

**Community Postabortion Care
Project (COMMPAC) in Nakuru
District, Kenya: Summary Report,
Phase I: July 2005-September 2006**

December 2007



USAID
FROM THE AMERICAN PEOPLE

the **ACQUIRE** project

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Acronyms/Abbreviations

ACQUIRE	Access, Quality, and Use in Reproductive Health
APHIA	AIDS, Population, and Health Integrated Assistance
CBO	community-based organization
COMMPAC	Community Postabortion Care Project
COPE®	client-oriented, provider-efficient
DC	district coordinator
DO	district officer
FBO	faith-based organization
FP	family planning
HC	health council
HIV	human immunodeficiency virus
MCH	maternal and child health
MOH	Ministry of Health
MP	Member of Parliament
PAC	postabortion care
PGH	provincial general hospital
SWAK	Society for Women and AIDS in Kenya
USAID	U.S. Agency for International Development

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Executive Summary

Education, mobilization, and promotion to prevent unplanned pregnancies and inform the community about delays in seeking care are critical to reducing complications related to miscarriage and unsafe abortion. Community empowerment through community awareness and mobilization is a core component of the U.S. Agency for International Development' (USAID's) postabortion care (PAC) model. As a focus country of the USAID/Washington Postabortion Care Working Group, Kenya was provided funding to replicate the PAC community mobilization model that has been implemented in Bolivia since 2004. Through the Catalyst Project in Bolivia, 50 community groups were trained in PAC and participated in facilitated trainings and meetings to improve community access to PAC services.

The ACQUIRE Project, through its local partner, the Society for Women and AIDS in Kenya (SWAK), implemented this activity. Using the community action cycle, SWAK worked with community leaders in five communities in the Nakuru District in Kenya to replicate and adapt the Bolivia PAC model. This made their communities more aware of complications related to miscarriage and unsafe abortion, and of the use of family planning (FP) to prevent unplanned pregnancy, and more able to devise community action plans to address these concerns and the barriers to PAC and FP services. In the Bahati, Njoro, Rongai, Nakuru Municipality, and Lanet Divisions,¹ a total of 412 community members from 16 community groups completed the community mobilization process, with 22–25 members in each group attending three community mobilization sessions. Following the process that was used in Bolivia, action plans were developed following these sessions. In both Bolivia and Kenya, the action planning process helped community groups to identify the causes of key problems related to PAC service delivery and to identify feasible solutions.

Common themes that emerged in all of the Nakuru District action plans included:

- ◆ Needing to access community development funds for roads, bridges, and facilities
- ◆ Developing a scheme to make PAC kits available and to get PAC-trained staff at facilities
- ◆ Informing communities about the need to recognize bleeding during the first five months of pregnancy as a danger sign and to seek care immediately
- ◆ Ensuring availability of FP and communities' awareness of it and ability to access available commodities

After completion of this first phase in September 2006, the groups continued to meet with SWAK monthly through February 2007 to make plans and to implement these plans.

Initial linkages meetings between stakeholders and communities were catalysts for improved relations among community groups, providers, and facilities. Core group leaders report that providers in their areas now work as partners. Community leaders report a heightened awareness in the community of warning signs for miscarriage or incomplete abortion. A knowledge, attitudes, and practices survey conducted with 285 individuals before and after the community mobilization activity showed a significant increase in knowledge of warning signs of complications in the first

¹ Lanet is actually part of Nakuru Municipality, but because the municipality was so large, for the purpose of the study it was separated into two divisions, Nakuru Municipality and Lanet.

half of pregnancy (high fever—21% to 77%; vaginal bleeding—67% to 91%). It is reported that the stigma associated with bleeding during pregnancy has lessened.

Poor infrastructure, resulting in poor access to services, was identified as a major issue by community groups. Community members gained the attention of local members of Parliament and successfully advocated for community development funds to renovate two Ministry of Health (MOH) facilities, expand six facilities to include maternity services, and construct four new facilities. In the Rongai Division, community groups got together and rehabilitated an abandoned house for the health provider, to ensure his presence in the community. In the Municipality and Njoro Divisions, funds were secured to improve roads or bridges. In all five communities, police posts were established to facilitate women's safe passage to health facilities. During and after Phase I, every group developed emergency transport plans, conducted discussions, and facilitated access to services for women who began bleeding in the first five months of pregnancy. In Bahati Division, the core group leader identified a bleeding woman who was in line for water, accessed funds the group had organized for emergencies, and got the woman transported to a facility with PAC services. Through their involvement in the Community Postabortion Care (COMMPAC) Project, community groups learned that it is possible to mobilize resources even in low-resource settings.

Despite these improvements, access to safe PAC services is limited by inadequate numbers of trained providers and insufficient equipment at public-sector sites. Though PAC services are available through a private-sector network of midwives, the majority of the population cannot afford these services. The ability to pay for services has been a significant challenge to adapting the Bolivia community action cycle model. In Bolivia, national health insurance is available to pick up the costs associated with PAC services. This is not the case in Kenya. ACQUIRE Kenya staff are working with district and national counterparts and in-country donors to secure funds for provider training and equipment in the Nakuru Municipality. Through COMMPAC, community groups learned about resources available through government systems and helped this process become transparent to the community so they could access needed funds for PAC.

Important lessons learned in the replication of this activity include:

- ◆ Basic methodologies for community engagement can be used, but replication must be adapted to sociocultural contexts. Resources and time for this adaptation need to be factored into replication projects.
- ◆ The community action cycle process can work in urban and rural settings.
- ◆ The community action cycle methodology was effective in building ownership of the problems and solutions identified by community groups.
- ◆ Mapping is an effective tool for motivating participants to see community needs, as well as for affirming their collective accomplishments as they implement their action plans.
- ◆ In the absence of PAC services and trained providers, communities can build partnerships with key stakeholders and advocate for resources to address infrastructure and services.
- ◆ Facilitated meetings between community groups and providers result in partnerships between community and providers.
- ◆ Partnerships between community groups and providers result in creative solutions for accessing local resources and services.
- ◆ It is possible to mobilize funds and in-kind resources in low-resource settings through collective action and collaboration.

