Author’s response to reviews

Title: What Contraception Do Women Use After Experiencing Complications From Abortion? An Analysis of Cohort Records of 18,688 Postabortion Care Clients in Tanzania

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To respond to each of the Reviewers’ specific comments, we include each comment (numbered) and in the paragraph that follows each of the numbered reviewer comments, we provide our response to the reviewer comment above.

Reviewer #1

1. Contraception after PAC in Tanzania This paper documents the promotion of post abortion care in primary care centers in four regions where it used to be available predominately in hospitals. The spread of postabortion care to new facilities seems much more interesting that contraceptive use, especially given that the authors can't report whether all methods were actually available.
This is noted and we thank the Reviewer for this observation. This paper comes from an earlier analysis that looked at postabortion contraceptive uptake which the authors asked to conduct for our funder, the US Agency for International Development (USAID).

2. I find that much of the language in the title and introduction suggest that abortion is more dangerous than it actually is. The word "surviving" in the title is misleading. Most women are at no risk of dying from complications. A more scientifically accurate, less inflammatory title would be "Contraceptive use after postabortion care in Tanzania".

Thank you for the observation. We have changed the title of this paper to “What Contraception Do Women Use after Experiencing Complications from Abortion.”

3. I would like some background about the level of complications women are experiencing.

Thank you for the interesting and pertinent request. During data collection, in addition to compiling service statistics from PAC registers (as described in the first version of this paper), research assistants also compiled service statistics that had been recorded in obstetrical-gynecological ward registers. They did so in order to understand the level of complications experienced by women who were not admitted to “PAC Rooms” (which are now described in this second version of the manuscript) for the same period, 2005 to 2014. They were admitted to the obs/gyn wards, presumably, because the severity of their complications indicated that uterine evacuation alone would not be suitable for curing their conditions. Although providers in the obs-gyn wards did not record that these complications were abortion-related, in the majority of cases, information on clients’ gestational age was recorded (however, there were a large number of cases for which this was not recorded). Accordingly, we considered any complication resulting during women’s first 28 weeks gestation as potentially abortion related. This information is now included in the article (page 9-10). Because we cannot confirm if these women received contraception (as this is not recorded in these registers because FP provision was not included in the treatment protocol for the conditions described on page 10), we did not include these complications in our statistical analysis. Thus, the data used in the analysis was limited to information in registers maintained in the evacuation settings (i.e. “PAC rooms”) established during the scale up.
4. I would have expected that many women would have used misoprostol to induce an abortion and their seeking of postabortion care is to check that the abortion is complete. Is this not the case?

Thank you for the comment. Unfortunately, during the time period that this paper reflects (2005 to 2014) and up until the present, the Ministry of Health of Tanzania prohibits the conduct of postabortion care with misoprostol. While this may happen on occasion, it, understandably, is not documented in health facility registers where the data used for this analysis was extracted. Misoprostol is available in these facilities and providers are authorized to use it for other conditions, such as postpartum hemorrhage.

5. Relatedly, I don't believe that the end of the first background paragraph is correct. 2/5 "suffer" complications without receiving "necessary" treatment. It is not known whether women who don't come in actually need treatment.

Thank you for the comment. Please note, although we did verify this finding in the citations provided, we have altered the language to address the reviewers point.

6. Many abortions are illegal but not unsafe and need little care. The citation for this is based on facility treatments for women who did need care. I don't think we can presume that women who don't come in have the same level of complications.

This point is well-taken; however, in the country (and regional) context that this paper represents, complications from early termination of pregnancy (spontaneous and induced) comprise a significant public health problem that causes a large number of maternal deaths. So, while we cannot presume that all women that have an abortion or miscarriage require medical care, it stands to reason that they should report to a facility for an examination to confirm this and, if needed, receive treatment, or, if not, obtain counseling and access to contraception. This said, I agree with the reviewer that we shouldn’t editorialize in the paper and misrepresent the risk inherent in early termination of pregnancy.

7. The “advised” delay of 6 months after an abortion is not evidence based. The citations 4-6 have nothing to do with recommended pregnancy intervals. The latest review of this topic
(published in Human Reproduction in 2017) disputes these recommendations. 

