To the Fullest Extent of Policy: Post-Abortion Care in Kenya

Saumya RamaRao, Chi-Chi Undie, Francis Obare, Lynn Van Lith, Hannah Searing and Mercy Wahome

THE RESPOND Project

Background

The right to health, according to the World Health Organization (2007), 'means that governments must generate conditions in which everyone can be as healthy as possible.' Policy and legal frameworks are instruments that governments use to design, organize, and implement programs to address the needs of their citizens. In many countries, the area of reproductive health and rights has been a contentious issue with health activists and rights advocates being aligned against other stakeholders. The fault lines have typically tended to be around women's reproductive rights and rights to certain kinds of health care. The discussions and negotiations around reproductive rights (including the right to quality reproductive health care) that crystallized in Cairo in the mid-1990s have continued since then in different regions of the globe. For example, in Africa, the Protocol on the Rights of Women was ratified by 15 African governments in 2005 (Centre for Reproductive Rights, 2006). This protocol affirmed access to reproductive health care – including health care services related to family planning – as a key human right.

The trend in global and regional discussions is reflected in Kenya as well. The context for the Kenyan debate has occurred within a wider political movement to reform the country's constitution. In early August 2010, the country held a referendum to approve a new constitution. The new constitution was passed by an overwhelming majority. This was a watershed moment since discourse on rights and liberties of citizens and the role of the state also included reproductive health and rights. Two key elements of particular salience include decentralization of political power to local bodies along with budgets for health programs and affirmation of the right of citizens to reproductive health care.

The passing of the new constitution provides further impetus to ongoing Ministry of Health (MOH) efforts to decentralize program planning and execution and to involve communities. For example, the recently drafted Community Strategy highlights the critical role that Kenyan communities play in articulating their health needs and their role in the planning and program monitoring process. Like other health-related strategic plans in Kenya, the concept of public-private partnerships in health provision is emphasized within the Community Strategy. With its goal of reaching millions of (mainly poor) households with health information and services, structures have been developed to facilitate the engagement of communities, civil society organizations, and other stakeholders in discourses around health policy.

Despite the existence of clear legal and policy frameworks, health programs and individual services are often not implemented to the "fullest extent of the law" due to a variety of reasons stemming from lack of clarity of the policy, lack of standards and guidelines for services, weak health systems among others.

In this paper, we discuss recent efforts in Kenya that harnessed the policy environment to address postabortion care (PAC) with support from the U.S. Agency for International Development (USAID) under the RESPOND project. The RESPOND Project —'Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services'— is a five-year (2008-2013) cooperative

agreement (GPO-A-00-08-00007-00) funded by the Office of Population and Reproductive Health, USAID, the purpose of which is to address the need for family planning (FP) through expanding contraceptive choices and program services. RESPOND is led by EngenderHealth, in partnership with five other organizations: FHI 360, the Futures Institute, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU/CCP), Meridian Group International, Inc., and the Population Council.
We present data from Naivasha District, Rift Valley Province, where the highest number of cases of abortion-related out-patient morbidity in Kenya has consistently been recorded since 2003 (Kenya Ministry of Health, 2005).

Data and Methods
The data presented are from a pre- and post-intervention, quasi-experimental study conducted in six 'community units' in Naivasha, Kenya, from 2010 to 2012. A community unit comprises five or more villages, each ideally covered by two community health extension workers (CHEWs) and 50 community health workers (CHWs). Information was collected through a community-based survey of women aged 18 to 49 (593 women at baseline and 647 women at endline). Semi-structured interviews were conducted with one health provider per health facility in the study areas (n=10) at endline, and service statistics were abstracted from April 2009 to December 2011 from all health facilities in the study areas to determine trends in the mean numbers of clients seeking FP and PAC services. Qualitative data were also collected through in-depth interviews with key informants (n=11) and focus group discussions (n=15) with a range of participants that participated directly or indirectly in the intervention.

