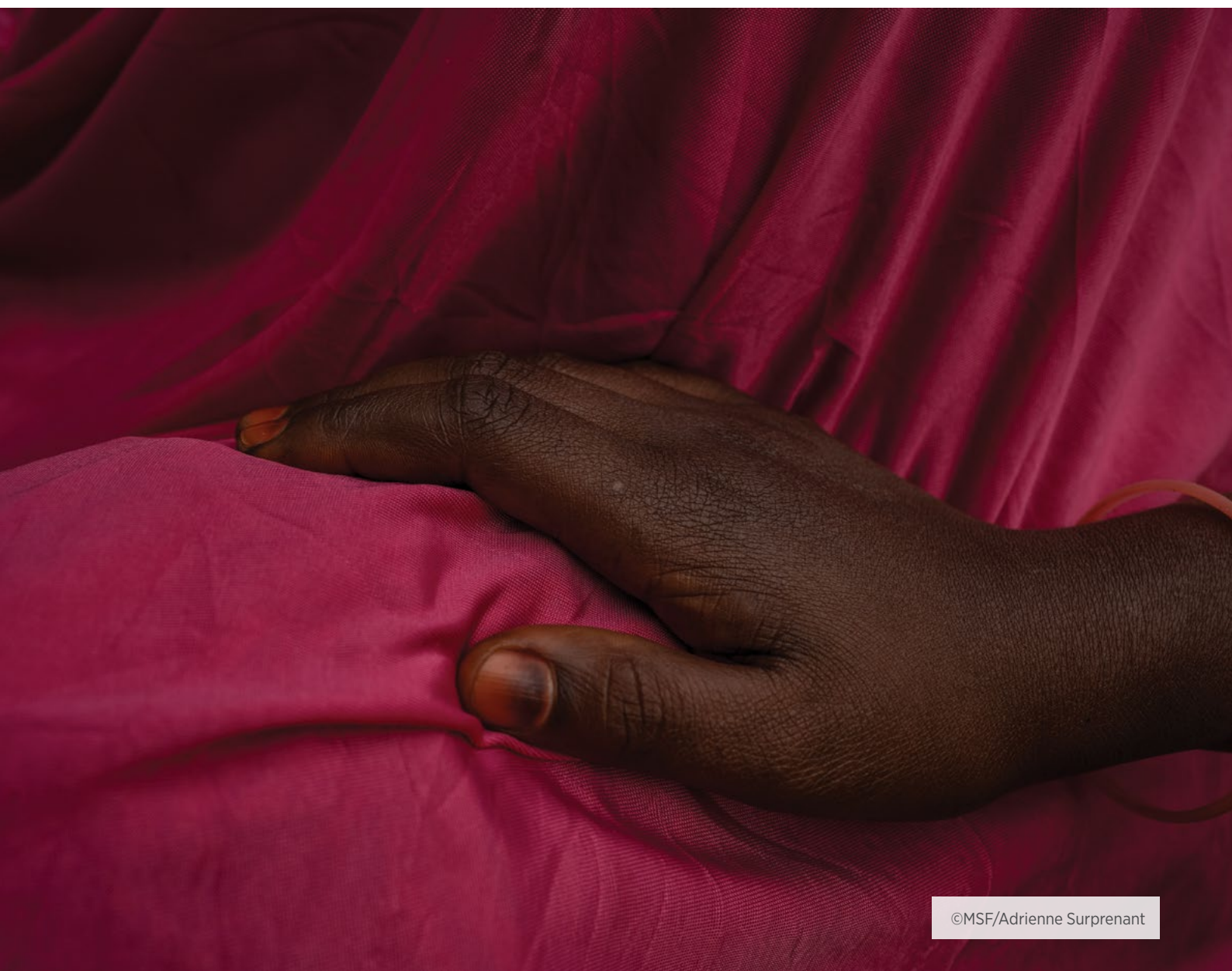


# KNOWLEDGE, ATTITUDES, PRACTICES, AND BEHAVIORS AMONG PROVIDERS OF ABORTION-RELATED CARE

Castors Maternity in Bangui, Central African Republic,  
a conflict-affected urban setting – Results of the AMoCo study



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# INTRODUCTION

Evidence on the burden of abortion-related complications in fragile and conflict-affected settings is still limited despite the need for sexual and reproductive health (SRH) care, including both postabortion care (PAC) and safe abortion care (SAC), likely increasing in these settings. The demand for services is high, due to an under-resourced health system, in addition to disruptions in contraceptive use and access and increased exposure to sexual violence or transactional sex among a population with a high level of displacement (1). In these settings, reducing unsafe abortion is even more critical because women may have difficulty accessing quality postabortion care due to security risks, migration, and a lack of community and family support important for accessing health care (2).

