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Exploring Peer Support Networks for the Provision of High-quality Postabortion Care by Private Nurse-Midwives in Kenya

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Acronyms

CO	Clinical Officer
DPHN	District Public Health Nurse
HIV	Human Immunodeficiency Virus
IV	Intravenous
MVA	Manual Vacuum Aspiration
MOH	Ministry of Health
NCK	Nursing Council of Kenya
NNAK	National Nurses' Associate of Kenya
PAC	Postabortion Care
RH	Reproductive Health
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development

Executive Summary

In 1997, private nurse-midwives from the National Nurses' Association of Kenya (NNAK) and Nursing Council of Kenya (NCK) in Kenya approached PRIME with an important RH need: lack of appropriate skills were preventing the providers from providing life-saving treatment to clients who arrived at their facilities with bleeding and other complications of incomplete abortion. Between 1998 and 2000, a PRIME I-assisted pilot project developed the capacity of 75 private nurse midwives to provide postabortion care (PAC) services in 44 facilities at the community level in three Kenyan provinces. After these providers had proved that nurse-midwives were indeed able to provide PAC services at the community level, an additional 155 nurse-midwives in 120 facilities received PAC training over the next couple of years, thus increasing access to greatly needed PAC services. The local PRIME partner is the NNAK with support from the Ministry of Health (MOH) and the NCK. USAID (United States Agency for International Development) provides financial support.

The PRIME partners worked to establish links between the public and private sectors and provide support for the private nurse-midwives trained in PAC through supervisory visits from the District Public Health Nurses (DPHNs). Although this approach showed results, it provided insufficient support since many DPHNs often face time and resource constraints. Therefore the PRIME-supported PAC training increasingly encouraged informal networks including consultations and support among the private providers to complement the supervision by the DPHNs, particularly when the second group of providers received training. In August 2001, the Kenya PAC supervision stakeholders recommended that a survey take place to examine the scope and location of the networks. Interviews of 107 private midwives took place between November-December that year.

Important findings about peer support

Almost half of the providers interviewed indicated that they are part of a *"group of nurse midwives organized to support each other's reproductive health work including PAC."* In addition, three-quarters of the providers reported attending meetings and seminars organized by private nurse-midwives in their districts.

Members of the peer groups indicated that the major functions of the groups are: information sharing, problem solving, and appraising or reviewing each other's strengths and weaknesses, followed by continuing education/updates and financial or "welfare" assistance.

Although slightly less than half of the providers currently belong to a nurse-midwife group, the great majority expressed interest in belonging to such a group. All of the providers were willing to leave their facilities to attend meetings, with nearly half preferring to meet quarterly and 36% monthly.

When asked about use of peers for assistance with PAC, around half (46%) of the providers stated that they had contacted a colleague for assistance. Reasons for contacting a colleague included: lack of confidence in MVA (Manual Vacuum Aspiration) skills, severe bleeding, and non-MVA problems. More than forty percent

of providers reported that they had been contacted by a colleague for assistance with PAC. Reasons for being contacted included severe bleeding, retained products of conception, and being unsure of management. Over ninety percent of those seeking assistance and those providing assistance said that the problem had been solved as a result of the contact. In order to solve the problem, the other person performed MVA, provided management counsel, or assisted with MVA.

Important findings related to factors that influence performance

When asked about factors that help their performance, the respondents most frequently mentioned:

1) adequate physical environment,
2) appropriate knowledge and skills, and
3) various types of support and motivation.

Factors that hinder performance included: clients' inability to pay, community attitudes/misperceptions about PAC, and lack of qualified staff/trained personnel. Nearly 80% of the providers stated that they have the equipment, supplies, and other resources needed to provide quality PAC services and almost 91% of the providers stated that they have the knowledge and skills to provide quality PAC services.

Important findings about supervision by the DHPN and other supervisors

Ninety percent of the providers said that they find visits by the DPHNs to be helpful. However, there is a considerable gap between the number of visits from the DPHNs the providers want and the number of visits they reported receiving, with one-fifth of providers stating that they had never received a visit from the DPHN.

When asked what they found helpful by the supervisors' visits, the most frequent responses were: when the supervisor raised problems and provided advice for improvement and when the supervisor provided updates.

Conclusions

Private nurse-midwives in Kenya trained by PRIME II in PAC report substantial interaction with peers to solve the problems they encounter. Peer support to improve provider performance and quality of care in PAC is feasible among these providers as a supplement to irregular off-site supervision by DPHNs and, in this study, this support produced positive results. More study is needed to document the long-term sustainability of this approach as a supplement or even partial replacement for more traditional forms of supervision in this context.

Background/Project Description

In 1997, private nurse-midwives licensed by the NCK requested PRIME I to develop their capacity to provide greatly needed services to clients seeking care for bleeding and other complications resulting from incomplete abortion. In partnership with the NNAK and with support and approval from the NCK and the MOH, PRIME I launched the pilot *Expanding Opportunities for PAC at the Community Level* in Nairobi, Central and Rift Valley provinces in Kenya. During the first phase of the intervention (1998-2000), 75 private nurse-midwives in 44 facilities received PAC training and, during the second phase (2000-2002), 155 nurse-midwives in more than 120 facilities.

PRIME II collaborated with EngenderHealth to establish links between the public and private sectors and encourage the DPHNs who received PAC training from EngenderHealth, to provide support for the PAC-trained private nurse-midwives. Working with NNAK and NCK, the POLICY Project trained advocacy teams made up of NNAK members at the district level. These teams targeted colleagues in the public sector and community leaders to create support for private providers and delivery of PAC services at the community level. The concept of peer support/ intervision was introduced to PAC trainees towards the end of the first phase of the initiative in an effort to provide increased post-training support beyond the supervision provided by the DPHNs.

In August 2001, the supervision stakeholders recommended a study to examine the peer support practices of private nurse-midwives that had evolved in some places. Documenting the current scope and practices of the clusters would provide useful information for forming such networks in the PAC program, which was being expanded to other areas. Moreover, the information collected on the clusters, supervisory practices, and factors that help or hinder good performance among the primary PAC providers would inform a new core-funded PRIME II peer support/intervision initiative.

Methodology

Instruments and selection of respondents

The instrument used for this descriptive study employed open and closed ended questions. These questions focused on PRIME I and II trained private nurse midwives' PAC experiences and practices, including providers' experiences with supervision and peer support as well as questions about the presence or absence of performance factors. The interview was conducted with 107 private nurse-midwives. Selection of providers for this study was purposeful. Seventy-one of the providers were selected based on their extensive experience with PAC in Kenya – in order for these providers to be included they must have seen at least ten PAC clients at the time of the survey. The remaining 36 providers were selected based on their proximity to the original 71.

Analysis of data

Data were entered using Epi-Info 2000 and analyzed using SPSS 10.1. Quantitative analysis consisted of simple frequencies of responses to closed-ended questions. For open-ended questions, responses were recoded using a list of common codes developed by the study team and frequencies for the new codes are presented. Since the respondents could provide more than one answer to some questions, the number of total responses or even responses within a code may total more than the number of nurse-midwives who answered the question.

Results

Background characteristics of providers

Characteristics of Private Nurse-Midwives and Their Facilities

Nearly three-quarters (73%) of the providers surveyed were female and 27% were male. The majority of the providers (58%) are located in urban, but underserved, areas in Nairobi and Nakuru. Of the other 42%, half are located in peri-urban areas, generally the outskirts of the major cities, while the other half are located in underdeveloped rural areas. Around half (45%) of the respondents are located in Nairobi Province, 31% in Central Province, 20% in Rift Valley Province and 5% in Coast Province (Table 1).

