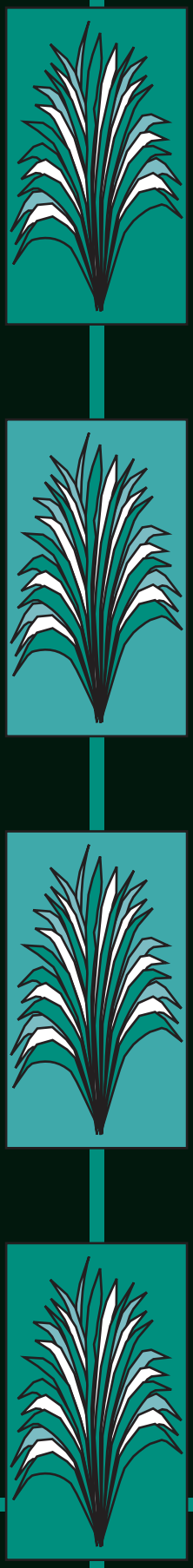

ACQUIRE Evaluation and Research Studies

Engaging Communities as Partners in Postabortion Care: A Desk Review of the Community Postabortion Care Project in Nakuru, Kenya

E & R Study #11 ◆ August 2008

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Acknowledgments

This desk review is a synthesis of all of the hard work of the communities involved in the Community Postabortion Care (COMMPAC) Project in Nakuru, Kenya, which was funded by the U.S. Agency for International Development (USAID) and was conducted by the ACQUIRE Project. The communities and the champions that experienced the energy of empowerment demanded access to quality postabortion care services. Several people from the ACQUIRE Project, EngenderHealth/Kenya, and the Society for Women and AIDS in Kenya (SWAK) were involved in project implementation. The authors would like to acknowledge first and foremost the committed staff of SWAK, and especially the project director, Mercy Wahome, and Ester Oloo for their tireless dedication to the communities of Nakuru, Kenya.

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This desk review is a testament to the energy, enthusiasm, and perseverance of all of the individuals above, and especially the individuals and community groups of Nakuru District, Kenya. This report was edited by Lisa Remez-McCormick and was formatted by Elkin Konuk; Michael Klitsch provided overall publishing management.

Acronyms and Abbreviations

APHIA II	AIDS, Population, and Health Integrated Assistance Program
CDF	community development funds
COMMPAC	Community Postabortion Care Project
C-PAC	Bolivia PAC Community Mobilization Program
FIDA-K	International Federation of Women Lawyers–Kenya
FP	family planning
HIV	human immunodeficiency virus
IEC	information, education, and communication
IR	Intermediate Result
KAP	knowledge, attitudes, and practices
KMA	Kenya Medical Association
KMOH	Kenya Ministry of Health
MOH	Ministry of Health
MVA	manual vacuum aspiration
NGO	nongovernmental organizations
PAC	postabortion care
RH	reproductive health
SWAK	Society for Women and AIDS in Kenya
USAID	U.S. Agency for International Development
WHO	World Health Organization

Executive Summary

Years of experience have shown the model of postabortion care (PAC) to be an effective approach to address the complications of unsafe abortion and miscarriage. The focus has been on improving emergency treatment, primarily through improved technology and decentralized services. There have also been numerous efforts to link PAC clients to family planning (FP) services. The overall approach has primarily been via medical and service-delivery avenues. More recently, the community's role in PAC services has received increased attention. This change recognized the need to address the demand side of services by raising awareness, reducing stigma, and involving communities.

In 2005, the ACQUIRE Project received support from the U.S. Agency for International Development (USAID)/Washington PAC Working Group to replicate a community-based project from Bolivia for the Kenya context to test approaches to community mobilization for PAC. ACQUIRE staff from New York and Kenya, and our partner the Society for Women and AIDS in Kenya (SWAK), worked to design a project using the Community Action Cycle process to improve community participation and ultimately meet the PAC needs of local women and couples in Nakuru, Kenya. Addressing unsafe abortion is important in Kenya, where an estimated 300,000 abortions are performed each year, with 20,000 women being admitted with abortion-related complications to public hospitals annually. This translates into a daily abortion rate of more than 800 procedures and 2,600 abortion-related deaths every year (KMA, FIDA-K, KMOH, & Ipas, 2004).

The project was implemented to build community confidence and to give community members the tools to help themselves make positive changes in their environment. The goal was to increase access to reproductive health (RH) and FP services, especially PAC.

Community mobilization had a substantial impact on the local environment and on health service delivery. Communities were engaged, and resources were found at the local level to implement activities that the communities decided were important to them. The following achievements were completed with local resources:

- Human resource and infrastructure improvements (building of health facilities and dormitories for staff[1]); increased retention of health personnel; and repair of two bridges and five roads
- Development of community champions for RH and PAC, including both men and women—and youth[2]
- Strengthened partnerships between communities and health facilities, leading to improved quality of care and resources
- A more than doubling of new FP users, from 2,034 in 2005 to 4,362 in 2006, with a concurrent increase in continuing users, from 8,565 in 2005 to 13,807 in 2006.

While the project was successful in improving access to RH services and in mobilizing the community around health issues, more rigorous evaluation is still needed to understand the most effective ways to involve communities in achieving the goals of the PAC model. Neither the Bolivia nor the Kenya community PAC interventions were set up as operations research projects. While this

[1] Four new health facilities built, two health posts renovated, and six health facilities expanded for PAC.
[2] PAC champions conducted 15 community forums reaching 2,195 community members and 1500 students.

design was fine to test implementation in an early phase, for scale-up and replication purposes, a more scientific evaluation process may prove important, especially to allow new stakeholders and country programs to accept and adapt the process.

Introduction

Community—The Neglected Partner in Postabortion Care

In many developing countries, poverty, a lack of knowledge about reproductive health (RH), and cultural and gender barriers all inhibit access to RH and family planning (FP) services. This is especially true with the sensitive issue of postabortion care (PAC). International efforts to improve access to services in a variety of health areas (HIV and AIDS, FP, malaria, child health) have pinpointed the need for greater community engagement (Wallerstein, 2006).

Beginning in 2001, the U.S. Agency for International Development (USAID) developed a Global PAC Strategy to discuss the full needs of PAC, including community empowerment. Discussions were held in many forums to discuss the strategy; to outline global and country activity plans; and to develop process and outcome indicators.

The three core components for PAC articulated in USAID's strategy were:

- Emergency treatment for complications of spontaneous or induced abortion
- FP counseling, service provision, evaluation and treatment of sexually transmitted infections, and HIV counseling and/or referral for testing
- Community empowerment via community awareness and mobilization

Supporting state-of-the-art PAC practices at all service-delivery levels through community empowerment[3] is a stated objective for USAID (Solo et al., 2004), as well as for many other local and international organizations, and led to the funding of the Kenya COMMPAC Project through the ACQUIRE Project.

The purpose of this desk review is to document the ACQUIRE Project's efforts in community engagement and mobilization for PAC in Kenya. The Kenya COMMPAC Project was a replication of the Bolivia PAC Community Mobilization Program (C-PAC), which was implemented by CATALYST and Socios para el Desarrollo/PROSALUD (2004–2007). Both the Bolivia and Kenya projects are important efforts funded by USAID to put the community PAC component into practice. The central goal of the Bolivia C-PAC project was to empower the community to mobilize itself to reduce maternal morbidity and mortality due to complications resulting from miscarriage and incomplete abortion (Ottolenghi, Riveros, & Blanding, 2007).

