Adaptation of the Bolivia Community Postabortion Care Model in Egypt and Peru

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The Extending Service Delivery (ESD) Project, funded by the United States Agency for International Development (USAID) Bureau for Global Health, is designed to address unmet need for family planning (FP) and increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, in order to improve health and socioeconomic development. To accomplish its mission, ESD strengthens global learning and application of best practices; increases access to community-level RH/FP services; and improves capacity for supporting and sustaining RH/FP services. ESD works closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associates Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, International Centre for Migration and Health, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

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ACRONYMS AND ABBREVIATIONS

BCC	Behavior change communication
CAC	Community action cycle
CDA	Community Development Association
CMP	Centro Materno-perinatal
CM	Community Mobilization
DHS	Demographic and Health Surveys
FEPROMO	Provincial Federation of Organized Women
FGD	Focus group discussion
FP	Family planning
KAP	Knowledge, attitudes and practices
MHS	Ministry of Health and Sports (Bolivia)
MINSA	Ministry of Health (Peru)
MOHP	Ministry of Health and Population (Egypt)
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
PAC	Postabortion care
PNA	Participatory needs assessment
RH	Reproductive health
STI	Sexually transmitted infection
SUMI	Seguro Universal Materno-infantil
USAID	United States Agency for International Development
WHO	World Health Organization

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PURPOSE

As an activity of one of the focus countries of the United States Agency for International Development (USAID) Postabortion Care Working Group and USAID/Bolivia, the CATALYST Consortium developed and pilot-tested the community postabortion care (PAC) model in Bolivia. The Consortium completed the first phase of the model which mobilized the community to identify problems associated with PAC and develop action plans to address these problems. The CATALYST Project ended in Bolivia in 2005 and CATALYST handed over the program to the Bolivia Ministry of Health and the USAID office in Bolivia to continue implementing community PAC activities. The Ministry of Health, Bolivia, with support from the Bolivia USAID office, carried out the second phase of the program to complete the community PAC model. The community PAC model mobilizes the community to recognize the danger signs of incomplete abortion and provides support to women exhibiting these signs to access PAC services. The intervention also helps the community to recognize gaps and shortfalls to access PAC services and encourages community members to formulate solutions to address these problems. The intent of this document is to provide a guide to organizations, cooperating agencies, bilateral projects, and communities interested in carrying out similar community PAC activities and to spark ideas for adaptations based on this model. The community PAC model has proved to be an excellent approach in increasing awareness of postabortion family planning at the community level. It is also effective in increasing accessibility to family planning services by postabortion care clients and complements ongoing clinical PAC services in the public sector. The community PAC model has been successfully adapted in Peru and Egypt. In Egypt the plan is to establish a control group that can be compared to the intervention group and assist in the validation of the community PAC model.

BACKGROUND

More than 500,000 women die annually as a result of complications associated with pregnancy and childbirth (World Health Organization (WHO), 2004). Of these deaths, approximately 68,000 (13% of all maternal deaths) can be attributed to unsafe abortion.[1] Spontaneous abortion, or miscarriage, further adds to maternal mortality and morbidity worldwide. Complications of unsafe abortion may include hemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus and abdominal organs. The WHO estimates that about 20-30% of unsafe abortions results in reproductive tract infections and that about 20-40% of these result in upper-genital-tract infection and infertility.[2] Postabortion care refers to a package of services for women who experience complications of spontaneous or incomplete abortion. At a minimum, PAC includes

[1] The WHO defines unsafe abortion as "a procedure for terminating an unintended pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both."

[2] David A Grimes, Janie Benson, Susheela Singh, et al. Published online November 1st 2006 DOI: 10.1016/SO140-6736(06)69481-6. Dept of Ob/Gyn, University of North Carolina School of Medicine, Chapel Hill, NC 27599-7570, USA

emergency treatment for these complications and provision of family planning (FP) counseling and methods if desired as well as referral to other services such as HIV and testing for sexually transmitted infection (STI) depending upon disease prevalence and available resources. PAC services contribute to lowering maternal mortality and morbidity by providing care and treatment for complications as well as by preventing future unwanted pregnancies and abortions through FP counseling and adopting a family planning method.

The mere availability of PAC services does not guarantee utilization of services. Numerous factors influence the utilization of services. Ensuring good quality care is one of the first steps in increasing the access to services. Other factors that prevent utilization of PAC services are socio-cultural factors and deep rooted traditional beliefs. These barriers can be addressed by working with the community members to help them understand the health benefits of timely access to PAC services. The decision to seek care is often delayed by a husband's lack of approval, undue family obligations, fear of stigmatization and lack of recognition that bleeding in pregnancy, fever, and signs of miscarriage are legitimate health problems that can be adequately and safely treated by trained health care providers.