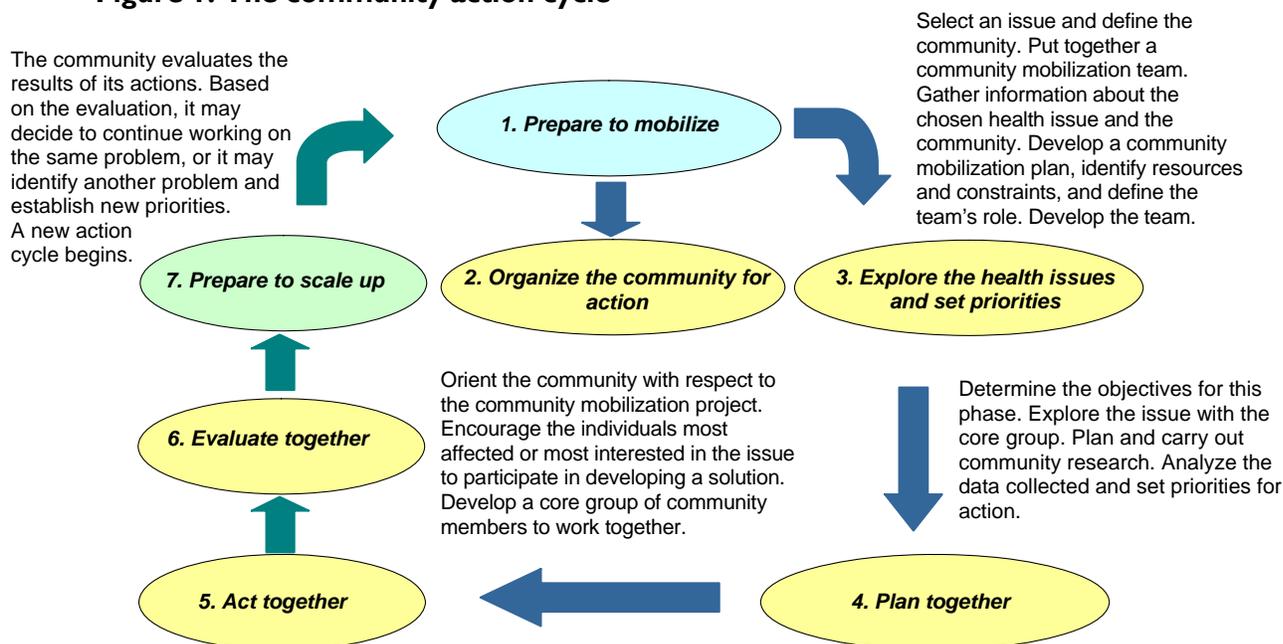
The USAID/Washington PAC Working Group has provided funding for Phase II of this project, which will involve further implementation of the community action plans from July 1, 2007, through June 30, 2008.

Background

An estimated 300,000 abortions are performed in Kenya each year, and 20,000 women are admitted with abortion-related complications to public hospitals annually. This translates into a daily abortion rate of 800 procedures and the death of 2,600 women every year.² Education, mobilization, and promotion for the prevention of unplanned pregnancies and postabortion care (PAC) are critical to reducing morbidity and mortality due to abortion. Community empowerment through community awareness and mobilization is a core component of the U.S. Agency for International Development's (USAID's) PAC model. Addressing women's empowerment and behavior change through knowledge and access to services, as well as constructive male involvement to support the use of contraception and services, are important factors that validate the importance of community-based programs and participatory approaches.

In 2003, the USAID/Washington Postabortion Care Working Group chose Kenya as one of its focus countries. The ACQUIRE Project was provided funding to replicate the PAC community mobilization model implemented in Bolivia since 2004. Using a community mobilization model based on the community action cycle³ (Figure 1), ACQUIRE and its local partner, the Society for Women and AIDS in Kenya (SWAK), has provided community members in Nakuru District, Kenya, with the tools and technical support needed to identify community problems and resources related to PAC and to develop their own action plans.

Figure 1. The community action cycle



² Kenya Medical Association (KMA), International Federation of Women Lawyers Kenya (FIDA-K), Kenya Ministry of Health, and Ipas. 2004. *National assessment of the magnitude and consequences of unsafe abortion in Kenya*. Nairobi.

³ Howard-Grabman, L., and Snetro, G. 2003. *How to mobilize communities for health and social change*. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, Health Communication Partnership (HCP), p. 264.

Replication of the Community Action Cycle for Postabortion Care in Kenya

Project Implementation

The Nakuru Community Postabortion Care (COMMPAC) Project was designed to use the same process for community engagement that was used in Bolivia. To replicate the Bolivia experience, representatives from the ACQUIRE Project and SWAK visited Bolivia to gain an understanding of the use of the community action cycle and a facilitator's guide for community self-diagnosis developed and used there. In Bolivia, COMMPAC facilitated sessions that enabled community groups to use the community action cycle as a process to bring the community together around a specific issue related to PAC. Together, they took action, evaluated their action, and moved on to a new issue, replicating the cycle multiple times. In Kenya, the action cycle was completed once during Phase I. In Phase II, the process will be replicated to help reinforce the skills learned under Phase I.

Phase I began in July 2005, ended in September 2006, and covered the first four parts of the action cycle—*1) prepare to mobilize, 2) organize the community for action, 3) explore the health issues and set priorities, and 4) plan together*—with 16 community groups, composed of 412 individuals, completing their action plans (Table 1, p. 4). Key opinion leaders and other stakeholders were involved from the beginning as a means of developing champions and to create an enabling environment for PAC activities.

Step I. Prepare to Mobilize

Prior to beginning the project activities in Kenya, SWAK and ACQUIRE staff visited the Catalyst Project in Bolivia and had the opportunity to discuss implementation details, challenges, and lessons learned with the Bolivia team. On their return to Kenya, the SWAK project staff received eight days of comprehensive training that included technical FP and PAC, community mobilization, and facilitation skills. The facilitation and implementation guides from the Bolivia Catalyst Project were translated and adapted for this training.⁴

Organizing the Community Mobilization Teams

Sixteen groups (412 individuals) representing five divisions (Bahati, Njoro, Rongai, Nakuru Municipality, and Lanet) were identified. Each group identified one member to serve as their representative in the core group. These identified members from each group constituted a core group with responsibilities for project activities. Core group members went through three days of training based on the Bolivia facilitation guide. The training included technical content on FP, miscarriage, unsafe abortion, facilitation, and community mobilization skills.