The COMMPAC Project in Kenya was a USAID/Washington global leadership activity undertaken to test and replicate the promising practices of Bolivia's C-PAC work. Kenya COMMPAC used the Bolivia experience with the community action cycle process and a local adaptation of the "three delays" framework to receiving safe motherhood and PAC services as organizing principles (Thaddeus & Maine, 1994). The three delays are:
1) Recognizing the problem
2) Deciding to seek care and reach the facility
3) Resolving the problem at the health facility

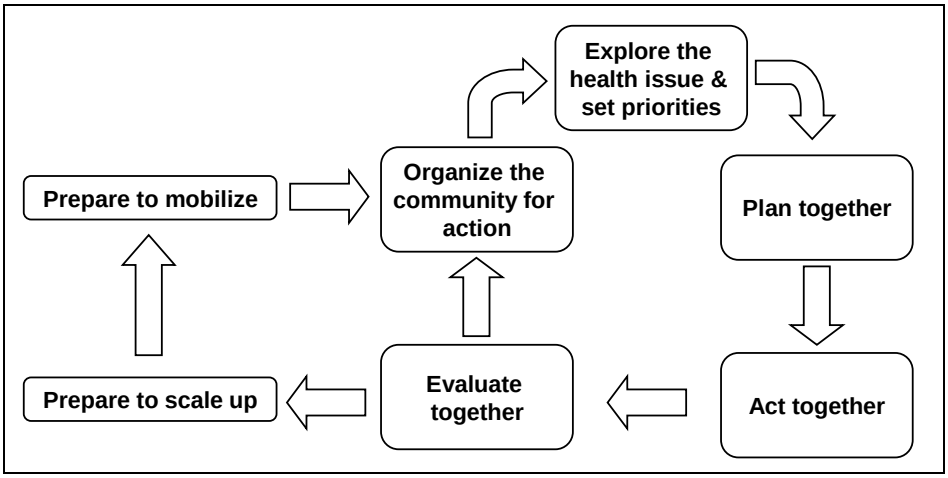
[3] Solo, J. et al. 2004. Postabortion care strategy developed by the U.S. Agency for International Development (USAID) Postabortion Care (PAC) Working Group. Washington, DC.

The community action cycle focuses on strengthening community members' abilities to identify, analyze, and address their most pressing needs—in this case, their reproductive health issues. Save the Children developed the process, which consists of the following:

> *….a core group of community members first identifies and explores health priorities and then leads a process of community-wide planning and action to achieve improvements and meet community needs. The core groups represent a cross-section of the community, including men, women, and youth. Monitoring and evaluation by the community ensures that they know whether the actions that they take are working and allows them to modify their approach when necessary. The emphasis of the CAC is on long-term development and sustainability of a process for addressing behavior change and problem solving by community members.*

A diagram of the community action cycle developed by Save the Children (Howard-Grabman & Snetro, 2003) is presented in Figure 1.

Figure 1. The Community Action Cycle



Prior to the beginning of the project activities, staff from the COMMPAC Project in Kenya visited the CATALYST project in Bolivia and had the opportunity to discuss implementation details, challenges, and lessons learned with the Bolivia team. The Bolivia community action cycle curriculum and facilitation guide were adapted and used by ACQUIRE for the Kenya COMMPAC project. Like Bolivia, the Kenya implementation followed a phased approach, yet that approach was strengthened. In Kenya, established local groups were used for implementation. Nakuru District, for example, already had organized groups that were addressing HIV and AIDS, orphans, and vulnerable children; faith-based organizations; labor unions; mothers' clubs; and men's groups. These Kenyan groups decided to simplify the action cycle slightly and created a four-stage community mobilization process that included: 1) exploration and prioritization of health issues; 2) preparation of community action plans; 3) implementation and follow-up; and 4) participatory evaluation.

This paper is a documentation of the community action cycle process as it was conducted in Kenya to increase community awareness and mobilization for PAC services. A total of $342,500 was spent for the COMMPAC Project between 2004 and 2007. This included $235,000 from USAID/Washington's PAC Working Group, $47,500 from global ACQUIRE funds, and the remainder from a cost-share from EngenderHealth/Kenya.

Desk Review Process

The ACQUIRE Project had planned to conduct an on-site evaluation of the COMMPAC Project in January-February 2008, through interviews with participants and stakeholders, visits to project sites, and review of relevant documents. However, a contested election in Kenya in December 2007 led to considerable violence and political conflict, with the project area of Nakuru being one of the areas most heavily affected. Staff from ACQUIRE partner SWAK indicated that the whereabouts of many of those in the COMMPAC Project were unknown. As of the drafting of this report, a ban on travel to Kenya was also still in effect. Given these conditions, yet recognizing the need of ACQUIRE to document its experiences before the global project ends, a desk review was conducted to address the study questions. These questions were adapted from those addressed by the Bolivia assessment (see Appendix 2), though some could not be answered thoroughly with a desk review.

The desk review consisted of a review of project reports including: COMMPAC quarterly reports; training curricula; presentations; and, materials from group discussions, including action plans (see Appendix 3). Other background documents include the USAID PAC Strategy and the World Health Organization (WHO) paper on empowerment and health improvements (Wallerstein, 2006).

This desk review will highlight what happened in Kenya in terms of project implementation and results. Work was focused on community empowerment to increase knowledge about the danger signs in pregnancy and the three delays; to shift attitudes and reduce stigma in PAC; and, ultimately, to increase use of PAC services.

It was not possible to interview those involved in the project as the project drew to a close. While this is a limitation for our conclusions, we still gleaned much information from written reports and from previous interaction with community members and SWAK staff in Kenya during the project implementation.

In reviewing the achievements of the Kenya COMMPAC experience, the desk review will correlate project achievements with the USAID PAC results framework and its intermediate results.

IR 1. PAC expanded and supported through service delivery
IR 2. PAC policy and advocacy supported and advanced
IR 3. PAC services expanded and supported through community empowerment via community awareness and mobilization.

Project Experiences

Overview of COMMPAC Project

Goals and Objectives

The COMMPAC Project had the following goal and objectives:

Project Goal: To increase awareness and utilization of PAC and related services in selected communities as a strategy to reduce maternal morbidity and mortality due to complications of incomplete abortion.

Project Objectives (the IR numbers in parenthases below correlate to the USAID PAC strategy):

Community mobilization

1. Complete a community mobilization process, including the development of action plans, aimed at the prevention of unsafe abortion, and support for treatment of pregnancy complications and complications from unsafe abortion or spontaneous abortions (miscarriages) offered through their own networks of community groups, including women, men, and youth representatives. (IR 3.5)
2. Increase the local capacity to address PAC-related needs such as the timely utilization of services and the strengthening of referral systems by doing an inventory of facility and provider names and locations where PAC, emergency obstetric care, FP, and other RH services are available, and disseminating this information within their communities. (IR 3.2)
3. Based on community interest and support, provide assistance in the development of sustainable community-based emergency transportation plans. (IR 3.3)
4. Explore the potential of developing payment schemes for PAC within a payment scheme for emergency obstetric care. (IR 3.1)

Education and information for improved awareness and stigma reduction

During the project, the groups were provided with:

1. FP-related information and education to prevent unintended pregnancy (IR3.4)
2. PAC-related information and education including danger signs, risk of HIV, and locations of services, with an emphasis on addressing the three delays—in identifying the problem, in decision making, and in taking action. (IR3.4)

The community mobilization sessions for PAC were organized to:

1. Encourage discussion in the community concerning the prevention of unplanned pregnancies and prompt care-seeking in the case of bleeding during pregnancy by pinpointing social obstacles to care (e.g., stigma) and ultimately reducing unsafe abortions and barriers to accessing services
2. Build awareness about FP in general, especially after an abortion, to ensure that men and women have the information to address their needs for spacing or limiting births, and to help them find a health facility or provider to assist them in their selection of a method
3. Build awareness about bleeding in the first half of pregnancy, reduce stigma, and, especially, link the community to health facilities that could offer antenatal care, emergency obstetric care, PAC, or referrals for these services
4. Address the three delays to accessing safe motherhood and PAC services.

Community mobilization sessions consisted of technical information related to FP and PAC and identification of problems and solutions oriented around the three delays that contribute to nonuse of maternal health services. Participants were assigned "homework" to go back to their communities to discuss the issues with several peers in the community and to collect additional information. These community meetings increased awareness among community members about the issues with PAC, as well as offered a way to bring in a broader range of perspectives to inform the groups' process.

The three delays framework was adapted in both Bolivia and Kenya to fit the local situations. The Bolivia training manual referred to the delays as: 1) delay in recognizing the problem; 2) delay in deciding to do something about the problem; and 3) delay in resolving the problem. The Kenya community members adapted this terminology using language that was more appropriate for them and their context: 1) delay in recognizing there is a problem; 2) delay in deciding to seek care; and 3) delay in receiving care.

