why the PAC room is not accessible during after-work hours in that it usually has all the necessary elements both for treatment and FP counseling.

## **Counseling**

Counseling is the component that intervenes at every step of care for complications of incomplete abortions. From the moment of receiving the patient to final referral, as she passes through treatment and the offer of contraceptive methods, the PAC model calls for continuing dialog between the provider and the patient. This dialog is important in order to give the patient confidence and an understanding of her problems and needs and to inform her of ways of handling certain situations. The word "dialog" implies oral exchanges between the patient and the provider, specific to each step of treatment.

On the whole, providers state that they counsel patients. But it turns out that there are no true exchanges, especially at the moment of treatment. They usually amount rather to directions given by the staff or questions requiring a yes or no type of answer.

The only time one can really think that counseling exists is when the staff tackles the question of contraception. Providers interviewed for this study spoke about counseling, but with emphasis on the offer of FP services. Most providers spoke at length of their conviction of the importance of counseling after PAC and use of contraceptive methods after an abortion. It is usually at the “return visit,” a week after emergency treatment, that the effectiveness of counseling is checked. Nevertheless it was noted that, contrary to FP counseling after treatment, counseling before and during emergency treatment is not systematic. The research team found the PAC rooms visited had FP counseling materials but that they were always left in facility and not accessible to night-time teams.

## **Contraceptive and Family Planning Services Offered**

In some health care facilities the method is offered immediately whereas in others the patients are referred to the FP unit after counseling. This unit may be located in the facility or outside of it.

The facilities visited in the six countries have a supply of contraceptives in the FP unit, with occasional lack of Norplant and IUDs. It should, however, be noted that these contraceptives are not usually available in emergency treatment rooms or in recovery rooms for women who have had PAC, with the exception of Guinea where the team found in the emergency room of the two facilities visited all contraceptive methods except implants and the female condom.

In Senegal, oral contraceptives were available in the PAC recovery room only in one health care center. In this country, reasons given for the non-availability of products were related to a problem of management of RH products. Contraceptives were included on the list of essential drugs and managed by their health committees at the depository for pharmaceutical products.

In Mali, only oral contraceptives were available in the PAC units. If patients wanted to use other methods, they were referred to the FP unit, which at times was located outside the facility.

Thus, after counseling, a woman who chooses a specific method is often sent to the FP unit (which is open only during work hours) where she receives a prescription that she must take to the pharmacy to be able to buy her contraceptive method. No data are available as to women who have followed this path.

This result of the situation, observed in Mali, Burkina, Senegal and Niger is that some women can go home after treatment without the benefit of a contraceptive method. In Niger, however, patients to whom a method is offered in the PAC unit of Maternité Issaka Gazobi, are followed up by the same staff members to ensure continuity of their contraception.

### **Links to Other Services**

The relationship between various RH services has, in our time, become a way of bringing about integration of services. This goal of this strategy, among others, is to take advantage of the presence of patients in the facilities to put at their disposal several of the services they might need. For this, PAC, by definition, contributes to the success of this strategy by integrating the offer of contraceptive methods to patients and by organizing continuation of the practice by referral to the FP units or centers that are most accessible. However, the practice of referring patients—who have been given a contraceptive method during abortion treatment—to FP facilities to ensure continuity of contraception has not been well documented. For this reason, it is difficult to draw any conclusions on its effectiveness, all the more so because at all the sites visited, the PAC unit is far away from the FP unit and mainly because there is no formal connection between these two entities. Information usually comes usually from an individual initiative and its completeness is not guaranteed.

The research team has noticed that another aspect of the relationship with other services is becoming more concrete in Guinea and Niger, where patients older than 24 are systematically referred to an outside facility to be screened for cervical cancer. The effectiveness of the referral is checked at the time of the follow-up visit a week after treatment.

This initiative did not seem to be systematized in the facilities visited at the time of the survey.

There is good reason, however, to optimize referral for cervical cancer screening given that the incidence of this disease is fairly rare worldwide (23 per 100,000 women). The idea would be to profit from the moment when providers are giving paracervical anesthesia to perform visual inspection with lugol or acetic acid (IVA). This would enable the provider to do a first triage at less cost and thus to refer only suspected cases. Cervical cancer detection is already performed by

midwives. Introduction of this activity should not add to the providers' heavy workload or significantly prolong treatment time.

In Burkina Faso, the most sought-after services for referral are gynecology, sexually transmitted infection (STI) services and cervical cancer screening, and to a lesser degree, urological and mental health services, but counseling for youth is equally desired at adolescent centers.

Habitually other services often solicited are cardiology and internal medicine for treatment of diabetics or persons living with HIV.

Data show that the referral/counter-referral system should be improved and strengthened. Information about to the place where the patient has been referred and her new status is not always available.

It should be noted that in none of the countries did the study show a link between abortion and the battle against malaria, knowing all the while that this disease is one of the main causes of spontaneous abortion. This link could be strengthened by supporting screening for the parasite, curative treatment if necessary and prevention by providing treated mosquito nets.