⁴ Staff also received refresher training after completing the three community mobilization sessions and before facilitating development of the action plans.

Table 1: Project implementation time line

Activity	Date
PREPARE TO MOBILIZE	
Visit to Bolivia community PAC project	April 2005
Development/submission of subagreement to USAID	July 2005
Recruitment/selection of COMMPAC Project staff and summer intern	July 2005
Orientation and training of SWAK project staff—including administrative procedures, project start-up work planning, PAC/family planning (FP), and the Bolivia community PAC model	July 2005
ORGANIZE THE COMMUNITY FOR ACTION	
Community PAC stakeholder meeting of opinion leaders in Nakuru	August 17, 2005
Meeting of representatives from potential community groups to select target groups and their representatives	October 10, 2005
PAC orientation and analysis workshops with community core group	October 2005
EXPLORE THE HEALTH ISSUES AND SET PRIORITIES	
Core group representatives and SWAK facilitators conduct three-session community mobilization sessions with respective groups	November 2005–January 2006
Community groups develop action plans	January–February 2006
PLAN TOGETHER	
Five joint action plans (3–5 groups each) developed at division level	April–May 2006
Linkages meeting with core group representatives and providers	May 2006
ACT TOGETHER	
Each division implemented actions, including: acquiring transport funds, improving roads and bridges, adding strategic police stations and chief camps along routes to health services, and developing or improving 12 facilities	September 2006–December 2007
Core group meetings and provider outreach continue in preparation for Phase II	
EVALUATE TOGETHER	
Monthly meetings with SWAK to check progress	February 2007–end of project
Phase II will add quarterly reviews with all core group leaders	

One of the lessons learned in Bolivia was the need to involve stakeholders, including key influential people, early and often in the project. Therefore, based on the Bolivia experience, the organization and involvement of key opinion leaders (referred to as stakeholders by the project) was added to the process. After establishment of initial contacts, one of the Kenya project’s first activities was to organize a meeting of 24 of these leaders, including local government authorities, village and area chiefs, religious leaders, health care providers, members of Parliament (MPs), and traditional birth attendants. The purpose of this meeting was to share the plans for the project and to get feedback and input on the strategy. This meeting initiated a collaborative relationship that continued throughout project implementation. The early involvement of key opinion leaders built champion stakeholders, people who are vital to promoting the support for FP and PAC, breaking down barriers to services, and ensuring appropriate action by all stakeholders.

Gathering Information

Knowledge surveys were conducted with 14 of the 16 participating groups (285 individuals) before and after their community mobilization sessions. One-third of those participating were men.

Prior to the community mobilization sessions, approximately 75% of the participants recognized FP as an issue that 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. The need to improve communication between men and women was ranked as a priority during action planning sessions.

Recognition of warning signs related to early pregnancy termination or miscarriage increased following the community mobilization session for five of the seven warning signs (Table 2). The concept that prevention of complications that cause maternal deaths in the first five months was understood by the majority of both men and women set the stage for addressing the delays that affect maternal death. Knowledge of FP was at or over 80% at both pretest and posttest, and knowledge of delays related to childbirth was greater than 90%. The overall high level of awareness of issues related to FP and maternal health help to ensure the development of these participants as champions in their communities.

Table 2: Percentage of participants reporting awareness of warning signs during the first five months of pregnancy, before and after community mobilization sessions

Signs of danger or alarm during first 5 months of pregnancy	Before community mobilization sessions	After community mobilization sessions
Severe headache	45%	45%
Fainting	20%	79%
High fever	21%	77%
Swelling of feet or hands	40%	76%
Convulsions	9%	87%
Vaginal bleeding	67%	91%
The baby stops moving	32%	31%

The surveys were useful in gauging technical knowledge before and after the COMMPAC trainings and were used to inform the curriculum for the training of the 16 community groups in Nakuru District. They were, however, less effective in assessing actual behavior changes.

Step 2. Organize for Action

Three community mobilization sessions included the development of action plans. SWAK staff, with technical assistance from the ACQUIRE senior community mobilization adviser, conducted sessions with each group at their own location. A total of 412 community members from 16 community groups completed the community mobilization process. Each group consisted of 22–25 members attending each community mobilization session. The community mobilization sessions were oriented around the “three delays” that contribute to nonuse of maternal health services, and ultimately, to increased maternal mortality. The Bolivia training manual referred to the delays as:

- ◆ Delay in recognizing the problem
- ◆ Delay in deciding to do something about the problem
- ◆ Delay in resolving the problem

The Kenya community members adapted this terminology and replaced it with the following:

- ◆ Delay in recognizing there is a problem
- ◆ Delay in deciding to seek care
- ◆ Delay in receiving care

Step 3. Explore Health Issues and Set Priorities

The three community mobilization sessions addressed the following themes:

Session 1—Problems associated with unplanned pregnancies (Delay No. 1, Recognizing there is a problem). This session led participants through a community autodiagnosis process, starting with a comparison of life histories between boys and girls, and then working with case studies looking at what happens to a woman who experiences bleeding during the first five months of pregnancy. The final step was to begin the development of a “Bridge of Possibilities.” Using the life histories and case studies, the community discussed actual and ideal situations, why there was a difference between ideal and actual, and what could be done to “bridge” the differences.

Session 2—Deciding how to resolve the problem and how to arrive at the health establishment (Delay No. 2, Deciding to seek care). While continuing the discussions from the previous session, the primary exercise for this session was a community mapping exercise leading to identification of care-seeking choices and barriers to access. The mapping exercise allowed the groups to identify where services were and the distance between communities and services. It helped them to see barriers, such as poor roads, lack of bridges, and security issues, such as location of police posts or chief camps (offices for chiefs). Again, this was followed by the “Bridge of Possibilities” exercise.

Session 3—Acting to solve health problems (Delay No. 3, Receiving appropriate care at the facility). The main exercise for this session was the development of sociodramas depicting actual and ideal experiences of women seeking services at the health facilities. This was followed by the “Bridge of Possibilities” exercise and a general summary of all of the problems identified throughout the three sessions.

