

**Technical Report 21:
Expanding Opportunities
for Postabortion Care
at the Community Level
through Private
Nurse-midwives in Kenya**

FINAL REPORT

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This report documents the PRIME postabortion care (PAC) pilot initiative in Kenya, including the design, processes of implementation, results and experiences in strengthening private nurse-midwives' capacity to provide high quality PAC services. It would never have been compiled without the invaluable support and inputs from colleagues and key organizations.

The partnership with the National Nurses Association of Kenya garnered support for the initiative among the nursing community. The launching of the initiative proceeded smoothly because of legislative and administrative support from the Nursing Council of Kenya and the Ministry of Health. The funding support received from USAID/Kenya, USAID core funds, and REDSO/ESA demonstrated USAID's commitment to reducing maternal mortality and morbidity resulting from unsafe abortion. The POLICY project undertook advocacy drives to ensure policy makers, public sector health professionals, and communities were sensitized to PAC.

The PRIME PAC planning team, led by Ms. Pauline Muhuhu, PRIME/Intrah Regional Director for East and Southern Africa, and Dr. Khama Rogo, Ipas Vice President for Medical Affairs, deserves special mention. The design developed by the PAC team – in consultation with others – provided direction for planning and implementing the initiative.

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The private nurse-midwives as a group merit acknowledgment for voicing, through the National Nurses Association of Kenya, their desire for PAC training to address communities' expressed needs. The private nurse-midwives selected for training were described by the trainers as easy to work with and eager to learn. The nurse-midwives were always willing to receive guidance from the PAC supervisory team as they initiated and established PAC services at their sites. Through telephone calls and informal and formal meetings the providers shared information and insights about the positive influence the training had on their ability to save women's lives. The nurse-midwives diligently documented the data required to monitor the effects of PAC training on service outcomes and most providers regularly forwarded the completed data collection forms to the PRIME/Intrah offices.

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Foreword

At the 1997 *Technical Review Meeting of Safe Motherhood +10* held in Colombo, Sri Lanka, Africa distinguished itself for one most undesirable quality: in the 10 years since the first *Safe Motherhood* meeting, which was ironically held in Nairobi, Kenya, all continents except Africa made substantial progress in reducing maternal mortality. Most African countries had committed resources to training traditional birth attendants, which left few resources to promote emergency obstetric services. Yet as discussed at this meeting, improving emergency care is probably the most significant step towards reducing maternal mortality.

Another distinct feature of maternal mortality in Africa compared, to other continents, is the disproportionate contribution of abortion and abortion-related complications to maternal mortality. While abortion accounts for less than 15% of maternal mortality in many areas of the developing world, it contributes to 30 – 50% of maternal mortality in Africa.

There is little argument that the war to save the mother's life in Africa must be fought on two fronts – emergency obstetric care and emergency gynecological care. With the former, unnecessary deaths from ante/postpartum hemorrhage, sepsis, toxemia and obstructed labor will be prevented. With the latter, complications from unsafe abortion will be prevented or promptly managed. The availability of trained clinicians is therefore paramount.

The physician-population ratio in sub-Saharan Africa stands at best at 1:100,000. Even in countries like Kenya where more doctors are available, 70 – 90% are stationed in the few urban centers that are home to less than 20% of the total population. The most skilled provider after physicians is the nurse-midwife. They are present in greater numbers (1:1,000) and are experienced in conducting uncomplicated obstetric and gynecological procedures such as deliveries and insertion and removal of intrauterine contraceptive devices. Nurse-midwives are more economical to train and more willing to work in rural communities. The rationale for training primary level providers to help mitigate the high maternal mortality rates is clear.

This project to expand opportunities for PAC at the community level through private nurse-midwives is one such step towards reducing maternal mortality due to abortion. Private nurse-midwives were trained to provide PAC and followed-up for over one year post-training. The results justify the pilot initiative: nurse-midwives can competently and economically provide safe, quality PAC services at the community level.

The message for health planners in Africa is straightforward. Directly in front of you are thousands of nurse-midwives. For years they have watched in frustration as women with abortion complications bleed to death. They could have saved those lives, but their hands were tied by policy and regulations. Review and modify these policies and regulations to empower nurse-midwives. They can and will save African women from dying unnecessarily from abortion-related complications. This is the message confirmed by the PRIME-assisted PAC pilot initiative in Kenya.

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Acronyms

DPHC	Division of Primary Health Care
DPHN	District Public Health Nurse
ECSACON	East, Central, Southern African College of Nursing
FP	family planning
GOK	Government of Kenya
ICPD	International Conference on Population and Development
IEC	information, education and communication
IUCD	intrauterine contraceptive device
KMA	Kenya Medical Association
KIMET	Kisumu Medical Trust
KNH	Kenyatta National Hospital
MOH	Ministry of Health
MVA	manual vacuum aspiration
NCK	Nursing Council of Kenya
NGO	non-governmental organization
NNAK	National Nurses Association of Kenya
PAC	postabortion care
PAFP	postabortion family planning
PRIME	Primary Providers Training in Reproductive Health project
RH	reproductive health
STI	sexually transmitted infections
USAID	United States Agency for International Development

Executive Summary

Unsafe abortion is one of the single largest contributing factors to maternal mortality in sub-Saharan Africa. In a part of the world where the physician-population ratio is at best 1:100,000, reducing maternal deaths resulting from abortion-related complications necessitates an alternative to the paradigm of the physician as the sole provider of emergency obstetric and emergency gynecologic care. To fully address the relationship between unsafe abortion and maternal mortality, postabortion care services must be available at the community level – the level where women can most easily and quickly receive the treatment needed to save their lives. The PRIME-assisted initiative entitled Expanding Opportunities for Postabortion Care at the Community Level through Private Nurse-midwives in Kenya, resoundingly demonstrates that trained nurse-midwives can successfully provide safe, quality PAC services using manual vacuum aspiration (MVA) at the community level. This initiative was funded by PRIME core funds, REDSO/ESA, and field support funds from USAID/Kenya.

In 1998, private nurse-midwives licensed with the Nursing Council of Kenya (NCK) requested PRIME's assistance to include PAC in the range of services they offer. In partnership with the National Nurses Association of Kenya (NNAK) and with support and sanctioning from the NCK and the Ministry of Health (MOH), the PRIME-assisted PAC initiative described in this report was launched in three provinces. From October – November 1998, prior to the start of the project, a baseline needs assessment was conducted to collect data from 151 nurse-midwives working in 49 facilities in Nairobi, Central and Rift Valley provinces. Among the key findings of the needs assessment was confirmation that private nurse-midwives have facilities that could enable them to provide quality PAC services to meet the communities' expressed demand.

Based on the findings of the needs assessment, advocacy activities designed to raise awareness and build policy support for PAC were an important project component adding to both the acceptance and the sustainability of this initiative. Participants at the various advocacy and information workshops were senior personnel from the Kenya Medical Association (KMA), MOH, NCK, NNAK, and provincial and district supervisory personnel based in Nairobi, Central and Rift Valley provinces. The POLICY project also helped the NCK organize a three-day PAC sensitization seminar for nurse-tutors and administrators from training institutions to build support for PAC among the Kenyan nursing community and stakeholder groups.

The three objectives of the PRIME-assisted pilot initiative were also guided by the results of the needs assessment: (1) strengthen the capacity of select private facilities operated by nurse-midwives to provide quality PAC services; (2) monitor use of PAC services, quality of services, and patient outcomes at the pilot facilities following training of private nurse-midwives; and (3) share challenges and lessons learned and propose recommendations for expansion of PAC services through nurse-midwives and other cadres operating at the primary care level.

By the end of the 19-week post-training period in mid-1999, 100% of the trained nurse-midwives that were assessed by the time of reporting had achieved an acceptable standard of performance in the provision of PAC services by having met the minimum established criteria. During this time there was a rapid expansion of PAC services provided by these trained nurse-midwives, including an increase in the proportion of facilities offering emergency treatment using MVA, postabortion family planning (PAFP) counseling and methods, and linkages with other reproductive health (RH) services. There was also an increase in the number of women seeking PAC services at these facilities. In fact, the availability and use of PAC services at the community level has impacted the number of PAC patients seeking care at referral facilities (teaching and district hospitals), forcing trainers to explore how and where nurse-midwife trainers can receive the needed PAC practical experience once these hospitals no longer see enough cases for training purposes.

This pilot initiative, in addition to showcasing nurse-midwives' skills as providers of quality PAC services, highlighted several factors relevant to the continued expansion of PAC services through private nurse-midwives. First of all, there has been a significant shift in policy throughout the MOH and other national policy making entities to embrace nurse-midwives as providers of postabortion care. The advocacy workshops were particularly useful in eliciting this change in opinion and the resulting change in policy. Second, since private nurse-midwives are already experienced providers of other maternal and RH services, training for PAC is relatively quick and therefore judged to be cost effective. The training also yielded unanticipated multiplier effects, such as on-the-job training by the newly trained nurse-midwives for service providers at nearby facilities. Third, PAC patients seeking care from private nurse-midwives' facilities are assured access to quality PAC services close to their communities. These primary level facilities are also willing to work out an acceptable payment schedule for the patient. A fourth factor that should influence the continued expansion of PAC services through private nurse-midwives is the potential to reduce the burden for PAC services at referral sites as well as opportunities for reinforcing private/private and private/public sector linkages through supervision and referral networks.

Even with the success of this pilot initiative, there were several challenges and lessons learned about expanding PAC services. To scale up PAC services to achieve greater impact, further expansion of PAC services in Kenya should occur within the framework of PRIME's Performance Improvement Approach. This approach will lead to a better understanding of performance issues related to providers and service delivery systems enabling improved efficiency in such areas as quality assurance and supervisory systems for private nurse-midwives. Record keeping practices at pilot facilities improved markedly since the start of this project, however it is still necessary to strengthen many of the data collection tools and processes to address problems encountered during data recording and collection. Appropriate infection prevention practices must also be better addressed since inconsistent procedures were witnessed during post-training follow-up. Lastly, despite the fact that women seeking pregnancy termination at the pilot facilities were counseled on the merits of keeping the pregnancy as well as the dangers of unsafe abortion, many of these women later returned to the facility requiring help for abortion-related complications. This elucidates the problem of unmet need for family planning to prevent unwanted pregnancies and repeat abortion.

Private nurse-midwives trained as PAC providers, in addition to the offered family planning information and methods, should be encouraged to promote sensitization, education, and provision of emergency contraceptive pills as an alternative method to prevent an unwanted pregnancy.

The private nurse-midwife as a provider of postabortion care services at the community level is an essential strategy to reducing maternal mortality in sub-Saharan Africa. This cadre of provider is both willing and able to help women suffering from the complications of an unsafe abortion where and when they need it most. This PRIME-assisted initiative has demonstrated both the demand for these services at the community level and the ability of private nurse-midwives to provide safe postabortion care using MVA. The decentralization and expansion of PAC services to clinics and maternity homes on a wider scale is the next logical step.

1. Introduction

1.1 Rationale for expanding postabortion care services through the private sector

The dialogue about unsafe abortion as a public health problem at the 1994 International Conference on Population and Development (ICPD) and the 1995 Beijing 4th World Conference on Women helped sensitize policy makers throughout the world to the need for improved postabortion care services. In Kenya, PAC now receives growing attention in the effort to address the consequences of unsafe abortion.

After the ICPD, the Government of Kenya (GOK) made a major move to decentralize health care services to improve the quality and access of all services, including PAC. In the implementation of the decentralized health care delivery system, the GOK emphasizes a multi-sectoral, integrated approach that involves collaboration with the community, non-governmental organizations (NGO), religious organizations, and the private sector. The GOK outlined its intent to strengthen the private sector's capacity to assume more responsibility for health care (ref: Kenya Health Policy Framework). This move recognizes the fact that in the delivery of health care, the private sector's role is equally as important as the public sector's.

According to a 1996 World Bank health survey in Kenya, 56% of health services were currently provided by the public sector, 24% by the private sector, and 20% by NGOs. Only 700 of the approximately 5,000 doctors and 18,000 of the more than 30,000 nurses in the country are employed by the GOK. In recent years, increasing numbers of nurses and midwives who have retired from public service and/or completed their contracts with NGO or private sector hospitals are starting their own clinics or maternity homes. The NCK is the national licensing body for nurse-midwives and determines the range of procedures nurse-midwives can perform. NCK records indicate that between January and November 1997, approximately 850 nurse-midwives renewed their licenses to practice privately. The private clinics and maternity homes operated by nurse-midwives tend to be located in areas underserved by physicians (i.e., urban slums and rural market places) and fulfill an important need in the health care sector. These nurse-midwives are often the only trained health care providers in the area and must provide a wide range of services, including managing complications from incomplete and unsafe abortions.

1.2 Manual vacuum aspiration offers opportunity to expand PAC services at the primary level

Until recently, treatment of complications resulting from spontaneous or induced abortion occurred mainly in hospitals where physicians treated women with the dilation and curettage method. The introduction of the MVA instrument and procedure, which may or may not be used with local anesthetic, presented the opportunity to decentralize and expand high quality PAC services beyond hospital settings. The MVA procedure is simple and safe enough to be performed by non-physicians. A number of African

countries, including Kenya, are now providing – or contemplating provision of – MVA training to non-physicians. The Kisumu Medical Trust (KIMET) project in Western Kenya began training private physicians in PAC in 1996 (ref: Rogo et al). That project has now expanded its training to clinical officers, including private nurse-midwives. Nurse-midwives emerged as a priority group for PAC training since they are already skilled in many RH procedures, including antenatal care, delivery, and family planning (FP), often including intrauterine contraceptive device (IUCD) insertion and removal. These skills provide a strong base for PAC training. In Ghana, an operations research project, supported in part by the United States Agency for International Development (USAID)-funded MotherCare Project, demonstrated that nurse-midwives can safely and effectively perform the MVA procedure. In Uganda, the Department of Obstetrics and Gynecology at Mulago Hospital, the MOH, and the PRIME project recently concluded a successful PAC pilot training program for public sector nurse-midwives.

In Kenya, the MOH, NCK, the NNAK (the national professional association for nurses and nurse-midwives), and the KMA are supporting trained nurse-midwives as PAC providers in both the public and private sectors. Private nurse-midwives licensed with the NCK requested PRIME's assistance to include PAC using MVA in the range of services nurse-midwives offer. In late 1998, in partnership with the NNAK and with support and sanctioning from the NCK and the Division of Primary Health Care (DPHC) of the MOH, a PRIME-assisted PAC pilot initiative was launched in three provinces. The aim of this PAC initiative was to expand PAC services through private nurse-midwives. To complement the PRIME initiative, the POLICY project undertook a series of advocacy activities to build support for PAC among the Kenyan nursing community and stakeholder groups in the districts in which the PRIME-assisted initiative was being implemented.

