Technical Report 12: Expanding Opportunities for Postabortion Care at the Community Level through Private Nurse-Midwives in Kenya

A Baseline Needs Assessment

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Final Report
July 1999

This publication was produced by the PRIME project funded by the United States Agency for International Development contract #CCP-C-00-95-00005-00. The views expressed in this document are the responsibility of PRIME and do not represent the policy of the U.S. Agency for International Development.

PRIME is a project for training and supporting primary providers of reproductive health services around the world. PRIME is implemented by INTRAH in collaboration with ACNM, IPAS, PATH, TRG, Inc., OMG Booksource and AMZCO, Inc.

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ACKNOWLEDGEMENTS

The PRIME Kenya PAC Team would like to acknowledge contributions provided by various groups and individuals in the completion of this needs assessment report.

Our thanks go to the many private nurse-midwives who not only agreed to participate in the exercise but also spent their valuable time preparing the various community groups to be interviewed in the catchment area of their clinics. All this preparation went a long way to enriching the data and information obtained for the needs assessment.

Many thanks go to the data collection team who spent many hours in the field collecting data from difficult terrain. We appreciate the part played by Mr. Kihoro in analyzing and generating usable information for project planning. It was these data that guided the selection of the project sites now hosting the Kenya PAC Pilot Project.

Our grateful thanks go to Ms. Michelle Folsom and Ms. Liz Kizzier of the REDSO/ESA and USAID/Kenya Mission, respectively, for providing comments on the first draft of the report.

We cannot forget the support and encouragement provided by Ms. Pauline Muhuhu, PRIME/INTRAH Regional Director for East and Southern Africa, Ms. Maureen Corbett, Area Program Manager for PRIME in East and Southern Africa, in liaison with Ms. Bertha French, Program Associate for PRIME/Ipas. Maureen generously offered to edit the final draft of this report and the effort meant so much to the staff of the PRIME/INTRAH Regional Office in Nairobi. We would also like to acknowledge the reviews and inputs from RO/N and CH staff, including Alfredo Fort and Marcel Vekemans, which contributed to the technical quality of this report.

We would like to recognize the facilitative role played by the USAID/Kenya Mission, whose support in the design of the needs assessment and financial assistance has gone a long way in realizing the goal PRIME set out to accomplish through the assessment.

LIST OF ACRONYMS

ANC	Antenatal Care
DAN	Diploma in Advanced Nursing
ENM	Enrolled Nurse Midwife
ESA	East and Southern Africa
FGD	Focus Group Discussions
FP	Family Planning
HELMA	Health Management Agency
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HLD	High Level Disinfection
IUD	Intrauterine Device
KECN	Kenya Enrolled Community Nurse
KIMET	Kisumu Medical Trust
KMA	Kenya Medical Association
KNH	Kenyatta National Hospital
KRN	Kenya Registered Nurse
KRN/M	Kenya Registered Nurse/Midwife
KSH	Kenyan Shilling (currency)
MCH	Maternal and Child Health
MOH	Ministry of Health
MVA	Manual Vacuum Aspiration
NCK	Nursing Council of Kenya
NNAK	National Nurses Association of Kenya
PAC	Postabortion Care
RH	Reproductive Health
RNM	Registered Nurse Midwife
STI	Sexually Transmitted Infection

TABLES AND FIGURES

EXECUTIVE SUMMARY

From October to November 1998, a PRIME team conducted a baseline needs assessment for a postabortion care (PAC) pilot initiative that PRIME was undertaking in collaboration with the National Nurses Association of Kenya (NNAK) and the Nursing Council of Kenya (NCK). The title of the pilot project is "Expanding Opportunities for Postabortion Care at the Community Level through Private Nurse-Midwives in Kenya[1]." The PRIME-assisted PAC initiative, including the activity described in this report, is financed from PRIME core funds earmarked for technical leadership and field support funds from REDSO/ESA.

In late 1998, private nurse-midwives registered with the NCK requested PRIME assistance to include PAC in the range of preventive and curative maternal and child health services they offer. These private nurse-midwives have their own clinics, offer services in areas traditionally underserved by physicians (e.g. urban slums and rural areas), and frequently care for women experiencing obstetric emergencies. In partnership with the NNAK and with support and sanctioning from the NCK and the Primary Health Care Division of the Kenya Ministry of Health, a PRIME-assisted pilot project was launched in 3 provinces: Nairobi, Rift Valley and Central Provinces. The provinces were selected following a country-wide survey of private nurse-midwives who had a current permit from the NCK to operate a private practice.

The purpose of the needs assessment was to generate baseline data that would contribute to the design of strategies to train, monitor and supervise private nurse-midwives as they establish and integrate PAC services at their respective facilities. Needs assessment findings will also be used to evaluate the extent to which the pilot project achieved its objectives and expected results.

The needs assessment team used 4 instruments for data collection (see appendices 1-4): a facility checklist; focus group discussion (FGD) guide for community opinion leaders; focus group discussion guide for youth; and client exit interview guidelines.

Data were collected from 49 facilities in 3 provinces and the 151 nurse-midwives working in those facilities. The 49 were selected from among the 101 facilities listed during the inventory as a convenience sample, using criteria which included ownership of the facility, interest in offering comprehensive PAC services and 2 nurse-midwives on staff who could be trained to provide PAC services. Data were also collected from community opinion leaders and youth who participated in a total of 33 FGDs and from 23 MCH/FP clients interviewed at-exit from 29 facilities (there were no clients appropriate for interviews at the remaining 20 facilities at the time of the baseline assessment).

[1] PRIME and the National Nurses Association of Kenya, proposal, revised December 1998.

Major findings from the assessment:

1. Potential for Private Nurse-midwives and Their Facilities to Offer PAC Services.

   An examination of selected indicators of access and quality of services currently offered at facilities served as a predictor of the extent to which PAC services could be easily accessed by potential patients.

   The data established that the majority of facilities are within easy distance for potential clients, and that all services offered at the facility are offered daily, including evenings and weekends, on demand. The waiting time for clients averaged 18 minutes and ranged from 4 to 60 minutes.

   All facilities met the minimum requirements for cleanliness, sanitation and overall condition of the building structure, and all had an adequate reception and waiting areas and were adequately furnished and ventilated. Ninety percent of the facilities had access to some form of running water and those that did not had improvised adequately. The vast majority of facilities have most of the equipment needed to provide PAC services.

   Infection prevention and control were found to be areas needing attention. For example, 22% of facilities had no chemical disinfectants needed for sterilizing and disinfecting equipment and 20% did not have covered containers for high level disinfection. Record keeping was also found to be poor because records were not up-to-date and accurate for most of the services offered.

2. Current Strategies for Management of Postabortion Patients
   Private nurse-midwives in 2 of the 49 facilities currently perform MVA for the emergency treatment of postabortion complications. The remaining facilities refer postabortion patients requiring emergency treatment to the nearest district hospital or private facility staffed with a trained physician. Facility in-charges from more than 75% of the facilities reported that they provide postabortion FP counseling and services to clients who seek services from their facilities after receiving emergency treatment elsewhere.

   Nurse-midwives in almost all facilities reported that they offer FP services, although only half reported to have received training in FP. Of those trained in FP, half were trained prior to 1995. More than 90% of all facilities routinely offer oral pills, Depo-provera® and condoms, and 84% reported to also offer IUDs. Although less than half of the facilities have a laboratory staffed with a technician, almost ¾ of the facilities offer STI screening and management.

3. Interest in PAC Training

   Ninety-six percent of the facility in-charges reported an interest in training and other support to enable them to meet the demand for postabortion care services. The 2 facility in-charges who declined participation in the PAC initiative cited the following reasons for lack of interest: patients' inability to pay for the services and counseling postabortion patients was too time consuming.

4. Exit Interviews with Clients and FGDs with Community Opinion Leaders and Youth

   Qualitative data were collected from 23 MCH/FP clients on their personal history with FP and views on contraceptive use, perceptions about abortion and the consequences of unsafe abortion, and preferred sites for PAC services. Similar issues were explored in depth in 33 FGDs, conducted separately with community opinion leaders (16 FGDs) and youth (17 FGDs).

   The majority of the MCH/FP clients who were interviewed were married with children, desired another child and had used a FP method. All but one client was aware of the issue of unwanted pregnancies and 86% perceived this as a major problem in their community. Interviewees were also aware of the social and health consequences of unsafe abortion, and advocated for providing information and education to all youth, especially young girls, about the dangers and consequences of unsafe abortion and the importance of abstaining from sex before marriage.

   Community opinion leaders and youth shared perceptions of the range of health problems facing youth today in Kenya, including unplanned pregnancy, unsafe abortion and complications, and STIs and HIV/AIDS. There is a lack of information for youth, and information that is available is often inconsistent, incomplete or was for the general public and not specifically directed at youth. All respondents knew of women and girls in their communities who had an unwanted pregnancy and sought to terminate it, and almost all community opinion leaders and all youth were in agreement that unsafe abortion was a serious problem in their communities.

   Community opinion leaders and youth agreed that youth should be educated and counseled about sexuality, but community opinion leaders felt that greater emphasis should be placed on abstinence rather than provision of FP services. Youth differed with this and felt that FP services should be provided, in addition to education and counseling.

   This assessment contributed to the training content and, the supervision and monitoring plan, for a PRIME PAC intervention that targeted 60 private nurse-midwives at 30 sites in Kenya.

1. Introduction

Postabortion care (PAC) is an approach for reducing mortality and morbidity from unsafe abortion and for meeting the reproductive health (RH) needs of women treated for complications of unsafe abortion, whether induced or spontaneous. It involves strengthening the capacity of health systems to offer and sustain a set of integrated reproductive health services that include:

- emergency treatment for complications of abortion;
- postabortion family planning counseling and services; and
- links between emergency treatment and other reproductive health care services.

WHO defines unsafe abortion[1] as a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both. Unsafe abortion accounts for high levels of maternal mortality throughout the world. In Africa, women experience the greatest risk of death from unsafe abortion (1 death from 150 unsafe abortions, versus 1 in 260 in Asia, 1 in 800 in Latin America and 1 in 1800 in Europe)[2] as well as short and long-term health problems that include infection, chronic pain and infertility. Although only 1 in 10 of the world's women live in sub-Saharan Africa, the region accounts for 40% of all pregnancy-related deaths worldwide[3] and an estimated 30% of all maternal deaths in sub-Saharan Africa are due to complications from unsafe abortion.[4] The situation in Kenya mirrors that of sub-Saharan Africa in general.

In September 1997, PRIME organized a PAC orientation workshop for staff from the Regional Office in Nairobi and invited several private nurse-midwives. The private nurse-midwives attending the workshop became interested in receiving the clinical training needed to provide PAC services in their service sites. Several indicated their willingness to purchase Manual Vacuum Aspiration (MVA) equipment at their own expense. Many admitted to having been forced by circumstances to try various procedures, including emergency uterine evacuations using dilation and curettage, to try and save women's lives despite their lack of training in such procedures.

The private nurse-midwives asked that PRIME work with the Nursing Council of Kenya (NCK) and the National Nurses Association of Kenya (NNAK) to organize PAC training for nurse-midwives in private practice for the purposes of expanding the array of services offered by the nurse-midwives to include comprehensive PAC services.