For each session, participants were assigned “homework”: to go back to their communities and interview and discuss the issues with several peers in the community and/or collect additional information. These discussions both led to awareness-raising with community members and offered a way to bring in a broader range of perspectives to inform the groups’ process. The homework assignments were composed of both closed- and open-ended questions and were copied directly from the Bolivia manual. Some questions were conducted by the group as a whole and some were individual interviews. The homework was designed to give the group members experience in conducting interviews while gathering information that becomes data for supporting priority problems and solutions. Appendix 2 is a sample of the problems and solutions identified by the groups. These became the list from which the groups identified their priority issues and began their action plans.



Women from Piave Women’s Group participate in a community mapping exercise.

Step 4. Plan Together

Approximately one month after the three community mobilization sessions were completed, SWAK staff facilitated planning sessions in which groups developed action plans to address the priority issues the group identified related to PAC and FP. Through their homework assignment, they identified problems and possible solutions. Since Nakuru is an area where there is little water or electricity and HIV prevalence and poverty are high, it was a challenge for the SWAK staff to keep groups focused on the priorities directly related to PAC. Good facilitation is really important in this phase of the community action cycle. Many of the groups were originally formed to provide care related to HIV and AIDS and have an interest in health and stigma issues. The facilitation process helped the participants see that by using the community action cycle process in addressing issues related to PAC, they were learning skills that would help them to address other issues in their communities. Each problem had to be reviewed with PAC-related issues identified.

During the action-planning sessions, the facilitator led the groups through prioritization and problem analysis before identifying specific activities to be completed. The exercise was followed as outlined in the Bolivia manual, which calls for using different-colored cards to prioritize problems according to the three delays—*recognize*, *decide*, and *resolve*. The SWAK facilitators found that the participants understood the delays better when they used these terms. The community members were to set their priorities under each of these headings and to color-code problems according to the delay the problem addressed and the level of priority. This became confusing to the groups. Many of their priorities overlapped, and they could not distinguish between the delays. The Bolivia action plan matrix headings were adapted and simplified for COMMPAC. The revised matrix was easily understood by the groups and helped them to see the relationship between their community mobilization sessions and their action plans. During the CAC process, the groups identified the key problems and solutions needed. (See Appendix 3.) This exercise was documented and will be revised for Phase II.

The project staff realized that many of the problems and activities were similar across the different groups, so all of the groups within each geographic division got together to compare their action plans and to coordinate for activities they had identified in common. Examples of some of the common problems included:

- ◆ Poor communication among couples and between parents and their adolescent children about issues of reproductive health and FP
- ◆ Lack of information about reproductive health services offered at health facilities in their areas
- ◆ Lack of adequate or factual information on FP and reproductive health
- ◆ Lack of access, which included lack of roads, bridges, and safety, as well as having few equipped facilities

The groups from each division planned together during the community mobilization sessions and action planning sessions with SWAK. When they returned to their communities, they then engaged the communities in the planning process.

- ◆ Needing to access community development funds for roads, bridges, and facilities
- ◆ Developing schemes to make PAC kits available and to get PAC-trained staff at facilities
- ◆ Informing communities about the need to recognize bleeding in the first five months of pregnancy as a danger sign and to seek care immediately
- ◆ Ensuring availability of FP and community awareness of it and access to available commodities

The SWAK-led sessions ended in September 2006; however, the groups continued to meet with SWAK monthly and continued to plan and implement their plans between September 2006 and

Phase I ended in September 2006, following the action planning workshop. The group leaders continued to meet monthly with the SWAK staff as they implemented their action plans. There were no funds, and the SWAK staff worked on a voluntary basis.

Step 6. Evaluate Together

In the community action cycle, participatory evaluation follows the implementation of the action plan and then leads back to the beginning of the cycle again to mobilize and identify priority issues. Originally, the COMMPAC action plans were to be implemented under Phase II. All of the groups implemented plans during the gap between Phase I and Phase II, between September 2006 and February 2007. The evaluation and planning session for Phase II, which involved all of the core group leaders, was held February 12–13, 2007. This session reviewed the accomplishments of Phase I, evaluating the accomplishments and gaps through mapping and storytelling, which led to the development of Phase II action plans.

The Bolivia model suggests a checklist process to review accomplishments and gaps. In Kenya, it was decided to use a different process. Mapping was used as a participatory process to help the groups value all that they accomplished through their action plans first, before identifying gaps. The groups in each location worked together to map out their areas in blue as they existed prior to COMMPAC. They then used red markers to identify all of the changes that happened since they had begun to implement their action plans. When the COMMPAC process started in 2005, all group leaders voiced doubt that they could achieve success, as they had few resources and no funding. Through mapping and telling their stories, they were able to celebrate their accomplishments, see all of the resources they were able to marshal, and identify the gaps. The new action plans will emerge from this process. Several leaders remarked that until they mapped out all of their achievements, they had been unaware of how much they had accomplished during the preceding seven months.

Evaluation and Planning Session—February 12–13, 2007:

1. Resource mapping exercise

Five groups, representing the five divisions, worked together to map their areas, marking anything new since the last time they had met (in September 2006). All partnerships and accomplishments in the communities had occurred in 5–7 months, with local resources—either with government funds or through community fundraising.

2. Storytelling through action plan matrix

Each group made a map of their area and all of the local resources. They presented the maps to point to the various facilities, roads, faith-based organizations (FBOs), and chiefs to illustrate the changes that had occurred during that five-month period. A matrix was used to organize the activities that had already happened, to tell the story of the outcomes to date, and to help the groups visualize what still needed to happen. This session was the evaluation phase of the community action cycle and helped to inform the groups about how much they had accomplished and how many resources they have in their communities.

3. Phase II, three-month action plan—using revised Phase I action plan

The new action plans started in March 2007, and the core group was to meet every three months to evaluate their plans, revise them if needed, or change them and then move forward, based on the community action cycle process.

Project Results to Date

Specific Results to Date, by Division

Bahati Division (population 181,611).

Veronica Wanjiru from the Women Coal Sellers Group represented Bahati. She mentioned that last year one woman died of bleeding following a pregnancy complication. Specific results included:

- ◆ ***New dispensary and maternity hospital built using community development funds.*** The Women Coal Sellers Group banded together with other women's groups and advocated for using community development funds to build and staff a new dispensary and maternity hospital.
- ◆ ***Water taps to allow time to go to health facilities.*** The group used community development funds for water taps, installed because women stood in line for hours for water and reported that they had no time to go to health facilities.
- ◆ ***Built support from local leaders.*** The chief is not supportive, but they get help from their local MP and health officer.