Recognizing that access to PAC services is hindered by geographic and financial limitations and social and cultural stigma, in 2003, USAID introduced a PAC model that included "community empowerment through community awareness and mobilization" as one of its core components.[3] By including a community component, USAID's model aimed to reduce stigma of accessing PAC services through community engagement and mobilization to support the utilization of these services by women who need them. CATALYST Consortium piloted the first phase of the community PAC model in Bolivia. The intervention was designed based on the community action cycle (CAC) developed by Lisa Howard-Grabman and Gail Snetro.[4] CATALYST scaled up the model in Peru and Egypt to validate the importance of community participation in increasing women's access to PAC services and to gather further evidence for this type of community intervention.

INTRODUCTION

The main objective of the community PAC model is to increase awareness of and strengthen access to PAC services. These include preventive services such as FP counseling and the provision of contraceptive methods in addition to treatment of complications of miscarriage and incomplete abortion. As a prerequisite to initiating a PAC community mobilization program, well established PAC services need to be in

[3] The other two components of the USAID PAC model are: "emergency treatment" and "FP counseling, provision, STI evaluation and treatment and HIV counseling and/or referral for testing."
[4] Howard-Grabman, L. and G. Snetro. "How to Mobilize Communities for Health and Social Change: A Health Communication Partnership Field Guide." Health Communication Partnership (HCP) with support from the United States Agency for International Development (USAID), 2002.

place because the community mobilization activities will generate greater demand and utilization of PAC services. Community PAC complements existing PAC clinical interventions. This is accomplished by bringing greater attention to the established PAC services and increasing the utilization of existent PAC services by women and communities in need.

The community PAC activities emphasize increasing the communities' awareness of where PAC services are available, recognition of the danger signs associated with complications of miscarriage and incomplete abortion, and the importance of utilizing FP methods in preventing unwanted pregnancies and practicing healthy timing and spacing of pregnancies for better health outcomes. By involving the community in the mobilization effort, the power dynamics between community members and groups that influence the issues in the community are altered, thus, providing opportunities for positive change.

To help generate ideas for adaptation of this model and to provide examples of its applicability in different countries and settings, this document will describe in detail the activities the CATALYST Consortium undertook for implementing the community PAC model in Bolivia, Peru and Egypt. The original model, which was conducted in Bolivia, was appropriately adapted for the cultural, social and clinical settings present in Peru and Egypt. This document will elaborate each of the country experiences and provide further details of the similarities and differences of the adaptations.

The Postabortion Care Community Mobilization Model

The PAC Community Mobilization (CM) model engages community members in identifying and providing solutions to issues by going through the following phases:

Phase 1 – Prepare to mobilize
Phase 2 – Organize the community for action
Phase 3 – Explore the health issue and identify priorities
Phase 4 – Plan together
Phase 5 – Act together
Phase 6 – Evaluate together

This document will describe the pilot model in Bolivia as the base model and the adaptations made in the Peru and Egypt community PAC activities. This will help the reader to understand how the model can be applied and adapted in different levels, settings and sociocultural contexts.

PILOT MODEL IN BOLIVIA

The RH/FP status of Bolivians is among the lowest in Latin America. Modern contraceptive prevalence among women aged 15-49 who are married or in union is 27% and unmet need among this group is 26% (Demographic and Health Surveys (DHS),

1998). Abortion is legally restricted in the country and the Ministry of Health and Sports (MHS) estimates that 27% to 35% of maternal mortality is due to complications of abortion.

Phase 1 – Prepare to mobilize

During the first phase of the project, four steps were taken:
Identification of project objectives

1. Selection of project communities
2. Identification of staffing needs
3. Development of the project team

Identification of project objectives:

The general project objective in Bolivia was to empower the community to recognize the complications of miscarriage and incomplete abortion and to take necessary steps to treat and prevent unintended pregnancy in the future. To achieve the general objective, specific objectives were identified. These included:

- Identify attitudinal, social, physical and financial barriers to prevention of unintended pregnancy and treatment of complications of miscarriage and incomplete abortion.
- Identify and strengthen local capacity for addressing the health needs associated with prevention of unintended pregnancy and treatment of complications of miscarriage and incomplete abortion.
- Develop community action plans for addressing the barriers to use of both FP and PAC services.

When developing project objectives, it was important not to preempt the community's ability to identify and provide their own solutions to issues. For example, "education about FP and PAC services" would not have been a relevant objective since community members may have perceived available services as inadequate. Instead, the community mobilization process should allow the community members to identify problems in their existing health care services and educate health workers about addressing these problems.

Selection of project communities:

After conducting community needs assessments, two urban sites were selected for project implementation, El Alto and Santa Cruz. El Alto is a city made up of mostly rural migrants in the Andean Mountain region while Santa Cruz is an ethnically diverse city located in the Amazon River Basin region. These sites were selected in collaboration with USAID in Bolivia and Washington for a number of reasons: existence of facilities providing quality PAC services, high rates of maternal mortality and dense populations where the number of maternal deaths due to complications of miscarriage and incomplete

abortion or other obstetric emergencies were large enough issues for the community members.