Respondents said that conditions for evacuation of a patient differ according to what the resources are at the CHU level (where it is just a matter of referral to the appropriate service, depending on the case), the health care center level, the health care post or the CMA. The team saw no specific logbooks for evacuation or referral of PAC patients, either in Niger, Mali, Burkina, Guinea or Senegal. When records exist, they are merely referral slips or linkage forms, depending on the country.

## **PAC AND THE COMMUNITY**

### **Partnership with the Community**

The introduction of this component actually brought about changes in the logic that supports the model for treatment of abortion complications. The three-part model was mostly centered on the patient within the facility. Logically, treatment should start with emergency treatment and finish with the offer of contraceptive methods and counseling about what to do in case of need, all occurring within health care centers.

Partnership with the community launches treatment in the patient's immediate surroundings. In this context, members of the community ought to be able to detect the signs of an abortion in progress, take the first emergency measures and organize referral to the most appropriate facility. Several studies or experiments conducted in Africa and elsewhere have shown the viability and relevance of such an approach. The analytical report from the 2002 PAC Conference proposed a partnership model with communities as seen in the following textbox.

## Text Box 2: Principal methods of community involvement in the management of pregnancy complications and PAC

- Identify a community representative.
- Give the community information about the advantages of using services.
- Train traditional birth attendants (matrones) and other community or village health care agents.
- Increase community knowledge of danger signs through the traditional birth attendants and other health care agents.
- Establish an emergency transportation system that includes: an evacuation plan, a fund for emergency payments, a means of transportation, a means of evacuation, a system for monitoring women who have been evacuated.

Nevertheless, with the exception of a few organizations such as FCI in Burkina Faso and Niger, few actors really integrate this component in their program. Furthermore, the steps to introduce PAC in these countries remain unchanged, with provision of materials to national level institutions and then to regional and district referral facilities reaching the primary level and ending at the community level. In this way more than ten years after the introduction of PAC in Francophone Africa, few countries have been able to cover all the steps, and consequently little has been done to encourage people to regard abortion as a public health problem that must be addressed with all necessary resources.

In general, relations of the facilities with the communities are limited to providing the communities with information and raising their awareness of the opportunity to be treated by a new method, which is less painful and less risky than the ones they know. Little or no educational efforts are conducted in these communities.

FCI action in Burkina Faso and Niger can be summarized with the following three major steps:

- At the beginning, first level workers of the health care pyramid were trained to master the basic steps: *"... skills were given to first level providers that enabled them to identify [and] diagnose complications that could be linked to problems of abortion and refer them if necessary. The same was true of other aspects that can make it possible to stabilize and refer a woman who arrives with an abortion problem "*;
- Next, they were taught community relations. *"They also learned about links with the community to be established so that, in one way or another, people are made aware of them and are able to make arrangements, either at the community level or at the patient transfer level to facilitate access to care."* To do this, teaching materials were adapted to the target. There were pictographs and flipcharts that had been tested in other countries, and their contents adapted to the local setting;
- And finally, *"... we have put in place, as elements of care, MVA, which was the real innovation in the treatment of women with obstetrical problems."*

Application of this five-component model, however, requires several preliminary conditions. One of the most important is to put in place a national policy that defines and codifies working rules for facilities at every level of the health care pyramid, including the horizontal and vertical relationships among them. Furthermore, this policy must define clearly the role of communities and stress ways of

implementing them and helping to organize accordingly. These measures should be accompanied by a legal and legislative framework putting instruments in place that guarantee access to quality services by means of fair and effective resources (human, material and financial). Previous problems that have arisen show the scope of efforts to achieve PAC services with attention to all their aspects.

In all the countries visited, medical aspects were put ahead of all the others, forgetting the regulatory framework that must define the role of different actors, as well as the means and resources which are intended to allow their implementation. Finally, because of gaps, PAC services remain the responsibility of donors and are limited to offering a few services in health care facilities. This was how a maternity clinic director in Bamako summarized the situation: *“The model taught is normally a five-component model, but the one that is most often used in the field is the three-component model. Often it is objective constraints of the setting that impose it.”*

### **Volume of Activity**

In a general way, the level of assessment of the volume of activity in the targeted countries differs according to the facility, the number of providers involved and the amount of their responsibility in the PAC unit.

It was not possible to see statistics in all the facilities, but the logbooks examined made it seem as if essential PAC services were provided by trained midwives. In these countries, physicians' participation in the treatment of abortion cases is often linked to complicated cases.

According to the data available, the number of cases varies according to the type of facility. In Burkina Faso, at the CHU Yalgado, the chief midwife of the PAC unit and her colleague in March 2007 treated 40 and 37 women, respectively, for PAC. During the first quarter of the same year, the number of clients ranged between 98 and 110 women. Their daily presence in the PAC unit during working hours explains the large number of women treated for complications of an incomplete abortion. These results are not comparable to those of the physicians interviewed in the same facility. Their involvement in treating abortion cases is often subject to their long hours on duty or to complications not managed by the midwives. The number of cases they manage does not exceed 15 per month, including those treated by doctors in private facilities.

