Improving private sector provision of post-abortion contraception in Kenya

Katy Footman, Marie Stopes International
Background

- 464,000 induced abortions in Kenya in 2012
  - 120,000 treated for complications from induced abortion
- Marie Stopes Kenya franchises >400 private clinics, expanding access to safe abortion services and post-abortion care
- Ensuring quality of services in private sector clinics is a challenge
- Post-abortion family planning counselling is inconsistent

<table>
<thead>
<tr>
<th>Clinic-level barriers</th>
<th>Provider-level barriers</th>
<th>Client-level barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of methods</td>
<td>• Lack of knowledge</td>
<td>• Fear of side effects</td>
</tr>
<tr>
<td>• Lack of trained staff</td>
<td>• Provider bias</td>
<td>• Partner disapproval</td>
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Evaluating the effect of a quality management intervention on post-abortion contraception

Aims:
1. to assess whether a quality management intervention increased post-abortion contraception counselling and uptake
2. to understand the drivers and barriers of contraceptive uptake for clients and providers

The intervention:

1) One-day **training** on post-abortion contraception
2) **Job aide** for step-by-step post-abortion contraceptive counselling
3) Monthly structured **supervision** visits

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**Checklist for procedures: Focus on PAFP**

**Pre-procedure**
1. Take client history
   - Ask about current use of family planning
2. Discuss CAC options
   - Ask about fertility intentions of client
3. Discuss contraception
   - Discuss previous experiences of family planning methods
4. Complete bimanual pelvic and speculum exams
   - Discuss client contraceptive preferences, convenience of use (e.g., whether repeat visits to clinic are required), and use effects (e.g., changes to bleeding)
5. Take pregnancy test, as indicated
   - Consider medical eligibility for PAFP options
6. Assess risk of STIs and treat syndromically, as indicated
   - Discuss PAFP options based on client’s preferences and medical eligibility
7. Confirm client eligibility and take informed consent
   - Check whether client has any questions
8. Fill in reproductive health client card
   - Informed consent form is signed if client wants to receive a family planning method

**Procedure**:
- Conduct surgical CAC, or administer medical CAC drugs according to MSK guidelines

**Post-procedure**
1. Disposal of waste
   - Provide or insert the client’s family planning method of choice
2. If surgical CAC, or medical CAC for <8 weeks, monitor and record vital signs, and administer analgesia and antibiotics appropriately
   - Inform the client about how to use the method, side effects (e.g., first-time clients can usually go away after a few months, and what to do in the case of complications and side effects
3. Provide or arrange PAFP based on client choice
   - Advise client to return as soon as possible if contraception is needed. If the client is unable to have a method inserted on the same day (e.g., if medical CAC client wants an IUD or tubal ligation)
4. If MAA for <9 weeks, give client mifepristone dose, verbal and written instructions on how to take misoprostol, pain killers, what to expect, and an emergency phone number
5. Ensure reproductive health client card is completely filled
6. Assess client for discharge and provide information
7. Document client visit in the CAC
Methods

**Design:** before and after study, no control group + qualitative component

**Timeline:** November 2015 - August 2016

**Setting:** 9 social franchise clinics, W Kenya

**Quantitative:**
- **Primary outcomes:** Contraceptive uptake (excluding condoms) on the day of abortion and 14 days post-abortion
- **Data collection:** In-person interviews on day of procedure + telephone follow up after 14 days
- **Sample size:** 883
- **Data analysis:** cross-tabulations with chi-square tests, multivariate logistic regression

**Qualitative:**
- **Semi-structured interviews:** 9 providers and 22 clients.

*Marie Stopes International*
Did the intervention improve provider behaviour?

– Limited increase in provision of information, but **quality of counselling** improved.

– Most aspects of satisfaction did not improve, except:
  – **provision of clear instructions** (69% vs 58%)
  – **taking enough time to understand client** (97% vs 93%).

– Mean number of methods counselled on increased from 2.9 to 3.3
  – Mix of methods counselled on did not change.

*Significant increase (p<0.05)
Did the intervention increase uptake?

<table>
<thead>
<tr>
<th></th>
<th>N (%)</th>
<th>aOR (95% CI)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Received same day contraception</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>77 (19.30)</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>Endline</td>
<td>113 (30.79)</td>
<td><strong>2.00</strong> (1.39- 2.86)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Received same day LARC</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>50 (12.59)</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>Endline</td>
<td>71 (19.45)</td>
<td><strong>1.82</strong> (1.19- 2.79)</td>
<td>0.006</td>
</tr>
<tr>
<td><strong>Received contraception 2-14 days post-abortion ‡</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>66 (33.85)</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>Endline</td>
<td>29 (23.39)</td>
<td><strong>0.57</strong> (0.32- 1.01)</td>
<td>0.053</td>
</tr>
</tbody>
</table>

Denominators: *All women  ‡ Followed up women who did not received same day PAFP. Adjusted for age group, education, occupation, marital status, number of children, fertility intentions, and use of family planning prior to the abortion.
Provider experience of the intervention

One-day orientation: considered useful - but providers want more regular training and updates.

The job aide was not commonly used or well-remembered.

Supervision visits

- Some felt their PAFP counselling and record keeping had improved as a result.
- “Well, they support us by encouraging us, where we have relaxed, they tell us not to relax.”
- Valued the advice from supervision visits.
Why did women not receive contraception?

- Barriers that are amenable to counselling were reduced at endline
- Women want to complete the abortion first
- Challenges returning to the facility for contraception
- Perceptions of risk
- Cost of family planning

![Bar chart showing reasons for not receiving contraception at baseline and endline.](chart)

- 11% did not receive any or enough information at baseline, compared to 4% at endline.
- 64% were undecided about contraception at baseline, compared to 52% at endline.
- 8% did not want the method at baseline, compared to 15% at endline.
- 1% was due to other reasons at baseline, compared to 3% at endline.
Conclusions

• Supervision and regular updates important for improving provider behaviour on contraceptive counselling.
• Performance management approaches can have lessons for other social franchise models and wider sector.
• Post-abortion contraceptive counselling must be sensitive to individual needs of clients.
• Follow up mechanisms to facilitate clients returning to the clinic may support delayed uptake.
Thank you

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