Identification of staffing needs:

Staffing needs depended upon the number of sites for the project. For the pilot in Bolivia, one project coordinator was hired and based in La Paz. The project coordinator was responsible for managing and overseeing the overall project activities at both sites. A local coordinator and two facilitators were recruited for Santa Cruz and one local coordinator and one facilitator worked in El Alto. The local coordinators were responsible for managing the project at the local level. The facilitators provided support in the documentation process and to the community members in carrying out the community mobilization sessions. A data analyst was also recruited for the pilot to compile and analyze the data collected from the community mobilization sessions. In recruiting the project team, preference was given to those with a strong knowledge of reproductive health and family planning issues and experience in facilitating community health sessions.

Development of the project team:

In developing the project team, specific skills in need of development included: community participatory skills (listening, facilitating discussion, inviting participation, conducting activities, exercises and managing power dynamics within the group), utilization of the participatory community assessment tool, data collection skills, reporting project information skills, and presentation skills. A workshop was held prior to project implementation in order to train the entire project staff in skills relevant to community mobilization.

Phase 2 – Organize the community for action

After receiving proper training, the community PAC project team members returned to their respective communities to begin the process of identifying community groups that would participate in the community mobilization process. The project entered the second phase, organizing the community for action, which consisted of the following steps:

1. Garnering support from community authorities
2. Selecting groups and identifying core group members
3. Training core group members

Garnering support from community authorities:

Community authorities were invited to participate in initial meetings and the project launch along with the community mobilization team. It was critical to gain the support of

the community authorities since their involvement would be essential once the community members developed their action plans. Their cooperation, support and active participation would help to push the changes and allocate resources to achieving the goals of the action plans. Failure to involve the community authorities from the beginning can have detrimental repercussions for the project since they may feel left out of the process. "Formal" leaders such as mayors, health administrators, religious leaders and leaders of neighborhood groups as well as "informal" leaders, nongovernmental/traditional community leaders, traditional healers and other community opinion leaders, should be included in the initial meetings and project launch with the community mobilization team.

Selecting groups and identifying core group members:

In Bolivia, a broad spectrum of community members (including women, men and adolescents) was selected from the two urban communities to participate in the community mobilization activity around PAC. Twenty-one community groups were identified in El Alto and twenty-seven in Santa Cruz. The groups included mother's clubs, adolescent groups (aged 15-24), neighborhood boards, men's groups and community health promoters. A total of 1,206 individuals participated at the two sites.

The groups then selected their own leaders to be a part of the community mobilization activity's core group. The core group members guide their respective communities through the community mobilization process and keep careful records of the sessions with the community members. It is helpful to have two leaders selected from each community group so that they can support one another during the community mobilization activities.

Training core group members:

Core group members training consisted of similar topics to the project team training such as facilitation skills and using the participatory community assessment tool. The core group members participated with the project team members in other related trainings as the activity progressed. Upon completion of the training, each core group member received a copy of a facilitator's manual.

Phase 3 – Explore the health issue and identify priorities

In the third phase of the cycle, community members explored the problems of unintended pregnancy and complications of spontaneous and induced abortions in their communities and identified the root causes of these problems. They mapped their communities which helped them to identify PAC and other health services available. They also interviewed health care providers and women using PAC services to obtain further information regarding the type of services available, the hours that PAC services were available, and

quality of services as perceived by actual patients. Community members also discussed quality of care at their local facilities in relation to the problems. The following steps were taken during this phase:

1. Implementing the participatory community assessment
2. Compiling data for analysis
3. Analyzing the data
4. Presenting the results

Implementing the participatory needs assessment:

A participatory needs assessment (PNA) is an instrument designed to guide a participatory community research process in which participants identify and prioritize their problems associated with a specific theme. In this case, complications related to miscarriage and incomplete abortions were identified as key problems.

The core group members utilized the facilitator's manual to implement the PNA through a series of three weekly three-hour sessions with the community participants in El Alto and Santa Cruz. To ensure maximum participation, no more than 25 members participated in each session. The three sessions of the PNA were organized around the "three delays" model of safe motherhood[5]:

- Delay in the decision to seek care
- Delay in arrival at a health facility
- Delay in the provision of adequate care

During the implementation of the sessions, core group members documented the discussions among community members on flip charts and in their own notes.

Compiling data for analysis:

After carrying out the PNA session, core group members drafted a report of the session with the support of the project team. To the greatest extent possible, core group members were encouraged to include a variety of comments and/or responses from the community members and to use exact words and phrases used in the sessions rather than rephrasing statements. Three reports (from the three PNA sessions) were compiled for each community group after the completion of the sessions.

[5] Thaddeus, S. and Maine, D., "Too Far to Walk: Maternal Mortality in Context." Soc. Sci. Med. Vol. 38, No. 8, pp. 1081-1110, 1994.

