PAC Compilation Document
The CATALYST Consortium is a global reproductive health and family planning activity initiated in September 2000 by the Office of Population and Reproductive Health, Bureau for Global Health of the United States Agency for International Development (USAID). The Consortium is a partnership of five organizations: Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International and PROFAMILIA/Colombia. CATALYST works in reproductive health and family planning through synergistic partnerships and state-of-the-art technical leadership. Its overall strategic objective is to increase the use of sustainable, quality reproductive health and family planning services and healthy practices through clinical and nonclinical programs.

Mission

CATALYST’s mission is to improve the quality and availability of sustainable reproductive health and family planning services.

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
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Introduction

Globally, nearly 68,000 women die from complications of unsafe abortion each year, accounting for about 13% of estimated maternal mortality.¹ Postabortion care (PAC) is a critical health care service that can save women’s lives. The CATALYST Consortium implemented PAC interventions that focused on scaling up PAC services addressing both access and quality issues. CATALYST implemented PAC activities through 3 main initiatives: (1) PAC community mobilization (Bolivia, Egypt and Peru), (2) scale-up of public-sector PAC services (Bolivia, Egypt and Peru), and (3) PAC grants projects with local nongovernmental organizations (NGOs) (Cambodia and Romania).

CATALYST led the way in increasing access to quality PAC services at the community level through community mobilization projects in Bolivia, Egypt and Peru. Based on the community mobilization model developed by Howard-Grabman and Snetro (Community Action Cycle, 2002), CATALYST provided community members with the tools and technical support needed to identify community problems and resources related to PAC and design their own solutions. The PAC community mobilization activity in Bolivia was implemented in two sites: El Alto and Santa Cruz. In each site, community members developed action plans with the goal of preventing maternal morbidity and mortality due to unsafe abortion. Sixteen action plans were developed and implemented. CATALYST also provided technical assistance in implementing and documenting a PAC community mobilization activity in Peru. This activity incorporated a gender sensitive approach to increase access to and improve quality of PAC services, including pre- and post-PAC family planning (FP) services, in the city of Tarapoto. In Egypt, the project mobilized a wide variety of community leaders, including religious leaders, literacy teachers, traditional and biomedical health providers and the media. Through community awareness sessions, these leaders disseminated messages about family planning for prevention of unintended pregnancy and seeking care in the event of complications of spontaneous and induced abortion in 54 communities in Upper Egypt.

CATALYST scaled up PAC services in three countries: Bolivia, Peru and Egypt. Within the three countries, services were scaled-up not only by expanding comprehensive PAC services to additional levels of health care, they were also scaled-up by providing selected components of PAC – such as identification of danger signs, stabilization, and referral to a hospital – at primary care facilities such as health centers and health posts. The Bolivia and Peru programs were initiated by Pathfinder International in 1999 and 1997 respectively, and were expanded significantly under CATALYST. The Egypt program, the youngest of the three, drew upon the Peru model to quickly scale-up a public-sector program. The three country experiences were similar in a variety of ways; they were all public-sector programs, they were all developed in a participatory fashion with national, regional, and local-level stakeholders, and they all focused on PAC programming at all levels of facilities and in communities.

In the second half of 2004, CATALYST awarded PAC grants to local NGOs in Romania and Cambodia. The programs focused on generating awareness on PAC issues among

community members and improving the skills of providers in providing correct and appropriate counseling on family planning services for women with abortion complications.

