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The Right Provider for the Right Place:

Private Nurse-Midwives Offering Primary-Level Postabortion Care in Kenya

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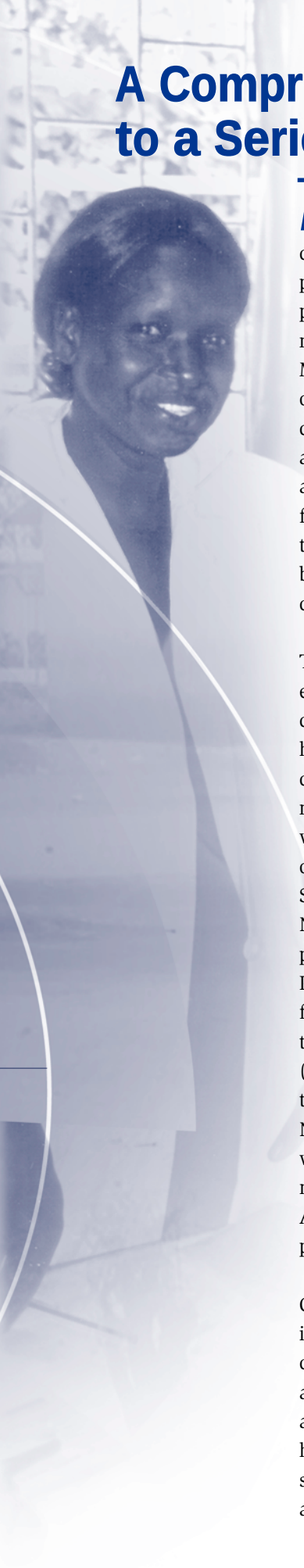
A Comprehensive Approach to a Serious Problem



Primary-level reproductive health care in Kenya is epitomized by providers like Agnes Thamaine, a private-sector nurse-midwife who runs the Namanya Medical Clinic in Mathare, a sprawling slum on the outskirts of Nairobi. For Thamaine, close relationships with her clients are essential to her basic beliefs about her profession: "They care for you because you have treated them. They need your services. You become friends and they feel they can tell you their secrets."

Thamaine's qualifications and experience in reproductive health care, along with the easy access to her services for a crowded peri-urban community with few transportation resources, suit her very well to treat women suffering the complications of unsafe or incomplete abortion. She began offering these services in November 2000 after training in postabortion care (PAC) by the PRIME II Project through a program for private nurse-midwives sanctioned by the Ministry of Health (MOH). Funded by USAID/Kenya, the program is supported by the Nursing Council of Kenya (NCK), which licenses private nurse-midwives, and the National Nurses Association of Kenya (NNAK), a professional organization.

Complications from unsafe or incomplete abortion are a major cause of maternal mortality in Kenya and add a tremendous strain on the already overburdened public-sector health care system. Hospital-based studies in Nairobi have shown that at least half of all gynecological admissions and more than a third of pregnancy-related deaths are due to unsafely induced abortion.[1] An estimated 4,300 women die each year in Kenya's public hospitals from pregnancy-related complications, and over half a million more suffer chronic pain, infertility, and short- or long-term morbidity.[2] These figures don't take into account the thousands of women and adolescent girls who are treated elsewhere or never seek care at all; many die at home, and the health of survivors is frequently severely compromised.

In an effort to reduce maternal mortality or morbidity and decrease the chances of repeat abortion among clients, the PRIME-assisted program for private nurse-midwives emphasizes a comprehensive approach to primary-level PAC services. In addition to providing treatment for potentially life-threatening complications, the nurse-midwives counsel clients about family planning and contraceptive options and provide or refer for methods to help clients prevent future unwanted pregnancies and practice birth spacing. The nurse-midwives also offer selected reproductive and other health services either at their clinics or via referral to another facility accessible to the client. While some clients may be too traumatized in the aftermath of an unsafe abortion to receive or respond to counseling for family planning and other services, taking advantage of a postabortion visit as an opportunity to improve women's overall reproductive health is critical, especially in light of the estimated 14% rate of HIV/AIDS infection among Kenyans aged 15 to 49.[3]

Private Nurse-Midwives: Accessible and Experienced

Agnes Thamaine, private nurse-midwife and owner of the Namanya Medical Clinic in Mathare.