The intervention was designed by the RESPOND Project and aimed at increasing awareness and use of PAC services and improving FP and reproductive health outcomes. The intervention was carried out over an 18-month period from July 2010 to December 2011 and involved the following activities:

1. Training MOH CHEWs and CHWs based in Naivasha on the Community Action Cycle[1] and approaches for working with communities in Naivasha using the Cycle. This included building the capacity through training of CHEWs to provide ongoing mentoring and support to CHWs in facilitating community dialogue around PAC and FP in the communities in their work areas.
2. Training service providers (primarily clinical officers, registered nurses, and registered midwives) within MOH dispensaries and health centers in Naivasha in the management of complications related to miscarriage and unsafe abortion, to respond comprehensively to potential demand for PAC services by community members. Providers at 11 participating health centers and dispensaries were trained in PAC (including FP).
3. Supporting trained CHEWs and CHWs in conducting community mobilization sessions in their communities and providing ongoing mentoring and support to trained CHEWs and CHWs via monthly monitoring visits and quarterly meetings, which enabled community-facility linkages and joint problem-solving.

RESPOND deliberately aligned its package of inteventions with the MOH Community Strategy, using 'community units' and the structures integrated within them as the entry point into Naivasha villages.

[1] The Community Action Cycle is a tested strategy for addressing the issue of unsafe abortion, and improving PAC and access to FP, and was the primary methodology used to facilitate the capacity-building process during the three-day community mobilization sessions. Its steps include (1) Preparing to mobilize the community; (2) Organizing the community for action; (3) Exploring health issues and setting priorities; (4) Planning together; (5) Acting together; (6) Evaluating their action plans together as a community; and (7) Preparing to scale up. It is a highly participatory process in which communities take action for their own health.

The Community Strategy aims to enhance community access to health care through decentralization of sustainable lower-level services and enhanced accountability and responsibility among all, including community members themselves. RESPOND focused its efforts, in part, on strengthening the interface between communities and the dispensaries and health centers that serve them.

Analysis of the community-based survey data occurred in two steps. In the first step, descriptive statistics on each variable at baseline and endline were generated, and comparisons drawn within the intervention and comparison sites, conducting Chi-square tests to determine whether there were any significant differences (calculated as $p<.05$). In the second step, the analysis comprised difference-in-differences estimation – i.e., the difference in changes over time between intervention and comparison sites. The outcomes considered included knowledge and use of PAC and FP, knowledge of danger signs in early pregnancy, and exposure to community mobilization. Data collected via the provider tools were reviewed manually while qualitative data were analyzed thematically.

Results

Knowledge of danger signs

Improving knowledge of danger signs in early pregnancy was a key element of the COMMPAC intervention, in addition to encouraging women, couples and communities to act immediately in such cases. Study results showed significant increases in the proportion of intervention area respondents reporting knowledge of certain danger signs in intervention sites (specifically, 'bleeding heavier than a normal period,' 'continued bleeding for two weeks,' and 'dizziness/fainting'). Significant increases in knowledge of other danger signs ('severe abdominal pain' and 'severe and constant headache'), however, were observed in intervention and comparison sites alike (Table 1).

The change over time in the intervention site in regard to the proportion of women that identified 'bleeding heavier than a normal period' was 2.05 times greater than was the case in the comparison site, according to the difference in differences analysis.

CHWs were responsible for sensitizing community members on the danger signs in early pregnancy. As excerpts from qualitative discussions demonstrate, unusual bleeding in particular seemed to resonate with community members:

> We did not know that bleeding even a spot of blood is risky. We did not know that a small amount of bleeding was bad. But we have now discovered and we now know the truth. So if you see just a small amount of blood, you should rush to hospital.
> *FGD with female youth resident in communities where the Community Action Cycle took place*

> Before we were trained by PAC [COMMPAC], our people died a lot from miscarriages, they didn't understand the danger signs. They thought it was normal and ended up dying. But now we have been trained and we've penetrated to the grassroots and even the ones who thought it wasn't a serious problem now know it's a serious problem. So, the extreme cases and miscarriages have reduced tremendously.
> *FGD with Community Leaders, Karunga*

Table 1: Percentage of respondents knowing various danger signs or complications in early pregnancy

	Intervention		Comparison	
	Baseline (N=388)	Endline (N=442)	Baseline (N=186)	Endline (N=205)
Increased bleeding	32.2	19.7**	43.0	20.5**
Bleeding heavier than a normal period	13.4	23.5**	21.0	20.5
Continued bleeding for two weeks	2.8	7.5**	1.6	4.9
Severe abdominal pain	38.4	50.0**	44.6	56.6*
Fever	7.2	5.9	8.1	8.8
Chills	6.2	1.1**	7.0	3.9
Foul-smelling vaginal discharge	3.9	6.1	6.5	4.9
Muscle aches	13.4	8.4*	10.2	6.8
Tenderness to pressure in abdomen	4.6	6.3	3.2	12.2**
Dizziness or fainting	15.2	24.4**	20.4	23.9
Feeling ill, weakness	39.4	37.3	38.7	36.1
Persistent nausea or vomiting	42.5	26.7**	42.5	33.2
Severe and constant headache	9.3	14.3*	5.9	12.2*
Other	16.5	20.6	18.3	17.1
*p<0.05; **p<0.01				