As a first step in responding to this request, PRIME worked with the NCK to conduct a countrywide inventory of private nurse-midwives who had a current permit from the NCK to operate a private practice. The purpose was to establish a national inventory of private nurse-midwives, including the number and location of facilities. A questionnaire was sent to all NCK registered private nurse-midwives which sought data on their qualifications, both basic and post basic, location of his/her practice, range of services

provided, and their interest in providing PAC services and participating in a PAC training workshop.

Four hundred and sixty three (463) questionnaires were administered via mail service to private nurse-midwives licensed by the NCK to practice as of November 1997. Of the 463, 162 (35%) were returned. All 162 of the respondents stated their interest in being trained to provide PAC services. The data were used to identify Nairobi, Rift Valley and Central Provinces as areas with the majority of nurse-midwives in private practice, with facilities located in both rural and urban areas and within low income communities.

The next step was for PRIME to plan and conduct a baseline needs assessment, documented in this technical report, for the purpose of assessing the strengths and limitations of private nurse-midwives as potential PAC service providers. The needs assessment also included interviews with nurse-midwives to further explore their interest in providing PAC services and their specific training needs. The facility assessment included a review of available equipment and supplies, adequacy of space and availability of a private room for performing MVA. Perspectives of community opinion leaders and youth on PAC were assessed through organized focus group discussions (FGD) to determine knowledge, attitudes and existing practices related to PAC.

2. Project Purpose and Needs Assessment Goal and Objectives

Purpose of the PRIME-assisted Pilot Project

In July 1998, PRIME proposed to work with REDSO/ESA and the NNAK to support a pilot project to demonstrate and document the potential role of private sector nurse-midwives in expanding access to quality PAC services. Decentralizing and integrating PAC services into the practices of private nurse-midwives is expected to make a significant contribution to improved maternal health, especially in underserved communities.

Goal of the Needs Assessment

To generate baseline data that will contribute to the design of strategies to train, monitor and supervise private nurse-midwives as they establish and integrate PAC services at their respective facilities.

Objectives of the Needs Assessment

1. To determine the potential for facilities operated by private nurse-midwives, and the potential of private nurse-midwife service providers, for PAC service provision.

2. To assess the demand for PAC services among MCH/FP clients and among members of communities (community opinion leaders and youth) in the facility catchment areas.

3. To collect data on service quality, FP client and postabortion case loads and referral patterns.

3. Methodology

3.1 Selection of the Provinces for the Needs Assessment

Nairobi, Central and Rift Valley provinces were selected for conducting the needs assessment for 2 reasons. First, the inventory established that the majority (69%) of private nurse-midwives' facilities are located in these 3 provinces. Second, many of the facilities in these provinces are located in periurban and rural areas that are densely populated and inhabited by low income groups, thereby offering an opportunity for PAC service expansion to needy communities.

3.2 Design of the Needs Assessment and Selection of Facilities

The needs assessment used a descriptive design. Forty-nine facilities operated by private nurse-midwives were selected for the assessment, of the 101 facilities in the 3 provinces listed during the inventory. (Initially, 50 facilities were selected for the assessment, approximately half of the 101 facilities. However, one facility which had been established as a jointly owned facility by a group of 25 Registered Nurse- Midwives (RNM) was considered an outlier and therefore excluded from the needs assessment sample.) The primary consideration for selecting the 49 facilities was the professional profile of the facility in-charge, or owner. Other criteria included the in-charge's interest in offering comprehensive PAC services and availability of 2 nurse-midwives on staff who could be trained to provide PAC services. Facilities operated by RNMs were given priority over facilities operated by Enrolled Nurse-Midwives (ENM) for the needs assessment because the inventory established that many of the RNMs were assisted by ENMs. ENMs will therefore automatically be included in the pilot project because the intervention design targets both the in-charge of the facility (RNM) and their assistants (ENM).

3.3 Preparation for the Needs Assessment

A PRIME team (one INTRAH and 2 Ipas) planned for and implemented the needs assessment from September to November 1998, with field visits taking place from October to November 1998. The team adapted 4 instruments from existing MOH tools and existing tools from the Kisumu Medical Trust (KIMET) and those used by the PRIME-assisted Uganda PAC pilot project. The instruments were:

1. a facility assessment checklist, designed to gather data on the facility infrastructure, type of equipment available, range of FP/RH services offered and management strategies and practices for postabortion clients;

2. focus group discussion guide for community opinion leaders, designed to explore views about RH problems faced by youths, need for PAC and access to quality RH care;

3. focus group discussion guide for youth, designed to explore views about RH problems faced by youths, need for PAC and access to quality RH care; and

4. client exit interview guidelines, designed to explore and investigate client's views about RH service provision, history of FP method use and perceptions about abortion and PAC.

Pre-testing of the instruments was carried out at 2 facilities in Nairobi Province that were not selected for the assessment. Based on the pre-testing exercise, the tools were modified as necessary. Before the start of the data collection, the PRIME team contacted the Health Management Agency (HELMA), a nurse-midwife agency working with private nurse practitioners involved in home-based care and training, in order to verify the location of the 49 facilities selected for the assessment. The private nurse-midwife owners of all 49 facilities were contacted through correspondence to explain the project purpose, including the purpose of the needs assessment, to seek permission to be visited and subsequently participate in the pilot project, and to propose dates for site visit. Face-to-face meetings were arranged with 34 of the 49 nurse-midwives and the remaining 15 were briefed by telephone or through correspondence (because of limited time and distances to the facilities) to provide further information about the project, clarify expectations of the nurse-midwives before and during the actual assessment, and address any other concerns the nurse-midwives may have.

3.4 Data Collection and Management

The Facility Survey

All 49 facilities selected for the assessment were visited. The facility survey aimed to explore the potential of private nurse-midwives as PAC service providers, identify PAC-related knowledge and skills gaps and gather baseline data on the current range of services. Service quality issues and practices were assessed through observation; for example, the availability of infection prevention equipment and adequacy of lighting; regular source of water; availability of an examination table; availability of a private room for performing MVA; a recovery room; and availability of a private room for postabortion family planning counseling and service provision.

Data on the monthly client load for the 12 months between July 1997 and June 1998 were compiled through document review for the purposes of establishing service use/output baseline prior to the PAC intervention, for the following indicators:

- Number of FP new clients and revisiting clients
- Number of antenatal visits
- Number of deliveries
- Number of post natal visits
- Number of clients diagnosed/treated for STIs
- Number of clients with incomplete abortion
- Clients referred by type of services referred for

Note: Data were not collected by client age because the nurse-midwives do not collect these data. They have data on total number of clients for specific services, but not by age.

The nurse-midwives operating each facility were interviewed to gather information on: profile of all staff employed at their facilities; FP service provision; extent of integration of RH services; current management strategies and practices for postabortion patients; and interest in being trained to provide PAC services. FP commodities in stock at the facility at the time of the visit were verified through observation.

Twenty-three female clients were interviewed at exit to seek information about services provided at the facilities, their views about abortion and PAC, and past and current use of FP methods.

Focus Group Discussions

A total of 33 FGDs were organized for members of communities living around the facility catchment areas. These included 16 discussion groups for community opinion leaders and 17 for young boys and girls, conducted with mixed sex groups. The facility in-charges were responsible for mobilizing FGD participants, and used their knowledge of and relationships with communities to select FGD participants. (The PRIME team conducting the FGDs organized separate discussions for boys and girls if they found that the boys dominated the discussion.) Among the community opinion leader participants were teachers, church leaders, lay religious leaders, small scale self-help group members (Juakali), retired health professionals and civil servants. Members of the youth groups included hair salon specialists, students from technical/vocational schools and house help. Discussions with both groups of participants were aimed at assessing community RH needs and perceived demand for comprehensive PAC services.

Data Management

Data collectors reviewed all completed data sets in the field to detect and correct omissions and logical inconsistencies. EpiInfo Version 6 software package was used for data entry of all quantitative data. The analytical approaches used were mainly univariate

and bivariate analysis and computation of means, as appropriate. The qualitative data generated from open ended questions and from proceedings of the FGDs were compiled by hand.

4. Results

4.1 The Needs Assessment Sample

The sample selected for the needs assessment included 38 sites operated by RNMs and 11 sites operated by ENMs. One quarter (12) of the 49 facilities were self classified as Nursing Homes and the remaining 75% (37) were classified by the owner as clinics.

Note: Nursing homes have both inpatient and outpatient facilities with 24 hour coverage, 7 days/week. Clinics have outpatient facilities only and are open at least 10 hours/day, 7 days/week, with provision for "on call" services when officially closed.

Table 1: Distribution of the Facilities Visited, by Type

	Number N=49	**%**
Type		
Nursing Homes	12	25
Clinics	37	75

4.2 Potential for Private Nurse-Midwife Facilities to Offer Sustainable PAC Services

Access to Services as a Predictor for Access to PAC Services

An examination of selected indicators of access to services currently offered at private nurse-midwives' facilities served as a predictor of the extent to which PAC services can be easily accessed by potential patients. The following indicators were used: location of the facility; time taken to reach the facilities from the client's home; the typical mode of transport used to get to the facilities; organization of services; and client waiting time.

Location of the Facilities

The majority of facilities owned and operated by private nurse-midwives' are located in underserved areas that are largely inhabited by low income communities. Table 2 shows the distribution of the facilities included in the needs assessment, by location. Twenty-eight (56%) of the facilities were located in a rural setting or in rural town centers, 16 (32%) in urban low income residential areas, and 3 (6%) in urban slums. Only 3 facilities were located in an urban area inhabited by communities within the medium income level.

Table 2: Distribution of the Facilities Visited, by Location

Location	N=49	%
Rural town centers (2)	16	32
Rural setting (1)	12	24
Urban low income residential areas (4)	16	32
Urban medium income residential areas (5)	3	6
Urban slums (3)	3	6

Travel Time and Mode of Travel to Facilities

Most of the facilities visited (63%) were located in rural areas, low income urban areas and urban slums and were also within easy reach of clients. Through exit interviews with 23 clients the needs assessment established that they spent an average of 25 minutes to reach the facilities, with maximum time being 60 minutes. Fifty-six percent (13) of the clients interviewed at exit reported that facilities were within walking distance, whereas 44% (10) took public transport to get to the facilities. Community members participating in the group discussions considered distance to private nurse-midwives' facilities as reasonable.

Organization of Services and Client Waiting Time

The Kenya Ministry of Health (MOH) advocates for an integrated approach for RH service provision at all levels of the national health care system, including the private sector. This means providing MCH and other RH services at a single visit, along with other preventive, curative and rehabilitative services, in so far as possible. The needs assessment found that service integration was available in 72% of the facilities operated by private nurse-midwives. Services that were integrated included: MCH/FP, antenatal care (ANC), maternity services, counseling services, curative services, and STI screening and management.

MCH/FP services were provided daily at 86% (42) of the facilities visited. FP services were provided at the majority of facilities (92%), including FP counseling, methods and referral for methods not available at the site (for example, tubal ligation and Norplant®). Sixteen percent (8) of the facilities mainly provided curative services, although they also provided some FP services to clients.

Data collectors observed that clients were served fairly quickly. Waiting time ranged from 2 minutes to 60 minutes with an average time of 18 minutes.

As a result, private nurse-midwives' facilities are well positioned to link postabortion emergency treatment services with postabortion FP and comprehensive reproductive health care.

