

**TESTING COMMUNITY LEVEL
STRATEGIES TO REDUCE UNWANTED
PREGNANCY AND UNSAFE ABORTION
IN WESTERN KENYA:**

**RESULTS OF THE END OF PROJECT
EVALUATION**

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BACKGROUND

The contribution of unsafe abortion to maternal mortality and morbidity has long been recognized globally. Of the five major causes of maternal mortality, unsafe abortion is the most easily preventable. Yet in Kenya, it is estimated that 30-50% of all maternal deaths are directly attributable to unsafe abortion. In responding to this situation, efforts have been made to strengthen the capacity of both personnel and institutions to deal with abortion related complications.

Investments have been made in Post Abortion Care (PAC) training and provision of equipment, as well as renovation and refurbishment of health facilities. While this has had the effect of reducing abortion related mortality and morbidity to some extent, it responds only when a medical emergency is present and a woman has reached a health facility.

Factors that contribute to maternal mortality and morbidity are due to unwanted pregnancy and unsafe abortion are not only medical and often begin long before a medical emergency is present. Community values, attitudes and norms as well as laws and policies together with health system limitations, all work in concert to determine whether the social and health care needs of a woman faced with an unwanted pregnancy will be adequately met.

In many communities decisions regarding the health of individuals and families are linked with other aspects of life and cannot be separated. Decision-making is linked to socio-cultural and economic status as well as norms and values and is often not solely an individual matter. Nowhere is this clearer than in the area of reproductive health (RH), particularly the health of women. Although efforts at improving the health of women have tended to target them directly, many women do not make decisions regarding their own health, and are often forced to rely on other family members to decide what actions should be taken in the event of a medical emergency. Access to Family Planning (FP) as well as utilization of reproductive health services is influenced by a variety of factors; key among them being family and societal influences.

Community values, attitudes and norms, as well as laws and policies and health system limitations, all work in concert to determine whether the social and health care needs of a woman faced with an unwanted pregnancy will be adequately met. Strengthening community level structures to enhance community participation is key not only to improving the health and general well being of women, but also to the promotion of community responsibility for maternal health.

In 1996, the Centre for the Study of Adolescence (CSA) and the Pacific Institute for Women's Health (PIWH) in collaboration with the Kenya Medical and Educational Trust (KMET) initiated a project to address community-level dynamics of unwanted pregnancy and unsafe abortion and their contribution to maternal mortality and morbidity. The Community-Based Abortion Care (COBAC) Project was rolled out in three distinct phases:

Phase one consisted of formative research to identify socio-cultural attitudes towards unintended pregnancy and abortion-seeking behavior in Western Kenya. Phase two consisted of dissemination of research findings, participatory intervention design and intervention piloting. The third phase implemented over a four year period focused on documenting and evaluating the effectiveness of community level strategies to prevent unwanted pregnancy, address unsafe abortion and strengthen Post Abortion Care (PAC) services as a way of reducing maternal mortality. This initiative was based on the premise that greater community involvement will accelerate change and make a difference in reducing abortion related maternal mortality and morbidity and addressing broader safe motherhood concerns. This brief provides an overview of the intervention processes and strategies, and highlights the findings of an End of Project Evaluation conducted in August 2004.

The project was implemented in Suba District, Kenya, which was chosen due to its poor health and development indicators. The district is characterized by a high rate of child mortality, high maternal mortality and morbidity, low service utilization, low literacy levels among women and high school drop out rates among girls.

Strategies and Activities

Interventions focused on community sensitization, public education and mobilization regarding attitudes and responses towards unsafe abortion and unwanted pregnancy. Emphasis was placed on creating demand for reproductive health services including family planning as well as the creation of a risk-reduced and supportive environment for women with unwanted pregnancies. Training was undertaken for clinical providers in PAC, and contraceptive technology updates were conducted in order to expand the range of choices and options available to women. Secondly, the project worked with community-level health workers to expand and strengthen their roles in preventing unsafe abortion through the provision of abortion-related Information, Education, and Communication (IEC) and timely referral to clinic-based, trained medical providers. This strengthened referral and linkage system incorporated both public sector health service delivery as well as an existing network of private providers who were already trained in PAC. In addition to community health networks and IEC and training efforts, facilitative supervision was also undertaken to strengthen monitoring of effective care, counseling and referral.

