Creation, Implementation and Impact of a CAC optimization strategy in the Western Cape, South Africa

14 September 2018

Royal College of Obstetricians & Gynaecologists

leading SAFE choices

Western Cape Government Health
In 2011 only 57% of designated facilities functioning

National and Provincial DOH report that service provision is suboptimal

A number of districts = NO SERVICES AT ALL (particularly rural areas)

Reasons given for suboptimal service provision:
- inadequate numbers of trained staff
- long waiting times
- conscientious objection by healthcare workers
Leading Safe Choices
The Three Pronged Approach

1. Develop and disseminate **best practice papers** on post-partum family planning and comprehensive abortion care

2. Implementing those best practices through **training and mentoring** of health care professionals in maternity hospitals and midwifery units in South Africa and Tanzania

3. Professionalise best practice through an **accreditation and certification** system, to acknowledge competence and increase uptake of quality services.
METRO HEALTH DISTRICTS

- Southern Western
- Northern Tygerberg
- Khayelitsha Eastern
- Klipfontein Mitchells Plain
RURAL HEALTH DISTRICTS

- Cape Winelands
- Eden
- Overberg
- Central Karoo
- Westcoast
## Population Estimates

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SA 57.5 MILLION
CTOP Act

- CTOP Act No 92 of 1996
- CTOP Amendment Act No 1 of 2008
Department of Health (DOH) CAC Training

- Metro – 2 committed CAC trainers
- Rural Districts – No CAC trainers
- Leading Safe Choices providing CAC training across Metro and Rural Health districts
DOH Service Delivery

- Conscientious objectors
- Managers are not being held accountable to provide the service
- No succession plans of HCP’s in CAC
- No psycho-social support for CAC providers
- Values Clarification workshops in initial stages of roll-out of CAC services but subsequently stopped
- Lack of community mobilization for CAC
Service Delivery Gaps

- HCP’s unsupported by their managers
- HCP’s and clients seeking abortion services stigmatised
- Increased unsafe abortion providers across rural and metro districts
- Abortion pills accessible on internet
- Consistent increase of 2\textsuperscript{nd} Trimester Abortions due to lack of early access
- Limited numbers of clients done per day
COMPREHENSIVE ABORTION CARE TRAINING
Comprehensive Abortion care Training

- 3 Day Classroom training
- Practice 5 MVA’s on pelvic model
- 10 MVA’s accompanied by a clinical mentor
- contraception including IUD insertion
Comprehensive Care Trainings

Number of CAC (MA & MVA) conducted 2015 to date:

- 2015: Master Training – 12
- 2016: 2 Trainings – 22
- 2017: 3 Trainings – 36
- 2018: 2 Trainings – 21

Number of CAC (Medical Abortion only) training:
- 2018: 1 Training – 11
Competency achievements

Metro Districts
CAC: 75
Number achieved competency in CAC: 37

Rural Districts:
CAC: 16
Number achieved competency in CAC: 10

Medical Abortion: 11
Number achieved competency: 8
Profile of women seeking abortions:

- Migrant and seasonal workers
- Low levels of education
- High rates of unintended pregnancies including teenage pregnancies
- High rates of gender based violence
- High rates of substance abuse
Context of CAC services

- Services: HCP’s providing CAC services
- Management: Conscientious objection protocol misinterpretation
- Clients travel to Cape Town e.g.:
  - Ceres – 232 km
  - Worcester – 190 km
  - Robertson – 272 km
  - De Doorns – 250 km
  - Montague – 316 km
2nd Trimester Abortions

- Numerous clients progress to the 2nd Trimester abortion due to unavailability of services and distances
- Retired Medical Dr. available intermittently
- Patients travel to facility, sleep in OPD and have the service the next day and return home same day
- Women report late for abortion
All clients seeking abortions referred to Social worker with initial consultation and perception that options must be discussed with a bias towards continuing with the pregnancy.

Managers are not held accountable to provide services at designated sites.
Barriers in Mentoring and Implementation

- Management and staff reliant on ultrasound to do gestational dating
- Daily operational issues affects availability of trainees for clinical mentoring
- Clients don’t honour appointments due to long distances from facilities and financial constraints
- Booking system not patient centred
Barriers in Mentoring and Implementation

- Staff unsupported by managers
- In most cases only one provider at facility – also has to perform all administrative tasks – suffers burnout
- No psycho–social support for HCP’s
- Other perceived competing priorities
Optimisation strategies

- Improved access and uptake of abortion care
- Mentoring staff
- Engaging managers
- Training staff
- Values clarification workshops for staff and management
- Equipping abortion facilities
- Continuous monitoring & QA
CAC training by LSC programme
Dedicated CAC mentor appointed May 2017
Quality assurance of CAC care–clinical mentoring
Initial engagement with all levels of management to guide and support the roll out of the services
Continued support to ensure implementation is seamless–quarterly meetings
Optimisation strategies

- Continuous quality assurance checks
- Relevant equipment provided for the implementation of services
- Psycho-social support for providers
- WhatsApp support group for all CAC providers
Values Clarification and Attitude Transformation (VCAT) as a Strategy

Number of VCAT trainings conducted:

Ceres: 4
Montague: 1
Robertson: 2

Total number of staff trained: 104
Outcomes of VCAT workshops

- All categories of staff attended
- 5 Professional nurses requested to attend the CAC training
- Staff acknowledged that women have the right to access safe abortions
- Expressed the need for the VCAT
Outcomes of VCAT workshops

- Change and perspective in staff attitude
- Opportunity to discuss other operational issues that influence access to safe abortions
- Advocate for integration of CAC services on the pathway of care
- Acknowledge the lack of trained providers in Sexual Reproductive Health, especially LARC’s
Outcomes of VCAT

- The need for psycho-social support for providers
- That managers also attend VCAT workshops
- Valued input on the CTOP Act and the DOH Abortion Care policy
Course participants’ assessments

- “Be more vigilant + open-minded about patients choices + circumstances”
- “Now that I have a better insight of abortion I am willing to counsel patient and refer them if they need an abortion and not judge them”
- “To treat every woman seeking abortion with respect and dignity. Provide enough information for her to make an informed decision, not to make a hasty decision. Every woman has a choice to make and receive proper counselling about safe abortion”
Impact

Rural Districts:
- 3 sites Ceres
- 5 sites Breedevalley
- 1 Stellenbosch Hospital
- 4 sites Garden Route

Metro Health Districts:
- 1 Du Noon
- 1 False Bay hospital
- 1 Cape Town Reproductive Health
- 4 Khayelitsha (3: City of Cape Town)

TOTAL: 20 NEW CAC SITES!
Conclusion

Multi-pronged Approach:

- DOH senior manager to hold managers to account to provide CAC services
- VCAT workshops for all staff and managers
- Psycho-social support for HCP’s
- CAC services part of SRH services—not a stand alone
- Proper management of DOH protocol on Conscientious Objection
Conclusion (cont)

- Include CAC training in training of medical students and nurses’ training
- Part of performance management of management and staff
- Increase the pool of CAC trainers in all districts
- Increase the number of CAC providers at all facilities
- Emphasize missed opportunities to provide safe and effective contraceptives
Thank You

POSSIBLE