Thank you for your important comment and observation. We have shifted he citations to the relevant place in this passage. Furthermore, we have provided a citation which reports on findings that postabortion inter-pregnancy less than 6-months are significantly associated with increased risks of adverse maternal and perinatal outcomes in the next pregnancy. Also, we cite the global recommendation authorized by FIGO, ICM and USAID, etc. that is based on that finding. If the reviewer still wishes for the paper to highlight the debate over this findings we can do so. We appreciate and have learned from the reviewers comment and are sharing this reference with our colleagues. Thank you for that.

8. What is the availability of medication abortion in Tanzania? Why are PAC services not using misoprostol? In mainland Tanzania, misoprostol is not permitted for treating complications from abortions in public healthcare facilities.

9. And, why are nearly 100% of women in PAC receiving a uterine evacuation? This must represent vast over-treatment, unless you only define a woman to be receiving postabortion care if she did have a uterine evacuation (in which case you need to say this and also report how many women didn't get a uterine evacuation). The levels of medical intervention you are reporting here seem alarming.

Thank you for your comment. I have introduced new text into the paper to address this concern (page 9). The data used for this analysis come from “PAC Registers” which were introduced into sites enrolled in the scale up of PAC as described in the paper. In these registers, providers maintained service statistics on women that were admitted and deemed in need of uterine evacuation. Whereas other clients may have been admitted and deemed in need of expectant management of abortion complications, these women would have either been admitted into the gynecological ward (where providers often omit from documentation information that might suggest the complication was abortion related because of legal concerns). Alternatively, women in need of expectant management might be advised to return home and only return if complications continued or exacerbated (we believe that this is often the case for women that may have incomplete abortion but do not require surgical evacuation of the uterus, as we did not observe many records of admissions for expectant evacuation in our review of obs-gyn registers). This may represent a limitation for our analysis since the sample is limited to women with
complications that providers believed required uterine evacuation via MVA or curettage. Similarly, it does not include data on women with more severe complications (severe blood loss, sepsis, uterine perforation, vaginal or cervical laceration, etc.) as we explain above.

10. Not knowing whether all methods are available at all sites is a major limitation. At a minimum, your models should be adjusting for clustered data by site - so that if hospitals don't offer short acting methods, or primary care clinics don't offer LARC, you are not attributing the shortcomings of the facility to the characteristics of their patients.

We appreciate this observation and have modified our analysis according to Reviewer’s suggestion. The revised results are presented in this version of the manuscript (see pages 12-17).

11. The paper needs to be edited. We don't typically talk about hospitals being decongested. The whole discussion needs to be rewritten for clarity.

Thank you for your comment. The term decongested has been removed from the paper and the paper has been edited, particularly the discussion section.

12. "family Planning" is a euphemism and it doesn't just mean contraceptives. Some people consider any method to plan to have a child, to avoid a pregnancy or avoid birth after pregnancy to be family planning methods. What you mean is contraceptive services. You can retain "Family planning" but you need to explain that you only mean contraceptive services.

Thank you for your comment. The difference, pointed out by the reviewer, between “family planning” and “contraceptive services” is noted in the last paragraph on page 3; however, this explanation has been expanded to clarify the distinction further. Throughout the paper we have removed the term “FP” to refer to the provision of contraception and replaced it with “contraceptive services” or “provision of a contraceptive method”.

13. The finding that MVA has become more common than sharp curettage is a wonderful finding. This is more important than the contraceptive use findings.
We thank the reviewer for noting this observation.

14. Where is postabortion care with misoprostol in the mix?

Please see the above explanation of the Government of Tanzania’s position on misoprostol for PAC.

15. The section on trends in decentralization seems important but I don't understand it. What does the sentence "however, the decentralization.. never resulted in significant changes in care seeking for PAC services" mean? it seems like there was a huge increase in patients.

Thank you for the comment. The passage the reviewer has mentioned has been revised for clarity (pages 18-20).