CATALYST’s PAC activities have contributed to increasing access to and improving the quality of PAC services. The emphasis on community involvement in PAC has raised community consciousness about the problem of complications of spontaneous and induced abortions, and has helped community members identify danger signs associated with complications and seek immediate treatment from appropriate providers. The interventions have also provided FP to PAC clients to help prevent unwanted pregnancies and repeat abortions. This report documents CATALYST’s three main PAC initiatives and provides lessons learned from each of the interventions.
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADX</td>
<td>Participatory community assessment <em>(Autodiagnóstico)</em></td>
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<tr>
<td>AED</td>
<td>Academy for Educational Development</td>
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<td>ARC</td>
<td>Analysis and research Committee(s)</td>
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<td>AOP</td>
<td>Annual operating plans</td>
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<td>BCC</td>
<td>Behavior change communication</td>
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<tr>
<td>CAC</td>
<td>Community action cycle</td>
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<td>CATALYST</td>
<td>The CATALYST Consortium</td>
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<tr>
<td>CBO</td>
<td>Community-based organization</td>
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<td>CDA</td>
<td>Community development association</td>
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<tr>
<td>CDC</td>
<td>Center for Competency Development (Peru)</td>
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<tr>
<td>CEDPA</td>
<td>Centre for Development and Population Activities</td>
</tr>
<tr>
<td>CESIM</td>
<td>Centro de Servicios Integrales de la Mujer (Comprehensive Women's Health Services Center)</td>
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<tr>
<td>CM</td>
<td>Community mobilization</td>
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<tr>
<td>CMP</td>
<td>Maternal and Perinatal Center <em>(Centro Materno-perinatal)</em></td>
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<tr>
<td>CNS</td>
<td>Caja nacional de salud (National Health Service)</td>
</tr>
<tr>
<td>CTHCFHP</td>
<td>Comprehensive treatment of hemorrhagic complications during the first half of pregnancy</td>
</tr>
<tr>
<td>D&amp;C</td>
<td>Dilation and Curettage</td>
</tr>
<tr>
<td>DfID</td>
<td>Department for International Development (United Kingdom)</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Surveys</td>
</tr>
<tr>
<td>DILOS</td>
<td>Distritos locales de salud (Local health districts)</td>
</tr>
<tr>
<td>DISA</td>
<td>Regional Health Authority (Peru)</td>
</tr>
<tr>
<td>DPHO</td>
<td>District public health office</td>
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<tr>
<td>EFCS</td>
<td>Egyptian Fertility Care Society</td>
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<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>FEPROMO</td>
<td>Provincial Federation of Organized Women (in San Martin)</td>
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<tr>
<td>FGD</td>
<td>Focus group discussion</td>
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<td>FGC</td>
<td>Female genital cutting</td>
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<tr>
<td>FP</td>
<td>Family planning</td>
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<tr>
<td>GBV</td>
<td>Gender-based violence</td>
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<tr>
<td>HC</td>
<td>Health center</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ICCPAC</td>
<td>Inter-Institutional Committee for the Coordination of Postabortion Care</td>
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<tr>
<td>IEC</td>
<td>Information, education and communication</td>
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<tr>
<td>KAP</td>
<td>Knowledge, attitudes and practices</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MCHW</td>
<td>Maternal and child health workers</td>
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<tr>
<td>MHS</td>
<td>Ministry of Health and Sports (Bolivia)</td>
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<tr>
<td>MINSA</td>
<td>Ministry of Health (Peru)</td>
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<tr>
<td>MMR</td>
<td>Maternal mortality rate</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health (Generic)</td>
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<td>MOHP</td>
<td>Ministry of Health and Population (Egypt)</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>MVR</td>
<td>Manual vacuum aspiration</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<tr>
<td>OB/GYN</td>
<td>Obstetrician/Gynecologist</td>
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<tr>
<td>OD</td>
<td>Operational district</td>
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<tr>
<td>OR</td>
<td>Operations Research</td>
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<tr>
<td>PAC</td>
<td>Postabortion care</td>
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<tr>
<td>PAC/CM</td>
<td>PAC community mobilization</td>
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<td>RACHA</td>
<td>Reproductive and Child Health Alliance</td>
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<td>RFP</td>
<td>Request for proposal</td>
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<tr>
<td>RH/FP</td>
<td>Reproductive health/family planning</td>
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<tr>
<td>SECS</td>
<td>Society for Education on Contraception and Sexuality</td>
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<tr>
<td>SEDES</td>
<td>Servicio Departamental de Salud (Departmental Health Service)</td>
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<tr>
<td>SOBOMETRA</td>
<td>Sociedad Boliviana de Medicina Tradicional (Bolivian Society of Traditional Medicine)</td>
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<tr>
<td>SOCIOS</td>
<td>Socios para el Desarrollo (Bolivian NGO)</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>SUMI</td>
<td>Universal Maternal and Child Health Insurance in Bolivia (Seguro Universal Materno-infantil)</td>
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<tr>
<td>TA</td>
<td>Technical assistance</td>
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<tr>
<td>TAG</td>
<td>Technical advisory group</td>
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<tr>
<td>TAHSEEN</td>
<td>CATALYST/Egypt project (from the Arabic <em>tahseen sihitna bi tanzeem usritna</em>, which means improving our health by planning our families)</td>
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<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
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<tr>
<td>UDSEA</td>
<td>Decentralized Health Unit of El Alto</td>
</tr>
<tr>
<td>UEB</td>
<td>Bolivian Evangelical University</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counseling and testing</td>
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<tr>
<td>VHSG</td>
<td>Village Health Support Group</td>
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<tr>
<td>VHWW</td>
<td>Village health workers</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WRA</td>
<td>Women of reproductive age</td>
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Chapter 1: PAC Community Mobilization:
Results and Lessons Learned from Bolivia, Egypt, and Peru

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Executive Summary

Globally, complications of spontaneous and induced abortion are a significant cause of both maternal mortality and morbidity and have a profound impact on the lives of women and their families. The cost of treating these complications takes a tremendous toll on health care systems, particularly in resource-poor settings.

In the early 1990s, international health organizations and donors began supporting postabortion care (PAC) programs to address the public health problem of complications of spontaneous and induced abortion. At minimum, PAC includes emergency treatment for these complications and FP counseling and provision of contraceptive methods if the client chooses. More than 10 years later, these same organizations recognized that many of the barriers that prevent women from seeking PAC services (including FP) are sociocultural, and determined that these barriers could only be reduced by working at the community level.

In 2003, the United States Agency for International Development (USAID) introduced a new PAC model that included “community empowerment through community awareness and mobilization” as one of its three core components. To further define community PAC programming, USAID selected the CATALYST Consortium, a global USAID reproductive health and family planning project implemented by five partners (Pathfinder International, the Academy for Educational Development, the Centre for Development and Population Activities, Meridian Group International, Inc., and PROFAMILIA/Colombia), to develop and implement the first stage of a model for community mobilization through its country office in Bolivia.

The Bolivia PAC community mobilization (PAC/CM) model aimed to mobilize community members to design and carry out activities to increase awareness of and strengthen access to PAC services, including preventive services (family planning) and treatment (PAC). By strengthening access to these services, the model seeks to reduce maternal morbidity and mortality. To achieve these goals, the model was based on the six-phase community action cycle (CAC), a framework for community mobilization (CM) developed by Save the Children.

After designing the model for Bolivia, CATALYST replicated the model in similar activities in Egypt and Peru. However, the experiences in the three countries differed significantly. In Bolivia, the CM model was implemented in two large urban areas and involved a broad spectrum of community members. In Peru, the project partnered with a local woman’s organization and the local maternity hospital and carried out the activity in 11 communities, ultimately linking the communities to their health facilities. In Egypt, the project mobilized a wide variety of community leaders to disseminate information about seeking immediate medical care when complications of spontaneous abortion occur and to wait at least six months before getting pregnant again.

In all countries, the activities resulted in increased community awareness about unintended pregnancies and complications of spontaneous and induced abortions and how to prevent these problems, mobilization and empowerment of CAC participants, and increased collaboration among different community organizations and between community organizations and health providers. Additionally, the project revealed that unintended pregnancy and complications of spontaneous and induced abortion are linked to broader community health problems. For example, in Bolivia and Peru, community members identified gender-based violence (GBV) as a
principal cause of unintended pregnancy, miscarriage and induced abortion. This underscores the importance of preparing CM teams to address GBV and other related community health problems during community meetings.

