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CLINICAL ARTICLE

Community mobilization and service strengthening to increase awareness and use of postabortion care and family planning in Kenya

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ABSTRACT

Objective: To evaluate whether a community engagement and service-strengthening intervention raised awareness of family planning (FP) and early pregnancy bleeding (EPB), and increased FP and postabortion care (PAC) use. **Methods:** The intervention was carried out in 3 communities in Kenya over 18 months; 3 additional communities served as the comparison group. A pre-post, contemporaneously controlled, quasi-experimental evaluation was conducted independently from the intervention. **Results:** Baseline characteristics were similar. Awareness of FP methods increased ($P \leq 0.001$) in the intervention group. The incidence of reported EPB (before 5 months of pregnancy) in the comparison group was 13.3% at baseline and 6.0% at endline ($P = 0.02$); 79% at baseline and 100% at endline sought care ($P > 0.05$). In the intervention group, recognition and reporting of EPB increased from 9.8% to 13.1% ($P > 0.05$); 65% sought PAC at baseline and 80% at endline ($P = 0.11$). The relative increase in EPB reports after the intervention was over 3 times greater in the intervention group ($P \leq 0.01$). **Conclusion:** The intervention raised FP and EPB awareness but not FP and PAC services use. As fewer comparison group respondents reported experiencing EPB, the PAC impact of the intervention is unclear. Mechanisms to improve EPB reporting are needed to avoid this reporting bias.

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1. Introduction

Unsafe abortion accounts for 9–13% of the pregnancy-related mortality globally [1,2]. In some countries, as many as 25% of all maternal deaths are thought to be attributable to unsafe abortion [2]. The WHO estimates that 99% of abortions performed in Africa are unsafe and that 60% of abortion-related maternal deaths occur in Eastern Africa [3,4].

Nearly 10% of the maternal deaths in Eastern and Southern Africa occur in Kenya, where the maternal mortality ratio is 488 deaths per 100 000 live births, representing 5500 annual deaths [5], with one-third of these attributable to unsafe abortion [6,7]. Since 2003, the Rift Valley Province has experienced the highest abortion-related outpatient morbidity in the country, with 10,958 abortion-related deaths in 2004 alone [8]. In recognition of this problem, the Kenyan government issued standards and guidelines for reducing the abortion-related morbidity and mortality in 2012 [9]. The guidelines emphasize the need for community education, sensitization, and advocacy in conjunction with the

training of community health workers (CHWs) and community health extension workers (CHEWs) to provide information and improve pregnancy prevention and abortion care services [9].

In an effort to increase the awareness of family planning, postabortion care (PAC), and reproductive health services and to improve access to, and quality and use of, these services in the Rift Valley Province, the Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services (RESPOND) Project designed and implemented the Community Mobilization for Postabortion Care (COMMPAC) intervention. This intervention used the community action cycle approach to centrally involve communities, in order to raise the awareness and use of family planning and PAC services. Community mobilization that fosters engagement through local participation is a popular mechanism to improve the planning for and use of health care in resource-limited settings [10]. Such mobilization can raise awareness of when health care is necessary, where effective care is available, and how to seek timely care, and it can leverage community resources, which—in addition to having the potential to reduce the stigma associated with PAC—ultimately improves well-being and responsiveness to health problems [11].

The COMMPAC intervention was supported by the PAC Working Group of the US Agency for International Development and approved

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and supported by Kenya's Ministry of Health (MOH). The intervention engaged districts and communities to strengthen institutional PAC service provision capacity; to expand community involvement in, and knowledge about, the prevention and treatment of postabortion complications; to build community capacity that addresses PAC-related needs; and to encourage the involvement of those who are most marginalized and most affected by abortion complications.

The project was aligned with the Kenyan MOH and its Community Strategy to support existing structures and use them as entry points into communities. Discussions with the MOH and the Naivasha District Health Management Team began in 2009. The intervention was approved by the MOH Division of Reproductive Health and the Division of Community Services. A joint orientation was conducted with the District Health Management Team to harmonize work plans and indicators.

The intervention activities and study sites ("community units") were selected jointly with the District Health Management Team and the CHEWs. The intervention package was guided by the principles of the Supply–Enabling Environment–Demand (SEED; EngenderHealth, New York, NY, USA) framework, an approach that promotes synergism between the components of supply, enabling environment, and demand to improve sexual and reproductive health. The intervention was carried out in selected communities in Naivasha District, Rift Valley Province from July 1, 2010, to December 31, 2011.

The present study attempted to determine whether this intervention of community engagement and service strengthening raised the awareness of family planning and danger signs in pregnancy—particularly early pregnancy bleeding (EPB)—and whether it increased the use of family planning and PAC services.