1.3 The PRIME PAC pilot initiative design

The pilot initiative had six components:

The pre-intervention components

- A baseline assessment to establish the potential for facilities operated by private nurse-midwives to provide PAC services and to assess demand for PAC services among communities.
- Systematic advocacy activities to ensure policy support and acceptance of private nurse-midwives as PAC service providers.

The intervention components

- Strengthening the capacity for district public health nurses (DPHN) to provide support and supervision to PAC trained nurse-midwives in private facilities and facilitate referral linkages to higher level facilities.

- Training and supportive supervision to a selected group of private nurse-midwives for the establishment of quality PAC services at their facilities.
- Establishing and maintaining a system for monitoring demand, quality of services, and patient outcomes at trained nurse-midwives' facilities.
- Disseminating results to solicit inputs from key stakeholders that will guide the development of recommendations for expansion of PAC services in Kenya by nurse-midwives and other cadres operating at the primary care level.

2. Pre-intervention Activities

2.1 The baseline needs assessment

From October to November 1998, PRIME conducted a baseline needs assessment to generate baseline data that would contribute to the design of strategies to train, supervise, and monitor private nurse-midwives as they integrate PAC services with other RH services at their facilities.

Data were collected from 151 nurse-midwives working in 49 facilities in Nairobi, Central, and Rift Valley provinces. Data were also collected from community opinion leaders and youth through focus group discussions and from 23 clients available for exit interviews.

Key findings from the baseline assessment (ref: PRIME Technical Report, no 12) include the following:

- ***The assessment confirmed that private nurse-midwives have facilities enabling them to provide quality, comprehensive, sustainable PAC services to meet the expressed demand for these services.***

Private nurse-midwives own facilities that are located in underserved areas largely inhabited by communities within the low income bracket. This strategic location, coupled with the availability of 24 hour service, offers communities easy access to affordable, integrated RH services. Almost all 49 facilities assessed offer oral contraceptive pills, Depo-Provera®, and condoms. Over 75% of the facilities offer IUCD insertion and sexually transmitted infections (STI) prevention, screening and management. Seventy-five percent of facilities also provide PAFP counseling and services to clients who received emergency treatment elsewhere.

Private nurse-midwives' facilities were stocked with the basic equipment and supplies for provision of PAC services. The proprietors of these facilities replenish supplies when necessary. This is unlike the situation in the public sector where complex procurement procedures sometimes hamper availability of essential equipment and supplies.

- ***Potential PAC patients needing prompt attention are assured of quality services by trained nurse-midwives who are willing and committed to providing comprehensive PAC services.***

Almost all (96%) facility incharges expressed an interest in PAC training and other support that would enable them to meet the demand for PAC services. Some reasons offered by private nurse-midwives to justify PAC training are that patients with abortion complications are

- Already in pain and fear that traveling long distances under poor road conditions will aggravate the intensity of their pain
 - More familiar with the procedures and staff at primary care facilities, including private nurse-midwives' facilities, and do not anticipate delays in receiving care at such facilities
 - Not afraid of being stigmatized at private nurse-midwives' facilities as they perceive providers at these facilities to be more sympathetic towards patients suffering from abortion complications
- ***Community opinion leaders and youth identified abortion and abortion complications as one of the major public health problems facing youths today in Kenya.***

Quote, community opinion leaders: *“Girls faced with the problem of unwanted pregnancy wait until month 5 before carrying out an abortion with the belief that everything comes out then.”*

Quote, youths: *‘We have too many problems...like STIs, abortion...but nobody cares to tell us what to do when we are faced with them. At home our parents think we are taught these issues in school and the same goes for the school...so where does that leave us?’*

- ***Infection prevention and record keeping practices need attention to expand PAC services through private nurse-midwives' facilities.***

The assessment found the nurse-midwives were knowledgeable and is trained in the importance of infection prevention and control. Twenty-two percent of facilities, however, lacked chemical disinfectants for sterilizing and disinfecting equipment, and 20% did not have covered containers for high level disinfection.

Record keeping practices were poor because records were not kept up-to-date and accurate for most of the services offered.

2.2 Advocacy drives to raise awareness and build policy support for PAC

Once the baseline assessment was completed and preliminary results were ready for sharing, PRIME organized an advocacy workshop in January 1999 to build support among policy makers for private nurse-midwives being trained in PAC. Participants were drawn from senior personnel from the KMA, the MOH – DPHC, the NCK Nursing Division, the NNAK, and from provincial and district supervisory personnel based in the three provinces selected for the pilot initiative.

The information shared at the advocacy workshop led to a shift in policy makers' stance from mere pronouncement of support for PAC to action for integrating PAC into the reproductive and child health services package. At this workshop, the NNAK and the NCK prepared action plans to advocate for PAC. NNAK follow-on activities were geared towards promoting a positive attitude about PAC among its members through publications in nursing journals and newsletters. NNAK branch chairs were sensitized to PAC at a one-day seminar. Selected members were also trained in advocacy by the POLICY project.

At the NCK's request, PRIME supported an orientation workshop for 30 NCK members in March 1999. The workshop aimed to raise awareness of PAC, provide an update on current global contraceptive and RH issues, and help prepare NCK members for a curriculum review activity that seeks to integrate PAC into pre-service training and continuing education curricula for nurse-midwives. In October 1999, with funding support from the POLICY project, the NCK organized a three-day PAC sensitization seminar for nurse-tutors and administrators from training institutions

Other follow-on activities planned by the Council for the immediate future include regular distribution of information, education and communication (IEC) materials to public and private health care institutions to ensure that a majority of service providers are informed about PAC, and a review of the nursing curricula to include PAC.

3. The Intervention

3.1 Intervention objectives (ref: Kenya PAC Initiative Proposal)

1. To strengthen the capacity of select private facilities operated by nurse-midwives to provide quality PAC services.
2. To monitor use of PAC services, quality of services, and patient outcomes at the pilot facilities following training of private nurse-midwives.
3. To share challenges and lessons learned and propose recommendations for expansion of PAC services through nurse-midwives and other cadres operating at the primary care level.

3.2 Description of the interventions

3.2.1 Strengthen the capacity of district public health nurses in supportive supervisory roles

Three provincial matrons, six DPHN supervisors located at the provinces and districts from which baseline data were gathered, and three referral doctors who participated in the January 1999 orientation workshop, all stayed for an additional two-day workshop (following the orientation). The aim of the follow-on workshop was to strengthen participant's ability to provide technical support and supervision to PAC trained private nurse-midwives whose facilities are located in their districts. Involvement of MOH personnel in the pilot initiative was expected to strengthen the links between the private and public sector and to facilitate referral linkages to higher level facilities.

Content areas covered during the workshop included supervisory roles for quality control; mechanisms for establishing referral linkages; record keeping and maintenance; and use of monitoring and supervision tools for assessing performance output and problem solving. The supervisors also had the opportunity to visit public and private sector facilities providing PAC services to observe the management of unsafe or incomplete abortion using the MVA procedure.

In provincial/district teams, the participants developed action plans that reflected their supervisory role.

3.2.2 Strengthen the capacity of selected private facilities to provide quality PAC services

a) Selection of facilities

Thirty-two facilities were selected to pilot test the intervention strategies. They were selected from the 49 facilities located in Nairobi, Central, and Rift Valley provinces from which baseline data were gathered.

The following criteria were considered in selecting the 32 pilot facilities:

- Expressed desire by the facility incharge to be trained in PAC
- Facility has a recovery room or can easily improvise one
- Facility provides integrated RH services (curative and preventive)
- Facility provides FP methods, including IUCD insertion
- Facility incharge has an assistant who is a trained nurse-midwife

b) Curriculum adaptation

The PRIME PAC pilot initiative team used the results of the baseline assessment to adapt an existing MOH PAC training curriculum and materials for the training of private nurse-midwives. The curriculum content included

- Diagnosis and treatment of incomplete abortion using MVA
- PAFP services, including counseling
- Pain control and management
- Infection prevention and control
- Timely and appropriate referral practices
- STI/HIV prevention and management
- Record keeping and reporting

c) Training in comprehensive PAC service provision

Training of private nurse-midwives from the 32 facilities began mid-February 1999 and ended in May 1999. To accomplish the training objectives, a three-member PRIME team facilitated six one-week workshops. Three of the workshops were conducted in Nairobi, the other three workshops were in Kisumu. Kenyatta National Hospital (KNH) and Kisumu Provincial General Hospital were used for practical experience. Each workshop catered to five pairs of facility incharges and their assistants (i.e., 10 trainees at a time). Incharges and assistants were trained as a team to ensure post-training support and continuity of services at their facility.

The training allowed for both theory and practice sessions on the curriculum content areas. The practicums differed slightly for the two training sites. In Nairobi, an adequate number of patients were available at all times. This made it possible to schedule the practical training. In Kisumu, the timing for practical training was influenced by availability of patients. To best take advantage of the practice opportunities presented by patients, the classroom training sessions were occasionally interrupted.

During the practicum, each trainee developed skills in handling MVA instruments and also preparing them for re-use. Each trainee performed at least two MVAs under supervision and was assisted with the management of patients presenting with a variety of postabortion and postpartum complications, including

- Puerperal sepsis associated with retained products of conception
- Retained placental tissue following normal delivery
- Severe vaginal bleeding with collapse
- Peritonitis following mismanaged postabortion care

Facility teams developed action plans based on learning acquired during the workshop. At the end of the one-week training, each participating facility was supplied with PAC reference materials and an MVA kit donated by non-PRIME sources. These materials

assisted trained nurse-midwives to initiate services at their sites while reinforcing MVA skills through on-the-job training.

3.2.3 Follow-up visits for supportive supervision, and to monitor demand, quality of services, and patient outcomes

The project design allowed for three follow-up visits to trained nurse-midwives at their facilities by a team of PRIME trainers and the DPHNs trained for supervisory roles. The visits were made according to the following schedule:

- First visit at three weeks post-training
- Second visit at eight weeks following the first visit (11 weeks post training)
- Third visit at eight weeks following the second visit (19 weeks post training)

The supportive supervisory tasks, performed as needed during the follow-up, included

- Assessment of the extent of implementation of action plans
- Assistance to trained nurse-midwives to reinforce skills needed for performing the MVA procedure
- Practical, on-site, problem solving
- Monitoring of infection control practices
- Guidance to nurse-midwives on how to use the standard checklists for record keeping
- Guidance to nurse-midwives to identify suitable linkage facilities for referral services and other support

Other tasks performed included

- Identification of facilitating and limiting factors for initiating PAC services and documentation of trained nurse-midwives' perceptions of the benefits of training
- Documentation of data on PAC case load and profile of PAC patient (*age, education, marital status*) using a standard checklist
- Collection of monthly reports compiled by trained nurse-midwives on PAC service output (*number of patients seen with abortion complications; number provided with emergency care using MVA; number counseled for and provided with an FP method; number referred*)

Figure 1: PRIME PAC Team Members Carrying Out Supportive Supervision Activities

DPHN and
PRIME PAC team
members



3.2.4 System to monitor demand, quality of services and patient outcomes

The project design made provision for monitoring and evaluation for quality assurance and for assessment of post-training performance guided by an evaluation plan. The evaluation plan provided details on the specific indicators to be measured to monitor progress and performance. Listed below are the indicators measured.

Patient related

- Number of patients seen for abortion related complications
- Number of patients receiving MVA for pregnancies less than 12 weeks gestation
- Profile (*age, education, marital status*) of PAC patients managed using MVA
- Number of PAC patients counseled for FP
- Number of PAC patients that received FP, by method
- Number of PAC patients referred, by reason for referral

Facility related

- Patient reception
- Waiting time
- Client-provider interaction
- Patient privacy
- Attributes of examination room
- Use of recommended drugs
- Volume of clients served (antenatal; postnatal; STI counseling, diagnosis, treatment)

A patient profile checklist, a facility assessment checklist, and a provider competency discussion guide were developed. During each visit, the PAC supervisory team used the patient profile checklist to compile data on the number and profile of patients provided with emergency care using MVA. This was planned to accurately estimate the MVA patient caseload at the pilot facilities over the life of the intervention period.

Through observations and interviews the team also obtained information on access issues, client-provider interaction, pain control management strategies, and facility attributes relevant to quality assurance. Findings were documented on the facility assessment checklist.

To begin development of good record keeping practices at facilities with PAC trained nurse-midwives, trainees were assigned data collection responsibilities. Using the standardized facility checklist, trainees were expected to compile monthly data on the number of patients contacting the facilities with abortion-related complications, provided with emergency care using MVA, counseled for FP and provided with a method, and referred to other facilities. Monthly reports were to be forwarded to the PRIME/Intrah office in Nairobi. The data gathered using the patient profile checklist and the facility checklist were compiled in a database maintained at the PRIME/Intrah office. The data were summarized after each round of follow-up visits to review project progress, to examine issues, and to make decisions on what could be enhanced or improved.

