THE respond PROJECT

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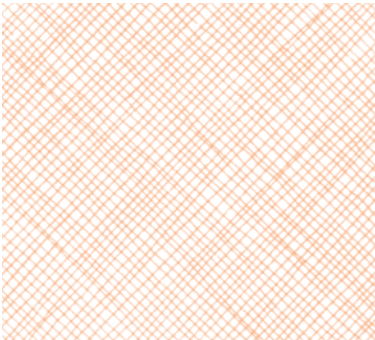
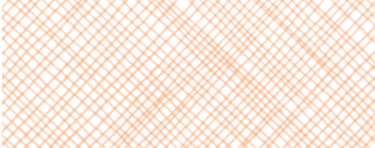
Communities Take Action in Kenya: Strengthening Postabortion Care





CONTEXT

Deaths from unsafe abortion in developing countries represent 13% of all pregnancy-related mortality, and in some countries as many as 25% of all maternal deaths (Curtis, Huber, & Moss-Knight, 2010). In Kenya, such maternal health complications are a leading cause of morbidity among women (KMOH, 2008). Kenya's Rift Valley Province has consistently had the highest level of abortion-related outpatient morbidity in the country since at least 2003, with almost 11,000 abortion-related deaths in 2004 alone (KMOH, 2005).

The RESPOND Project designed an intervention package aimed at increasing awareness and use of postabortion care (PAC) services[1] and improving family planning, reproductive health, and maternal health outcomes. Known as the Community Mobilization for Postabortion Care (COMMPAC) intervention, this package builds on efforts by The ACQUIRE Project (2005–2007) to address PAC and increase family planning uptake by focusing on the central role that communities can play in improving access to services.

RESPOND worked with districts and communities to: strengthen service delivery points to provide PAC services; conduct community mobilization to improve community members' involvement in and knowledge about the prevention and treatment of postabortion complications; build communities' capacity to address needs related to PAC; and encourage those most marginalized and most affected by postabortion complications to engage in community action to improve the situation. The intervention package was carried out in selected communities in Naivasha District over an 18-month period, from July 2010 to December 2011 (Undie, Obare, & RamaRao, 2012).

THE COMMPAC MODEL

As part of the COMMPAC intervention package, the Ministry of Health's community health extension workers (CHEWs) and community health workers (CHWs) based in Naivasha were trained in the Community Action Cycle,

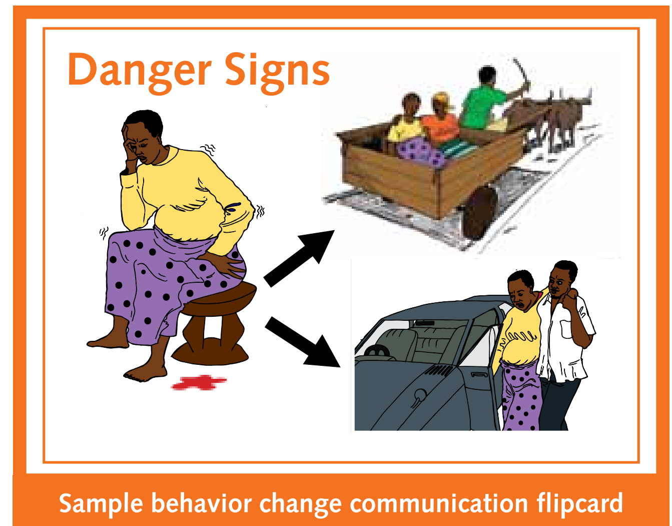
[1] Throughout the intervention, postabortion complications are referred to as "bleeding in the first half of pregnancy," given the sensitivities of talking about abortion and PAC in the Kenyan context.

an approach of working with communities, and received ongoing mentoring. RESPOND also trained service providers at Naivasha dispensaries and health centers in PAC services.

RESPOND's goal was to support existing structures at the district level and to partner with the Ministry of Health in implementing its Community Strategy by strengthening community units (comprising five or more villages), thereby building on what is hoped to be a sustainable structure supporting good health. The Community Strategy aims to enhance communities' access to health care by decentralizing sustainable lower-level services and enhancing accountability and responsibility among all, including among community members themselves (KMOH, 2007).

The Community Action Cycle (see Figure 1) was the primary methodology used to facilitate the capacity-building process during three-day community mobilization sessions. These steps echo the goals outlined in the Ministry of Health's Community Strategy. The Community Action Cycle is a highly participatory process in which community members learn how to take action for their own health.