Key Activities

As noted above, community mobilization activities were modeled on the community action cycle, which was developed by Save the Children and uses a participatory approach involving community diagnosis, planning together, implementation of plans, and participatory evaluation. ACQUIRE and its local partner, SWAK, provided community members in Nakuru District, Kenya, with the community action cycle tools and technical support needed to identify community problems and resources related to PAC and to develop their own action plans. This participatory approach was combined with the provision of essential and accurate information about the causes of maternal mortality, unwanted pregnancy, bleeding in pregnancy, and abortion/miscarriages.

Throughout the project, the Kenyan community groups implemented their 4 stage process. Communities learned about bleeding in pregnancy and post abortion care (stage 1); they made action plans including a mapping of local communities and resources (stage 2); they implemented activities, speaking with groups and local health and political authorities with confidence (stage 3). From the beginning, work was done to begin monitoring and documenting the communities' knowledge, attitudes, and practices in RH and PAC (stage 4).

Lessons learned by community members during mobilization sessions:

- Bleeding during pregnancy is not normal. It is dangerous and medical attention should be sought immediately.
- Women need annual check-ups to address complications before they get out of hand.
- FP is an issue that concerns both men and women.
- Solutions can come from within the community.

Social norms were addressed in meetings with community peer groups, and stigma was broken down through outreach to community leaders and the general community. Even when funding constraints led to a break in activities, local community groups and specific individuals became champions of the COMMPAC cause. They continued to talk about PAC with peers; pushed their local governments to assist them in improving access to services; and looked for additional resources to implement action plans (Stage 3). When the project resumed several months later, the project designers took these achievements into account in implementing stages 3 and 4. After reconnecting with the local communities, project designers decided to continue work with the original groups to support their Stage 3 work, as well as to expand to new geographical areas within the district to begin replicating COMMPAC project stages.

An important component of the USAID PAC strategy is the recognition that PAC services can be expanded and supported with community awareness and participation. Stakeholder meetings

emerged as an important component both at the project's start-up and during its implementation. Stakeholders differed slightly in each locale, but overall, they consisted of chiefs, religious leaders, district council members, and even Members of Parliament (MPs). Project staff and reports emphasized the importance of stakeholder involvement. They recommended that stakeholders' meetings should be a continuous process rather than a one-off activity, thus ensuring continuous support from providers, community leaders, and other leaders who cannot all be assembled in a single start-up meeting.

Timeline

COMMPAC was undertaken in two funding phases: 1) from July 2005 until September 2006, which involved 16 focus groups and a total of 412 individuals in Nakuru District; and 2) from February 2007 through December 2007, which expanded to 10 additional groups consisting of 368 people in Nakuru District. By the end of the project, a total of 26 community groups had made 26 action plans involving an estimated 780 individuals in COMMPAC.

Funding Phase 1: July 2005–September 2006

Initially, a total of 16 groups participated in the COMMPAC Project. For purposes of rapid start-up, and in view of the relatively limited time period for project implementation, it was a strategic decision for the project to target groups that were already organized and active. These included groups of: youth (four groups), men (two groups), women (seven groups), and both sexes (three groups), which were engaged in different activities, such as planting trees, selling charcoal, educating their peers, and creating awareness on HIV and AIDS. These groups were located in five divisions of Nakuru: Municipality, Njoro, Lanet, Bahati, and Rongai. Sixteen community mobilization sessions took place for two days each for a total of 32 meetings, beginning in November 2005 and finishing by February 2006. Each group identified one member to serve as their representative at the core group, which held monthly meetings to introduce reproductive health issues, the concept of bleeding in pregnancy, to plan visits to community health centers; to assign "homework"; and, to check in on overall progress. By the end of the sessions, a total of 412 community members had participated in community engagement for PAC activities, with between 22 and 25 members attending each session.

Using the three-delays model mentioned earlier, the groups were able to identify, classify, and set priorities for problems related to PAC, based on their new knowledge and experience. Communities then came up with solutions to the problems presented, focusing on what could be done at the local level. Generally, all groups identified similar problems and came up with similar solutions. Some of the problems identified included: insufficient knowledge of RH and FP issues; poverty leading to inability to afford medical attention; and, inadequate local health facilities, drugs, and personnel.

Table 1: Selected problems identified, by type of delay

Delay	Problem identified
Delay in recognizing there is a problem	♦ Lack of knowledge about PAC services ♦ Men's lack of interest and involvement in RH and FP
Delay in deciding to seek care	♦ Lack of transportation to the health facility ♦ Poor road network to get to facilities
Delay in receiving care	♦ Poor attitudes of health providers ♦ Lack of supplies and trained providers at facilities

Project staff undertook a number of activities to review the progress and lessons learned at different times in the process, including a study to determine the knowledge, attitudes, and practices of people concerning PAC. This study included a questionnaire and focus group discussions. In

addition, health facility service statistics for a subset of sites, collected by the ACQUIRE Project, shed light on the impact of COMMPAC. SWAK and ACQUIRE staff noted that PAC services were not always available in the public sector due to staff shortages, and that the private midwives who were trained and available might be beyond clients' ability to pay.

A) KAP survey: A knowledge, attitudes, and practices (KAP) survey was conducted with members of the community groups, with the pretest occurring during Stage 1 of the community mobilization sessions and the posttest administered during Stage 2 (i.e., in November 2005 and February 2006). Fourteen of the 16 groups were included; these were made up of seven women's groups, one men's group, two mixed groups, and four youth groups. A total of 285 respondents drawn from the various groups took part in the pretest, and 218 took part in the posttest. More than 60% of the KAP survey respondents were female.

The findings showed important changes in attitudes and knowledge. For example, prior to the community mobilization sessions, approximately 75% of the participants recognized that FP should be the responsibility of both male and female partners. The posttest results revealed that approximately 86% of women now thought that family size was a joint decision between husband and wife. In addition, recognition of five of the seven warning signs related to complications of miscarriage or unsafe abortion increased significantly following the community mobilization sessions.

B) Focus group discussions: Focus group discussions were carried out on June 6 and 7, 2006, at the project sites in Nakuru. To get honest and objective feedback, the focus group discussions were conducted by a team of four SWAK staff from the National Secretariat who had not been part of the project. The main objectives were to obtain general reactions to the project, explore the effects of the project, and gauge the level of leadership and participation in the project. The team conducted eight focus group discussions with a total of 73 participants. The groups included: one men's group (urban); two women's groups (one rural, one urban); one mixed-sex group (rural); two youth groups (one rural, one urban); and two core groups.

Through the focus group discussions, as well as through informal discussions throughout the project period, SWAK and ACQUIRE staff observed a change in attitude regarding individual and community responsibility to take action. In the beginning, the groups wanted SWAK to find funds for them, but SWAK continually challenged the participants to look within their own communities. As the groups gained success in accessing government funds, they also began to raise funds within their communities for emergency transportation (16 emergency transport plans were developed), as well as for transportation for providers to come to communities to speak about PAC and FP. An important result of all this work was that collaboration between community members, community leaders, and other stakeholders raised awareness about Community Development Funds[4] (CDF), which were not originally known to the community groups.

Funding Phase 2: February 2007–December 2007

Funding phase 2 of COMMPAC focused on helping the first groups implement their action plans and form 10 new groups in new locations within the original five divisions. Five original champions helped SWAK facilitate the community action cycle process with the new groups. The mentorship and role modeling of experienced COMMPAC groups with newer groups was an important aspect of the project, especially for solidifying champions and attempting longer term sustainability.

[4] These are government funds that are devolved to the local level, where decisions on their use are made by local authorities.

A one-day meeting was held on July 20, 2007, in Nakuru for 73 local groups in the new locations. This meeting was useful for telling a larger constituency about COMMPAC, yet funding levels could only accommodate relatively limited participation. Ten groups were chosen to be added to the COMMPAC project in the second funding phase, along with the original groups. The new groups included four women's groups, three mixed-sex groups, one youth group, one widows' group, and one group of disabled people.

