

Creating Linkages Between Incomplete Abortion Treatment and Family Planning Services in Kenya

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Postabortion care has received increasing emphasis as an important intervention to address part of the problem of unsafe abortion. Although a good deal of attention has been paid to improving emergency treatment of abortion complications, the other elements of postabortion care, including providing postabortion family planning services, have received less attention and are rarely found in health-care settings around the world. This report describes a study that was conducted in Kenya to test three different models of ways to provide postabortion family planning. The study shows that these new services are both feasible and acceptable to providers and patients, and also shows how effective they can be. Whereas only 7 percent of women received family planning counseling according to the baseline survey, this proportion increased to 68 percent in the postintervention period. In addition, 70 percent of women who decided to begin using contraceptives received a method, compared with only 3 percent at baseline. The provision of postabortion family planning counseling and methods on the gynecological ward by ward staff was found to be the preferred and most effective model. (STUDIES IN FAMILY PLANNING 1999; 30[1]: 17–27)

Unsafe abortion constitutes a major public health problem throughout the world. Approximately 20 million women undergo unsafe abortions every year (WHO 1994). Unsafe abortion is defined by the World Health Organization as a procedure for terminating an unwanted pregnancy either by persons lacking necessary skills or in an environment lacking the minimal medical standards, or both (WHO 1993). The phrase “unsafe abortion” also refers to the inappropriate management of complications caused by spontaneous abortion or miscarriage. Approximately 70,000 women die annually from complications related to unsafe abortion (WHO 1994), making it one of the five main causes of maternal mortality.

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In Kenya, as throughout the world, the health consequences of unsafe abortion for women of reproductive age are significant. Access to abortion is severely restricted in Kenya and is legally permitted only when it is necessary to save the life of the woman. Hospital-based studies in Nairobi have shown that unsafely induced abortion accounts for as much as 35 percent of maternal mortality and at least 50 percent of hospitals’ gynecological admissions (Lema et al. 1989; Rogo 1993). These figures underestimate the true extent of the problem, however, because they represent only those women who are able to reach public hospitals for treatment; women who seek services from private providers or through other means are excluded from these estimates, as are women who do not seek or who lack access to services.

What these numbers represent are individual women, each with her own story. The following accounts from the study’s in-depth interviews illustrate some of the circumstances that can lead to a woman’s arriving at a hospital with an incomplete abortion, as well as some of the challenges of providing appropriate and effective services:

A 20-year-old unmarried woman who was a farmer came to the hospital after an induced abortion. It had been her first pregnancy. She

had a regular partner, but did not want to have children until she was married. When she arrived in the hospital, her cervix was torn because a quack had used scissors to perform the abortion. Asked why she was not using a family planning method at the time she became pregnant, she said that whenever she asked her boyfriend to use a condom, he bought a sweet and asked her to eat it with the wrapper on. This, he said, is the same way he would feel if he had sex with a condom on. She was afraid to use the pill because she thought it could make her barren.

A 30-year-old married woman with four children came to the hospital after experiencing a miscarriage, her second one that year. She was emphatic that she did not want any more children. She had not wanted this last pregnancy, but her husband had insisted on having another child. She believed that her miscarriage resulted from her looking after her youngest child (19 months old) who had been continuously ill. She was determined to leave the hospital with a method and even requested that the providers talk to her husband and convince him that she should be discharged with a method, preferably tubal ligation.

Following the international endorsement of post-abortion care at the International Conference on Population and Development (ICPD) in Cairo in 1994, the concept of postabortion care has gained wide acceptance as one way to improve services provided to women with complications from spontaneous or unsafely induced abortions, to help break the cycle of repeat abortions, and to help to reduce maternal morbidity and mortality. It consists of three elements (Greenslade et al. 1994): (1) emergency treatment for complications of spontaneous or unsafely induced abortion; (2) postabortion family planning counseling and services; and (3) linkage of emergency abortion treatment services and comprehensive reproductive health care.

One way to improve emergency treatment, the first element of postabortion care, is through the introduction of manual vacuum aspiration (MVA), a technique that has been shown to be safer and less costly than dilatation and curettage (Baird et al. 1995). Providing the second element, postabortion family planning, enables women to avoid repeated unwanted pregnancies and therefore also to avoid unsafely induced abortions. It allows women who have had spontaneous abortions a period of rest and waiting before their next pregnancy, should they want or need one. Anecdotal evidence and

empirical data from this study illustrate the high prevalence of repeat abortions; almost one-fourth (24 percent) of women interviewed for this study had experienced previous pregnancy losses. Links of postabortion-care services to other reproductive health-care services, such as management of sexually transmitted infections, improves women's health. Currently, linkages among the postabortion-care components are rarely found in health-care settings in most of the world.