In the CMA of Sector 30, the situation is different. Only midwives responded to this question. The head of the PAC unit remembers having treated eight cases during March and only 16 during the first quarter of 2007, taking into account her absence of one month for vacation. Her colleague and assistant received and treated 30 women for complications of incomplete abortion during the month of March and 67 during the quarter.

All the cases received by providers interviewed are correctly accounted for by these respondents with the exception of five, according to one of the CHU midwives. The reason for this deficiency is the degree of complication of these cases linked to the voluntary interruption of pregnancy by having taken abortive products not indicated, for which they had to be referred for better treatment.

**Senegal Case Study:** The following table shows the number of cases at seven centers and two hospitals from January to June 2006.

**Table 3: Statistics of PAC activities in three types of health care facilities in Senegal, January to June 2006**

	Health Care Center I (Number = 5)	Health Care Center II (Number = 2)	Hospital (Number = 2)
Number of deliveries	2944	1077	662
Number of PAC patients	292 (range 6–100)	213 (range 70– 94)	191
Number of patients treated by MVA	206 (71%)	147 (69%)	98 (51%)
Patients treated by digital curettage	67 (23%)	59 (28%)	60 (28%)
Patients treated by D&C	0	7 (3%)	25 (12%)
Patients referred	81	69	0
Patients given FP counseling in PF	285 (95%)	185 (87%)	165 (86%)
Patients who received a FP method	173	48	85
Percentage having received a method	59%	29%	45%
Percentage of patients counseled	61%	34%	52%

**NB:** Health care centers provide primary health care, obstetrical services and other RH services. They also provide short-term in-patient care. There are two types, according to whether or not they have surgical facilities. Type II (CS II) has an operating room and Type I does not. The staff is composed of gynecologists, general practitioners, a surgeon and an anesthetist in health care centers with an operating room, midwives, traditional birth attendants, nurses and assistant nurses (aides infirmières).

**In Guinea,** at the university hospital, the head physician of the PAC unit had not received a case during the month before the visit of the investigators. This is due to the fact that the director of the unit is much more involved in PAC training in the framework of expansion. He does, however, acknowledge having received five cases during the last quarter. On the other hand, the assistant director for PAC states that he has treated at least three cases, without specifying the quarter, whereas the general supervisor of the maternity estimates that about ten were received, making a total of about 30 cases. One provider acknowledges not having treated any cases over the last month, and does not remember the number of treatments conducted during the past quarter.

At the Centre de la Minière, only two providers gave answers. Each of them stated that they had received three cases each during the month preceding the investigators' visit and seven or eight cases during the past quarter. The other providers don't know or do not provide complete PAC services (according to the head of the FP unit).

Cases of complications linked to incomplete abortion were all treated by the providers interviewed, with the exception of a woman at the university hospital who presented with a case of peritonitis or

pelviperitonitis and should be listed under the cases of the reception service, according to the provider.

In **Niger**, Maternité Issaka Gazobi received and treated 90 cases of abortion in May 2007, either in the PAC room or the labor and delivery room. The director of the PAC room treated a third of the cases. The others were treated by the other PAC midwife and by night teams in the labor and delivery room.

In **Mali**, at the University Hospital Gabriel Touré and at the Commune 5 Health Care Center, during the month preceding the survey, physicians and midwives personally treated from two to ten patients (i.e., an average of four patients per provider). During the last three months, four providers performed an average of six PAC treatments each. One provider supervised those who were learning and another had no PAC service cases. It should be noted that, in general, at both sites, the midwives performed more cases than the physicians.

### Cost of Services

The following table describes costs in the countries visited.

**Table 4: Cost of PAC services in the six countries, by level of health care facilities**

Country	Cost of Services	Health Care Facility
<b>Guinea</b>	15,000 FG* treatment + 5,000 FG medications	CHU Donka
	10,000 FG treatment + products	CS La Minière
	Treatment gratis + products 6,000 FCFA	CHU Bamako
<b>Mali</b>	7,500 FCFA treatment + products : 6,000 – 7,000 FCFA	Community Health Care Center
<b>Togo</b>	7,550 FCFA treatment + 6,000 for medications	CHU Lomé
	15,000 FCFA treatment + medications, antibiotics not included	Hôpital Bé
<b>Burkina Faso</b>	14,000 FCFA treatment + products, medications	CHU Yalgado
	10,000 FCFA treatment + products	Regional hospitals
<b>Senegal</b>	7,500 FCFA treatment + products	Health care center

Costs of post-PAC prescription drugs are not included in the costs shown above.

