Deep Dive: An Exploration for Innovation
Improving Quality in the Private Sector
May 24, 2005

Case Study: Scaling Up Post Abortion Care Services
Contributed by IntraHealth International

Name of Project
Prime II
Country
Kenya
Years of activities
1998 – present

The PRIME II Project collaborated with the Kenya Ministry of Health and key stakeholders, including the Nursing Council of Kenya (NCK) and the National Nursing Association of Kenya (NNAK) to train private and NGO sector nurse-midwives in post abortion care. PRIME introduced the pilot program in 1999, which was a partnership approach to ensure stakeholder buy-in, create training and supervision structures within the private sector, and strengthen links between the private and public sectors. The pilot established PAC services by trained nurse-midwives at 44 private sector facilities in six districts, serving both urban and rural populations.
Background/Context:
Building on a successful pilot, PRIME II dramatically scaled up a program in three of Kenya’s seven provinces to create accessible, high quality primary-level PAC services by trained private sector nurse-midwives. This initiative has been continued and expanded under the ACQUIRE Project. The pivotal role these nurse-midwives can play in treating emergency complications, increasing use of family planning, and providing or making referrals for other reproductive health services holds promise for reducing maternal mortality and decreasing the chances of repeat abortion among PAC clients, many of whom are adolescents.

Complications from unsafe abortion account for more than a third of all maternal mortality in Kenya. Starting in 1999, PRIME collaborated with the Kenya MOH and key stakeholders - including the Nursing Council of Kenya (NCK) and the National Nursing Association of Kenya (NNAK) - to train private and NGO sector nurse-midwives in PAC. To implement the pilot program in 1999, PRIME introduced a partnership approach to ensure stakeholder buy-in, create training and supervision structures within the private sector, and strengthen links between the private and public sectors. The pilot established PAC services by trained nurse-midwives at 44 private sector facilities in six districts, serving both urban and rural populations. The success of the program convinced the MOH, NCK, and NNAK that nurse-midwives are capable of providing quality PAC services and that this care increases the accessibility and use of FP services. The key stakeholders worked first with PRIME II then starting in 2004, with ACQUIRE and other agencies in the scale-up of the program.

How was the Intervention launched?

Improving Accessibility
Improving the accessibility and use of PAC services in the provinces of Nairobi, Rift, and Central by increasing the number of private nurse-midwives and NGO facilities offering quality PAC services from 44 in 1999 to 144 by 2002. From July 2002 to June 2004, PRIME II trained 101 providers, including 79 private nurse-midwives and 22 clinical officers. As of June 2004, at least 658 clients with incomplete abortion had received emergency care at the trained provider facilities.

Scaling Up
Scaling up private and NGO sector training; strengthening private and public sector linkages for supervision and referral, including referral facility capability to manage complications.
Assessing Sustainability
Assessing the sustainability of PAC services by private nurse-midwives by focusing on fees for services and implications for maintaining equipment and supplies

Increasing Outreach
Increasing community outreach activities to promote family planning and contraception and help educate community members about the consequences of unsafe abortion

Offering Other RH Services
Determining, through a special study, what other RH services should be offered to post abortion women at primary-level facilities or via referral.

How did you prepare to launch the intervention?
PRIME II team and Stakeholders
At the initiation of the activity the PRIME II team built consensus and support for the activity by working very closely with key stakeholders including the Kenya MOH, the Nursing Council of Kenya (NCK) and the National Nursing Association of Kenya (NNAK). The last two groups were heavily involved in the training of the nurse midwives.

The success of the program convinced the MOH, NCK, and NNAK that nurse-midwives are capable of providing quality PAC services and that this care increases the accessibility and use of FP service. It ensured their buy in and their solid support of the scale up of the program to other districts.

What steps were used in implementing the intervention?
Clinical Standards
PRIME II developed Performance Standards for Health Providers and a standard PAC training curriculum in 2000 for its training programs. The curriculum was used as the basis for the MOH’s national PAC curriculum, which came out in 2003-2004.

QI Tool or Approach
The performance improvement and COPE tools were utilized to guide the training and implementation of the program in the private sector facilities.

The Essential Elements of Post Abortion Care Model guided the implementation of the approach.