Access to timely and high-quality comprehensive abortion care (CAC) can decrease the magnitude and severity of abortion-related complications (3) and health care providers have important roles in providing this care (4). Many elements have been identified that influence the provision and quality of CAC by health care workers. These include insufficient training and gaps in clinical skills (4), a lack of awareness of regulations and legality of abortion (5), personal convictions and conscientious objection based on moral, religious beliefs or stigma, and negative attitudes of health professionals surrounding abortion leading

to discrimination during facility-based care (6). However, little is known about these elements related to providers in humanitarian settings.

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This evidence brief presents selected results of one component of the AMoCo Study (**A**bortion-related **M**orbidity and **M**ortality in **C**onflict-affected and **F**ragile Settings). This knowledge, attitudes, practices, and behaviors (KAPB) survey was given to health professionals providing abortion-related care. The primary objective of the KAPB survey was to describe the knowledge, attitudes, practices, and behaviors of PAC-providing health care workers in the hospital. The secondary objectives were to identify provider-related barriers in the pathway of care that limit women from receiving adequate CAC and to identify points for improvement in the provision and accessibility of CAC.

# STUDY SETTING

This study took place in the Maternity of Castors in Bangui, the capital of the Central African Republic where the maternal mortality ratio is among the world's highest (829/100,000 live births) (7) and with abortion-related complications estimated to be responsible for 24% of maternal deaths (8). The 66-bed facility is one of the capital's best-known

maternities. In 2019, the facility recorded over 10,000 deliveries and assisted more than 2,600 women seeking postabortion care. Between 2014 and 2017, abortion-related complications caused over 33% of maternal deaths in the facility (MSF monitoring system).

# METHODS

The KAPB survey consisted of a standardized anonymous questionnaire self-administered in September and October 2019 to health professionals, including physicians, midwives, nurses, and nurse/midwife assistants, who were involved in the provision of CAC at the study site and were literate in French. The only exclusion criterion was refusal to participate. Eighty-four of the 89 eligible staff participated for

a 94% response rate. Five staff were unavailable due to clinical duties. Seventy-five percent of providers were midwives, 17% physicians, 2% nurses and 6% nurse/midwife assistants. Eighty-five percent of providers were female; 92% of males were physicians and 87% of females were midwives.

**Most of the respondents were female midwives; physicians in the sample were early in their careers.**

|                                | Total (N=83) | Female (N=70) | Male (N=13) | Professional Experience |
|--------------------------------|--------------|---------------|-------------|-------------------------|
|                                | n (%)        | n (%)         | n (%)       | Years (mean)            |
| <b>Midwife</b>                 | 62 (75)      | 61 (87)       | 1 (8)       | 8.0                     |
| <b>Physician</b>               | 14 (17)      | 2 (3)         | 12 (92)     | 2.4                     |
| <b>Nurse/midwife assistant</b> | 5 (6)        | 5 (7)         | 0           | 11                      |
| <b>Nurse</b>                   | 2 (2)        | 2 (3)         | 0           | 14.5                    |

# KEY FINDINGS



## Personal experiences with abortion complications

- Personal experience with abortion complications was common: 91% of respondents knew someone personally who had died from a complication due to an unsafe abortion, while 76% had ever cared for a woman who died of complications of abortion.