Why the Focus on the Community?

The decision to carry a pregnancy to term is not always solely a woman's decision. It is often influenced by a variety of factors such as marital and socio-economic status, the legal and policy environment as well as health care service delivery systems. Subsequent efforts aimed at dealing with unsafe abortion must be designed to take into account all of these factors. Yet in most cases, the role of the community has been largely ignored. When it has been considered, perceived solutions are often imposed on communities without a proper understanding of the community level dynamics towards unwanted pregnancy and unsafe abortion. In most cases tokenism has been the main guiding principle in so called "Community Based" approaches. It is not surprising therefore that abortion related mortality remains relatively high in many places.

In the COBAC Model, the focus shifts from the facility and clinical settings to the community. In this initiative, community-based women's groups and youth-serving organizations form an integral part of community level efforts for sensitization and mobilization. Other community leaders, religious organizations, schools and teachers have been recognized and incorporated as important stakeholders.

In collaboration with the Ministry of Health and community social and health care networks, community level initiatives have complemented and strengthened existing clinical PAC efforts. They have also facilitated more effective and efficient access to (PAC) and other reproductive health services, such as preventing unwanted pregnancy and providing early referral for pregnancy care and obstetric complications.

END OF PROJECT EVALUATION

In September 2004, an End of Project Evaluation was conducted to establish the extent to which project objectives had been met in terms of reducing abortion related mortality and morbidity. The evaluation adopted both qualitative and quantitative methodologies to evaluate the impact of interventions implemented over a four -year period. A total of 1495 people were interviewed using a variety of tools including Focus Group Discussions (FGDs) and structured questionnaires.

Results: There was a significant increase in the level of knowledge of reproductive health issues in general and abortion complications in particular. Awareness of risks associated with unprotected sex and the danger signs of unsafe abortion was quite high. This resulted in the reduction of delays, and facilitated referrals from the community to the health facilities where women could receive the care they required. It also facilitated a change in attitudes towards women seeking abortion related care as well as adolescent access to RH services.