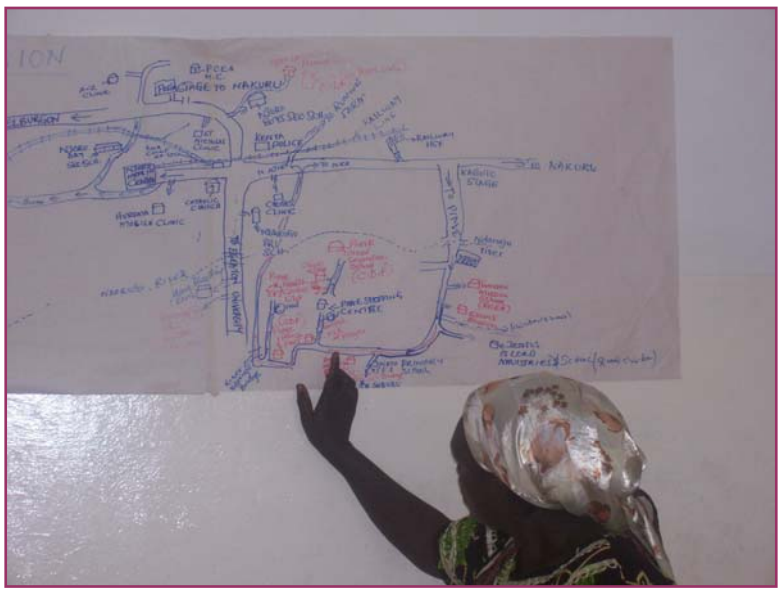
After the groups were selected, each chose leaders who had not been a leader before. Twenty people participated in the first workshop, which served as an orientation to the community action cycle process. The five champions also co-facilitated, getting on-the-job training as facilitators.

On the supply side, ACQUIRE, working with EngenderHealth/Kenya and the Ministry of Health (MOH), conducted medical site visits to 14 locations in June 2007. Based on findings from the visits, the ACQUIRE Project, EngenderHealth/Kenya, and the MOH developed a training plan for COMMPAC providers and conducted the training in December. Using both outside funds from EngenderHealth (from The William and Flora Hewlett Foundation) and working with funding from USAID's AIDS, Population, and Health Integrated Assistance Program (APHIA II) project, COMMPAC area providers were trained in PAC. Outside donor funds supplied equipment and expendable supplies for COMMPAC area sites where providers were trained in PAC techniques and services.

Implementation of Action Plans

The SWAK team and ACQUIRE staff reviewed the community action plans with community groups in a meeting held in February 2007. The 16 core group members separated into five groups representing each division, and then worked together to review resource maps developed earlier in the project. This involved reviewing local resources (roads, health facilities, bridges, religious institutions, police stations, community-based organizations, nongovernmental organizations [NGOs], and local partnerships) found in their community. They noted all new facilities and partnerships that had come up since the last time they met (September 2006) and mapped resources by marking them in red.

Figure 2: A core group member from Njoro presents its resource map



The resource maps were presented to the larger group, and out of this exercise, the core group members were surprised at how many new or improved local resources were available to them. Having new or improved resources brought about by community action made them realize how empowered they could be and how they could tackle their own community problems with available resources. Specific accomplishments of each division are noted below.

Njoro Division (Population 99,988)

The Njoro location is a model for other COMMPAC areas. Through the leadership of key health care providers and the Piave Women's Group, partnerships between government, volunteer agencies, and community members were solidified. As a result, a dispensary, housing for staff, roads, a bridge, and a maternity facility were built or repaired. A new police post was built as well, and now police escorts are available for women needing assistance getting to health facilities at night. In addition, mechanisms were put in place to purchase manual vacuum aspiration (MVA)[5] kits and PAC supplies. Stockouts of the injectable contraceptive Depo-Provera were also a problem. The solution to the problem was that providers in Njoro purchased commodities and sold them to women at cost. The community and providers actively collaborated and cooperated to reach solutions. The funds and labor from a Canadian NGO to build the maternity facility were leveraged through the efforts of the collaboration between the community and government providers.

Figure 3: Photo of a new dispensary built using CDF funds

Perpetua (SWAK), Esther (group leader), Caleb (doctor), and Esther (SWAK)

Bahati Division (Population 181,611)

After the community groups spoke with health workers, one health practitioner raised her own funds and paid for her own training at the provincial hospital. The group worked with the nurse to set aside a PAC room in her facility. The groups in Bahati also worked together to ensure that women have escorts and advocates to accompany them to PAC services. Partial funding was received from the government to build a maternity facility. The community groups continue to advocate for the completion of this building.

[5] MVA, which is recommended for PAC procedures, is the safest, most appropriate technology for lower level facilities.

Municipality Division (Population 292,246)

Nine health facilities now have PAC-trained personnel, while prior to COMMPAC none did. A road was improved and a bridge constructed to improve access to health facilities, all using CDF funds. In addition, police posts were developed along routes to health facilities so that women could travel safely at night; previously, women reported that they were either harassed or attacked along these routes.

Lanet Division (part of Municipality)

A maternity hospital was built that offers maternal and child health services. Community groups conducted education programs at nine local schools to talk about the importance of preventing unwanted pregnancies.

Rongai Division (Population 97,860)

The community groups got together and rehabilitated an abandoned house for a health provider, to ensure his presence in the community. They were also able to advocate for CDF funds to be used to construct a new dispensary. Hours at a health facility were increased from 10AM–1PM to 8AM–6PM. Finally, the community groups were able to advocate for the transfer of two providers, one who had treated clients badly and the other who had been absent from work on many occasions.

As noted above, COMMPAC achieved a number of impressive accomplishments often going beyond the initial objectives of the project. Table 2 shows what was accomplished in each geographical area.

Table 2: Summary of accomplishments by community groups

Activity	Accomplishment	Community groups involved
Construction of new health facilities	4 new facilities were constructed	Bahati, Njoro, Rongai, Lanet
Renovation of old facilities	2 old facilities were renovated	Rongai, Lanet
Expansion of existing facilities	6 existing facilities were expanded to include maternity and PAC services	All
Community outreach by group members	15 community forums reaching approximately 2,195 community members	All
Education outreach to schools	Outreach to 10 schools reaching approximately 1,500 pupils in standards 6–8	All
Construction of police posts	2 police posts were constructed to improve security	Njoro, Municipality
Accessing CDF funds for health purposes	Facilities built and rehabilitated, 5 roads and 1 bridge built	Njoro, Municipality
Relationships built with health providers	Trainings of community people in PAC knowledge, gloves given, kits bought through facility fees, PAC patients do not wait in queues	All

The COMMPAC Project achieved many things that they set out to do as a project. In addition, COMMPAC achieved many of the results that are outlined in the USAID PAC strategy. Table 3 matches project objectives, achievements and USAID PAC results. Limited resources and the pilot design (which was not set up as an operations research project) limit our ability to assess behavior changes in the broader community; however, we do see changes in knowledge and/or behavior in the group members themselves. We do know that the community groups conducted a number of outreach sessions that reached over 3,600 members of the wider community (youth in school and general community membership), so changes in awareness in the project area likely occurred.

