Expanding Access to Family Planning:

Community Mobilization for Postabortion Care in Kenya

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Photo by Staff / EngenderHealth

THE respond PROJECT

Managing Partner: EngenderHealth; Associated Partners: FHI 360; Futures Institute; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; Meridian Group International, Inc.; Population Council

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COMMPAC Goal and Objectives

Goal:

Increase communities' **awareness** and **use** of postabortion care (PAC) and related services to reduce maternal mortality and morbidity.

1. Increase community knowledge of the danger signs of abortion-related complications, locations of services, and family planning (FP)–related information and services
2. Capacity building to address PAC and FP needs
3. Encourage involvement of most marginalized in community action
4. Mobilize communities to prevent and treat incomplete abortion
5. Strengthen service delivery points providing PAC and FP

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Intervention: 2009–2012

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- Builds on work from ACQUIRE—2005
  - In Nakuru district
  - New FP visits doubled (2,034 to 4,362)
  - Return FP visits increased 61%
- Political violence led to premature ending of activities
- Recommendation to revitalize activities and conduct rigorous evaluation
- Rift Valley Province: Nakuru and Naivasha
- RESPOND partners:
  - EngenderHealth
  - JHU·CCP
  - Population Council

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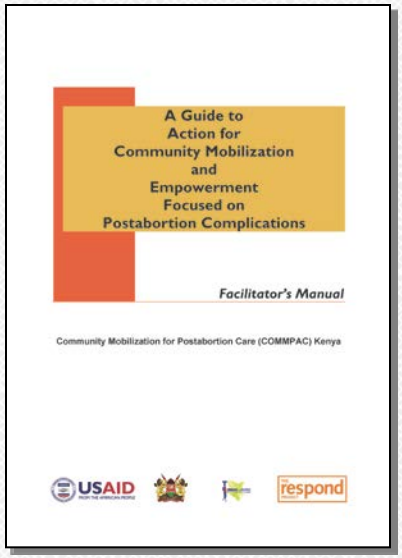
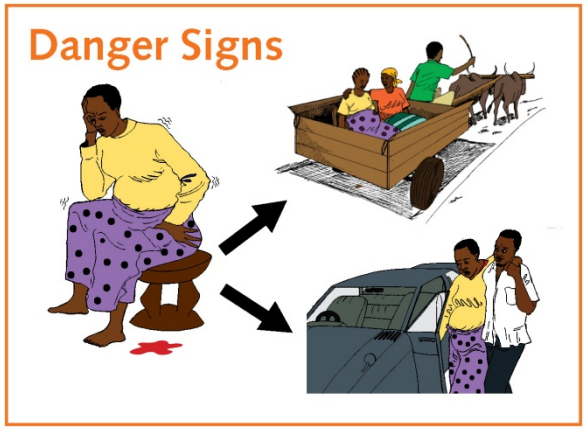
COMMPAC: 2009–2011

- Ministry of Health (MOH) Community Strategy w/ district health management teams (DHMTs)
  - Community health extension workers (CHEWs) and community health workers (CHWs) as primary links—sustainable structures
- Facilitate Community Action Cycle for PAC
  - Train CHEWs/CHWs
  - Support CHEWs/CHWs to conduct community mobilization sessions
  - Focus on the three delays—support groups to develop and implement action plans
  - Mentoring and support to build capacity of CHEWs/CHWs
- Train providers in *comprehensive* PAC services
- Build provider-community partnerships