Private Nurse-Midwives Preparedness to Offer Comprehensive PAC Services

To assess nurse-midwives preparedness to offer PAC services, data were gathered through interviews with the facility in-charges about:

1. basic and post basic training received by all nurse-midwives in the facility, including training in family planning (FP)
2. in-charges membership status to professional organizations
3. availability of support staff
4. current strategies for management of postabortion patients
5. expressed desire for training in PAC service delivery

Basic and Post Basic Training

Data on private nurse-midwives' basic and post basic training status were documented for the 151 nurse-midwives working at the 49 facilities sampled for the needs assessment. Fifty-four were Kenya RNMs and 97 were Kenya ENMs (table 3). Among the 54 Kenya RNMs, 28 % (15) held a Diploma in Advanced Nursing (DAN) and 43 % (23) had post graduate qualifications in Community Health (table 4). About half of the ENMs also graduated as Community Health Nurses.

The findings on basic and post basic training status, including training in family planning, suggest both advantages and disadvantages for PAC. The advantage lies in the assurance that the private nurse-midwives working at the 49 facilities sampled for the needs assessment are qualified to offer preventive and curative services, including MCH, to the communities they serve, and therefore have basic knowledge and skills to perform procedures related to PAC, including speculum examination and estimation of gestation period. The potential therefore exists to develop private nurse-midwives further to offer a wider range of RH services, including PAC services. The disadvantage for PAC was detected in the area of FP training.

Table 3: Distribution of Nurse-Midwives, by Basic Training Received

PROVINCE				
BASIC QUALIFICATIONS	**NAIROBI**	**CENTRAL**	**RIFT VALLEY**	**TOTAL**
Kenya Registered Nurse Midwives (KRNM)	22	16	16	54
Kenya Enrolled Nurse Midwives (KENM)	41	28	28	97
Total	63	44	44	151

Table 4: Distribution of Registered Nurse-Midwives, by Post Graduate Training Received

PROVINCE				
POST BASIC QUALIFICATIONS	**NAIROBI (n=22)**	**CENTRAL (n=16)**	**RIFT VALLEY (n=16)**	**TOTAL (N=54)**
Kenya Registered Community Health Nurse (KRCHN)	10 (45%)	7 (44%)	6 (38%)	23 (43%)
Diploma in Advance Nursing (DAN)	7 (32%)	5 (31%)	3 (18%)	15 (28%)
Total	17 (77%)	12 (75%)	9 (56%)	38 (71%)

Family Planning Training Status

The RH policy guidelines formulated by the Kenya Government in 1997, following the ICPD conference, advocates for comprehensive RH care that includes FP service provision, RH services for youth, adolescents, single parents and PAC services (counseling and FP). The guidelines also stress the need for providers not to impose their values beliefs and/or morals on those making RH choices. This shift in the configuration of RH service delivery poses several challenges. One such challenge is the training of service providers to acquire the necessary knowledge and skills and a positive attitude to be able to provide safe and effective RH services.

For this needs assessment, it was important to identify gaps in knowledge and skills in FP counseling and service delivery, because providers require skills in counseling and FP to be able to offer postabortion FP services, and to incorporate messages about FP to prevent unwanted pregnancies in their community education and outreach activities.

Just over half (58%) of the 151 nurse-midwives working at the 49 facilities interviewed reported to have received training in FP. The remaining 42% have not been formally trained in FP. Of the 87 nurse-midwives who reported to have been trained, 40 were

RNMs and the remaining were ENMs. The ENMs trained in FP were those who graduated as Community Health Nurses and therefore received FP training as part of their basic training program.

Table 5 presents the number and classification of private nurse-midwives trained in FP during in service, by internal year of training. About one quarter (28%) received their FP training in the 1980s and 20% were trained between 1990-1994. Even though information on FP updates was not directly explored, private nurse-midwives volunteered information on this issue. Four nurse-midwives reported to have received FP updates. Two gave more precise information, replying that they had attended a 1 - 2 week orientation on FP provided by the KMA. (This training does not cover IUD insertion.)

The above findings have implications for PAC. First, about half of the private nurse-midwives have not been trained in FP service provision, yet almost all facilities (92%) reported to be offering FP services. This suggests that private nurse-midwives who had not attended a formal FP training course are likely to be providing FP services. Second, the majority of those trained were trained using outdated curricula that did not address current RH needs. Thus there is a need to ensure that this group of service providers is trained and/or updated in FP to enable them to provide comprehensive PAC services.

Table 5: Distribution of Nurse-Midwives Trained in Family Planning, by Year of Basic Training

Qualification	**Year of Basic FP Training**			
	1980-1984	**1985-1989**	**1990-1994**	**1995-1998**
Kenya Registered Nurse Midwives (KRN/M), including KRCHN and those with DAN **(N=40)**	4 (10%)	11 (28%)	13 (33%)	12 (30%)
Kenya Enrolled Community Nurses (KECN) **(N=47)**	1 (2%)	8 (17%)	4 (9%)	34 (74%)
TOTAL (N=87)	**5(6%)**	**14.55(22 %)**	**17(20%)**	**46(53%)**

Membership to the National Nurses Association of Kenya (NNAK)

The needs assessment also sought to establish the status of facility in-charges membership to the National Nurses Association of Kenya (NNAK). The NNAK is the professional body with responsibility to ensure that all members adhere to the Kenya Nursing Code of Ethics and an implementing partner of this project. It was important to know the proportion of in-charges who were members of NNAK to satisfy NNAK's request that registered members of the association be given priority for PAC training. NNAK argues that members were more likely to comply with guidelines and standards on PAC to be developed by the association. It was important to know the proportion of facility in-charges who were committed and obligated to maintain a high standard of practice at their facilities through membership to NNAK.

Seventy-one percent (35) of the facility in-charges were registered members of NNAK, meaning they attend monthly meetings on a regular basis and submit quarterly on selected service indicators, while the remaining maintained a dormant status, meaning they pay NNAK dues but do not attend meetings and do not submit quarterly reports. It is therefore reasonable to expect that the facility in-charges who are active members of the NNAK will better comply with PAC guidelines which the NNAK expects to develop in late 1999/early 2000.

Availability of Support Staff

The facility checklist made provision for listing all staff members by name, job title and qualification. These data generated information on the profile of other staff members employed by the facility in-charge (the owner), apart from other nurse-midwives. The findings confirmed that other support staff are employed to assist with services.

Personnel employed at the 49 facilities, apart from nurse-midwives include nurse aides (79) and support staff (65) such as receptionists, cleaners and drivers. Some of the nurse aides have been trained in basic skills, on-the-job, depending on the facility. Some of these nurse aides also deputize for the facility in-charge when she is away from the facility, and others also function as a receptionist. All of the facilities visited hired clinical officers and nurses from the public sector on a part-time basis. Twenty facilities with a laboratory employed a laboratory technician. Facilities with laboratories were at an advantage for linking emergency postabortion treatment services with comprehensive RH care, especially in the area of detection and management of sexually transmitted infections, assuming providers had the knowledge and skills necessary for providing these services.

However, the reliance on part-time staff at some facilities has implications. It may not be cost effective to train part time staff in PAC with the aim of sustaining services at target project sites because of the lack of assurance of commitment to continue working in such facilities in the long term.

Current Strategies for Management of Postabortion Patients

Even though treatment of complications resulting from spontaneous or induced abortion is known to occur mainly in hospitals with physicians providing the treatment, midwives are well-positioned to be one of the first referral points for the majority of obstetrical emergency patients. They are widely distributed throughout the health service delivery systems in many countries, including Kenya, and frequently care for women experiencing obstetric emergencies.

The needs assessment sought to explore private nurse-midwives' current practices regarding the management of postabortion patients, as a way to identify potential gaps in the provision of comprehensive PAC services. The specific questions asked of facility in-charges pertain to the following areas:

- experience in emergency treatment services, including use of MVA;
- provision of postabortion family planning counseling and services; and
- opportunity for linking emergency treatment services and comprehensive RH care.

At the time of the needs assessment, emergency treatment for complications of abortion was a rare occurrence at sites operated by private nurse-midwife practitioners. For example, at the 49 facilities visited, only 2 in-charges (one in Nairobi Province and one in Central Province) reported to be currently carrying out uterine evacuation procedures at their sites, using MVA. Five had introduced MVA in the past. Each of the 2 facilities where MVA is performed for treatment of abortion complications performed the MVA procedure the day before the site visit. Two other sites no longer offered the procedure because the doctors trained to perform the procedure no longer worked at the site, and one site had not offered the service since 1995 (for unexplained reasons). The remaining facilities (over 95%) refer postabortion patients requiring emergency treatment to the nearest district hospital or private facility. Kenyatta National Hospital (KNH) was frequently mentioned as the referral site for patients needing emergency treatment for abortion complications.

The average case load from July 1997 to June 1998 at the 16 sites where data were maintained on the number of clients seen with incomplete abortion included: 26 patients at sites in Nairobi Province; 92 patients at sites in Central Province; and, 33 patients at sites in Rift Valley Province.

Emergency treatment practices and pain control practices were also explored. The 2 facilities currently providing emergency treatment using MVA perform the procedure either in an operating theater, the labor ward or a procedure room. Pethidine is administered for pain control before the procedure and patients were given tranquilizers during the procedure. Postabortion patients seeking evacuation are charged an average

fee of 480 KSH* (US$8) for the procedure, 397 KSH (US$6.60) for bed occupancy (for the entire stay and 500 KSH (US$8.30) for medication.

Whereas the PRIME-assisted PAC project in Kenya is the first time that private nurse-midwife practitioners are being trained to provide emergency treatment using MVA (the first element of comprehensive PAC services), second element of PAC - postabortion FP counseling - is already an established service at their facilities. Table 6 shows that over 80% of facilities offer FP counseling and services to postabortion patients who, according to in-charges, reach the private nurse-midwives facilities through their own initiative after receiving treatment elsewhere.

Table 6: Distribution of Facilities Offering Postabortion FP Services, by Province

Postabortion FP Services	Nairobi Province N=18	Central Province N=18	Rift Valley Province N=13	Total N-=49
FP counseling	13 (72%)	17 (94%)	11 (86%)	41 (84%)
FP methods	14 (78%)	16 (89%)	11 (86%)	41 (84%)

There is evidence from the needs assessment that there is potential to achieve the third element of PAC (linking emergency treatment services and comprehensive RH health care) at private nurse-midwives' facilities. Baseline data showed that 72% of private nurse-midwives' facilities offered integrated RH services, including antenatal, intrapartum and post-natal care, FP services and STI screening and management. In the case of STI management, the available service data compiled for all 49 sites indicate that 1,266 clients were diagnosed and/or treated for STIs between July 1997 and June 1998, for an average of 2 clients per site per month.

This means that at facilities operated by private nurse-midwives, there is an opportunity to provide postabortion FP counseling and methods and to link postabortion patients with other RH services, such as STI screening, diagnosis and treatment and STI prevention education and counseling. Young postabortion patients can also receive education on the importance of healthy reproductive behavior, including the use of FP methods to avoid unwanted pregnancies and use of condoms to prevent STI and HIV infection. Early detection of STI/HIV infection is also possible at the 22 facilities which have laboratory facilities.

* Estimated exchange rate is KSH 60 = US$1

Expressed Desire for PAC Training

Forty-seven facility in-charges (96%) expressed a desire for training in postabortion care (PAC) to enable them meet the demand in the community for the services. Private nurse-midwives provided several reasons why they felt that postabortion patients would seek services from their primary level facilities, rather than going to referral or tertiary level facilities. The reasons are following, starting with the reason most mentioned:

- Patients lacked money to meet transportation costs to the referral facility and the high medical charges at the referral facility.