\*7 FG (Guinean francs) = 1 FCFA at the time of the survey; \$1.00 = 440 FCFA

In FCFA countries, the cost of services varies from 6,000 to 15,000 FCFA (\$14 to \$34), without taking into account postnatal prescriptions and contraceptives. In one and the same country this diversity of charges within the same country ought to lead the authorities to initiate a harmonization policy, preferably a policy of lowering service costs, because in Guinea, PAC services cost no more than about 3,000 FCFA (\$7.00)

Opinions gathered from the community showed that for certain patients, costs are a barrier to the benefits of PAC services. These financial barriers were mentioned by both women and men during the group discussions.

*“The prices are too high; they should be reduced to help women”* (a woman in Burkina Faso)  
*“I would rather buy aspirin at the pharmacy or drink a lemonade or fruit juice . . . it’s less expensive. . . .”*  
(a woman in Senegal)

In addition to the cost of the service, women must often buy quite a number of products such as bleach, gloves and analgesics. If they want to begin using a contraceptive method, they must take into account the price of the product. Their expenses rise when they have to pay for transportation.

*“... we pay for a taxi: 1,000 FCFA during the day and 2,000 FCFA at night ... “...sometimes we sell part of our merchandise to pay for our wives’ transportation...”* (a man in Senegal)

Furthermore, participants pointed out that women sometimes consult traditional birth attendants (matrones) because they are short of money. The *matrones* charge about 1,000 or 2,000 FCFA for their services and, because they live in the community, there is no transportation problem.

*“...to reach the health care post takes five minutes; two hours to reach the hospital...”* (a woman in Senegal)

Costs of services and financial difficulties were also mentioned by health committee members. In some communities, these committees organize and participate in the costs, offering quite varied amounts of money. Some have set up strategies to mobilize funds (e.g., selling treated bed nets). Others save money for emergency transportation, if needed, especially for indigent patients.

*“...a solidarity fund is in place in the villages for emergency transportation of pregnant women...”* (a man in Senegal)

*“... religious leaders often collect funds for emergency transport of pregnant women...”* (a woman in Senegal)

On the whole, the respondents think the PAC costs are high for the community.

*“It’s a bit pricey; not everyone has the means to pay. There are women who can pay but there are others who really do not have the means; what should they do—stay at home and continue to bleed for lack of money?”* (Provider/Mali)

## **PAC AND HEALTH CARE POSTS: THE CASE OF SENEGAL**

Every community in Senegal has a health care post (case de santé), but the majority of these facilities are not functioning. The Ministry of Health and Medical Prevention (MSPM) are making an effort to establish minimum services in all these health care posts, which are the responsibility of the community and are financed by community funds. Two fairly accessible health care posts were

visited to evaluate their capacity to participate in PAC service provision. At these sites, the staff consists of seven *matrones*, three of whom have been trained in PAC. These traditional birth attendants are responsible for treating uncomplicated deliveries as well as providing immunization and other services for child survival. They do not offer FP counseling, even those who are supposed to have had minimum training in PAC. The team was not able to determine whether or not these birth attendants also work as traditional birth attendants in the community.

The two health care posts visited were comfortable and clean, had running water, good lighting, toilets in good condition and a place for deliveries in one of them. Basic equipment and infection prevention material (a two-valve speculum, forceps, sterile gloves, a sharps box, bleach) and analgesics are available—but FP methods, particularly condoms, are lacking. Thirty-eight women delivered at these two health care posts between January and June 2006 and one of them was referred. No patients with postabortion complications were registered, and no women had received FP counseling.

Most of the providers interviewed at health care centers and posts think there is potential to expand “targeted PAC activities” to the health care posts on the following subjects: community education on prevention of pregnancy, warning signs during pregnancy, identification of complications, rapid referral and help with transportation for emergency cases; follow-up of women who had been seen in health care centers, FP counseling and distribution of FP methods they had selected. No patient interviewed at these sites recommended that emergency treatment should be given there.

### **Patients’ Perception of the Quality of Services**

On the whole, most of the PAC patients (in Burkina, Mali, Guinea, Niger) are satisfied with the services they received. Various providers interviewed confirmed this opinion and listed the elements they particularly appreciated. They were pleased with the reduced waiting time due to MVA and, according to the providers, the patients found MVA less expensive, taking into account the package of services offered with MVA. Pain control is also an important point that patients raised. “*Ha, really, madame, I was so scared; I thought it would hurt, because the last time I had a curettage it really traumatized me*” (Malian patient)

Interaction with the provider through counseling throughout the procedure is much appreciated by patients who find MVA less traumatic. The degree of satisfaction of these patients is further seen in the return of some of them to the facility for any health problems they may have. “*Their satisfaction is even visible when compared with their anxiety when they arrive and their smile or thanks when they leave.*” (Guinean provider)

### **Community Opinion of Services Offered**

Nevertheless, barriers related to service quality were noted during focused group discussions. Some women remembered occasional incidents of disrespect, which led them to go to a traditional birth attendant rather than to a midwife in case of a problem.