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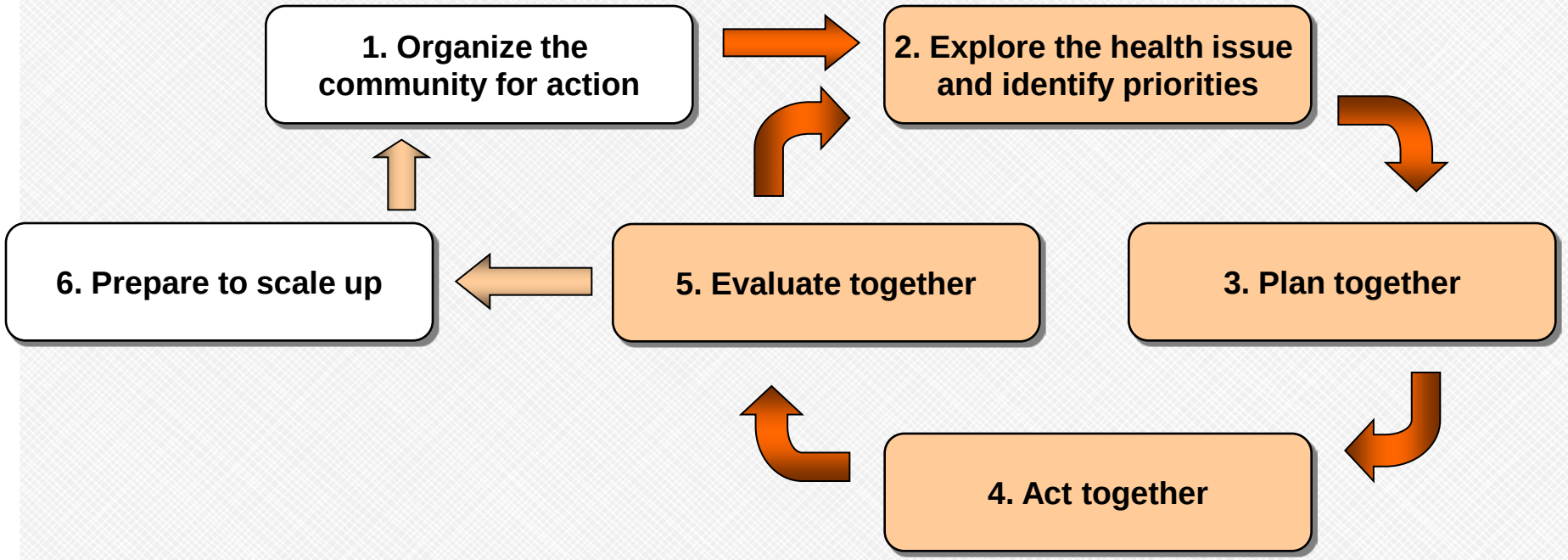
What is the Community Action Cycle?



Evaluation

- Quasi-experimental design
  - Control group for comparison; matched pair of three units each
  - Unit = approx. 5,000 people or five villages with two CHEWs & 50 CHWs
  - Pre-post measurements in both arms to measure change over time
- Baseline: June 2010
- Endline: January 2012
- Quantitative and qualitative measures
  - Community survey of 600 women aged 18–49
    - > *Exposure to PAC community mobilization*
    - > *Sources of care: maternal and child health (MCH), PAC FP*
    - > *Perceptions of quality of care*
    - > *Use of MCH, PAC, and FP services*
  - Inventory and interviews with providers
  - Exit interviews with PAC clients, if possible
  - Monitoring data on client loads for PAC and FP services
  - Focus group discussions, in-depth interviews: CHWs, CHEWs, leaders