A set of community behavior change communication flipcards were also shared with each trained CHEW and CHW for use during outreach, in house-to-house visits, and on dialogue and action days (RESPOND Project, 2010). Two community-facility linkage meetings also brought the trained CHEWs and CHWs together to share progress on their action plans and jointly solve problems together.



Sample behavior change communication flipcard

More than 439 community members participated in mobilization sessions at the intervention sites. Problems identified in the action planning process ranged from negative rumors about family planning methods, religious opposition, and a lack of partner support to such problems as long distances to the nearest facility, poor roads, lack of trained providers, unfavorable facility hours, poor provider attitudes, and lack of equipment and

FIGURE 1. THE COMMUNITY ACTION CYCLE

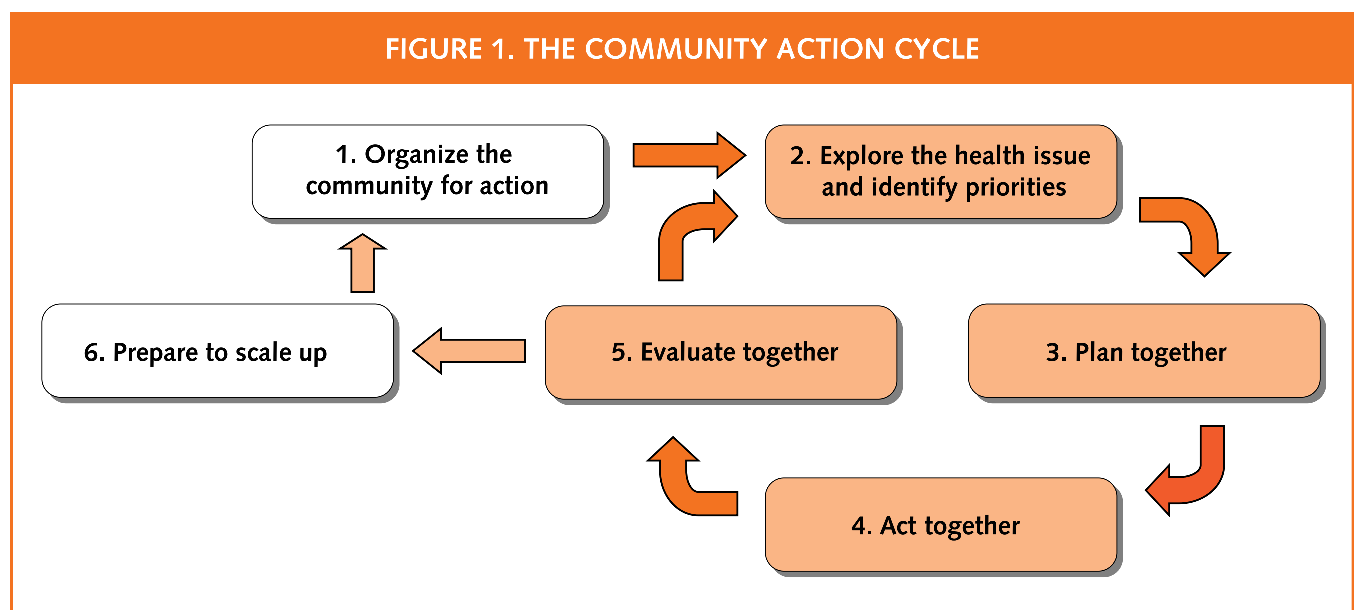
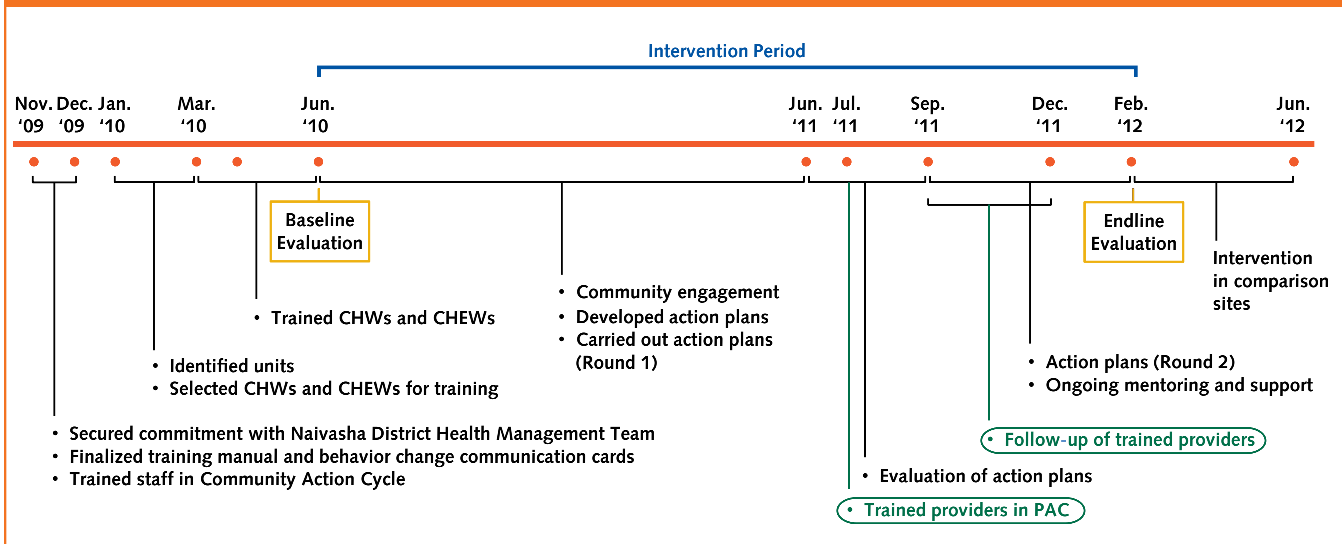


