Community Mobilization around Postabortion Care and Integration of Family Planning

FP-MNCH-Nutrition Integration Technical Consultation March 30th, 2011
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CATALYST: Community Postabortion Care

CATALYST Bolivia 2004-2005
In two different regions

CATALYST Peru 2004-2005
In eleven communities in Tarapoto

APHIA II & YFPAC Kenya 2007-2008
Three districts in Central Province
Target groups:
• youth 15-24,
• service providers, and
• local communities around facilities
CATALYST: Community Action Cycle (CAC)*

Organize community for action → Explore the issue → Plan together → Act together → Evaluate together → Organize community for action

*Howard-Grabman and Snetro 2002: xi.
Some similarities and differences of approaches

**Similarities**
- All 3 used the community action cycle
- Bolivia and Peru conducted the process around the “3 delays”
- All engaged community leaders: traditional, religious, and political
- All addressed other related issues in addition to PAC

**Differences**
- **Bolivia**: Paid staff worked with community leaders to conduct the CAC
- **Peru**: The Federacion de Mujeres de San Martin directly facilitated the CAC and partnered with the local MOH hospital
- **Kenya YFPAC**: The CAC was done by staff along with 90 trained youth peer educators connected to 3 developed YFPAC clinics
Action Plans – similar and different

- **Bolivia**: Action plans focused on activities addressing:
  - Health Centers – discrimination, lack of respect for clients
  - SUMI (Universal Maternal & Child Health Insurance) information
  - Community Organization to address other issues, e.g. GBV
  - Training and sensitization

- **Peru**: Action plans focused on: Adolescent pregnancy, shortage of providers, unintended pregnancy (FP and PAC), QOC of clinic services, and gaps in service provision.

- **Kenya**: Help young ♀ prevent unwanted/mistimed pregnancy;
  - Support YFPAC including facilitating ♀ access to services;
  - Advocate for youth focused health care,
  - Make referrals for care, and
  - Address abortion-related stigma.
Some of the results related to family planning

Bolivia
• Increase in knowledge
  – About at least one FP method (88.3% to 94%)*
  – About availability of PAC services (64.8% to 71.3%)*
• Change in practices
  – Used FP method in last sexual intercourse (45.6% to 54.2%)*

Peru
• Between July 2002 - 2005
  – 11,976+ PAC clients
  – 67% counseled on FP
  – 21% received an FP method

Kenya
• Prevention of unwanted pregnancy (contraception) primary

- Continuation of ongoing program with Pathfinder International
- PAC training in 47 hospitals and 83 health centers in 5 departments
- 39,591 clients

Year/total number of clients

- Counseling (%)
- FP Method (%)
- Referral (%)

2000 / 5,740: 52%
2001 / 7,414: 59%
2002 / 8,055: 78%
2003 / 9,685: 82%
2004 / 8,697: 71%
CATALYST Bolivia: Challenges & Lessons Learned

**Challenges:**
- Length of projects too short
- Community prioritized issues other than PAC – was facilitated more effectively in later projects
- Not sufficient involvement of opinion leaders, CHW’s, CBO’s early on

**Lessons Learned:**
- The facilitation of the CAC has to be skillful enough to ensure the focus on PAC and FP while still promoting community empowerment and action
- The CAC for PAC can empower communities to effectively address other priority issues for the community

*Statistically significant (p<.01)*
CATALYST Kenya: YFPAC Job Aids

- Postabortion-Care Counselling for Young Clients (Booklet)
- Youth-Friendly Postabortion-Care Cue Cards for Providers
- Counselling Techniques (flyer)
- Principles of Effective Counselling (flyer)
- Pain Management (flyer)
- Postabortion Care Rights of Clients (poster)

Copies of all job aids can be found at www.pathfind.org/pubs
RESPOND Kenya: Community PAC

• Builds on work from ACQUIRE—2005
  – Nakuru district
  – New FP visits doubled (2,034 to 4,362)
  – Return FP visits ↑ 61%

• Political violence—premature ending of activities

• Recommendation to revitalize & conduct rigorous evaluation under RESPOND

• Rift Valley Province: Nakuru & Naivasha

• RESPOND Partners: EngenderHealth, JHU-CCP, Pop Council
**RESPOND Kenya: Intervention**

- MOH Community Strategy w/ DHMT
  - CHEWs & CHWs as primary link—Sustainable structures
- Facilitate Community Action Cycle for PAC
  - Train CHEWs/CHWs
  - Support CHEWs/CHWs to conduct CM sessions
  - Focus on 3 delay—support groups to develop & implement action plans
  - Mentoring & support to build capacity of CHEWs/CHWs
- Train providers in *comprehensive* PAC services
- Build provider-community partnerships
RESPOND Kenya: Evaluation

- Quasi-Experimental design
  - Control group for comparison; matched pair of 3 units each
  - Unit = approx. 5,000 people or 5 villages with 2 CHEWs & 50 CHWs
  - Pre-post measurements in both arms to measure change over time
- Baseline: June 2010
- End-line: Planned for January 2012
- Quantitative & qualitative measures
  - Community survey of 600 women aged 18-49
    - Exposure to PAC community mobilization
    - Sources of care: MCH, PAC FP
    - Perceptions of quality of care
    - Use of MCH, PAC, & FP services
  - Inventory & Interviews with providers
  - Exit interviews with PAC clients if possible
  - Monitoring data on client loads for PAC & FP services
  - FGDs, IDIs: CHWs, CHEWs, leaders

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<th>Control</th>
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<td>Karunga</td>
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**RESPOND Kenya: Baseline Results**

11% Experienced Bleeding (N=61)

- Women (ever been pregnant) (N=558)

**Type of Services Sought**
- 36/43 (Government)
- 7/43 (Private)

**Sought Care**
- 24/37 (Intervention)
- 19/24 (Control)

**Sought Care Outside Community (1-2 hrs)**
- 16/24 (Intervention)
- 8/19 (Control)

**Did Not Seek Care**
- 13/37 (Intervention)
- 5/24 (Control)

Most didn’t think bleeding was serious enough to seek care

**CATALYST: COMMUNITY PAC**

**RESPOND**

**CONCLUSIONS**
RESPOND Kenya: Summary of Baseline Results

1. PAC services not offered at any of 11 health facilities
2. PAC services are needed and in demand
3. Knowledge of FP high; actual use is significantly lower
4. Women identify & use Gov’t facilities—primary place where FP info is obtained
5. Just over ½ report discussing FP w/ partners, that partners approve, & use FP
6. Significant unmet need for FP
   - large % of women not using yet report desire to space or limit
   - 76% (n=182) & 80% (n=92) (intervention & control)
7. Exposure to community interventions is low
Conclusions

1. Integrated Services: increase coverage, cost, quality, use, effectiveness & impact?
2. Best practices, processes tools?
   – Lead by DHMT using MOH Community Strategy & structure
   – Community engagement key to success
   – Building skills & capacity = take action for their health
   – Community empowerment combined w/ quality service side improvements
   – Link facilities w/ communities to increase utilization of health services throughout pregnancy
3. Barriers?
   – CHEWS/CHWs/community groups have other responsibilities
   – Wide geographic coverage; lack of incentives; equipment & supplies
   – Stigma surrounding abortion
   – Sufficient time needed
4. Gaps?