During the third visit, the supervisory team assessed trainees' level of performance for the provision of PAC services. Two criteria set by the PRIME PAC team were used to certify competence in PAC. The first criteria was a score of at least 70% on knowledge questions testing recall on

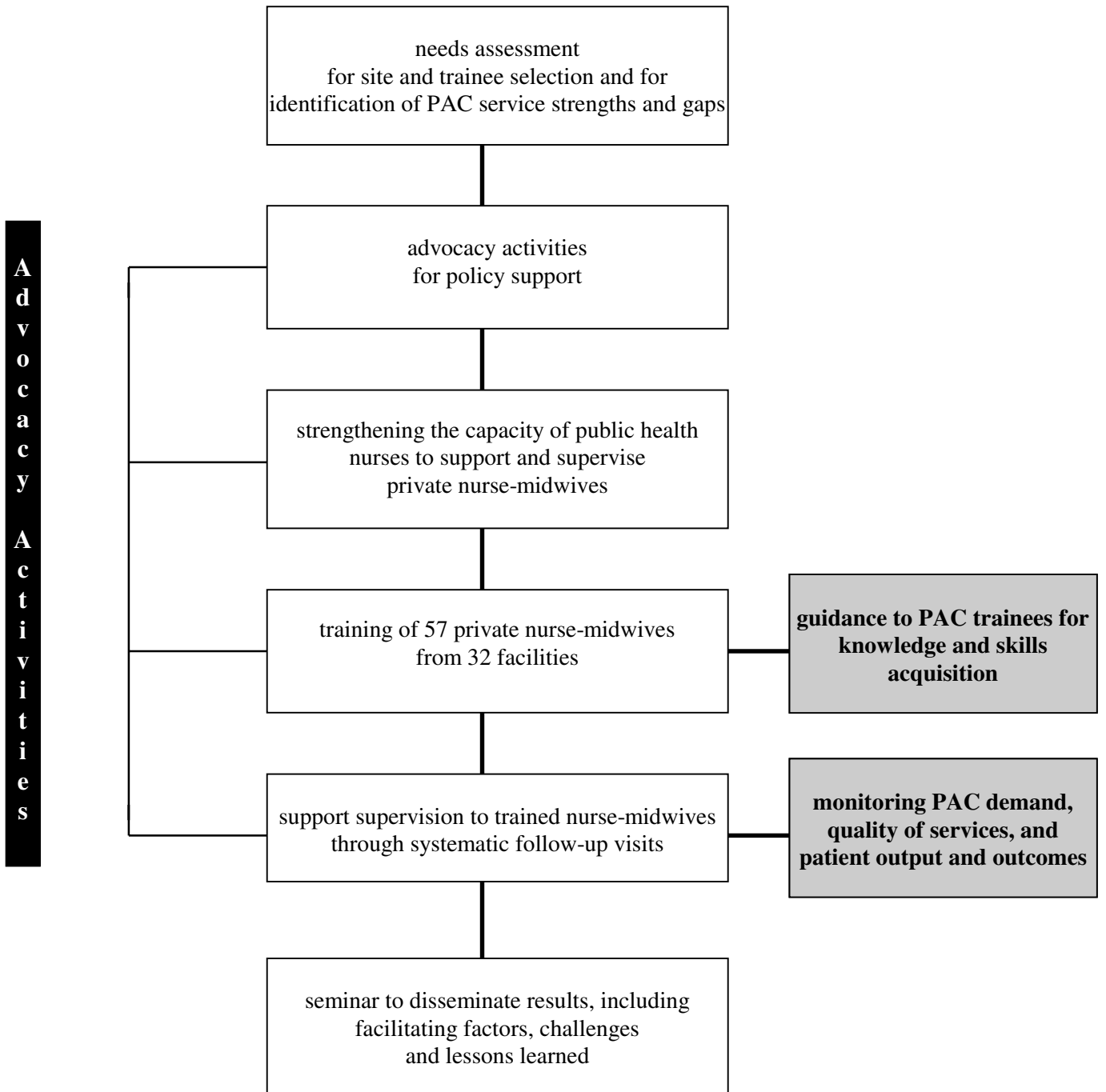
- Procedural steps to follow when performing MVA
- Process steps for performing the MVA procedure and for preparing the MVA instruments for re-use
- Information and help given to patients who have received emergency care or patients who had sought care after the abortion was complete

The second criteria were having performing at least 10 MVAs. Trainees who met both criteria by the end of the intervention period were recommended for immediate certification as PAC providers using MVA.

3.2.5 Dissemination seminar to share results, lessons learned, and to formulate recommendations for PAC expansion

PRIME and NNAK at the end of the project (November 1999) jointly organized a national dissemination seminar. The purpose of the seminar was to share results, challenges, and lessons learned with the MOH, NCK, NNAK, USAID collaborating agencies, and other organizations. Participants also assisted PRIME in identifying and confirming facilitating factors and barriers in using nurse-midwives to provide PAC services. Participants' contributions, including suggestions and recommendations, are provided in Section 5 of this report.

Figure 2: Summary of the Kenya PAC Pilot Initiative Implementation Steps, including monitoring of PAC trainee knowledge and skills acquisition



4. Results

This section is organized by project objective. Section 4.1 examines the achievement of training and supervision targets. Section 4.2 examines the extent to which the capacity of pilot facilities was strengthened to provide quality PAC services. Factors that favor private nurse-midwives as PAC providers are described in Section 4.3. Challenges for expansion of quality PAC services and lessons learned as a result of the implementation of the PAC initiative based on the Kenya model are shared in Section 4.4. This section also offers recommendations addressing challenges and lessons learned.

4.1 Training output and supervision status

Of the planned 60 private nurse-midwives targeted for training, a total of 57 (95%) private nurse-midwives from 32 facilities were trained. The supportive supervision visits to the 32 pilot facilities were completed according to schedule. Except for two facilities, trained nurse-midwives in all pilot facilities were visited three times as planned.

Table 1: PAC Training Output, By Province

Province	Number earmarked for training	Number of private nurse-midwives trained	% Trained
Nairobi	20	21	105
Central	20	19	95
Rift Valley	20	17	85
Total	60	57	95

4.2 Evidence showing the extent to which pilot facilities have been strengthened to provide quality PAC services

4.2.1 Trained private nurse-midwives assessed have achieved an acceptable level of performance required for the provision of PAC services

The assessment done at the end of the 19-week post-training period to establish PAC providers standard of performance showed encouraging results. All 32 of the 57 PAC trained providers that were assessed by the time of reporting had achieved an acceptable standard of performance in the provision of postabortion services by having met the minimum established criteria. All 32 trainees scored at least 70% on three critical procedures (Table 2) and successfully performed 10 MVAs on patients presenting with abortion-related complications whose pregnancies were less than 12 weeks.

Table 2: Distribution of PAC Providers’ Overall Knowledge Scores for Critical PAC Procedures

Number of providers assessed = 32

Maximum expected score = 74%

Passing score = 70%

Score Range (%)	Number of PAC trained providers achieving score	% of PAC trained providers achieving score
70 - 74%	4	13
75 - 79%	6	19
70% and above	32	100
80% and above	22	69

4.2.2 Expansion of PAC services following training of private nurse-midwives

Following training, there was a rapid expansion of PAC services provided by trained private nurse-midwives. We are able to examine two indicators of expansion.

- a) Increase in the proportion of facilities offering emergency treatment using MVA, PAFP counseling and methods, and linkages with other RH services.
- b) Increase in PAC caseload estimates for patients treated using MVA.

a) Increase following training in the number of facilities offering emergency care using MVA

At the time of the needs assessment, only two of the 32 facility incharges (one in Nairobi province and one in Rift Valley province) reported performing uterine evacuation procedures using MVA at their sites. The procedure was, however, performed by doctors. The remaining 30 facilities (94%) referred postabortion patients requiring emergency treatment to the nearest district hospital or private facility. In Nairobi, KNH was frequently mentioned as the referral site.

By the end of the intervention (post-training and supportive supervision), private nurse-midwives at 28 of the 32 pilot facilities (88%) had initiated emergency MVA treatment services to address postabortion complications presenting at their facilities.

Table 3: Increase in the Proportion of Facilities Offering PAC Using MVA

N = 32 pilot facilities

	Number of facilities offering emergency treatment using MVA	% of facilities offering emergency treatment using MVA
At baseline	2*	6
19 weeks post-training	28	88

* MVA performed with the help of doctors

b) Increase in case load estimates of PAC patients treated using MVA at facilities with trained nurse-midwives

By the end of the intervention, trained private nurse-midwives at 28 facilities had provided emergency MVA treatment for incomplete abortion to a total of 436 patients. Table 4 shows the weekly average per site of PAC patients treated using MVA. The data indicate an average output of nearly one PAC patient per facility per week.

Table 4: Average Case Load per Site per Week

N = 28 sites

Total number of patients treated using MVA	Duration of PAC services	Average number of PAC patients treated using MVA/site /week
436	19 weeks	0.8

The distribution of the number of patients treated using MVA by facility and by province is provided in Appendix 1. Lack of baseline data prevents an assessment of the change in the number of patients treated using MVA at the two pilot facilities that had reported access to MVA services prior to training. Interviews with the two incharges, however, revealed that the patient load before training was low even though doctors were available to offer the service.

The distribution of patients provided with emergency MVA treatment over the intervention period shows that when compared to the other facilities, three facilities in Nairobi served more patients. These three maternities – Kasarani Maternity and Nursing home (72 patients), Genesis Nursing Home (61 patients), and St. Veronica Medical Clinic (39 patients) – were known prior to the PRIME intervention, however, for having doctors that provided PAC services. It is likely that patients needing PAC services sought help from these facilities knowing they would receive the needed attention.

The patients provided with emergency MVA care confirms that private nurse-midwives, if trained, will contribute to bringing PAC services closer to the community. The incharge of the ward used for the PAC practicum at KNH reports already noticing that

training of private nurse-midwives will lessen the burden at referral sites. The expansion of the training of nurse-midwives in PAC to further reduce the burden on the already overstretched health care system is promising.

4.2.3 Diversity in the demographic profile of PAC patients served at trained nurse-midwives' facilities

Figures 3, 4 and 5 give the graphical distribution of patients treated for incomplete abortion using MVA by age, marital status, and educational status. Two conclusions can be drawn from the results. First, trained private nurse-midwives do not deny access to PAC because of age or marital status. Sixteen percent of the 420 patients provided with emergency MVA care and for whom data on age were available were under 20; thirty-eight percent were single. Second, the results contradict community and youth perceptions expressed during the needs assessment that the majority of women seeking abortion services are school-aged, unmarried, and with limited or no education. The mean age of women provided with emergency care was 25. Of the 262 patients who provided information on formal education, over half (56%) had post secondary education. Incidentally, the demographic profiles of these PAC patients are comparable to the PAC patient profile delineated by a similar project in Kenya (ref: Preventing Unsafe Abortion in Western Kenya).

Figure 3: Percent Distribution of Patients Using MVA, by Age Group
(N=420)

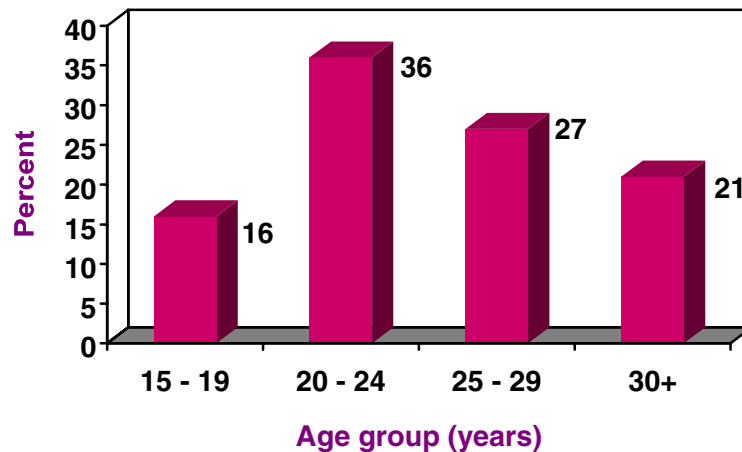


Figure 4: Percent Distribution of PAC Patients Using MVA, by Marital Status (N=378)

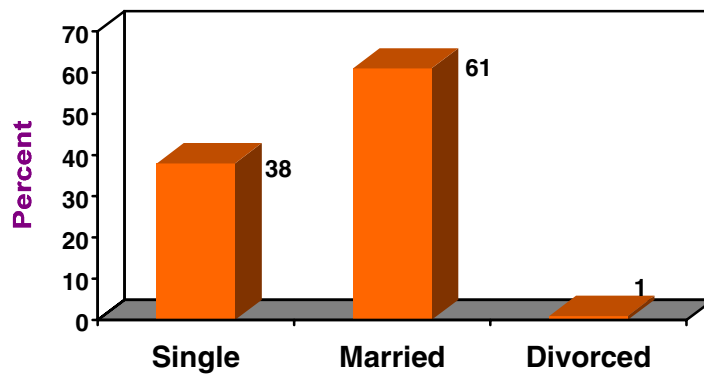
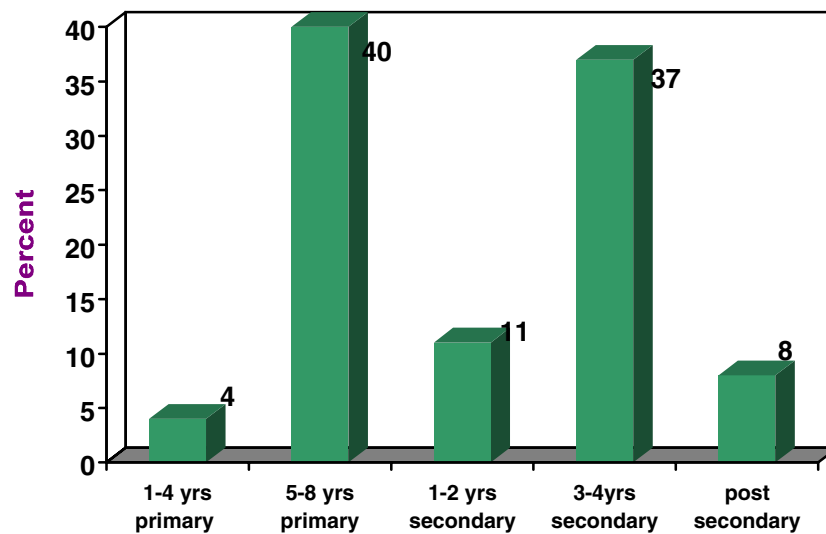


Figure 5: Percent Distribution of PAC Patients Using MVA, by Educational Status (N=262)



4.2.4 Management strategies adopted by trained nurse-midwives for patients seeking care following an abortion are appropriate

Four indicators were considered for investigating the management strategy pattern adopted by trained providers for patients seeking care following an abortion. The indicators are the proportion of patients provided with emergency MVA care whose pregnancies were less than 12 weeks; the proportion of patients counseled for FP; the proportion of patients provided with an FP method; and the proportion of patients referred for other services, including other RH services.

As is typical in many longitudinal-type assessments, compliance with reporting requirements was rarely optimal. Not all of the 28 pilot facilities submitted monthly reports with the relevant data for each of the five months during which skills were

applied at the work site. Twenty-four facilities reported for at least three of the five months. Fourteen facilities reported for at least four of the five months. The results discussed are based on the analysis of data from the 24 facilities that had reported complete information on all four indicators for at least three months.

It was expected that the reported number of patients served at these 24 facilities during 12 to 19 weeks post-training would be lower than the total number of patients served at all 28 facilities during 19 weeks. For example, we know that 436 patients received emergency treatment using MVA from the 28 facilities within 19 weeks following training because the PAC supervisory team systematically documented data on the number and profile of patients treated using MVA during each supervisory visit.