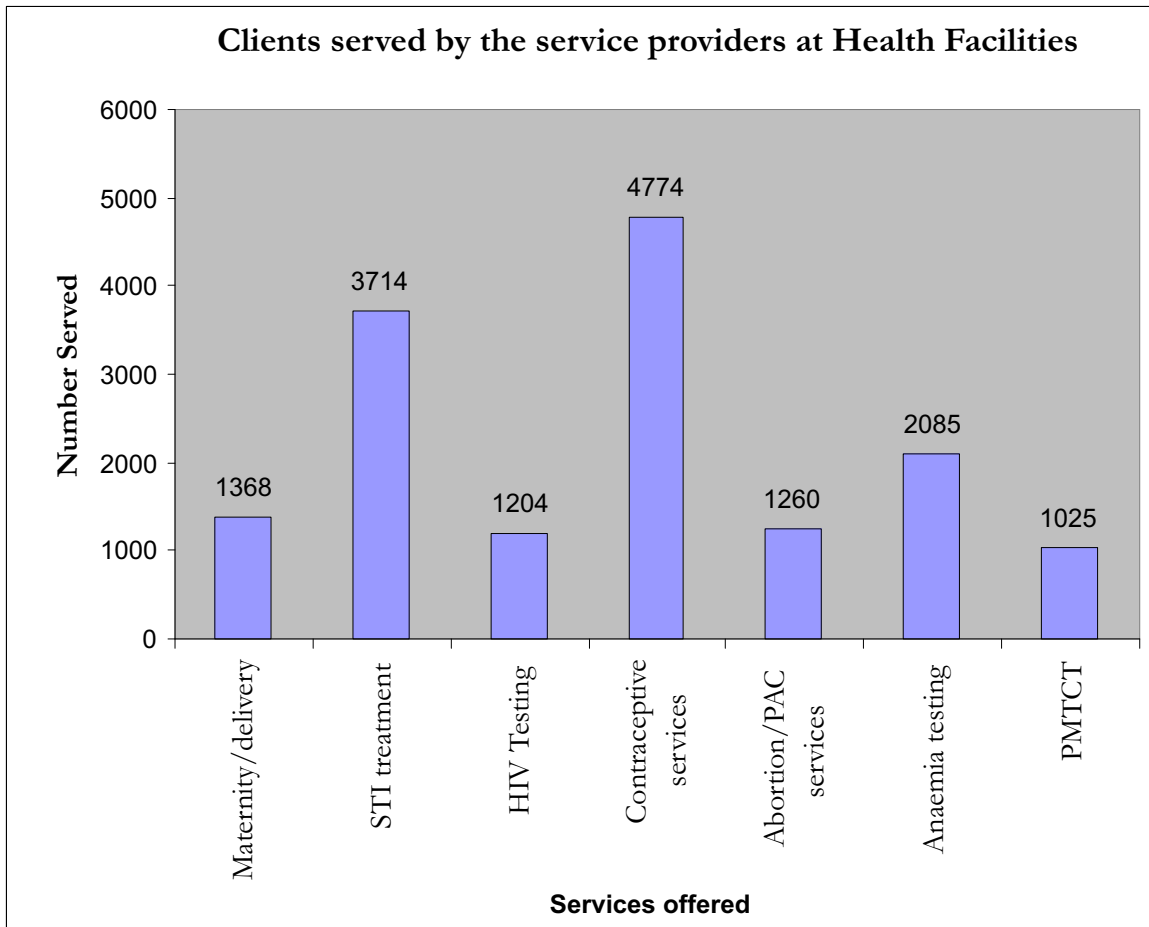
The inability to meet the increased demand could have serious repercussions as people may go back to using traditional healers as was previously the case.

Increase in the utilization of health services: This increase in knowledge levels led to increased demand for all types of services including non-reproductive health services such as immunization. Although the focus was on reducing unwanted pregnancy and unsafe abortion and related mortality and morbidity, demand for information on other aspects of health necessitated an expansion of the education and sensitization activities to include other areas of health. Subsequently demand for health services went up significantly compared to baseline. It was clear from the service statistics and the long queues at health facilities that the demand for services had increased.

One of the goals of the COBAC project was to promote increased access to reproductive health service. Service statistics and facility records show a that clients sought a range of reproductive health services including Pre and Post Partum care, PAC, MR, STI treatment as well as VCT. The increase in the number of women seeking post-partum care was particularly significant given the low numbers at baseline and the contribution of post-partum heamorrhage to maternal mortality and morbidity. [Figure 1 shows clients served at selected facilities by service provided.](#)

Although the increased demand for services is a positive outcome and an indication that the community, education, sensitization and mobilization is working, the pressure on health facilities has increased making it difficult for them to meet the demand. While the number of patients has increased, this has not been accompanied by a corresponding increase in the number of providers. The inability to meet the increased demand could have serious repercussions as people may go back to using traditional healers as was previously the case. Also, it may affect the quality of service delivery as few providers struggle to keep up with the pace.