Reviewer #2

1. Please clarify in the introduction whether this is concerning women who have had a spontaneous abortion with retained products perhaps or those who have had a induced termination of pregnancy (unintended pregnancy or due to foetal abnormality) and then they have complications and attend for PAC.

Thank you for your question. We assume that the sample included women with both spontaneous and induced termination of pregnancy. Induced abortion in Tanzania is only legal under circumstances when the life of the woman is at risk and if two physicians sign off on this procedure. Otherwise, the penal code imposes severe consequences (imprisonment) unto women that have abortions, even if by a provider or on her own, unless there is proper documentation of following the law. In our sample, we did not observe any documentation of the legality of the procedure for any women. Thus, the intentionality of abortions that reflected in service statistics is not known. Nevertheless, we can assume that a portion of these abortions were spontaneous and others were induced. This was mentioned in the background section of the paper, and is now included in the methods section as well.
2. If the abortion is induced then where is it done. What is the legality in Tanzania as regards induced abortions and choices for contraception. It's not clear. I wondered if the PAC was a euphemism for abortion clinics. With abortion providers there is an expectation that adequate contraception is provided. These clarifications should be throughout the paper.

Thank you for your questions and comments. As stated above, abortion is prohibited by law in Tanzania and whereas there are providers that offer it, it is done so clandestinely even when the procedure is safe (e.g. anonymous NGO that provide abortions). This is now discussed in the paper. It cannot be known if any of the procedures reflected in our analysis were, in fact, induced abortion, but we shall assume that they did not since they were recorded in PAC registers in settings where conducting abortion is, almost always, illegal and punishable by imprisonment. In Tanzania, PAC is not a euphemism for abortion clinics. PAC is seen as an emergency service for women that are experiencing a complication from an abortion (spontaneous or induced) that was undertaken earlier. In the context of Tanzania, while FP services for PAC clients is discussed in policy documents and curricula, it is not a standard practice throughout the country and health system. This is due to a variety of factors, such as biases of providers and policymakers concerning abortion and FP, cost recovery schemes that require clients to pay for PAC and FP services in distinct locations of health facilities, myths and misconceptions clients hold about contraceptive methods, spousal and gender-related influences and others.

3. As it reads it basically says these women are presenting with complications post abortion - not where or whether it was induced - unsafe or otherwise. It would be good to get a grasp on how big this issue is in Tanzania - how many unplanned pregnancies are there that may have abortions and compared to ongoing pregnancies. What is the death rate of women post abortion.

Thank you for your question. Background information of the sort that the reviewer has requested is now included on pages 5-6.

4. Background Suggest second sentence be split up and referenced as it's a bit confusing. Is the life saving treatment the PAC package.

Thank you for the observation and suggestion. This has now been clarified in the first paragraph of the background section.
5. Is more detail needed for the holistic programming model as pertains to Tanzania Page 5 para 2 line 40 - somewhere it would be good to have a local picture- where abortions are done- are they legal etc and how does Tanzania fit into examples given above.

We have introduced a section that describes the legal status of abortion on pages 5-6. Where the abortions reflected in the service statistics we analyzed were done is not known. This is because, as explained above, abortion is not legal, and women that have them fear persecution. Therefore, it is not document, in fact, that the abortions were induced and/or voluntary and where these took place.

6. Discussion The message around decentralization and training allied health professionals to improve access to services for women is a good one. Of interest what was the contribution of local researchers to this paper - I see that it appears that both the first and senior authors are not local from Tanzania?

Thank you for the comment. The authorship listing was based on a decision we made as a team. It is true that the first and last authors are not Tanzanian nationals. We have elaborated on the roles and contribution of each author. Please see below.