Analyzing the data:

The data collected from the community groups was analyzed to extract dominant themes of the PNA, dominant needs and priorities identified by the community groups, and an understanding of why from the community's perspective, the problems exist.

The project team in Bolivia also compiled a *Community Health Resources Directory* for each community. The directories revealed gaps in health service coverage and provided vital data about how community members perceived quality of care at their local facilities.

Additional data can also be collected to gain a more comprehensive picture of the issue from the perspective of stakeholders. Interviews with hospital managers, male partners and relatives can be especially useful. Data can also be collected at the facility through observation or exit interviews with clients, when possible.

Presenting the results:

When data analysis was completed, results were presented to the community. The results were presented to the following groups:

- Community groups who participated in the community mobilization activity
- Other community groups who did not participate in the community mobilization activity
- Local institutions and authorities: health, education, church, etc.

Sharing results helped to validate the data analysis to those who participated in the community mobilization process. It also helped to stimulate interest among the community at large and relevant authorities in the action planning.

Phase 4 – Plan together

In this phase, community participants and core group members work to recognize, decide and resolve issues that have been prioritized by creating action plans. Ideally, authorities should be invited to participate in the development of the action plans so that they can also take part in the implementation process.

The action planning occurred during the last of the PNA session and is described in detail in the facilitator's manual. Groups prioritize their identified needs and work through an action planning matrix to answer questions that help to focus their plans such as: What? How? Who? With what? (See an example of the action-planning matrix below). By the end of the session, the groups should have identified action plans that are *realistic*, *attainable* and *feasible* and focus on the prevention of unintended pregnancy and treatment of complications of spontaneous and incomplete abortion.

Table 1: Action Planning Matrix

Problem	Who does it affect?	What is the cause of the problem?	What do we want to achieve ?	How are we going to resolve the problem?	Intervention	With what?	Responsible person(s)	Time (start date - end date)

In Bolivia, a total of 16 action plans were developed, 6 in El Alto and 10 in Santa Cruz. The plans covered four general topics that were common to both communities: health centers, the universal maternal and child health insurance (Seguro Universal Materno-infantil or SUMI), community organization and training. The majority of activities planned involved meeting with community organizations and health facilities to discuss the problems identified in the PNA and developing solutions in collaboration with those entities. For example, participants in El Alto identified gender-based violence as a cause for unplanned pregnancies.

Phase 5 – Act together

Once the action plans have been formulated, the project team, participants, local authorities and other relevant stakeholders collaborate in the implementation of the action plans. By involving relevant stakeholders in the participatory planning phase of the intervention, they were more likely to commit to the action plans and be involved in their implementation. Some of the actions taken by the groups as a result of the action plans were as follows:

In El Alto:

- Activities such as fairs, Pap smear campaigns and screening of education videos at the health centers on different reproductive health and family planning topics.
- Home visits by community providers to identify pregnant women and physical abuse of pregnant women and children by spouses and fathers.

In Santa Cruz:

- Coordination meetings between the neighborhood authorities and health authorities.
- Training workshops with psychologists at the Bolivian Evangelical University.
- Development of posters on what type of care clients are entitled to receive posted in health facilities.
- Improved organization at the network level to prevent a lack of supply of medications from the SUMI.

Phase 6 – Evaluate together

Participatory evaluation occurs on an ongoing basis throughout the community mobilization process. A more intensive evaluation occurs after the action plans have been implemented, and communities develop new action plans. During the evaluation phase, community groups expressed their motivation to continue meeting because they believed their leaders needed their support. Participants also wished to explore activities related to other topics. The model also generated interest in individuals who did not participate in the activities. The community continues to receive support from a local nongovernmental organization (NGO), Socios en el Desarollo, to replicate the community PAC model in other areas.

Results from Bolivia

Changes in knowledge, attitudes and practices (KAP) occurred at both sites as a result of the interventions. A 22-question KAP survey was administered to participants prior to the first PNA session (1,076 respondents) and after the participatory action-planning phase (888 respondents). There was a statistically significant[6] increase in the percentage of participants who knew about at least one FP method (88.3% to 94%) and where PAC services were available (64.8% to 71.3%). The percentage of participants who believed that unintended pregnancies could bring negative consequences increased significantly (from 82.4% to 84.8%). Also, the number of participants who stated that they had used a contraceptive method in their last intercourse rose significantly (45.6% to 54.2%). All findings are statistically significant at p value of 0.05. The participants also felt they were empowered to organize their communities for action.

Key Lessons Learned from Bolivia

- The community mobilization process should not preempt the communities' ability to identify their own objectives and solutions to their PAC related issues.
- It is important to identify qualified and motivated candidates to assist in the project activities as coordinators and facilitators. These persons are the backbone of the implementation and can determine its success or failure.
- Garnering support from local authorities and other relevant stakeholders early in the project is essential to the outcome of the activities.