- Patients were unfamiliar with the procedures at the referral site, perceived delays in receiving care at referral sites, and rate quality of services offered, especially at government facilities, as poor.

- Patients do not want to be recognized for fear of being stigmatized.

- Patients perceive providers at referral sites as unsympathetic towards patients suffering from abortion complications.

- Patients were already in pain and fear that traveling long distances under poor road conditions would aggravate the intensity of the pain.

- Patients suffering from severe complications want the private nurse-midwives or support staff to accompany them to referral sites. (Nurse-midwives noted that they preferred not to accompany patients to referral sites for fear of being accused of starting the abortion.)

The 2 nurse-midwife facility in-charges who did not wish to be trained cited patients inability to pay for the services and that counseling postabortion patients was too time consuming as the main reasons for not being interested in being trained to provide PAC services. One commented that her facility is not likely to attract postabortion patients, because potential patients may fear being interrogated to reveal the identity of the initiator of the abortion.

4.3 Functional Status of Private Nurse-Midwives' Facilities to Support Quality PAC Services

The functioning of subsystems at facilities operated by private nurse-midwife practitioners is essential for the provision of high quality PAC services. For the purposes of this needs assessment, the functional status of the subsystems was assessed by examining a number of service level factors influencing quality care. The factors were:

- status of the building (general cleanliness, type and condition of the building);
- adequacy of space;

- attributes of the consultation/treatment room;
- extent to which sanitation requirements are met;
- availability of basic equipment necessary for PAC;
- availability of FP services;
- infection control procedures;
- quality of record keeping;
- availability of education and IEC materials; and
- existence of outreach programs.

The results are presented by grouping factors considered positive attributes/strengths for PAC and factors considered to be limiting, that will need to be addressed for high quality PAC service provision.

4.3.1 Strengths of the Facilities to Offer PAC Services

The Status of the Buildings

The data collection team inspected and graded the characteristics of the 49 physical structures (cleanliness, type and condition) as very good, good or poor. Of all the facilities visited, only one in Nairobi was graded as poor for cleanliness. All but 2 of the buildings were permanent structures and all were described as being in good condition (table7).

Table 7: Status of the Buildings

Characteristics of Facility Building	Number of Facilities N=49	% of Facilities
General Cleanliness		
Very good	23	47
Good	25	51
Poor	1	2
Type of Building		
Permanent	47	96
Semi-permanent	2	98
Condition of building		
Good	49	100

Adequacy of Space and Availability of Basic Items in the Facility

All of the health facilities visited had adequate reception and waiting areas and were adequately furnished and ventilated. All facilities had clean consultation/treatment rooms which provided visual and auditory privacy and adequate lighting. Of the 49 health facilities visited, 63% (or 31) had more than one room used for consultation/treatment. Some of those which did not have a second room could easily partition the available

room to create a second room. Ten of the 12 Nursing Homes had an operating theater. Less than half of the facilities had client changing areas, air conditioning or a fan.

The majority of facilities (90%) had access to some form of running water (table 8). Those facilities that had no running water improvised adequately.

Table 8: Attributes of the Facilities, by Province

Attributes of the Facility	Nairobi Province N=18 (%)	Central Province N=18 (%)	Rift Valley Province N=13 (%)	Total N=49 (%)
Consultation/Treatment room available	18 (100)	18 (100)	12 (93)	48 (98)
Clean	18 (100)	17 (94)	12 (93)	47 (96)
Offers privacy	17 (94)	17 (94)	12 (93)	46 (94)
Adequate lighting	16 (89)	17 (94)	12 (93)	45 (92)
Access to running water	16 (89)	17 (94)	11 (86)	44 (90)
Electricity supply	17 (94)	17 (94)	12 (93)	46 (94)
Torch or other emergency light source	12 (67)	11 (61)	11 (85)	35 (71)

Extent to Which Sanitation Requirements Were Met

Sanitation requirements were satisfactorily addressed in all of the facilities. The only limitation was at facilities which performed deliveries yet did not have a special pit for burying the placenta.

Refuse disposal was mostly by incineration or by throwing the refuse into pit latrines.

Table 9: Distribution of Facilities by Method of Waste Disposal, by Province

Method of Waste Disposal	Nairobi Province N=18 (%)	Central Province N=18 (%)	Rift Valley Province N=13 (%)	Total N=49 (%)
Incineration	14 (78)	15 (83)	10 (77)	39 (80)
Pit	8 (44)	14 (78)	10 (77)	32 (65)
Crude method	0	0	1 (8)	1 (2)

Availability of Equipment and Supplies to Support PAC Services

Even though the majority of private practitioners' facilities do not currently offer comprehensive PAC services, most of the facilities already had various equipment that is necessary and required for establishing PAC services (Table 10). Much of the equipment is already being used. For example, specula, tenacula, examination couches, trays and buckets for sterilization and decontamination.

This means that facility in-charges and other staff members will need only an orientation to the use of selected equipment for PAC services, such as MVA supplies and equipment.

Nevertheless, it is important to mention that facilities were low on equipment for assisted respiration/ventilation such as oxygen and ambu bags. These are essential for dealing with cases of lipothymia or any hypersensitivity reaction to drugs.

Table 10: Distribution of Facilities by Availability of Basic Equipment, by Province

Basic Equipment	Nairobi Province N=18 (%)	Central Province N=18 (%)	Rift Valley Province N=13 (%)	Total N=49 (%)
Stethoscope	18 (100)	18 (100)	13 (100)	49(100)
Blood pressure machine	18 (100)	18 (100)	13 (100)	49 (100)
Thermometer	18 (100)	18 (100)	13 (100)	49 (100)
Instrument table/tray	17 (94)	17 (94)	13 (100)	47 (96)
Cusco speculum (small, medium, large)	16 (89)	17 (94)	13 (100)	46 (94)
Examination table with stirrups	14 (79)	17 (94)	13 (100)	44 (90)
Stool	16 (94)	16 (89)	12 (92)	44 (90)
Sponge holding forceps	16 (89)	14 (79)	12 (92)	42 (86)
Adjustable floor lamp	4 (22)	12 (67)	8 (57)	24 (49)
Other specula (Sims, Auvard)	4 (22)	4 (22)	5 (38)	13 (27)
Sterilizing or high level disinfecting equipment • autoclave • boiler • dry heat • covered containers for High Level Disinfection (HLD)	8 (44) 16 (88) 2 (11) 15 (83)	9 (50) 13 (72) 4 (22) 14 (79)	8 (57) 10 (77) 2 (15) 10 (77)	25 (51) 39 (80) 8 (16) 39 (80)

Table 11: Availability of Emergency Equipment in Facilities, by Province

Emergency Equipment	Nairobi Province N=18 (%)	Central Province N=18 (%)	Rift Valley Province N=13 (%)	Total N=49 (%)
IV sets/needles	14 (79)	9 (50)	10 (77)	33 (67)
IV fluids	14 (79)	9 (50)	10 (77)	33 (67)
IV stand	14 (79)	9 (50)	10 (77)	33 (67)
Torch or other emergency light source	12 (57)	11 (61)	11 (86)	34 (69)
Oxygen tank, tubing, mask, flow-meter, tank full	7 (39)	6 (33)	6 (46)	19 (39)
Ambu bag	8 (44)	4 (22)	6 (46)	18 (37)
Oral airways	7 (39)	4 (22)	6 (46)	17 (35)
Suction apparatus	9 (50)	7 (39)	6 (46)	22 (45)

Table 12: Availability of Expendable Supplies in Facilities, by Province

Expendable Supplies	Nairobi Province N=18 (%)	Central Province N=18 (%)	Rift Valley Province N=13 (%)	Total N=49 (%)
Gauze, cotton wool	17 (94)	17 (94)	13 (100)	47 (96)
Antiseptics	16 (88)	18 (100)	11 (85)	45 (91)
Sterile gloves	14 (79)	17 (94)	13 (100)	44 (90)
Bleach	16 (88)	16 (88)	11 (85)	43 (88)
Sterilizing/HLD equipment	14 (79)	17 (94)	11 (85)	43 (88)
Decontamination buckets	14 (79)	17 (94)	12 (92)	43 (84)
Sharp disposal containers	12 (67)	16 (94)	12 (92)	40 (78)
Blood collecting tubes X-matching equipment	14 (79)	10 (59)	9 (69)	33 (67)
Chemical disinfectants	13 (7)	14 (79)	11 (85)	38 (78)
Soap • hand washing • washing of instruments	 18 (100) 18 (100)	 18 (100) 18 (100)	 12 (92) 12 (92)	 48 (98) 48 (98)

Table 13: Availability of Routine Drugs in Facilities, by Province

Routine Drugs	Nairobi Province N=18 (%)	Central Province N=18 (%)	Rift Valley Province N=13 (%)	Total N=49 (%)
Analgesics	17 (94)	18 (100)	13 (100)	48(98)
Antibiotics	17 (94)	18 (100)	13 (100)	48(98)
Oxytocic	13 (72)	17 (94)	11 (86)	41(84)
Anesthetics	12 (67)	16 (89)	11 (86)	39(80)
IV Fluids	13 (72)	12 (67)	9 (69)	34(69)
Blood products/expanders	2 (11)	???	2 (15)	???

Table 14: Availability of Emergency Drugs in Facilities, by Province

Emergency Drugs	Nairobi Province N=18 (%)	Central Province N=18 (%)	Rift Valley Province N=13 (%)	Total N=49 (%)
Adenaline	17 (94)	18 (100)	12 (92)	47 (96)
Hydrocortisone	17 (94)	17 (94)	11 (86)	45 (92)
Diazepam	15 (83)	16 (89)	12 (92)	43 (88)
Atropine	5 (28)	8 (44)	8 (62)	21 (43)
Other drugs	16 (89)	15 (83)	11 (86)	42 (86)

Availability of FP Services

Women who have experienced a complication of abortion, whether induced or spontaneous, and wish to delay a future pregnancy and/or avoid another unwanted pregnancy, often desire FP services. To enable these women to choose a method, it is best that the method be available at the facility. Facility in-charges provided information on the types of FP method in stock at the time of the visit and the methods routinely available and offered. Table 15 shows the distribution of facilities by FP method routinely offered. Almost all facilities (90%) provided oral pills, condoms and Depo Provera® on a regular basis while as many as 84 % offer the IUD. Fewer than 10 % of facilities offer spermicides, Norplant® or sterilization.

Table 15: Facilities Routinely Offering FP Services, by Method

FP Methods	Nairobi Province N=18 (%)	Central Province N=18 (%)	Rift Valley Province N=13 (%)	Total N=49 (%)
Oral Pills	17 (94)	17 (94)	13 (100)	47 (96)
Injectables	16 (89)	17 (94)	13 (100)	46 (94)
Condoms	16 (89)	17 (94)	12 (92)	45 (92)
IUD	15 (83)	17 (94)	9 (69)	41 (84)
Natural methods	5 (28)	10 (59)	2 (26)	17 (35)
Spermicides	2 (11)	2 (11)	0	4 (8)
Norplant	2 (11)	2 (11)	-	4 (8)
Female sterilization	2 (11)	3 (17)	0	5 (10)
Male sterilization	2 (11)	-	-	2 (4)
Emergency Contraceptives	2 (11)	4 (22)	-	6 (12)

4.3.2 Limitations of the Facilities to Offer PAC

Infection Control

The needs assessment established that infection control is a major area of weakness and will require proper orientation and emphasis in order to initiate and sustain all components of comprehensive PAC service provision.