Colin Baynes is a Senior Manager for Monitoring, Evaluation and Research for EngenderHealth based in New York and works considerably in Tanzania. He wrote the paper and conducted the data analysis. Justin Kahwa is a Program Associate for Monitoring, Evaluation and Research and collected the data, reviewed versions of the transcript and developed the figures. Grace Lusiola is a Project Director of the Postabortion Care Family Planning Project, the project which funded the development of this transcript. Feddy Mwanga was the Technical Director, Juliana Bantambya is the Regional Program Manager and Lawrencia Ngosso is the Clinical Advisor for EngenderHealth programs in the Lakes Region where the interventions described on this paper took place. They all directed and/or managed the expansion of PAC services in the areas described in this article during the period reflected in the analysis. Maurice Hiza is a National Family Planning Coordinator and oversaw the expansion of PAC services in from his positon in the Ministry of Health. Carolyn Curtis is a Public Health Specialist/Nurse Midwife for USAID, the donor that funded this work, and conceived of the idea of developing this manuscript, reviewed versions of the manuscript and inserted segments of text that remain in this final version.
7. Do you have any data re women having repeat pregnancies over time post their PAC?

Unfortunately, this information is not available from the service delivery registers where we obtained the data used for our analysis.

8. Figure 1- don't use acronyms - be good to expand what they all are- what did emergency treatment consist off.

Figure 1 has been modified based on the Reviewer’s comment. The treatment methods used for uterine evacuation is manual vacuum aspiration with limited use of sharp curettage, which is now explained on page 7.

9. I have not got a clear impression of the methodology behind the community empoerment bit.

Thank you for the comment. Of note, we have submitted a paper on the implementation processes and lessons learned from the scale up of PAC services to another journal and, similarly, it has been accepted on the condition that we make revisions. This includes a description of the community empowerment component and how this evolved over time. On Page 7 of this manuscript we provide further detail on the community component in order to address the Reviewer’s pertinent comment.

10. Fig 5 probably could be in the text.

We have introduced text which explains the finding illustrated in Fig 5 and agree to remove this figure from the paper.

11. Figure 2 reflects that the clinics are gradually being recruited to the new service. Is that correct.? Do we have any idea of presentation to the clinics before they started with PAC services - numbers and whether they received care or was it all central at this stage.
Thank you for the important question. PAC was introduced to the sites discussed in this paper, as Figure 2 illustrates. As discussed, a component of the package introduced to new sites during the scale up were registers for recording PAC service statistics. These were, and continue to be, kept in evacuation rooms (i.e. PAC Rooms) in these sites. Prior to the scale up, there was no separate room or register for PAC clients, and all abortion-related complications were treated and documented in obstetric and gynecological wards and registers, respectively. Prior to the introduction of PAC to these sites, in this documentation (in the obs-gyn registers), providers that treated these cases did not indicate if the complications were abortion-related and frequently omitted information on clients’ gestational age. In particular, we suspect that during this period, in obs-gyn wards, sharp curettage was under-recorded, so as to omit from documentation any suggestion that the client had induced an abortion since it is criminal offense and documentation of it, providers fear, could prompt a police inquiry. Because of this is was not possible to accurately ascertain if cases treated in these settings before the introduction of PAC services were in fact abortion-related. It follows that we could not determine the number of clients treated for abortion complications during this period in these settings. As PAC was introduced to these sites, the team at the time worked toward improving the quality of data recorded in obstetric-gynecological registers, as well as in the PAC Registers. A primary aim of this was to ensure that records indicated clients gestational age. Information on clients treated for complications before 28 weeks gestational in obstetric-gynecological wards during the period after PAC was introduced at these sites is now provided on pages 9-10 of the revised manuscript.

12. Figures would benefit from titles being more explicit For example Fig 4 should have contraceptive method in title. Was there a zero percent for natural method- I would leave it out then - we could debate whether that is a modern method.

This has been revised according to the Reviewer’s comment.

13. Figure 3. Title and the colour coding not consistent - suggest you define in text modern FP method and use no method for other. This has no method in title but without a modern method as a descriptor

This has been revised according to the Reviewer’s comment.
14. Finally - the title is a good one but perhaps after answering questions re the inclusion criteria of group it may change - Contraceptive choices post abortion complications in Tanzania. But this paper is more than that it also includes the training of health professionals and decentralisation of services. Is there anyway this can be linked to a reduction in maternal mortality which is feasible with adequate emergency treatment and contraception.

Unfortunately, our data do not support an analysis of the effects of this program on maternal death. The other reviewer recommended a change in the title of the paper and we have accepted this. It reflects the theme on method choices after PAC that you have suggested.