Rongai Division (population 97,860).

The representative from Rongai Division presented that there are a high number of single parents in the central area of Rongai. The only doctor must travel 12 miles on a bicycle for visits. Specific results included:

- ◆ ***Housing built for provider, to ensure his presence in community.*** The groups got together and rehabilitated an abandoned house for the health care provider. The provider is now available 24 hours a day, which is very critical for PAC services.
- ◆ ***Facility hours increased.*** Providers' hours were 10 a.m.–1 p.m., and are now 8 a.m.–6 p.m.



Local women visiting their health facility, which was improved using community development funds.

- ◆ ***A problematic provider replaced with PAC-trained provider.*** The local health care provider was identified by the community as being a problem, treating clients badly, and often being absent from his post. When he was not able to meet the community demands, the government agreed to transfer him. This action became a model for addressing problems related to staff at facilities.

Nakuru Municipality Division (population 292,246).

Specific results included:

- ◆ ***Nine new health facilities developed with PAC-trained staff.*** Nine health facilities with PAC-trained personnel were created, reducing the distance needed to travel for services. Equipment is still needed, as only private facilities have equipment. No facilities had PAC-trained personnel prior to COMMPAC.
- ◆ ***Road and bridge built to improve access.*** A key road and bridge were improved through community development funds, thereby increasing access.
- ◆ ***Provided security for clients accessing services.*** Chief camps and police posts were developed and placed strategically along routes to health facilities to allow for the safe passage of women. The homework assignment had revealed that women were either harassed or attacked when they traveled these routes at night.

Lanet Division (part of Nakuru Municipality).

Specific results included:

- ◆ ***Maternity hospital and maternal and child health (MCH) services established.*** Groups were successful in getting a maternity hospital built, to provide MCH services.
- ◆ ***Education programs at nine local schools.*** The three groups arranged to speak at nine schools—three each—to talk to 50 students about the importance of preventing unplanned pregnancies. Before going, they arranged for medical personnel to come speak to them so they would have technical knowledge. The groups paid for the transport of the medical people and provided tea. Following the meetings between groups and providers facilitated by SWAK, providers were willing to do education meetings without charge (except for transport).
- ◆ ***Improved early identification of danger signs.*** After COMMPAC training, Jane, a COMMPAC core group member, told a neighbor who had had several miscarriages and who was pregnant again to alert her at the first sign of bleeding; she then accompanied the woman to a health facility. She has helped other women and has become known as an expert on this issue. She was invited to a church to speak to 30 women, and continues to be a resource to the community.

Njoro Division (population 99,988)

Njoro Division is predominantly a farming community. The locations represented by Piave Women's Group, Simama Imara Women's Group, and Rumwe Women's Groups do not have electricity. Water is also scarce, and literacy is low. Esther Nyokabi, the core group leader for Piave Women's Group, is illiterate. She had not been a leader in her group until she became a representative for COMMPAC. As a mother of 10 children—who had no access to FP and who once delivered twins in the bush—she became a passionate advocate for PAC. Through her leadership, the groups in Njoro Division achieved the following outcomes:

- ◆ **Obtained community development funds for health services**
 - ◇ ***Increased community involvement in PAC.*** Piave Women's Group, through the leadership of Esther, got 300 community people to attend a meeting to speak with their MP to negotiate the building of a health facility. A number of older people were lobbying to use community development funds for a marketplace.

- ◇ **Improved access to PAC, FP, and health services.** These funds were also used to repair the road. It is now possible to organize transport by community members from villages over the bridge to the road—and public transport has agreed to pick them up from there.
- ◇ **Increased security for PAC clients.** A new police post was built, and Esther convinced police to agree to be available for night escort.
- ◆ **Increased involvement of providers and improved access to services**
 - ◇ **Meetings with providers.** Esther has brought groups together to meet with new providers on multiple occasions, including a new registered nurse named Caleb Oduor.
 - ◇ **Requested PAC-trained provider.** Caleb Oduor has advocated to other providers to accept PAC clients, and he gave them gloves to allow them to assist bleeding clients. (Due to the high prevalence of HIV, many people had been hesitant to touch women who were bleeding.) The gloves gave the volunteers more confidence to deal with women who are bleeding and in need of help.
 - ◇ **Community planning a maternity addition.** The community has worked through the local MP to get electricity for the dispensary. They also got funds to build housing for Caleb Oduor, as he said he would then be available for deliveries and emergencies. A maternity wing is planned as well, and the community has volunteered their time to dig a borehole for a well for the dispensary and proposed maternity wing.
 - ◇ **Njoro District Hospital acquired kits through fees charged for other services.** This was at the request of Piave Women’s Group, lead by Esther.
 - ◇ **Improved volunteer linkage with facilities.** Esther organized people from Piave Women’s and other groups to meet with providers, to learn what they, as community members, need to know to address emergencies before arriving at the facilities.
 - ◇ **Improved attitudes of providers.** The community has noticed that providers’ attitudes have changed. There is no waiting now for PAC services. Accident cases and other health issues are now better attended. A recent accident victim donated a television in appreciation of the good care provided.



Esther Nyokabi of Piave Women’s Group and Perpetua Gaciuki of SWAK inspect the bridge and road improvements.

◆ **Improved sharing of information—empowerment of communities**

- ◇ ***Doctors responding to emergencies.*** The doctor from a local health center now comes in emergencies, which was not the case before the group started meeting with facility staff.
- ◇ ***Recruited private providers as volunteers.*** St. Nicholas is an expensive private facility that Esther and group approached. A private doctor now attends emergencies for free.
- ◇ ***Sustainable process.*** Esther expressed confidence that she and the community will continue the community action cycle process to improve PAC and FP, and, in addition, they will improve the supply of water to the community.
- ◇ ***Speaking and outreach.*** Groups (men and women) worked together to attend existing meetings. Each meeting had about 100 people. Esther, invited by health workers, spoke to more than 200 people.
- ◇ ***Fewer reported abortions—more FP accessed.*** Because people had more accurate information, there was a reduction in rumors and resulting stigma over bleeding, and people felt freer about reporting early bleeding. This led to an increase in prevention and a reduction in reported abortions.