Summary of Pilot Model in Bolivia

The overall objective of the community mobilization process was to transform relationships of power to enable and sustain changes in behavior that are necessary to improve the health of the community, especially with relation to postabortion care

[6] Statistically significant is defined as P-values below 0.05.

treatment and prevention. Through the different participatory community mobilization exercises, community members explored how social relationships impact their ability to seek health services. Individuals on both sides of the power relationship expressed their viewpoints, and each group was sensitized to the situation of the other group in the hopes of positively changing the power dynamics in the community. The groups involved were men and women and health care providers and health care receivers.

The community PAC model encouraged the use of local resources and demonstrated the potential for sustainability. The model empowered community members to objectively look at issues and formulate solutions to address them. With the promising results and knowledge gained from the Bolivia pilot, CATALYST adapted the model and introduced it in Peru and Egypt.

ADAPTATIONS OF THE COMMUNITY PAC MODEL

CATALYST adapted the community PAC model in Peru and Egypt where CATALYST had existing country programs. In Peru, the CM activities closely paralleled those of Bolivia; the major difference was that the project collaborated closely with local health providers throughout the entire process. The composition of the participants also differed from Bolivia in that CATALYST partnered with a local women's organization and a maternity hospital instead of working with the community at large. In Egypt, rather than working directly with the community members, the activity involved a wide variety of community leaders, including religious leaders, health care providers and educators. In the following sections, this document will describe in detail the rationales for adaptations in the two countries and provide information on the process of the implementations. Instead of repeating each of the major steps in the model, this document will highlight the major differences between the pilot in Bolivia and the adaptations in Peru and Egypt.

ADAPTATION OF MODEL IN PERU

There are nearly 6.7 million women of reproductive age in Peru. More than half of these women (56%), and more than 31% of women in unions either do not use FP methods or use methods incorrectly (DHS, 2000). These low rates of FP use contribute to high rates of unsafe, clandestine abortion, since the procedure is legally restricted. Approximately 35% of the one million pregnancies that occur in Peru each year end in induced abortion.[7] Complications of spontaneous and induced abortion are among the principal causes of maternal mortality, which was 188/100,000 live births in 2003 (DHS).

The adaptation of the model in Peru was implemented in and around the city of Tarapoto, located in the Amazon River Basin. The activity was implemented in 11 communities (urban, peri-urban and rural), ranging in size from 1,396 to 69,501 residents. As

[7] Ferrando, Delicia, "Clandestine Abortion in Peru, Facts and Figures, 2002." Lima, Peru: Centro de la Mujer Peruana Flora Tristan and Pathfinder International.

mentioned above, the intervention was modified and implemented in collaboration with a local women's organization and a maternity hospital instead of the community at large. There were several reasons for the modifications. The first was the fact that the targeted communities were served primarily by the maternity hospital, the Centro Materno-perinatal (CMP). Thus, by working directly with the CMP, it helped to create a partnership between the community and CMP that would allow for ongoing communications in the future. Second the community members were reluctant to discuss early pregnancy, sexually transmitted infections (STIs) and other RH issues, directly with their health providers. CATALYST reached the community by working through a trusted women's organization, the Provincial Federation of Organized Women (FEPROMO), to facilitate the community mobilization activity. Since FEPROMO had an established relationship to the community, the group acted as an interface between the community and the CMP. The PNA instrument was also modified in Peru, and was conducted in four sessions instead of three, including issues specific to the setting such as highlighting quality of care at the CMP. However, the framework for the PNA, the "three delays" model, was the same as in the Bolivia pilot.

Phase 1 – Prepare to mobilize

The project team in Peru included a project coordinator, two facilitators working at the community level, and a doctor from the CMP who supported communication between the project and the CMP. The project team underwent similar training as the Bolivia project team. CATALYST was able to draw from existing study findings from a focus group study conducted by Pathfinder International before initiating a national comprehensive facility based postabortion care program in 2001. The study found that traditional methods were frequently used by the local population for inducing abortions though it was evident at the same time that any form of abortion, induced or spontaneous, was highly stigmatized. Although women recognized the relationship between unwanted pregnancy and the non-use of family planning methods, they did not recognize the relationship between non-use of family planning methods and abortion, or between unwanted pregnancy and abortion. The study also demonstrated the lack of knowledge among community members about preventive measures in reproductive health and family planning. More than half of the focus group participants, 58% believed that the cause for unintentional pregnancy was non-use of family planning methods.

Phase 2 – Organize the community for action

Four FEPROMO representatives were elected from each of the 11 communities to form the core group. They were trained in the PNA instrument and conducting sessions with the community members. A total of 373 people participated in the community mobilization activity. They were organized into 14 groups, one group of women[8] from

[8] Some males participated in Shapaja.

each community and three groups of mixed female and male adolescents (aged 10-19) from three different communities.

