Utilization of post-abortion care services in three regional states of Ethiopia

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Abstract

Background: In Ethiopia, utilization of post-abortion care service is minimal and it seems that the expanding services are underutilized. The purpose of this study was to assess factors which influence decisions for utilization of abortion related services at community level.

Methodology: The study was carried out in six selected districts (woredas) within the three big regions of the country, namely Amhara, Oromiya and SNNPR. The study employed a descriptive cross-sectional design. Both quantitative and qualitative study techniques, including structured interview questionnaires, focus group discussions (FGDs), and in-depth interviews. The study population comprised randomly selected 1,492 women of reproductive age, service providers, and key informants of the sampled districts.

Results: Majority of respondents said that they prefer public health facilities. According to the respondents, the reason why women do not visit health facility for PAC services include lack of community support, unavailability of services, services are expensive, facilities are distantly located and lack of means of transportation. From the multivariate analysis it appears that public health facilities are preferred by younger respondents, those with no education, those with no history of unwanted pregnancy and those with better income. The qualitative study indicated that women do not go to health facilities for PAC mainly because of inappropriate treatment by providers at the health facilities.

Conclusion: Public health facilities especially health centers are the most preferred but there are barriers that should improve. Introduction of supportive supervision should be considered as a tool for improving quality of care. A mechanism should be in place to obtain community opinion regularly and use it to continuously improve services. To correct some misconceptions and improve community awareness on abortion related issues community providers, including reproductive health agents and health extension workers can teach about availability of services and about abortion related complications. [*Ethiop. J. Health Dev.* 2010;24 Special Issue 1:123-129]

Background

Ethiopia is one of the counties with highest maternal mortality ratio which is currently estimated at 673/100,000 live births (1). Main contributing factors for this high death toll include unsafe abortion, among others (2, 3). The total fertility rate is still very high (4, 5) and there is huge unmet need (34.0%) for family planning in the country (1).

Problems related to abortion were neglected and access to quality post-abortion care was very limited (4, 5, 6, 7). Complications resulting from unsafe abortion are major public health problem in the country which affects all women in reproductive age. Significant proportion (45%) of women seeking care for abortion related complications are adolescent girls. Majority of health facilities were not providing post-abortion care services and where available services were delivered in un-integrated setup and ill-equipped facilities. Until the year 2004 the law on abortion related issues was one of the very restrictive in the world denying women accessing safe abortion services.

Major contributors to unwanted pregnancy and unsafe abortion in Ethiopia include low level of access to family planning services and cultural practices such as early marriage and marriage by abduction (1, 8). Harmful traditional practices greatly influence health of women in Ethiopia. Several forms of harmful traditional practices are practiced in the country among which early marriage as early as 14 years of age and marriage by abduction are the common ones and they contribute to the magnitude of unwanted pregnancy and, hence, unsafe abortion (8).

Communities decide pregnancy related health service seeking after it is too late and became difficult to avoid complications that result in maternal and newborn morbidity, disability and death. Some of the reasons for not utilizing health facilities early or at all, as reported by women, are long waiting hours at health facilities, unavailability of drugs at the facilities and maltreatment by service providers. According to the 2005 DHS (Demographic and Health Survey), perceived problems in accessing health care by women are lack of money for treatment (75.6%), no health facility nearby (67.7%), and lack of permission to go to health facilities (34.5%), lack of a companion (61.4%) and concern that there may not be a female provider (72.5%) and concern that there may not be a service provider in general (80.5%) (1). A study done in north eastern Ethiopia found that women are ashamed of exposing their body to a stranger, especially a male attendant, and their husbands feel that it is against their religion and discourage their wives from visiting health facilities (9).