Postabortion care-seeking within respondents' own communities

The intervention involved training providers at dispensaries which were closest to the communities and encouraging women in the communities to visit their closest health facility to reduce the delay in obtaining care. At baseline, no clients had received PAC services in the intervention and comparison health facilities. A review of service statistics from the health facilities shows that by endline, a total of 30 women had received such services at the intervention area health facilities (Table 2), and none had obtained PAC services from the comparison site.

Table 2: Number of clients recorded as having sought PAC services at intervention site health facilities (December 2010 to December 2011)

Karunga	**Kiambogo**			**Longonot**	
Karunga Dispensary	Kiambogo Dispensary	Kiptangwanyi Dispensary	Oljorai Health Center	Holy Trinity Health Centre	Longonot Dispensary
3	**10**	**10**	**7**	**0**	**0**
Total number of clients = 30					

Another focus of the COMMPAC intervention was on women seeking care at the closest service delivery point to reduce delays in obtaining postabortion care. Intervention area participants were more likely to seek care for bleeding in early pregnancy within their own communities at endline than at baseline (from 33% to 50%), getting to health facilities either by walking or by using transportation. In contrast, comparison site participants were less likely to seek care within their own communities at endline compared to baseline (58% to 41%) (Table 3).

Table 3: Mode of transportation to place where care was sought for bleeding in early pregnancy

	Intervention		Comparison	
	Baseline (N=24)	Endline(N=42)	Baseline(N=19)	Endline(N=12)
Within community at walking distance	12.5	21.4	26.3	25.0
Within community but need transportation	20.8	28.6	31.6	16.7
Outside the community, at walking distance	4.2	0.0	0.0	0.0
Outside the community and need transportation	62.5	50.0	42.1	58.3

Providers' skills enhanced in intervention site

Unlike their peers in the comparison sites, intervention site providers indicated that they felt equipped to offer postabortion care. Moreover, all intervention site providers interviewed (n=6) regarded the provision of PAC services as a responsibility of their health facility. They also considered themselves competent to practice manual vacuum aspiration (MVA) in particular, and had each personally used the MVA method to treat PAC clients. Conversely, none of the comparison site providers (n=4) considered PAC services an integral part of the services offered in their health facilities, nor were PAC services offered in any of these facilities. At endline, while comparison site providers accurately cited 3-5 danger signs in early pregnancy (an average of 4 signs), intervention site providers were each able to accurately cite 5-8 danger signs (an average of 6 signs each).

Current use of family planning

Substantial increases in FP use occurred within intervention sites (47% at baseline to 54% at endline) and comparison sites (46% at baseline to 60% at endline), as shown by Table 4. The injection and the pill remained the most commonly-used methods across the study period, while there was a significant decrease in the use of the Standard Days Method by both intervention and comparison respondents. There were also non-significant increases in the use of long-acting/permanent methods in both intervention and comparison sites. A statistically significant increase was observed in intervention areas (3% to 7%) and comparison sites (0% to 6%) with regard to the current use of hormonal implants.

The observed increases notwithstanding, the difference-in-differences analysis shows that there were no significant changes over time in the intervention sites versus the comparison areas in the proportions of women that were currently using FP between baseline and endline.

Table 4: Current use of family planning

	Intervention		Comparison	
	Baseline	Endline	Baseline	Endline
% currently using family planning	46.9%(N=343)	53.9%(N=397)	45.9%(N=172)	59.5%(N=185)*
% distribution of family planning methods currently used:				
	N=160	N=215	N=77	N=110
Injectable	58.8	46.0*	57.1	51.8
Pill	10.0	14.4	18.2	15.5
Standard days method	6.9	0.5**	10.4	1.8*
Female sterilization	6.3	9.8	3.9	8.2
IUD	5.6	10.2	2.6	9.1
Fertility awareness methods	4.4	4.7	2.6	7.3
Condom	3.8	4.7	2.6	0.0
Lactational amenorrhea method	0.0	1.9	2.6	0.0
Hormonal implants	2.5	7.0*	0.0	5.5*
Emergency contraceptive	0.6	0.0	0.0	0.0
Other	1.3	0.9	0.0	0.9
*p<0.05; **p<0.01				

Some of the main reasons for women's non-use of FP methods persisted between baseline and endline in the intervention and comparison areas alike. These reasons include: not being married, breastfeeding, and fear of side effects. However, by endline, intervention site respondents were less likely to cite their own opposition to the use of FP as the reason for their non-use (Table 5).