Providers and policymakers in Kenya have been active in implementing postabortion-care services since 1989, although most work has focused on introducing MVA to improve treatment services. In an effort to expand postabortion-care activities to incorporate the second element—postabortion family planning—into its services, the Ministry of Health (MOH) supported the project presented in this report to determine the most effective, feasible, and acceptable way to deliver post-abortion family planning counseling and methods in a hospital setting. The recently revised reproductive health guidelines of the MOH include a section on postabortion care, emphasizing the importance of providing counseling and services to postabortion patients (MOH, Kenya 1997b).

Study Design

The Population Council's Africa Operations Research and Technical Assistance (OR/TA) Project II, the Kenyan MOH, and Ipas collaborated on a study to test different ways of providing improved postabortion-care services, including creating linkages between incomplete abortion treatment and family planning services. In addition to improving emergency treatment through either the introduction or upgrading of MVA services, three different models of providing postabortion family planning were tested, as illustrated in Table 1. These three models varied by where services were offered and by who provided the services.

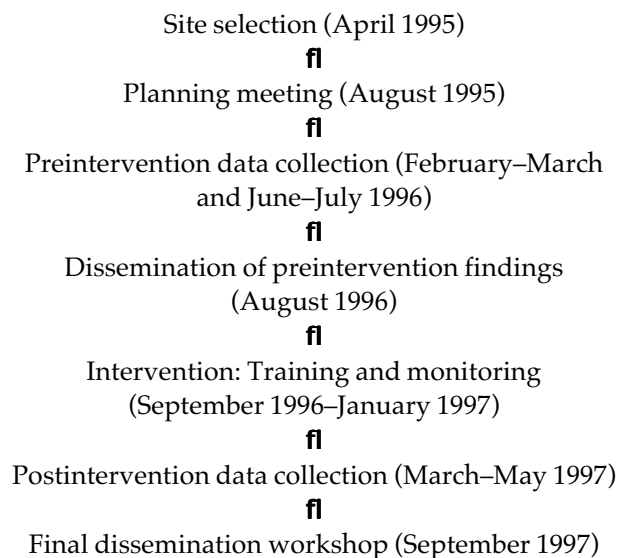
Table 1 Postabortion family planning models tested, by hospital, Kenya, 1996–97

Model	Site
Model 1: FP services provided on the gynecological ward by ward staff	Coast Provincial General Hospital, Mombasa and New Nyanza Provincial General Hospital, Kisumu
Model 2: FP services provided on the gynecological ward by MCH-FP staff	Nakuru Provincial General Hospital and Meru District Hospital
Model 3: FP services provided in MCH-FP clinic by MCH-FP staff	Eldoret District Hospital and Nyeri Provincial General Hospital

MCH-FP = Maternal and child health–family planning.

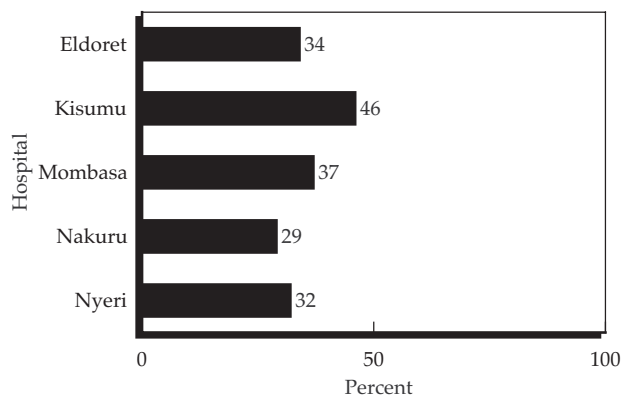
This study aimed to test and compare the feasibility, acceptability, quality, and effectiveness of the three models, with each model being introduced and implemented at two hospitals. The goal of all of the models was to make postabortion family planning services more accessible to women immediately after treatment and before discharge from the hospital. These models were designed for Kenyan MOH hospitals, all of which have maternal and child health–family planning (MCH–FP) clinics on site. These clinics, however, are generally distant from the gynecological wards, and no formal linkages exist between the two units. Each model had different potential benefits: In Model 1, the distance between services is bridged, and the same provider can be responsible for all aspects of a patient’s management; in Model 2, the distance is bridged, and providers with family planning experience can provide the services; and in Model 3, experienced family planning providers offer the services, commodities do not have to be moved from the clinic to the ward, and referral to a family planning clinic potentially could lead to easier follow-up.

The study consisted of four main components: (1) site selection; (2) preintervention data collection; (3) intervention; and (4) postintervention data collection. The following diagram outlines the time schedule for these main components, as well as for the dissemination and planning meetings.