Similar to other maternal health services, utilization of PAC has also remained low although access to better quality PAC services have improved significantly in the last few years. In the year 2000, only around 50.0% of facilities in the major regions in the country were able to provide care for patients with abortion related

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complications. At that time, only 13.0% of public health facilities in the capital Addis Ababa were able to provide the services. From facilities which were providing the services, only a quarter were able to provide uterine evacuation using MVA and they were heavily dependent on sharp curettage. Provision of post-abortion contraception was practiced only by below a quarter of health facilities (4). A follow-up study done in 2004 indicated that this picture has changed significantly and availability of PAC services in general and MVA and the practice of PAC family planning have improved greatly (10). The achievement was as a result of joint effort by the Ministry of Health at different levels and partners working in the area of abortion related care. The reports from supervisory visits by MOH and partners also show improved availability of PAC services and MVA kits in the health facilities. However, the utilization of services is less than expected in these facilities.

The purpose of this study was to assess factors which influence decisions for utilization of abortion related services, especially at the community level.

Methods

The study was carried out in six selected districts (woredas) within three big regions of the country, namely Amhara, Oromia and SNNPR, in September 2006. The main reasons for focusing on these three regions were: (1) these regions constitute over 80% of the Country's population (11), (2) these regions do represent diversities in several respects, (3) considerable PAC service improvements were implemented in these regions. The study had employed a descriptive cross-sectional design. Both quantitative and qualitative study techniques, including structured interview questionnaires, FGDs, and in-depth interviews were used. Two districts/health facilities were selected from each region using simple random sampling technique with the help of computer-based random numbers. The study population comprised randomly selected women of reproductive age, 15-49 years, service providers, and key informants of the sampled districts.

To calculate the adequate minimum sample size for the quantitative interview, in the absence of similar study, we have assumed that 50% of women reproductive age would know the presence of PAC services in the nearby health facility. We have considered 95% confidence level, design effect of 2.0 as we used multistage sampling and added 15.0% of the calculated sample size for possible non-response rate which gave a total sample of 1,380 women of 15-49 years. Finally we have increased the sample size to 1, 500 to ensure adequacy for breakdown analysis. A sample of 60% (900) was drawn from rural and 40% (600) from urban communities of each district.

FGDs were held separately for rural and urban as well as for 15-24 and 25+ years of women groups in each woreda. For the sake of understanding the provider's perspectives, in-depth interviews were conducted among the respective woreda program and health facility service focal personnel. Focus group discussions were held in order together better understand insights from community members around the issues of PAC service utilization and closely related subject matters. Four FGDs were conducted per woreda with considerations of rural and urban dimensions. Five experienced interviewers and one supervisor conducted data collection in each woreda.

The quantitative data was collated, cleaned, analyzed and interpreted using SPSS software package. The qualitative data was transcribed, collated, analyzed and synthesized manually.

Findings

In total, the study had enrolled 1,492 respondents and the total response rate for the structured interview was 99.5%. It is only approximately 15.0% of the respondents who may need to travel more than two hours of a distance to seek services. The great majority (close to 70.0%) of the respondents would have to travel an hour or less to reach the nearby health facility. Except in one district where there was a hospital and health center, the closest health facility in all the other districts was a health center.

Close to three fourth (73.0%) of the respondents belong to the age category 20-39 years (Table 1). Great majority of them were married at the time of the survey. Orthodox Christian and Muslim were the dominant religion in the sampled area. Only about a third of the respondents reported attending school at primary or higher level and 56.5% have never attended school.

Table 1: **Selected socio-demographic characteristics of respondents, Amhara, Oromia and SNNPR regions, September 2006**

Variables	Number (%)
Age in years	
15-19	168 (11.3)
20-24	239 (16.0)
25-29	376 (25.2)
30-34	261(17.5)
35-39	228 (15.3)
40-44	109 (7.3)
45-49	64 (4.3)
Not specified	47 (3.2)
Marital status	
Currently married	1161(77.8)
Divorced	152(10.2)
Never married	173(11.6)
Other	6(0.4)
Religion	
Orthodox	714(47.9)
Muslim	503(33.7)
Protestant	248(16.6)
Other	27(1.8)
Education	
None	843(56.5)
Read and write	117(7.8)
Primary	229(15.3)
Secondary	263(17.6)
College/University	40(2.7)

Majority of the respondents were housewives or farmers. Only 110 (7.4%) reported that they are formally employed. Close to half of the respondents perceive their economic status as satisfactory compared to their neighbors while 30% said that they consider themselves as poor compared to others. Majority (78.5%) said that they do not have autonomy to independently decide on health service seeking and they need approval from their partner or family members (Table 2).