The number of patients that were provided with emergency treatment using MVA in the 24 facilities during 12 to 19 weeks post-training was 263. The figures presented in Table 5 and described in the next paragraph are therefore the proportion of patients served rather than the absolute number of patients.

The results in Table 5 indicate that uterine evacuation using MVA was performed in 263 of the 366 patients (72%) that had contacted the 24 pilot facilities with abortion-related complications. Over 85% of the patients were counseled for FP. Seventy-four percent were provided with the FP method of their choice. Although data on the methods chosen are incomplete, there are indications that the two most commonly chosen methods were injectables and pills.

The observed pattern in the management of patients seeking care from private nurse-midwives' facilities is very likely the true picture, as the pattern remained the same when the analysis was restricted to the 14 facilities with complete data on all four indicators for four or more months.

4.2.5 Evidence of linkages of PAC with other appropriate RH services at pilot facilities

Forty-nine of the 366 patients (13%) with abortion-related complications were referred for other services, including other RH services. Among the reasons cited by trained nurse-midwives for referring the 49 patients were severe laceration of the cervix, pelvic injury, hemorrhoids, suspected cancer of the cervix and/or breast, severe anemia, and hypertension.

No incidence of MVA complication was reported. Most patients reported at the facility one week after the procedure and no post-procedure complications were detected either. (These data will be collected during the expansion phase.)

The results demonstrate the use of an integrated approach to RH care with evidence of PAC linkages with other appropriate RH services, and the existence of a link between private nurse-midwives' facilities and higher level facilities. The difference between the patients counseled for PAFP (320) and those that received a FP method (269) is

believed to be a real difference. One theory accounting for this difference is that the gap may be comprised mainly of women experiencing spontaneous abortions who want to immediately try again for another pregnancy.

Table 5: Management Strategies for Patients Seeking Care Following an Unsafe or Incomplete Abortion (at facilities with complete data for at least 3 months on all 4 indicators)

Number of patients presenting with abortion-related complications at 24 facilities = 366

	Number	Percent
Patients with incomplete abortion evacuated using MVA	263	72
Patients with complete abortion (MVA not necessary)	103	28
Patients counseled for PAFP	320	87
Patients provided with a family planning method	269	73
Patients referred for other services, including RH services	49	13
Patients referred as a result of complications resulting from MVA procedure	0	0

4.2.6 Pain and bleeding control strategies adopted by trained private nurse-midwives are appropriate

Preoperative and postoperative sedation or analgesics are customary elements in clinical protocols and are shown to have a positive effect on the reduction of patient pain (ref: Postabortion Caseload in Egyptian Hospitals: A Descriptive Study 1998). Interviews with trained private nurse-midwives indicate that unlike in public facilities, in private facilities steps are taken to provide medication to reduce pain.

Before the MVA procedure, the majority (67%) of nurse-midwives interviewed administered Buscospan either orally or by injection. For others, the intensity of pain is minimized by Paracetamol injection. Diazepam is used to calm overanxious patients and Ergometrine is the preferred drug for controlling bleeding following MVA.

4.2.7 Evidence of beginning links with the community following PAC training

At baseline, none of the 32 pilot facility incharges reported the existence of regular, coordinated health education outreach and reproductive health programs. After training, PAC trained nurse-midwives have used a variety of approaches to educate communities about RH, including the use of FP to prevent unwanted pregnancies and to achieve desired spacing of pregnancies. Trained nurse-midwives also launched campaigns to raise community awareness of the risks of unsafe abortion and to sensitize communities to the urgency of seeking treatment for complications arising from abortion. Some trained nurse-midwives organized meetings targeting community opinion leaders, women and youth while others liased with community based distribution agents working in the facility catchment areas to implement advocacy activities or used videos to support the community mobilization.

4.3 Factors favoring expansion of PAC service through private nurse-midwives

In this section, an attempt is made to more closely examine factors favoring an expansion of PAC services through private nurse-midwives. The discussion uses mainly anecdotal data gathered through observation and informal interviews. Other data sources supporting training private nurse-midwives for PAC were policy documents, the baseline assessment report, the PAC initiative training and supervision reports, and the POLICY project activity reports.

4.3.1 Conducive policy environment

The Government of Kenya's level of commitment to address the public health problem of unsafe abortion through postabortion care is clearly outlined in the 1994 National Health Policy for sustainable development and the Kenya Health Policy framework. The statement is

To provide safe, comprehensive and integrated PAC services through the public, NGO, and private sectors.

In operationalizing this mandate, the June 1997 revised national RH/FP Policy Guidelines and Standards for Service Providers support the provision of PAC services at the first available opportunity by trained clinical practitioners (doctors, clinical officers, nurses).

The policy change at the government level has been complemented by the NCK. The Council issued a statement supporting an expanded PAC role for nurse-midwives.

The statement calls for incorporating all aspects of PAC, except for MVA, as a core competency in the basic nurse-midwifery curriculum by the year 2000. The Council proposes that MVA be taught in post-basic programs.

A NCK official emphasizes the Council's commitment to PAC services. She said,

'We at the Nursing Council of Kenya feel that postabortion care is a good package for the future of nursing and midwifery in Kenya because it equips the nurse-midwife with knowledge and skills and attitudes to be able to practice, and empowers the nurse to have confidence in providing the service.'

4.3.2 Prospects for continued support for PAC among the nursing community through advocacy

The POLICY project activities, aimed at building support for PAC among the Kenyan nursing community and the stakeholder groups in PRIME PAC pilot districts, started implementing activities to advocate for PAC in early 1999. A sensitization and advocacy workshop for NCK and NNAK members resulted in district advocacy teams and the development of action plans to guide advocacy activities.

Already, the district advocacy teams, in partnership with private nurse-midwives trained in PAC through the PRIME pilot initiative, have started the advocacy activities defined in the action plans. Activities implemented thus far target District Health Management Teams and NNAK members to sensitize them about the importance of PAC as a way of avoiding repeat abortions and reducing maternal mortality and morbidity resulting from unsafe and incomplete abortion.

4.3.4 Training of private nurse-midwives may be cost-effective

Four attributes lend support to the argument that training private nurse-midwives for PAC may be cost-effective.

First, all 32 pilot facilities offered a wide range of RH and FP services prior to PAC training. It is therefore likely that a group of private nurse-midwives with experience in FP and other RH service provision is ready to receive training for PAC service provision. The training duration will be relatively short because of private nurse-midwives' existing RH and FP knowledge and skill base.

Second, private nurse-midwives recruited for the PAC pilot initiative had expressed a willingness to pay the tuition cost to receive the training and to purchase resupplies. Even though the offer to cost share the training was not pursued for the pilot initiative, the offer indicates that the idea of cost sharing will be acceptable to private nurse-midwives for future PAC training activities.

Third, the fact that trained PAC providers in 28 of the 32 pilot facilities applied their PAC skills almost immediately after training implies little ‘wastage’ of the resources expended to train nurse-midwives. Moreover, PAC skills acquired during training will be further reinforced as trained providers meet the known demand for PAC services in the community.

Fourth, there is evidence that the PAC training for private nurse-midwives has yielded unanticipated multiplier effects. A few PAC trained providers are carrying out on-the-job training for other service providers at their facilities and/or nearby facilities.

4.3.4 Trained private nurse-midwives sustained interest in providing PAC services

The interest expressed by incharges of the pilot facilities to receive PAC training during the baseline assessment was translated into action immediately after training. Although it was not mandated for PAC training since the facilities already met the basic requirements, the incharges were motivated to upgrade and/or reorganize their facilities for improved PAC services. Nineteen facilities (59%) created MVA rooms and eight (25%) installed stirrups in their delivery room or FP couches to perform the MVA procedure. Some purchased basins for decontamination and sterilization purposes or acquired recommended emergency drugs, while others displayed posters showing PAC services as one of the RH services offered in the facility as a way of advocating for PAC.

At about half of the facilities, the clinic was either reorganized for better client flow and for privacy or the facility infrastructure was improved (partitioning rooms, fitting of new cupboards, painting) for friendlier services.

4.3.5 Trained private nurse-midwives enthusiasm to meet women’s needs for PAC

Women seeking postabortion care often risk being denied the quality of care they deserve. Providers may not be adequately trained to offer the service or may delay care based on their own personal or religious beliefs about abortion. The PRIME-assisted intervention sought to monitor perceived changes as a result of training by informal interviews with trained nurse-midwives. The interviews probed for self assessment of competency level to provide emergency services using the MVA procedure, perceived changes in their own attitude towards PAC, and narratives of real life situations of a “before” and “after” training experience.

Although the perceived benefits from training were mixed, it was evident that private nurse-midwives were enthusiastic about receiving PAC training. For some private nurse-midwives, PAC training led to a confidence boost in providing emergency care using MVA to manage complications arising from abortion. Others recognized a change in their own attitude towards patients seeking care after an abortion. A number of nurse-midwives most appreciated being able to arrest bleeding within their own facilities and to provide comprehensive RH services as a result of PAC training.

One of the trained private nurse-midwives working at the Mukunga Maternity and Nursing Home in Nairobi province narrated to PRIME her experience with two of her clients requiring PAC – one before and one after attending the PAC training workshop. The interview, provided as part of the appendices to this report, illustrates that training private nurse-midwives has immense potential for reducing unnecessary deaths from complications related to pregnancy.

A sample of quotations on perceived benefits as a result of training, extracted from the informal interview proceedings with PAC trained private nurse-midwives, are shared below. The quotations exemplify increased confidence, attitude change, and improved ability to offer comprehensive RH services.

Increased confidence as a result of PAC training:

‘Before the PAC training I used to get nervous and frightened because of the bleeding. I would give them Ergometrine to stop the bleeding, then refer them to Kenyatta National Hospital. But after the PAC training when I receive the patient, I handle them with confidence because I know what to do. They [the patients] are usually frightened due to the bleeding and I assure them I will be able to remove the remains.’

‘I feel confident and challenged, since I now receive all types of patients. For example today I had a patient with hydatidiform mole.’*

‘I feel good now and proud of what I am able to do now.’

Change in attitude towards patients needing care after an abortion:

‘PAC training challenged my way of thinking. I used to judge these people (i.e. patients with incomplete abortion). But PAC training changed my way of thinking. I started giving the services to clients regardless of how they started the abortion.’

Appreciation of being able to offer comprehensive RH services:

‘Training has expanded my scope of management. I am now able to assess and decide on those requiring referral and those I can attend to.’

‘I now know the importance of postabortion family planning before discharge and linkage with other RH services, especially women with a suspicious cervix.’

* Hydatidiform Mole: a development anomaly of the placenta in which a degenerative process in the chronic villi causes all or part of the villi to become a mass of cyst-like clear vesicles hanging in clusters from thin pedicles, resembling a bunch of grapes. Varney’s Midwifery Third Edition Chapter 21. Screening and Collaborative Management of Ante-partal Complications.

'PAC training has resulted in the introduction of emergency contraceptive pills (ECP) to other FP services and proper education to clients. Counseling skills have improved and all clients are properly counseled.'

'PAC training was an added advantage and makes RH more integrated than before.'

4.3.6 Access to quality PAC services at private nurse-midwives' facilities

PAC patients seeking care from private nurse-midwives' facilities are assured of access to quality PAC services. Pre-intervention assessment showed that private nurse-midwives' facilities are within easy distance from the communities they serve. This proximity has enabled the nurse-midwives to provide prompt service for patients needing care for complications arising from abortion.

Most of the facilities offer affordable, integrated RH services. Apart from offering affordable RH services, private nurse-midwives are known to be flexible in their demand for payment. Clients that could not afford to pay for care immediately are served on credit or for a low fee. This is unlike the situation at higher level private facilities where prompt service is provided on an ability to pay basis.

Patients seeking emergency care from trained private nurse-midwives' facilities are therefore assured of receiving the best possible PAC services available at the primary level. PAC trained providers were found networking and providing support to each other. This practice suggests that when a private nurse-midwife experiences problems handling a patient, the provider will consult with or seek help from another trained provider in the network.

The 32 pilot facilities met the PRIME criterion of having a separate room where patients could recover in privacy after the procedure. The facilities also met the minimum requirements for cleanliness and sanitation. The PRIME PAC supervisory team also noted good interpersonal relationships between private nurse-midwives and their clients. This will create an environment for dialogue with PAC patients and will reduce patients' anxieties about the use and safety of the MVA instruments. One PAC trained provider (Mkunga Maternity and Health Centre) reported that as a result of good interpersonal relationships with patients seeking postabortion care, she is now seeing more husbands/partners accompanying their spouses seeking PAC services.

Patients will also not have to wait too long to receive quality services. Waiting time at the majority of facilities was under one hour. Basic facilities required for minimizing the risk of cross-infection are available at all 32 pilot facilities. All the facilities had running water, sterile gloves, decontamination solution, liquid soap and high-level disinfection containers.

4.3.7 Potential to reduce the burden for PAC services at referral sites through training of private nurse-midwives

In section 4.2.2b, it is shown that within 19 weeks post-training, private nurse-midwives at 28 pilot facilities had provided emergency care for incomplete abortion using MVA to a total of 436 patients. The volume of patients managed for complications arising from abortion confirms that private nurse-midwives, once trained, will contribute to bringing PAC services closer to where people live. Training of private nurse-midwives for PAC service provision will also lessen the burden at referral facilities to allow the facilities more time to address complicated cases.

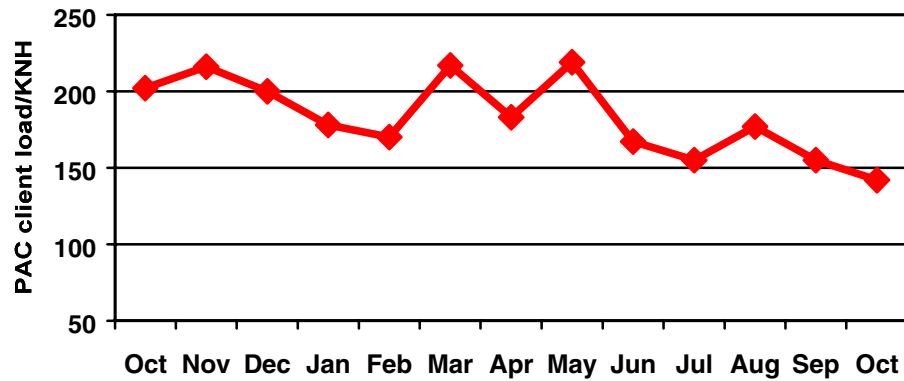
The incharge of the ward at the KNH used for the PAC practicum has already recognized signs that private nurse-midwives, if trained, will reduce the burden experienced at referral sites thereby conserving scarce health resources. The incharge commented,

“Florence, your program is really working. These days we are receiving very few patients for MVA, like today there are only five.”