Key Lessons Learned from Phase I for Sustainability and Replication

Building upon existing groups that are registered with the Social Services Ministry (including those focused on HIV and immunizations) saved time, energized the maternal health activities and the existing group activities as a result of the new inputs, and avoided the complication of developing yet more parallel and ad hoc groups. Lessons learned include:

- ◆ Scale-up and sustainability are enhanced by the project’s approach of selecting and training core group members who understand and represent their communities, facilitating community ownership.
- ◆ The experiential approach of COMMPAC using the three delays framework completely changed the way people learned about and acted upon the issues of unplanned pregnancies and complications related to miscarriage and unsafe abortions. This will be reinforced through the repeated use of the community action cycle.
- ◆ As seen with similar approaches used at the facility level (e.g., COPE[®]), people need to go through several cycles of analysis and action to improve their ability to define problems and practical solutions that depend on their own resources.
- ◆ The community action cycle participatory process empowers new champions and builds momentum in the communities, resulting in ongoing meetings, transport system development, and other activities, even after donor-supported activities end. The Piave Women’s Group now has an office and sells soap to finance their costs while they organize the community to cover transport costs for PAC.
- ◆ It is possible to build partnerships and mutual respect between communities and providers through well-facilitated joint meetings that include clear objectives, a strong leader, and active participation.
- ◆ Health service providers can take an active role in working with community groups to address some of the issues identified for PAC—including visiting the community—with the community paying the transport fees.
- ◆ The politicizing of community development funds is offset by developing informed community leaders who are empowered to mobilize their communities to access resources through their local MPs.
- ◆ The Kenyan experience helps to confirm some of the lessons learned in Bolivia and contributes to learning more about the value of participatory learning in addressing PAC, MCH, and FP.
- ◆ Engaged communities are effective in addressing stigma and improving timely recognition of emergencies.
- ◆ The retirement and relocation of government-trained public PAC providers remains a challenge to service provision.
- ◆ It is important that community groups understand up front that, as volunteers, there is the potential that the community will see them as a resource for information beyond PAC and FP.
- ◆ It is also important that donors and international nongovernmental organizations (NGOs) help local NGOs and community groups to convey the message that community volunteers are not being paid, as this is often the assumption of community members. The lack of clarity on this issue can be problematic for volunteers.

Next Steps: Phase II Start-Up and Implementation

The lessons learned from Phase I lay the groundwork for Phase II. A planning meeting involving ACQUIRE and SWAK staff was held February 12–13, 2007, to begin Phase II action planning.

Key Next Steps for Phase II

- ◆ Review the lessons learned from Phase I.
- ◆ Establish criteria for the selection of new groups
- ◆ Select new groups within the five divisions. (This will extend complete coverage to all five divisions.)
- ◆ Do a baseline of all facilities in the new areas and update the information on all of the facilities in the Phase I areas.
- ◆ Conduct a pre- and postknowledge survey of Phase II groups.
- ◆ Work with the MOH and the AIDS, Population, and Health Integrated Assistance (APHIA) Project in Nakuru to provide PAC training and kits to providers in Phase I and Phase II locations.
- ◆ Review action plans—evaluate and continue the community action cycle every three months with SWAK and Phase I groups.
- ◆ Prepare Phase I core group leaders to be associate facilitators for Phase II expansion.
- ◆ Identify indicators and establish a monitoring system that will capture:
 - ◇ Individual behavior change at the community level, such as changes in knowledge and attitudes of community members and providers
 - ◇ Changes in community norms (for example, more open communication in the community regarding bleeding related to pregnancy complications)
 - ◇ Empowerment of community individuals and groups (for example, the number of individual and group champions who lead advocacy efforts related to improving access to PAC and FP services)
 - ◇ Key lessons learned related to replication (such as in the number of changes and modifications made to the facilitator guide)

Opportunities for the Implementation of Phase II

- ◆ The Bolivia facilitator’s guide will be adapted based on lessons learned in Phase I, making it easier to develop new groups.
- ◆ Expansion within the divisions will allow all five divisions to be completely covered.
- ◆ By expanding within divisions, groups from Phase I will be able to take leadership roles in facilitating sessions along with SWAK staff.
- ◆ Stakeholders from Phase I will be role models for stakeholders in Phase II and will help build partnership between communities and stakeholders, including providers.

- ◆ In a meeting held with the MOH, SWAK, and ACQUIRE, the medical officer indicated that PAC training is in their work plan and will be a priority. There will be follow-up discussions with Family Health International and the APHIA Project.

Potential Challenges to the Implementation of Phase II

- ◆ Obtaining PAC-trained providers and kits for all of the facilities
- ◆ Meeting high expectations on the part of the community (The volunteers are valued resources, and there is an expectation that they are receiving an income for their work.)
- ◆ Ensuring that the new groups and areas are started with enough time for them to develop a work plan

Appendix I:

COMMPAC Core Groups and Representatives

Name	Division	Group
Shadrack Ngeno	Rongai	Rongai Orphans
Mary Keana	Rongai	Ushindi Women's
Henry Odera	Rongai	Jubo Youth Group
Esther Nyokabi	Njoro	Piave Women's
Mary Karina	Njoro	Simama Imara Women's
Mary Ann	Njoro	Rumwe Women's
Mary Nduta	Njoro	Subuku F.F.S.
Veronica Wanjiru	Bahati	Stoo Makaa Women's
Fridah Nyambura	Bahati	Heshima Exodus Youth
Regina Wairimu	Bahati	Bahati Youth
Peter Munga	Lanet	Lanet Team Men's
Gitau Evens	Lanet	Buyanzi Women's
Joseph Akach	Nakuru Municipality	United Tenant
Ann Githinji	Nakuru Municipality	Bright Light Youth
Alice Chepchirchir	Nakuru Municipality	Umoja Focus Women's

Appendix 2:

Examples of Problems and Solutions Identified by Community Groups

Problem	Possible Solution
1. Lack of communication between parents and children, leading to unplanned pregnancies	Counsel boys and girls, with their parents, to increase dialogue between sexes and hold parent-youth forums.
2. Parents encouraging and assisting their school-going daughters to abort	Sensitize parents on the dangers of abortion.
3. Lack of drugs and qualified personnel at a health facility to assist when bleeding occurs in the first five months of pregnancy	Liaise with MOH personnel through local administrators to provide drugs and qualified personnel to the health center.
4. In cases of unplanned pregnancies, men do not care about the problem of bleeding during the first five months of pregnancy	Counsel the men in forums to understand the dangers of bleeding during pregnancy, since they are the cause of the pregnancies, whether planned or unplanned.
5. Use of illegally made and potent alcohol by men, often resulting in violence toward pregnant women	Liaise with local administration to ban illicit brews, to reduce incidents of violence targeted toward pregnant women.
6. Lack of transportation to health facilities	Start income-generating activities to enable communities to pool funds to pay for transportation during emergencies
7. Inaccessibility of health facilities due to the long distances that have to be traveled to get to them	Try to approach health authorities to make provisions for well-staffed health facilities that are nearer to the community.
8. Ignorance of community members (both men and women) regarding reproductive health issues	Use of resource persons from the community to sensitize them on reproductive health issues.
9. Poverty hindering attendance at antenatal clinics	Start income-generating activities to enable pooling of funds in order to start an emergency fund in the community.
10. Poor attitude of health officials at public health institutions	Have community group leaders visit the health facilities and talk to the health institution authorities to change their attitudes.
11. Peer pressure leading to abortion	Sponsor peer counseling in communities and in schools on the effects of abortion.
12. Poor road network leading to delays in getting to health facilities	Meet with local counselors and area MPs to map out strategies on improving road network.
13. Availability of transport affecting the decision of whether to take a woman to a health facility	Inform community members who own means of transportation that they can contribute to solving problems related to the transport of pregnant women.
14. Insecurity at night, due to the presence of many robbers in the area	Start community policing, with help from the local administration.
15. Corrupt health personnel who ask for bribes even during emergencies	Report cases of corruption to authorities at the health institutions.
16. Lack of knowledge on PAC services offered in private and public health institutions	Educate the community on available PAC services in the health institutions.
17. Unwillingness of people who own vehicles to assist those without vehicles, even when bleeding occurs during the first five months of pregnancy	Hold community meetings where the leaders talk of the importance of good neighborliness in cases of emergency.
18. Limited operating hours of health facilities (8 a.m.–5 p.m.)	Talk to health authorities to have personnel work in shifts, or be on-call when bleeding emergencies occur at night.

Problem	Possible Solution
19. Seeking out faith healers when bleeding occurs during the first five months of pregnancy	Sensitize the community on the importance of seeking qualified medical personnel when bleeding occurs during the first five months of pregnancy.
20. Poor communication between community-based organizations (CBOs), local authorities, and the community regarding the issue of bleeding during the first five months of pregnancy	Identify the proper communication channels to be used to encourage communication between CBOs, local authorities, and the community.
21. Lack of openness between women and their husbands	Encourage openness by counseling both men and women on the importance of dialogue and the dangers of bleeding during the first five months of pregnancy.
22. Lack of nearby facilities or health institutions	Lobby the government, through local authorities, for the introduction of mobile facilities.
23. Lack of pregnancy planning or emergency planning	Educate the community on the importance of birth planning and planning for emergencies.
24. Refusal of public transport operators to transport to the hospital women who are bleeding during the first five months of pregnancy	Hold sensitization workshops in <i>matatu</i> and bus terminals to educate transport operators on the dangers that bleeding during the first five months of pregnancy pose for women and on the need for emergency transportation to the nearest health facility.

Appendix 3: Examples of Community Action Plans

I. Bahati Division

Key Problem	How Did You Know (Data)	Short-Term Indicators (Outcomes)	Steps Taken to Resolve	Resources
Lack of extra facilities	Three women died.	A maternity facility is in progress, and clients are being referred to Provincial General Hospital (PGH).	Core group leaders called a meeting with the community, discussed the issue, and sent three people to the MP, who promised to help through community development funds, and now maternity is on-process.	<ul style="list-style-type: none"> ◆ MP ◆ Chief ◆ Community development funds
Long distance between health facilities (public)	Three women died.	<ul style="list-style-type: none"> ◆ Dispensary was renovated. ◆ The division has a maternity facility, and MP has promised to support introduction of PAC. 	<ul style="list-style-type: none"> ◆ Mobilized community (60) ◆ Talked to MP about PAC services ◆ To follow-up 	<ul style="list-style-type: none"> ◆ Stoo Makaa Women's Group ◆ Heshima Exodus Youth Group ◆ MP ◆ Community members ◆ MOH
Use of traditional methods to induce an abortion	About 20 women and girls bled due to induced abortions from using traditional herbs.	Since July 2006, no cases of induced abortion have been reported.	Organized education forum with 200 women.	<ul style="list-style-type: none"> ◆ Community members ◆ Core group members from the three groups
Lack of recognition that bleeding during the first five months of pregnancy is a problem	15 women lost their pregnancies (within three months).	More women are seeking reproductive health care (12 women).	Nurse from Health Council (HC) organized two community education sessions for 100 women.	<ul style="list-style-type: none"> ◆ Nurse from Kabatini Health Centre ◆ Matron from Bahati Sub-District Hospital

2. Rongai Division—Rongai Orphans Group, Ushindi Women’s Group, Jubo Youth Group

Key Problem	How Did You Know (Data)	Short-Term Indicators (Outcomes)	Steps Taken to Resolve	Resources
Attitude of health worker	Complaints from the (80) clients referred from the CBO	<ul style="list-style-type: none"> ◆ Good referrals from CBOs to health center ◆ Improved working hours (from four to nine hours) 	Held a meeting between CBOs, officer in charge, and community through the SWAK office.	<ul style="list-style-type: none"> ◆ CBO ◆ Community members ◆ SWAK office
Transport (roads)	Poor roads/ infrastructure	<ul style="list-style-type: none"> ◆ CBOs collaborated with community to construct a dispensary nearby. ◆ CBOs and community development funds were used to maintain roads. 	<ul style="list-style-type: none"> ◆ Road was constructed. ◆ Easy means of transport 	<ul style="list-style-type: none"> ◆ Community members ◆ Community development funds ◆ Latif (municipality funds that the groups accessed)
Teenage unplanned pregnancy	<ul style="list-style-type: none"> ◆ School drop-outs (five per school) ◆ Teenage pregnancies 	Visited two schools and talked to students.	<ul style="list-style-type: none"> ◆ Fewer school drop-outs ◆ Fewer teenage pregnancies 	<ul style="list-style-type: none"> ◆ Jubo Youth Group ◆ Assistant chief
Distance between health centers (21 km)	<ul style="list-style-type: none"> ◆ It took three hours to reach health center ◆ No health care providers living in the neighborhood 	<ul style="list-style-type: none"> ◆ Organized a harambee. ◆ Approached MP for more support through community development funds. ◆ Renovated house. 	<ul style="list-style-type: none"> ◆ Distance was reduced between health facilities. ◆ Dispensary was constructed. ◆ Started construction of housing for health care providers. 	<ul style="list-style-type: none"> ◆ Community development funds ◆ MP ◆ Jubo Youth Group ◆ Community members