Table 2: **Livelihood source and health care decision making among women respondents, Amhara, Oromia and SNNPR regions, September 2006**

Livelihood source	
Housewife	507 (34.0)
Farming	443 (29.7)
Under family support	174 (11.7)
Petty trade	232 (15.5)
Employed	110 (7.4)
Other	26 (1.7)
Perceived economic condition	
Desirably optimal	44 (2.9)
Very good	203 (13.6)
Satisfactory	703 (47.1)
Poor	434 (29.1)
Very poor	88 (5.9)
Difficult to comment	20 (1.3)
Health care decision	
Independent	270 (18.1)
Partner	426 (28.6)
Family	745 (49.9)
Other	51 (3.4)

History of abortion, knowledge of signs and consequences of abortion

Overall 15.1% of the respondents said that they have had at least one abortion episode in the past (Fig 1). Number of abortion in the past ranged from 1 to 4 and 175 (77.4%) and 37 (16.4%) reported one and two episodes of abortion respectively. Spontaneous abortion was reported by 199 (87.7%) and induced abortion was reported by 28 (12.3%).

Multivariate analysis (Adjusted for marital status, place of residence and religion) showed that abortion is common among the older age group compared to the youngest (15-19 years) and the likelihood of abortion increases as age increases from 2.85 times in the age group 20-24 to 6.34 times among the age group 40 and above. Abortion is less common among those who are educated to the level of secondary and above [(OR (95% CI) 0.49(0.28, 0.87)]. Those women who were not current users of family planning were more likely to report abortion [(OR (95% CI) (1.53(1.04, 2.27)] compared to non users. Those with no history of unwanted pregnancy were less likely to report abortion in the past [(OR (95% CI) (0.66(0.46, 0.95)]. Compared to the housewives, farmers [(OR (95% CI) (0.58 (0.40, 0.85)], women who were dependent on family support [(OR (95% CI) (0.42 (0.19, 0.89)], and those who were employed [(OR (95% CI) (0.37 (0.16, 0.85)] were less likely to report abortion.