Appropriate, participatory methodologies are vital to the success and sustainability of all CM activities. Such methodologies should be used continuously throughout the project. They engage community participants from the outset and keep them engaged by creating opportunities for building leadership skills. Ultimately, the project team gradually withdraws its support as the community participants assume increasing responsibility for identifying and resolving community health problems.
I. Introduction

Annually, more than 500,000 women die due to complications associated with pregnancy and childbirth (WHO, 2004). Approximately 68,000 deaths (13% of all maternal deaths) can be attributed to unsafe abortion, and still others to spontaneous abortion or miscarriage. In 1993, a group of international health organizations joined forces as the Postabortion Care (PAC) Consortium to address the impact of unsafe abortion on maternal morbidity and mortality. PAC refers to a package of services for women who experience complications of spontaneous or induced abortion. At a minimum, these services provide treatment for women, FP counseling and contraceptive methods to prevent repeat abortions. Since the formation of the PAC Consortium, member organizations have provided technical support to implement PAC services globally. USAID and other donors have also provided financial and technical support.

At the beginning of the new millennium, organizations working in PAC began to recognize that sociocultural barriers can prevent women from seeking PAC services (including FP). Many women may not be able to seek services autonomously because social norms do not permit them to make decisions without their partner’s consent, or because they do not have control over the economic resources needed for services. This may mean that they delay seeking care or never seek care at all. Sociocultural barriers also are manifested in facilities. Providers may discriminate against PAC clients due to the stigma associated with complications of induced abortion, which may prevent clients from seeking care. Once PAC Consortium agencies had recognized the profound impact of sociocultural factors on access to PAC services, they determined that these barriers could only be reduced through community-level work.

In 2003, USAID incorporated “the community” into its PAC model, which includes the following components:

- Emergency treatment;
- FP counseling, provision, STI evaluation and treatment and HIV counseling and/or referral for testing; and,
- Community empowerment through community awareness and mobilization.

After developing this model, the USAID/Washington PAC Working Group began funding projects to define the model’s three components. USAID/Washington selected USAID/Bolivia and CATALYST/Bolivia to develop and implement the first stage of a model for CM on the issue of PAC (PAC/CM). The CATALYST model was developed as a pilot activity in Bolivia (implemented from April through October of 2004); after that time, project activities were transferred to Socios para el Desarrollo (Socios), a Bolivian NGO, with full support from USAID/Bolivia. The activity was also replicated by CATALYST through its country programs in Egypt (beginning March 2004 and ongoing as of August 2005) and Peru (July 2004 through June 2005).

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2 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.”
3 AVSC International (now EngenderHealth), the International Planned Parenthood Federation, Ipas, the JHPIEGO Corporation and Pathfinder International established the PAC Consortium in 1993.
4 CATALYST does not perform or actively promote abortions.
II. The PAC Community Mobilization Model

The CATALYST PAC/CM model is based on How to Mobilize Communities for Health and Social Change, a Health Communication Partnership Field Guide (Howard-Grabman and Snetro: 2002). The authors define CM as “a capacity-building process through which community individuals, groups or organizations plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others” (page 3). To achieve CM, an external agent, such as CATALYST, carries out a community action cycle (CAC) process, which includes the following phases:

**Phase 1 - Prepare to mobilize:** CATALYST develops a CM plan, selects project communities, hires local staff if necessary and creates and trains the CM team.

**Phase 2 - Organize the community for action:** The CM team identifies and trains community leaders who will lead the CM process at each project site.

**Phase 3 - Explore the health issue and set priorities:** Community members explore the problems of unintended pregnancy and complications of spontaneous and induced abortions in their communities and identify the root causes of these problems. They also discuss quality of care at their local facilities in relation to the problems.

**Phase 4 - Plan together:** Based on the results of Phase 3, the communities develop action plans and present those plans to local authorities to garner their support. Ideally, authorities participate in the development of the plans.

**Phase 5 - Act together:** Participating community members implement the action plans. All action plans focus on prevention of unintended pregnancy and treatment of complications of spontaneous and induced abortion.

**Phase 6 - Evaluate together:** Participatory evaluation occurs on an ongoing basis throughout the CM process. A more intensive evaluation occurs after the action plans have been implemented, and communities can develop new action plans.

The overall objective of the CM process is to transform relationships of power to enable and sustain the changes in behavior that are necessary to improve the health of the community. These relationships of power can exist between community authorities (such as health providers) and community members, men and women, adults and youth and community members of different ethnic groups or social classes. It is important to bear in mind that gender power dynamics do not occur exclusively between partners; these can be manifested in any female-male relationship. Additionally, expectations defined by normative gender roles—for example, a mother’s expectations about her daughter’s actions—can influence contraceptive decisions and care-seeking behaviors, even when a female-male relationship is not directly involved.

Through the different participatory CM exercises, community members explore how social relationships impact their ability to seek health services. Individuals on both sides of the power relationship can express their viewpoints, and each group is sensitized to the situation of the other group. Ultimately this exchange may change the power dynamics. For example, after
hearing community members’ perspectives about quality of care, providers may change how they offer services so that the client-provider relationship is more client-centered.

III. Case Studies

One of the major differences between the three activities was the composition of the CM participants. In Bolivia, a broad spectrum of community members (including women, men and adolescents) in two distinct urban communities participated in the CAC. In Peru, CATALYST partnered with a local women’s organization and the local maternity hospital and carried out the activity in 11 communities, including urban, peri-urban and rural sites. In Egypt, a wide variety of community leaders, including religious leaders, health care providers and educators, implemented the CAC process; community members in Egypt were not actively involved in the CAC (as they were in the other two countries) but participated in community awareness sessions carried out by community leaders. Despite these differences, major results in all sites included increased community awareness about unintended pregnancies, complications of spontaneous and induced abortions and how to prevent these problems; mobilization and empowerment of CAC participants; and increased collaboration among different community organizations and between community organizations and health providers.