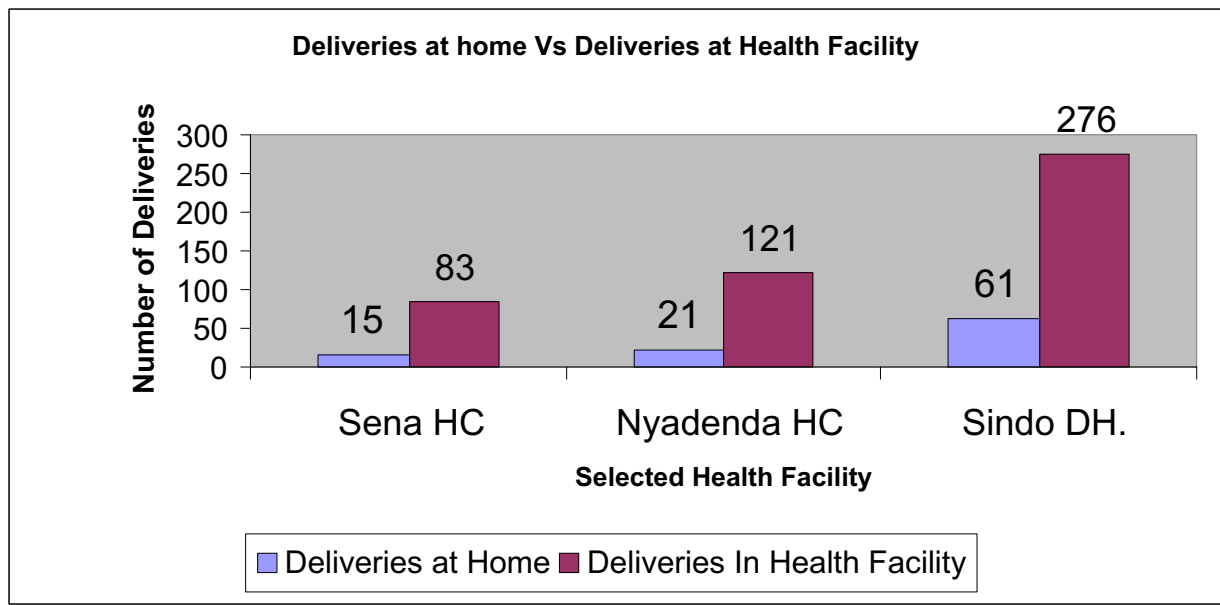
Figure 1: Clients served at health facilities by service provided



Increase in the utilization of family planning services: There has been a significant increase in the utilization of family planning services. The availability of contraceptives at the community level has improved access for most women who no longer have to travel long distances to health facilities. Currently, over 65% of women receive their contraceptives from CBHWs in their villages. Referrals are made for methods, which cannot be provided at the community level.

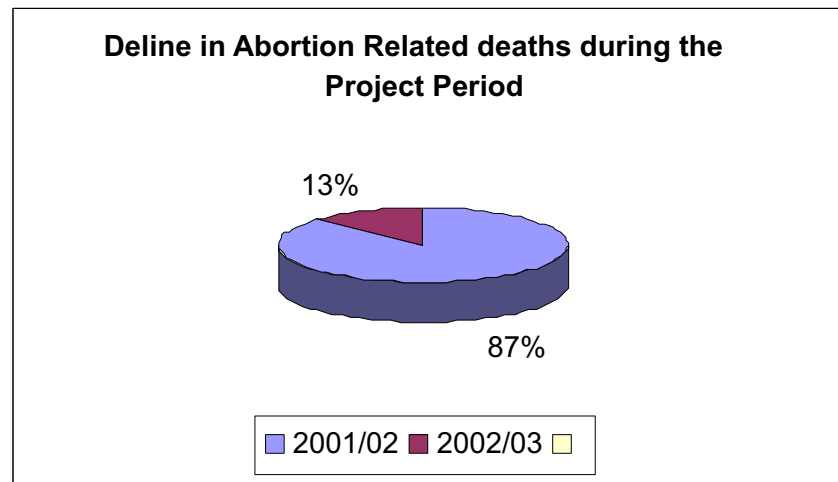
Increase in the number of deliveries attended by skilled attendants: In Kenya, less than half of deliveries (44%) occur within health facilities. In Suba the number is even lower. There has been a significant increase in the number of women delivering at health facilities. This has reduced complications, and subsequently lowered mortality and morbidity levels. In most cases, women are referred or accompanied to the health facility by Traditional Birth Attendants (TBAs) who would previously have delivered them at home. [Figure 2 shows increase in number of women delivering in health facilities](#)