*“...women usually prefer to find the traditional birth attendant at home because they are more experienced and they are kind...”* (woman in Senegal)

*“...some providers insult and mistreat unmarried women who come for PAC...”* (woman in Senegal)

*“...sometimes they are aggressive and insult us..., they should be more humane, welcoming and kind.”*  
(woman in Burkina)

### **Perception and Attitudes of Providers toward Women and Young Girls Who Have Voluntarily Interrupted a Pregnancy**

With a percentage of about 5% to 30 %, according to providers, voluntary interruption of pregnancy is not an inconsiderable matter in Burkina, Niger, Guinea and Mali in cases of incomplete abortion-related complications. This relatively high percentage is explained by the persistence of unprotected sex.

Adolescents are the victims of induced abortions, often at a young age (between the ages of 15 and 18) and with total ignorance of the consequences. These are often illiterate adolescents, but sometimes they are also students.

The profile of women who practice voluntary interruption of pregnancy shows that all categories are involved. With a few exceptions, one finds the same type of person in all the countries visited.

For the providers, treating of these cases is no different than treatment of spontaneous abortions (miscarriages). Counseling is given according to the person—an adolescent, an unmarried women, a widow or a married woman.

## CONCLUSION AND SUGGESTIONS

The 2002 Conference on Postabortion Care was a key moment in promoting the introduction of the PAC initiative in Francophone African countries. All topics related to PAC were addressed. Still, given that the participants were only at the beginning of the initiative, the big challenges were to identify ways and means to introduce PAC in the countries. For this purpose the following model had been proposed:<sup>9</sup>

- A local champion who would remain actively involved from the moment of decision to introduce the new service model until total adoption of the program by appropriate stakeholders
- Advocacy to explain the necessity, simplicity and advantages of PAC services
- Respect for clients' rights by officials, administrators, providers and others
- A vertical program from the beginning to show clearly the effects of the new service model
- A few initial sites to guarantee high quality, resulting from concentrated effort, and to facilitate supervision
- An intensive phase of introduction, perhaps an OR study or pilot project with an element of rigorous evaluation, adequately accompanied by technical assistance and external financial support
- Training by qualified and experienced trainers
- Intensive supervision and monitoring to guarantee that the providers continue to apply their new skills and identify potential barriers to success of the intervention
- Equipment and supplies needed to provide all services

Evidently, the main idea of this model was to pay special attention to advocacy and to creating a favorable impression of what the main players must contribute to PAC to make it acceptable to decision makers. Therefore, this model describes a process that Burkina Faso, Senegal and Guinea had already followed to introduce PAC in their countries.

Respondents to this evaluation remembered some of this model's proposals, for example, those relating to leadership given by champions, the role of advocacy and emphasis on the comparative advantages of the new PAC service package. In recounting the major events that characterized the fate of PAC introduction in their country, respondents often referred to the role of certain people. These were people whose commitment was credited with bringing actors and decision makers around to understanding and supporting the process that they now wanted to implement. Directors interviewed highlighted the role of OR that had been carried out in Burkina Faso and Senegal; they furnished key information on the advantages of the PAC model that facilitated decision-making, even in other countries.

It should, however, be noted that ten years after the introduction of PAC in Francophone Africa, the context has changed—now the PAC approach is accepted in most countries. For this reason, it now

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<sup>9</sup> Questions about postabortion care, expansion of services in Francophone Africa, analytical report on the regional Francophone conference on postabortion care. 82 p.

seems necessary, depending on the country, to curtail, or at least mitigate, some of the steps that formerly appeared unavoidable. Furthermore, sometimes private initiatives have forged ahead of the program's official establishment. This change of context has shown the importance of other essential components that are linked to expanding and sustaining PAC services (e.g., scale-up and/or decentralization, institutionalizing and strengthening human resource capacity, supervision, supply of materials and continuity of service provision).

## **SCALE-UP AND DECENTRALIZATION OF PAC**

In all the countries visited, the will to make PAC available throughout the area was expressed by all. In some countries, however, there was talk of taking PAC all the way to communities; in others, such as Mali, this was not yet on the agenda. Incidentally, decentralization or scale-up schemes were also different, certain countries having adopted a centralized approach at the national level, predicated on a single plan and spokesman for all the actors and partners. Others preferred a decentralized approach, calling on local groups to define and lead their own strategies. The latter seemed the most fruitful option in that it automatically made decentralized entities responsible for the defining and financing their strategies and actions, as opposed to the centralized approach, which continued to solicit the help of sponsors, either for supplies or for training providers.

Implementation of the decentralized approach would never succeed unless a clear legislative or legal framework, which authorizes the transfer of resources as well as administrative and financial skills, is first established.

## **INSTITUTIONALIZATION OF PAC**

All countries have developed or updated their document(s), Policies, Normes and Protocols (PNP) to include PAC. In some countries, this document included PAC even before the model was put in place. After the 2002 Conference, the PNP for PAC were established, or about to be established, based on five components. We must, however, note an inadequacy between the PNP and general documents that regulate the health care sector. This is the case especially in Senegal, where partnership with communities is covered in the PAC section and activities are supposed to be conducted and supervised by health care centers and their staff. The health care system in this country, however, does not count community health care centers among health care facilities. Therefore, theoretically it is the head nurse of the health care post who is supposed to supervise the activity of the centers, but these are not accounted for in the health information system. Therefore, in situations requiring it, the general texts of the health care system and the PNP must be harmonized so as to attain logical decentralization.