Table 1: Geographical distribution of the sampled private nurse-midwife providers (N=107)

Geographic Area	n (%)
Nairobi Province	**Total 48 (44.9%)**
Nairobi	48 (44.9%)
Central Province	**Total 33 (30 8%)**
Kiambu	14 (13.1%)
Nyeri	8 (7.5%)
Thika	11 (10.3%)
Rift Valley Province	**Total 21 (19.6%)**
Nakuru	21 (19.6%)
Coast Province	**Total 5 (4.7%)**
Mombasa	5 (4.7)
Total all provinces	**107 (100%)**

Most of the providers (84.1%) reported working in a clinic. A clinic offers a limited number of services, usually curative and maternal and child health care. The clinic may also offer emergency delivery services to patients who present in the second stage of labor. It does not usually offer 24-hour services although some geographic clusters of nurse-midwives have been providing round–the-clock services through informal networks. The clinics cater mainly to outpatients and each clinic usually has only one qualified provider.

Ten of the respondents (9.3%) reported working in a nursing home. A nursing home is a facility that offers a wide variety of services, both curative and preventive, and also provides in-patient services with a minimum of four beds. Most nursing homes also provide labor and delivery services.

The remaining providers reported working in dispensaries (3.7%), maternity homes (1.9%) or health centers (1.0%). Dispensaries generally offer curative as well as preventive care and have a pharmacy separate from the consulting room for dispensing medicine. They usually have a fully qualified pharmacist who is able to dispense medicine for minor ailments without consulting the service provider. A dispensary will usually have two or three beds for labor and delivery clients. A health center is typically an outpatient facility in a rural area. It is very similar to a

clinic and offers the same range of services. However, depending on the distance to the referral facility from the health center and clients' stage of labor upon arrival, providers in these rural facilities often offer emergency delivery services.

Factors that influence provider performance

Many different factors influence how well service providers perform their job. The first part of the questionnaire was designed to establish the presence or absence of essential performance factors. In addition to overall organizational support, the five factors in the PRIME II Performance Improvement (PI) model include:

1) clear job expectations;
2) immediate performance feedback;
3) adequate physical environment;
4) motivation and incentives;
5) appropriate skills and knowledge.

The questions took into consideration that nurse-midwives are *private* practitioners and work in facilities where they are the primary provider of reproductive health services, including PAC.

Providers were asked a series of yes/no questions about factors that have an impact on their performance. These results are presented in Table 2.

Table 2: Responses for selected performance factors*

Factor	n (%)
Do you have the knowledge and skills that you need to provide good quality PAC services?	97 (90.7)
Do you have the equipment and supplies that you need to provide good quality PAC services?	85 (79.4%)
Does the community support your work in PAC	98 (92.5%)
Do you know what clients expect of you?	107 (100.0%)

* N=107 for each question except for community support where N=106

Clear job expectations

It is important to keep in mind that these are private providers, some of whom work alone and do not have a supervisor who regularly discusses work expectations or provides feedback on performance. However, clients arrive at the facility with expectations - and may also provide feedback. When asked, all 107 nurse-midwives answered that they know their clients' expectations. When asked how they know, the great majority of the nurse-midwives (97) mentioned verbal communication, saying that "*clients tell me,*" "*we have a dialogue,*" "*provider creates dialogue,*" or "*they always ask questions.*" However, discussions with providers during and after dissemination of the results, highlighted that providers cannot always determine clients' level of satisfaction with the services. For example, sometimes they provide services to clients who come from a distance and who do not return for follow-up or other services.

Twenty-seven of the nurse-midwives said that non-verbal communication, or a combination of verbal and non-verbal communication, help them understand clients' expectations. Some of the statements were as follows: *"(Clients) behave in a manner to suggest that's what they need," "by physical behavior,"* or *"facial expression – some look uncomfortable if there is another client in so I realize they need privacy."*

When the nurse-midwives were asked to name two or three things that clients expect from them, they most frequently mentioned quality services, a good job or safe services (81 times). They mentioned privacy and confidentiality 63 times followed by sympathetic, empathetic and kind services and counseling/guidance/education 35 and 29 times, respectively.

Feedback on performance

In order to assess how the nurse-midwives receive feedback, they were asked how they know when, or if, they are doing a good job of providing PAC services. This question revealed that providers equate safe management of cases with positive feedback on performance. Of the 102 nurse-midwives who responded to this question, 55 mentioned client recovery, lack of complications, or successful procedures. Customer orientation appears strong in this group of providers. They mentioned client appreciation and feedback 49 times. The providers also mentioned clients' return for follow-up or other services (31 times) and referral of new client(s) and increase in clients (25 times), and, conversely, no or few referrals (seven times). (See Table 3.)

Table 3: How do you know if you are doing a good job in PAC?

Category of response	# of responses (%)
Client recovery/lack of complications/good or successful procedures	55 (33%)
Client appreciation/feedback/verbal response	49 (29%)
Clients return for follow-up/other services	31 (19%)
Clients refer new clients/increase in clients	25 (15%)
No/few referrals	7 (4%)
Total	167 (100%)

The survey did not seek verification at nearby hospitals, but according to the PRIME II database of client outcomes, the providers have referred only a small number of clients (about five percent of the total number of clients who have received PAC services). These referrals were generally for complications that clients already had upon arrival at the private providers' facility, and that providers felt merited treatment by a higher cadre of provider in a hospital.

Physical environment

When the nurse-midwives were asked directly if they have the equipment, supplies and other resources they need to provide good quality PAC services, the majority of the providers (79.6%) answered yes and less than 20% answered no (one provider was unsure). While finding that 80% of providers feel that they are adequately

equipped is a positive finding, the fact that a fifth do not feel adequately equipped highlights a need for more work in this area. In addition, need is a very subjective concept. When supplies and equipment were discussed with providers at the dissemination meeting, many thought that the number of providers stating that they have what they need may be an overestimate. In this context, it is important to note that space-related issues and lack of supplies and equipment represented almost a quarter (23%) of responses to when providers were asked about factors that hinder their work in PAC.

Among the providers who stated that they do not have what they need, Table 4 describes specific needs that the providers expressed. In addition, two providers mentioned increased skills and knowledge; one of whom specified skills to provide Norplant® implants.

Table 4: Equipment, supplies and tools needed by providers

Items needed	# of responses (%)
Appropriate couch	6 (22%)
Appropriate/larger space	6 (22%)
Autoclave	3 (11%)
PAC/MVA Kit	3 (11%)
Additional staff	2 (7%)
Lamp	2 (7%)
Regular supplies of syringes and cannulae	1 (4%)
Trolley instruments	1 (4%)
Blood expanders	1 (4%)
Beds for recovery	1 (4%)
Electricity	1 (4%)
Total	27 (100%)

Motivation and incentives

The private providers' responses indicated that this is a very motivated group of service providers. When the nurse-midwives were asked what motivates them to do a good job, personal motivation, job satisfaction/professional challenge, and doing one's duty were most frequently mentioned (45 times). Another 30 responses reflected the providers' satisfaction from doing a good job. As discussed above, the providers' responses included successful treatment, quick recovery, and no complications. The providers expressed sentiments such as *"I love my job," "I enjoy my work. I strive for excellence," "I get satisfied after doing a good job," "job satisfaction from helping others,"* or *"desire to grow in my work."*

Many of the service providers (31) mentioned client satisfaction or appreciation. One provider stated as follows *"at the end of the procedure, my clients are grateful and feel I have saved their lives."*

Table 5: What motivates you to do a good job?