The PRIME PAC trainer team also observed a downward trend in client load at KNH between February 1999, when the PAC training began, and May 1999 when the PAC training ended. The team documented that during the first two rounds of training, the queue of patients at the KNH waiting to receive emergency treatment for uterine evacuation was sufficient for trainees to have adequate practice using the MVA. At the end of a practice day, there would still be patients queuing up for emergency treatment. By the last two rounds of training, there was a noticeable drop of PAC patients, such that trainees could hardly get adequate patient practice. Information on the patients’ area of residence revealed that the patients were not from areas having PAC trained nurse-midwives.

Data on monthly distribution of PAC client load compiled for October 1998 through October 1999 at KNH shows signs of a downward trend (Figure 6). The drop in client load appears to be more consistent after the training of private nurse-midwives. Although one cannot conclusively attribute the decline to the training of nurse-midwives, it will be worthwhile to investigate the effect of PAC training for primary level providers on client load at referral sites.

Figure 6: PAC Client Load at Kenyatta National Hospital, October 1998 - October 1999: PAC Training – February to May



4.3.8 Opportunity for reinforcing private/private and private/public sector linkages through supervision and referral networks

The PRIME PAC initiative design made provision for reinforcing the links between trained private nurse-midwives and the public sector through supervision and referral. This was to ensure that the PAC service network is effective and can be sustained. Public sector nurses received orientation enabling them to provide supervisory support to the trained private nurse-midwives (Section 3.2.1).

During training, private nurse-midwives were sufficiently sensitized to identify PAC patients needing further assessment and care and to refer them to the appropriate facilities. Although the design of the initiative emphasizes the referral of patients to public sector facilities, some patients preferred referrals to higher level private facilities. This yielded an unanticipated private-to-private referral link as well as the expected private-to-public referral link.

In any case, the referral system for managing RH complications shows positive beginnings. Forty-nine patients presenting with abortion complications at 24 of the pilot facilities were referred to higher level facilities for advanced investigation and treatment. There is the need, however, to strengthen the feedback mechanism so that PAC providers receive information from patients referred for further treatment to referral sites.

4.4 Challenges, lessons learned, and recommendations for the expansion of PAC services through private nurse-midwives

4.4.1 The challenges

4.4.1.1 Supervision related factors

In Section 3.2.1, it is noted that DPHNs in the PAC pilot districts have been prepared to undertake independent supervision of trained nurse-midwives at their facilities as a way of linking the public sector with the private sector.

All six DPHNs joined the PRIME PAC team to make the first round of supervisory visits. The public health nurses in charge of Thika, Nyeri and Nairobi districts carried out one other follow-up visit. The DPHN incharge of Thika district visited all PAC pilot facilities in her district, while the DPHN in charge of Nairobi and Nyeri visited at least two of the pilot facilities within their district catchment areas. The remaining three DPHNs were not able to carry out supervisory visits on their own up to the time of reporting. The main hindrance, according to the DPHNs, is lack of transportation to facilities. The inability of DPHNs to accommodate visits to PAC trained private nurse-midwives within their regular supervisory visit schedule threatens the desired PAC link between the private and public sectors.

Recommendation

Application of the PRIME Performance Improvement Approach would result in better understanding of the recommended supervisory system in Kenya and the real problems influencing supervision of nurses-midwives in the private sector. Partners in PAC should explore the possibility of addressing the issue of supervision using this approach. Stakeholders will be guided by results of the performance needs assessment to design different supervisory options and to select the most suitable option for improving supervision of private sector nurse-midwives trained in PAC in different settings.

Possible networks that could be explored for supervision of nurse-midwives in the private sector to ensure adherence to standards include networks with district-based NGOs, MOH, and municipalities on the one hand and legislative bodies on the other hand (i.e., NCK, KMA). Problem solving, mutual support and technical updates can be organized through peer supervision.

4.4.1.2 Record keeping practices

Record keeping practices at pilot facilities have improved markedly since training compared to the baseline status. Evidence gathered during the baseline assessment revealed that except for deliveries, records kept by private nurse-midwives were either not up-to-date or the content was inaccurate. The claim of improved reporting

standards following training can be justified by the fact that the quantitative data discussed in this report are based on the post-training records kept at the pilot facilities.

However, the data compiled at the pilot facilities were not of optimal quality. Two factors contributed to this – trained nurse-midwives’ recording and reporting practices and minor problems in the design of one of the instruments.

On the part of the nurse-midwives, underreporting of PAC cases occurred due to either failure to submit all monthly reports or failure to capture all relevant cases. Only half of the 28 pilot facilities that initiated PAC services submitted at least four of the five expected monthly reports. Twenty-four facilities submitted at least three monthly reports. Independent observers also noted that because providers kept several record books, some of the cases pertinent to the management of PAC were captured in other record books, but not on the PRIME reporting form. In a couple of facilities, providers on late duty at pilot facilities were not sufficiently sensitized on the use of the PRIME reporting forms. As a result, the care offered to patients managed after regular hours were recorded on other registers.

On PRIME’s part, there were two problems in the design of the facility checklist. The checklist accounted for the number of patients presenting with abortion-related complications who were referred to other facilities to receive services, including other RH services, but not the number who received RH services apart from FP services at the pilot facility. This shortfall prevented a complete assessment of the extent to which PAC trained nurse-midwives accomplished the third component of PAC: *“links between emergency postabortion treatment services and RH care.”*

Another problem with the facility checklist is that it did not allow for segregation of the number of PAC patients referred immediately after assessment from those who were managed at the facility and then referred for further treatment or investigation.

Recommendation

Stakeholders in PAC service expansion should identify the key indicators for which data must be gathered in order to fully evaluate the effect of PAC training on service delivery. The PAC curriculum should allow for adequate time to cover the following topics:

- Type of information to be collected and why
- How information is to be collected and used for monitoring facility performance
- Usefulness of maintaining records in a systematic manner
- Importance of timeliness of reporting
- Frequency of reporting and the reporting channel

During the expansion phase, PRIME should strengthen the tools to address the observed problems.

4.4.1.3 Infection prevention practices

There was noticeable improvement in the area of infection control at the nurse-midwives' facilities. At the time of the baseline assessment major problems were observed. For example, 11 of the 49 facilities (22%) visited had no chemical disinfectant and 10 (20%) did not have covered containers for high level disinfection.

Infection prevention practices through application of proper decontamination process for instrument re-use received special attention during training. At five of the 32 pilot facilities, however, inconsistent practices in preparation of chemical strength (too strong or too diluted) and in timing for decontamination (too short or too long) were observed during supervision visits.

Recommendation

PRIME and trained private nurse-midwives need to identify the real reasons for these practices and together resolve the problem.

4.4.1.4 Request for abortion services

Clients requesting pregnancy termination are seeking help in all of the pilot facilities. The clients are counseled on merits for keeping the pregnancy and also on the dangers of unsafe abortion. PAC trained providers note that many end up seeking abortion through unsafe means. The providers are at loss on what steps to take and view the provision of PAC services as addressing abortion complications, regardless of the nature of the abortion. For example,

A 16-year-old student who had sought help for terminating a pregnancy at one of the pilot facilities was counseled appropriately. A fortnight later, the girl turned up at the pilot facility with a letter from the KNH for dressing her abdominal wound. The girl had apparently sought help from an unskilled provider who badly perforated her uterus and severed her cervix. A laparotomy was performed for removal of the uterus. When examined at the pilot facility, she was badly infected with much pus oozing out of the wound.

Similar experiences were encountered for older, married women suggesting the demand for safe abortion services cross all demographic groups.

Recommendation

Given that abortion is illegal in Kenya, PRIME and other organizations interested in FP and PAC service expansion should explore additional ways to address unmet need for family planning to prevent unwanted pregnancies and repeat abortion.

PAC trained private nurse-midwives and other trainees should be encouraged to promote/step up the sensitization, education, and provision of emergency contraceptive

pills as an alternative method to prevent an unwanted pregnancy, as well as community education about how to prevent pregnancies and the consequences of unsafe abortions.

4.4.2 Lessons learned

4.4.2.1 Trainee selection criteria

The PRIME PAC initiative recommends training as a team the facility incharge plus one other nurse-midwife working full time at that facility. The strategy ensures sustainability of the services. The extent to which this criterion was met at the end of the six rounds of training is summarized as follows:

- Number of facilities where two nurse-midwives working full-time were trained as a team: 16 of 32 (50%)
- Number of facilities where part-time nurse-midwives were trained: 5 of 32 (16%)
- Number of facilities where second nurse-midwife works at another facility (own facility or on hire): 6 of 32 (19%)
- Number of facilities where only one nurse-midwife was trained: 5 of 32 (16%)
- Number of facilities where location of second trainee is unknown after training: 2 of 32 (6%)

The above summary indicates that half of the 32 pilot facilities met the prescribed criteria. In 11 facilities, the nurse-midwife working full-time teamed up with either a nurse working part-time from the same facility or with a nurse from another facility. Five facilities only offered one candidate for training. Two of the PAC trained private nurse-midwives could not be traced after training.

Even though three facility incharges did not receive PAC training as per the recommended trainee selection criteria, they gave adequate support to trained providers at their facilities.

PAC services may not be readily accessible at facilities that were unable to fulfill the criterion of having two full-time providers trained for PAC. For example, at St. John's Clinic in Nairobi, one of the PAC trainees works part-time at that facility. PAC services have not been accessible to patients needing emergency care, especially at night. Often such patients were referred, but the decision was not recorded in a systematic manner. The facility incharge noted that in some cases the number of patients seeking care at night far exceeded the number seeking care during the day.

The situation at facilities in which the second trained provider works at another facility, although not ideal, does have an advantage. The trained PAC providers working at other sites are likely to initiate some PAC services at their work location, thereby further expanding PAC services.

Recommendation

For the expansion phase, the names of proposed candidates from target facilities, trainee work location, and trainee employment status need to be established and verified as part of the planning phase. The training should be configured to meet the characteristics of the trainees. For example, training should be organized for facility teams if facilities meet the selection criterion that calls for the selection of two nurse-midwives working full-time.

For situations in which facilities are constrained in releasing two nurse-midwives at the same time to receive the training, it should be arranged so that the two proposed candidates attend separate training activities. Even though the latter situation may not be ideal, the two providers, once trained, will be able to work as a team to sustain PAC services at their facilities. In the case where the teaming is between the target facility incharge and a provider working at another facility, steps need to be taken to ensure that the second facility meets the required criteria for PAC.

4.4.2.2 Adequacy of client load for practicum

Kenyatta National Hospital offered a large enough client load to allow each participant to practice the MVA procedure with at least two patients. At Kisumu Provincial General Hospital, the patient load was rather low, possibly due to practicing physicians trained in PAC by the KIMET project. It was reported in Section 3.2.2c that the low client load at this hospital interfered with the acquisition of skills. There are early signs that the PAC patient load at KNH is also gradually decreasing as a result of the training of the private nurse-midwives for this pilot initiative. The decline is likely to continue as expansion of PAC services is accelerated through training of nurse-midwives and other cadres working at the primary care level. Though the decline in PAC patient load at referral sites is desired to reduce the burden at those sites, there are implications for training. Without a reasonable number of patients needing emergency care following an abortion, trainees using referral sites for practice will not have adequate practical training, especially in the use of the MVA procedure.

Recommendation

PRIME and other stakeholders involved in PAC training need to start identifying and developing alternative approaches to training to ensure trainees acquire skills, under supervision, in the use of the MVA procedure for providing safe emergency and non-emergency care.

4.4.2.3 Demand for training

Although postabortion family planning was covered during the PAC training, there were no contraceptive technology updates. The newly trained PAC providers acknowledged attrition in FP knowledge and skills because of both the length of time since receiving FP training and the lack of FP/RH updates. The group frequently underscored the need for FP/RH updates and expressed a desire to be trained for Norplant® insertion and removal in particular.

Recommendation

The MOH, in partnership with NGOs (including PRIME), should

- Look for opportunities for providing in-service training/refresher courses/update training in FP/RH for providers in the private sector. The weak reading culture found among private nurse-midwives should be taken into account in developing approaches for providing updates. Private nurse-midwives should also be encouraged to participate in district level training activities.
- Explore the use of distance-based and other innovative approaches for training PAC trainees in selected FP/RH skills.
- Explore the use of the KIMET approach wherein all providers involved in PAC education and/or service provision (e.g. community-based distributors, community health workers, nurse-midwives, clinical officers, medical officers and gynecologists) are brought together for two days each year to share experiences and receive updates.

5. Recommendations Proposed at the Dissemination Seminar

Dissemination of the initiative objectives, processes of implementation and results to key stakeholders was obligatory as the final step of the Kenya PAC initiative design. In addition to sharing the results and experiences gained, the dissemination activity was designed to solicit inputs from stakeholders to confirm service barriers and policy issues in using nurse-midwives to provide PAC services. A second expectation was to obtain recommendations from participants for the expansion of PAC services in Kenya through nurse-midwives and other primary providers. PRIME will also be guided by the recommendations to assist the 14 member countries of the East, Central, Southern African College of Nursing (ECSACON) to design a PAC training strategy for the expansion of PAC through training of nurse-midwives in the region.

The group work approach was used to obtain inputs from participants. Each of the four groups at the seminar deliberated on one of the following themes:

- Suggestions for minimum criteria needed for trained nurse-midwives to safely provide PAC services

- Barriers and facilitating factors for including PAC as part of standard services provided by nurse-midwives
- Ensuring sustainability and provision of quality PAC services
- Identification of priority strategies for scaling up PAC services

The group outputs are given in Sections 5.1 to 5.4, and the group tasks can be found in the appendices. The detailed account of the dissemination activity is documented as a separate report.