Bolivia

In Bolivia, CATALYST designed and provided technical assistance during the implementation of the first four phases of the project (through the development of the community action plans). Then, at the request of USAID/Bolivia, CATALYST transferred the activity to Socios in November 2004 to facilitate sustainability of the activity.

Background

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% (DHS, 1998). Since abortion is legally restricted, many unintended pregnancies lead to clandestine, unsafe abortion; the Ministry of Health and Sports (MHS) estimates that complications of abortion account for 27% to 35% of maternal mortality. In recent years, maternal mortality has declined significantly, from 390 in 1994 (DHS) to 230 in 2003 (preliminary data from DHS), although this figure varies significantly throughout the country.

In 2000, USAID/Bolivia selected Pathfinder/CATALYST and Ipas (another US-based NGO) to provide technical assistance to the Bolivian National PAC Program. Each agency was responsible for supporting program implementation in different regions of the country. Between July 2000 and May 2005, CATALYST trained providers in 166 facilities in five of the country’s nine departments (Beni, Cochabamba, La Paz, Oruro and Santa Cruz). CATALYST also helped integrate PAC into national policy; PAC services are free of charge to all Bolivian women through the Universal Maternal and Child Health Insurance (SUMI) program. In July 2005, CATALYST transferred the responsibility for technical assistance to clinical PAC activities to EngenderHealth, with full support from USAID/Bolivia.

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5 These data were provided by the Interagency Group for the Reduction of Maternal Morbidity and Mortality, comprised of the Pan-American Health Organization (PAHO), UNFPA, UNICEF, Family Care International, the Population Council, the Inter-American Development Bank, and the World Bank. From “La Experiencia en Bolivia de la Atencion Postaborto” (The Bolivian PAC Experience) (2004), a document developed by stakeholders of the Bolivian PAC program.
The PAC/CM model was piloted in two urban sites: the community served by the Los Andes Hospital in El Alto, a city located in the Andean Mountain region, and the community served by the Metropolitana Norte Hospital in Santa Cruz, a city located in the Amazon River basin. These communities were selected in collaboration with USAID based on availability of quality PAC services and high maternal mortality, among other criteria.

El Alto’s 649,958 residents are primarily migrants from rural communities in the department of La Paz. The majority of residents is of Aymara\(^6\) descent and is bilingual (Spanish and Aymara). The unmet need for FP is 24%, and, in the 1994 DHS, the maternal mortality ratio in El Alto (397/100,000 live births) was slightly higher than the national average of 390/100,000 live births. The Los Andes health service network serves a population of approximately 253,867.\(^7\)

With a population of 1,135,526, Santa Cruz is larger than El Alto, and, in contrast to the relative homogeneity in El Alto, it is an ethnically diverse city. The majority of residents is mestizo (of mixed Spanish and indigenous descent) and speaks Spanish; prominent indigenous groups include Quechua-speaking groups and the Guaraní. The unmet need for modern FP methods is 20%, while the maternal mortality rate in the Amazon River Basin region in which Santa Cruz is located is 166/100,000 (DHS, 1994). The health service network of Hospital Metropolitana Norte in Santa Cruz serves a population of 317,946.\(^8\)

**Methodology**

The local teams in Bolivia were comprised of one local coordinator at each project site, two facilitators in Santa Cruz, and one facilitator in El Alto. In Phase 1, the two teams participated in CM training, and then returned to their respective communities. In Phase 2, the teams identified community groups (21 in El Alto and 27 in Santa Cruz) with which they would work. These groups included mothers’ clubs, groups of adolescents (aged 15-24), neighborhood boards, men’s groups and community health promoters. In Santa Cruz, 55% of groups were mixed (participants included both men and women); in El Alto, mixed groups comprised 15% of the total groups. Despite the variation in types of groups, the majority of participants at both sites were women—92% in El Alto and 80% in Santa Cruz. A total of 1,206 individuals participated at the two project sites.

In each community, a representative from each group was elected as a group leader and participated in a “Core Group.” In Phase 3, the Core Group members facilitated a participatory community research process called an autodiagnostico (ADX) with their respective community groups of approximately 25 participants. The ADX explored the problems of unintended pregnancy and complications of spontaneous and induced abortion and was carried out in a series of three, 3-hour sessions. To implement the ADX, Core Group members used an instrument developed by CATALYST and received technical support from the local teams.

Each session focused on one of the three delays—recognizing the need for care, deciding to seek care and receiving care at the facility—and included one or two participatory research techniques; analysis of the experiences and issues raised through the application of these techniques; and prioritization of the needs identified during the session. After the first two sessions, participants interviewed relatives and neighbors about their perspectives on unintended pregnancy and complications of spontaneous and induced abortion. This created

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\(^6\) The Aymara are one of the two largest indigenous groups in Bolivia.

\(^7\) National Health Information System (SNIS) and the Departmental Health Services (SEDES), La Paz, 2003.

\(^8\) National Health Information System (SNIS) and the Departmental Health Services (SEDES), Santa Cruz, 2003
awareness about the CM process in the community by generating dialogue on the issues; it also empowered participants, since they became researchers in their own communities.

After the completion of the ADX, the project team analyzed the information and presented the findings to community participants. They also compiled a *Community Health Resources Directory* for each community based on findings from the second session of the ADX and additional information they had collected on PAC-related services in the communities. These directories revealed gaps in health service coverage and provided vital data about how community members perceive quality of care at their local facilities.

In Phase 4, community groups joined together according to their local primary health care facility and developed action plans based on the priority problems identified in the ADX, including the assessment of health resources. Next, participants presented the plans to community authorities from the health and other sectors to garner their support for implementation. Phases 5 (implementation of action plans) and 6 (participatory evaluation of activities conducted by all project stakeholders) were implemented by Socios.