Response	# of responses (%)
Personal motivation/satisfaction/duty	45 (21%)
Client appreciation/satisfaction	31 (14%)
Skills and knowledge/training	31 (14%)
Successful treatment/quick recovery/no complications	30 (14%)
Equipment, tools, supplies	27 (13%)
When clients pay/income	20 (9%)
Staff relationship	9 (4%)
Patient referrals/patients returning for follow-ups	7 (3%)
Adequate facilities	7 (3%)
Organizational support (Intrah)	6 (3%)
Community support	5 (2%)
Total	218 (100%)

Many providers (31) stated that gaining new knowledge and skills motivated them. Some mentioned resulting increase in confidence, and others mentioned the challenge of learning something new.

Providers mentioned adequate equipment, tools and supplies as a motivation 27 times. Another seven providers mentioned adequate facilities.

Several provider statements reflected the importance of good support in one form or another. For example, they referred to relationships with other staff, support from IntraHealth through the PRIME project, and community support nine, six, and five times respectively.

Twenty providers mentioned income, i.e., when clients can pay for services, as a motivating factor. It is important to remember that even more providers (33) mentioned clients' ability to pay and being paid for PAC services in order to cover costs when the providers were initially asked about the two or three things that hinder or get in the way of providing PAC services. One provider stated that he *"feels good about providing the services even when patients cannot pay."* (See Table 5.)

Knowledge and skills

The providers were asked if they have the knowledge and skills to provide good quality PAC services, including RH services to women seeking PAC. Of a total of 107 providers, 97 (90.7%) answered yes and ten (9.3%) answered no.

The ten providers who felt that they do not have adequate knowledge provided 14 suggestions for training (Table 6). Most of the suggestions (seven) focused on PAC; how to deal with emergencies/ complications, diagnosing the pregnancy and needed lab skills. There were six suggestions that FP training is needed, and two providers requested Norplant® implants training specifically. Only one provider asked for training in HIV (Human Immunodeficiency Virus) testing.

Table 6: Areas for additional training

Area where training is needed	# of responses (%)
PAC: deal with emergencies and complications	7 (50%)
FP	6 (43%)
HIV testing	1 (7%)
Total	14 (100%)

Facilitating items

Participants were asked an open-ended question about the two or three things that make their work in PAC easier. The responses were analyzed by grouping them under the performance factors (Table 7).

Table 7: Items that facilitate providers' work in PAC

Factor	# of responses (%)
Adequate physical environment	**110 (43%)**
Supplies (drugs & equipment)	81 (32%)
Facility	29 (11%)
Appropriate knowledge & skills	**83 (33%)**
Support and motivation	**57 (22%)**
Support from colleagues & staff	24 (9%)
Client-related issues	22 (9%)
Community awareness/support	10 (4%)
Love of work	1 (0%)
Other	**5 (2%)**
Total	**255 (100%)**

Providers most frequently mentioned aspects of a*dequate physical environment* as a facilitating factor, and they mentioned supply-related issues more frequently than issues related to infrastructure, respectively 81 and 29 times. When they referred to their facilities, providers often mentioned good set-up and well organized space, having a room for PAC services or enough space for client privacy. One provider stated, *"I have enough room for privacy."* The providers also mentioned convenient clinic location for easy client access.

When they mentioned supplies, the providers most frequently emphasized having the MVA kit. Some stated that having emergency drugs and being able to provide pain relief to clients facilitate their work in PAC. Availability of water, electricity and proper lighting did not appear to be an issue, probably indicating that this does not represent a problem for most of these providers whose facilities were screened according to certain criteria before they could be trained. A couple of nurse-midwives mentioned transportation as a facilitating factor.

Secondly, the providers mentioned having *appropriate skills and knowledge*. They stressed the importance of good technical skills to provide PAC services, including opportunities to practice new skills. Some also mentioned the counseling skills they had acquired during the training as well as being able to take a good medical history. Some highlighted the results of the training intervention, namely the confidence they feel when they provide PAC services. Providers made statements such as *"I'm confident because I have the knowledge," "counseling patients before the procedure*

- *make patients relax,"* or *"having no fear"* because of the new knowledge. Two providers said that they now are able to provide more integrated services to clients.

Thirdly, the providers mentioned different aspects related to *support and motivation*. In this context, they described various types of support from different sources such as colleagues and staff, clients, and community. When they described support from staff and colleagues, the nurse-midwives mentioned, among other things, well trained staff including back-up and help from doctors, a cooperative work environment, and networking. One provider highlighted that their staff, *"work like a team."* Only one provider mentioned support from the *"boss,"* perhaps reflecting the work situation for many of the nurse-midwives who own and practice in their own clinic.

This and other responses indicated the level of motivation and customer orientation among these private providers. Clients' trust is important for the private providers as is acceptance, co-operation, and open communication with clients. As an example of client cooperation, some providers mentioned clients providing correct medical history, probably reflecting the particular problems that PAC providers face when clients try to conceal the fact that they have taken steps to induce an illegal abortion.

Only ten providers mentioned change in community awareness, cooperation and support. One person mentioned the importance of enjoying one's work as something that makes work easier: *"The fact that I love my work – the working environment."*

The last category "other" includes four providers who emphasized the importance of having guidelines and reference materials. One provider stressed the issue of effective linkages with referral centers.

Hindering Items

When asked about what factors hinder their work in PAC, the providers most frequently mentioned client and community related issues, for example, clients' financial status and their inability to pay (Table 8). One provider stated the problem as follows: *"Sometimes the patients have no money and yet we must treat them. It is difficult because we need drugs and they are bought,"* or *"the cost of treating clients who cannot afford to pay 2,000 (KS) (about $25)."*

The group of private providers attending the dissemination meeting and a subsequent focus group discussion with six providers validated that inability to pay is indeed a problem. Providers do not appear to refuse clients even if they have little or no money. Some clients pay something later while others do not. For some providers, the clients who pay the full fee subsidize the PAC services received by those who do not pay or pay very little. For other providers other services subsidize PAC services received by non-paying clients.

Table 8: Items that hinder providers' work in PAC

Category of response	# of responses (%)
Ability to pay/cost	33 (23%)
Community attitudes/misperceptions about PAC	26 (18%)
Lack of qualified staff/trained personnel	20 (14%)
Lack of supplies and equipment	19 (13%)
Lack of space	18 (13%)
Client misinformation/uncooperative	17 (12%)
Lack of Electricity	6 (5%)
Complications too serious	2 (1%)
Lack of transport	2 (1%)
Total	143 (100%)

The next most frequently mentioned impediment in PAC service delivery include different types of community misperceptions about PAC: *"Some community members have not fully understood the PAC services. They mistake PAC services for abortion."* One provider expressed that she is *"afraid of being arrested due to the misunderstanding."* Others had problems with the Clinical Officer (CO) and doctors in the area, an indication that the advocacy groups that were formed to help the providers did not always succeed in getting the midwives' colleagues or public sector providers "on board," or, perhaps, there should have been more advocacy activities: *"They spoil our names by saying that we do abortions."*

Some providers implied that there is distrust: *"Some people think the clinic is not suitable for PAC. They think PAC should be done in a maternity hospital."* For the first private providers trained to provide services at the community level, this issue was indeed a big change since PAC was a hospital-based service before the nurse-midwives received PAC training. The providers' statements may be an indication that some providers still need assistance to explain PAC services to the community in order to gain their support. For example, a recent USAID evaluation of the PRIME PAC program indicates that providers in some areas are low performers or never began to provide PAC services at all. This is an issue, which requires more attention.