Figure 2: Number of Deliveries at Selected Health facilities Vs Home



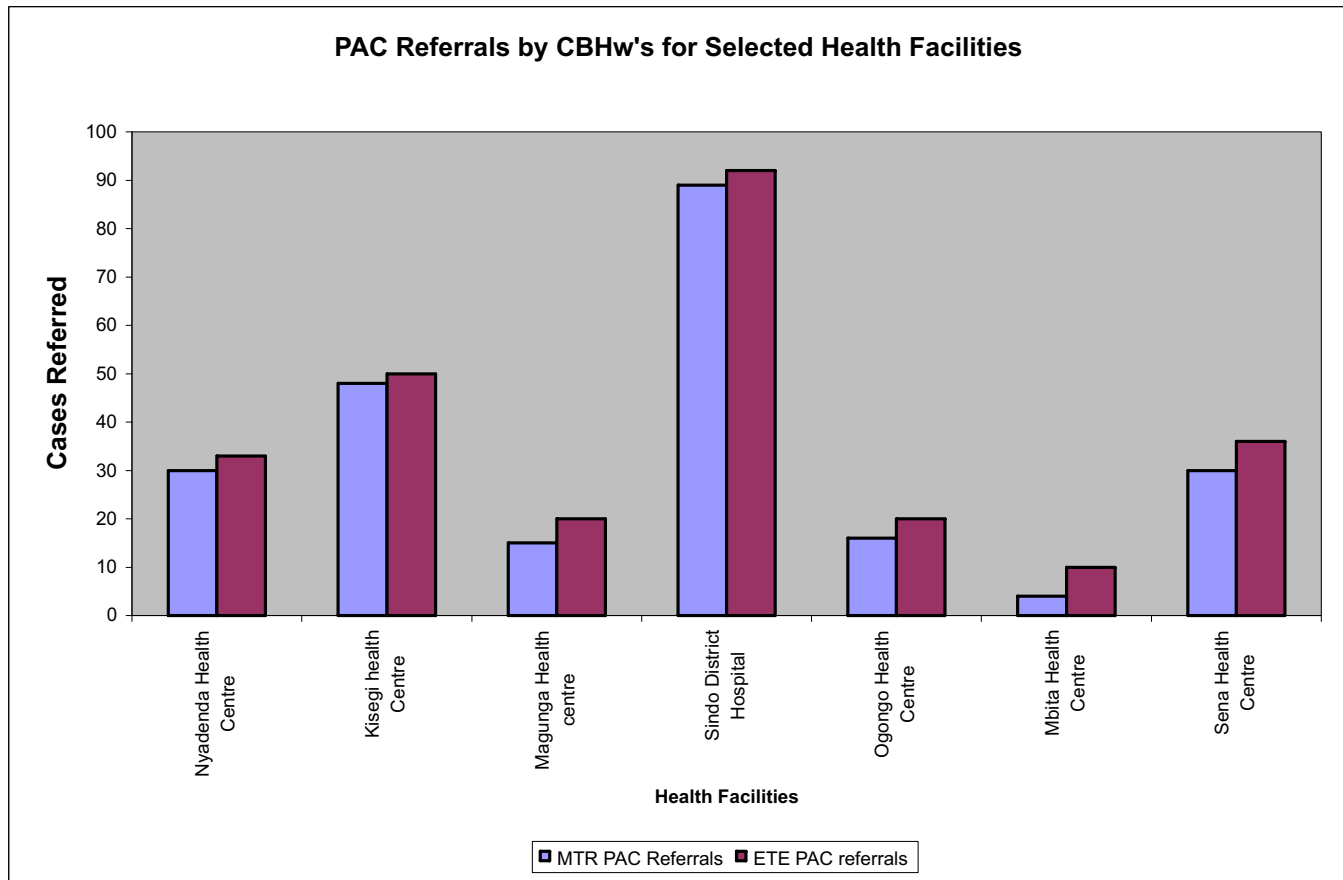
Reduction in Abortion related mortality and morbidity: There has been a clear reduction in abortion related mortality and morbidity and an increase in the utilization of PAC services. Abortion related mortality reduced from 87% in 2000/01 to 13% in 2002. There were no abortion related deaths at the district hospital, the only Emergency Obstetric Care (EmOC) center in the district, between January 2003 and August 2004 when this evaluation was conducted.