5.1 Theme: Suggestions for minimum criteria needed for trained nurse-midwives to safely provide PAC services

5.1.1 Trainee related

- The two providers selected from a facility (incharge and assistant) to receive PAC training must be nurse-midwives
- PAC trainees must have had training in FP service provision
- PAC trainees must have been an active NNAK member for at least one year
- Only nurse-midwives interested in providing PAC services should be selected for training
- For nurse-midwives who have not been practicing in the geographic area for more than six months, it is recommended that the individual be attached to the area for at least four weeks
- Both private and public sector nurse-midwives meeting the above criteria are eligible to receive PAC training
- Nurse-midwives working at rural facilities should be given priority over nurse-midwives at urban facilities for the next series of training activities for PAC service expansion

5.1.2 Facility related

- PAC trained nurse-midwives must receive commitment and support from the administrative management of the facility once certified as competent to provide PAC services
- A facility selected to provide PAC services must have available space (i.e., consultation room, sterilization area, recovery room, record storage facility) and minimum equipment necessary for PAC such as specula, tenacula, sponge holding forceps, buckets for decontamination and chemical sterilization, sterilizer or autoclave, and kidney dishes or trays

5.2 Theme: Barriers and facilitating factors for including PAC as standard service provided by nurse-midwives

5.2.1 Barriers

- Lack of PAC trainers and supervisors oriented to oversee PAC service provision
- Inadequate supplies and equipment to sustain PAC services at many facilities
- Lack of integrated RH services in most public health facilities
- Shortage of nurse-midwives trained for PAC
- Inadequate funds for training nurse-midwives in PAC
- Poorly established referral systems
- Resistance of doctors and clinical officers in accepting nurse-midwives as PAC service providers

5.2.2 Facilitating factors

- Willingness of the nurse-midwife to offer PAC services
- Commitment by the donors to fund PAC equipment
- Already existing RH integrated services to be used for PAC training and providing PAC services
- Positive results from Kenya and Uganda PAC initiatives
- Support from MOH, NCK, NNAK and KMA for nurse-midwives to be trained in PAC

5.2.3 Ways of overcoming barriers

- Look for funds for training PAC trainers, trainees and their supervisors
- Adequately equip all health facilities to provide quality PAC services
- Include PAC in nurse-midwife pre-service training curriculum
- Streamline the MOH referral systems to support private practitioners
- Launch advocacy drives for doctors and clinical officers to support nurse-midwives as PAC providers
- Arrange for frequent forums for nurse-midwives and doctors to exchange ideas for quality PAC services

5.2.4 Ways the NCK can maximize the existing facilitating factors

- Update curricula for nurse-midwives to include the PAC services and solicit support and funds from MOH
- Organize in-service courses for those already in the field
- Create awareness of PAC among nurse tutors and administrators
- Ensure high standards are maintained at PAC service sites

5.3 Theme: Ensuring sustainability and provision of quality PAC services

5.3.1 Ensuring availability of MVA kits and other supplies

a) private sector

- Starter MVA kits provided immediately after training
- Replenishable parts are available for purchase from Ipas
- Private sector charges fee for service and could therefore afford purchasing of the required parts as needed

b) public sector

- Mechanism already exists for centralized purchasing of medical equipment supplies or through use of local purchase order
- Cost sharing mechanisms are already in place
- Need for sensitizing health care providers in the public sector, especially those in administrative capacities to understand the importance and need for PAC services, so that they can give equal priority to the ordering and purchasing of PAC related equipment and supplies

5.3.2 Upholding good quality of PAC provision

- Organize regular updates for PAC trained nurse-midwives on all RH services, including PAC
- Promote facilitative supervision by District Health Management Teams
- Prepare and distribute to PAC service sites manuals and leaflets on critical areas such as infection prevention and control
- Promote on-the-job training for PAC
- Encourage nurse-midwives to attend workshops on RH and to enroll as members of professional associations
- Licensing procedures, especially renewals of licenses to practice, should be linked to updates received

5.3.3 Ensuring good record keeping practices

- Reach agreement on a standard set of PAC service indicators for assessing service outcomes
- Develop standard PAC register(s)
- Develop reference manuals for use of the registers
- Training for PAC should cover relevance of the indicators selected, how to document the information, and use of the data for clinic management
- Ensure PAC records and returns are submitted quarterly to the district level
- Records on RH service provision, including PAC, maintained at service sites should be audited during follow-up visits to assess quality of care and quality of record keeping practices

5.3.4 Community mobilization and education for PAC

- Strengthen community outreach services and encourage social marketing for PAC
- Develop suitable IEC messages about “what is PAC?” and its importance for preventing maternal morbidity and mortality, and adapt the appropriate messages to target community opinion leaders, community members attending meetings, youth groups, church gatherings and schools
- Design expanded community PAC programs that include advocacy and partnership with the facility to ensure timely community mobilization and action for seeking assistance at signs of abortion

5.4 Theme: Identification of priority strategies for scaling up PAC services

- Clarify legal, regulatory and policy issues about PAC
- Create supportive policies and include MVA kits in the MOH lists of essential supplies and in national logistics system
- Expand advocacy activities for PAC
- Incorporate an advocacy package in all training
- Develop capacity for training and supervision to accelerate preparation of nurse-midwives in PAC service provision and intensify support supervision
- Train PAC service providers
- Establish innovative supervision systems for PAC service
- Explore the role of the NNAK in supporting its members and maintaining the code of ethics in the provision of PAC services
- Explore ways to improve affordability of PAC services
- Encourage partnerships with other stakeholders, e.g. NGOs
- Expand community outreach services

6. Concluding Remarks

The results from this pilot initiative indicate that there is demand for PAC services to be provided closer to the community and beyond the district hospital level; that women are seeking these services; that nurse-midwives can provide safe emergency care using MVA; and that private nurse-midwives are offering outreach services including PAC. There is therefore the need for scaling up the decentralization and expansion of PAC services to clinics and maternity homes, mostly operated by primary providers of RH services.

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Appendix 1
Number of Patients Provided with PAC using MVA, By Facility

Nairobi Province	Number of Patients Provided with PAC using MVA			
Facility Name	VISIT 1 (3 weeks post-training)	VISIT 2 (8 weeks after first visit)	VISIT 3 (8 weeks after second visit)	TOTAL (19 weeks post-training)
Dandora Maternity Centre	5	9	7	21
Genesis Nursing Home	13	22	26	61
Kasarani Maternity Home	22	44	6	72
Mukunga Maternity and Nursing Home	8	16	5	29
Ogwendhi Health Clinic	4	7	3	14
St. John's Health Clinic	1	3	11	15
St. Veronica Health Clinic	6	23	10	39
Wakibe Medical Clinic	1	1	9	11
Wangu Medical services	1	0	1	2
St. Mary's Maternity	0	4	2	6
Radiant Health Clinic	0	0	0	0
Ruri Medical Clinic	4	4	--	8
TOTAL	65	133	153	278

0 = no patients treated -- = visit not performed

Central Province	Number of Patients Provided with PAC using MVA			
Facility Name	VISIT 1 (3 weeks post-training)	VISIT 2 (8 weeks after first visit)	VISIT 3 (8 weeks after second visit)	TOTAL (19 weeks post-training)
Boores Medical Clinic and Nursing Home	5	0	7	12
Charity Medical Clinic	4	5	1	10
Family Health Centre	1	5	2	8
Health Watch Medical Clinic	3	0	0	3
Mariini Maternity MCH/FP/OPD	2	6	3	11
Vicky Medical Clinic	7	14	9	30
Imani Medical Clinic	0	1	3	4

Ndenderu Health Services	4	4	0	8
Mweiga Rural Health Clinic	0	0	0	0
Waka Maternity and Health Services	0	1	0	1
TOTAL	26	36	26	88

0 = no patients treated -- = visit not performed

Rift Valley Province	Number of Patients Provided with PAC using MVA			
Facility Name	VISIT 1 (3 weeks post-training)	VISIT 2 (8 weeks after first visit)	VISIT 3 (8 weeks after second visit)	TOTAL (19 weeks post-training)
Ngata Hospital	3	8	2	13
Site Medical Clinic	6	2	0	8
Nakuru Nursing Home	3	3	5	11
St. Jude Medical Clinic	2	1	0	3
Wanainchi Jamii Maternity Home	3	7	7	17
Integrated Ngongdu Medicare Clinic	--	0	0	0
Rhemis Medical Clinic	0	4	7	11
Gazelle Medical Clinic	0	0	4	4
KKIT Health services	0	1	2	3
Ngong Primary Health Rehabilitation Centre	0	0	0	0
TOTAL	17	26	27	70

0 = no patients treated -- = visit not performed

Appendix 2

A Nurse-midwife's Real Experiences Before and After PAC Training: An Interview with Mrs. Evelyn Mutio of Nairobi, Kenya by Florence Githiori

Evelyn Mutio is a private nurse-midwife working at a primary care facility in Nairobi, Kenya – the Mukunga Maternity and Nursing Home. Two months after attending a PRIME-sponsored workshop on postabortion care, Mrs. Mutio talked with PRIME/INTRAH about 2 of her clients requiring postabortion care: 1 prior to and 1 after attending the PAC workshop.

Case 1: Before PAC training: Mrs. Mutio told Mrs. Githiori about a client she had treated prior to being trained to provide PAC services, a 23-year-old single mother of 3 children. The woman's last child was 3 years old and this was her fourth pregnancy. In the following interview excerpt, Mrs. Mutio describes her encounter with the young mother:

Mrs. Githiori: What was her condition when she came to the health facility?

Mrs. Mutio: She was semi-conscious. Some children who were playing near her house saw blood coming from her room and alerted the neighbors. When the door was opened, she was found lying in a pool of blood on the floor and was brought to our clinic by the neighbors. Her name was not known.

We at once started resuscitating her. We gave her hydrocortisone, oxygen, and dextrose because she was bleeding, bleeding. We gave her intravenous fluids. We removed a lot of clots and gave her Ergometrine, raised the foot of the bed, and sent for an ambulance, which took 40 minutes to arrive. By this time the patient had improved a bit and told us that she is called Muthoni and has 3 kids who stay with her mother.

We prayed with the patient. The patient asked for water - "maji". [Maji is the Swahili word for water.] This is a bad sign, a sign of danger. I did not know whether to put in a speculum but there were a lot of clots. [Mrs. Mutio was hesitant about using the speculum because, prior to PAC training, she had not been trained in how to use one. She did learn how to properly use a speculum during PAC training.] When the ambulance arrived, a nurse from the facility accompanied her to the national hospital [Kenyatta National Hospital] but she did not reach the hospital.

Mrs. Githiori: What happened?

Mrs. Mutio: She collapsed and died. Her last words were:

“Mama yangu” [my mother], “watoto wangu” [my children], “Mungu nisamehe” [God forgive me], then she died.

Instead of being taken to the hospital, she was taken to the mortuary. That was one of the worst experiences I have ever had. The incident is still very clear in my mind.

Case 2: After PAC training: Next, Mrs. Mutio told Mrs. Githiori about a client she had after PAC training. This client is a 23-year-old mother of 1 child, a 3-year-old who is alive and well. The woman was not using a family planning method because she wanted to have another child. She said she had not had a previous abortion or miscarriage.

Mrs. Githiori: What happened to her and why did she come to your clinic?

Mrs. Mutio: She just started bleeding and my clinic was the nearest health facility. She had not been my client before. The husband was desperate and thought his wife was going to die.

Mrs. Githiori: What was her condition on admission?

Mrs. Mutio: She was bleeding so much, and collapsed as she arrived at the facility. The husband said that she had bled so much at home that his house looked like a slaughter house with blood all over. We put her on the couch [regional term for examining table] right away and gave her 50% dextrose intravenously and then 5% dextrose, followed by Hartmann solution. She was about 10 weeks pregnant and, on speculum examination, I saw that her cervix was 3 centimeters open but looked healthy.

The patient asked for water, “Nipe maji” - not a good sign - and then she collapsed again. I did MVA [manual vacuum aspiration] using canula no. 10 and 12. I aspirated 250 millimeters of blood. The patient was stable following MVA. I kept the patient overnight and gave her antibiotics (Amoxil, Flagyl) and ferrous sulfate. I also took blood for hemoglobin.

The husband and patient were very grateful. The husband said that they wanted another child. We counseled them on family planning and the husband said he would use condoms until the wife felt better and was healthy enough to carry another pregnancy. She was given a follow-up appointment for 2 weeks later, which she kept. She was looking much better.

Mrs. Githiori: Before PAC training, what knowledge and skills did you have on managing postabortion emergencies?

Mrs. Mutio: Before PAC training, when a patient came to me I would take her history, do observations, assess blood loss, do a speculum exam to see the source of bleeding, and refer her to a doctor. My big limitation was no MVA experience because I could have helped them. Also, I did not do proper counseling.

Following PAC training, I am equipped to manage the emergencies and can perform MVA and provide counseling and postabortion family planning and can provide other services that may be needed, or refer the patient for services.

Mrs. Githiori: Do you feel the training you received was beneficial and to whom?

Mrs. Mutio: Yes, very much. It was beneficial to the community and to myself. I do not mean beneficial in a financial way, but from the satisfaction of helping people in real need. There was this patient who came in bleeding and continued to bleed even after MVA. Her cervix was all torn up and we gave her Ergometrine. Then I realized the bleeding was coming from the badly torn cervix. I referred the patient to Kenyatta National Hospital for further management.

Mrs. Githiori: What type of FP services did you give your patients before training?

Mrs. Mutio: I did not spend much time with the postabortion patients since we referred them to other clinics. There was no follow-up on these patients.

Following PAC training, most patients now come back to our clinic for FP methods where they get Depo-Provera® or another FP method before discharge. Two out of 3 husbands who have brought their wives to the clinic have opted to use condoms so their wives have time to rest before having babies.

Mrs. Githiori: What about referral services?

Mrs. Mutio: There is a Dr. Mwaniki within the estate who has been trained in MVA and managing postabortion complications. I have referred a patient to him. Most patients with complications, such as a torn cervix and/or suspected cancer of the cervix, are sent to a referral hospital and always with referral notes. We have established linkages with the hospitals and patients are accompanied by a member of our staff who waits with the patient until they have been admitted.

Mrs. Githiori: Any suggestions for improving the current PAC training?

Mrs. Mutio: The training is very good. However, I wish I could know the magnitude of the problem. We are at the receiving end but we have not addressed the source of the problem - the unsafe abortions. There is a need to educate the community. FP programming does not seem to have had enough of an effect. We need to do more to prevent unwanted pregnancies.