Again, the providers mentioned lack of transparency and cooperation among clients (17 instances): *"At times, clients cheat about the gestation period,"* or *"They fear the MVA procedure. Some scream during the process attracting attention of those outside."* This may be an indication that some providers need to improve the provision of pain relief and that their infrastructures need to be upgraded to improve their auditory privacy.

Twenty providers mentioned the lack of qualified or trained staff support or personnel. Some providers stated that they need more knowledge and skills themselves. They did not specify what type of training, but it is important to remember that the providers mentioned a need for updates in many different areas in response to other questions. When asked directly, more than 90 percent stated that they have the knowledge and skills to provide quality PAC services

Providers mentioned lack of supplies/equipment and inadequate space as barriers 19 and 18 times respectively. One provider said that *"there is no theatre and there are very many clients."* Some providers mentioned uneven supplies of electricity or no availability of electricity during the night, which is beyond their control unless they own a generator. The private providers who stated they have deficiencies in areas related to infrastructure, supplies and equipment mentioned the lack of a proper couch, MVA kits, and, to a lesser extent, drugs and infection prevention (IP) supplies. Some indicated that they have problems with transportation and the distance to referral sites.

Some of the providers' statements reflected the particular challenges in providing PAC services, particularly if there are no other providers who can take over other work while they manage the PAC client: *"The procedure takes a long time, so other patients run away."* Other providers emphasized the lack of a "resting" area if other services are to be provided at the same time. As mentioned above, the facilities were screened for appropriateness before the private providers were approved for the PAC training. However, some providers have moved from the facility where they worked before they were trained and now work at facilities that may not have been approved. Some of these providers are struggling to improve their sites – the cost of renting additional rooms or building more space presents a problem for some. It is important to keep in mind that, based on results from other studies, these providers are able to safely manage emergency needs at the community level (PRIME's Technical Report # 21: *Expanding Opportunities for Postabortion Care at the Community Level through Private Nurse-midwives in Kenya*). However, inadequate space may compromise privacy.

A few providers discussed the limitations in the care they can provide. Providers are helpless in the face of difficult family situations. For example, some of their patients feel they cannot tell their partner about their PAC treatment following the induced abortion. Furthermore, the providers receive requests for induced abortions that they are unable to provide.

Nine providers indicated that they felt they had no barriers to providing PAC services.

Support for the primary care providers

Many private providers own the clinics where they practice, so with the questionnaire an effort was made to assess possible sources of support such the community, public sector supervisors, as well as peers.

Support from the community

The private providers were asked if the community supports their work in PAC. Of the 106 providers who responded, 98 (92.5%) stated that the community is supportive while six (5.7%) stated that it is not. Two of the providers (1.9%) were unsure. In this context, it should be recalled from the earlier discussion about things that hinder their work in PAC that 26 providers expressed that community misperceptions and community lack of awareness were impediments.

This high number of providers who stated that the community is supportive may be overestimated in this survey as a result of the selection of the interviewees. As discussed, the Project encouraged providers to reach out to the community to create awareness about the new services and included Advocacy Teams to help the providers. Some of the providers encountered considerable problems in the beginning but appear to have overcome them over time. In this survey, this group may have been over-represented because 71 of the providers interviewed had performed more than ten PAC procedures. Other studies indicate that for some of the trained providers, lack of community support may have led to low performance or not starting to provide PAC services. In fact, according to the USAID final evaluation of the Kenya PAC project, around 20% of providers were classified as low or non-performers. Low performers were providers who had seen only a few cases since they were trained and non-performers had either stopped providing services or had not initiated PAC services after the training.

According to the providers, community members show support in many different ways. For example, 80 responses mentioned that community members send clients to their clinic, 30 said that the community helps create awareness about the services in different ways, 16 mentioned appreciation, praise and encouragement while four responses mentioned material support from the community, for example, fetching of water (Table 9). One emphasized how important this is in a rural area where water is not easy to get. Protection and transportation are other contributions that were specified.

Table 9: If yes, how do they (community) support your work?

Category of response	# of responses (%)
Send more patients/clients	80 (62%)
Creating awareness	30 (23%)
Appreciation/praise/encouragement	16 (12%)
Material support (fetch water)	4 (3%)
Total	130 (100%)

One provider explained that *"after talking to the chief, he (the chief) talked to other church leaders and as a result I have received several invitations to talk to people about PAC."* Some providers specifically mentioned that they have been asked to talk at *barazas* (chief's meetings) and that community members use the *barazas* to advertise their clinic's services. One service provider explains that *"the village elders take around the message."* Others said that they had brought the message about providing PAC services into public schools and women's organizations.

Most – if not all – of the providers had to deal with initial resistance, and some resistance may persist. For example, one provider said as follows: *"They refer each other to me apart from those few church elders who are not sure whether I don't do abortions."* Among the six providers who said that the community is not supportive, most said that there is confusion regarding MVA and abortion or fear that PAC will encourage abortion. Three of these providers indicated that the community is not aware of the services, an indication that they may need to increase their level of effort in doing outreach to the community.

Support from the public sector supervisors

The Project has made efforts to actively involve the DPHNs in supervising the private sector primary care providers who have been trained in providing PAC services. The survey contained several questions addressing the supervision performed by the DPHNs, the providers' perception of the usefulness of this supervision, and their suggestions for improving it.

Frequency and length of visits

The providers were first asked to tell when they had last received a visit from the DPHN. Seventy-two providers responded to this question (Table 10). Time since the last visit varied from zero days, indicating that they had received a visit the day of or the day before the interview, to 607 days (with a mean of 146 days, i.e., almost five months). Fifty-two of these providers had received a visit from the DPHN in the last six months while 20 had not.

Table 10: Mean number of days since last supervision visit by type of supervisor (N=106)

Type of provider	Mean number of days since last visit (n)
DPHN	145.9 (72)
NCK	188.0 (8)
RH Specialist	231.8 (20)
NNAK	282.5 (6)

The providers were also asked how frequently the DPHN visits. Of 107 providers, 44 stated that they received a yearly visit, 13 received quarterly visits, one received monthly visits, and 23 stated that they had never received a visit. Sixteen providers responded that the DPHN comes at any time, when needed, or that it is unpredictable. Another ten providers stated that the DHPN had only come once. It should be mentioned that the DPHN is expected to visit the private nurse-midwives at least once a year in order to renew their licenses.

According to retrospective estimates by the respondents, the average time that supervisors of any type stayed at the facility was 40 minutes, ranging from five minutes to five hours.

When the providers were asked how often they would like for the DPHN to visit, 77 suggested either yearly or quarterly visits. Table 11 below shows the providers' responses in terms of desired and actual visits. It appears that the providers receive fewer visits than they would like to receive, especially when no one listed "never" as their preferred number of visits while 23 providers reported that the DPHN had never visited. It is important to keep in mind that these responses are not matched, i.e., the 44 providers who desired yearly visits are not necessarily the same 44 providers who reported receiving yearly visits.