At many sites there is no real codified and institutionalized data collection system; the quality of the data depends chiefly on the willingness of one person, or several people. This is true even though the PAC data are systematically recorded and, most often, in standardized logbooks, sometimes with printed forms. The problem is partly the diversity of points of treatment for abortion complications, particularly those performed by nighttime teams. Because support for PAC is not available at these times, many postabortion activities are not recorded. The solution should be to make the PAC activity logbook available to the staff, paying close attention to the quality of the completion of the

forms. An excerpt of the information recorded in this aid could then be copied in the logbook at the point of service (labor and delivery room or operating suite).

## **TRAINING OF PROVIDERS**

In spite of the general recognition that strengthening human resource skills is important and one of the key aspects of PAC, in one of the countries in the study, a formal policy for this aspect of the program does not exist. As with all innovations, to respond to the need to scale up, most providers acquire skills with financial help from the partners. The viability of this approach, however, is not guaranteed because of the mobility of trained personnel, which requires “permanent starting over.” Two approaches have been identified to confront this problem. In the first, trained providers help their colleagues acquire the skills needed to treat abortion complications. Although this approach seems to have given interesting results in some countries, it has not functioned well in others, such as Senegal. Nevertheless, because of its important potential, pointed out by several people, this approach deserves to be documented and supported, if need be, by establishing a coaching mechanism and validating the services provided by trainees. This would make it possible to train both the daytime and night staff. The second approach would be to introduce PAC training modules in the curricula of medical schools and schools of nursing and midwifery. Different countries are at different more or less advanced stages of managing the respective projects. Partner institutions should give more support to the process by means of advocacy and logistics, particularly for developing skills at training course sites.

## **SUPERVISION**

The difficulty of establishing an effective and durable system of supervision for PAC was brought up by all respondents. Either it is the lack of skilled human resources or the non-exclusive character of supervisory visits that is the cause. In fact, the problem may have a structural origin, given that, on the one hand, clinical supervisory activities are also provided by the health care system among its regular activities, or by the programs that are supposed to support them, and are often assigned to the same team. It often happens that the objectives and methods of the program do not fit in with the availability and real possibilities of the supervisory teams. They are faced with many different programmatic requests. These excessive activities do not allow for in-depth supervision of any one aspect. This is contrary to the requirements of good formative supervision, such as is needed for PAC programs. Furthermore, the idea of formative supervision poses an even more difficult problem of human resources. In this context the supervisor must have the qualities of a trainer to be able to identify faulty performance and to correct it. This profile is not often found among members of regional and district teams assigned to supervise PAC activities. It would therefore be wiser for trainers to conduct formative supervision and for regional and district teams to conduct facilitative supervision, which seems to be more within their capacity. Mastery of this kind of supervision would require no more than one training session instead of a long and costly training series whose result cannot be guaranteed because of the mobility of staff.

## **SUPPLY OF PAC EQUIPMENT AND SUPPLIES**

The problem of supply of PAC materials, particularly MVA syringes, is very acute in the countries visited. These products are usually provided by partner organizations whose programs are not

sustainable. On the other hand, national health care systems have not yet succeeded in establishing effective and sustainable mechanisms for acquiring PAC materials, although many temporary systems have at times been tried. Currently, a solution that being studied, or that is on the point of being implemented, is putting MVA syringes on the list of essential materials. This is the case in Guinea.

Meanwhile, peripheral facilities (health care centers or their equivalent) have succeeded in establishing ways to ensure their supply of MVA kits with their own funds, thanks to cost-recovery systems. These successful examples should inspire facilities of the same type, given that their systems are fairly uncomplicated and that the maternities are usually in the first row when it comes to generating resources for these centers.

Hospitals, because of the large number of their services and their centralized management systems, require a sensitization and advocacy effort with their respective administrations, to lead them to regard PAC as a full-fledged component of their catalog of services—no longer as an external program.

## **ORGANIZATION OF CARE AND SERVICES OFFERED**

Although PAC is offered continuously at the sites visited, PAC units are usually accessible only on working days and during working hours. At other times patients are treated by on-call teams. There are differences in the quality of service offered because night-shift teams often have neither the time nor the equipment necessary for correct and complete care of abortion complications. To solve this human resource problem, facilities are organized so that there is always at least one provider trained in PAC on each team. In several facilities, the PAC area, where the MVA equipment is kept, is closed after normal service hours. For this reason, the night-shift teams do not have access to the equipment needed for treating and counseling, nor do they have access to contraceptive products. They therefore resort to D&C or digital curettage for uterine evacuation, and they are not able to provide counseling or to offer a contraceptive method.