Table 3: Achievement of project objectives

Project Objectives	Project Achievements	USAID PAC Strategy IR 3 Indicators and subresults 3.1–3.5 (see subresult definitions at bottom of table)*
1. Complete a community mobilization process, with action plans for PAC via networks of community groups, including women, men, and youth representatives	16 community groups completed the community action cycle twice 10 community groups completed the community action cycle once 26 action plans developed 26 community groups consisting of an estimated 780 individuals were meaningfully involved in COMMPAC	3.5: Number of PAC programs that meaningfully involve members of vulnerable or underserved populations in the design of programs
	Proportion of activities in action plan implemented: Proportion not known but most activities were ongoing or were completed in all groups	3.5: Number of PAC programs that meaningfully involve members of vulnerable or underserved populatins in the design of programs.
	Payment schemes developed: Begun but full number not known. Referral books reportedly printed and distributed from MOH.	3.3: Number of communities with established referral systems between the community and primary, secondary and teriary resources for PAC
2. Build awareness about FP and PAC to address their needs and to help them find a health facility or provider to assist them in their selection of a FP method	KAP showed increase from 75% to 86% of couples thinking FP is a joint decision	
	4 new facilities constructed in 4 divisions (Bahati, Njoro, Rongai, Lanet)	3.1: Number of NGO/faith-based or community-based organizations providing PAC services
	2 old facilities renovated in 2 divisions (Rongai, Lanet)	3.1: Number of NGO/faith-based or community-based organizations providing PAC services
	6 existing facilities expanded to include PAC and maternity services (Bahati, Njoro, Rongai, Lanet and Municipality Divisions)	3.1: Number of NGO/faith-based or community-based organizations providing PAC services
	16 emergency transport plans developed Constructed 2 police posts to improve security in 2 Divisions (Njoro, Municipality)	3.3: Number of communities that have an established transport plan for obstetric emergencies
	Accessed CDF funds to build and rehab facilities; used CDF fund to build 5 roads and 1 bridge in 2 divisions (Njoro, Municipality)	3.3: Number of communities that have an established transport plan for obstetric emergencies
	5 training sessions by health providers to community members in PAC/FP (Bahati, Njoro, Rongai, Lanet and Municipality Divisions)	1.1 Percent of clients served by PAC programs who are members of vulnerable or underserved populations
	Increase in FP visits at 22 health facilities from 2005 to 2006: ♦ New users: from 2,034 to 4,362 ♦ Continuing users: from 8,565 to 13,807	1.1 Percent of clients served by PAC programs who are members of vulnerable or underserved populations

Table 3: Achievement of project objectives (*cont.*)

Project Objectives	Project Achievements	USAID PAC Strategy IR 3 Indicators and subresults 3.1–3.5 (see subresult definitions at bottom of table)*
3. Build awareness about bleeding in the first half of pregnancy, reduce stigma and link community to health facilities or referrals for services.	KAP: knowledge of bleeding in pregnancy as a danger sign increased from 67% to 91%	3.4: Percentage of men and women aged 15–49 who can cite one danger sign of an obstetric emergency
	Assesement of 14 facilities found to be lacking in PAC services	1.3: Percent of service delivery points providing PAC services that meet a defined standard of quality care.
	12 service providers trained in PAC by ACQUIRE	
	15 community forums done by community members reaching approximately 2,195 community members	3.4: Percentage of men and women aged 15–49 who can cite one danger sign of an obstetric emergency
	Outreach to 10 schools reaching approximately 1500 pupils between Standard Form 6–8 (youth)	3.4: Percentage of men and women aged 15–49 who can cite one danger sign of an obstetric emergency

* I.R. 3 PAC Services expanded and supported via community empowerment and mobilization

3.1	Number of networks or coalitions providing PAC services formed by nongovernmental organizations (NGOs)/faith-based organizations (FBOs)/community-based organizations (CBOs)
3.2	Number of communities with established referral systems between the community and primary, secondary, and tertiary resources for PAC
3.3	Number of communities that have an established transport plan for obstetric emergencies
3.4	Percentage of men and women aged 15–49 who can cite one danger sign of an obstetric emergency
3.5	Number of PAC programs that meaningfully involve members of vulnerable or underserved populations in the design of programs.

Collection of Statistics on Health Service Use

MOH service statistics reports for the districts were reviewed to assess FP use in the area. The baseline was January–December 2005 compared with January–December 2006. The numbers of both new and continuing FP clients increased at the 22 health facilities in the project area during this time. The number of new users more than doubled, from 2,034 in 2005 to 4,362 in 2006, while the number of continuing users increased from 8,565 in 2005 to 13,807 in 2006. Community mobilization activities began in September 2005 and continued periodically in all project areas through 2007. Although the increase in FP users cannot be attributed solely to the COMMPAC Project, it does indicate that there was an impact in the broader community.

Comments on the Community Mobilization Process

Involvement and responsibility. Core group members were impressed with the fact that they, as community members and representatives, were asked to be fully involved in the planning of the schedules and that they were given the responsibility to be co-facilitators of the process. In response to the question "Who planned the schedule of the different group sessions and how did they do this?" core group members responded that the first meeting was organized by core group members but that subsequent meetings were planned by community members. Core group members liked the bottom-up approach taken in this project, whereby the information, reflection, and priorities were

drawn from the community members at the grassroots level, rather than from the regional and national levels.[6]

Men and women often see things differently—programs need to involve both

When the community mobilization sessions were conducted with men, they tended to blame not seeking health care on their wives (as this is something that is traditionally the woman's domain).

Many women on the other hand blamed their partners, saying that men do not want them to use FP.

Timing issues. Both the facilitators and the community participants felt that the 3–4 hours allocated for each session, which were suggested by the Bolivia project, were inadequate. They identified two options to address this problem: either doing the community mobilization for PAC in more than the total of four designated sessions, or having the groups commit to attending sessions that lasted much of the day, as opposed to half days. The full-day session was selected since it worked best in Kenya.

Importance of involving men. The sessions involved about 124 men overall. The sessions were an eye-opener for all of the participants, especially for the male participants themselves, who were involved for the first time in an issue that was previously viewed as a women's domain. The participants were intrigued by the fact that both men and women need and use FP and RH services. The issues of maternal health and FP were very relevant to the participants' lives, and women and youth were also happy to participate in the forums—to have their voices heard and to hear what men thought about these important RH/FP issues.[7]

Relative difficulty of working in urban areas. In Kenya, groups in rural areas tended to be easier to work with than groups in urban areas. Challenges identified with working in urban areas included:

- Although urban groups have more exposure to RH and therefore are engaged in more discussions, they are also more likely to hold misconceptions and disseminate incorrect information.
- It is difficult to organize community forums because there are so many different subsets of communities in urban areas.
- The misconception that NGOs have a lot of money led urban communities to expect to get paid for their participation.
- Community leaders politicized the issue of community mobilization in urban areas, which supports the need to have regular stakeholder meetings to ensure a common understanding and to clarify goals and resources.[8]

Group dynamics. There were differences in group members' ability to grasp and express issues. For example, the youth groups had more facility with communication than the women's groups. There were varied levels of comfort in discussing RH and FP issues between all the groups. Because levels of education, exposure to these issues, and social standing also varied widely, certain group members took more of the lead in discussions and contributed and participated more than others. One suggestion to remedy this problem is to assess group membership and social dynamics prior to working with a group, or to use a strategy of small working groups.[9]

[6] As noted by ACQUIRE staff in trip reports.
[7] As noted by ACQUIRE staff in trip reports.
[8] SWAK, "Project Experiences and Lessons Learned." July 2007 report
[9] SWAK, "Project Experiences and Lessons Learned." July 2007 report

Postabortion Care Services

Nakuru District was chosen for a variety of reasons. Among them was the fact that SWAK worked there already and that there were providers present in the district. As noted earlier, at the time that the project was designed, there were private nurse-midwives and numerous public providers who were newly trained in PAC services. However, during the implementation of the COMMPAC Project, community members noted that most of the COMMPAC clientele could not afford to pay for PAC or FP services through private-sector providers, and that some of the public-sector providers had been relocated.

As the project unfolded, the community had numerous opportunities to meet with health facility personnel and management. Community members voiced their concern that public-sector PAC personnel had recently been transferred out of their district and that services were hard to reach. The communities looked for guidance from SWAK, ACQUIRE, and, most importantly, their districts to see how to meet their PAC needs. [10]

As a result of the communities' demands, PAC services were located closer to the communities and requests for PAC provider training were granted. MOH officials requested that ACQUIRE/Nairobi staff conduct medical site assessments in June 2007 at 14 health facilities. The assessments showed significant gaps in trained staff and equipment; only three facilities were providing PAC services and only two of these offered FP as part of PAC services.[11] Following these site visits, ACQUIRE obtained funding from the Hewlett Foundation to conduct PAC training with 12 providers in December 2007. After this two-week training, each provider also received one MVA kit from private sources.

Community–Health Provider Linkages

The COMMPAC Project led to the building of actual bridges. Just as important, project activities helped to bridge the gap between communities and the health system. The COMMPAC activities highlight the importance of Component 3 of the USAID PAC strategy: *PAC services expanded and supported through community empowerment via community awareness and mobilization.* An important step in making the project successful was the Health Provider Linkages meeting, which was held on May 9, 2006. The meeting had three main objectives:

1. Introduce the COMMPAC Project to service providers working in health facilities across the five divisions included in the project
2. Provide a contraceptive technology update and PAC update to health service providers in the project sites, to better address the FP/PAC needs of the community
3. Initiate new working relationships between the COMMPAC participant groups and health providers in their divisions.