Table 11: Desired and actual number of visits to providers by DHPN

Schedule for visits	Number of visits desired	Actual visits provided
Yearly	44	44
Quarterly	33	13
Twice a year	17	-
Whenever they want to come/unpredictable	4	16
Every 2-3 months	2	-
Monthly	9	1
Only once	-	10
Never	-	23
Other	3	4

Tasks accomplished and usefulness of supervision visits

When the providers were asked to describe in detail what the supervisor did during the visit, they mentioned one to five items each. Eighty-one providers stated that the supervisor inspected the facility indicating that the supervisor reviewed several things during the visit. Specific things that the providers mentioned are outlined in Table 12.

Table 12: Please describe in detail what the supervisor did during his/her visit

Response	# of responses (%)
Inspected facility	**100 (72.5%)**
Check license	19 (13.8%)
Check drug supply/storage	24 (17.5%)
Check vaccine supply	10 (7.2%)
Inspect for cleanliness	19 (13.8%)
Checked records	19 (13.8%)
Check equipment	9 (6.5%)
Gave advice/answered questions	**18 (13.0%)**
Updated knowledge/skills	**10 (7.2%)**
Other	**10 (7.2%)**
Total	**138 (100%)***

Of the 89 providers who reported a visit by the DPHN, 80 (89.9%) found the visit was helpful. Of the 11 providers who reported a visit by the NCK, all found the visit was helpful. Of the eight providers who reported a visit by the NNAK, seven (87.5%) found the visit was helpful. Of the 28 providers who reported a visit by the RH Specialist, 24 (85.7%) found the visit was helpful (Table 13).

Table 13: Percentage of providers who reported that a supervision visit was helpful by type of supervisor

Type of supervisor who visited	% of providers who found the visit helpful (n)
DPHN	89.9% (80)
NCK	100% (11)
RH Specialist	85.7% (24)
NNAK	87.5% (7)

When the providers were asked what they found useful, they gave numerous responses presented in the Table 14. The providers most frequently mentioned raising problems and giving advice for improvement (51 times). In 33 of these statements, the providers did not emphasize any particular area, but those who did, specified record keeping, storage of drugs, and advice about where to get supplies. The types of supplies mentioned were for delivery of FP and immunization services. "Other medical" included referral for sterilization and malnutrition and helping the provider set a lower price for immunization services to make it more easily available to the many poor clients who have difficulties with paying.

Table 14: What did the providers find helpful during the supervisors' visit?

What the supervisor did that was helpful	# of responses (%)
Raised problems - gave advice for improvement	**51 (53%)**
General	33 (35%)
Record keeping	6 (6%)
Storage of drugs	5 (5%)
Where to get supplies	4 (4%)
Other medical – referral of client	3 (3%)
Provided updates	**20 (21%)**
Invited to seminar/informed about future updates	**5 (5%)**
Motivated	**9 (10%)**
Helped with license	**7 (7%)**
Raised community awareness about services	**2 (2%)**
Provided supplies	**2 (2%)**
Total	**96 (100%)***

Twenty providers stated that they appreciated the updates the supervisors provided. When the providers specified the type of update provided, it was most commonly on immunization, infection prevention/waste disposal, or to update on current practice or technology. STI (Sexually Transmitted Infections) screening, malaria and screening for paralysis was also mentioned. In addition to being updated during the supervision visit, five providers mentioned being invited to seminars or being made aware of future updates.

Nine providers specifically mentioned the motivating effect of the supervision visit. One provider stated *that "I felt [as though I were] part of them and encouraged to do*

a good job," and another stated *"I was encouraged so I feel part and parcel of the health team."* A third *provider "felt that there was a support system,"* and yet another felt that the support increased morale.

When the supervisor helped with issues related to licensing, it was mainly related to license renewal. Two providers specified that the DPHN helped create awareness about her services in the community. Two providers mentioned that the DPHN provided supplies; one mentioned a disposable kit and the other supplies for immunization.

One provider stated that the supervision visit *"made me aware of areas where I was lax."* According to this provider, the visit led to improved results. He went out and purchased a thermometer for monitoring vaccines. Two other providers made similar statements: *"The surprise visit made me aware that I need to keep things in order always"* and the provider *"realized they may come to visit at any time and I am now always prepared for a similar visit.*"

Of the nine providers who did not find the visit helpful, three felt that the supervisors had come to harass or victimize. The provider who felt victimized mentioned that she was asked to change the laboratory technician because he was not government-trained. One of the two providers who mentioned harassment stated that the provider was harassed to give a bribe in order to receive a license. According to other providers, the supervisor did not stay long enough or did not play a role in identifying areas that need improvements. In this respect, it is important to keep in mind that the supervisors stayed from five to minutes to five hours. If a supervisor stays a short time, problem solving is difficult or impossible to do.

Table 15: If no, why wasn't the visit helpful?

Why the visit was not helpful	# of response (%)
Came to harass/victimize	3 (34%)
Did not stay long enough	1 (11%)
Just brought the visitors and went to wait in the car	1 (11%)
Clients were not updated	1 (11%)
Did not identify areas that need to be improved	1 (11%)
Wanted provider to open blocked windows	1 (11%)
Suggested dry storage of instruments	1 (11%)
Total	9 (100%)

Providers' expectations of the DPHN

The providers were also asked about their two or three most important expectations of the DPHNs. (To the extent possible, these answers were classified as in Table 15 above where the providers were asked what the DPHN did during the visit that was helpful). Thirty-three percent of the providers' expectations focused on the need for problem identification and advice/guidance/assessment in order to correct mistakes and provide quality services. Some of these providers mentioned the DPHNs' role in quality assurance and implementing government policy.

Table 16: Providers' expectations from the DPHN

Providers' expectations of the DHPNs	# of responses (%)
Identify problems - give advice for improvement	**62 (33%)**
General	48 (26%)
Record keeping	4 (2%)
Storage of drugs	3 (2%)
Other	7 (4%)
Provide updates, seminars, continuous education	**60 (32%)**
Do visits regularly, follow-up, be available in case of need	**29 (15%)**
Motivate	**19 (10%)**
Help with license	**4 (2%)**
Help with community education/awareness	**1 (1%)**
Provide supplies – help with cost sharing	**11 (6%)**
Total	**186 (100%)**

Sixty responses were related to learning, indicating that providers expect updates, seminars, and continuous education from the DPHNs. This number is far higher than the 25 providers who stated that the DPHN had actually updated or invited them to a seminar and indicates unmet learning needs among the providers. The request for advice, updates and problem solving also shows that the providers want to stay up-to-date in their profession. They want to know about new findings, technologies and drugs in their field.

Nineteen responses addressed expectations in terms of regular supervisory visits, follow-up, and availability of the DPHN in case of need. The providers were not directly asked to specify "regular," but they were asked to suggest how often they want supervisory visits (Table 16).

In the 19 motivation-related responses, the providers mentioned that they want cooperation and encouragement. Some suggested letters of inspection followed by recommendations or certification. Some specifically mentioned that the DPHN should be friendly and understanding and share experiences.

Eleven of the suggestions addressed the expectation that the DPHN should help with supplies; some requested help with cost sharing. When the providers specified the type of supplies, it was related to FP and immunization.