Whereas a number of facilities had running water of some kind, some did not adhere strictly to the principles of infection control. Eleven (22%) facilities had no chemical disinfectants and 10 (20%) facilities did not have covered containers for high level disinfection.

Table 16 details the number of facilities by availability of basic items needed for disinfecting and sterilizing instruments.

Table 16: Availability of Basic Items for Sterilizing Instruments in Facilities, by Province

Basic Items Needed for Instrument Processing	Nairobi Province N=18 (%)	Central Province N=18 (%)	Rift Valley Province N=13 (%)	Total N=49 (%)
Running water	18 (100)	18 (100)	11 (86)	47 (96)
Chemical disinfectants	13 (72)	14 (78)	11 (86)	38 (76)
Sterilizing for HLD equipment	--	--	--	--
Autoclave	8 (44)	9 (50)	8 (62)	25 (51)
Boil	16 (89)	13 (72)	10 (77)	39 (80)
Dry heat	2 (11)	4 (22)	1 (8)	7 (14)
Covered container for HLD	15 (83)	14 (78)	10 (77)	39 (80)

Quality of Record Keeping and the Implication for Client Load

Accurate data on the number of clients served by type of service received is important for the assessment of client case loads and service trends. It was also critical for this needs assessment to establish reliable baseline data to measure service changes which occur as a result of the PAC interventions.

Evidence gathered revealed that private nurse-midwife practitioners do not maintain up-to-date and accurate records for most of the services offered, except for deliveries. Among the reasons cited were: need for confidentiality and secrecy; lack of appreciation of the value of record keeping; and, record keeping is tedious and time consuming.

Nevertheless, monthly summaries for July 1997 through June 1998 were compiled to obtain an estimated baseline prior to the PAC interventions.

The available data, though incomplete, indicate that private nurse-midwife practitioners serve a large number of MCH clients. As expected, the client load was heaviest at facilities located in Central Province where the population density is higher compared to the other 2 provinces. Private nurse-midwives in Central Province served 7 times as many new FP clients per month (average 108 clients) while over 15 new FP clients were served per month in Nairobi Province and 9 clients in Rift Valley Province. Within the same period, a month's average of 8 clients with incomplete abortion were seen by private nurse-midwives in Central Province. The corresponding average number of clients was 2 clients in Nairobi Province and 3 in Rift Valley Province.

Availability of Education/IEC Materials

Although almost all of the facilities (94%) had some form of written education materials, especially on STIs/HIV and AIDS topics, most of these materials were fairly outdated. At least 75 % of the facilities had IEC materials for client education which were written at language and reading levels appropriate for the client groups.

Existence of Outreach Programs

All the facilities did not have regular coordinated outreach health education and reproductive health programs. This limited communities' knowledge of what services they offer, especially for youth. This finding implies missed opportunities to educate communities about FP, raise community awareness of the risks of unsafe abortion, educate the community to recognize danger signs of unsafe abortion and to understand the urgency of seeking treatment for complications.

Client and Community Perceptions about Abortion and PAC

An important component of any assessment concerning health seeking behavior involves the understanding of client and community needs. This was achieved through the baseline assessment exit interviews with 23 MCH/FP clients visiting 29% of the facilities sampled about available FP methods. Questions covered the clients' personal history, views of contraceptive use, perceptions about abortion as a major problem, consequences of abortion, and preferred service sites for postabortion services. Similar issues were explored in depth during focus group discussions with community members, including opinion leaders and youth.

Clients' Profile and Perception about Abortion and PAC

On the average, the 23 MCH/FP clients interviewed were about 27 years old, over two-thirds (71%) were married, about half (12) were Christian and 10 followed the traditional faith. All had some education. Nine had attained up to secondary education and 3 had pursued post graduate studies. Nineteen clients had children. Sixteen (70%) expressed a desire for another child; among these, 8 were less than 25 years old. Fifteen (65%) had used a FP method at one time or another had received a FP method at the same private nurse-midwife facility where the exit interview was conducted.

Almost all (22) clients interviewed were aware of the issue of unwanted pregnancy and 19 (86%) perceived this as a major problem in the community. Clients confirmed that women they know who were faced with an unwanted pregnancy opted to terminate the pregnancy, often outside the formal health sector. Among the perceived methods of inducement used outside the formal health sector, clients cited self medication (for example, an overdose of malariaquinne); introduction of a catheter; swallowing Omo (a detergent); and ingesting goat or cow waste. When asked reasons which influence a woman's decision not to seek abortion services in the formal health sector, clients

mentioned problems such as stigmatization, lack of privacy, high cost, and fear of being seen/known among principle factors.

Clients were aware that unsafe abortion has social and health implications. The following lists represent client's perception of health and social consequences of unsafe abortion.

Health Consequences
- infertility due to infection
- death
- heavy bleeding
- damage to the womb
- sepsis
- repeated miscarriages
- general ill health

Social Consequences
- disability
- depression
- guilt

Clients advocated for providing information and education to all youth, especially young girls, about the dangers and consequences of unsafe abortion and the importance of abstaining from sex before marriage. Strategies recommended for reaching youth include seminars organized by schools or churches, "bazaras" (a local term) and counseling sessions offered at clinics. Clients expressed the need for parents and the community at-large to play a more active role in educating youth at an early age about the consequences of unsafe sex and unsafe abortion. Clients argued that youth who were already sexually active, and girls faced with an unwanted pregnancy, must be able to seek FP and/or safe abortion services from a recognized health facility without fear of intimidation.

Although the exit interviews did not explore clients' personal experiences with induced abortion or miscarriage, it was interesting to note that 4 clients opted not to disclose information on the number of pregnancy losses. The non-response rate to this question was the highest among the 6 questions aimed at obtaining information on the clients' profile.

Table 17: Characteristics of Clients Interviewed at Exit

Characteristics	N = 23	%
Age		
< 25	14	61
25 and over	9	39
Parity		
0	4	18
1-3	15	69
4-5	3	13
Marital status		
Married	17	73
Single	4	17
Divorced	2	3
Previous pregnancy losses		
none	15	65
1	4	17
Not stated	5	22
Ever used a FP method		
Yes	15	65
No	7	30
Not stated	1	5
Desire for another child	(n=22)	
Yes	16	73

Table 18: Clients Views and Perceptions about Abortion and PAC

Item	Total Responding to Question	Number Responding YES to Question	% Responding YES to Question
Awareness of issue of unwanted pregnancy	23	22	96
Awareness of attempts at pregnancy termination	23	21	91
Awareness of attempts to terminate pregnancy outside the formal health sector	22	19	86
Abortion as a major problem in the community	22	19	86
Willingness to advise young girls to seek care for safe abortion at a health facility	23	23	100

4.4 Community Perception about RH Problems Faced by Youth, the Need for PAC Services and Access to Comprehensive RH Care

4.4.1 RH Problems Faced by Youth

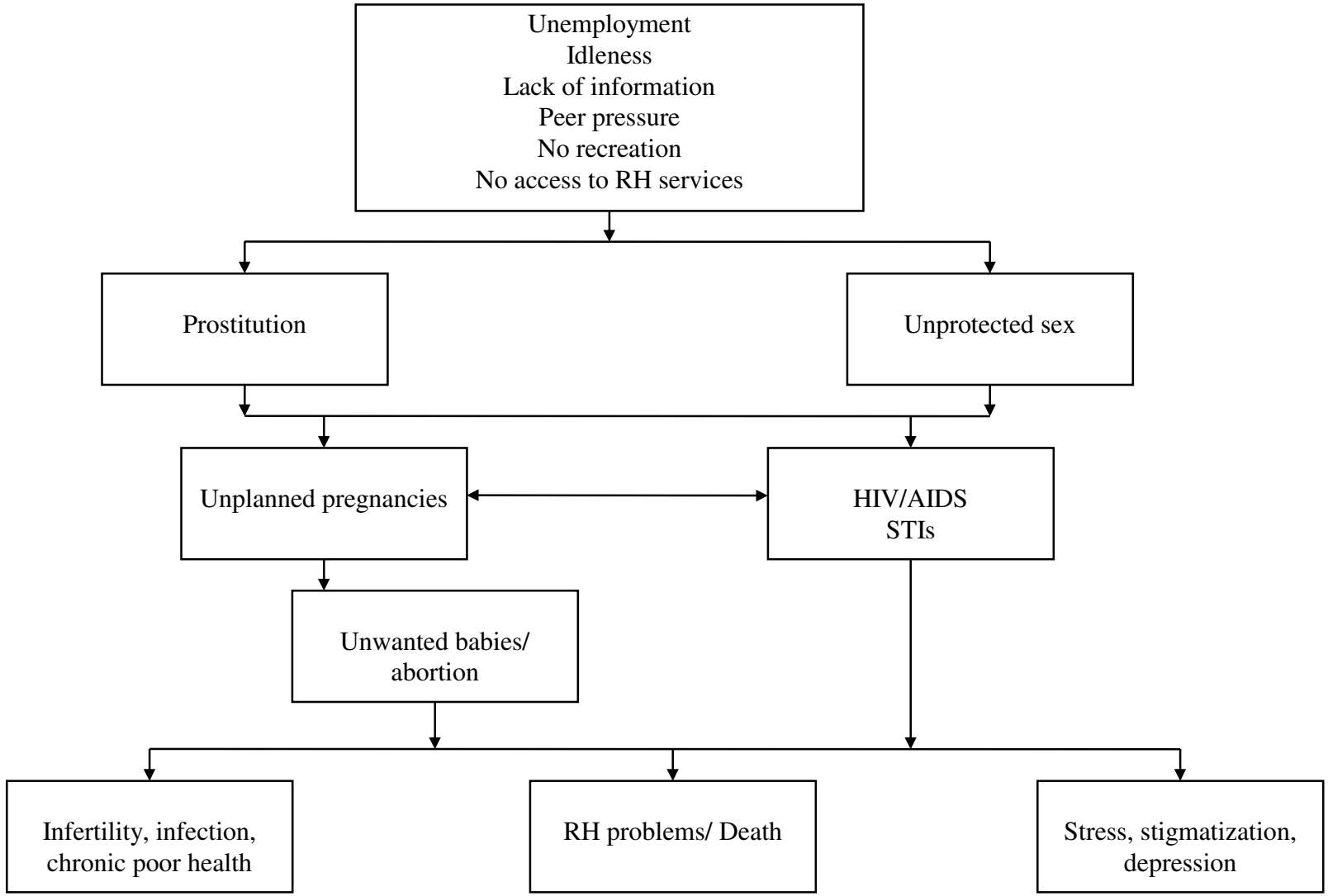
The current generation of youth in Kenya is faced with a myriad of health-related problems. Evidence from 33 Focus Group Discussions (FGDs) conducted among young people in 3 provinces as part of the PAC baseline assessment revealed that absence of meaningful employment, idleness, and lack of and sometimes conflicting information on reproductive health issues has resulted in youth engaging in sexual activities at early ages. Irrespective of place of residence and gender, the most frequently mentioned problems resulting from sexual activity were unplanned pregnancies, unsafe abortion and contraction of STIs including the Human Immunodeficiency Virus (HIV). The following list draws out the key problems as mentioned by youth starting with most mentioned through to the least mentioned:

- Unplanned pregnancy;
- Unsafe abortion;
- Sexually transmitted infections (STIs), and,
- HIV/AIDS.