During the site-selection phase, 18 public hospitals were visited and six were chosen as study sites. This selection was based primarily on the hospital’s caseload of women presenting with incomplete abortion so that adequate numbers of women could be interviewed to assess the differences in the models being tested. Figure 1 shows the proportion of gynecological ward ad-

Figure 1 Percentage of gynecological ward admissions for treatment of incomplete abortion, five Kenyan hospitals, 1997



missions for the treatment of incomplete abortion for five of the hospitals.¹

The intervention consisted of three elements: (1) training of staff in MVA and postabortion family planning; (2) provision of equipment and supplies; and (3) reorganization of services. Project monitors and Ipas trainers made monitoring and evaluation visits to the sites to help staff address problems in the delivery of services throughout the intervention period from September 1996 to January 1997.

Training in both MVA and postabortion family planning was conducted in the months of September and October 1996. Each training course took place over a five-day period. Approximately five staff members at each facility were trained in MVA and five were trained in postabortion family planning. In Model 1, the gynecological ward staff members who participated in the MVA training also received training in postabortion family planning, whereas in Models 2 and 3, gynecological ward staff received MVA training and MCH–FP staff received postabortion family planning training.

To ensure that those who were trained returned to their sites and implemented MVA and postabortion family planning services immediately, equipment and supplies were provided as part of the project and delivered to the sites directly after the training. These included MVA instruments,² sterilizers, portable lamps, gynecological couches, blood-pressure machines, kidney dishes, tenacula, specula, and surgical gloves. The equipment provided for each hospital differed somewhat according to the specific needs of the site.

Reorganization of services included two important aspects: either renovating or creating MVA rooms on or next to the gynecological wards and linking treatment of incomplete abortions to postabortion family planning

services. The latter involved procedural reorganization, including reallocation of staff time and responsibilities to provide the new services. For sites implementing either Model 1 or Model 2, doing this also required creating a private space for counseling postabortion patients and arranging for contraceptives to be available on the ward, which was accomplished in collaboration with the MCH-FP clinic at each site and posed no major problems.

Table 2 indicates the number of structured interviews conducted with patients, staff, and patients' partners during the pre- and postintervention periods. One interviewer was stationed at each hospital for the duration of data collection. Women arriving at the hospital with incomplete abortions, without additional serious complications, and with gestations of 16 weeks or less from their last menstrual period were selected to participate in the study. They were included after interviewers had obtained their verbal informed consent and were interviewed after having received all of their services and as close to the time of their discharge as possible. Interviews focused on the patient's evaluation of the services and the information she received, on her waiting times, family planning history, and intended contraceptive use. Interviews with staff members were conducted throughout the pre- and postintervention periods and focused on their responsibilities, attitudes, and knowledge of MVA and postabortion family planning.

In the postintervention period, women's husbands or partners were also interviewed if the woman, separate from the man, first consented to such an interview and the man provided his consent. In addition, researchers completed logsheets to document the daily gynecological ward admissions, daily bed occupancy, and caseloads of incomplete abortions. Researchers also kept diaries of their experiences at the hospitals, which added depth and context to the quantitative data collected. Feasibility questionnaires were administered to medical superintendents and hospital matrons in the postintervention period.

Table 2 Number of interviews conducted with patients, staff, and patients' partners in pre- and postintervention periods, by hospital, Kenya, 1996–97

Hospital	Patients (preintervention)	Patients (postintervention)	Staff (preintervention)	Staff (postintervention)	Male partners (postintervention)
Eldoret	80	50	26	20	15
Kisumu	51	50	22	11	22
Meru	75	45	22	19	16
Mombasa	93	71	17	9	19
Nakuru	121	60	20	18	6
Nyeri	61	43	33	29	14
Total	481	319	140	106	92

Results

During the course of this study, information was collected from gynecological ward registers to assess the caseloads of incomplete abortion and the proportion of ward admissions related to this problem as an indicator of its magnitude.³ On average, more than one-third (35 percent) of gynecological ward admissions during the two-month period of postintervention data collection at five hospitals in the study were the result of incomplete abortion (489/1,404). This proportion ranged from a low of 29 percent to a high of 46 percent (as shown in Figure 1). These figures are comparable to those found in other studies conducted in Kenya, and they demonstrate the extent of the problem of unsafe abortion. Clearly, the consequences of unsafe abortion pose a substantial problem for these hospitals. These data represent only a portion of the total problem of unsafe abortion, however, because they refer only to women who came to the hospital for treatment. Although exact figures are lacking, the assumption that only a small proportion of women who undergo unsafe abortion come to a public health facility for treatment is widely accepted as reasonable.