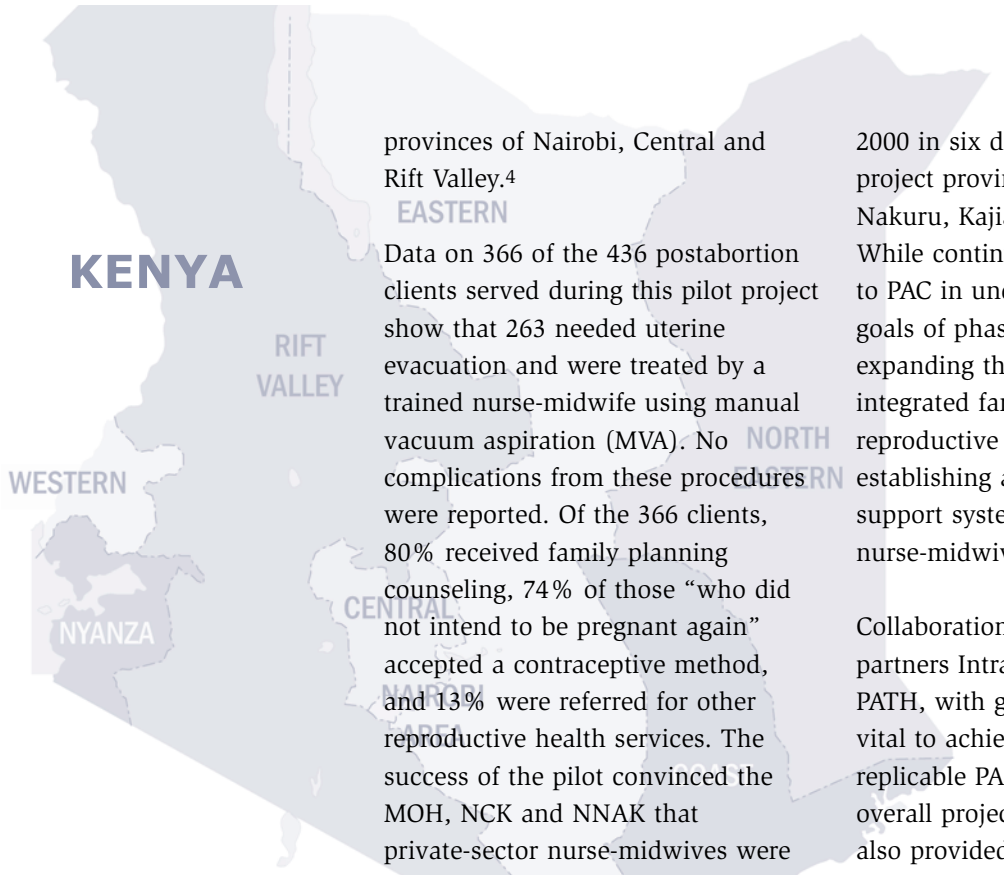
With the goal of reaching underserved populations of Kenyan women closer to where they live and work, PRIME's PAC strategy relies on community support and awareness, especially since PAC services have the potential to become controversial or even confused with abortion itself. Maintaining the confidentiality of clients and providing nonjudgmental counseling and treatment are essential to ensure that women in need seek these services. The empathy for clients displayed by most private nurse-midwives shows how well they fit into the sensitive nature of PAC. "We are able to help those women who do not want to be exposed to government hospital because we provide privacy," says nurse-midwife Hannah Gacoka of the GEWA Medical Clinic in Thika district. "Last Saturday there were demonstrations in Thika by a pro-life group about abortions. The demonstrations did not worry me because I know I don't carry out abortions but [only] help clients who come to my clinic with incomplete abortion."

Provision of PAC services is supported by the Government of Kenya through the 1996 National Strategy for Reproductive Health Care and the 1997 National Reproductive Health Policy Guidelines. These initiatives set the stage for PRIME to begin discussions with the MOH in 1997 in response to a request from NCK-registered private nurse-midwives for assistance in expanding the services they offer to include PAC.