FIGURE 2. TIMELINE FOR COMMPAC INTERVENTION IN KENYA



supplies for manual vacuum aspiration (MVA). At the start of the intervention, none of the local dispensaries had the capacity to provide PAC services. As a result, RESPOND trained 16 providers (clinical officers and nurses) in PAC and 20 in family planning, and MVA kits were provided to the facilities using private funds.

METHODOLOGY

The evaluation used a quasi-experimental design with intervention and comparison groups and baseline and endline assessments at six study sites within Naivasha District. Each site, known as a community unit, comprises five or more villages; each unit ideally has two CHEWs and 50 CHWs covering it. Community units were selected and matched based on their similarities in regard to the urban-rural distribution of the population, service coverage, socioeconomic profile, and level of economic development. The six community units were then randomly allocated to be intervention or comparison sites (Table 1).

TABLE 1. COMMPAC INTERVENTION AND COMPARISON UNITS

Intervention	Comparison
Karunga	Eburu
Kiambogo	Maraigushu
Longonot	Moi Ndabi

The evaluation design (see Figure 2) included both the health facilities offering services (11 public and private health care facilities) and the communities served by them. A community-level survey of 593 women aged 18–49 years who resided in the six community units provided information on knowledge levels of women residing in the community regarding danger signs in pregnancy, access to and quality of PAC services at the focus facilities, and uptake of PAC services. At endline, 647 women in the same age range and residing in the same community units were interviewed.

At endline, in-depth interviews and focus group discussions (FGDs) were held with a range of key informants and intervention site community members; short, semi-structured interviews were conducted with providers in both the intervention and the comparison areas; exit interviews took place with PAC clients at intervention sites; and service statistics for the period April 2009–December 2011 were gathered from health facilities in both the intervention and the comparison settings.

FINDINGS

Pregnancy Experiences and Complications

The proportion of intervention-area respondents reporting knowledge of certain danger signs (specifically, "bleeding heavier than a normal

period," "continued bleeding for two weeks," and "dizziness/fainting") increased significantly from baseline to endline; similar increases were not seen at the comparison sites. Results from a difference-in-differences analysis demonstrated that the change over time at the intervention sites regarding the proportion of women who identified "bleeding heavier than a normal period" was 2.05 times greater than was the case in the comparison site, with this change attributable to the COMMPAC intervention. As a respondent explained:

> *We did not know that bleeding even a spot of blood is risky. We did not know that a small amount of bleeding was bad. But we have now discovered and we now know the truth. So if you see just a small amount of blood, you should rush to hospital.*
>
> —FGD with female youth living where the Community Action Cycle was used

Service statistics indicate that no clients had received PAC services at baseline. However, by the endline period, a total of 30 women were recorded as having received such services at the intervention-area health facilities, while none had done so at the comparison sites.

Participants in the intervention areas were more likely at endline than at baseline to have sought care for bleeding in early pregnancy within their own communities (50% vs. 33%). In contrast, participants at comparison sites were less likely to have sought care within their own communities at endline than at baseline (41% vs. 58%). This finding relates directly to COMMPAC's focus on seeking care at one's closest service delivery point, to reduce delays in obtaining PAC.