Table 5: Main reasons for not using family planning

	Intervention		Comparison	
	Baseline(N=182)	Endline(N=183)	Baseline(N=92)	Endline(N=75)
Is Not married	22.5	22.4	20.7	24.0
Is not having sex	8.2	15.3*	12.0	17.3
Having infrequent sex	3.3	7.7	2.2	2.7
Is Menopausal/hysterectomy	6.6	4.9	0.0	4.0
Is subfecund/infecund	2.2	0.0*	5.4	0.0*
Is breastfeeding	17.6	19.1	17.4	16.0
Is fatalistic	0.6	0.5	0.0	1.3
Respondent is opposed	6.0	3.8	7.6	8.0
Husband/partner opposed	4.4	6.0	8.7	10.7
Others opposed	0.0	0.5	0.0	0.0
Religious prohibition	5.5	3.3	3.3	2.7

Health concerns(interferes with body's natural processes)	5.0	9.8	5.4	9.3
Fear of side effects	11.5	14.8	13	20.0
Lack of access/too far	0.0	0.0	0.0	0.0
Costs too much	0.0	1.1	0.0	0.0
Inconvenient to use	2.2	0.0*	1.1	2.7
Interferes with body's natural processes	5.0	1.1*	5.4	5.3
Knows no source	0.0	0.0	2.2	0.0
Don't know	0.0	2.7*	0.0	0.0
Other	0.0	4.9**	0.0	14.7**
*p<0.05; **p<0.01				

Discussion and Conclusion

Access to important services such as PAC is critical for the poor, and for hard-to-reach communities such as Naivasha. Collectively, the findings highlight the fact that heightening community awareness and mobilization is essential for strengthening post-abortion care. The COMMPAC intervention proved effective in: increasing women's overall awareness of danger signs in early pregnancy; providers being able to effectively offer PAC services at the lower-level health facilities (dispensaries); raising awareness of PAC; getting women to seek and obtain PAC services at the dispensary level and in their own communities. The intervention was less successful in increasing women's current use of family planning.

Given the current policy environment in Kenya with myriad openings for making a difference in health outcomes, there is a need for government programs to be responsive to the citizenry and to implement innovative and effective programs that will contribute results to MDGs 4 and 5. The RESPOND intervention is one such innovation. To ensure that PAC services are implemented to the fullest extent of policy, however – and given the importance of FP for any PAC program – there is a need to ensure that family planning is strengthened as an element of postabortion care at all levels of this particular intervention.

It is possible that the duration of the COMMPAC intervention was too short to observe improvements in family planning use. A study of a community-based newborn-care intervention package conducted in Sylhet, Bangladesh found some significant health-related benefits, but only in the last 6 months of a 30-month intervention period (Baqui et al., 2008). Although the results show that the COMMPAC intervention raised awareness and reduced social stigma surrounding PAC, a verbal autopsy assessment might have helped to elucidate the extent to which reports of bleeding in early pregnancy, or pregnancy complications, were missed due to abortion-related death.

References

Baqui AH, El-Arifeen S, Darmstadt GL, Ahmed S, Williams EK, Seraji HR, Mannan I, Rahman SM, Shah R, Saha SK, Syed U, Winch PJ, Lefevre A, Santosham M, Black RE; Projahnmo Study Group. 2008. Effect of community-based newborn-care intervention package implemented through two service-delivery

strategies in Sylhet district, Bangladesh: a cluster-randomised controlled trial. *Lancet* 371(9628):1936-1944. doi: 10.1016/S0140-6736(08)60835-1.

Center for Reproductive Rights, 2006. The Protocol on the Rights of Women in Africa: An Instrument for Advancing Sexual and Reproductive Rights. http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bp_africa.pdf.

Kenya Ministry of Health. 2005. A Report on Performance Status Health Management Information System: 2003-2004 Annual Report.

World Health Organization, 2007. The Right to Health. Fact Sheet No. 323. August 2007. http://www.who.int/mediacentre/factsheets/fs323/en/index.html.