Other problems of overwhelming concern to youth which were cited in most of the FGDs, and particularly those held in Nairobi Province, were prostitution, drug abuse, and high school dropouts. Figure 1 helps to illustrate how the youth in Nairobi conceptualize their problems.

As shown in Figure 1, the challenges facing youth stem from mainly 3 sources: unemployment; lack of access to reproductive health services, including information and counseling; and peer pressure. In a FGD in Nairobi, a girl narrated what most of her peers experienced. *" When you have no money and you see other girls with sugar-daddies -- dressed well and well taken care of, you really want to be like them..... He abandons you when you are pregnant."* Another group of young men in Limuru noted that the lack of information and counseling regarding sexuality emanated from their parents' fear of discussing these issues. In Nyeri, young people said they were confused by conflicting information and messages, as expressed in the following narratives.

Figure 1: Social Problems Affecting Youth in Three Provinces in Kenya



"Unajua wakiona umesoma sana umebeba vitabu wanakuogopa"
When you are educated your parents feel uncomfortable discussing reproductive health issues with you.

Sentiments of a young man in Nyeri: "In the media we hear that we should use condoms and when we go to church we are told not to use condoms… We do not know which one to follow."

In the Rift Valley, the youth said:
We have too many problems…like STIs and abortion…but nobody really 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?

It is important to note that the youth did not differentiate between problems and their causes, resulting in an overlap in the responses to questions about problems they face and their causes. In general, when asked to explain the causes of their problems, youth in Nairobi, Rift Valley and Central Provinces felt that lack of counseling and adequate information led to widespread ignorance about the consequences of their sexual activities. There was a general concern among youth living in Nairobi and the Rift Valley over the fees for condoms. They said they could not afford the cheapest condom charged at KSH10 (US$0.13) and therefore had to do without them. Contrary to this, youth in Central Province felt that ignorance rather than cost was a major challenge as expressed by members of a youth group:

"*A lot of us think that only prostitutes can contract the HIV/AIDS infection and that you cannot get pregnant the first time so we feel secure in whatever we do."*

In general, youth in the 3 provinces reported a general lack of access to crucial information on prevention of unwanted pregnancies, STI's and HIV/AIDS. What information did exist was for the general public, with almost no services specifically directed at them.

Community opinion leaders drawn from various respectable organizations such as the church, women's groups and hospitals were asked 3 questions:

(1) whether they knew of girls or women who had been pregnant and did not want to be;
(2) whether abortion was a major problem; and
(3) if they knew of girls who had tried to terminate a pregnancy.

In response to the first question, all the respondents, irrespective of the Province, said they knew of "MANY" such girls and women in their communities. In Nairobi and Rift Valley Provinces, leaders felt that this problem affected mainly schoolgirls due to ignorance, whereas in the Rift Valley and Central Provinces, contraceptive method failure and rape were also attributed to this situation. To underscore the role of ignorance in

sexual matters, a woman in Nakuru narrated in an FGD a case of a small girl as illustrated below.

A case of total ignorance

This little girl aged 11 in our plot got pregnant, and when asked she did not even know that she was. Later she delivered by C-section but persistently denied having had sexual intercourse. Eventually, when pressured by relatives, she admitted that so and so's son" alinikojolea" i.e. urinated on me!

All opinion leaders also confirmed that they knew of girls and women who had tried to terminate a pregnancy. But when asked whether abortion is a serious problem almost all participants in FGDs conducted in Nairobi and Central Provinces agreed that it is, whereas only about half in the Rift Valley Province agreed. In the Rift Valley Province, among the Maasai, unwanted pregnancy and the need for abortion was not considered a serious problem as girls are married off immediately after giving birth. Pregnancies, when they occur, are therefore considered legitimate.

In the Central Province, opinion leaders noted that in addition to inducing an abortion to get rid of unwanted pregnancies, some girls also resort to abandoning unwanted babies:

"Girls here carry pregnancy to full term and then dispose of the infant whereas others wait until month 5 before carrying out an abortion with the belief that everything comes out then."

All the opinion leaders observed that it is common practice for girls to attempt to terminate a pregnancy without visiting a hospital due to the fact that "abortion is illegal," hence fear of being arrested, particularly in government health facilities. Many of the opinion leaders knew of several sources where girls who intended to terminate a pregnancy sought help. Friends, self, quacks, other women known to perform the procedure and private clinics were the most commonly mentioned sources in that order, while in the Rift Valley, traditional birth attendants and herbalists were also mentioned as abortionists. The apparatus used to terminate pregnancy were often crude ranging from of catheter, sharp instruments such as biros and knitting needles, detergents such as Omo, drugs like malariaquinne, and herbs such as *mukengeria.* Like the youth, they observe that most girls go to public hospitals as a last resort when they have already punctured the uterus or taken some concoctions and are experiencing complications. Girls in rural areas were better off in the sense that they knew the person in the community who performed the abortions and treated STIs, and payment was often in cash or kind and payable in installments.

With the exception of Maasai opinion leaders in the Rift Valley, youth and community opinion leaders agreed that unwanted pregnancies and abortion are major challenges facing youth. The leaders further recognized that the consequences of unsafe abortion are often very serious and complicated, particularly considering the crude and extremely dangerous methods that are used.

Opinion leaders were also well aware of medical complications of unsafe abortion including excessive bleeding leading to anemia, chronic pain, raptures in the uterus, infections, infertility, "rotting womb," psychological trauma, stress and death.

4.4.2 Opinion Leaders' and Youth's Perceived Need for PAC

There was general consensus among the youth and community opinion leaders on the need to provide adequate, timely and relevant information to youth in all 3 provinces. Youth in Nairobi noted that because of the seriousness of the situation, it was necessary for counseling to begin at home and should be extended to schools in the form of Family Life Education. They suggested that counseling and education services should focus on prevention of STIs, HIV/AIDS and pregnancy, and promotion of condom use. Although some of the youth advocated for abstinence until marriage, they were quick to add that sexually active youth should have access to preventive services. Youth in the Rift Valley and Central Provinces, like their Nairobi counterparts, advocated for establishment of counseling services in health centers, in addition to FP services.

Although community opinion leaders agreed with the youth that education and counseling about sexuality and overall reproductive health should be fostered, most of them said that greater emphasis should be placed on counseling youth on abstinence rather than provision of contraceptive services. In Nairobi, opinion leaders agreed that services should not go beyond prevention education and they insisted that "contraceptives will encourage immorality." In Central Province leaders insisted that "family planning services are for families."

Conflicting information as to whether youth should be provided with services emerged among the community opinion leaders. Initially, when asked whether youth should be provided with family planning services, the majority of respondents suggested that information and counseling should be the only options. Later they agreed that given the crude measures used to terminate pregnancies, and considering the complications girls undergo in the hands of non-medical persons, they (leaders in Nairobi and Central Provinces) changed their perception of FP. They suggested that youth who cannot abstain should be offered FP services at health centers and added that the government should organize workshops for youth as a forum for providing accurate and up-to-date information on reproductive health matters. Contrary to the these views, Rift Valley leaders advocated strongly for education and counseling for youth in order to foster preventive behaviors. A much tougher stance came from opinion leaders in Limuru, Central Province who posed a challenge to the government to *"legalize abortion and let us stop hiding our heads in the sand."*

When religious considerations on youth and FP were brought into FGDs in Nairobi, one woman got up from her seat and said "*usiniambie mambo ya kanisa ("do not tell me what the church says, instead, tell me how to educate these daughters and granddaughters").* Her sentiments echoed those expressed by the youth who wondered why these services

are not provided in the first place to prevent girls from having unplanned and unwanted pregnancies. A church leader in Central Province who said "*we know it is illegal but are we doing anything about it?"* expressed similar sentiments.

However, opinion leaders from all 3 provinces, irrespective of gender, agreed that they would advise a girl who is experiencing problems related to an unsafe abortion to visit a health facility.

4.4.3 Perceptions of Opinion Leaders and Youth about Access to Quality RH, including PAC

Currently, youth have limited access to reproductive health services and therefore resort to unsafe abortions. Even where sources such as private clinics are known, only a small proportion of youth can afford to seek services from these facilities. One opinion leader in Nairobi slums said that it was unethical for providers to charge too much. "*You can't sleep hungry and go to have a termination…so you look for the cheapest person who can do it for KSH 300 or less."* For most girls in Central Province, the only way to gain access to a district hospital is: "Yo*u induce the pregnancy with herbs such as mukengeria then you are taken to the nearest private clinic which assesses your situation and rushes you to the district hospital for cleaning up."*

In Nairobi and Rift Valley Provinces, unethical approaches and negative attitudes of service providers result in youth being reluctant to seek services from these facilities, even for advice. Girls added that most facilities denied them services unless they could prove that they already have a child. In Central Province, high school drop-outs said that service providers embarrass them with questions and too much probing, which make them shy away from such facilities.

In Rift Valley and Central Provinces, the cost of services and fear of being identified by a relation or family friend in clinics offering FP services inhibit access to such facilities. Consequently, when postabortion services are required, girls in the Rift Valley prefer to travel far from home where chances of meeting such people are remote. In all of the FGDs distance to facilities was not considered an obstacle.

Even where youth had access to facilities providing condoms, they felt that they had no privacy and did not receive counseling on proper use.

The youth who participated in the FGDs said they preferred not to mix with older people when seeking reproductive health services. They had strong views on what would attract them to seek services. The following list includes the most common recommendations cited by youth in the 3 provinces:

- Taking home updated educational materials on reproductive health issues.

- Providers with the following attributes: young, of the same sex, competent and

knowledgeable, polite and friendly, and must feel at ease discussing HIV/AIDS problems and other reproductive health issues.

- Separate services for youth and adults provided in different areas of the facility if separate clinics cannot be established. There were no objections to having girls and boys served in the same area of the facility.

- Youth must be involved in the design of youth programs so they can motivate their peers to seek services.

- Important to advertise available services to attract new clients.

- Provide entertainment in the form of television and videos to attract and encourage youth to use the services available at the facilities.

Opinion leaders on the other hand, when asked to suggest improvements needed at health facilities to improve the availability and quality of RH care for youth, made suggestions aimed at improving preventive and curative services, including more information and education. Improvements suggested by opinion leaders in all 3 provinces include:

- Provide effective counseling services and educational materials, especially for youth
- Provide operating theater and laboratory services
- Improve antenatal care and delivery services
- Expand in-patient facilities, especially maternity facilities
- Establish pediatric services
- Establish functioning support services (e.g. ambulance services, adequate blood and oxygen supplies)

4.4.4 Summary of Proceedings from the Focus Group Discussions

Results of FGDs among youth and opinion leaders in 3 provinces of Kenya show that youth, irrespective of geographical location, face a wide range of health problems. Most common were unplanned pregnancy, unsafe abortion and complications associated with unsafe abortion, and contraction of sexually transmitted diseases and HIV/AIDS. Most opinion leaders and all the youth were in agreement that abortion was a major problem in their communities.

Many girls who get pregnant often did not want to. Whereas older women who fall in this category attribute it to method failure, for younger girls the major contributing factor was lack of information on matters regarding sexuality or ignorance of the consequences of sexual acts, as repeatedly mentioned by opinion leaders and youth in group discussions.