**Results**

El Alto groups developed six plans and Santa Cruz groups developed ten plans. Plans at both sites included activities designed to:

1. Improve quality of care from the community members’ perspective by increasing hours of operation and reducing delays in receiving care; improving transportation and health infrastructure; and improving client-provider relations, e.g., participants in El Alto noted that providers discriminate against them.
2. Educate community members about the availability of PAC services through the SUMI and collaborate with health facilities to facilitate application of SUMI procedures according to Bolivian law.
3. Train community members on topics such as contraceptive methods, danger signs associated with complications of spontaneous and induced abortion, communication between partners and parents and children about RH/FP issues, gender, domestic violence and community health resources.
4. Organize the community to improve coordination among community-based organizations (CBOs) and between CBOs and local health centers.

During the ADX, El Alto groups cited GBV as a major cause of unintended pregnancies, miscarriage and induced abortion. Therefore, many El Alto also plans addressed GBV, including emotional and physical abuse and rape.

The first four phases of Bolivia PAC/CM activity resulted in changes in knowledge, attitudes and practices, community mobilization and empowerment, and increased community organization at both sites.

**Changes in knowledge, attitudes and practices:** To determine whether the sharing of experiences among community members resulted in changed knowledge, attitudes and practices (KAP), CATALYST implemented a 22-question KAP survey with 1,076 participants prior to the first session of the ADX and 888 participants after the action planning session.
Survey results revealed a significant increase in the percentage of participants who knew about at least one contraceptive method (88.3% to 94%) and about PAC services (64.8% to 71.3%). There was also a significant increase in the percentage of participants who had used contraception in their last sexual intercourse (45.6% to 54.2%). A decrease (p-value<.05) in the percentage of participants who indicated that their health problem was resolved the last time they visited a health facility (53.2% to 50.7%) may reflect poor quality of care, but could also reflect a more critical view towards health facilities.

**Mobilization and empowerment of participants:** The qualitative evaluation showed that the activity mobilized the community to act and to continue the activities:

> This is like a thread. We initiate it and we pass it on [to others]. The information continues and [community members] begin to know more, whereas before they did not know where to go in an emergency, now they do and they receive quality care; they are finding out through us. (Core Group member, Santa Cruz).

Additionally, Core Group members now have expertise the need to solve community problems, including skills in organizing meetings and public speaking: “[B]efore coming here, I couldn’t talk [in public]. In these courses I have learned, and, for that, I would like to thank the ladies. They told me: ‘Don’t be afraid; you can do it’ and I’ve done it” (Core Group member, El Alto).

**Increased community organization:** Implementation of action plan activities involved coordination with a variety of CBOs and other entities at the two project sites (seven in El Alto and nine in Santa Cruz). El Alto activities emphasized community education, while Santa Cruz activities emphasized improved coordination between communities and health providers.

> In the community, there is also more participation, more collaboration and more understanding. I think that we live in greater harmony; we understand each other better because we understand the things that have happened and what each one goes through, and we are supportive of each other somehow. (Community participant, Santa Cruz)

The Bolivia PAC/CM activity is ongoing, and, as of July 2005, Socios had supported action plan implementation and participatory evaluations with the original participants, and had also replicated the ADX with new community groups at the two project sites.

**Peru**

The Peru CM activity closely paralleled the Bolivia experience. The major difference was that the project collaborated closely with local health providers throughout the process.

**Background**

There are nearly 6.7 million women of reproductive age in Peru. More than half of those 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. Complications of

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9 “Significant” indicates that changes were statistically significant (p-value below .01).

spontaneous and induced abortion are among the principal causes of maternal mortality, which was 188/100,000 live births in 2003 (DHS).

With technical support from Pathfinder International and funding from the United Kingdom Department for International Development (DFID), the Peruvian Ministry of Health (MINSA) implemented a national “Comprehensive Postabortion Care Project” between 1997 and 2002. Through this project, Pathfinder supported implementation of PAC services in 50 hospitals located in all 24 departments of Peru. In 2002, with funding from USAID/Peru through CATALYST, Pathfinder built on the PAC model to implement an Emergency Obstetric Care (EmOC) program, developing comprehensive maternal health services in seven departments in the Amazon basin (Ayacucho, Cusco, Huanuco, Junin, Pasco, San Martin and Ucayali).

As in Bolivia, Pathfinder initiated community PAC activities by carrying out a focus group study to assess community perceptions about PAC in a Lima neighborhood. In 2004, CATALYST decided to replicate the Bolivia activity in Peru, and piloted the CM activity in and around the city of Tarapoto (located in the Amazon River Basin) at the request of USAID/Peru. The activity was implemented in 11 communities. Some were neighborhoods in Tarapoto, while others were in rural communities as far as three hours away from the city by car. These communities ranged in size from 1,396 to 69,501 residents.

Service data from the Centro Materno-perinatal (CMP), the local referral hospital in Tarapoto, reveal that many women from the region seek care there for complications of spontaneous and induced abortion; on average, the CMP provides care to one PAC client daily (382 cases in 2004). One in four PAC clients is an adolescent, and half of PAC clients are between 20 and 29 years old. The ratio of clients coming from urban and rural areas is approximately three to two.

**Methodology**

In contrast to the Bolivia model, the Peru activity was implemented in partnership with two local organizations: the Provincial Federation of Organized Women (FEPROMO) of San Martin and the CMP. In addition to the general goals of CM, the Peru community PAC activity sought to facilitate the creation of a partnership between the community and the CMP that allowed for ongoing communication about quality of services for prevention and treatment of their RH/FP problems, particularly complications of spontaneous and induced abortion.

The local project team included a project coordinator, two facilitators who worked at the community level, and a CMS doctor, who supported communication between the project and the CMP. The Peru activity used the same ADX instrument as the Bolivia model; it was adapted to focus on issues specific to Peru (highlighting quality of care at the facility) and was implemented in four sessions rather than three. Four FEPROMO representatives from each community were trained to implement the instrument and carried out the session with a total of 373 participants in 14 groups—one group of women from each community and three groups of mixed female and male adolescents between the ages of 10 and 19 from three different communities.