Intervention Training
The Prime II team worked very closely with the Nursing Council of Kenya (NCK) and the National Nursing Association of Kenya (NNAK) to train private and NGO sector nurse-midwives in PAC.
How did the Intervention improve quality of services provided?
An analysis of client tracking forms over three months showed that:

- 1,603 women with post-abortion complications were treated successfully with MVA: 81% of clients were counseled in Family Planning and 56% of clients left with a FP method.
- Community outreach was conducted at 70 of the facilities to raise awareness about contraceptive methods and prevention of unplanned pregnancies. The providers are meeting other RH needs of PAC clients.
- Over half of all PAC patients received counseling for prevention of HIV/STIs.
- At the 94 facilities analyzed, 690 women who presented with complications of spontaneous or induced abortion needed uterine evacuation and were successfully treated by a nurse midwife using MVA.

How was the private sector involved?
This program was implemented in the private sector.

What worked best in this experience?
The approach of clustering Private Nurse Midwives (PNMs) in the same geographical areas for peer support. Many of the PNMs were formally organized in groups of 8-15 PNMs with designated leaders, and regular meeting schedules. At these peer support cluster meetings, the PNMs discuss clinical cases, logistics issues, exchange tips for working with the MOH, share equipment and commodities, and generally provide strong moral support to each other.

What were the potential roadblocks and challenges?
- Getting the word out that the PAC services were available, since many people in the community were not aware that this service existed,
- Educating community that the PAC services are not the same as abortion,
- Insufficient business skills for setting and collecting fees, and managing the clinic finances
- Lack of capital to fund clinic improvements

What advice do you have for others?
The lessons learned from the Postabortion Care Sustainability Study in Kenya conducted by Prime II in the spring of 2004 to identify “What needs to be done to increase the sustainability of comprehensive PAC services offered by private nurse-midwives in Kenya, both current PAC providers and for PAC providers targeted for future scale-up?” yielded the following recommendations:
**Strengthen business and management capacity**

Private providers need help in better understanding how to operate their clinics so that clinics can be responsive to the community and financially viable for them. Future interventions should consider offering business skills training for providers.

**Develop organizational representation**

Private providers need a strong organization that represents their needs and could mobilize resources to address these needs. They need an organization to be their advocate and enable them to become a more visible part of the health care delivery system. Developing such organizational capacity helps protect the investment in private provider training by institutionalizing it within an organization and its members. It also can create a mechanism for monitoring and supervision post training. A professional organizational body can also help self regulate the sector and deter practice by unauthorized and unlicensed providers. Further it can potentially be a conduit for accessing capital for providers. For example, a loan program for private providers could be operated through such an organization in conjunction with local financial institutions.

**Redesign and strengthen PAC advocacy to be broader based**

Communities are interested in learning about a range of health issues and PAC can be integrated into a broader discussion of reproductive health topics. Advocates for this expanded approach to reaching the community should include political leaders.

**Expand and support peer clusters and share best practices**

This recommendation complements the recommendation on building organizational capacity. Providers appreciate the peer clusters. Further support to these networks in the form of training, sharing best practices, peer supervision and other activities is warranted. On the other hand it is important to direct any support in such a way that it preserves the homegrown aspect of these support networks and the strong voluntary involvement of providers at the local level.

**Expand PAC expansion strategically**

Findings from this study suggest that it is wise to invest in training private providers in comprehensive PAC and other priority services. In scaling up the program to other areas it is important to select providers that are more likely to succeed.

PAC expansion might also be considered within the context of helping facilities offer a range of integrated services especially in the area of reproductive health. In this way private clinics can fulfill many health care needs in their convenient community based locations.
**Link providers to sources of capital**

Providers lack access to capital to invest in their facilities and do not know how to access whatever programs might be available. Business skills training should also enhance the creditworthiness of clinics by preparing them to be able to access credit. The provision of equipment through loans or grants might also be an option.

**Foster an appreciation for monitoring and evaluation among providers**

It is important to recognize that to obtain good data for monitoring and evaluation purposes will require a long term, concentrated and sustained effort. It will also require providers to see the value in tracking the data. This study has shown that private providers often lack records and recordkeeping skills. They do not know how to use data to their advantage. Further, they get frustrated by repeated appeals for data for different purposes within the same project.

**Contact Information**

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