Dispersed throughout the country, from rural marketplaces and coffee plantations to inner cities and peri-urban areas like Mathare, more than 4,000 registered nurse-midwives work in private practice in Kenya. They are the major source of prenatal care, family planning and other reproductive health services in many parts of the country. Their role at the primary level meshes with the Government of Kenya's strategy to decentralize health care and expand the role of the private sector in the delivery of health services. Because many of these private nurse-midwives own their facilities, they represent the potential for a national, financially sustainable base of non-hospital PAC services. Perhaps most importantly, they are experienced providers who must spend ten years as nurse-midwives in public, private or mission institutions before being licensed for private practice by the NCK.

A Five-Year Commitment to Building PAC

To assess the potential for adding PAC to the nurse-midwives' array of services, USAID/Washington and USAID/Regional Economic Development Office for East and Southern Africa funded a two-year pilot project designed by PRIME in 1997 in conjunction with the MOH, NCK, NNAK and other partners. During 1998 and 1999, PRIME trained 75 private nurse-midwives from 44 health facilities in the



provinces of Nairobi, Central and Rift Valley.[4]

Data on 366 of the 436 postabortion clients served during this pilot project show that 263 needed uterine evacuation and were treated by a trained nurse-midwife using manual vacuum aspiration (MVA). No complications from these procedures were reported. Of the 366 clients, 80% received family planning counseling, 74% of those "who did not intend to be pregnant again" accepted a contraceptive method, and 13% were referred for other reproductive health services. The success of the pilot convinced the MOH, NCK and NNAK that private-sector nurse-midwives were clearly capable of delivering quality PAC services and that this care would also increase the accessibility and use of family planning and contraceptive services.

Building on this momentum and additional funding from USAID/Kenya, program partners and stakeholders implemented "phase two," a two-year scale-up of PAC training that began during May 2000 in six districts of the three pilot project provinces: Thika, Nairobi, Nakuru, Kajiado, Kiambu and Nyeri. While continuing to improve access to PAC in underserved areas, the goals of phase two also included expanding the availability of integrated family planning and reproductive health services and establishing a more effective support system for the private nurse-midwives.

Collaboration among PRIME II partners Intrah, EngenderHealth and PATH, with global partner Ipas, was vital to achieving a sustainable and replicable PAC program. In charge of overall project management, Intrah also provided leadership in training, monitoring and evaluation. EngenderHealth trained over 40 nurse-midwives to use the Cost Analysis Tool (CAT) to more efficiently charge clients for services. PATH focused on community involvement and mobilization, while Ipas, with its own funds, concentrated on distribution of MVA kits, sold to the providers at subsidized rates via a local distributor.

The PRIME II Training Approach

The private nurse-midwives shared the cost of training, paying for their own transportation and room and board to further enhance the financial sustainability of the program. Training took place in Nairobi so that the providers could benefit from PAC clinical training opportunities at Kenyatta National Hospital, with its high caseload of postabortion clients. By training providers ten at a time in groups from the same geographic areas, PRIME endeavored to keep the sessions intimate and encourage post-training peer support. Training concentrated on 13 key components:

- Introduction and clarification of values
- Client-provider interaction and counseling
- Management of complications from unsafe or incomplete abortion
- MVA procedures
- Infection prevention

- Pain management
- Postabortion family planning counseling and method provision (including emergency contraception pills)
- STI/HIV management
- Record keeping
- Legal aspects of providing PAC services
- Introduction to peer supervision
- Community outreach and participation
- Performing practical procedures under supervision.

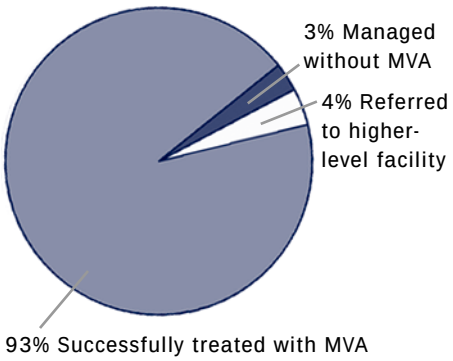
In addition to being certified by NCK for private practice, nurse-midwives were required to satisfy several other criteria in order to be considered for training. Their facilities had to meet minimum standards for sanitation, with running water and essential equipment, adequate space to ensure client privacy, and access to the basic infrastructure for restocking supplies and making referrals. They also had to demonstrate an interest in providing PAC services and show that they were already integrating other reproductive health care into their prenatal and delivery services. During phase two, PRIME trained 155 nurse-midwives to provide PAC services at 120 facilities, 20 more than originally planned.[5]