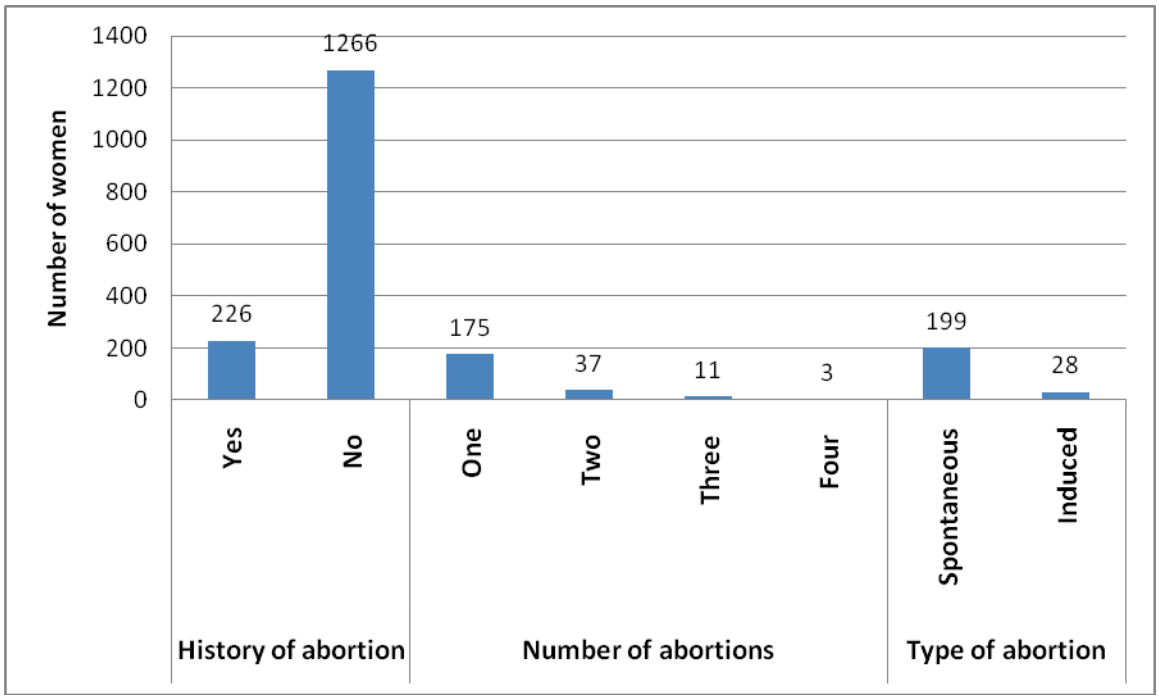

Figure: **History of abortion by women respondents from Amhara, Oromia and SNNPR regions, September 2006**

As to the possible consequences of unsafe sexual intercourse, unsafe abortion was recognized only by 11% of the respondents. While it is true that not every unsafe sexual intercourse will result in pregnancy and then lead to abortion, but full recognition, by all, on the existence of chances should have been appreciated. Apparently, considerable portion of respondents indicated the two main ways of abortion occurrence: spontaneous (44.5%) and induced (52.4%). In relation to the possible consequences of unsafe abortion, bleeding (62%) and death (43.5%) have come out more prominently as opposed to infection (18%), anemia (34.7%), injury (29.2%) and mental disorders/psychological disturbances (13.4%).

Qualitative data some of the discussants specifically pointed out about the lack of 'safe abortion' services and they demanded for such services to be available at nearby public facilities. *"As far as I know, the government health facilities do not provide safe abortion service at the will of the woman. Therefore, we observe many of our sisters suffering and passing away as the consequences of unwanted pregnancies. In our country, we women are misfortune (helpless) creatures. We are coerced. We carry unwanted thing. Those males who have created the problems upon us would not wish to see us albeit loving us. We do not have our own choice and life. We even do not have the legal support."* Rural woman.

They have indicated that they resort to the illegal practitioners to get services because it is not available at nearby facilities. Discussing about the benefits of having safe abortion services at nearby facilities a woman said *"if it is done here at the near by health center, the costs will be affordable and the procedure will be safer compared to when it is done by illegal practitioners"* Urban woman.

Post-abortion care service preferences: Majority of women prefer to go to public health centers and hospitals for termination of pregnancy. The three main reasons why they prefer to go to these facilities are the existing quality of care, good attitude of service providers and closeness of the health facilities. Close to 17.0% also said that they have no other choice (Table 3). On the other hand possible reasons mentioned regarding why women do not visit health facilities for post-abortion care include unavailability of services, services are expensive, facilities are distantly located and lack of means of transportation. One third of the respondents said that it is because there is no community support scheme to help patients' access services. According to the respondents, partner involvement in decision making with regard to seeking post-abortion care is relatively high (42.4%) but in most of the cases the women make independent decisions (46.2%) to seek services.

Table 3: **Postabortion care seeking and site preferences by women respondents in Amhara, Oromia and SNNPR regions, September 2006**

Variable	Number (%)
Choice of place for terminating (SAC) pregnancy	
Public health center	964 (64.6)
Public hospital	181(12.1)
Private clinic	25 (1.7)
Nearby pharmacy/drug store	22 (1.5)
Traditional healer	104 (7.0)
Illicit abortion practitioner	85 (5.7)
Other	12 (0.8)
Do not know	99 (6.6)
Reason for choosing a facility	
Closeness	286(19.2)
Good service provider	258(17.3)
QOC	458(30.7)
Affordable cost	116(7.8)
No other choice	247(16.6)
Other	18(1.2)
Do not know	109(7.3)
Why women do not visit health facility for PAC	
Service not available	168(11.3)
Poor QOC	76(5.1)
Service expensive	241(16.2)
Distance	157(10.5)
Lack of transportation	166(11.1)
Lack of community support	549(36.8)
Other	24(1.6)
Do not know	111(7.4)
Decision maker to seek PAC services	
Respondent	689(46.2)
Spouse	632(42.4)
Other	156(10.5)
Do not know	15(1.0)
Seeking PAC from a health facility	
Strong agree	840(56.3%)
Agree	485(32.5)
Difficult to comment	50(3.4)
Disagree	40(2.7)
Strongly disagree	77(5.2)

As the public sector is the main source of health service in the country we categorized respondents by their place of preference taking the public sector (hospitals and health centers) as one category and the rest (private clinics, traditional practitioners and backstreet providers) as another category for multivariate analysis.