The Peru activity also involved an assessment of the facility carried out by nine FEPROMO leaders who participated in a two-day training and interviewed 24 female clients at the CMP. The interviews sought to ascertain clients’ perceptions about the quality of care they had

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11 FEPROMO is self-reliant; it does not receive donor funds to carry out activities.
12 Some males participated in Shapaja.
received and their needs and suggestions about how quality of care could be improved. The FEPROMO leaders 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.

**Results**
A total of twelve community action plans were developed through the Peru activity. FEPROMO groups in 10 communities each developed an action plan, a combined group of adolescents from the three communities developed one plan, and CMP representatives developed a plan in collaboration with FEPROMO representatives. Action plan implementation began in May 2005.

As in Bolivia, the activity increased community awareness, mobilized and empowered participants, and increased community organization, particularly by strengthening the relationship between FEPROMO and local health facilities.

**Increased community awareness:** Community members recognized that the CM process increased awareness about health issues and quality of care and enabled discussion about these topics. One urban FEPROMO leader mentioned that the ADX sessions broke the silence about sensitive issues: “...the workshops carried out in each site made it [so] that the women would approach us and tell us about their problems like violence and vaginal bleeding.”

**Mobilization and empowerment of participants:** The ADX sessions motivated the FEPROMO leaders to mobilize:

> These cases [we are discussing] are important, because the people don’t go to the HC because they know that if they don’t bring money then they can’t rely on anything. It is like this if you are not insured then what can you do? What we need to do is organize ourselves for emergencies and have a fund … don’t you think? (Urban leader speaking in ADX session)

In a focus group discussion carried out after the development of the plans, another leader noted that the project had created an opportunity for community members and women:

> The other important [aspect] has been the creation of a management and coordination committee, because we have not seen until today that a public institution will want to have this connection with civil society, and especially with the women, because we have always been excluded. They say that [women] are just for the house, that we can’t do anything else, but it’s not like that. (Urban leader)

**Establishment of community-facility committees:** A Committee for Monitoring and Transparency in Health was officially established on June 30, 2005, and the regional health authority donated an office space for this committee. The National Office of Transparency and Health at MINSA provides technical support to the committee, which is comprised of four members from FEPROMO and three from the CMP. In addition, health care management, coordination and monitoring committees comprised of three or four FEPROMO representatives have been established in each of the 10 communities. These committees have assumed responsibility for implementing the action plans.

**Increased community organization:** To implement the action plans, the local committees are working with their municipalities, health centers, schools, the San Martin health network, local NGOs, private facilities and the National University of San Martin, among others. Many of the
communities have coordinated with schools to educate adolescents about unintended pregnancy, the risks of complications of spontaneous and induced abortion, psychosocial skills and self-esteem. Others are working with their municipalities to hold community-wide educational sessions on topics such as gender, FP and vaginal infections.

As of July 2005, responsibility for continuation of the activity was transferred to the central Committee for Monitoring and Transparency in Health and the local committees in each community. As noted above, these committees are receiving support from community organizations and the national MINSA.

Egypt
CATALYST’s activities in Egypt are funded through the USAID/Egypt-funded TAHSEEN project. Since early 2003, TAHSEEN has implemented a comprehensive package of family health services in underserved areas in Upper Egypt and underserved groups in other areas, such as the urban poor in Cairo. RH/FP indicators in these areas lag behind national averages; rural areas of Upper Egypt are also culturally and religiously conservative.

Unlike in Bolivia and Peru, the Egypt CM activity was introduced simultaneously with clinical PAC activities, enabling a “dynamic” development of the program through ongoing dialogue between community members and providers. Additionally, the primary CAC actors in Egypt were community leaders rather than community members. Finally, the Egypt activity differed 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 that was also scaled up.

Background
Reproductive health status in Egypt has improved significantly over the last few decades. Efforts carried out by the Ministry of Health and Population (MOHP) and its USAID-funded partners dramatically reduced maternal mortality, from 174/100,000 live births in 1992-3 to 84/100,000 live births in 2000.\(^\text{13}\) Between 1980 and 2003, modern contraceptive use among married women increased from 24% to 57%, and the total fertility rate decreased from 5.3 to 3.2.\(^\text{14}\)

Despite these improvements, the problem of unintended pregnancies remains a significant issue. Women who experience unintended pregnancy often resort to abortion, which is religiously impermissible and legally restricted except when the woman’s life is at risk. 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).\(^\text{15}\) Complications of spontaneous and induced abortions also have a profound impact on the health system. In a 1997 study of 89 public hospitals, these complications accounted for 19% of all admissions (340,000 clients annually).\(^\text{16}\)

TAHSEEN launched PAC activities in March 2004, initiating program activities in the Upper Egyptian governorate of Minia. In October of that year, PAC activities were scaled up to the

Beni Suef and Fayoum Governorates. It should be noted that these activities are ongoing as of the writing of this paper (August 2005), therefore the methodology section describes the general model rather than the experience of implementing the model in a specific community.

Methodology
To increase access to and quality of PAC services, the Egypt model aims to engender cooperation between community leaders for dissemination of information about healthy behaviors such as FP to avoid unintended pregnancy; seeking medical care immediately after an abortion; and using a FP method of choice for at least six months after an abortion. In collaboration with local authorities, TAHSEEN identifies appropriate leaders in each community, including Coptic priests and Muslim sheiks, community educators, agricultural workers, primary care physicians and nurses, CDAs, dayat (traditional birth attendants) and the media.