Phase 3 – Explore the health issue and set priorities

In addition to conducting the PNA sessions, nine FEPROMO representatives carried out an assessment of the CMP facility. They interviewed 24 women clients at the CMP and sought to ascertain the clients' perceptions about the quality of care they had received and their needs and suggestions about how quality of care could be improved. The FEPROMO representatives also worked with the project team to carry out two focus group discussions (FGDs) with CMP staff, exploring providers' perception of what type of care clients are entitled to receive, quality of care and community participation in health services.

Phase 4 – Plan together

A total of twelve action plans were developed through the Peru CM activity. Ten groups of FEPROMO women from 10 communities each developed one action plan, a combined group of adolescents (male and female) from three communities developed one action plan, and CMP representatives developed another plan in collaboration with FEPROMO representatives. The action plans focused on addressing several frequently cited issues: adolescent pregnancy, shortage of providers, unintended pregnancy, quality of care, and gaps in service provision.

Phase 5 – Act together

Action plan implementation resulted in establishing a *Committee for Monitoring and Transparency in Health*.[9] The committee comprised of four representatives from FEPROMO and three from the CMP. The National Office of Transparency and Health at the Ministry of Health (MINSA) provided technical support to the committee. The committee was responsible for advocating to the authorities for the community groups as well as overseeing the action plan implementation.

Local coordination committees were established that assumed responsibility for the actual implementation of action plans. Several committees coordinated with schools to educate adolescents on unintended pregnancy, risks of complications due to spontaneous and incomplete abortion, psychosocial skills and self-esteem. Others worked with their municipalities to hold community-wide educational sessions on topics such as gender, FP and vaginal infections.

[9] Established on June 30, 2005.

Phase 6 – Evaluate together

Implementation was monitored in four of the ten communities which created action plans. An evaluation was conducted by two groups of FEPROMO representatives through focus groups discussions with select participants of the community mobilization activities. The focus group discussions found that there was an increase in knowledge as a result of the action plan implementations in several areas: reproductive health and family planning, client's rights, and risks of vaginal hemorrhage. Participants also found that FEPROMO's organizational capacity increased and was strengthened as a result of participating in the activities and working with the government. Many of the participants felt that they were empowered and were less reluctant to discuss issues related to reproductive health and family planning. Their relationships with health providers were enhanced since the quality of care improved. The evaluation also found that community members were still interested in the project and planned to continue activities after funding from CATALYST ended.

At the end of the program, family planning methods were made available within PAC procedure rooms and family planning services were being offered at the time of PAC services. Clients who desired a family planning method could leave the facility with a FP method of their choice. All PAC patients received counseling on family planning at the CMP in Tarapoto. Of these patients, 30% left the facility with a contraceptive method. The other 70% either chose to utilize periodic abstinence/rhythm method, or promised to return with their husbands for contraceptives. The CMP currently treats approximately 60 PAC cases per month, for a total of 720 a year. This is a 10% increase from previous year service data.[10]

Results from Peru

Similar to the community mobilization in Bolivia, the activity in Peru increased community awareness, mobilized and empowered participants, and increased community organization, particularly by strengthening the relationship between FEPROMO and the local health facilities. The community mobilization activities also strengthened the community's participation in civil society by encouraging them to be a part of improving the quality of care at the health facility through collaboration with local authorities. The community PAC program opened the doors for establishing a blood bank at the CMP.

[10] Information from Dr. Raul Arroyo, Chief of Obstetrics and Gynecology at CMP.

The Community PAC project made a significant impression on the lives of the women who led FEPROMO in Tarapoto. For example, Ms. Simi Cohen, a former President of the federation, was elected as a member of the Tarapoto Municipal Council during the November 2006 Municipal Elections in Peru. Ms. Cohen is the first council person in Tarapoto and the woman who holds the highest political position in the region. The empowerment tools that were introduced during the training for the Community PAC project became a springboard for Ms. Cohen and her colleagues in pursuing greater participation in civil society and politics.

Key Lessons Learned from Peru

- It is important to utilize all available resources and data findings during the design of the program. This information provides greater insight into issues that need to be addressed and identifies communities that are good candidates for intervention. Examining existing data also proves to be cost-effective.
- Collaborations with existing organizations that have built up trust in the community can assist in reaching the community members and allowing them to be more open and accepting of the intervention.

ADAPTATION OF THE COMMUNITY PAC MODEL IN EGYPT

In Egypt abortion is legally restricted and prohibited by the major religions in Egypt (Islam, Coptic Christians). A 1993 study found that approximately 26% of all women aged 35-60 in Egypt have had one or more abortions (either spontaneous or induced).[11] A 1997 study of 89 public hospitals, found that complications of spontaneous and induced abortions accounted for 19% of all hospital admissions (340,000 clients annually).[12] The same study also revealed striking statistics on the quality of PAC services at the hospitals surveyed: only 20% of clients received an FP method as part of PAC services; only 3% were treated with manual vacuum aspiration (MVA); 89% were treated under general anesthesia and only 47% of PAC clients reported ever having used a FP method.

