Integration of FP into Decentralized Comprehensive Postabortion Care (cPAC) Services

A case study of Tanzania

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FP-MNCH-Nutrition Integration Technical Consultation

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Background

- ~ 16% of the 7,000 maternal deaths in Tanzania per year related to complications of abortion (MOHSW, 2010)
- 2000 - PAC included in Tanzania's National Package of Essential Reproductive and Child Health Interventions
- 2005 - Pilot of decentralized cPAC services in Geita District, with integration of FP (district hospitals to lower level facilities).
- Since 2008, decentralized cPAC scaled up to 21 districts in Mwanza and Shinyanga Regions and Zanzibar through the USAID-supported ACQUIRE Tanzania Project (ATP)

Tanzania cPAC Decentralization Locations

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Methods / Program Description:
Establishment of Services

- Establishment of services included:
  - Facility audit; renovation and equipping as needed
  - Training of mid-level health workers to provide manual vacuum aspiration (MVA), FP counseling & FP services
  - Trainees develop action plans, including for conducting on-the-job training in cPAC to other providers
  - Trainee follow-up and supervision by district trainers
    - Progress on action plans is assessed
    - Challenges addressed onsite

A Renovated cPAC Room

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Methods / Program Description:
Community Sensitization (CommPAC)

- In Mwanza and Shinyanga Regions, communities and local authorities / opinion leaders sensitized / mobilized:
  - How unsafe abortion and miscarriage affect their communities
  - How to prevent unwanted pregnancies
  - How to address complications of abortion (including miscarriage) through prevention of the three delays in accessing care

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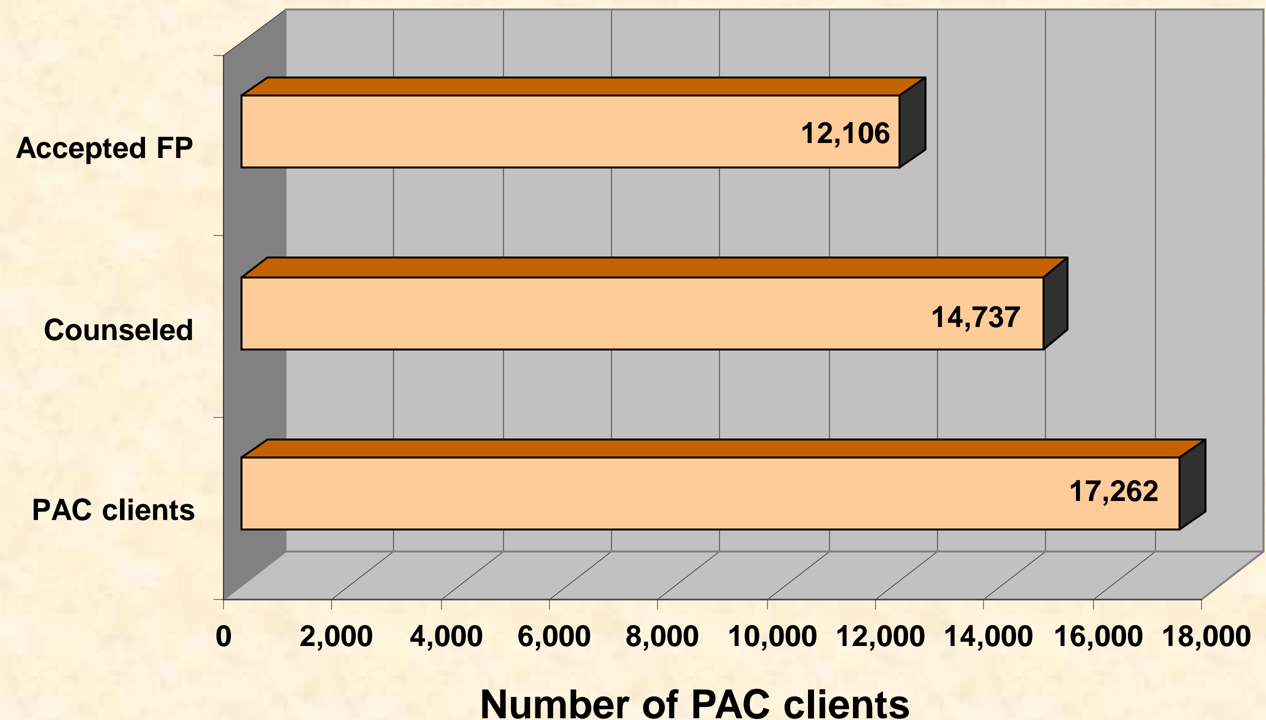
Results / Lessons Learned

Results:

- Decentralized cPAC services in 21 districts
- 293 health care workers trained
- FP counseling and services in 224 sites



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Results / Lessons Learned (2)

cPAC Clients by Year, 21 Districts in Tanzania (October 1, 2007 - September 30, 2010)

	Total number of cPAC Clients	% of cPAC clients counseled on FP methods	% of cPAC clients counseled accepting an FP method
2007-08	1,482	100%	87%
2008-09	6,217	84%	81%
2009-10	9,563	84%	82%

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Conclusions and Recommendations

- Feasible and desirable to decentralize cPAC services
- Key integration needs and challenges include:
  - Sustained access to essential equipment and supplies e.g., MVA kits and FP equipment and commodities
  - Need resources for on-going provider supervision and mentoring
  - Outreach for community awareness of complications of unsafe abortion and miscarriage, and actions communities can take in order to address the “three delays”
  - Funding needed for further scale-up
- cPAC services, including FP integration, should reduce the recurrence of clients seeking unsafe abortions

1. Do integrated services increase service coverage, cost, quality, use, effectiveness, and impact?
   - Yes!: Decentralization of services, plus integration of FP counseling and provision of FP methods increases coverage and improves quality, use and effectiveness/impact of cPAC services
   - > 200 cPAC sites in ATP-assigned regions now offer high quality services:
     - >17,000 PAC clients served
     - Upwards of 80% counseled on FP
     - Upwards of 80% of those left with an FP method

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1. Do integrated services increase service coverage, cost, quality, use, effectiveness, and impact?
   - Task-shifting to nurses and nurse-midwives in health centers and dispensaries results in increased availability and use of cPAC services
   - "Congestion" at higher-level facilities is reduced
   - Costs of care go down as services are brought nearer to communities
   - Substantial benefits to families of women whose lives are saved
   - Average cost of decentralizing services to health centers: $762

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2. What are the best practices, processes and tools that lead to effective, integrated services?
   - Initial piloting before replication and scale-up
   - Decentralization and task shifting to lower cadres where possible
   - Ensuring regular availability of FP commodities and equipment
   - Ensuring regular availability of skilled providers
   - Support for training, monitoring/mentoring and supervisory support

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3. What are the barriers to effective integration?
   - Integration may mean adding to an already heavy provider workload
   - Therefore how to “sell” integration to providers and facility in-charges (i.e., “What’s in it for you”)
   - Lack of strong national and local leadership to define, reinforce and facilitate steps needed for integration

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4. What are the gaps (in evidence/research and programs)? What more do we need to know?
   – Produce and share more analysis of the economic and opportunity costs of integrated services, for both clients, providers, and programs
   – Move from conceptual frameworks for integration to documentation of case studies & successful scale-ups
   – Share best practices through study tours and South-to-South technical assistance

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Karibuni sana !

(Thank you all very much!)