### Health care workers have personal experience & knowledge of unsafe abortion

Personally knew someone who had died from complications of unsafe abortion



91%

Provided care to someone who died from complications of an unsafe abortion



76%

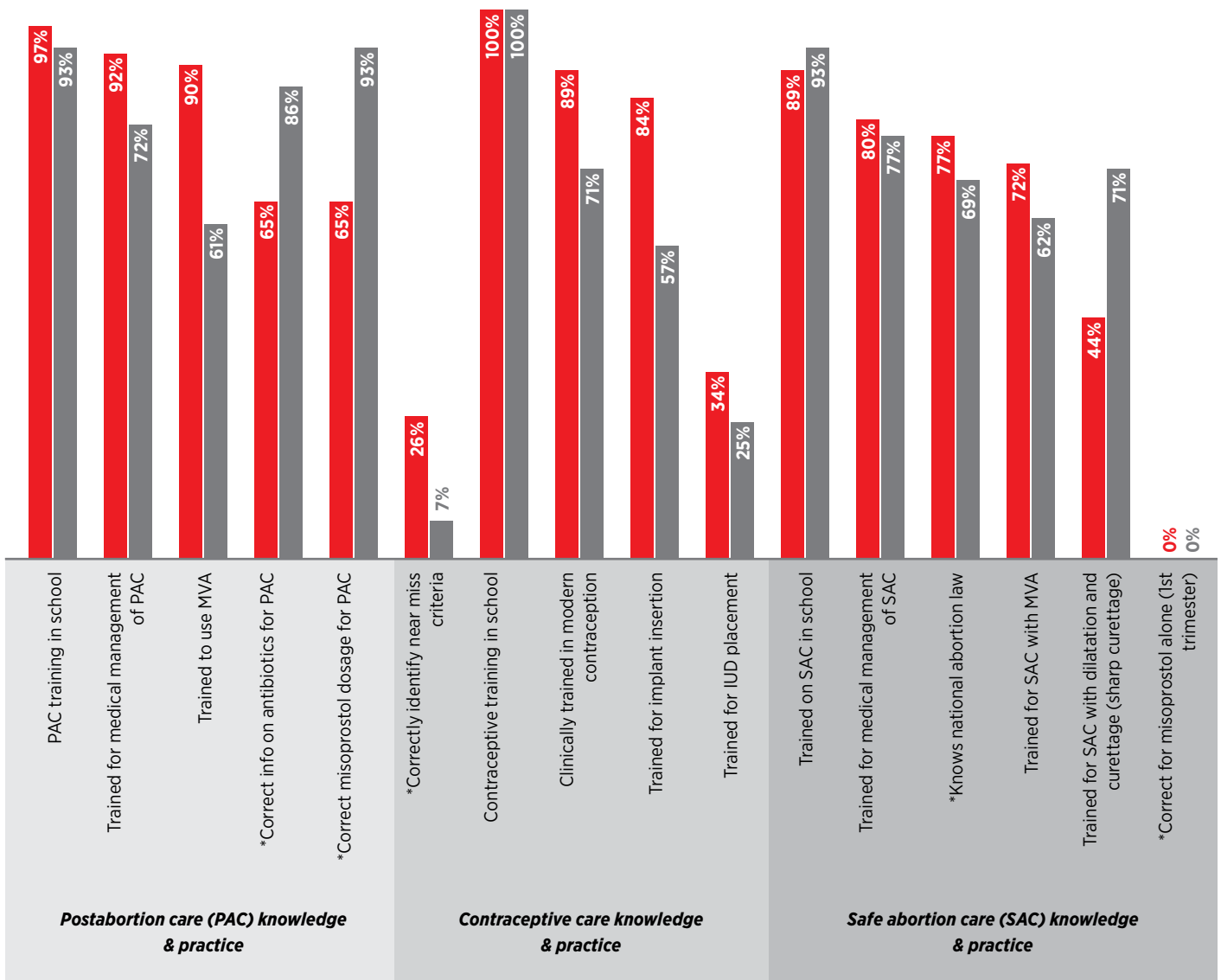


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 Knowledge

- Despite a significant severe abortion complications case load in the facility indicated by study data, only 21% of respondents correctly identified 4 out of the 5 the abortion-related near miss criteria (severity criteria). Midwives performed better on this question than doctors with 26% and 7% correctly identifying these criteria respectively.
- While all the providers surveyed said they had training on modern contraceptive methods, only three-quarters (76%) of respondents were trained on implant insertion, and approximately one-third (32%) to insert intra-uterine devices (IUD).
- While 76% reported being trained on medication abortion, only 14% knew the correct dosage for the combined regimen of mifepristone and misoprostol and none knew the correct misoprostol alone regimen.

## Experience and \*knowledge of PAC and contraception was high overall, but was lower for SAC



■ Midwives    ■ Doctors



## Attitudes

- Despite the stigma, complexities, and the restrictive legal environment for abortion in the country, providers in this hospital had positive attitudes towards abortion; 79% considered PAC and 67% considered SAC to be the right of every woman in CAR.
- 70% expressed agreement with the statement that health professionals should refer patients to another provider if they have objections to SAC provision.