The linkages meeting between community members and health care providers allowed for an airing of perceived problems, more dialogue, and forward planning. The community discussed the lack of quality services and the failure of providers to arrive at work on time. Providers described such challenges as: lack of equipment and staff; clients' not paying fees; the high cost of MVA kits; and the lack of linkages between the health providers and the community. SWAK staff did an excellent job of facilitating the meeting by ensuring that all parties had an opportunity to speak and explain

[10] As reported by ACQUIRE staff trip reports

[11] One of these two was the Provincial General Hospital. This was the only facility with good records on PAC and FP: Of 284 PAC clients, one-third (96) were discharged with an FP method. FP methods are offered on the ward before the client is discharged.

their issues. The meeting increased awareness of the challenges facing both providers and the community and helped the group move past complaints to concrete actions to improve the situation.

Both parties expressed a good deal of enthusiasm about creating stronger linkages. The health providers and the core group members were happy that an opportunity had been created for them to link up. As an outcome of the meeting, the health providers and core group members made a commitment to work together in addressing PAC, RH, and FP issues in their respective areas. They came up with a workplan for each project division, and agreed on roles for both health providers and core group members (Table 4).

Table 4: Roles for health providers and community core group members to strengthen linkages

Roles of health providers	Roles of core group members
♦ Give information and knowledge on PAC to the community to help them identify the three delays ♦ Act fast when PAC clients are brought to the health facility ♦ Address the community's needs with positive attitudes and avoid misdiagnosing cases of bleeding	♦ Mobilize members of the community to receive information on PAC from health providers ♦ Sensitize the communities to take full responsibility for members and avoid abandoning bleeding PAC patients in the health facility ♦ Make the community aware that not all health workers are trained in PAC services ♦ Act as mediators between health facility management and community members whenever misunderstandings arise between community members and health workers

The experience was a powerful lesson for communities in how to build partnerships with key stakeholders and advocate for resources to improve services, even in the absence of PAC services and trained providers. Similarly, health providers saw that they could take an active role in working with community groups to address the PAC issues that were identified; that role sometimes included visiting the community, with the providers' transportation costs being paid for by the community.

Importance of Leadership

Champions

One important indicator of successful community mobilization efforts is the development and strengthening of champions. What are champions? During the ACQUIRE COMMPAC training on "Using Storytelling for Advocacy," the ACQUIRE trainer modified the dictionary definition of champions to mean "*individuals or organizations who are willing to take calculated risks, and, as leaders, act as catalysts for collaborative actions, beyond their job descriptions.*" COMMPAC produced many champions for PAC who may have never been champions without this experience. SWAK and the communities used their stories for local advocacy purposes via the SWAK newsletter that focused on the COMMPAC Project and highlighted the stories of four champions. Excerpts from these champion stories are presented in Appendix 5, highlighting COMMPAC experiences in the voices of a young person, two women and a man from Nakuru.

Stakeholder Engagement

The community leaders and community participants assured the project of their support in achieving the project goals and in fostering community ownership. Many stakeholders attended community

mobilization sessions to encourage the participating groups. The involvement of different stakeholders during stakeholder meetings contributed to the success of the COMMPAC Project. All of the stakeholders had a sense of belonging to the project and therefore were able to work together. The community mobilization sessions received support from the local administration and religious leaders, including three area MPs, three area chiefs, the district councilor, and seven church pastors. For example, as noted in the champion story about Shadrack Ngeno (Appendix 5), this young man got the attention of his Member of Parliament to assist his locale to get CDF funds to support PAC. Another example is the Chief from Rongai Division who attended the third session of Stage 1 of the community mobilization process in the Ushindi Women's Group. He inspired and encouraged the group members to volunteer their time to complete the project. He noted the importance of RH services and stated that the project had come at the right time, as there were many unplanned pregnancies and unsafe abortions among young girls in the area.

Other stakeholder meetings doubled as training opportunities for group members. Some meetings were led by the more experienced community groups, who presented their activities and achievements to the newer groups. The participants said that this meeting was very effective, since testimonies from the champions, health committee representatives, and health workers were a great encouragement to the newer stakeholders.[12]

Adapting the Bolivia Experience

While a team was able to conduct an evaluation in Bolivia, which included interviews and site visits, because of unrest in Kenya at the time, the Kenya review is a documentation of experiences. A consideration of both projects shows some interesting differences between the two and how adaptation of project design is critical during the replication process.

While COMMPAC replicated much of the Bolivia PAC program model, modifications were made based on lessons learned from Bolivia and specifics were adapted to the Kenya context. One such modification included increased stakeholder involvement in the beginning of the program in Kenya, since stakeholder involvement proved to have been too limited in Bolivia. The half-day sessions in Bolivia were increased to day-long sessions in Kenya. Because HIV prevalence is high in Kenya, SWAK incorporated HIV issues into the COMMPAC work, while the Bolivia model did not address HIV.[13]

The ability to pay for services has been a significant challenge to adapting the Bolivia model. In Bolivia, national health insurance is available to cover the costs associated with PAC services. This is not the case in Kenya. Public providers often charge additional fees (e.g., for registration and supplies), and the inability of most community members to afford PAC services from private providers was a major constraint to improving access. Perhaps as a result, there were more efforts in Kenya to get community groups to find their own resources to implement activities, thereby leading to a hopefully more sustainable model.

Both projects saw the importance of linking facilities, providers, and communities. In Kenya, meetings were held to specifically address the needs of communities and health providers. (This was also done in Bolivia.) These meetings were extremely productive and led to tangible and impressive results in terms of improving services.

[12] As noted in ACQUIRE trip reports.

[13] This was, in part, due to many community groups in Kenya already being involved in issues around HIV, as well as to Kenya's having a higher HIV prevalence than Bolivia.

Conclusions

The Kenya COMMPAC Project, as implemented by ACQUIRE and SWAK, certainly highlights how the USAID PAC strategy can be put into action. The following conclusions and recommendations are useful for those who want to know more details about strategies for community engagement and, more specifically, for people interested in advancing community RH and PAC.

Communities Can Be Powerful Partners in Postabortion Care

As communities become mobilized and involved, they can play an increasingly larger role in the allocation of budgets and human resources, and ultimately have more access to quality health services. Developing leaders and champions who were not in those positions before was important. Identifying new representatives from each of the participating community groups energized the groups and helped develop a depth of skills in organizing, planning, and budgeting.

The mentorship and role modeling of experienced COMMPAC groups with newer groups was an important aspect of the project, especially for solidifying champions and attempting longer term sustainability. Having core group leaders take part in the actual facilitation of the community mobilization sessions also emerged as important. There is an advantage to working with community members as co-facilitators because they often understand the local dialect. Many community members cannot express themselves in the national languages, so this contribution from community partners can be very valuable.

Community mobilization had a substantial impact on the local environment and on health service delivery. Communities were engaged, and resources were found at the local level to implement activities that the communities decided were important to them. The following achievements were completed with local resources:

- Human resource and infrastructure improvements (building of health facilities and dormitories for staff[14]); increased retention of health personnel; and repair of two bridges and five roads
- Development of community champions for RH and PAC, including both men and women—and youth[15]
- Strengthened partnerships between communities and health facilities, leading to improved quality of care and resources
- A more than doubling of new FP users, from 2,034 in 2005 to 4,362 in 2006, with a concurrent increase in continuing users, from 8,565 in 2005 to 13,807 in 2006.

Lessons for Replication

Methodologies must be adapted to the local context, and resources and time for this adaptation need to be factored into replication projects. This was an important lesson learned from the implementation of the Kenya COMMPAC Project. Overall, the replication from Bolivia to

[14] Four new health facilities built, two health posts renovated, and six health facilities expanded for PAC.
[15] PAC champions conducted 15 community forums reaching 2,195 community members and 1500 students.

Kenya—with different health systems, community organizations, and political situations—required some tweaking of the approach.