At most sites, locking PAC units is explained by the fact that PAC sites are often located in places rather far-off from the labor and delivery room or from the surgical suite. They therefore are often isolated from the usual traffic of the night shift. In this situation it would not be easy to check coming and going and use of the equipment. From the psychological point of view, the “isolation” of the PAC unit can unconsciously make the staff feel as if it remains a separate program. One solution might be to place PAC units nearer to emergency obstetrical and neonatal care facilities (operating room and suite) so that access to MVA equipment and care for it—as well as access to counseling material, contraceptive products and material needed for data collection—could be managed in the context of a normal night shift. This solution does not exclude separation of the PAC unit from other services, given that it gives patients direct access to care and avoids their being in competition with other types of gynecological or obstetrical complications that are often considered priorities.

Moreover, costs of service remain high, no matter what type of treatment facility is involved, according to the providers and the patients. This is a paradox, in view of the fact that the PAC

service package, especially if MVA is included, is supposed to make PAC more accessible financially. It would be wise to revisit all procedures and patient circulation to identify the sources of superfluous expenditures.

## **COUNSELING**

The possibility for the night-shift teams to give FP counseling would be a notable advance for women in continuous access to quality services. Interaction between patients and providers before, during and after treatment still needs to be strengthened. To accomplish this, tools and specific guides for providers should be developed, reflecting the goals of FP counseling. In fact, this innovation introduced with PAC, should radiate throughout all medical and paramedical service provision.

## **HOW CONTRACEPTIVE METHODS ARE OFFERED**

All the facilities visited offer contraceptive methods. For women treated for abortion complications, however, in some health care facilities, the method is offered immediately, whereas in others, the patients are referred to the FP unit after counseling. This unit may be situated in the health care facility or elsewhere. In still other facilities (in Senegal), contraceptive products are purchased by the patients at their normal pharmaceutical outlet. This situation can be explained by the fact that contraceptive products are included on the list of essential medications. However, a study conducted in Kenya in 1996 and 1997 showed that offering a method immediately after uterine evacuation by the provider who treated the patient, provides the best guarantee of acceptance and use of contraception.<sup>10</sup> This, moreover, is the approach that was used during OR and which continues to be taught to the providers. It is therefore important to convince the directors of health care institutions to put contraceptive methods in the PAC units with an effective cost-recovery system. The range of methods should be as wide as possible, as they are in FP units.

## **LINKS WITH OTHER SERVICES**

Counseling, with the offer of a contraceptive method, is one of the strong points of PAC, because one of the major objectives of the program is to prevent unwanted pregnancies and repeat abortions as a means of FP. From this point of view, referral of women treated for an abortion complication to the FP units ought to be systematized. It would also be interesting to create close ties between PAC and other programs (e.g., those that fight against cervical cancer and malaria).

Cervical cancer is combated by prevention, by systematically detecting abnormal presentations when receiving postabortion treatment using visual inspection with acetic acid or lugol. Integration of PAC and cervical cancer screening services would make it possible to lighten the costs both for patients and for facilities responsible for a diagnostic confirmation.

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<sup>10</sup> *Solo J et al. 1998. "Détermination de la relation entre le traitement d'une interruption de grossesse incomplète et les services de planification familiale au Kenya: quelle est la meilleure approche?" (Determining the relationship between induced incomplete abortion and family planning services in Kenya: What is the best approach?) See also: "Amélioration des soins post abortum destinés aux patients des hôpitaux, résumés de RO." (Improvement of postabortion care for hospital patients: Summary of operational research) January 1998.*

Fighting malaria is a matter of prevention but also of treatment, because this disease is one of the chief causes of miscarriage. In practice, PAC program support for screening for the parasite, treatment if necessary and the offer of treated mosquito nets would combat malaria made more effectively.

## **PARTNERSHIP WITH COMMUNITIES**

Establishment of links between PAC and programs for maternal and infant health further legitimize the involvement of communities in improving access to care for these purposes. In addition to the fact that communities have, from now on, a role in recognizing signs of abortion [miscarriage] and organizing evacuations, it is clear that all health care activities based on (or including) prevention have the communities as their principal spokesperson. Too few actions have been initiated, however, by those responsible for PAC programs aimed at communities. Until now, only a few partner institutions have invested in this area, for which no country has as yet developed or implemented an action plan. The delicate nature of the question cannot be said to be unrelated to this lack of initiative. A solution would therefore be to establish multifaceted programs at the community level, including PAC. Joining with the program to combat malaria might be another point of entry.

Ten years after the introduction of PAC in Francophone Africa, the promoters of this strategy have crossed a number of bridges, which now are responsible for its current success. Nevertheless, several challenges continue to arise on its way to generalization and sustainability. Throughout this evaluation, the most important roadblocks have been identified. The chief motivation to succeed is the growing enthusiasm stimulated by the model among decision makers and the general population. The assessment also enabled us to identify the most promising paths for finding advantageous solutions. It is therefore proper to urge serious thought and to conduct appropriate actions to further the cause and achieve the task we have undertaken.