Once the leaders are identified, TAHSEEN uses a series of discussion guides to carry out an initial workshop in which leaders discuss the problems of unintended pregnancy and complications of spontaneous and induced abortion and suggest solutions to those problems. In March 2004, leaders participating in the first workshop in Minia noted that many women live with their extended families, including their mothers-in-law, and cultural norms often dictate that women first consult with their mothers-in-law when they are confronted with a health problem such as bleeding during pregnancy. Mothers-in-law or husbands may suggest that women delay seeking care and wait for the bleeding to pass.

At the end of this first workshop, community leaders form groups comprised of a broad spectrum of leaders (e.g., religious leaders, providers, media professionals, traditional leaders). Each group develops a two-month action plan to address the problems they have identified. The majority of action plan activities are community education sessions about healthy PAC-related behaviors. TAHSEEN also developed a series of posters in collaboration with participants in the first workshop in Minia. These posters present the following messages:

- Complications of spontaneous and induced abortion (or bleeding) are an obstetric emergency and require immediate medical attention.
- Women who experience complications of spontaneous and induced abortion need support from their families and communities, both in reaching the facility and upon their return from the hospital after receiving treatment.
- Return to fertility after complications of induced and spontaneous abortion is different from return to fertility after delivery; postabortion clients who do not want to become pregnant soon should initiate use of an FP method within seven days.\footnote{In Egypt, the Standards of Practice approved by the MOHP state that the use of FP methods should start after 15 days. CATALYST recommends that an effective FP method should be initiated immediately after and no later than seven days to prevent unwanted pregnancy. CATALYST is making a recommendation to the MOHP to include the updated information in the Egyptian Standards of Practice.}
- PAC clients who want to become pregnant should wait at least six months before trying to become pregnant again and should use an appropriate FP method for spacing. Research conducted by CATALYST shows that waiting 6 months after PAC before becoming pregnant again can reduce the likelihood of adverse perinatal and maternal outcomes.\footnote{Conde-Agudelo, A., J.M. Belizan, R. Bremman, S.C. Brockman, and A. Rosas-Bermudez (2005). Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America. International Journal of Gynecology and Obstetrics 89: S34-S40.}
At the end of the two-month action plan implementation period, TAHSEEN meets with community leaders again to discuss successes and propose solutions to the challenges they may have faced during the community awareness sessions. Leaders develop action plans for the next two-month cycle, selecting sites in coordination with TAHSEEN. They often choose villages in which TAHSEEN has opened a clinic or initiated other community activities. Through the follow-up sessions, TAHSEEN also aims to maintain the integrity of the PAC messages; health messages are reviewed during semi-annual “refresher courses.”

Results
The Egypt results are similar to results in the other project sites, and include increased community awareness, mobilization of community leaders and a strengthened relationship between the community and the facility.

Increased community awareness: Between March 2004 and May 2005, more than 12,600 community members in 54 communities participated in 246 PAC community awareness sessions. The activity has successfully increased awareness among community members about the critical health messages associated with PAC, and also increased community support for women who experience complications of spontaneous and induced abortion. A pre-post test carried out with 1,474 awareness-session participants showed that knowledge about when fertility returns postabortion increased from .7% to 99.7%; the percentage of participants who knew which FP methods could be used postabortion increased from 0% to 99%.

Community members have capitalized on the presence of physicians and religious leaders in the sessions, asking the physician to give a biomedical explanation for how FP methods function or querying religious leaders about the compatibility of specific FP methods with a religion; for example, some women have asked whether oral contraceptives interfere with religiously-mandated fasting.

Improved quality of PAC: Between July 2004 and June 2005, TAHSEEN provided training to staff at 14 district hospitals. Three thousand four hundred and ninety five clients received PAC services at 12 of these hospitals. Sixty-six percent (2,290) received counseling on FP. Ten percent (348) received an FP method prior to discharge and 42% (1,461) received a referral for FP services upon discharge. The percentage of clients receiving methods upon discharge has also increased considerably during the first year of programming. In July 2004, 14% of clients (11/77) received a method prior to discharge at three hospitals; in June 2005, 24% (99/420) received methods at 11 hospitals. It should be noted that provision of contraception at the point of service is particularly challenging in Egypt, given that PAC and FP services are provided through two different divisions of the MOH.

Mobilization of community leaders: The TAHSEEN community PAC activity successfully mobilized community leaders to improve maternal health in their communities. Some leaders have even initiated activities to supplement community awareness sessions. In Minia, an employee from a local radio network developed a radio drama about PAC, highlighting the

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19 The percentages were lower during some of the interim months, particularly immediately after services had been scaled up to additional facilities.
danger signs of complications of spontaneous and induced abortion and the fact that women need to seek care at the facility immediately if they experience complications.

Communication between the community and facility: Through the involvement of local primary health care providers in the majority of the community awareness sessions, the Egypt model also provides a mechanism for community feedback to the facility. For example, the Head of the Family Planning Health Directorate in Beni Suef is actively involved and participates in the community leaders’ bimonthly meetings; thus, the community leaders have the opportunity to deliver feedback provided by community members directly to the Head, who can then implement changes. These changes have the potential to profoundly impact health services; they are made at the policy level and may impact service delivery throughout the governorate.

IV. Challenges
Given the short period of time CATALYST had to evaluate these activities, the long-term impact remains unknown. It is hoped that the participatory approach to capacity-building has planted the seeds for social and behavior change around the issues of unintended pregnancy and complications of spontaneous and induced abortion. These activities will likely continue to yield other, unexpected outcomes that may contribute to improved community health and well-being.
V. Lessons Learned

The challenge mentioned above yielded a critical lesson learned: In order to document results and help ensure sustainability, CM activities should be sustained for at least one to three years. Additionally, to help ensure support for action plan implementation, all stakeholders (including community authorities) should be continuously involved throughout the process.