The adaptation of the community mobilization activity in Egypt differed from that in Bolivia since the primary actors in the mobilization were community leaders rather than community members at large. Clinical PAC services were non-existent in the geographic area of intervention. The project took the opportunity to simultaneously introduce the PAC clinical services as well as the community PAC model for community mobilization. This approach enabled a "dynamic" development of the program through ongoing dialogue between community members and providers. Finally, the Egypt activity differed

[11] National Population Council/Research Management Unit and Suez Canal University, "Women's Health Problems in Egypt: Focusing on Cancer of the Cervix," Final report, 2003.
[12] Egyptian Fertility Care Society and The Population Council, "Postabortion Case Load Study in Egyptian Public Sector Hospitals," Final report, 1997.

from the other two activities in Bolivia and Peru because it was piloted and scaled up to 54 communities within a period of 15 months. This was largely possible because community PAC was introduced as part of an integrated, community-based family health program.

Adaptations were necessary in Egypt because bleeding in early pregnancy was not recognized as a major problem by the community. Also, community members tended to shy away from discussing these aspects of women's health. Both cultural and religious barriers prevented women from seeking care for postabortion complications. Finally, without the proper support from local leaders, external assistance on these issues would have been difficult, and not welcomed. The involvement of local leaders validates the CM and assures community members that the topic of postabortion care is morally and legally appropriate. Building trust among the community members was imperative for the success of this activity.

Phase 1 – Prepare to mobilize

The community mobilization activity was conducted in 54 communities in three governorates of Upper Egypt: Minia, Beni Suef, and Fayoum. These governorates were selected, as they were priority areas for the Ministry of Health and Population (MOHP), and traditionally had not received needed health services.

CATALYST's activities in Egypt were conducted through the USAID/Egypt-funded TAHSEEN project. A group of staff members from TAHSEEN made up the project team that initiated the CM activities. The project team collaborated with local authorities to identify appropriate community leaders to involve in the activity. In Minia, leaders were identified through the Director of the local Family Planning Department. In Beni Suef, an individual who worked in the communications division of the local MOHP office identified the leaders. Leaders in Fayoum were identified by a representative from the local TAHSEEN office.

In collaboration with these local authorities, TAHSEEN identified appropriate leaders in each community, including religious leaders (Coptic priests and Muslim *sheiks*), community educators, agricultural workers, primary care physicians and nurses, Community Development Associations (CDAs), *dayat* (traditional birth attendants) and the media.

Phase 2 – Organize the community for action

Once the leaders were identified, TAHSEEN staff convened a meeting of the community leaders. Using a series of discussion guides, the staff led the community leaders in discussing problems related to unintended pregnancy and complications of spontaneous and induced abortion. The first discussion was organized around the "three delays" model and included discussions of "critical pathways" followed by women who experience

postabortion complications. The second set of discussions allowed the community leaders to identify the community members' needs in terms of health services and ways in which the community members could contribute to the improvement of health services. The leaders also discussed obstacles in seeking PAC services in their communities. The third set of discussions identified other community leaders/community members/organizations the community leaders wanted to work with in addressing issues and finding solutions.

Phase 3 – Explore the health issue and set priorities

During the discussions, the community leaders explored the issues of unintended pregnancy and complications of spontaneous and induced abortion. Some of the issues identified were the following:

- Causes and impact of pregnancy loss and how to recognize when complications are grave enough to warrant seeking professional care.
- Where to seek care when postabortion complications occur.
- Cultural barriers that prevent women from seeking care, including the need to consult with husbands or mothers-in-law prior to seeking care.
- Lack of health care providers at primary care facilities. In particular, the lack of female providers.

The issues were prioritized as to which required immediate attention. Priority was also given to issues that could be addressed quickly.

Phase 4 – Plan together

At the end of the workshop, the community leaders formed groups that each comprised a broad spectrum of leaders (e.g., religious leaders, providers, media professionals, traditional healers). The groups developed two-month action plans to address the problems they had identified. The majority of action plans were related to conducting community education sessions about healthy PAC-related behaviors. The community leaders also requested that TAHSEEN develop "banners" or posters that could be used to facilitate the community awareness sessions.

Phase 5 – Act together

The community leaders collaborated closely with the TAHSEEN staff in producing the community educational materials and planning and conducting the community awareness sessions. At the request of community leaders, TAHSEEN developed three banners on postabortion complications for use in the community awareness sessions. The banners stressed the importance of seeking health services, the care of women upon returning from the hospital after PAC services, and how to prevent unintended pregnancy. The banners disseminated four major PAC messages to the community:

- Postabortion complications are a type of obstetric emergency and require immediate medical attention.