When faced with the difficult decision to terminate a pregnancy, many girls sought

services of non-physicians who were often friends, relatives, quacks, or traditional birth attendants. The youth knew that abortion is illegal and thus public health facilities do not offer abortion services. It was noted that only a small proportion of girls could afford the charges at private health facilities. Most of the abortions were performed using traditional concoctions such as *mukengeria*, detergents like Omo and jik, sharp objects such as knitting needles, catheters, biro pens, and drugs such as chloroquine.

The consequences of unsafe abortion cited during FGDs ranged from infections, infertility, excessive bleeding, psychological trauma and death. With regard to reproductive health services for youth, opinion leaders initially expressed strong sentiments against provision of contraceptives. Although most of them said "yes" when asked whether young people should be provided with FP services, further probing revealed that they meant that youth should be offered education and counseling services, with an emphasis on pregnancy prevention and abstinence. When asked what measures they would take to reduce the magnitude of abortion, community leaders from Nairobi and Central Provinces expressed views contrary to focusing only on pregnancy prevention and abstinence – now they cited use of FP methods to be provided along with counseling. The strongest evidence calling for establishment of postabortion care in these discussions emerged when all community leaders agreed that they would advise a girl experiencing complications from an unsafe abortion to seek services of qualified medical practitioners in a health facility. The message coming from the youth, however, was clear and consistent. They lamented the lack of services to address their reproductive health problems. Throughout the discussions, they emphasized the need for education and counseling on reproductive health matters. They demanded access to health care services tailored to their needs and provided at a venue suitable to them in terms of privacy. They also said that services such as FP and management of abortion complications should be offered free to youth, given that cost can be a major barrier to access.

Apart from bridging access barriers, youth felt that services should be made more attractive in a number of ways. Establishment of youth clinics will minimize chances of meeting close relations and hence ensure privacy. Training and otherwise preparing service providers to address reproductive health issues specific to youth, in addition to ensuring that they have the right attitude, can encourage youth to motivate their peers to seek similar services.

On the other hand, if existing facilities have to be used, youth suggested that services for them be situated in a building separate from services focused on mothers and children. Additional entertainment such as televisions and videos, and carry away IEC materials, could also attract youth to these heath facilities.

Finally, most young people prefer to be attended to by health care providers of the same sex, especially during counseling sessions.

[1] The Alan Guttmacher Institute. *Sharing Responsibility: Women, Society and Abortion Worldwide*. 1999. (Definition of unsafe abortion based on WHO's *The Prevention and Management of Unsafe Abortion. Report of a Technical Working Group*, Geneva, 12-15 April 1992. Geneva: WHO, 1993.)

[2] WHO. *Abortion: A Tabulation of Available Data on the Frequency and Mortality of Unsafe Abortion, 3rd Edition*. Geneva: WHO, 1997.

[3] *SD Development Newsletter*. Editors: Jacqueline Rodrequez and Patricia Mantley. Africa Bureau Information Center. Fall 1998.

[4] WHO. *Complications from Abortion: Technical and Managerial Guidelines for Prevention and Treatment*. Geneva: WHO, 1995.

EXPANDING OPPORTUNITIES FOR PAC FOR COMMUNITIES THROUGH PRIVATE NURSE/MIDWIVES IN KENYA

Facility Assessment

This tool will be used to collect data related to the strengths and limitations of the potential health facility sites for provision of PAC services. The tool addresses two parts namely, general information related to the health facilities and information related to service provision at the sites.

Instructions

The following information should be obtained from the health facility in-charge or her/his deputy.

Name(s) of Person(s) completing form/providing information

.....

.....

.....

Date: .....

Name of health facility: .....

Type: Hospital 1 ☐ Nursing Home 2 ☐ Clinic 3 ☐

Others (specify) .....

Location (Province) Rift Valley ☐
Nairobi ☐
Central ☐

Contact Address: .....

Telephone Number: .....

Fax Number: .....

E-mail Address: .....

I. Facility Infrastructure Checklist

Instruction

Complete the following information by placing a tick at the appropriate box. NB, for all responses which are poor or negative comment on/explain in space provided.

1. General cleanliness:

   i) Compound: Very good ☐ Good ☐ Poor ☐

   ii) Building: Very good ☐ Good ☐ Poor ☐

   Comments .....

   .....

2. Building status: Permanent ☐ Semi permanent ☐

   Building Condition: Good ☐ Poor ☐

   Comments: .....

   .....

3. Reception/Waiting Area

i)	Available	Yes ☐	No ☐
ii)	Adequate	Yes ☐	No ☐
iii)	Available Reading/IEC Materials	Yes ☐	No ☐
iv)	Furniture Available	Yes ☐	No ☐

   Comments .....

   .....

4. Consultation Rooms Status:

i)	Privacy	Yes ☐	No ☐
ii)	Adequate Lighting	Yes ☐	No ☐
iii)	Adequate Ventilation	Yes ☐	No ☐
iv)	Availability of Educational Materials e.g. Booklets	Yes ☐	No ☐

   Comments: .....

   .....

5. Examination/Treatment Room

i)	Available	Yes	☐	No	☐
ii)	Privacy	Yes	☐	No	☐
iii)	Adequate Lighting	Yes	☐	No	☐
iv)	Access to running water	Yes	☐	No	☐
v)	Clean	Yes	☐	No	☐

Comments: .....

.....

6. Evacuation Room/Treatment Room: Facilities (Tick as appropriate).

	Not Applicable	**Yes**	**No**	**Comments**
Operating theatre				
Exam room				
Client changing area				
Visual privacy				
Auditory privacy				
Toilet for client				
Sink				
Running water				
Room lighting				
Ventilation				
Air conditioning or fan				
Clean linens				
Electricity				
Other Source of Power				
Storage cabinet				

7. Sanitation:

i)	Toilet/Latrine:	Available	Yes	☐	No	☐
		Clean	Yes	☐	No	☐
		Status	Good	☐	Poor	☐
ii)	Waste Disposal by:	Modern methods				
		Incineration	Yes	☐	No	☐
		Pit	Yes	☐	No	☐
		Crude method	Yes	☐	No	☐
iii)	Placental pit:	Available	Yes	☐	No	☐

Comments: .....

.....

II. EQUIPMENT

1. Evacuation Room/Treatment Room: Equipment (Tick appropriate column).

	Yes	No	Comments
Exam table with stirrups			
Instrument table/tray			
Stethoscope			
Sphygmomanometer			
Thermometer			
Cuscos speculum # (small, medium, large)			
Other speculum (Sims or Auvard)			
Sponge holding forceps			
Adjustable floor lamp			
Stool			
Blood collection tubes/cross matching equipment			
Antiseptics			
Sterile gloves			
Sharps disposal containers			
Decontamination buckets			
Bleach			
Sterilizing/HLD equipment			
Expendable supplies (e.g. gauze, cotton wool, gloves)			
Others (specify)			

Comments: .....

.....

2. Evacuation Room/Treatment Room: Routine drugs (Tick appropriate column)

	Yes	No	Specify Names of Drugs
Anesthetics			
Analgesics			
Antibiotics			
Oxytocic			
IV Fluids			
Blood products/expanders			

Comments: .....

.....

3. Evacuation Room/Treatment Room: Emergency Equipment (present and functioning)

	Yes	No	Comment
Oxygen tank, tubing, mask, flow-meter, tank full			
Ambu bag			
Oral airways			
Suction apparatus			
IV sets/needles			
IV fluids			
IV stand			
Emergency drugs • atropine • diazepam • hydrocortisone • Adelinaline Other drugs			
Torch or other emergency light source			

4. Instrument Processing Area

	Yes	No	Comment:
Running water			
Electricity			
Heavy utility gloves			
Soap • hand washing • washing of instruments			
Chemical disinfectants			
Sterilizing or high-level disinfecting equipment • autoclave • boiler • dry heat • covered containers for HLD			

III. PERSONNEL

Write the names and titles of the health facility staff below:

Name	Title	Qualification	Training In FP		Year Of Training
			Yes	No	

IV. SERVICE PROVISION

1. Initial contact with client (give reasons for/explain poor and no responses in space provided).

   i) Clients reception: Good ☐ Poor ☐
   ii) Waiting time:
   Less than 1 hour ☐
   1-2 hours ☐
   Over 2 hours ☐
   iii) Integration of services: Present; Yes ☐ No ☐

   Comments .....

   .....

2. When are the following services offered at this health care facility? Tick the appropriate column.

Evacuation Performed		Family Planning Clinic Open
Day	Hours	Hours
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

   b) For example, yesterday, at what time were evacuations performed?

   .....

3. Do staff in this health facility routinely provide the following to post-abortion clients: - -
   - Family planning counseling? Yes ☐ No ☐
   - Family planning methods? Yes ☐ No ☐
   - Referral to FP services in the community? Yes ☐ No ☐

   If no, please provide reasons/opinions as to why not; i.e., what are the existing major obstacles to providing these services? .....

   .....

   .....

4. During their stay in the health facility are Post-abortion clients routinely provided with referral sites or information about where to get family planning methods in their communities? Yes ☐ No ☐

   If no, why not? .....

   .....

5. Family planning methods available (in stock) at the facility at the time of the visit. Tick at the appropriate column.

TYPE OF CONTRACEPTIVE	AVAILABLE	NOT AVAILABLE	COMMENTS
A. Combined Pill			
B. Progestin Only Pill			
C. Condom			
D. Spermicides 1. Foaming Tablets 2. Foam 3. Jelly			
E. IUD			
F. Injectables 1. Depo Provera 2. Noristerat			
G. Diaphragm			
H. Norplant® Implant			

Comments: .....

.....

6. Which methods are routinely made available to Family Planning clients?

Methods	Available
Oral Pills	Yes ☐ No ☐
Condoms	Yes ☐ No ☐
IUD	Yes ☐ No ☐
Spermicides	Yes ☐ No ☐
Injectables	Yes ☐ No ☐
Norplant	Yes ☐ No ☐
Female Sterilization	Yes ☐ No ☐
Male Sterilization	Yes ☐ No ☐
Emergency Contraceptives	Yes ☐ No ☐
Natural Methods	Yes ☐ No ☐

7. For what reasons do you refer clients to other health facilities?

.....

.....

8. What obstacles/difficulties do you foresee in referring post abortion clients for Family Planning Services?

.....

.....

9. Are post-abortion clients referred to this clinic, or do they come on their own initiative? (Tick appropriately) Referred: Yes ☐ No ☐

Own initiative: Yes ☐ No ☐

10a. Where are post-abortion clients referred from? .....

.....

10b. Where are post-abortion clients requiring further management referred to?

.....

.....

11. Where in the health facility are clients with incomplete abortion evacuated?

.....

.....

12. Where does the client wait before the evacuation? e.g. on benches, in bed, hallway, particular room. Describe .....

    .....

13. Where does the client stay after the treatment procedure? Describe in detail (e.g. on benches or in beds? In hallway? On a particular ward? Crowded or not?)

14. Has MVA ever been used at this facility for treating incomplete abortion? Tick one;

    Yes ☐ No ☐

    If yes, when was the last time? .....

    If MVA services stopped, why? .....

15. What is the fee charged to clients for treatment of incomplete abortion for the following?

    Evacuation .....
    Bed .....
    Drugs .....

    .....

    .....

16. What pain medications do you routinely give to clients prior to and/or during treatment?

    Prior: ..... During: .....