There is a need to look holistically at both supply and demand. Even a project that is focused on community action needs to pay attention to supply, and this should happen at the beginning of a project and continue throughout with site assessments to identify availability and gaps in services. As levels of awareness increase, service availability may be unable to handle the increase in demand meaning that a supply-side intervention would also be necessary. A similar problem was found in the Bolivia project: "A noted project shortcoming is that women who have hemorrhage in pregnancy are instructed to seek care at their nearest health center, but clinical emergency treatment is not available at these sites" (Ottolenghi et al., 2007).

The community action cycle is just one tool for engaging communities in dialogue about their needs for health care. Although it is very effective, it can also be a long, intensive process. The community action cycle process should be used when it is the best choice for addressing a problem and there is local capacity to use it with minimal outside assistance. Whether a program uses this process will depend on project goals and timelines; it is most appropriate as a methodology to empower people, not necessarily to quickly increase the numbers of people utilizing health services.

Funding for a process like the community action cycle must cover an adequate period of time for preparation, going through the cycle, and implementing action plans. The need to apply for additional funding led to a hiatus in Kenya, which then meant there was inadequate time to work with the newer community groups. Although activities did take place during the gap and local resources were found, it is obviously preferable to have steady support for full implementation.

The stakeholder and linkages meetings were catalysts for improved relationships between the community groups and providers, and these types of meetings should be encouraged in all PAC programs. All of the core group leaders mentioned that providers in their areas now work as partners.

Monitoring and evaluation processes need to be built in from the beginning to document and understand the process and impact of community PAC work. Plans for baseline and endline assessments should be incorporated into the projects. These assessment mechanisms should consist of 1) a community survey to gauge the impact on knowledge, behavior, and community norms beyond just the community group members; and 2) a health facility assessment to see changes in service utilization and quality.

Monitoring should include a wide range of indicators to capture key activities. The following activities should be monitored: 1) outreach sessions; 2) meetings with health providers and communities; 3) examples of accessing local resources as an indicator of mobilization; and 4) stories of the development of champions. Documentation of program inputs is an important component for replication, including an explanation of the type of staff, level of effort, and details of the implementation process needed to launch this important endeavor.

What Next for COMMPAC?

The sustainability of projects is often affected by factors beyond our control. The postelection conflict in Kenya has, of course, disrupted COMMPAC activities. There is only limited information about the extent of the conflict's impact on the communities involved in the project, although we

know that many people have been displaced and have suffered injuries or worse. Many of the health care providers have been transferred, and some are now working with the internally displaced population in the country, which is estimated to reach 500,000.

SWAK representative, Mercy Wahome, attended the Global Health Conference in May 2008. She reported that COMMPAC groups continued to work together after the postelection conflict and displacement of people. COMMPAC groups visit internally displaced refugee camps to discuss bleeding in pregnancy and family planning, and some members have escorted women for PAC services. Family planning services are being arranged in the camps as well. Rongai initiated mobile family planning clinics to make up for lack of access to the services in town. Overall, while some services are available, they are limited since many providers were displaced or transferred. Ms. Wahome reported that the community groups remain strong and continue to implement their action plans with support from each other. As peace and stability return to Kenya, it would be interesting to conduct interviews with community groups and see if they are still working together and if they have been able to apply the skills acquired through COMMPAC over the longer term to address the current problems faced by their communities.

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Appendix 1: COMMPAC Project Timeline

Dates	Activity
2005	
March 28–April 8	Trip to Bolivia by ACQUIRE and SWAK staff
June	COMMPAC proposal authorized by USAID
July	Project begins
July	Subagreement signed by SWAK
July 18–22 and August 1–3	Orientation and training of six project staff
August 17	Workshop held with 20 stakeholders: participants included the Ministry of Health (MOH), private heath providers, religious leaders, and local chiefs
October 7	Core group meeting to identify community groups
October 17–19	Core group orientation to community mobilization sessions
October 31–November 3	Training of four core group members as co-facilitators
November 24	Community mobilization sessions begin with seven groups
December 22	Core group meeting
2006	
January–February	Community mobilization sessions with nine more groups (Stage 1)
February 3	Core group meeting
March 1	Core group meeting
March 6	Second stage of community mobilization sessions began—action plans developed
April 5	Community Action Plans submitted (only three met deadline)
April 27	Staff meeting to identify lessons learned
May 9	Health facility providers linkages meeting with 23 health providers
June 6–7	Focus group discussions conducted in project sites
June	Completion of analysis of Knowledge, Attitudes, and Practices (KAP) data
August 1–September 30	No-cost extension (initially scheduled to end July 18)
September	Project funding phase ends
September 20	Follow-on planning meeting
December 15	USAID approves SWAK subagreement for additional funding and activities
2007	
January 1	Second funing phase begins
February 9	Planning meeting
February 12–13	Evaluation of community action plans
March 26–30	Review of action plans for the five locations
May 3	Stakeholder meeting
May 8-11, 15	Evaluation of action plans
June 4-8	Follow-up medical site visits to14 health facilities
July 20	One-day meeting in Nakuru to select 10 additional groups
September 23–26	Training in using stories as advocacy tools
December 3–14	EngenderHealth sponsors training of two providers in PAC
December 31	Project ends

Appendix 2: Study Questions

Program inputs

1. What inputs did ACQUIRE make to increase staff capacity to support COMMPAC, including facilitation of the process? What resources were tapped?
2. How and where were postabortion care (PAC) services provided at the beginning of the project, in terms of training, equipment, trained providers (both public and private) and any communications and information, education, and communication (IEC) materials? What was the situation of community engagement before the project? What inputs were made during the project to address the gaps in these areas?

Planning and management of the activity

3. How did the activities completed by the project compare with what was stated in the overall and specific objectives of the program? Identify the objectives that were not met and indicate why the objective could not be met.
4. What were the roles of the different partners (e.g., chiefs, local government health advisory committees, government representatives and community groups) involved in COMMPAC?
5. How did the organization, management, and finances influence the accomplishment of the project? Has the investment of CORE funds paid off in terms of global learning? Was the budget sufficient to complete the planned activities and obtain the results? Was the investment on behalf of USAID worthwhile? What were the challenges of working through a local NGO (SWAK)?
6. What has been the added value of the financial support and technical assistance provided by ACQUIRE and USAID/Washington's Postabortion Care Working Group on postabortion care community mobilization in Kenya?

Overall results of the interventions

7. When the community groups developed their action plans, what were the causes for, needs and interventions identified to address the complications of unsafe abortion, unintended pregnancy, miscarriage, and family planning?
8. How has the project strengthened the local capacity of communities and providers for addressing the health needs and barriers to services associated with unintended pregnancy and the treatment of complications related to miscarriage and incomplete abortion?
9. What types and amounts of resources did the community groups in the program leverage?
10. Identify how this program has increased the community's knowledge of family planning and PAC services and their access to them, if at all. Review the PAC results framework and indicators.
11. What were the key results of COMMPAC? [Consider changes at the individual (increased advocacy or awareness), structural (e.g., new and improved facilities, roads and access) and social levels (e.g., policies, community, and government involvement).] How did the project activities influence the delivery of family planning and PAC services at the community health centers, private establishments or other facilities identified by the communities? (Consider activities across a range of themes, for example, mentoring, networking, advocacy,

empowerment, and innovations.) Describe the level to which services were integrated, if at all. Also, identify referral mechanisms, any barriers, and how the community and providers addressed these.

12. How has the current political conflict in Nakuru affected the work carried out through COMMPAC?

Added value of the community action cycle

13. What were the barriers identified through the community action cycle, using the three delays as a framework? Note the three delays in the PAC results framework.
14. How has the community action cycle process used in Bolivia been adapted to fit the context in Nakuru? What were the key challenges? What were the changes made?
15. What methodologies developed during the project can be applied in USAID's central and field PAC programs?
16. What has been the contribution of adapting and using the community action cycle process to define the third component of USAID PAC model through community awareness and mobilization? [Need to really address this using the PAC results framework and indicators. This is what this question is asking.]

Recommendations and next steps

17. Based on this assessment, what are the lessons learned and recommendations?
18. What examples can be gleaned from project implementation to show the effectiveness of using the community action cycle for community PAC mobilization to improve access, quality and use of PAC and affect other areas of reproductive health? [Again, need to refer back to the results framework and indicators.]