Peer support – current practices

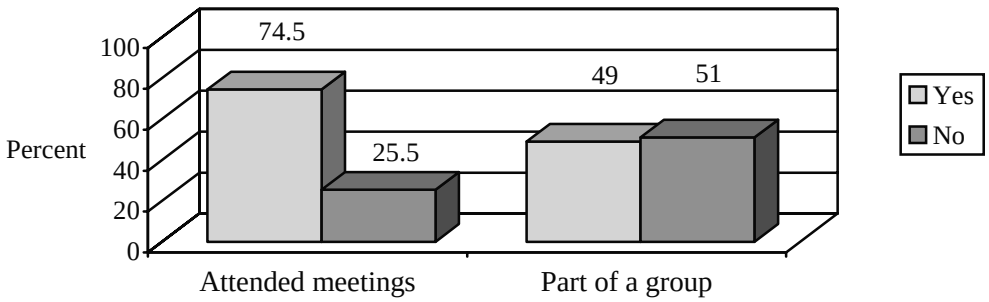
Towards the end of Phase I in the PAC project, PRIME I staff observed that some of the PAC-trained providers began to informally network to provide post-training support to each other. Subsequently, PRIME began to encourage such networking during the training. This survey was commissioned to shed more light on these networking practices in order to strengthen them in future activities.

Provider involvement in support groups

When the private service providers were asked if they have attended any meetings or seminars organized by private nurse midwives in their district, 79 (74.5%) responded

that they had. Although the majority of the nurse-midwives have attended meetings or seminars, far fewer indicated that they were *"part of a group organized to support each other's RH work, including PAC."* Slightly less than half of the nurse-midwives, 52 (49%), stated they were part of such a group.

Graph 1: Percentage provider involvement (N=106)



Providers were asked about how many members were in their peer support group. Out of the 48 respondents, 19 (39.6%) are members of groups that have between 11-30 members, 15 (31.3%) are members of larger groups, and 14 (29.2%) of smaller groups.

One of the questions addressed the process of forming the peer support groups. The majority of the respondents indicated that their support groups were formed "independently." Ten providers indicated that the group was formed as a result of the PAC training (Table 17). This would appear to be consistent with developments in the training during the Project. It is notable that, although the nurse-midwives were encouraged to form peer groups, they received no concrete outside assistance to support each other if they had questions or needed assistance. However, anecdotal evidence indicates that some providers increased their networking efforts after the August 2001 supervision stakeholders' meeting in Nairobi.

Table 17: How the peer groups were formed

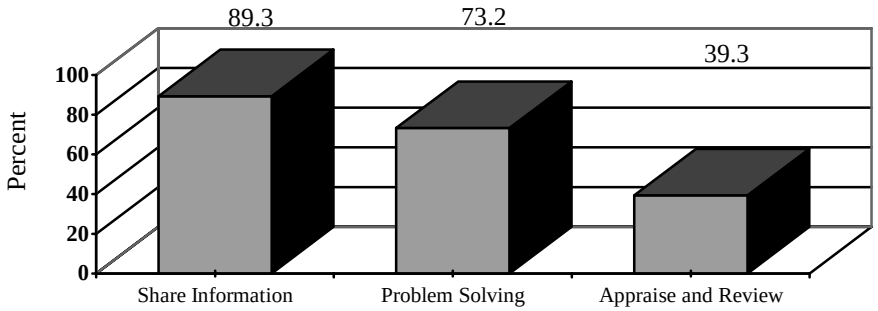
Response	# of responses (%)
Independently	30 (53%)
After training/as a result of training	10 (17%)
Branched from other group	4 (7%)
DPHN (District PH Nurse)	1 (2%)
Professional organization, NNAK other	4 (7%)
Don't know	8 (14%)
Total	57 (100%)

The providers were also asked if the group has a leader and, if yes, how the leader was selected. Forty-seven providers (83.9%) said that their group has a leader and nine said that it does not. The great majority of the nurse-midwives responded that

the leader had been elected through ballot. Of the 47 who responded, 33 (68.8%) said that the leadership rotates while nine (18.8%) said that it does not. Six of the providers (12.5 %) were not sure.

The service providers were asked about the main roles and functions of the group. Of the 56 responding, 50 (89.3%) agreed that information sharing is a main role/function while 41 (73.2%) and 22 (39.3%) agreed that problem solving and appraising and reviewing each other's strengths and weaknesses respectively were main functions.

Graph 2: Major functions of groups



The 27 providers who mentioned "other roles/functions" elaborated on the topic, and the responses are presented in Table 18. Twenty-one specifically mentioned continuing education/updates/seminars, and eleven providers mentioned financial assistance, welfare and/or having a co-op.

Table 18: Other functions of groups

Response	# of responses (%)
Continuing education/updates/education/training/ seminars/information sharing	21 (57%)
Financial assistance/welfare/coop	11 (30%)
Social functions	3 (8%)
Ensure quality	1 (3%)
Feedback/support	1 (3%)
Total	37 (100%)

Thirty-nine providers stated that the roles and functions of the groups are documented, 14 said that they are not, while three did not know or were unsure. The most common way of disseminating roles and functions to the members seems to be through minutes/in writing.

The providers were asked when they had the last meeting or communication. The responses were recoded into months since last meeting and are presented in Table 19 below. The recodes are approximate since the data collection spanned two calendar months and providers were not asked to give the exact date of the meeting. The recent dates of the last meeting are most likely the result of the supervision

stakeholders' meeting that took place in August of 2001 before the data collection in November-December.

Table 19: Months since last meeting (N=56)

Months since last meeting	N (%)
One to three	33 (59%)
Same month as data collection	18 (33%)
Four to seven	4 (%)
Total	56 (100%)

The providers were asked about the reason for the latest meeting or communication. Their responses are presented in Table 20.

Table 20: Reasons for the meeting/communication

Response	# of responses (%)
Updates/continuing ed (PAC, FP, abortion)/ seminars/lectures/info sharing	29 (38%)
Regular/routine/usual meeting	17 (22%)
Financial assistance/welfare	11 (15%)
Feedback/how to improve	5 (7%)
Group structure/membership/policies	5 (7%)
Socializing/getting to know one another	5 (7%)
Inspection/licensing	3 (4%)
Total	75 (100%)

The providers were asked what, in their view, are two or three things that help their groups work well. It should not come as a surprise that cooperation, togetherness, sharing, support of each other, and unity are most frequently mentioned by these providers who generally practice alone. Thirty-six providers mentioned this, and 15 providers mentioned financial assistance. Seventeen providers mentioned commitment as an important precondition for the group to work well (Table 21).

Table 21: Factors that facilitate providers' groups

Response	# of responses (%)
Cooperation/togetherness/sharing/support one another/unity	36 (32%)
Commitment	17 (15%)
Financial assistance	15 (13%)
Communication	12 (11%)
Updates, education, information	10 (9%)
Good turn-up/attendance	8 (7%)
Common purpose/goals	7 (6%)
Leadership	4 (4%)
Proximity/accessibility	2 (2%)
Support by outside organizations	1 (1%)
Total	112 (100%)

Conversely, the providers mentioned lack of time/funds and financial problems as things that impede the group from working well. Both were mentioned 18 times each. Such problems may result in low attendance and what may appear as low commitment, which were mentioned respectively 14 and 13 times (Table 22).