It appears that preference of public health facilities decrease as age increases and those who belong to the age group 40 and above are the most likely not to prefer the public sector [(OR (95% CI) (0.48 (0.27, 0.84)] compared to the younger age group (Table 4). Compared to those with no education, the public facility is less preferred by those who are able to read and write [(OR (95% CI) (0.38 (0.24, 0.61)], those who have attended up to primary level [(OR (95% CI) (0.52(.35, .77)] and those

who have advanced to secondary or above [(OR (95% CI) (0.50(.32, .78)]. Muslims prefer public facilities when compared to Orthodox and Protestants. Those with better income reported better preference to public facilities compared to those with low income. Those with no history of unwanted pregnancy prefer to receive services at the public facilities [(OR (95% CI) (1.52 (1.09, 2.12)] compared to those with history of unwanted pregnancy. No significantly different preference was observed by place of residence and marital status.

Table 4: **Adjusted odds ratio for attending public health facilities for termination of pregnancy* by women respondents in Amhara, Oromia and SNNPR regions, September 2006**

Variable	Adjusted OR (Conf. Interval)
Age	
15-19	1
20-24	1.63(0.89, 2.96)
25-29	1.07(0.62, 1.83)
30-34	0.81(0.46, 1.43)
35-39	0.66(0.37, 1.19)
40 and above	**0.48(0.27, 0.84)**
Education	
None	1
Read and write	**0.38 (0.24, 0.61)**
Primary	**0.52 (0.35, 0.77)**
Secondary and above	**0.50 (0.32, 0.78)**
Religion	
Muslim	1
Orthodox	**0.62(0.44, 0.88)**
Protestant	**0.11(0.08, 0.17)**
Other	1.86(0.41, 8.56)
Orthodox	1
Muslim	**1.62 (1.15, 2.28)**
Protestant	**0.18 (0.13, 0.25)**
Other	2.72 (0.61, 12.10)
Level of monthly income in Birr-1	
Less than 500	1
500-1000	**2.77 (1.57, 4.87)**
Above 1000	**6.43 (2.20, 18.77)**
Level of monthly income in Birr-2	
Above 1000	**1**
500-1000	**0.18 (0.06, 0.50)**
Less than 500	0.46 (0.15, 1.43)

*Adjusted for marital status, history of unwanted pregnancy, place of residence and current family planning utilization

It was found from the qualitative study that some of the discussants are aware that PAC is provided in the nearest health facility while others are not aware of the availability of the service. The discussants said that women first hope for spontaneous relief from their abortion and if not they try different options. Women visit health facilities when pain gets worse or when they have severe bleeding. This is how a woman discussant described illustrative chain of actions: "*My friend got pregnant without her desire and she was not married. First, in fear of her family's rebuke, she tried with the traditional medicine. When the traditional medicine failed, she went to the health facility. As she did not get the help there she went to the private health provider. The conception was around six months. They have inserted a plastic tube into her vagina which made her to bleed to death.*" Urban Discussant.

In addition to late presentation to facilities lack of proper treatment and lack of drugs discourage women from going to health facilities. *"Recently, one woman who was pregnant had abortion with the assistance from illegal provider and then she was taken to hospital because of the continuing bleeding. At the hospital, although they removed and cleaned the remnant conception it was not possible for them to stop the bleeding and she passed away. Therefore, post abortion care is being provided at health facilities but since the service seekers present late they may die without getting the proper treatment. Some of them, even if they go on time, there are many who fall into problems because they do not get the medicines and services they need."* Rural Discussant.