Profile of the Patients

As Table 3 indicates, no major differences were found between the sociodemographic characteristics of the women interviewed in the preintervention and postintervention periods. The variety among these patients is striking; the profile of an incomplete abortion patient goes beyond that of the young, single schoolgirl that is typically portrayed by providers. In particular, women presenting with incomplete abortions include a large number who are older than 30 (22 and 17 percent in the pre- and postintervention periods, respectively) and a substantial number of married women. The majority of women interviewed, however, were between 20 and 29 years old, and a large proportion (18 and 17 percent, respectively) were adolescents (between ages 15–19).

In both the baseline and the postintervention periods, a need for family planning was manifest among a substantial number of these patients. In the postintervention period, 16 percent reported that they did not want to have more children, whereas almost half stated that they would like to space their next birth; 22 percent said that they would like to wait one to two years for their next child, and 24 percent said that they would like to wait more than two years.

Among the women interviewed in the postintervention period, just over half (51 percent) had ever used a family planning method, with the pill being the most

Table 3 Percentage of patients with incomplete abortion interviewed during the pre- and postintervention periods, by selected characteristics, Kenya, 1996–97

Characteristic	Preintervention (N = 481)	Postintervention (N = 319)
Age		
15–19	18	17
20–24	38	42
25–29	23	24
30–34	11	9
≥35	11	8
Parity		
0	33	32
1	29	31
2	15	15
>2	23	21
Marital status		
Married (monogamous)	63	61
Married (polygamous)	8	8
Single	23	23
Other	6	8
Previous pregnancy losses		
1	15	17
≥2	9	7
Preferred timing of next birth		
Less than one year	18	20
Wait 1–2 years	22	22
Wait more than 2 years	20	24
No more children	23	16
Up to God	4	5
Don't know	13	13
Using contraceptive at time of last pregnancy		
Yes	22	17

common method used (31 percent) followed by injectables (18 percent), condoms (10 percent), and the IUD (9 percent) (not shown). Seventeen percent of women had been practicing family planning at the time they became pregnant. The majority of these women had been using the pill (47 percent) or practicing periodic abstinence (19 percent) (not shown). Compared with the women interviewed in the postintervention period, a slightly higher proportion of women interviewed before the intervention had ever used a method (59 percent, not shown) and had been using one at the time they became pregnant (22 percent).

Profile of the Providers

Providers who were involved in the postabortion-care process at each hospital were interviewed. As shown in Table 4, in both the pre- and postintervention periods, the majority of the providers interviewed were nurses, and the remainder included medical officers, clinical officers, and obstetric and gynecological specialists. Most providers were stationed on the gynecological ward or in the MCH–FP clinic. On average, providers were about

Table 4 Percentage of postabortion-care providers interviewed during the pre- and postintervention periods, by selected characteristics, Kenya, 1996–97

Characteristic	Preintervention (N = 140)	Postintervention (N = 106)
Occupation		
Nurse	67	72
Medical officer	16	18
Clinical officer	10	9
OB/GYN specialist	6	2
Location		
Gynecological ward	57	80
MCH–FP clinic	22	18
Operating room (main or VSC theater)	16	1
Whole facility (matron)	5	1
Sociodemographic		
Age (mean years)	35	34
Marital status		
Married	69	71
Single	26	26
Religion		
Protestant	65	71
Catholic	31	27
Muslim	3	1
Other	1	1

VSC theater = Voluntary surgical contraception theater.

35 years old, more than two-thirds were married, and most were Protestant or Catholic.

No significant differences were found between the pre- and postintervention samples except for the location of staff within the hospital. During the baseline, operating room staff were interviewed, because at that time, evacuations were performed in the main operating room in Meru and in the voluntary surgical contraception theater in Mombasa. Typically, they were no longer involved in providing these services in the postintervention period, because MVA services were being provided in a room on the ward instead of in the operating theater.

A little more than one-fourth (27 percent) of the providers were trained in postabortion family planning, whereas 37 percent were trained in MVA (not shown). Both of these proportions had increased from the baseline rates of 6 percent and 27 percent, respectively, because training in postabortion family planning and in the MVA procedure was a part of the study intervention. Not all of the providers who were interviewed had taken part in these trainings, because only a small number of providers from each site were trained during the intervention.

Improved Postabortion-care Services

The intervention focused on two aspects of postabortion care: improving emergency treatment services through

introducing or upgrading MVA services, and introducing postabortion family planning. Substantial improvements were gained in treatment services after the intervention, including improvements in providers' attitudes, information provision, and a dramatic decrease in the duration of patients' stay at the hospital. This report focuses on the introduction of postabortion family planning services and a comparison of the three different models that were tested.