USAID Evaluation Shows Strong Results

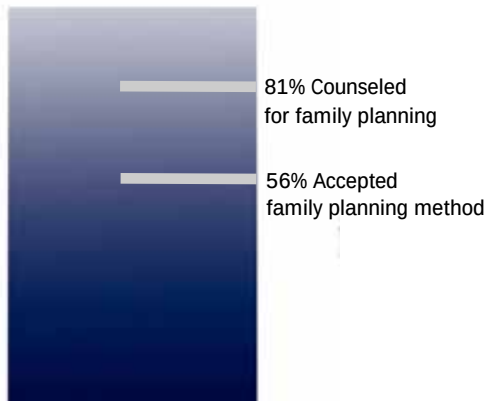
A USAID team evaluating phase two of the program reported extremely positive results, reinforcing the findings of the pilot project. Data on more than 1,600 clients served by PRIME-trained nurse-midwives for complications from unsafe or incomplete abortion during phase two revealed that 93% were successfully treated using MVA and 3% were managed without MVA. Only 4% had to be referred to higher-level facilities after arriving with advanced complications that could not be treated by the nurse-midwives. The small number of referrals—mostly for shock, sepsis and profuse bleeding—gives good evidence of the nurse-midwives' ability to handle a wide variety of complications and emergencies.[6]

PRIME reported that 81% of the PAC clients received counseling for family planning, with 56% either leaving the facility with a contraceptive method

Patient Management n = 1603



Family Planning Counseling and Acceptance n = 1603

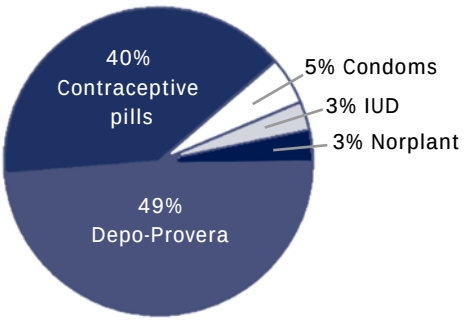


or saying they would return to purchase one. Almost half of the family planning clients chose Depo-Provera, with 40% accepting contraceptive pills. Of the remaining options—condoms (5%), Norplant (3%) and IUD (3%)—Norplant would have been chosen by more clients but was often unavailable. In collaboration with Marie Stopes International, NNAK has been coordinating Norplant training for additional private nurse-midwives. To counter stigma and bias against condom use, one facility—St. Theresa's Health Services in Nairobi's Eastleigh community—sought to increase their use by making condoms available indiscreetly and free of charge in a nearby public telephone booth that a midwife restocks every day.

Considering the trauma of unsafe abortion and the sensitivity of many PAC clients who minimize their visit to the health care facility so as not to attract attention—and the evidence that postabortion family planning reduces the incidence of repeat abortion—the percentages of women receiving family planning counseling and accepting methods are quite encouraging.[7] As nurse-midwife Milka Mathea of the Jamii Medical Clinic in Namanaga says, "PAC is helping very much. It has improved the management of clients, not only those with incomplete abortion but also others. Generally, the cases of clients coming with incomplete abortion have gone down. I visited the government health center here and I also learned that the abortion cases are fewer there. People have understood about family planning. My records show an increase in the number of FP clients."

A profile of 1,500 PAC clients whose ages were recorded by PRIME-trained nurse-midwives underscores the importance of linking treatment of unsafe or incomplete abortion with family planning. The majority of those clients were under the age of 25, and 13% were teenagers. Reaching adolescents and young unmarried women with the right messages about family planning is imperative for preventing future unwanted pregnancies. "PAC is a way of providing family planning to these clients," stresses Hannah Gacoka. "Some clients tell us that they thought family planning methods were [only] for those who are married. We are able to help them."