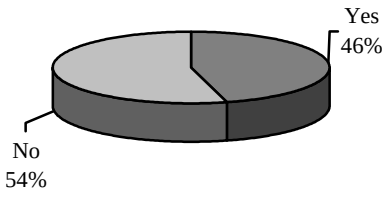
Table 22: Factors that hinder the provider's groups

Response	# of responses (%)
Lack of funds/financial difficulties	18 (20%)
Lack of time	18 (20%)
Attendance/low turn-up	14 (15%)
Lack of commitment	13 (14%)
Communication problems	11 (12%)
Too much distance between members	7 (8%)
Lack of PAC knowledge training	6 (6%)
Lack of unity	4 (4%)
Personal issues (gossiping)	1 (1%)
	92 (100%)

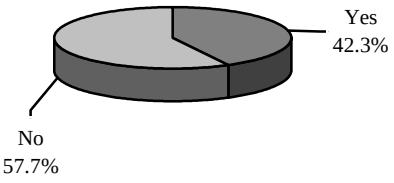
Assistance sought from or provided to a colleague

The providers were also asked if they have ever contacted a colleague when they had a problem or question when clients presented with abortion complications. More than half, or 58 providers (54.2%), have never contacted a colleague while 49 (45.8%) have. Conversely, the providers were asked if they have ever been contacted by a colleague; and 42.3% of those respondents said they had been; compared with 52.7% who had not.

Graph 3: Percentage of providers who have ever contacted a colleague (N=107)



Graph 4: Percentage of providers that have ever been contacted by a colleague (N=107)



The nurse-midwives were asked about what type of provider they had contacted most recently for assistance (Table 23). Equal numbers of respondents indicated that they had contacted a doctor or a nurse-midwife. This has interesting implications for a formal peer support network. It appears that such a network would need access to a higher-level cadre of provider than the member nurse-midwives for some problems.

Table 23: Type of provider contacted most recently (N=47)

Response	N (%)
Doctor (any kind)	19 (40%)
Nurse/midwife	19 (40%)
Nurse	9 (20%)
Total	47 (100%)

The providers had very simple rationales for initiating or accepting communication (Table 24). The desire for a second opinion about a diagnosis or treatment was most frequently mentioned followed by the provider feeling that she/he was "not confident" to proceed without assistance.

Table 24: Reasons for contacting or being contacted by a colleague

Reasons for contact	Number of providers making the contact giving these reasons (N=50)	Number of providers being contacted giving these reasons (N=45)
Wanted a second opinion	32% (16)	37.8% (17)
Not confident	34% (17)	22.2% (10)
Lack of personal experience	18% (9)	35.6% (16)
Other	16% (8)	4.4% (2)
Total	100 % (50)	100 % (45)

When the providers were asked about the **specific** problem or question for which they had sought assistance, ten indicated that they lacked confidence in their MVA skills and nine stated severe bleeding (Table 25). It is notable that nine providers sought help with problems that were not related to providing PAC services. Some of these cases were related to IUD services (two providers mentioned lost coil), Norplant® implants removal, management of persistent urinary tract infection, infertility, miscarriage, and delivery, including retained placenta and bleeding (two). From the responses, it is clear that the providers have been able to manage a variety of abortion and other complications with which clients have presented to their clinics.

Table 25: Specific problem(s) or question(s) for which the provider requested assistance

Response	# of responses (%)
Lack of confidence in MVA skills	10 (20%)
Severe bleeding	9 (18%)
Not related to PAC	9 (18%)
Unsure of management	7 (14%)
Difficulties performing MVA	7 (14%)
Retained products of conception	3 (6%)
Infection/sepsis	2 (4%)
Injury from induced abortion	2 (4%)
Services not available (i.e., lack of MVA equipment or no lab)	1 (2%)
Total	50 (100%)

Similarly the providers who had received requests for assistance were asked about the nature of the inquiries. Table 26 below presents their responses. Most of the reasons for the contact were severe bleeding (21), retained products of conception (10) and lack of confidence in MVA skills (seven).

Table 26: Specific problem(s) or question(s) with which providers assisted colleagues

Response	# of responses (%)
Severe bleeding	21 (39%)
Retained products of conception	10 (19%)
Lack of confidence in MVA skills	7 (13%)
Unsure of management	5 (9%)
Difficulties Performing MVA	3 (6%)
Non-MVA problem	3 (6%)
Mid-second trimester abortion	1 (2%)
Injury from induced abortion	1(2%)
Religious beliefs	1 (2%)
Not qualified to provide PAC services/lack training in PAC	1 (2%)
Infection/sepsis	0 (0%)
Total	53 (100%)

It is interesting to note that the providers' perceptions are very similar concerning the encounters with peers and the level of success in solving the problems (Table 27). Among the 50 providers seeking assistance who answered the question, 47 (94.0%) stated that the problem had been solved, while two (4.0%) stated that the problem had not been solved. One provider (2.0 %) was unsure. Among the 44 providers assisting a colleague who answered the question, 40 (90.9%) stated that the problem had been solved, while four (9.1%) said that it had not been solved.

Table 27: Problems solved as a result of the contact

Providers' responses	Perceptions of providers seeking assistance (N=50)	Perceptions of providers giving assistance (N=44)
Yes	94.0% (47)	(90.9% (40)
No	4.0% (2)	9.1% (4)
Don't know/unsure	2.0% (1)	-
Total	100% (50)	100% (44)

Table 28 describes how the problem was solved according to the providers who requested assistance. In 11 cases, the other person performed MVA. In nine cases, management counseling appeared to be enough and, in another eight cases, the provider received assistance with the MVA procedure. Five stated that the cases had to be referred.

Table 28: Ways that PAC problems were solved

Response	# of responses (%)
MVA performed by other person	11 (23%)
Management counsel	9 (19%)
Assistance with MVA procedure	8 (17%)
Referred to hospital	5 (11%)
Problem not related to providing PAC services solved	5 (11%)
Medication	4 (9%)
No intervention required	2 (4%)
Reassurance	2 (4%)
Uterine massage	1 (2%)
Total	47 (100%)

The providers who assisted colleagues provided short responses that describe how they helped. Some examples are as follows:

- *"I advised him to repeat egometrin and do manual uterine massage."*
- *"I advised them on how to approach the community."*
- *"I advised to insert the IUCD."*
- *"I advised him to reassure the patient more – make her relax, then start with the smallest cannula."*
- *"I assisted her in looking for the vein. Then we inserted the IV line."*
- *"I explained to him how to put down the records."*
- *"I gave him the MVA kit."*
- *"The placenta was removed."*

The providers who had requested assistance were asked whether there are other situations in which they would contact a colleague for assistance with PAC provision (Table 29). The providers mentioned severe bleeding most frequently (13 times). It is interesting to note that non-MVA related cases were mentioned relatively more frequently in response to this question. The following were specifically mentioned: hanging breech and bleeding, anemia – blood transfusion, stitching, cancer, and labor that takes too long. Other problems that could be either related to PAC or other services included: provision of IV (Intravenous) fluids, shock, resuscitation, violent patients, unconscious patient or patient in coma, and transportation. In this context, it must be mentioned that these providers often care for victims of accidents, violence, etc., because they may be the only providers in their community or the nearest provider.