Postabortion Family Planning: A Comparison of the Models

Postabortion family planning counseling and provision of methods were introduced at each of the hospitals. Although family planning services were already offered at the hospitals involved in the study, they were provided at the MCH-FP clinic, which often was located far from the gynecological ward. Providing postabortion patients with family planning information and methods was not standard practice. Although this linkage was new to the hospitals, providers embraced it as an important addition, and patients indicated satisfaction at receiving family planning services as part of their hospital stay.

In the postintervention period, 68 percent of women interviewed received family planning counseling. Sixty-nine percent decided to begin using contraceptives, and of these, almost three-fourths (70 percent) received a method before leaving the hospital,⁴ a dramatic increase from the baseline, when only 7 percent received family planning counseling, 22 percent decided to begin using family planning, and of these, only 3 percent received a method.

Information for Nyeri Provincial General Hospital is excluded from the data given above, because the situation at this hospital was unique. After a preliminary planning meeting held in August 1995 at the beginning of this project, staff from Nyeri were so enthusiastic about the idea of postabortion family planning services that they began implementing their model immediately. Therefore, in the baseline, they were already offering these services, and 98 percent of women interviewed were receiving family planning counseling. Sixty-two percent had decided to begin using contraceptives. Almost all of these women (97 percent) received a family planning method before leaving the hospital. These services have continued successfully at Nyeri; in the postintervention period, 91 percent received counseling, 88 percent decided to begin practicing family planning, and 95 percent of these women received a method before discharge.

As described in Table 1 above, the three models of postabortion family planning tested were: Model 1, fam-

ily planning counseling and methods provided on the gynecological ward by ward staff; Model 2, family planning services provided on the ward but by staff from the MCH-FP clinic; and Model 3, patients escorted from the ward to the MCH-FP clinic to receive family planning services. In comparing the models, four dimensions are considered: effectiveness, feasibility, acceptability, and quality of care.

Effectiveness

Two primary measures were used to determine effectiveness: (1) the proportion of women who receive family planning counseling before discharge from the hospital, and (2) for those who decide to begin using family planning, the proportion who leave the hospital with a method. Model 1 was the most effective of the three models by both of these measures, with 92 percent of women receiving counseling, compared with 62 percent for Model 2 sites and 54 percent for Model 3. Not only did more women receive counseling with Model 1, but a higher proportion of those who decided to begin using contraceptives left the hospital with a method (82 percent for Model 1, compared with 63 percent and 75 percent for Models 2 and 3, respectively).

Feasibility

Information was collected on feasibility by focusing on the following components: facility upgrading; staffing required to provide postabortion family planning; procedural reorganization; and patient flow.

Facility upgrading. Sites implementing a model of postabortion family planning in which services were offered on the ward (Model 1 or 2) had to create a private space there for family planning counseling. This modification was accomplished in different ways; for example, by designating an unused room or by creating new space with partitioning. In all cases, existing facilities were adapted within limited budgets.

Staffing. In spite of the additional investment to set up counseling on the ward, many providers noted the advantages of allowing the same nurse to be responsible for a patient's management at the facility, from treatment to counseling to discharge, as is possible in Model 1. This approach was viewed by many providers as optimal for staffing. In addition, because the staff offering postabortion family planning and their patients were located in the same place in Model 1, greater flexibility was available for offering services, explaining, in part, the greater effectiveness of this model. The coordination between different units required for the staffing of Model 2, in which clinic staff go to the ward to provide services, proved to be particularly difficult.

Procedural reorganization. All sites needed to reorga-

nize some procedures because postabortion family planning was new. Sites offering services on the ward were all able to obtain contraceptive methods (the combined pill, injectables—Depo Provera and sometimes Noristerat—and condoms) from the MCH–FP clinic at the hospital, which presented no problems at any of the sites. Other institutions that might choose to implement postabortion family planning and do not have supplies readily available on site would have to identify alternative methods of obtaining and maintaining a steady supply of contraceptives.

Patient flow. Patient flow is also affected according to the model of postabortion family planning that is used. In Nyeri (a Model 3 site), where, typically, patients were treated within a couple of hours after they arrived at the hospital, they now must wait until the morning to be escorted as a group to the MCH–FP clinic to receive family planning services, adding to the time they spend in the hospital. An unanticipated problem arose: Bringing these women as a group to the clinic stigmatized them as “abortion patients.” Clearly, greater flexibility in provision of postabortion family planning is possible when these services are offered on the ward.

Based on the findings described above, Model 1 is the most feasible of the three, given the infrastructure and setup of the hospitals in which this study took place. Ensuring a supply of contraceptives on the ward and setting up a private space for counseling proved to be less problematic than creating the support and logistics for escorting women to the family planning clinic or for coordinating family planning clinic staff so that they could be available on the ward.

Acceptability

Acceptability was measured by a series of questions posed to staff members about the timing, staffing, and location of postabortion family planning services, according to the model implemented in their hospital. Almost all found the timing, which was typically after treatment and before discharge (90 percent), and the staff delivering the services (93 percent) to be appropriate. No statistically significant variation was found by model.