Figure 3: Abortion related mortality 2001/02 and 2003/04



More women using PAC services: More notable was the increase in the number of women seeking PAC as well as the facilities offering these services. The average age of women seeking PAC and Menstrual Regulation (MR) services was 21.4 years with the majority being married. The youngest clients came from the remote islands where the average PAC client was below 20 years of age. The difficulties that adolescents face in accessing RH information and services, coupled with low contraceptive use and early marriage, may explain the high rate of unwanted pregnancy and unsafe abortion in this group.

Figure 4: PAC referrals by CBHWs to selected facilities Improved capacity at health facility level:



Most health facilities are able to offer an expanded range of services due to training and capacity building activities undertaken within the project. The training of providers in PAC, contraceptive technology updates and provision of equipment have all contributed to this.

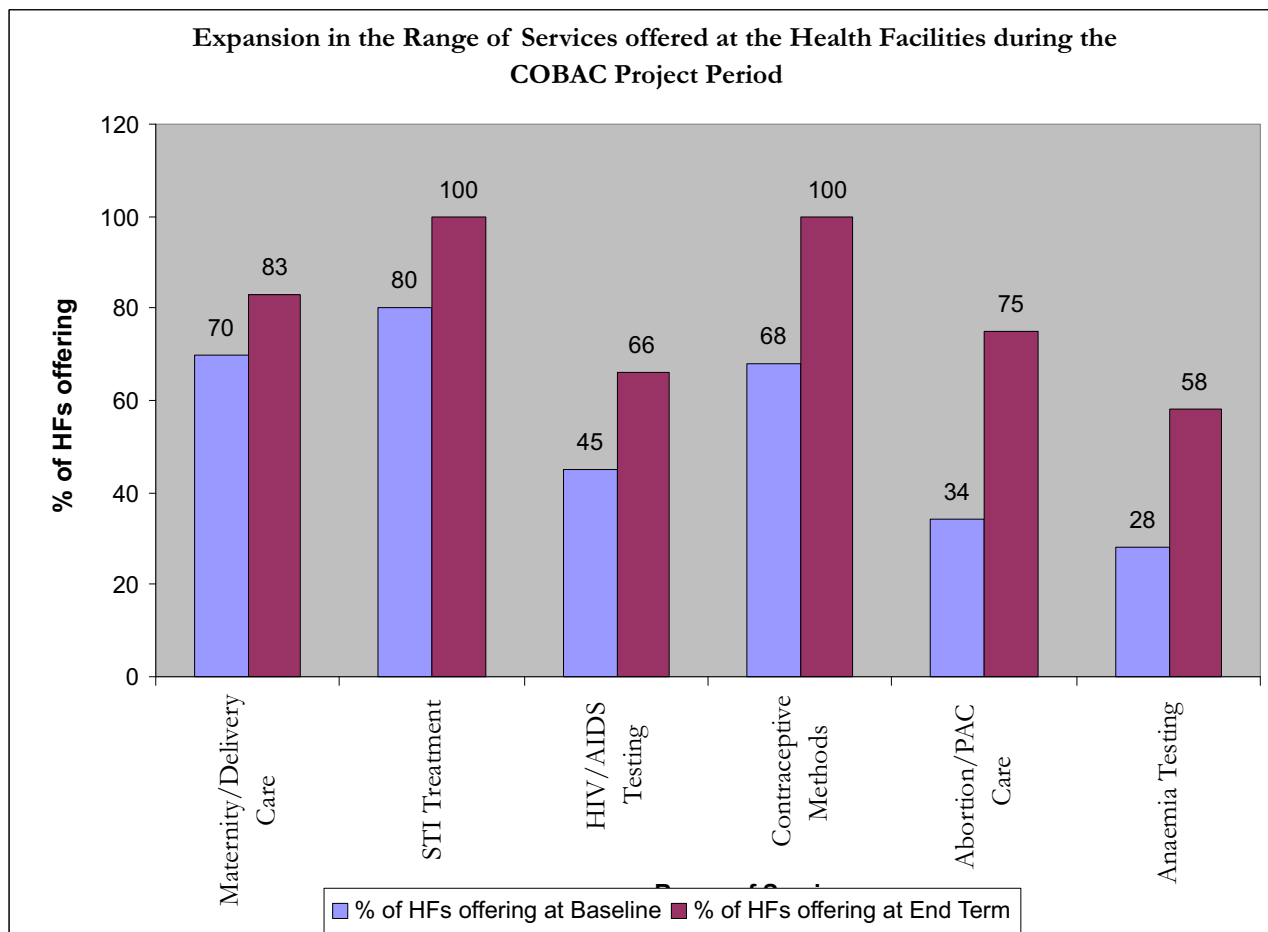
The improved capacity at health facility level has resulted in the expansion of the range of services offered. Additional services such as HIV testing are now available at more health facilities (66%) than at baselines when less than 50% of facilities were able to offer the service. Despite this however, most of the young people interviewed indicated that they were not able to access VCT services easily. Figure 3 shows range of services offered at baseline and End Term