As a corollary to this point, providers interviewed at the intervention sites stated that they felt equipped to offer care for bleeding in pregnancy, but their peers at the comparison sites were not. The six intervention-site providers interviewed all regarded the provision of PAC services as a responsibility of their health facility. Furthermore, they all considered themselves competent to practice MVA, and each personally had used MVA to treat PAC clients. In contrast, none of the four comparison-site providers[2] considered PAC services to be integral to the services they offered; accordingly, PAC services were not offered at any of these facilities.

By the endline period, 60% of intervention-site respondents reported spending less than one hour traveling to obtain PAC services, compared with 33% of comparison-site respondents. Thirty-one percent of those at the intervention sites reported not having incurred any travel costs to obtain these services, compared with 25% of their comparison-site counterparts. Intervention-site women who had experienced bleeding were also less likely to have paid more than 1,000 Kenyan shillings to obtain care (2%) than were their comparison-site peers (17%).

Perceptions of Quality of Care for Bleeding in the First Half of Pregnancy

Waiting times improved between baseline and endline for respondents in the intervention areas who sought services for bleeding in the first half of pregnancy. There was a statistically significant reduction in the proportion of women at the intervention sites who had to wait for more than 1.5 hours (from 21% to 5%), while the proportion of those who did not have to wait at all doubled.

Respondents from the intervention sites who had sought care were more likely than those from the comparison areas to feel that they were accorded enough privacy during their visit (99% vs. 91%); that the provider's explanation of the procedure was clear (79% vs. 67%); and that they were treated very well by other health facility staff (65% vs. 50%).

[2] At baseline, five health facilities in the comparison site and six intervention-site health facilities formed part of the study (for a total of 11 health facilities). By endline, however, one of the comparison-site facilities (a private health facility) had closed.

A total of 25 women at the intervention and comparison sites experienced a pregnancy loss due to complications and received information on family planning following the pregnancy loss (19 from the intervention sites and six from the comparison areas). Eighteen of the 19 women at the intervention site who sought care for bleeding had a skilled health professional speak to them about family planning methods, as was the case with all six women from the comparison areas. However, very few of these women chose to adopt family planning—none of the six women from the comparison areas, compared with three of the 18 women from the intervention areas.

Exposure to Community Interventions

At endline, the percentage of women in the comparison areas who had participated in any meeting sponsored by a nongovernmental organization (NGO) or a community group that focused on bleeding in the first half of pregnancy remained virtually the same as at baseline. In contrast, this proportion tripled in the intervention areas. The change observed with regard to the proportions of women who had participated in any NGO/community group/CHW meeting or activity focused on bleeding in the first half of pregnancy was greater in the intervention areas than in the comparison settings. However, difference-in-differences estimates for these outcomes were not statistically significant. This may be because the endline evaluation coincided with family planning outreach activities conducted by at least one other NGO in both the intervention and the comparison areas.

Women role-play carrying a bleeding client to receive PAC services.

Given the 18-month duration of the intervention, there may not have been enough time for this element to produce significant quantitative results. Qualitative data obtained from the communities and from members of the District Health Management Team involved in the COMMPAC intervention reported enhanced community ownership, confidence, and capacity to take action for community health. For example, many communities built or repaired roads to ease passage to dispensaries for women seeking PAC, while others partnered with local authorities to build or expand dispensaries in their communities:

> *PAC [COMMPAC] has also trained us on how to unite people so that they can be able to do work for themselves. We have seen that they have started to do many things in places where nothing could be done before. Things have been able to take place through PAC.*
>
> —FGD with community members (older men), Karunga, Kiambogo, and Longonot

Family Planning Knowledge

There was a highly statistically significant increase in the intervention areas in respondents' overall awareness of family planning between baseline and endline (from 93% to 98%). In comparison, while awareness increased at the comparison sites as well, the difference was not statistically significant. Respondents' knowledge about long-acting and permanent methods of family planning rose significantly between baseline and endline in both the intervention and the control areas.

Results from a difference-in-differences analysis showed that over time, there were no statistically

significant differences between the intervention sites and the comparison areas in the change in proportions of women aware of family planning in general or of long-acting and permanent methods. Knowledge about specific methods increased significantly not only at the intervention sites, but also within the comparison areas. This is probably because of the family planning outreach activities conducted by another NGO in the intervention and comparison areas.

Source of Information

A primary thrust of the intervention focused on generating discussion around family planning at the community level, although there were also service-side improvements focused on training providers in family planning. Government health facilities were the primary channel through which the majority of participants in the intervention and comparison areas had been exposed to information on family planning methods, at both baseline and endline. It is noteworthy, however, that the proportion of respondents who mentioned government health facilities as being their source of family planning information declined in both the intervention and the comparison areas.