Similar to the quantitative finding, most of the discussants showed preference to the public sector *"The private providers are not the better options for us. They prescribe too many drugs and they just collect their money. I prefer the nearest government facility"* Urban woman. Another urban woman said *"Up to now, I know that the health center in our locality provides post-abortion care. If the health center is given the mandate to perform abortion legally, I think people will make it their*

first choice and I will do the same. I do not trust the private clinics, particularly, in relation to the cleanness of the setup" Urban Discussant.

However, some of the participants expressed the presence of maltreatment by the providers at public health facilities *"we took a poor woman who had abortion to nearby facility. We were harassed and treated badly by all staff starting from the guard to the physician. On top of that the payment was too high"* Urban Discussant. *"If a woman with illegal abortion goes to the hospital, it is only after discourteous communication and insulting that they will admit and treat her. The woman gets the insult as if the woman alone has done it. It is the woman who gives birth and takes the troubles. It is the pregnant woman who receives the insult. It is the woman who gets the discomfort and complications if she resorts to abortion. Therefore, the services at the health institutions need to be improved in many respects. It is encouraging illicit abortion otherwise."* Rural woman.

It seems that generally women prefer to receive services at the health centers compared to the hospitals mainly for proximity and cost reasons. However, few indicated their preference of hospitals as they are relatively well equipped and staffed. There were also women who showed preference to the for-profit sector. The main reason given for this was good provider attitude and respect for patients.

The qualitative findings both from the community and providers indicated that several areas for improvement. Generally access to services should improve which includes having appropriate equipment, supplies and adequate staffs at health facilities. Some health facilities do not have water and electric supply. Education, which targets women in general and young girls in particular in the areas of abortion related services and on the prevention of unwanted pregnancy was recommended.

Improvement of provider attitude towards women suffering from abortion and the long waiting time were mentioned as areas that need improvement according to the discussants.

Discussion and conclusions

General access to health facility is very good and only few had to travel for more than two hours to obtain services. This is a clear indication of the expanding health infrastructure in the country. Women empowerment indicators such as employment, education and independent decision making of health service seeking were very low.

Reported history of abortion is low but fairly comparable with other similar studies conducted in southern western Ethiopia (17.0%) and northern Ethiopia (20.8%) (12, 13). Close to a quarter of abortion is due to induction and the remaining was spontaneous.

Important predictors of abortion were increasing age, education, current family planning use, history of unwanted pregnancy and employment. The fact that education, current family planning use and employment came out as significant predictors of abortion indicate the interplay between women empowerment and women's health.

Women prefer to go to the nearby public health centers and hospitals for PAC services. This finding is similar to the study by Medhanit W., in south western Ethiopia (13). Very few showed preference to use the for-profit or other providers. Although this is a very encouraging finding the respondents mentioned several issues why services are currently underutilized in these facilities. Most of the reasons were related to quality of care and were due to lack of money for transport and service fee. In the multivariate analysis older women and those with better education showed less preference for public sector. Those with history of unwanted pregnancy showed less interest for public sector.

The key message from this study is that problem related to abortion is prevailing, women need abortion related services and they prefer to be served at the public facilities especially at the health centers as long as they receive good treatment from the providers and the services are affordable. Previous studies on quality of care showed that services need to improve greatly in the area of client provider integration, service delivery setup and integration of services including post-abortion family planning (5, 6).

Introduction of supportive supervision should be considered as a tool for improving quality of care at public health facilities. There should be a forum which brings the providers and the community together. The providers and managers should know community's opinion on a regular basis and there should be a mechanism in place for this. Feedbacks could be gathered from patients through exit interviews.

Post-abortion or abortion care should be made one key component of community based service delivery. Community providers, including the health extension workers, could teach the availability of services, about abortion related complications, and the content of the revised penal code among other issues. Training of the community providers should include how to target high risk women: those who are young, less educated, and rural. Efforts should be made to include abortion related issues including case identification and referral as one of the agendas for discussion during monthly review meetings and refresher training of the community providers. Interventions needs to be in place to address stigma and build support at family and community level.

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