The expansion in the range of services is more notable in the area of family planning where at baseline; facilities could only offer the pill, condom and injectables. Now more facilities are able to offer other longer-term methods such as IUD and Norplant. This expansion in the range of services and improvement in the method mix has expanded women’s FP choices and options motivating more of them to choose methods convenient to them. Despite this progress, logistical problems and recurrent shortages are likely to negatively affect women’s access.

Also expansion in the range of services does not automatically translate in an increase in the uptake of newly introduced methods. For example the number of women using Norplant low either because women are still not aware of their existence or are low to change preferring to stick with what they know. An inventory of the health facilities showed that 16 facilities had Norplant while the country had been experiencing a shortage that had lasted a more that a year.¹

¹ The slow uptake of Norplant is not only experienced in Suba district, but is countrywide. Findings from the latest KDHS show that most women Still prefer the Pill and injectables with a higher number of new users including adolescents choosing the latter.

Figure 5: Range of services offered at baseline and End Term



Strengthened linkages between the community level structures and the health facilities: There was a significant increase in referrals from CBHWs to health facilities, using a Referral Card system. About 90% of PAC clients at the District hospital alone were referred by CBHWs. Community groups form part of a referral network that links the community to medical providers in both the public and private sectors and helps in reducing delays in seeking care. These social networks also provide support, which enable women to make decisions early and seek care in time, thereby reducing complications.

The important role of the community health worker as a reproductive health agent was confirmed by the findings showing increased confidence in their ability to offer certain services. Over 80% of the community believes that the CBHWs have adequate skills to carry out their tasks effectively. This has reduced their confidence in herbalists and other traditional healers to deal effectively with pregnancy related complications. Only 36% of the population trusts herbalists and traditional healers in managing abortion complications.

CHALLENGES & POLICY IMPLICATIONS

Despite these achievements, several challenges were experienced in the implementation of the project. Access to health services, resource availability and socio-economic and cultural factors continue to be barriers to service utilization. Whereas demand for both curative and preventive health services has increased, there were wide regional disparities in access and availability. In some regions such as the islands, women have to travel as far as 20 kilometres to the nearest health facility. Other challenges include quality of health care, frequent stock-outs of drugs and contraceptives, poverty at the household level, and cultural and traditional practices.