## Practices

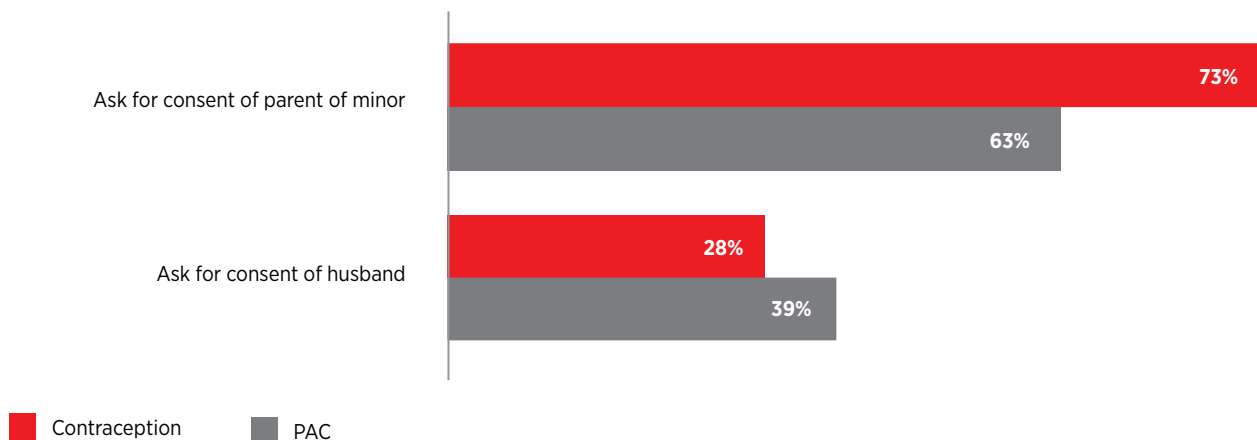
- Over one-third, 41% of respondents, providing PAC reported using dilatation and curettage despite the method no longer being recommended by WHO clinical guidelines.
- Despite the restrictive legal environment, 59% of providers surveyed said they would consider providing induced abortion to any woman requesting it, including minors, if they were allowed to do so.



## Behaviours

- Among those providing PAC services, 39% would ask for husband's consent before providing PAC, and 63% would ask for parental consent if the patient is a minor.
- Among those providing contraception, 28% would ask for husband's consent before providing contraception, and 73% would ask for parental consent before providing contraception to a minor.
- In response to the question, "Would you feel comfortable to provide Safe Abortion Care (SAC) personally in some circumstances?", 82% answered yes, with 97% selecting fetal abnormality as the most acceptable indication, life of the woman at risk next at 90%, rape 73%, and only 12% indicating they would provide SAC for any reason.

### Significant percentages of providers seek permission of others for provision of PAC and Contraception



# CONCLUSIONS

**Most health professionals in this facility have a supportive attitude regarding comprehensive abortion care**, especially for the global provision of PAC and contraception. More diverse opinions were seen for the provision of safe abortion care and contraception to minors. Nevertheless, their **knowledge and practices still reflect shortcomings**.

Knowledge about the national legal framework regarding third-party consent, the protocols to provide contraception to minors, the placement of implants and intrauterine devices and the near-miss criteria to evaluate severity of complications need to be further strengthened by continuous campaigns, trainings and clinical mentoring. National standards and guidelines or institutional policies may be ambiguous, poorly disseminated, or simply not be fully implemented. Additionally, low levels of knowledge about the WHO-recommended regimens of misoprostol for PAC or induced abortion, indicate a high-priority area for improvement.