2. Materials and methods

A pre–post, controlled, quasi-experimental evaluation was conducted independently by the Population Council under the RESPOND project. Six study clusters (community units) in Naivasha District were selected in collaboration with the MOH, based on similarities in their urban–rural population distribution, service coverage, socioeconomic profile, and level of economic development (Table 1). Each cluster comprised 5 or more villages and was theoretically being served by 2 CHEWs and 50 CHWs. Three clusters were randomly allocated to the intervention group and the remaining 3 clusters comprised the comparison group.

Although the community units had been selected with the aim of obtaining study groups with similar characteristics, there were more than twice as many women in the intervention group (baseline $n = 378$, endline $n = 421$) as in the comparison group (baseline $n = 181$, endline $n = 200$) both before and after the intervention (Table 2). The attained harmonic mean sample size of the baseline and endline surveys for the comparison group was 200 and that for the intervention group was 398, with an 80% power to detect a 30% difference in the use of family planning methods, assuming a baseline family planning use of 45%, a Type I error of 5%, and a 2-tailed test.

Table 1
COMMIMPAC intervention and comparison site characteristics.

Community unit	Population size	MOH dispensary	MOH health center	Private medical clinic	Faith-based health center
Comparison group					
Eburu	6798	1	0	1	0
Maraigushu	10 000	1	0	0	0
Moi Ndabi	7000	1	0	0	0
Intervention group					
Karunga	12 874	1	0	0	0
Kiambogo	32 450	2	1	1	0
Longonot	4722	1	0	0	1

Abbreviation: MOH, Ministry of Health.

Household baseline surveys were conducted from May 5 to June 30, 2010 (before the intervention activities commenced), and endline surveys were implemented from January 5 to February 29, 2012 (18 months after the intervention became operational). Four villages were randomly selected from each community unit; in each village, every third household was visited, beginning with a starting point identified by the CHWs. One eligible respondent—a female household member aged 18–49 years—was randomly selected from each household. Selected households that did not include an eligible respondent were replaced with the next available household with an eligible respondent. All consenting, eligible women participated in individual interviews to assess their sociodemographic characteristics, pregnancy and child-bearing experiences and intentions, knowledge and use of reproductive health services, and exposure to community-based healthcare interventions. The May–June 2010 and January–February 2012 cross-sectional surveys were conducted in the same villages.

Written informed consent was obtained from all participants before the interviews were conducted. The study tools were translated into, and the interviews conducted in, Kiswahili, the national language. The study received ethics clearance from the Ethics Review Committee of the Kenya Medical Research Institute on January 25, 2010, and from the Population Council Institutional Review Board on March 17, 2010.

The intervention was implemented with the approval and support of the MOH. Naivasha-based CHWs and CHEWs were trained on the community action cycle (Fig. 1), a highly participatory capacity-building process that facilitates community mentoring, involvement, and mobilization through 3-day sessions in which community members learn how to take action for their own health. It also engages communities to self-diagnose underlying issues related to health problems and inspires them to look to community-endorsed leadership and available resources to address identified issues.

A set of community behavior change communication flip cards (Fig. 2) was provided and reviewed with the CHEWs and CHWs; the CHEWs and CHWs then used the flip cards in house-to-house outreach visits and on community dialog and action days. Topics covered included misconceptions and negative rumors about family planning methods, religious opposition, and lack of partner support for problems such as long distances to the nearest facility, poor roads, lack of trained providers, and poor provider attitudes. More than 630 community members participated in the mobilization sessions.

In addition, 2 community–facility linkage meetings were held with the trained CHEWs and CHWs to discuss progress on their action plans and to jointly resolve problems (including negative rumors about family planning methods, religious opposition, long distances to the nearest facility, poor roads, lack of trained providers, unfavorable facility hours, lack of partner support, poor provider attitudes, and lack of equipment and supplies for manual vacuum aspiration).

None of the local dispensaries had the capacity to provide PAC at the project's inception. Accordingly, in partnership with the MOH, the RESPOND Project improved the service capacity in facilities serving the communities in the intervention group. This was achieved by training 16 providers (clinical officers and nurses) at existing Naivasha dispensaries and health centers in PAC and by training 20 providers in family planning. The clinical officers and nurses had received previous training in related health procedures; as part of the project, they received an additional week of PAC training and a week of family planning training. The PAC training included instruction regarding surgical procedures and manual vacuum aspiration; issues related to patient comfort, privacy, hygiene, and cleanliness in the diagnostic, waiting, and recovery areas; relevant medications, instruments, and supplies; and post-procedure counseling. The family planning training included instruction on patient intake, insertion and removal of intrauterine devices and implants, oral and injectable contraceptives, and condoms. Community problem diagnosis also provided insights to the project as to how services could be refined to meet the communities'

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