There was a significant increase from baseline to endline in the proportion of intervention-area participants who listed NGOs or community- or faith-based organizations (0% to 3%), CHWs (0% to 6%), or fellow community members (23% to 30%) as their main source of family planning information. In the comparison areas, the proportion of respondents who mentioned CHWs as their source of family planning information also increased significantly. Notably, the comparison sites registered a decline in the proportion of respondents who cited fellow community members as their source of family planning information.

The highly significant increase in the proportion of respondents at the comparison sites who reported receiving information about family planning from a CHW may be linked to the work of other organizations in the same areas.

PROGRAMMATIC IMPLICATIONS

In summary, the COMMPAC intervention was successful in increasing knowledge of a critical danger sign in early pregnancy, in enabling providers to effectively offer PAC services at the dispensary level, in raising awareness of PAC, in helping women seek and obtain PAC services at the dispensary level, in inspiring communities to take action for their own health, and in generating interest among key stakeholders in sustaining the intervention.

The COMMPAC intervention was less successful in improving family planning knowledge and current use; women's approval and partners' approval of family planning use; knowledge of dispensaries and health centers as service delivery points for PAC among the general population of women; partner support for obtaining PAC services; and participation in community discussions around PAC.

Given these realities and the interest among key stakeholders in sustaining the COMMPAC intervention, it is important to note that there are certain clear areas for which replicating and sustaining the model holds merit (e.g., awareness creation around PAC, provider training to offer PAC services at lower level health facilities, and creation of community ownership around a health issue).

Sustainability and Replicability

Respondents repeatedly referred to the community approach employed within the COMMPAC intervention as being remarkable and as leading to the successes registered by the project. Key informants within the Ministry of Health noted that building the COMMPAC intervention upon the National Community Strategy has essentially ensured the sustainability of many COMMPAC components.

Community ownership was another important aspect that shows the potential for the model's sustainability. Working with existing community

structures (where some cohesion already existed) and strengthening their ability to identify, prioritize, and act on issues that they determined to be important was essential. The participants reached a consensus that their capacity to mobilize their communities had been enhanced in a variety of ways. Many respondents believed that the knowledge and skills they had received through training under the COMMPAC intervention was sufficient to ensure the project's sustainability. Aspects of the COMMPAC model can clearly be sustained in the communities that have experienced this intervention.

Eighteen months is a relatively short time period over which to expect to see any significant results or changes at the community level, yet the endline results portray a situation in which community capacity has been built to address certain reproductive health issues. Program features that contributed to potential sustainability and scale-up include: focusing on community-led activities, through identification and prioritization of issues by the community themselves; using local resources in resolving community problems; allocating duties and responsibilities among community members; ensuring participation and accountability; recognizing achievements by community members using the Community Action Cycle; and conducting simultaneous improvements at the facilities to deliver quality services.

SUMMARY OF KEY MESSAGES

- Overall, women in the intervention areas were more aware about danger signs in early pregnancy than were their peers at the comparison sites.
- Women in the intervention areas were more likely to seek PAC services at dispensaries when they experienced pregnancy complications.
- Knowledge about where PAC services may be obtained did not increase significantly among the general population of women.
- Providers became more confident about offering PAC services.
- Intervention-site respondents perceived the quality of care available for postabortion complications as being higher than did those at the comparison sites.
- Among women who sought PAC services, the proportion who reported having received family planning information and methods rose at intervention sites.
- Although family planning was an integral part of the COMMPAC model, by the endline no significant increase in women's current use could be attributed to the intervention.
- The evaluation showed evidence that members of the community were empowered to take action for their own health.
- There was evidence of preparedness within the District Health Management Team in Naivasha District to replicate and/or scale up components of the COMMPAC model, as appropriate.

RECOMMENDATIONS

1. Given the importance of family planning for any PAC program, there is a need to ensure that family planning is strengthened as an element of PAC at all levels of the COMMPAC intervention.

2. Community participation and mobilization should be part of programs that seek to expand access to PAC services. The majority of the outcomes for which an effect was observed in this research are related to the Community Action Cycle, which forms an important part of the COMMPAC intervention.

3. The provision of PAC services at the dispensary level is a novel undertaking that was tested under the COMMPAC model and found to be feasible. As dispensaries are more accessible than higher-level health care facilities, introducing PAC services to dispensaries that are reasonably ready to provide them is recommended as a means of expanding women's access to these services.

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