Appendix 3: Materials Reviewed

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Appendix 4: Sample Action Plan

LANET Division

Key problem	How do you know	Steps you will take to resolve	Short-term (3 months) & long-term indicator	Resources you will use	Person responsible	Start to end
Lack of PAC trained personnel and kits in Lanet dispensary and Wesley mission hospital	Core group, other members have visited the facilities Had cases of women who had bleeding problem and could not be assisted	Talk to area counselor and MP to ensure maternity wing is opened Lobby with MOH to ensure personnel is trained and kits are available Constitute local health management committee	**Short-term** Local health committee constituted **Long-term** To see maternity wing complete Health provider trained in PAC To have PAC kits	CBOs MOH (Council) Councilor Chief MP Community Mrs. Odhiambo Rhoda Ratif	**Lanet team** Peter James Mboya Macharia **Lanet youth** Evans Gitau James Maina Irene Njenga Buyanzi Jane Ayuma Violet Wela Bathsheba	March–April
Lack of information about dangers of teenage pregnancy and unwanted pregnancy	Seen approximately 30 cases of school dropout due to teenage unwanted pregnancy (13 cases of abortion among teenagers) in less than 1 year	Ask school head for permission to talk to pupils and students Educate the community on the dangers of teenage pregnancy Initiate youth activities Conduct outreaches in schools, chiefs' *baraza* (Kiswahili for assemblies) and youth groups	**Short-term** Youth activities introduced in Lanet Conduct 14 youth and chiefs' barazas visit **Long-term** Dropout rate due to unwanted pregnancy decreasing Introduction of youth-friendly activities in other youth groups Fewer abortion cases	The 3 CBOs FBO leader Head teacher Village Elder Chief Health provider Esther	**Lanet team** George Maina Antony Mugambi Buyanzi Bethseba Jane Violet **Lanet youth** Eric Maina Irene NJenga	March–April

Appendix 5: Stories of Champions

Shadrack: Youth with a Difference
(Adapted from *SWAK News*—Issue No. 7. 2007)

Mr. Shadrack Ngeno, 24, is the firstborn of five siblings living in Rongai Division. He is a holder of a Certificate in Management and hopes for more schooling. During his downtime, Shadrack is active in the Rongai Orphans group, which creates awareness of the needs of those living with and affected by HIV and AIDS. He was chosen to learn about PAC and the "three delays." After his training, he remembered a local woman who almost died due to bleeding in pregnancy. His vivid memories were of the woman having little access to health care because roads were poor and a health facility was not nearby. Once he made the link between access to life-saving health care and the woman's needs, he became convinced that he could help.

He reached out to others in his group, mobilized them, and brought the issue to his Member of Parliament (MP), Honorable (Mrs.) Alicen Chelaite. They pushed for CDF funds to construct a health facility, located between two villages to serve two ethnic groups; as a result, the Ngesumin-Moricho Dispensary was born. The dispensary's health committee was made up of members from both locales and ethnic groups, with both men and women serving on the committee. He then pushed the envelope further, and got two 25-kilometers roads repaired. Access to health care certainly improved.

The Power of Sharing Experiences

Shadrack, a 24-year-old man who is the leader of the youth group in Rongai, visited Njoro to get advice and inspiration from Esther and the Piave group. Based on that visit, Shadrack felt empowered to go to his MP and get communities active. Rongai was able to access CDF funds to construct a much-needed dispensary. This shows how men can effectively advocate for RH services and that PAC is not just a women's issue.

Although he is young man, Shadrack feels empowered to go to MPs; work in community groups; and tackle what was formerly thought of as a "women's issue" to help improve maternal health. He is a champion for male involvement in RH.

Mama Monica: Dedicated to Safe Motherhood
(Adapted from *SWAK News*—Issue No. 7. 2007)

Mrs. Monica Wangu, 74, is a well-known local human rights activist who led the "Freedom Corner of Uhuru Park" group, which worked to free political prisoners, including her son, in the early 1990s. She continues her human rights activities in addition to watching over her seven children, 20 grandchildren and three great-grandchildren. She also leads an organization of women who sell charcoal to make do, as well as a group that helps orphans from AIDS and children whose mothers died in childbirth.

Mama knows about unplanned pregnancies, unsafe abortion, and complications of pregnancy in her area. She also learned about the "three delays" in the ACQUIRE/SWAK COMMPAC training for leaders and champions. This spurred her on to be an advocate for FP and maternal health—and she reached out to women where they gather (e.g., at water pumps) and to school children with

information about FP and the dangers of pregnancy complications. She has convinced local officials to waive fees for the very poor so women are no longer turned away from services.

Mama reports a new attitude of cooperation and collaboration with local health officials, individual providers, and the community they serve. Even though she is illiterate, Mama Monica prides herself on the fact that not one woman has died in the last year due to pregnancy complications. Women now know the danger signs and are immediately escorted to the health facility if bleeding in pregnancy occurs. Certainly, Mama knows that more work needs to be done to increase access to services, yet she is inspired to keep the cause moving on. Mama received the "White Ribbon" pin for her work in improving maternal health.

Esther's Story: A Champion Arises (Adapted from *SWAK News*—Issue No. 7. 2007)

Esther Nyokabi has lived in Njoro Division of Nakuru, Kenya, for all of her life. Like many women in her area, Esther had little schooling and is illiterate. She married in her teenage years and delivered 10 children, including two sets of twins. Only once did she deliver in a hospital. She is a member of Piave Women's Group, which was founded in 2004 to help the growing number of children orphaned in Njoro due to HIV/AIDS.

The Piave Women's Group chose Esther to represent them in the COMMPAC Project. Previously, Esther had never participated in a group setting that included men. She had never held a leadership position, nor had she ever spoken before a group. But with COMMPAC, that all changed.

Esther led her group to mobilize 300 people to attend a meeting with local government officials, where a vote was held on the use of CDF funds that had been made available to local districts. With Esther's leadership, the 300 people she brought helped divert those funds, which were originally allocated to build a market, to be used instead to build a dispensary, repair a road, and build a new bridge. In addition, Esther and Piave Women's Group got the police to build a post near the dispensary, because the road was not safe and women had been waiting until daylight to travel for emergencies.

It was through COMMPAC that Esther learned about deaths related to bleeding in pregnancy. And Esther's passion was fueled by the fact that friends, neighbors, and family members had died or suffered due to hemorrhage and lack of FP services. She knew of at least three deaths in her community in the past year due to hemorrhage. She was inspired to learn that such suffering was preventable through community efforts. Since the initiation of COMMPAC, there have been no deaths due to hemorrhage in her area.

Joseph Akack: Sheding Light on PAC (Adapted from *SWAK News*—Issue No. 7. 2007)

Joseph Akach, 40 is an accountant by trade and a community mobilizer in his heart. He was active over the last few years in HIV and AIDs, including assisting orphans in a local resident's organization called United Tenants. Based in the impoverished Flamingo area of Nakuru, near the Lake Nakuru National Park, Joseph's passion for helping others in his community expanded about two years ago to include women's health issues during pregnancy. His interest was sparked when a friend's daughter died during pregnancy. "The death really traumatized me…and since then I had been yearning to know more about problems in pregnancy".

Luckily for Joseph, United Tenants was one of the local organizations involved with COMMPAC, and Joseph has been in the forefront of the effort from the beginning. Since the ACQUIRE training in PAC issues and community participation, the group has carried out awareness raising activities in churches, women's groups, men's groups and public meetings. After talking to these groups Joseph noted that people did not want to go to the hospital even during emergencies at night, due to the real threat of robbery. Since then, Joseph and his group advocated for street security lights and they were installed. His advocacy for better infrastructure didn't stop there, and later a bridge was built to get people to the facilities, and two additional health centers are under construction.

Joseph notes that "in the beginning, there was no understanding between the health workers and the community but talking to them has facilitated dialogue." Joseph's role in shedding light on the need for improved provicer-client interaction, and community involvement in healthcare services reaped results. The number of people visiting health facilities has increased, according to United Tenants volunteers who have gone to the facilities to follow up.