Intervention	Control
Karunga	Eburu
Kiambogo	Maraigushu
Longonot	Moi Ndabi

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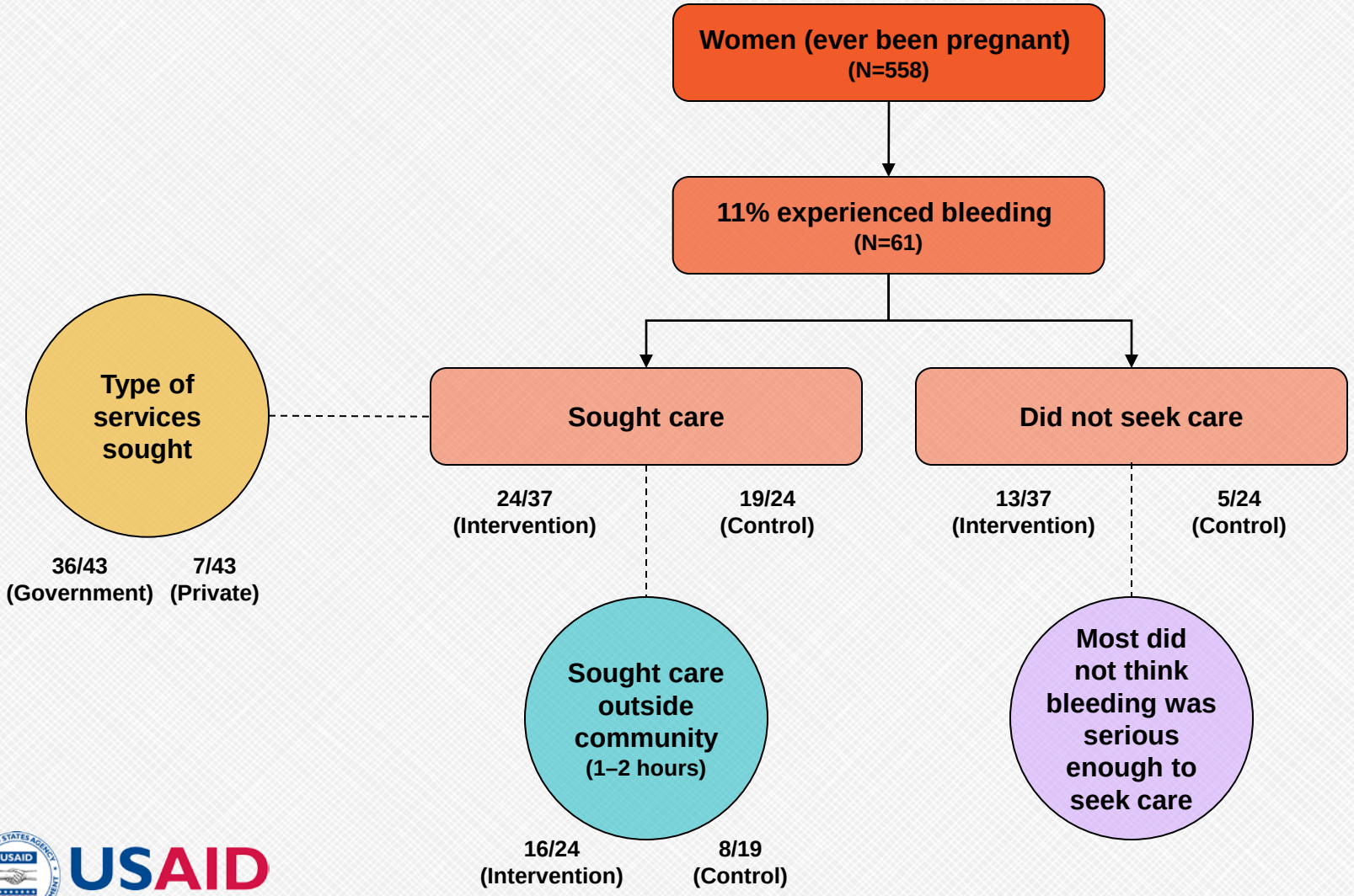
Baseline Results



Summary of Baseline Results

1. PAC services were not offered at any of the 11 health facilities.
2. PAC services are needed and are in demand.
3. Knowledge of FP was high; actual use was significantly lower.
4. Women identify and use government facilities—primary place where FP info is obtained.
5. Just over one-half report discussing FP w/partners, that partners approve, and use FP.
6. There is significant unmet need for FP:
   - A large percentage of women are not using, yet report desire to space or limit births
     - *76% (Intervention, n=182)*
     - *80% (Control, n=92)*
7. Exposure to community interventions is low.

Photo by M. Wahome / EngenderHealth

Herb commonly used for family planning in Naivasha

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Special Family Planning Issues

- Providers witness repeat abortions.
- FP is not offered in same room as PAC services.
- High numbers of young clients:
  - Cost is a barrier to FP.
  - There is stigma in providing youth with FP and PAC services.

Photo by M. Wahome / EngenderHealth

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Action Plans: Problems Identified

1. Delay in recognizing the dangers of bleeding in pregnancy	✓ Myths about FP ✓ Lack of partner support ✓ Poor spousal communication
2. Delay in deciding on and seeking care	✓ Long distance to facility *(3–5 hour walk)* ✓ Wild animals ✓ Security concerns ✓ Self-medication ✓ Religious opposition to FP/PAC ✓ Little use of health facilities; home delivery ✓ Poor infrastructure *(roads and phones)*
3. Delay in resolving the health problem	✓ Lack of trained personnel ✓ Lack of equipment & supplies for MVA ✓ Poor provider attitudes ✓ Unfavorable facility operating hours

Conclusions

Best practices/processes/tools

- Country-led by DHMT, using MOH Community Strategy and structure
- Community engagement is key to success
- Building skills and capacity = taking action for their health
- Work with local social community networks
- Community empowerment must be combined w/quality service improvements
- Link facilities w/communities to increase use of health services throughout pregnancy

Challenges

- CHEWS/CHWs/community groups have other responsibilities
- Wide geographic coverage
- Lack of incentives; equipment and supplies
- Stigma surrounding abortion
- Sufficient time is needed

Photo by A. Smith / EngenderHealth

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