Location of services, however, was not acceptable according to 23 percent of providers interviewed. Of these 24 providers, 21 worked at sites offering postabortion family planning services in the family planning clinic (see Model 3). The problem most commonly mentioned (71 percent of the 24 providers) was the long distance from the ward to the family planning clinic, which was viewed as a burden to both patients and staff. Although this model worked well in Nyeri, many of the providers there said that they would prefer to offer postabortion family planning on or near the ward, and cur-

rently they are exploring ways to create a counseling space.

When staff members were asked what advice they would give to hospitals wishing to set up similar services, in addition to stating the importance of training (43 percent) and of obtaining and maintaining the necessary equipment (32 percent), many emphasized that they should provide family planning after the MVA procedure (21 percent), that they should provide services on the ward (10 percent), and that they should set up a counseling room there (11 percent).

Many of the providers interviewed (58 percent) have additional responsibilities since the introduction of improved postabortion-care services. The majority (89 percent) find these responsibilities acceptable. Of the seven providers who do not, five said that they feel overworked. These new responsibilities include counseling patients about family planning, assisting in MVA procedures and the maintenance of equipment, escorting patients to the MCH–FP clinic, training other providers on the job in postabortion care, and providing preprocedure counseling.

Quality of Care

In examining quality of care in postabortion family planning services, the following elements are considered: (1) women’s evaluation of the services they received; (2) choice of methods; and (3) information provided about the method a woman receives (how the method is used, the possibility of changing methods, what to do if problems occur, and the method’s side effects).

Almost all women felt that the staff providing family planning counseling to them were both acceptable (99 percent) and easy to understand (99 percent). Most (89 percent) said that the length of the consultation was about right, whereas 8 percent felt that it was too short, and 3 percent said it was too long. Of the 59 percent of women surveyed who said that they had questions, 90 percent said that they were given an opportunity to ask them, and almost all of these women (94 percent) felt that they had received satisfactory responses to their questions. Although these figures are encouraging, most likely some courtesy bias occurred in these answers. As other researchers have noted, women are often reluctant to express to interviewers their dissatisfaction with services.

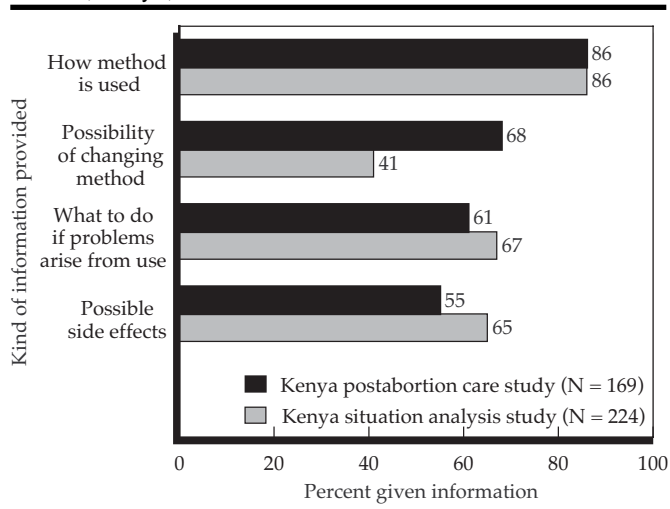
About two-thirds (64 percent) of women who received a family planning method left the hospital with the combined pill. The second most commonly chosen method was an injectable contraceptive (20 percent), followed by the condom (11 percent). Only a few women chose Norplant® implants, the IUD, or female sterilization. This method mix varied somewhat by model; fewer women at Model 1 sites received the pill (55 percent, compared with 68 and 73 percent at Model 2 and 3 sites,

respectively), and more women at Model 1 sites received condoms (14 percent, as opposed to 9 and 8 percent at Model 2 and 3 sites, respectively). A similar proportion at all sites received injectables (19, 23, and 19 percent, respectively, for the three models).

Figure 2 indicates that most women were told how their chosen method is used, and about the possibility of changing methods. Only slightly more than half of the women, however, were told about possible side effects of the methods offered. Providing this information is important, because the occurrence of side effects is a common reason for method discontinuation. In addition, this information enables women to make an informed choice of contraceptive methods. These results are fairly similar to data from the 1995 National Situation Analysis Study in Kenya, which assessed quality of care among family planning clients (Ndhlovu et al. 1997), although post-abortion clients were told much more frequently about the possibility of changing methods and were less frequently informed about possible side effects.