Continuing ongoing improvement efforts will sustain and strengthen the facility's advances towards the provision of the full range of CAC. These efforts include regular workshops on Values Clarification for Action and Transformation (VCAT) about abortion (9); organizing continuous education of all staff, including physicians, about current protocols for PAC and SAC; providing up-to-date information on

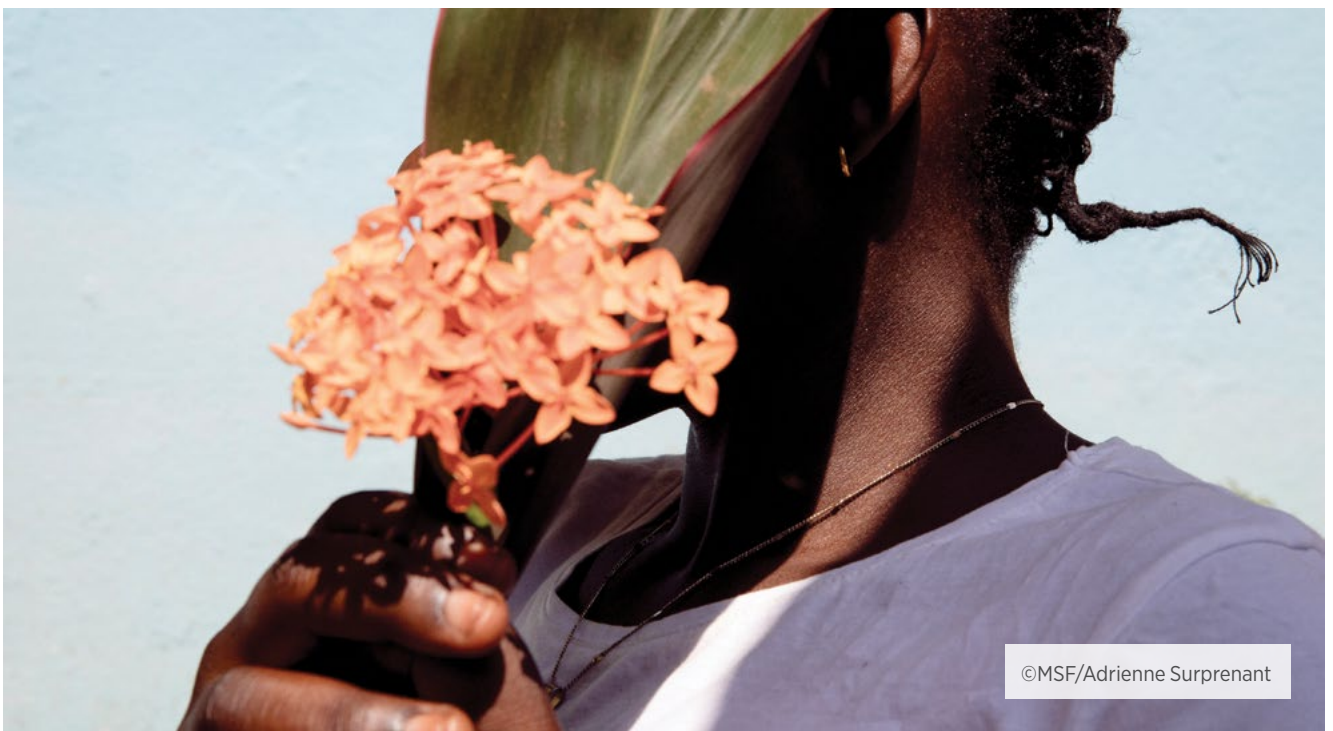
legislation and regulations; simplifying the near-miss approach; and expanding the contraceptive methods mix. Given that midwives are providing most of the routine abortion-related care, their relatively strong performance on many of the assessed practice elements, and their greater professional experience and longevity with the facility than physicians, continuing and enhancing investments in this cadre will strengthen services and grow their leadership in in this area.

While contraceptive and abortion-related care is traditionally centered in the facility, accurate information, including dispelling myths and misinformation, also needs to be prioritized and occur in communities. Self-care strategies for contraception and abortion are now recommended by the WHO and can be supported to increase choice and autonomy for patients and to relieve over-burdened health systems (4, 10).

In conclusion, up-to-date protocols and regulatory information, continuing education including VCAT sessions, task-sharing, robust contraceptive method mix, and supporting self-care interventions are likely to strengthen CAC in facilities beyond this one. More research is needed about the factors associated with health professionals' positive attitudes, behaviors, and practices towards each component of CAC, including the potential impact of their personal experiences with unsafe induced abortion, as well as on the long-term impact of VCAT workshops (9).



***Indeed, up-to-date protocols and regulatory information, continuing education including VCAT sessions, task-sharing, robust contraceptive method mix, and supporting self-care interventions are likely to strengthen CAC in facilities beyond this one.***



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