Appendix 3
Supportive Supervision Follow-up Schedule

FACILITY NAME	PROVINCE/ DISTRICT	LOCATION	TRAINEE/ PROVIDERS	TRAINING	VISIT 1	VISIT 2	VISIT 3
St. Veronica Medical Clinic	Nairobi	Buruburu Phase I (Extension)	Veronica Onger, Christine Amugure	2/8-12/1999	3/12/1999	05/14/1999	07/15/1999
Radiant Health Clinic	Nairobi	Juja Road	Margaret Mwaura	2/8-12/1999	3/12/1999	05/14/1999	07/15/1999
Mkunga Maternity and Nursing Home	Nairobi	Dandora Phase 1	Evelyn Mutio, Joyce Rutere	2/8-12/1999	3/11/1999	05/14/1999	07/16/1999
Kasarani Maternity and Nursing Home	Nairobi	Kasarani	Ann Mulinge	2/8-12/1999	3/11/1999	05/14/1999	07/16/1999
St. John's Medical Clinic	Nairobi	Githurai	Grace Njunge, Waithaka	2/8-12/1999	3/11/1999	05/14/1999	07/16/1999
Health Watch Health Clinic	Central, Kiambu	Githunguri	Phoebe Ngechu	3/1-5/1999	4/8/1999	5/14/1999	8/12/1999
Dandora Medical Centre	Nairobi	Dandora Phase IV	Gladys Gicheru	3/1-5/1999	4/8/1999	6/14/1999	8/12/1999
Mweiga Rural Health Clinic	Central, Nyeri	Mweiga	Mary Wangombe, Jane Kiarie	3/1-5/1999	4/9/1999	6/11/1999	8/13/1999
Family Health Clinic	Central, Nyeri	Nyeri Town	Dorcas Githinji, Maina Muragu	3/1-5/1999	4/9/1999	6/11/1999	8/13/1999

FACILITY NAME	PROVINCE/DISTRICT	LOCATION	TRAINEE/ PROVIDERS	TRAINING	VISIT 1	VISIT 2	VISIT 3
Mariini Maternity MCH/FP OPD	Central, Nyeri	Karatina	Josephine Gikunju, Ann Wanjohi	3/1-5/1999	4/9/1999	6/11/1999	8/13/1999
Waka Health Services and Maternity Home	Central, Nyeri	Ruringu	Regina Gatimu	3/1-5/1999	4/9/1999	6/11/1999	8/13/1999
Imani Medical Centre	Central, Kiambu	Limuru Town	Winnie Karori, Rose Wanjiru	3/22-26/1999	4/27/1999	7/1/1999	8/26/1999
Ndenderu Health Services	Central, Kiambu	Ndenderu	Jane Karago, Catherine Njoroge	3/22-26/1999	4/27/1999	7/1/1999	8/26/1999
Vicky Medical Clinic/Maternity	Central, Kiambu	Gitaru	Lucy Maruru, Naomi Njenga	3/22-26/1999	4/27/1999	7/1/1999	8/27/1999
Charity Medical Clinic	Central, Thika	Igegania	Elizabeth Gakure, Mary Kimuhu	3/22-26/1999	4/28/1999	7/2/1999	8/27/1999
Boores Medical Clinic	Central, Thika	Thika Town	Violet Njue, Janet Imanyara	3/22-26/1999	4/28/1999	7/2/1999	8/27/1999
Rhem's Medical Clinic	Rift Valley, Nakuru	Naivasha Town	Truphosa Nyamweya, Ezekiel Kibeta	4/19-23/1999 5/17-21/1999	6/3/1999	7/22/1999	9/9/1999
Site Medical Clinic	Rift Valley, Nakuru	Naivasha	Margaret Kaguo	4/19-22/1999	6/3/1999	7/22/1999	9/9/1999
Integrated Ngondu Medicare Clinic	Rift Valley, Njoro	Egerton	Peninah Omonge	4/19-23/1999	6/4/1999	7/23/1999	9/10/1999

FACILITY NAME	PROVINCE/ DISTRICT	LOCATION	TRAINEE/ PROVIDERS	TRAINING	VISIT 1	VISIT 2	VISIT 3
Ngata Hospital	Rift Valley, Nakuru	Nakuru	Aisha Kilele, Phelesia Nyakundi	4/19-23/1999	5/28/1999	7/4/1999	9/10/1999
Nakuru Nursing and Maternity Home	Rift Valley, Nakuru	Nakuru Town	Grace Kamunge, Teresa Muturi	4/19-23/1999	5/28/1999	6/4/1999	9/10/1999
Ogwedhi Medical Clinic	Nairobi	Kahawa West	Ambrose Ngere	5/3-7/1999	6/2/1999	7/29/1999	9/16/1999
Wangu Medical Clinic	Nairobi	Dandora Civil Servant Estate	Apofia Kinuthia, Milliana Ndagire	5/3-7/1999	6/2/1999	7/29/1999	9/16/1999
Wakibe Medical Clinic	Nairobi	Huruma	Margaret Wainaina	5/3-7/1999	6/2/1999	7/30/1999	9/17/1999
St. Mary's Health Clinic	Nairobi	Kibera	Constance Okoth, Imelda Wadungwe	5/3-7/1999	6/2/1999	7/30/1999	9/17/1999
Genesis Nursing Home	Nairobi	Parkroad	Grace Mule, Jackline Bartenge	5/3-7/1999	6/2/1999	7/30/1999	9/17/1999
KKIT Health Services Clinic	Rift Valley, Kajiado	Ongata Rongai	Eunice Kithinji Jael Waswa	5/17-21/1999	6/15/1999	8/5/1999	9/23/1999
Gazelle Medical Centre	Rift Valley, Kajiado	Ongata Rongai	Mellab Situma, Rose Muchina	5/17-21/1999	6/15/1999	8/5/1999	9/23/1999

FACILITY NAME	PROVINCE/ DISTRICT	LOCATION	TRAINEE/ PROVIDERS	TRAINING	VISIT 1	VISIT 2	VISIT 3
St. Jude's Medical Health Clinic and Maternity	Rift Valley, Kajiado	Ongata Rongai	Magdelene Guandai	5/17-21/1999	6/15/1999	8/6/1999	9/24/1999
Wananchi Jamii Maternity Home	Rift Valley, Kajiado	Ongata Rongai	Magdelene Thiga, Esther Wanjohi	4/19-23/1999	6/3/1999	7/23/1999	9/9/1999
Ngong Primary Health Rehabilitation Center	Rift Valley, Ngong	Ngong Town	Margaret Ng'ang'a	5/17-21/1999	6/15/1999	8/6/1999	9/24/1999

Appendix 4

Themes and Assignment Task Developed for the Dissemination Seminar Group Work

Group 1 Theme: Suggestions for minimum criteria needed for trained nurse-midwives to safely provide PAC services

Facilitator: Rose Olouch, Chairperson, NNAK

Assignment task

Based on the learnings from presentations and discussions, examine the criteria used to select pilot facilities, keeping in mind expansion and decentralization

1. To what extent are the criteria suitable/appropriate for PAC services by nurse-midwives in a variety of settings (hospitals vs. health centers vs. dispensaries vs. private clinics)?
2. Give reasons for your responses to question #1 and make recommendations for future selection criteria for expansion.
3. Put your answers on newsprints.
4. Share your outputs in plenary.

Group 2 theme: Barriers and facilitating factors for including PAC as part of standard maternal services provided by nurse-midwives

Facilitator: Grace Kandie, Chief Nursing Officer, MOH

Assignment task

Given the current nursing and midwifery education, practice and leadership and need for improved maternal health through safe motherhood initiative

1. Identify potential barriers and facilitating factors for including PAC as part of the standard maternal health services provided by nurse-midwives.
2. Suggest ways to overcome the identified barriers including potential partners in addressing the barriers.
3. Suggest ways in which the Nursing Council of Kenya can maximize the already established facilitating factors.
4. Put your answers on newsprints.
5. Share your outputs in plenary.

Group 3 theme: Ensuring sustainability and provision of quality PAC services

Facilitator: Dr. Oyoo, Provincial Gynecologist, Nyanza Province

Assignment task

1. What needs to happen to ensure PAC service sustainability and quality care by nurse-midwives? Consider the following aspects in your discussions
 - availability and maintenance of MVA kits and other supplies
 - upholding good nursing and midwifery practices in the provision of PAC services, including effective infection prevention and control practices
 - good record keeping and use in information for service
 - community mobilization and education for reduction of unwanted pregnancies, unsafe abortion, and community action to ensure women get help as soon as signs of abortion are noted
2. Put your answers on newsprint.
3. Share your outputs in plenary.

Group 4 theme: Identification of priority strategies for scaling up PAC Services

Facilitator: Dr. Charles Kiggundu, Department of Obstetrics and Gynecology, Makerere University, Kampala, Uganda

Assignment task

The pilot study and the maternal mortality statistics indicate a need for increasing access and quality of post abortion services

1. Outline some strategies for expanding PAC to ensure accessibility of services at various levels of healthcare delivery system. Consider the following in the discussions:
 - availability of services (proximity)
 - acceptability of services
 - affordability of services

2. What enabling systems need to be put in place to facilitate expansion of services through nurse-midwives? Consider the following in your discussion:
 - enabling systems within and among public and private sectors, including NGOS
 - partnerships
 - linking PAC with other RH services such as FP, STI detection and management, screening for cancers, etc.
 - community involvement
 - other
3. Put your answers on newsprint.
4. Share your outputs in plenary.

Appendix 5

Steps Undertaken by the PRIME Project for PAC Service Expansion

Given the positive results of the pilot initiative and the desire to maintain the momentum between the phase and the scaling up phase, nurse-midwives from another 10 facilities have been trained to provide PAC services. One of the facilities selected is a FPAK Nairobi based clinic. Of the remaining nine facilities, five have been selected from the new districts created in Nyanza province, (Nyamira, Migori, Kuria) and four from two districts (Kwale, Mombassa) in the Coast province.

The following criteria guided the selection of the district location/site of the 10 additional facilities for the expansion phase:

- Districts in Nyanza and Coast province that are implementation sites for USAID supported HIV/AIDS prevention projects.
- Districts in Nyanza province representing newly created districts. These districts were given preference over other districts because the referral systems addressing health care problems are known to be less developed in the newly created districts.
- The Family Planning Association of Kenya (FPAK) is an established organization with potential for its own expansion and training as well as training other NGO and private sector service providers.

Nineteen private nurse-midwives drawn from the 10 facilities (four in Coast province, one Family Planning Association of Kenya clinic in Nairobi, five in Nyanza province) have received training for provision of PAC services. This brings the total of private nurse-midwives trained to date to 76 in 42 facilities.

**Appendix 6:
Tool 1**

MONITORING AND SUPERVISORY CHECKLIST

1. Name of Private Nurse/Midwife
2. Qualifications
3. Name of the Health Facility
4. Province 5. District
6. Location
7. Today's Date

For monitoring visit	MV	1	<input type="checkbox"/>	
		MV	2	<input type="checkbox"/>
		MV	3	<input type="checkbox"/>

8. Instructions

- The purpose of this tool is to collect data on PAC service provision and the status of the health facility run by Private Nurse/Midwives since training in PAC.
- Prior to the visit trainer/DPHN may wish to review the facility assessment information on needs assessment tool for a particular health facility to establish the status then.
- The first visit is conducted at 3 weeks following the PAC training and is aimed at providing technical assistance for the initiation of PAC services in health facilities not yet established and also address issues that the providers may have including those of MVA procedure competencies.
- The subsequent visits are provided at two months interval following this initial visit.
- The trainer and or the DPHN should interview, observe the Private Nurse/Midwife and or review documents as appropriate.
- Complete the following sections by answering the questions as appropriate.

Tick as appropriate

ITEM	YES	NO	COMMENT
<p>I. <u>PATIENT RECEPTION</u></p> <ul style="list-style-type: none"> • Facility welcoming and clean • Patient reception is good • Waiting time is less than 1 hour • Waiting time is more than 1-2 hours • Waiting time is over 2 hours • There is interactive communication between the provider and patient • Patient is provided with relevant information • Patients' privacy (visual and auditory) is respected. 			
<p>II <u>FACILITY FOR EXAMINATION AND TREATMENT</u></p> <ul style="list-style-type: none"> • Provision for adequate lighting exist. • There is access to running water. • Appropriate/current IEC materials available. • Has adequate equipment for carrying out MVA procedure. <ul style="list-style-type: none"> – Table with stirrups – Complete MVA equipment – Speculum (small, medium, large) – Sponge holding forceps – Adjustable lamp – Recommended antiseptics – Sterile gloves – Decontaminating solution (bleach e.g. JIK) – Soap - liquid – Buckets – Expandable supplies such as gauze, cotton wool, sanitary pads, gloves. 			

ITEM	YES	NO	COMMENT
<ul style="list-style-type: none"> • Has disposal facilities e.g. for: <ul style="list-style-type: none"> – Sharps containers – Disposal bags on containers. • Suction apparatus available • Has an ambu bag • Has oxygen tank, tubing and mask • Has facilities for sterilizing or high level disinfection (HLD) of equipment <ul style="list-style-type: none"> – autoclave – boiler – HLD containers • Oral airways available • IV sets and needles available • Others specify 			
<p>III RECOMMENDED DRUGS <u>AVAILABILITY</u></p> <ul style="list-style-type: none"> • Anaesthetics • Analgesics • Antibiotics • Oxytocic drugs • IV fluids • Emergency drugs <ul style="list-style-type: none"> – atropine – diazepam – hydrocortisone – adrenaline – Others (specify) 			

IV SERVICE PROVISION SINCE TRAINING

Family Planning

- FP methods currently provided to postabortion patients. Please tick as appropriate.

	By interview	Document review confirmation
Pills	<input type="checkbox"/>	<input type="checkbox"/>
Injectables	<input type="checkbox"/>	<input type="checkbox"/>
Condoms	<input type="checkbox"/>	<input type="checkbox"/>
Spermicides	<input type="checkbox"/>	<input type="checkbox"/>
IUD	<input type="checkbox"/>	<input type="checkbox"/>
NORPLANT	<input type="checkbox"/>	<input type="checkbox"/>
Natural	<input type="checkbox"/>	<input type="checkbox"/>
Others (specify)	<input type="checkbox"/>	<input type="checkbox"/>

- The pain medication given to patient prior and during MVA procedure include: (Enter the drugs in appropriate column below).

NAME OF DRUG PRIOR TO MVA	NAME OF DRUG DURING MVA

- Average period of stay for the patient at the facility following MVA procedure hours.
- Average cost for MVA

V. SERVICE DATA

SERVICES	PAC Training Date	MONTHS AFTER TRAINING											
		1	2	3	4	5	6	7	8	9	10	11	12
No. of patients seen with abortion related complications.													
No. of patients with incomplete abortions evacuated through: <ul style="list-style-type: none"> • MVA • Others (specify) 													
No. of patients provided with postabortion family planning methods.													
No. of patients referred with complications of: <ul style="list-style-type: none"> • Incomplete abortion • MVA • Others (specify) 													
No. of FP new clients													
No. of FP revisits													
No. of clients given emergency contraceptive pill (ECP)													
No. of antenatal clients													
No. of deliveries													
No. of postnatal clients													
No. of clients diagnosed for STDs.													
No. of clients treated for STDs.													