Provision of information about the method a woman received varied substantially by model (not shown); Model 3 generally performed better than both Models 1 and 2: 71 percent of women were told about the side effects of various contraceptive methods at Model 3 sites. This proportion dropped to 51 percent for Model 1 and to 45 percent for Model 2 sites. Similarly, at Model 3 sites, 79 percent were told what to do if they experienced any problems with the method they chose; 64 percent received this information at Model 1 sites, and only 38 percent received it at Model 2 sites. Variation was found among sites, and, in fact, one of the Model 1 sites performed as well as the Model 3 sites.

Figure 2 Information provided to women about contraceptive method chosen, postabortion care and situation analysis studies, Kenya, 1995–97



That Model 3 tended to perform better in terms of family planning counseling is to be expected, because the nurses at these sites regularly provide this service in their usual setup. That one of the Model 1 (on-ward) sites performed as well is encouraging.

Summary: Which Model Works Best?

Model 1 (provision of postabortion family planning on the ward by ward staff) was the easiest to set up, the most effective, and the most acceptable to clients and staff of the three models. Model 3 ranked highest on various indicators of quality of care, although one of the Model 1 sites performed almost as well. At sites implementing Models 2 and 3, providers suggested as preferable that ward staff offer postabortion family planning on the ward—that is, shift to Model 1. Overall, Model 1 is recommended for specific sites; emphasis on family planning counseling and method provision during the training of gynecological ward staff may be required. This model was most effective at ensuring that all women treated for abortion complications receive information about their rapid return to fertility and about a variety of methods they can use either to avoid another unwanted pregnancy or to rest before becoming pregnant again.

Male Involvement and Partner Communication

An unanticipated benefit to offering services on the gynecological ward occurred in terms of men’s potential access to these services. In the baseline research, 41 percent of women were found to have visited the hospital accompanied by their husbands or partners. As a result, and because of increasing interest in involving men in reproductive health care, interviews with men were added to the postintervention research. Similarly, in the postintervention period, 42 percent of women were accompanied by their husbands or partners. Almost one-third (29 percent) of the women’s husbands or partners were interviewed during the postintervention fieldwork. In addition to expressing a great deal of interest and concern in learning more about their wives’ or partners’ conditions, the vast majority of men were also interested in receiving family planning information. Not all husbands or partners were interviewed, but only the ones who happened to accompany the women seeking care at the hospital; therefore, this sample is not representative of all partners of patients seeking treatment for incomplete abortion. As is always the case with male involvement, the necessity of protecting the confidentiality of a wom-

an's care and assuring that she is consulted first before involving her partner is paramount.

Only 14 percent of the men interviewed said that they had received any information about their wives' conditions, and almost all who did not (94 percent) would have liked to. They indicated that they were primarily interested in learning about what caused the problem (82 percent) and how to avoid the same problem in the future (47 percent).

Few men (15 percent) received family planning counseling. Men rarely receive any counseling, and providing it was not an official part of the intervention. Almost all of these men (10 of 14) were interviewed in Mombasa, a site providing postabortion family planning on the ward with ward staff. The staff at this hospital decided that a need existed to counsel men, because a common reason women gave for not using a family planning method was their having to consult with their husbands before doing so. Therefore, when men were present, the staff counseled couples together if the woman first agreed. This unexpected benefit came about from providing family planning services on the ward; providers have greater access to men there, compared with the MCH-FP clinics, which men rarely visit.

By providing information to men, the Mombasa hospital has begun to meet a need that exists elsewhere as well. At all of the sites, men expressed a desire for information; almost all men (92 percent) who did not receive family counseling indicated that they would have liked to have been included in these services. In addition, 93 percent of women said they would have liked to have had their husbands or partners receive these services. All of the men who received counseling received it together with their wives or partners as a couple, and most (86 percent) who would have liked to receive counseling would have preferred to receive it in this way, as a couple. A somewhat lower proportion of women (72 percent) said that they would like to be counseled together, whereas 20 percent said that they would like separate counseling (15 percent of the men said that they would prefer separate counseling), and 9 percent did not state a preference for either mode. Clearly, women should always be consulted first to determine whether they wish their partner to be counseled. Although most (93 percent) said that they would, 5 percent said that they would not.

Sustainability

Providers were optimistic about the sustainability of postabortion family planning services. Most (89 percent) felt that these services would continue during the fol-

lowing year; only 1 percent said the services would not continue, 6 percent said maybe they would, and 5 percent did not know. Some of the reasons for continuing cited by providers were that the services had become part of the hospital routine (17 percent), that the staff was dedicated (14 percent), and that more providers were being trained on the job (20 percent). This continuity depends, however, on a constant availability of supplies (24 percent).