- Women who experience postabortion complications need support from their families and communities, both in reaching the facility and after receiving treatment from the hospital.
- Return to fertility after postabortion complications is different from return to fertility after delivery; postabortion clients who do not want to become pregnant again should initiate use of an FP method within 15 days.[13]
- After a miscarriage or induced abortion, the recommended interval to the next pregnancy should be at least six months in order to reduce risks of adverse maternal and perinatal outcomes.[14]

TAHSEEN also developed a facilitator's guide that provides instructions for use of the banners in the community awareness sessions. Community leaders were trained on the facilitator's guide and the use of the banners for the sessions. After the training, the community leaders formed small groups to carry out the awareness sessions. Each group usually included both Muslim and Christian religious leaders, a physician (to provide support with medical questions), as well as other community leaders.

The community awareness sessions were held in places where people gathered, such as schools, Muslim and Christian worship services, community centers, health centers, among others. The number of attendees per session ranged from 25-200 individuals. More than 12,600 people were reached through 246 community awareness sessions in 54 communities.

Phase 6 – Evaluate together

At the end of the action plan implementation period, TAHSEEN met with the community leaders again to discuss successes and proposed solutions to challenges they faced during the community awareness sessions. Some of the challenges identified by the leaders included the lack of behavior change communication (BCC) materials such as videotapes, in addition to banners, to carry out the awareness sessions. Leaders then developed action plans for the next two-month cycle and selected sites for implementation with TAHSEEN. The TAHSEEN staff also provided refresher courses to the community leaders to ensure that the integrity of the PAC messages was maintained.

Results from Egypt

It is important to note that there were no PAC services available in the intervention sites before the introduction of community PAC model. Both clinical and community PAC activities were introduced simultaneously which allowed both activities to progress very swiftly. As a result of the community mobilization activities, community knowledge and

[13] This has been corrected to recommend that postabortion clients should initiate use of an FP method immediately or within 7 days.
[14] WHO. Birth spacing - report from a WHO technical consultation. 2006. Available at: http://www.who.int/making_pregnancy_safer/publications/policy_brief_birth_spacing.pdf

awareness of PAC issues increased. A pre-post test carried out with 1,474 awareness session participants showed that knowledge about when fertility returns postabortion increased from 0.7% to 99.7%; the percentage of participants who knew which FP methods could be used postabortion increased from 0% to 99%. Both findings are statistically significant.

Over 3,400 clients received PAC services at the 12 hospitals serving the communities involved in the community mobilization activities. Sixty-six percent (2,290) received counseling on FP, 64% (2,251) were treated using the MVA technique and 42% (1,457) were treated under local anesthesia. Ten percent (348) received an FP method prior to discharge and 42% (1,461) received a referral for FP services upon discharge. Many clients were referred for FP methods because they were not available on-site or the dispensary was not open at the time of their discharge.

The community mobilization activity also provided an opportunity for community feedback to the facility through a feedback mechanism. Since primary health care providers were involved in the majority of community awareness sessions, feedback by the community during the sessions about quality of services or community needs were transmitted directly to the facility through the participating provider. Changes in the facility could be immediately implemented based on the suggestions and feedback received from the community members.

Key Lessons Learned from Egypt

- Involving religious and local leaders in the community mobilization activities can increase the effectiveness of the community PAC program.
- Garnering political support for the project allows the activity to move with greater speed and at a larger scale.

SUMMARY

The table below summarizes the similarities and differences of the community PAC model in the three settings. It highlights the adaptations that were made in terms of the target audiences for the activities, the groups responsible for implementation of actions plans and the types of PAC clinical services the CM activities were linked to.

Table 2: Summary of the three Community PAC Model

	Bolivia	Peru	Egypt
Target audience for activities	Community at large	NGO and maternity hospital	Community leaders (particularly, religious leaders)
Formulation of action plans	Community members	Community members and maternity hospital	Community leaders
Implementation of action plans	Directly by community members	Assisted by NGO at community level	Directly by community leaders
Evaluation of action plan implementation	Community members	Community members and maternity hospital, assisted by NGO	Community leaders
Relation to PAC clinical services	Linked to existing PAC curative service	Linked to existing emergency obstetric care/PAC program	Initiated as part of a comprehensive integrated FP program
Training materials	Facilitator's guide	Facilitator's guide with minor language adaptations to fit cultural context	Facilitator's guide with components condensed to one workshop session

Programmatic Implications

- The community PAC model is adaptable at different levels, settings and a variety of sociocultural contexts.
- Communities are empowered to take action to address their own problems, thus, building sustainability for their own solutions.
- The CM activities encourage communication and collaboration between individuals, communities, organizations, and governing bodies to improve health.
- The community PAC model helps to build the capacity of collaborating individuals, communities, organizations and governing bodies.
- The model complements existing PAC clinical services and creates greater awareness and demand for these services.

CONCLUSION

The implementation of the community PAC model in the three countries demonstrates that the model is adaptable at different levels, in different settings and in a variety of sociocultural contexts. In order to affect positive changes, it was important to create strong cohesive communities as driving forces for change in addressing issues related to complications of miscarriage and incomplete abortion. The community PAC model also encourages the use of local resources and exhibits the potential for sustainability through community ownership.