Family Planning Acceptance By Method n = 904



Nurse-midwife Grace Njunge, owner of St. John's Medical Services, with PRIME II's Florence Githori and Rose Wahome

Increasing Access to Other RH Services

74% Counseled for STI/HIV prevention

48% Counseled for breast cancer

38% Counseled for cervical cancer

50% Counseled for nutrition

Counseling for other RH issues

n = 1603

According to PRIME's data, PAC clients also received counseling for STI/HIV prevention (74%), breast cancer (48%), cervical cancer (38%) and nutrition (50%). To further explore the issue of what other counseling and services should be offered to PAC clients at treatment, follow-up or via referral, PRIME undertook a special study of this "third component" of the original model for PAC services: "links between emergency abortion treatment services and comprehensive reproductive health care." The study used detailed interviews with providers and examinations of client records to draw on the experiences of 71 PRIME-trained private nurse-midwives from 59 facilities in urban (62%), peri-urban (17%) and rural (21%) areas of Kenya.

The designers of the study recognized several assumptions at the outset. Women who have had unsafe abortions are at higher risk for other negative reproductive health outcomes; thus, any opportunity to offer other reproductive health services to postabortion women seeking treatment should not be missed. These clients would prefer to receive other RH services at the same facility where they receive PAC rather than to be referred elsewhere, especially to large public hospitals where seeing a doctor might entail transportation costs and long waiting times. Clearly, there are few physicians to serve many clients in Kenya; this situation necessitates a primary-level alternative to hospital-based emergency obstetric and gynecological care.

According to the providers surveyed in the study, the other reproductive health services most frequently requested by their PAC clients were STI/HIV counseling and testing (45%), nutrition counseling (34%), other counseling including hygiene, infertility, anemia, prenatal care and child immunization (22.5%), screening for breast and cervical cancer (21%) and prenatal care and maternity services (20%). Most of these are typically available at the private nurse-midwives' facilities.

Two Challenges: Fees for Services and Community Awareness

The PRIME special study established cost as the biggest barrier to clients receiving additional RH care. The average client fee for PAC services was 1,454 Kenya shillings ($19), but only a quarter of clients reportedly paid their bills in full. Many arranged to pay in installments or were given a reduced rate based on their ability to pay. "Regarding challenges," says Milka Mathea, "it is only that not all clients are able to pay. The economical status is very low, but I use the sliding scale that we were taught during the CAT (Cost Analysis Tool) training. Those who are able to pay, pay for those who can't." Clients' lack of awareness about other RH services was also identified as an impediment to care. In addition, the study pointed to the need for more reliable availability of family planning commodities and other equipment and supplies. More than half of the nurse-midwives reported running out of one or more family planning method (especially contraceptive pills) during the six months prior to the study.

Both PRIME's special study on other RH services and the USAID evaluation pointed to community outreach as another area needing more emphasis as PAC services expand. Almost 90% of the private nurse-midwives said that they had made attempts to increase awareness in their communities about PAC services and preventing unsafe abortion by using family planning and contraceptive services. These efforts included distributing posters and fliers and making visits to churches, women's groups, youth groups, village leaders, and other health care facilities. Still, dispelling misconceptions about PAC remains a formidable obstacle in some communities—several providers reported being harassed by local police convinced they were performing abortions.

Peer Support for Sustainable Supervision

Establishing a viable supervision system for the trained private nurse-midwives has also presented challenges during the scale-up of PAC services. Under the auspices of the MOH, District Public Health Nurses (DPHNs) are charged with supervising and supporting the performance of private nurse-midwives. While well intentioned, the DPHNs have not been able to function effectively in their role as supervisors—they are overworked with public-sector responsibilities and at times face such basic logistical problems as not having enough fuel to drive to the nurse-midwives' facilities. During phase two, PRIME's Nairobi office took on a more extensive role in providing support after training and managed to visit 82% of the trained nurse-midwives at least twice. While providers reported that those visits were very helpful in reinforcing skills, ensuring that infection prevention procedures were being followed, and checking on supplies, PRIME did not have adequate staff to provide sufficient post-training support. Further, the interval between the end of training and the first visit was often longer than ideal for supporting the nurse-midwives' efforts to start up PAC services in their facilities.