Supply side logistical problems: Frequent Contraceptives and Commodity stockouts: Stock-outs are frequent and continue to plague the facilities, threatening to reverse the significant gains already made. While the project tried to ensure that facilities with high case loads had a constant supply of contraceptives, a long-term policy solution is required to deal with this. Currently the government depends almost entirely on donors for family planning commodities and STI treatment supplies. There is no provision for family planning commodities in the Kenyan national budget. The current “push” system where commodities and supplies are sent out to facilities without consideration of facility specific needs is flawed and inefficient.

High Staff turnover: Frequent transfers out of the district are greatly hampering service provision. The district is remote and is not attractive to health workers. The health sector has also been hit by a severe staff shortage of health workers as most migrate in search of greener pastures. Consequently, many facilities are unable to deal with the increased demand for services. The district hospital, the only EmOC in the district is often without a Medical Officer.

Cultural and traditional values: The persistence of certain cultural practices such as early marriage that hinder the empowerment of women, have had a negative impact on project activities. Men are still not very supportive of the use of family planning as most are in favour of large families. The low literacy levels among women are also affecting their health seeking behaviour.

SOME KEY LESSONS

- ★ The community participation approach of the COBAC Model is a cost effective way to expand reproductive health care services to the geographical and social periphery of a community. In Suba, this enabled RH services to reach remote parts of the district such as the Islands of Mfangano, Rigiti and Remba, which are separated from the rest of the district by poor communication and transport links.
- ★ Empowering communities to work with the health sector is critical. But equally important is empowering the health sector to work with communities. In COBAC, the community and health service collaboration was promoted through approaches that involved the community in defining and monitoring the quality of care.
- ★ The public health care system must be optimally functional to support the implementation of COBAC. Even if project activities are well designed, the health care system, particularly the referral must be able to function well to support the project. While it is important to increase capacities and awareness at the community level, linkages within communities and between communities and health services must be strengthened at the same time. The absence of a well functioning referral system negatively affects access and acts as a deterrent to women seeking care for abortion complications.
- ★ The improved health conditions that are essential for development may depend more upon the self-help motivation of local people than upon the provision of modern health facilities. Such motivation can be created by the culturally-appropriate dissemination of health education at the community level.
- ★ Early targeting of young people can result in real change in reducing unwanted pregnancy and unsafe abortion. Results from the COBAC project show that where young people were targeted early with information, pregnancy rates declined markedly.

- ★ Building on existing community level structures is essential to the success of any community led initiative. Recognizing the existing of community level health care structures and working within them to improve knowledge and attitude can lead to reduction in abortion related mortality and morbidity.
- ★ Special attention should be paid to other interventions that address the status of women within the family and community as health outcomes of both positive and negative are determined largely by decisions made within the household. Where a project focuses on improving the health status of women while ignoring community values and norms regarding women and their roles, it is not likely to be sustainable.

CONCLUSION

Unsafe abortion is a complex issue that requires a multi-pronged approach combining both clinical responses and community education and sensitization in order to effectively address pregnancy related mortality and morbidity. The decision to carry a pregnancy to term is not always solely a woman's decision. It is often influenced by a variety of factors such as marital and socio-economic status, the legal and policy environment as well as health care service delivery systems. Subsequent efforts aimed at dealing with unsafe abortion must be designed to take into account all of these factors. Very clear linkages must be made between community level structures and the formal health care system, to promote prevention and create demand for services. Yet in most cases, the role of the community has been largely ignored. When it has been considered, perceived solutions are often imposed on communities without a proper understanding of the community level dynamics towards unwanted pregnancy and unsafe abortion. In most cases tokenism has been the main guiding principle in so called "Community Based" approaches. It is not surprising therefore that abortion related mortality remains relatively high in many places.

The results from this project provide significant opportunities for increasing service utilization in other areas. Recent KESPA findings indicate that utilization of health services remain low in most parts of the country, but more so in Nyanza. There are lessons here for working with the community to create demand for and improve the utilization of services such as PMTCT, immunization and delivery with skilled attendance, as ways of reducing maternal and child morbidity and mortality.

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