Table 29: Other situations in which the provider would like contact with colleague for assistance

Response	# of responses (%)
Severe bleeding	13 (23%)
Problem not related to providing MVA	12 (21%)
Post-abortion complications	11 (19%)
Unsure of management	8 (14%)
Injury from induced abortion	5 (9%)
Infection/sepsis	4 (7%)
Lack of confidence in MVA skills	3 (5%)
Retained products of conception	1 (2%)
Total	57 (100%)

Costs for requesting or providing assistance to peers

The providers were asked whether they incurred any expenses when they either sought or provided assistance. Table 30 indicates that most of the time no cost was incurred. Those requesting assistance incurred costs more often than those providing assistance.

Table 30: Costs incurred for seeking or giving assistance

Cost incurred	Providers requesting assistance (N=49)	Providers giving assistance (N=44)
Yes	42.9 % (21)	27.3 % (12)
No	57.1 % (28)	72.7 % (32)
Total	100.0 % (49)	100.0 % (44)

Table 31 shows the types of costs that were incurred when providers requested or provided assistance. The costs included telephone, doctor's fees, hospital charges, supplies and transport. Telephone costs are most frequently mentioned, but the other costs are far higher. For example, one provider reported paying over KS100,000 (approximately $1300) in hospital charges and transportation.

When this issue was discussed during the dissemination meeting, the providers present stated that they generally have an agreement with the consulting providers, and, as a result, most do not pay a fee when they refer.

Table 31: Types of costs incurred

Type of cost incurred	Providers requesting assistance	Providers giving assistance
Telephone	20	8
Doctor's fee	3	
Transportation	4	4
Hospital	1	
Drugs/supplies		1
Time/overnight stay		2

Issues related to time

The providers who sought assistance were asked how long it took to receive assistance (Table 32). More than three-quarters of the providers (77.6%) stated that it took less than one hour to receive assistance. For another two providers, it took one to two hours, for one provider, the assistance was immediate (there was presumably another provider in the same facility), and for the rest it took from five hours to one month. One provider did not receive assistance. We have no additional information what happened in these instances.

Table 32: Length of time to receive assistance (N=49)

	% (n)
Less than 1 hour	77.6% (38)
1-2 hours	4.1% (2)
5-6 hours	2.0% (1)
Other (specify)	16.3% (8)
Total	100.0% (49)

The providers who assisted other providers were asked how much time was involved in responding to these requests (Table 33). Most of the respondents (72.1%) stated that it took less than one hour of their time. This indicates that the person assisting the provider was either in the same facility, from a nearby facility, assistance was provided via telephone, or that transportation was not a significant barrier in that situation.

Table 33: Length of time required to assist a colleague (transportation and contact time if applicable) (N=43)

	% (n)
Less than 1 hour	72.1% (31)
1-2 hours	23.3% (10)
3-4 hours	2.3% (1)
Other (specify)	2.3% (1)
Total	100.0% (43)

Desired levels of peer support

Although slightly less than half of the providers stated that they are members of a group of nurse midwives that was organized to support each other, providers were asked what they thought about joining a *"group of nurse-midwives that was organized to support each others' reproductive health work, including PAC."* All of the providers responded positively to the idea of having a peer network. When asked about possible roles or actions for the network, many of the providers highlighted the potential for regular updates in RH topics and the potential for sharing information and experiences with their peers.

In anticipation of future peer support/network interventions, providers were asked *"How would you feel if your colleagues in such a group visited your facility and gave you feedback on what they observe?"* All the respondents (107) indicated that it would be a positive experience for them. Illustrative responses included: *"[I]Would*

welcome it. It would be encouraging and help me improve." and *"This would help uplift the standard of the facility because I would make better the areas where I was told to improve."*

Providers were asked if they would be willing to leave their facilities to attend meetings of such a group. All the respondents (100%) indicated "yes."

Providers were asked how often they felt such a group should meet. Nearly half (48.6%) stated that the group should meet quarterly while 35.5% suggested that the group should meet monthly. Eight respondents (7.5%) indicated that the group should meet every two months. This has important implications for any formal peer support intervention.

The participants were asked about which topics they would like such groups to address. There were numerous suggestions (Table 34). The providers most frequently mentioned PAC and STI/HIV, 35 and 31 times respectively. The 39 providers who expressed a general need for updates covered a number of different types of services such as management of various diseases and how to use new drugs and manage patients. Although difficult to capture in a table, there is an expressed wish for experience sharing related to the problems the private providers face in their daily work related to licensing; fee setting; subsidization by the government; charges by city commission; referral of patients; and standardizing care.

Table 34: Topics suggested for the group (of nurse/midwives) to address

Response	# of responses (%)
General health updates/topics (skin diseases, TB) in-service training	39 (18%)
PAC – complications/updates	35 (16%)
HIV/AIDS/STI	31 (15%)
Patient management	24 (11%)
Cost/cost-sharing/payment	15 (7%)
FP	14 (7%)
Management of emergencies	11 (5%)
Drug updates	11 (5%)
Community awareness	8 (4%)
License issues – government fees	8 (4%)
Other RH services (including Adolescent RH)	8 (4%)
Infection prevention/control	5 (2%)
Antenatal care	3 (1%)
Infertility	2 (1%)
Total	214 (100%)

Limitations

The findings of this study should be considered in light of limitations based on its design. Since the selection process was geared towards more experienced providers, it is not possible to generalize the results of the survey to providers at large, although it is reasonable to assume that less experienced providers would need and use peer support at similar rates, if not more frequently.

Another limitation of the study is a lack of observed provider performance data related to PAC, FP and RH services. Although we do not have observed performance data to confirm the providers' reports of improved services as a result of peer support, the PRIME database of client outcomes and other published PRIME technical reports indicate that the private providers can provide PAC services safely at the community level.

Conclusions and Recommendations

The survey provides considerable insights that will inform the next phase of the project activities in Nairobi, Central and Rift Valley provinces. Lessons learned in these areas should provide useful information for strengthening peer support and scaling up PAC services in other areas in Kenya and beyond:

1) Many private nurse-midwives in the Kenya PAC project can, and do, provide support to their peers in assisting with PAC and general RH challenges. Additionally, some providers reported that support from peers helped them to positively resolve some PAC complications and other RH problems.

2) The private providers are clearly interested in providing and receiving additional support through peer networks. Although DPHNs in some areas are supportive, they are busy people facing considerable time and resource constraints. However, training in supportive supervision for the DPHNs may improve the support they are able to provide. Peer support could complement the support provided by the DPHNs and take some of the load off their shoulders, which would help them focus on bigger problems.

3) Providing PAC services is expensive and many providers face problems with high costs. Future activities need to explore innovative mechanisms for cost sharing.

4) Supplies and equipment represent an area where improvements can be achieved. The licensed private providers need to have an SDP number and be able to access supplies available in the government stores.

5) The private providers desire regular updates to stay current and even improve the services they provide. The next stage of the project needs to explore ways of tapping into training and other learning activities that could be made available to the private providers. The cost of training that is offered is an issue; the private providers lose income when they are away. Expensive training fees and other expenses are also out of reach for some providers.

6) Advocacy efforts need strengthening. There are some indications that some providers may be low performers, or do not provide PAC services at all, because of inadequate support in the community. This area requires more study.

Based on the results of this and other studies of this group of PAC-trained private-nurse midwives, peer support appears to have a large potential for improving the range and quality of services offered by this cadre. As a result of these findings, PRIME II and its partners have implemented interventions and a special study designed to document the effects of peer support on the actual performance of providers in several areas of reproductive health including family planning counseling. These results should be available in 2004.

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