To supplement the supervision efforts of the DPHNs and the post-training visits by PRIME staff, the nurse-midwives were encouraged during their PAC training to support each other informally by talking together to solve problems, share information and keep up-to-date in RH. These peer support groups hold the key to dealing effectively with a number of practical issues. A PRIME study of supervision practices and needs conducted in November and December 2001 examined the scope and location of such peer support among the nurse-midwives, finding organized clusters in the districts of Nakuru and Kiambu. The Nakuru network meets once a month and members consult each other whenever they need assistance with challenging cases. At times they perform procedures together when such support is needed. The cluster has also organized seminars and updates on reproductive health topics.

The smaller Kiambu group also includes some private-sector providers in the district who have not been formally trained in PAC. Gathering at a different facility each month, the cluster carries out evaluations, provides feedback to clinic owners, and shares experiences. Members also pool resources when a provider needs supplies or faces financial problems, partly because of clients' inability to pay. Replication of similar peer support networks in other districts holds great promise for helping the trained nurse-midwives sustain and enhance their knowledge and skills to best advantage.

Expanding to New Provinces

The USAID/Kenya evaluation team identified the potential for expansion as one of the strengths of the Kenya PAC program. Recommendations from the evaluation are now being used to shape PRIME II's scale-up of PAC training for private nurse-midwives in Coast province in conjunction with USAID's bilateral AMKENI project, which focuses on developing client-centered, community-based integrated family planning, reproductive health and child survival services.

As the PAC program expands throughout Kenya, private nurse midwives will surely continue to confront obstacles—from running out of water and contraceptive supplies to facing down the police. Fortunately, most of them are up to the challenge. Through the five years of the Kenya PAC program, the private nurse-midwives have shown exceptional resilience and proven without a doubt their ability to deliver high quality services. As PRIME program officer Florence Githiori says of Agnes Thamaine's dedication to her community, "The right provider for the right place has been trained!" And as trained primary-level PAC providers like Thamaine increase in number, so will the chances of improved health outcomes for women across Kenya.

"I am very grateful," sums up nurse-midwife Herman Kiarie of the Kahuho Private Dispensary in Kiambu district. "The PAC training helped me to help the clients and the community is very thankful, has really accepted the services and is very positive. I am very encouraged and I feel I am doing something good."

Notes

[1] *Folsom M. The Situation of Unsafe Abortion in Kenya. Nairobi: USAID/REDSO-ESA, 1999.*

[2] *Graham WJ, Murray SF. A Question of Survival? A Review of Safe Motherhood. Nairobi: Kenya Ministry of Health, Division of Primary Health Care, 1997.*

[3] *Population Reference Bureau, 2001.*

[4] *Between the pilot project and phase two of the PRIME-assisted program, an additional 13 providers from the provinces of Nyanza and Coast were trained in PAC.*

[5] *However, 32 of the trainees proved to be "non-starters" who, as of March 2002, had yet to offer PAC services at their facilities.*

[6] *Findings from the evaluation are taken from Mburu FM. Evaluation of PRIME II Kenya Postabortion Care Project, May 13 to June 27, 2002. Draft Report. Nairobi: USAID/Kenya, 2002.*

[7] *For strong evidence on the value of postabortion contraception see Johnson BR, Ndhlovu S, Chipato T, Farr SL. Reducing unplanned pregnancy and abortion in Zimbabwe through postabortion contraception.* Studies in Family Planning *2002;33:195-202.*

[8] *In 2002, the Postabortion Care Consortium announced an expanded and updated* Essential Elements of Postabortion Care. *The new model includes* ***community and service provider partnerships*** *for preventing unwanted pregnancies and unsafe abortion, mobilizing resources to help women receive appropriate and timely care for complications from abortion, and ensuring that health services reflect and meet community expectations and needs;* ***counseling*** *to identify and respond to women's emotional and physical health needs and other concerns;* ***treatment of incomplete and unsafe abortion*** *and complications that are potentially life-threatening;* ***contraceptive and family planning services*** *to help women prevent an unwanted pregnancy or practice birth spacing; and* ***reproductive and other health services*** *that are preferably provided on-site or via referrals to other accessible facilities in providers' networks.*

Acknowledgments

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