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# APPENDICES

## Directors of Programs and Institution Interviewed

### **Burkina Faso:**

- Mr. Lat Sémé Médina, Director of Studies of the National Institute of Public Health
- Dr. Charlemagne Ouédraogo, Chief Physician of the CMA Maternity of Sector 30, Ouagadougou
- Dr. Azara Bamba, Advisor to World Health Organization, Ouagadougou
- Dr. Sanou Dieynaba Ouédraogo, Directorate of Family Health, Ouagadougou
- Mme. Dieynaba Diallo, Coordinator, FCI, Burkina Faso
- Dr. Birahima Bassane, Project Director, Initiative for Qualified Care, FCI, District of Wargadj
- Prof. Blandine Thiéba, Assisitant Director of the Maternity at CHU Yalgado Ouédraogo, member of CRESAR and PAC point person in Burkina Faso
- Prof. Bibiane Koné, Former Chief of Service, CHU Yalgado Ouédraogo, former President of CRESAR, Burkina Faso
- Dr. Olga Sankara, Program Director, UNFPA Ouagadougou

### **Guinea:**

- Dr. Bademba Diallo, Director of Training, Ministry of Health, Guinea
- Dr. Bouba Touré, Program Director, EngenderHealth
- Dr. Gouma, Section Head, Division of Reproductive Health (DSR)
- Dr. Kouyaté, Chief Physician, Centre Médical Communal, Conakry
- Prof. Yolande Hydjazi, Professor at the Faculty of Medicine, Associate Chief of Gynecology Service, Hôpital Donka, Conakry. PAC Point person, Guinea

### **Mali:**

- Dr. Bineta Keïta, Director, Division of Reproductive Health
- Dr. Boubacar Traoré, PAC Focal Point
- Prof. Amadou Dolo, Head of Gynecology Service, Hôpital Gabriel Touré
- Prof. Mamadou Traoré, Chief Physician, Commune 5 Reference Center

### **Niger:**

- Mr. Ali Boukary, Administrator, FCI
- Dr. Madi Nayama, Chief Physician of the Issaka Gazoby Maternity, Niamey

## **Togo:**

- Prof. Koffi Akpadza, Professor at the Faculty of Medicine, Chief of Gynecology Service, Hôpital Tokoin de Lomé
- Dr. Ntapi Kassouta, Director of the Division of Reproductive Health

## **PROVIDERS INTERVIEWED**

### **Burkina Faso:**

- Dr. Thiémoko Ouattara, gynecologist at CHU Yalgado Ouédraogo
- Dr. Djibril Kabré, CHU Yalgado, Ouagadougou
- Dr. Issaka Kaboré, Gynecologist at CMA du Secteur 30, Ouagadougou
- Dr. Lidjo Sabine, Gynecologist at CMA du Secteur 30, Ouagadougou
- Chief Midwife, PAC Unit of CHU Yalgado
- Midwife at PAC Unit
- Chief Midwife, PAC Unit of CMA du Secteur 30, Ouagadougou
- Midwife at PAC Unit of CMA du Secteur 30, Ouagadougou

### **Mali CHU (University Hospital):**

- Dr. Abdourahmane Samaké, CHU Gabriel Touré
- Dr. Niani Mounkoro, CHU Gabriel Touré
- Mme Hawa Soumaré Diane, CHU Gabriel Touré
- Mme Fanta Fofana Traoré, CHU Gabriel Touré

### **Mali Peripheral Facilities:**

- Dr. Oumar Traoré, Referral Center, Commune 5
- Dr. Zoumana Traoré, Referral Center, Commune 5
- Mme Kadiata Doumbia Touré, Referral Center, Commune 5
- Mme Fatoumata Touré Maïga, Referral Center, Commune 5

### **Guinée CHU:**

- Dr. Hawa Condé, CHU Donka
- Dr. Ibrahima Sylla, CHU Donka
- Dr. Suzanne Austin CHU Donka
- Mme Salimatou Baldé, CHU Donka

### **Guinée Peripheral Facilities:**

- Dr. Mariama Kaba, Centre de Santé Municipal la Minière
- Dr. Nfamara Camara, Centre de Santé Municipal la Minière
- Mme. Christine Théa, Centre de Santé Municipal la Minière
- Mme. Mariama Binéta Diallo, Centre de Santé Municipal la Minière

### **Togo:**

- Prof. Koffi Akpadza, Gynecologist, Chief of maternity service, Hôpital Tokoin, Lomé
- Dr. Adama Hondegla

### **Niger:**

- Dr. Fatima Zahra Diallo, Associate Chief Physician, Maternité Issaka Gazoby, Niamey
- Mme. Ganda Balkissa, Midwife of PAC Unit, Maternité Issaka Gazobi, Niamey
- Mme. Nana Aïchatou Sani, Midwife of PAC Unit, Maternité Issaka Gazoby, Niamey
- Mme. Aïssa Issa
- Mme. Kadidja Coulibaly, Midwife of PAC Unit, Maternité Poudrière, Niamey