In order for postabortion family planning services to continue, hospitals must institute on-the-job training. Only a limited number of providers were trained at each site for the purposes of this study. Some of the sites have already proceeded to train more providers, and their initiative must be encouraged and continued. In addition, to maintain high-quality services and to continue training others, staff refresher courses should be offered. For long-term sustainability, postabortion care must be institutionalized in preservice training for all relevant cadres.

Conclusions

The study's findings show that provision of postabortion family planning services on the gynecological ward by ward staff was the preferred model. A dissemination workshop was held in September 1997 in Nairobi with more than 80 participants, including representatives from the six hospitals, the Ministry of Health, provincial medical officers, and many organizations working in the reproductive health field. Much enthusiasm was expressed for the success of the project, and after the presentation of findings, participants developed provincial-level plans for expanding postabortion-care services so that the Ministry of Health can achieve its goal of providing such improved services at all of its hospitals. Model 1 will be promoted for providing postabortion family planning services, but the ministry planners recognize that this model might not be feasible for all sites.

The authors of this study recommend that any health facility that plans to introduce postabortion family planning services conduct a needs assessment to determine whether certain conditions are met to facilitate implementation of Model 1: (1) adequate staff in the area where postabortion patients are treated; (2) private space on or near the ward for counseling, or the potential to create this space; (3) space to store family planning commodities; and (4) a plan for keeping the ward stocked with contraceptives.

The feasibility of setting up services will vary depending on whether or not these conditions are met. For example, if the staff have no training in family planning provision, costs will accrue for providing training or the

facility will have to consider transferring staff with this training (if they are available) to the ward. For a counseling room, if space is available, setting one up on the ward is fairly easy and inexpensive. In some settings, however, doing so may not be possible. Finally, making methods available is essential for providing women with a full range of services. Contraceptives were easily available on site in Kenyan MOH hospitals, but in cases where they are not, additional costs will arise for developing the facility's ability to obtain and maintain supplies. Even if methods are not available on site, however, providing counseling and referring women to facilities where they could receive methods are still important services.

Overall, the authors found a great deal of support for improved postabortion-care services, and therefore, strongly recommend that these services be promoted in efforts to improve women's reproductive health. Such services can address only a small segment of the overall problem of unsafe abortion, because only a small proportion of women who undergo such abortions seek services at hospitals. In addition, postabortion care can help a woman to avoid a repeat unplanned pregnancy, but it cannot prevent the initial unsafe abortion that led her to seek treatment for complications. Therefore, increased efforts should be made to understand the circumstances causing unsafe abortion at the community level and to develop effective interventions.

A need remains for addressing the third element of postabortion care, linkages to more comprehensive reproductive health care. Such linkages could include primary prevention, detection, and management of sexually transmitted infections (STIs). STIs are an important contributor to spontaneous abortions, and this study, as well as other work in the area of postabortion care, indicates that a substantial proportion of incomplete abortion patients have experienced a spontaneous abortion (see Huntington et al. 1998). Providing more comprehensive care to these women could help identify the causes of their miscarriages and thereby help them avoid future pregnancy losses.

Further research is needed concerning what happens to women after they leave the hospital to determine whether they continue to use the family planning method the hospital provided (or another method) and are able to achieve their reproductive intentions. Knowing that the hospital provided them with a method is not enough. The concept of postabortion care has anticipated benefits of reducing repeated unplanned pregnancies and thereby decreasing the number of unsafe abortions and the incidence of maternal mortality and morbidity.

This impact should be documented, however, to determine its extent. Many methodological and ethical difficulties confront those conducting this kind of research, but some attempts are already under way. For example, preliminary findings from a study conducted in Zimbabwe indicate a high frequency of unplanned pregnancy within the six-month period following hospital discharge after women have received postabortion family planning services (Johnson et al. 1998). Research in social security hospitals in Mexico City for which women were interviewed after six months illustrates the importance of identifying women's concerns throughout the postabortion-care process (Fuentes Velásques et al. 1998). Findings from these two projects that included follow-up interviews with women underscore the importance of ensuring that counseling and method provision are sensitive, appropriate, and in accordance with their needs.

Notes

- 1 Data were not available for one of the six hospitals involved in the study.
- 2 MVA equipment was supplied through the Postabortion Care Consortium drawdown account and was not purchased with USAID funds.
- 3 In a recent review of safe motherhood in Kenya (MOH 1997a), the authors note the difficulty of obtaining reliable data on the contribution that abortion makes to maternal mortality and morbidity. They point out in one study that "abortion only featured as an important cause of admission but was omitted as a cause in the death register—a fact the authors attribute to the stigma attached to abortion-related mortality."
- 4 The proportion of women presented here includes only those who wanted to begin using contraceptives and who received a family planning method. A number of women wanted to become pregnant again or did not want to begin using a method for a variety of reasons. Therefore, the authors felt that it was more important to learn if the women who wanted a method received one.

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