ISSUES/PROBLEMS

- List of issues/problems raised by the private nurse/midwife at site.

.....
.....
.....
.....

- List of issues/problems observed by trainer on supervision at site.

.....
.....
.....
.....

- Action taken by:

Service Provider:

.....
.....

Trainer:

.....
.....

Supervisor:

.....
.....

- Any other learned/experiences on PAC management.

Please explore

.....
.....
.....

Appendix 7: Reporting Format

1. Facility Name: 2. Province:
3. Location:4. Date:.....
5. Month reported on: 6. PAC Training Date:

Instruction

Please complete the information in this form as appropriate and submit/send a copy to INTRAH Regional Office Nairobi and another copy to the District Public Health Nurse for the MOH i/c of the District where you operate. INTRAH will ensure that the NNAK gets a copy.

SERVICES	# OF CLIENTS	COMMENTS IF NECESSARY
No. of patients seen with abortion-related complications.		
No. of patients with incomplete abortions evacuated through: <ul style="list-style-type: none"> • MVA • Others (specify) 		
No. of patients provided with postabortion family planning counselling.		
No. of patients provided with postabortion family planning methods.		
No. of patients referred with complications of: <ul style="list-style-type: none"> • Incomplete abortion • MVA • Others (specify) 		
No. of FP new clients.		
No. of FP revisits.		
No. of clients given emergency contraceptive pill (ECP).		
No. of antenatal clients.		
No. of deliveries.		
No. of post-natal clients.		
No. of clients diagnosed for STDs.		
No. of clients treated for STDs.		

**Appendix 8:
Tool 4**

PROFILE OF PAC PATIENTS

Monitoring visit : 1 2 3
.....

Date Service Provider received training

Date of visit :

Province:

Facility Name	Facility ID	Patient ID	Patient Age	Education (Class Completed)	Marital Status	Residence	Intervention	Comments
				1-4 yrs Primary 1 5-8 yrs Primary 2 1-2 yrs Sec. 3 3-4 yrs. Sec. 4 Post Sec. 5	Married 1 Single 2 Separated 3 Divorced 4		MVA 1 Referred 2 Other 3 Specify	
				1-4 yrs Primary 1 5-8 yrs Primary 2 1-2 yrs Sec. 3 3-4 yrs. Sec. 4 Post Sec. 5	Married 1 Single 2 Separated 3 Divorced 4		MVA 1 Referred 2 Other 3 Specify	
				1-4 yrs Primary 1 5-8 yrs Primary 2 1-2 yrs Sec. 3 3-4 yrs. Sec. 4 Post Sec. 5	Married 1 Single 2 Separated 3 Divorced 4		MVA 1 Referred 2 Other 3 Specify	
				1-4 yrs Primary 1 5-8 yrs Primary 2 1-2 yrs Sec. 3 3-4 yrs. Sec. 4 Post Sec. 5	Married 1 Single 2 Separated 3 Divorced 4		MVA 1 Referred 2 Other 3 Specify	

Appendix 9: Draft PAC Performance Standards for Primary Providers

Definition of Standard

A standard is a desirable and achievable level of performance that provides:

- ◆ Clarity of expectations in a form of task statement.
- ◆ Criteria on which task is assessed.
- ◆ How performance is to be measure.

Purpose of Standards

The purpose of standards of practice is to:

- ◆ Enhance quality of care of clients.
- ◆ Protect the public.
- ◆ Provide the provider with the means to be self-regulating.
- ◆ Give direction for professional practice.

The PAC components constitute the major focus for PAC performance standards. They are:

- ◆ Emergency treatment of complications from spontaneous or unsafely induced abortion.
- ◆ Family Planning counselling and services.
- ◆ Access to comprehensive reproductive health care.
- ◆ Community education to reduce the need for abortion and improve reproductive health.

Standard I: PAC trained Nurse/Midwife Providers Comprehensive post-abortion care to women with complications of spontaneous or induced abortions by a PAC trained nurse/midwife.

Pre/training requisites:

Nurse/Midwife

- ◆ Holds a current valid license to practice.
- ◆ Trained in Family Planning provision (otherwise FP training precede PAC training).
- ◆ Indicate interest for providing PAC services.
- ◆ Recommended by the District Medical Officer of Health (MOH) through the District Public Health Nurse (DPHN).

Nurse/Midwife's facility

- ◆ Offers integrated RH services e.g. MCH/FP.
- ◆ Has adequate space to provide consultation/treatment room, sterilization area and a recovery room/space.
- ◆ Has a couch for which stirrups could be fitted.
- ◆ Privacy for client can be ensured.

- ◆ Has minimum equipment including:
 - specullae
 - Tenaculla
 - Sponge holding forceps
 - Buckets for decontamination and high level disinfection
 - Sterilizer/autoclave
 - Kidney dishes and trays
- ◆ A second trained Nurse/Midwife also available for training.

Standard 2: When providing PAC services the trained Nurse/Midwife upholds and fulfills the individual rights of clients/patients regardless of client’s age, religion, political belief, social-economic status, ethnic origin, marital status geographical location or any other characteristic that may place individual at risk of discrimination.

Criteria: Client/Patient has rights to:

- ◆ Prompt emergency care.
- ◆ Information including the risks of treatment, benefits, relevant services e.g. Family Planning.
- ◆ Safety including the use of safe procedure for treatment of incomplete abortion and prevention of cross-infection.
- ◆ Choice includes right to freely decide whether or not to use a contraceptive.
- ◆ Privacy and confidentiality include providing services in an environment where bodily privacy is respected - client is forewarned of the type of physical examination done and the number of people that she would get into contact during the process. All information about clients medical history and condition is treated confidentially.
- ◆ Dignity and comfort - regardless of client status humane and comfortable accommodation during treatment is provided.
- ◆ Continuity - client receives counselling and access to contraceptives as long as necessary.
- ◆ Opinion - client encouraged to express own opinion regarding care to be provided and state concerns about the services received and any changes that need to be made regarding the services.

Standard 3: Positive interaction between patient/client and PAC trained Nurse/Midwife help ease the anxiety and concern that patients/clients may feel, facilitate treatment and improve patients satisfaction with the care received.

Criteria:

- ◆ Clear and open two-way communication to collect information on medical history before, during and after treatment.
- ◆ Asking open-ended questions to get thorough responses.
- ◆ Making patient/client understand that:
 - Information provided is confidential.
 - What tests she would undergo.
 - Nature and severity of her present health condition.
 - What MVA procedure involves and its risks.
 - When the procedure will be performed.
 - Where the procedure will be performed.
 - What to expect during the procedure.
 - When she would be discharged.
 - Any short or long-term health implications.
 - Family Planning counselling, services and or referral services available.

- ◆ Address particular needs for information on special concern that an individual has.
- ◆ Address particular needs for information on special concern that an individual has.
 - Keep message simple, organised and stress important points.
 - Avoid sophisticated medical terms.
 - Use supportive non-verbal communication e.g. nodding.
 - Listen attentively.
 - Answer questions directly in a non-aggressive manner.
 - Provide a written and/or illustrated summary of discharge instructions.
- ◆ Provides an atmosphere in which the patient/client gives consent for treatment.

Standard 4: PAC trained Nurse/Midwife provides quality emergency treatment to patients/clients seeking assistance in her facility using MVA procedure.

Criteria

- ◆ Makes an initial assessment of a woman who has an incomplete abortion.
 - Finds out about LMP vaginal bleeding cramping passage of tissue to identify incomplete abortion.
 - Assess for shock and other life-threatening conditions e.g. haemorrhage, sepsis/infection, injury to internal organs.
 - Apply emergency resuscitation measures as appropriate e.g. IV fluids, blood for cross-matching.
 - Begins treatment and or refers appropriately.
- ◆ Takes medical history for incomplete abortion as per medical assessment card/ format OR asks about.
 - Date of LMP.
 - Vaginal bleeding, duration, amount.
 - Cramping.
 - Tissue passage.
 - Steps that may have been taken to end the pregnancy.
 - Reproductive health history
 - Drug allergies.
 - Tetanus vaccination status.
 - Possible exposure to tetanus.
 - History of bleeding disorders.
 - History of STIs.
- ◆ Performs appropriate physical examination.
 - Assess patient for;
 - Presence of POCs in the vagina and cervix by speculum examination.
 - Condition of the pelvic organs (tears, perforation, infection).
 - Uterine size by bimanual pelvic examination.
 - Amount of POCs still in the uterine cavity.
 - Presence of foreign bodies in the genital tract.
- ◆ Prepare patient for procedure.
 - Counsel and explain diagnosis and planned treatment.
 - Allay fears by explaining what is expected.
 - Obtain consent, administer pain control drug.
- ◆ A quite non-threatening treatment room is a requirement while providing PAC services.
- ◆ Prepare the room, equipment and materials for MVA (NB provider must, ascertain that the equipment and

instruments are sterile and functioning properly).

- ◆ Performs MVA correctly.
 - Patients empties bladder.
 - Put patient in lithotomy position and clean vulva with antiseptic and drape patient.
 - Confirm size and position of the uterus by bimanual pelvic examination.
 - Prepare the syringe and select cannula to be used.
 - Gently insert the speculum and check the cervix for tears or protruding POCs. Remove any protruding POCs by sponge or ovum forceps.
 - Hold cervix with the tenacula.
 - Dilate cervical canal with cannulae of progressively increasing sizes when cervical canal will not allow the selected cannula.
 - While gently applying traction with tenacula, insert the cannula through the cervix into the uterine cavity just past the internal OS until it touches the fundus. Withdraw the cannula slightly.
 - Attach pre-charged syringe to the cannula.
 - Release the pinch valve on the syringe to transfer vacuum through the cannula to the uterine cavity.
 - Evacuate any remaining POCs by gently rotating the syringe and then moving the cannula gently and slowly back and forth within the uterine cavity.
 - Check for signs of completion
 - red or pink foam and no more tissue seen in the cannula;
 - a gritty sensation is felt as the cannula passes over the surface of the evacuated uterus;
 - uterus contract and the cervix grips the cannula making its movement into and out of the uterus difficult.
 - Withdraw the syringe and cannula. Detach syringe and place cannula in decontamination solution. Empty the contents of syringe and observe.
 - Remove tenacula and speculum and put into decontamination solution.
 - Check for vaginal bleeding. Repeat bimanual examination to ensure that uterus is well contracted.
 - Check patients vital signs, check for severe vaginal bleeding and general condition of patient.
 - Allow patient to rest comfortably.

Standard 5: PAC trained Nurse/Midwife documents and maintains complete, legible PAC records.

Criteria:

- ◆ Provides written documentation of risk assessment, course of management, and outcome of care.
- ◆ Provides a mechanism for sending a copy of the PAC record or referral on transfer to other levels of care.
- ◆ Treats patients/clients records as confidential documents.
- ◆ Submits reports on PAC patients to Ministry of Health and other stakeholders following the laid down procedures.
- ◆ Periodically uses facility service data to evaluate the results of services provided and acts accordingly.

Standard 6: The PAC trained Nurse/Midwife carries out relevant procedures for control and prevention of cross-infection.

Criteria:

- ◆ Process all instruments for re-use.
 - Decontaminates all instruments by placing in 0.5% Chlorine (JIK 1:6) solution for 10 minutes.
 - Cleans with soap and water.
 - Rinses thoroughly with clean tap water.
 - Performs High Level Disinfection by submerging instruments in JIK 1:6 for 20 minutes or CIDEX solution for 10 hours.
 - Rinses instruments with sterile/distilled water.
 - Stores dry in a previously HLD air tight container.
 - All metal instruments/equipment boiled for 20 minutes or autoclaved.

Standard 7: PAC trained Nurse/Midwife ensures that patients/clients treated in her/his facility do not suffer repeat abortions and are adequately informed on how to avoid unwanted pregnancy, STI/HIV/AIDS prevention and control measures and maximizing access to other reproductive health services.

Criteria

- ◆ Inform client/patient before discharge that:
 - She will be at risk of repeat pregnancy as soon as 2 weeks from treatment.
 - There are a variety of safe contraceptive methods that can be used immediately to avoid pregnancy.
 - Where and how to get family planning services.
 - Characteristics of all FP methods (informed choice process).
 - How to use the selected method including how, where and when to get additional supplies.
 - Provides emergency contraceptive pills e.g. to patients who have had unprotected sex previously.
 - Most FP methods do not protect against STI/HIV/AIDS and therefore if client is at risk may require to apply preventive measures as use of condoms.

Standard 8: PAC trained Nurse/Midwife guided by clients history and physical assessment diagnoses patients/clients requiring referral to higher level facilities and refers them appropriately.

Criteria:

- ◆ Inform referral facility by telephone if possible.
- ◆ Writes referral note.
- ◆ Arranges for escort.
- ◆ Uses appropriate means of transportation.
- ◆ Follows up with referral facility to monitor patient's condition and treatment provided.
- ◆ Encourages patients/relatives to return to the facility for follow-up care including postabortion - family planning counselling and services.

Standard 9: PAC trained Nurse/Midwife keeps her/him self-updated in Reproductive Health services.

Criteria:

- ◆ Reviews materials and personal notes obtained during PAC training.
- ◆ Volunteers name for Reproductive Health update workshops/seminars available through MOH, NNAK etc.
- ◆ Seeks assistance from NNAK, Private Nurse/Midwives practitioners, DPHN and or lead non-governmental organizations for areas not quite sure about.

Standard 10: PAC trained Nurse/Midwife ensures that all facility staff are familiar with the PAC elements.

Criteria:

- ◆ Carries out OJT on PAC elements depending on the clinic staff capability.
- ◆ Supervisors facility staff and providers support as required.

Standard 11: PAC trained Nurse/Midwife carries out community outreach services in order to empower the community on RH services, also help change the communities' attitudes towards PAC.

Criteria:

- ◆ Sensitize the community on PAC services.
- ◆ Educate the community to recognize signs and symptoms of abortion-complication and what to do about these.
- ◆ Educate the community on Unsafe abortion.
- ◆ Provide family planning information and services.
- ◆ Involve the adolescents in all the above.