17. Look at records for the last five patients evacuated and note medications given prior and during treatment as applicable.

IP #	Medication given before	Medication given during	Medication given after

18. What complications do you usually treat or refer in this facility? .....

    .....

V. SERVICE DATA

No. of clients served by the health facility. Please complete the information below:

O = No Clients
NA = Not available

	July '97	Aug '97	Sep '97	Oct '97	Nov '97	Dec '97	Jan '98	Feb '98	Mar '98	Apr '98	May '98	Jun '98	Total
FP new clients													
FP revisits													
Antenatal													
Deliveries													
Post-natal													
No. of clients diagnosed/treated for STD.													
No. of clients with incomplete abortion.													
No. of clients who received Postabortal FP													
No. of clients referred.													

EXPANDING OPPORTUNITIES FOR PAC FOR COMMUNITIES THROUGH PRIVATE NURSE/MIDWIVES IN KENYA

Focus group discussion guide for community leaders

The aim of this tool is to obtain information on communities perspectives regarding PAC services and the community's willingness to obtain services at the identified facilities should these be initiated.

This tool will be used as a guide during the FGD. Ideally at least two members of the data collecting team should be present at the FGD so that one facilitates the group process while the other records the participants responses/inputs.

Name(s) of person(s) facilitating the focus group discussion: .....

.....

Date: .....

Name of the health facility: .....

Location (Province): Nairobi ☐
Rift Valley ☐
Central ☐

Facility contact:

Address: .....

Telephone #: .....

Fax Number: .....

E-mail address: .....

I. Warm-up and explanation

1. Introduction
   - Self introductions (Facilitators and Participants)
   - Thank the group for responding
   - Acknowledge the importance of them being there
   - Explain the composition of the group

2. Inform the group the reason for discussion e.g. interested in getting their ideas on the major health problems affecting the youth and women.

   Inform the group that there is no right or wrong answers and that both positive and negative comments will be appreciated.

   Inform group that all should participate in the discussion.

General Perceptions about PAC

1. What health services do you see being provided to young people and women in this facility? Tick the appropriate as mentioned by the group.

   Primary health services ☐
   Ante-natal care ☐
   Delivery services ☐
   Family planning ☐
   Others (specify) ☐

2. What would you like improved in this health facility? .....

   .....

   .....

3. Do women in your community know how to avoid being pregnant?
   Yes ☐ No ☐

   If no, explain why .....

   .....

4. What methods do women use to avoid pregnancy? Tick appropriately.
   Traditional methods (specify) ☐ .....
   Family planning methods ☐ .....
   Others (specify) ☐ .....
5. Do you think young people should be given preventive services e.g. Family Planning?

   .....

   .....

   .....

6. Do you know of girls/women who have been pregnant and did not want to be pregnant?

   Explain .....

   .....

7. Do you know of girls/women who have tried to stop their pregnancy?
   Yes ☐ No ☐

8. What methods do they use? .....

   .....

   .....

9. Where do these girls/women seek help from? .....

   .....

   .....

10. What has been the consequences of abortion? .....

    .....

    .....

11. Is it common for girls or women to try to end a pregnancy without going to the hospital?
    Yes ☐ No ☐

    If yes, what are the reasons that make girls/women not use the health facility?

    .....

    .....

12. In your opinion, is abortion a major problem in your community?
    Yes ☐ No ☐

    .....

    .....

13. What needs to be done in your community to reduce the magnitude of the abortion problem?

    .....

    .....

14. Would you advise girls or women to go to the health facility if they are suffering from problems of abortion? Yes ☐ No ☐

III. General Reactions

1. How do participants feel about what has been discussed today? Probe for:
   - Positive aspects
   - Negative aspects

2. What conclusions can be made from what was discussed? Probe for:
   - Insights
   - Applicability

IV. Closing

1. Find out whether everyone has anything else to add.

2. Thank the group for participation.

EXPANDING OPPORTUNITIES FOR PAC FOR COMMUNITIES THROUGH PRIVATE NURSE/MIDWIVES IN KENYA

Focus group discussion for youth

The aim of this tool is to obtain information regarding PAC services from the youth perspectives in the under-served areas through focus group discussion with the youth in the health facility catchment areas.

This tool will be used as a guide to facilitate discussions. Ideally at least two members of the data collecting team should be present during FGD so that one facilitates discussions while the other records the participants' responses/inputs.

Name(s) of person(s) facilitating the focus group discussion:

.....

.....

.....

Date:.....

Name of the health facility: .....

Location (Province) Nairobi ☐
Rift Valley ☐
Central ☐

Facility contact:

Address: .....

Telephone #: .....

Fax Number: .....

E-mail address: .....

Focus group guide

I. Warm-up and explanation

1. Introduction
   - Self-introductions (Facilitators and Participants)
   - Thank the group for responding
   - Acknowledge the importance of being there
   - Explain the composition of the group

2. Explain to the group the reason for discussion e.g. interested in getting the youth perspectives on major health issues affecting them

   - Inform the group that there is no right or wrong answers and that both positive and negative comments will be appreciated.

   - Inform the group that all should participate in the discussion.

II. General Perceptions about PAC

1. What are the major health problems faced by youth in this community?

   .....

   .....

2. What are the reasons why young people engage in sexual activities in this community?

   .....

   .....

3. What are the results of these sexual activities? Probe for:
   - STI/HIV
   - Pregnancy
   - Abortions
   - School dropouts
   - Other social concerns or problems

4. Why does youth experience these problems? Probe for:
   - information
   - accessibility
   - availability of preventive services
   - counselling

   .....

   .....

5. How do you think these problems can be solved?

   .....

   .....

6. What preventive services should be offered to young people? Probe for:
   - type of services to be provided
   - where, time, by whom

7. Are there clinics in the community that provide these services? Probe for:
   - when
   - what do you think about these clinics?
   - what is your opinion about the services provided?
   - should they provide services to young people?

   .....

   .....

8. What problems do young people face in reaching these services? Probe for:
   - distance
   - cost
   - privacy
   - stigmatization and any others

   .....

   .....

9. How can preventive services for youth be improved? Probe for:
   - mixed services/special clinics
   - adult/youths
   - boys/girls
   - cost
   - time

10. How can clinics attract more youths for health service provision? Probe for:
    - entertainment
    - girls/boys
    - time
    - other ways of attracting

11. Should young people have special clinics or should the existing ones be improved? Probe for reasons: .....

    .....

III. General Reactions

1. How do participants feel about what has been discussed today? Probe for both positive and negative aspects. .....

   .....

   .....

2. What do you think should be done for this community following our discussion? Probe for what they feel should be done regarding the issues discussed.

   .....

   .....

Closing

1. Find out whether any of the participants has something else to add.
2. Thank the participants for their participation.

EXPANDING OPPORTUNITIES FOR PAC FOR COMMUNITIES THROUGH PRIVATE NURSE/MIDWIVES IN KENYA

Exit interview guide for reproductive age women who visit the health facility for MCH/FP services

The aim of this guide is to collect information through sample exit interviews of reproductive age women who visit the health facility. Information obtained will further show the communities perspectives on whether or not need exist for establishing PAC services for the community served by the health facility.

Name of interviewer: .....

Date of the Interview: .....

Name of the Health Facility: .....

Location (Province)

- Nairobi ☐
- Rift Valley ☐
- Central ☐

Contacts:

Address: .....

Telephone Number: .....

Fax Number: .....

E-mail Address: .....

Exit Interview Guide:

I. Introduction

1. Create good rapport with the client
   - greeting
   - self introduction

2. Inform client that you would like her help in identifying some health areas/issues that may need to be improved and or added in the health facility.

3. Inform the client that information she gives will be considered confidential and that her name will not be recorded or asked for.

4. Find out from client if she accepts to be interviewed and thank her whether she accepts to be interviewed or not.

5. Interview takes place in a quiet private area.

II. Clients' Background

Instructions

Interviewer to complete the information at the spaces provided.

1. How old are you? ..... years.

2. How many pregnancies have you had? .....

3. How many still births or miscarriages or other pregnancy looses have you had? .....

4. How many children do you have? .....

5. Would you like to have more children? Yes ☐ No ☐

6. How many more children would you like to have? .....

7. When would you like to have your next child? .....

8. What is your religion? Tick the appropriate box.

   Catholic ☐
   Protestant ☐
   Muslim ☐
   Traditional ☐
   Other (specify) ☐

9. Educational status (please tick one).

1-4 years of Primary	☐	1-7/8 years of Primary	☐
1-2 year of Secondary	☐	1-4 years of Secondary	☐
Post graduate	☐		

10. What is your marital status? Tick appropriate box.

Married	☐
Single	☐
Divorced	☐
Separated	☐

11. Distance transport and cost of services

i. How long did it take you to come to this health facility? .....

ii. What means did you take? Probe for main means. .....

iii. What type of service did you receive? .....

iv. Have you paid for the services you have received? Yes ☐ No ☐

v. How much did you pay? .....

vi. Do you consider the amount paid: (Tick the appropriate box)

Too much	Yes	☐
A little too expensive	Yes	☐
Acceptable	Yes	☐

Give reasons: .....

.....

III. Services Provided

1. How long did you wait before you were attended? .....

2. What activities were you engaged in while waiting?

Reading	Yes	☐	No	☐
Listening to health talks	Yes	☐	No	☐
Watching Video/TV	Yes	☐	No	☐
Talking to other clients	Yes	☐	No	☐
Just sitting	Yes	☐	No	☐
Others (specify)	Yes	☐	No	☐

3. Are you happy with the services provided today? Yes ☐ No ☐

If no, explain .....

.....

4. What would you like improved in this health facility? .....

   .....

   .....

5. What health services do you see being provided to young people and women in this facility? Tick the appropriate as mentioned by client.

   Primary health services ☐
   Ante-natal care ☐
   Delivery services ☐
   Family planning ☐
   Others (specify) ☐

6. Do women in your community know how to avoid being pregnant?
   Yes ☐ No ☐

   If no, explain why .....

   .....

7. What methods do women use to avoid pregnancy? Tick appropriately.
   Traditional methods (specify) ☐ .....
   Family planning methods ☐ .....
   Others (specify) ☐ .....

8. Have you ever used an FP method? Yes ☐ No ☐

   If yes, which methods? .....

   Have you been counseled about Family Planning in this facility?
   Yes ☐ No ☐

9. Have you received FP services from this facility? Yes ☐ No ☐

   If no, why not? .....

   .....

10. Do you feel Family Planning services are necessary in this facility?
    Yes ☐ No ☐

    If no, why not? .....

11. Do you know of girls or women who have been pregnant and did not want to be pregnant?
    Yes ☐ No ☐

12. Do you know of girls or women who tried to stop their pregnancy?

    Yes ☐ No ☐

13. What do you know of the consequences of abortion? .....

    .....

14. Where did these girls or women seek the help from? .....

    .....

15. Is it common for girls or women to try to end a pregnancy without going to the hospital?
    Yes ☐ No ☐

    .....

    If yes, what are the reasons that make girls/women not use the health facility?

    .....

    .....

16. In your opinion, is abortion a major problem in your community?
    Yes ☐ No ☐

17. What needs to be done in your community to reduce the magnitude of the abortion problem? .....

    .....

18. Would you advise girls or women to go to the health facility if they are suffering from problems of abortion? Yes ☐ No ☐

Closure

Thank the client for the information volunteered and bid her farewell.