3. Municipality Division—United Tenant Group, Bright Light Youth Group, Umoja Focus Women’s Group

Key Problem	How Did You Know (Data)	Short-Term Indicators (Outcomes)	Steps Taken to Resolve	Resources
Lack of good road and bridges	<ul style="list-style-type: none"> ◆ Vehicles could not reach the community to collect clients ◆ Delay in reaching hospital in time to reported death with bleeding problems (November 2006–January 2007) ◆ Interviews 	Roads and bridges have been constructed to allow easier means of transport to hospital.	<ul style="list-style-type: none"> ◆ Community sensitization completed ◆ Meeting with the MP was organized ◆ The MP promised to give community development funds ◆ The council donated money from Latif to assist in the road construction 	<ul style="list-style-type: none"> ◆ MP ◆ Community development funds ◆ Latif ◆ CBO ◆ Chief ◆ Pastors ◆ Council representative
Lack of security	<ul style="list-style-type: none"> ◆ Mugging of the client at night, 55 reported cases ◆ Four per month, leading to delays in reaching the health facilities (January–December 2006) ◆ Interviews 	<ul style="list-style-type: none"> ◆ Chief camp has constructed a strategic area (with four security personnel) ◆ Fewer cases of mugging ◆ No cases reported in January 2007 ◆ Daily patrol 	<ul style="list-style-type: none"> ◆ Meeting with the District Officer (DO) was organized and attended by the security personnel and District Coordinator (DC), who promised daily patrols every day and night ◆ Chief has been posted 	<ul style="list-style-type: none"> ◆ DO of Municipality ◆ Area councilors ◆ DC ◆ Community development funds ◆ Community residents
Lack of reproductive health services	<ul style="list-style-type: none"> ◆ 30 schoolgirl pregnancies ◆ Ten deaths due to bleeding ◆ Interviews 			

4. Njoro Division—Piave Women’s Group, Simama Imara Women’s Group, Rumwe Women’s Group

Key Problem	How Did You Know (Data)	Short-Term Indicators (Outcomes)	Steps Taken to Resolve	Resources
Attitude of health worker	Complaints from the (80) clients referred from the CBO	<ul style="list-style-type: none"> ◆ Referrals from CBOs to health center ◆ Improved working hours (from four to nine hours) 	Held a meeting between CBOs, officer in charge, and community, through SWAK office	<ul style="list-style-type: none"> ◆ CBO ◆ Community members ◆ SWAK office
Transport (roads)	Poor roads/ infrastructure	<ul style="list-style-type: none"> ◆ CBOs collaborated with community to construct a dispensary nearby. ◆ CBOs and community development funds to maintain roads. 	<ul style="list-style-type: none"> ◆ Road was constructed. ◆ Easy means of transport 	<ul style="list-style-type: none"> ◆ Community members ◆ Community development funds ◆ Latif
Teenage unplanned pregnancy	<ul style="list-style-type: none"> ◆ School dropouts (five per school) ◆ Teenage pregnancy 	Visited two schools and talked to students.	<ul style="list-style-type: none"> ◆ Fewer school dropouts ◆ Fewer teenage pregnancies 	<ul style="list-style-type: none"> ◆ Jubo Youth Group ◆ Assistant chief
Distance between health centers (21 km)	<ul style="list-style-type: none"> ◆ It took three hours to reach health center. ◆ No health care providers living in the neighborhood 	<ul style="list-style-type: none"> ◆ Organized a harambee. ◆ Approached MP for more support through CDF. ◆ Renovated house. 	<ul style="list-style-type: none"> ◆ Distance was reduced between health facilities (two health facilities). ◆ Two dispensaries were constructed. ◆ Started construction of housing for health care providers. 	<ul style="list-style-type: none"> ◆ CDF ◆ MP ◆ Jubo Youth Group ◆ Community members

5. Lanet Division—Lanet Team Men’s Group, Buyanzi Women’s Group

Key Problem	How Did You Know (Data)	Short-Term Indicators (Outcomes)	Steps Taken to Resolve	Resources
Unplanned pregnancies	<ul style="list-style-type: none"> ◆ 14 cases of unplanned pregnancies in this area.= ◆ Ten cases of school dropouts due to unplanned pregnancies ◆ Three cases of abortion leading to bleeding ◆ Three rapes ◆ Information gathered from community and health centers through homework assignment 	<ul style="list-style-type: none"> ◆ Reduced unplanned pregnancies (from 14 to two cases) ◆ Reduced abortion cases (community data) ◆ Talked to dispensary. ◆ Fewer cases of school dropouts. 	<ul style="list-style-type: none"> ◆ First established friendly relationship with health workers from MOH ◆ Mobilized the community and invited health workers to come and teach reproductive health ◆ Talked to both the parents and children, referred them for PAC services at PGH, and advised the parents to take them to school (nine schools, 1,250 people) 	<ul style="list-style-type: none"> ◆ Health workers ◆ CBOs ◆ Community members ◆ Oasis Church ◆ Lanet Team Men’s Group ◆ Buyanzi Women’s Group ◆ Lanet youth (contributed fare) ◆ Chief (Lelei)
Lack of knowledge about bleeding during the first five months of pregnancy	Three women lost their pregnancy due to miscarriage (one woman had lost pregnancy three times).	Two of the women have carried their pregnancy almost to full term.	<ul style="list-style-type: none"> ◆ Talked to the three women and advised regarding where to seek help early. ◆ Organized a talk in the church (30 women). 	<ul style="list-style-type: none"> ◆ Buyanzi Women’s Group ◆ Health workers ◆ Pastor of Ebenezer Church

Appendix 4:

List of Resources Reviewed

General Documents

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15. SWAK and Russell, N. 2006. Internal notes on meeting regarding COMMPAC Activities. Nairobi. September 20.
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