CATALYST also found that, although PAC is a sensitive topic, community members will mobilize around the issue. In Bolivia and Peru, the participatory approach allowed community members to discuss the issues in their own terms; for example, the ADX instrument in Bolivia used the term “bleeding during the first half of pregnancy” (rather than abortion) and enabled community members to discuss the causes and consequences of this bleeding. In Egypt, the success of the CM activities can be attributed to the fact that they were implemented in the context of a broader, community-based RH/FP program. TAHSEEN renovated clinics and introduced other less-sensitive topics (such as birth spacing) prior to introducing PAC; this sequence created trust among community members. The involvement of established community authorities also strengthened the Egypt efforts; the presence of respected religious leaders, including female religious leaders, validated the awareness sessions and assured community members that PAC is a morally and legally appropriate topic.

Because of the community-driven nature of the CM activities, they had a much broader impact than originally anticipated. The participatory forum of the ADX sessions allowed community members to address other topics that they felt impacted or related to unintended pregnancy and complications of spontaneous and induced abortion, such as GBV and parent-child relationships in Bolivia and Peru, and menopause and female genital cutting (FGC) in Egypt. This illustrates that the community sessions in all countries fulfilled a community need by addressing RH/FP topics. It also underscores the importance of preparing CM teams to address these topics during community meetings.

VI. Conclusions

The three experiences show that CM goes beyond more conventional community-based initiatives and is both a consciousness-raising and capacity-building experience for participants. The success of the experiences also validates the critical importance of CM for a broad spectrum of health initiatives. Only community members themselves can accurately describe the multiple dimensions of community problems and develop feasible, sustainable solutions.

The involvement of a broad spectrum of community members, including individuals on both sides of power relationships, e.g., community authorities and community members and women and men, can lead to the most profound results. For example, the facility assessment in Peru allowed FEPROMO leaders to understand the internal organization of the CMP. They also had an opportunity to observe the providers’ commitment to their work, something about which they were not previously been aware. For their part, providers had an opportunity to hear community members’ perspectives about quality of care for the first time. Involving providers had the added benefit of gaining their interest in and support of the activity.

Appropriate, participatory methodologies are vital to success and sustainability of CM activities. Such methodologies should be used continuously, achieving the following at different stages:
• From the outset, participatory approaches stimulate community interest by actively engaging community members in issues that affect their own and their family’s health. They also allow community members to address issues that are most important to them.
• Capacity-building continues throughout the project. This can involve strengthening and enhancing leadership skills of existing community leaders or carrying out similar CM processes with new community members to create a critical mass for social change.
• Responsibility for the activities gradually shifts from the project team to the community participants, so that they eventually assume full leadership, continuing to identify community problems and implement solutions on their own.

One of the rural leaders in the Peru activity validated the impact of the project as a catalyst for continued community action: “…[S]ome projects have worked [here] but then they go, in contrast this project has left the seed and we will continue.”
Chapter 2: Community Mobilization around Postabortion Complications in Bolivia

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Acknowledgements

We sincerely hope that this document, based on the Bolivia experience, serves as an inspiration and guide to other institutions seeking to improve women's health worldwide.

The development and implementation of the model were made possible thanks to the technical and financial support of the U.S. Agency for International Development (USAID), both in Washington and Bolivia. We are thankful for their confidence in CATALYST’s ability to develop this model and for the opportunity to join forces with the community members in El Alto and Santa Cruz. Without a doubt, our deepest appreciation is for each and every one of the individuals who collaborated in these two communities. Their honesty, transparency and seriousness allowed for completion of the activities within the anticipated timeframe. Their dedication and enthusiasm during the activities became a source of inspiration for the team members. Their voices have been heard.

It is our sincere hope that, through the implementation of the action plans, the communities’ aspirations will become reality.

Many thanks!
Yuspagara (Aymara)
Executive Summary

For more than 10 years, some organizations working in international reproductive health and family planning (RH/FP) have undertaken efforts to reduce maternal morbidity and mortality due to complications of miscarriage and unsafe abortion through postabortion care (PAC) programs. The U.S. Agency for International Development (USAID) has supported these programs, and, in 2003, introduced a new PAC service model in its first PAC Strategy, which included the component of “community empowerment through community awareness and mobilization.”

The activity described in this report represents USAID’s commitment to the development of the community mobilization (CM) component, applied in this case to developing a model for CM around the issues of unintended pregnancy and complications of miscarriage and unsafe abortion, with the goal of empowering the community to participate actively in defining and monitoring PAC services. Empowerment is defined by CATALYST as the “sustained ability of individuals and organizations to freely, knowledgeably and autonomously decide how best to serve their strategic self-interest and the interest of their community in an effort to improve quality of life.”

The seven-month CM process was implemented by USAID/Bolivia and CATALYST/Pathfinder International (Pathfinder)-Bolivia—with funding from the USAID/Washington PAC Working Group and technical assistance (TA) from CATALYST/Washington—in two Bolivian communities: the community served by the Red Los Andes (Los Andes Network) in the city of El Alto, in the Andean Mountain Region, and the community served by the Red Metropolitana Norte (Northern Metropolitan Network) in the city of Santa Cruz, located in the Amazon River Basin region.

To achieve the general objective, “empowering the community to mobilize itself with the goal of contributing to the reduction of maternal morbidity and mortality due to complications of miscarriage and unsafe abortion,” the project followed the Community Action Cycle developed by Save the Children. The cycle involved a participatory community assessment carried out by community members and culminated in the development of action plans at each site. A guide for carrying out the three participatory community assessment sessions and the participatory planning session also was developed.

The implementation team was comprised of seven members in Bolivia. These individuals identified 48 grassroots groups (21 in El Alto and 27 in Santa Cruz), including women’s groups, men’s groups and mixed groups of adults and adolescents. Each group elected a representative or leader to be a member of the core working group, called the “Core Group.” A Core Group was established for each community.

Through the participatory community assessment, community members identified RH/FP needs. Unintended pregnancy, non-use of contraception and complications of miscarriage and unsafe abortion were among the most commonly identified problems. After conducting the participatory community assessment and presenting the results to the communities, including appropriate authorities, the same groups developed their action plans.

The activities in the community action plans addressed topics, such as the prevention of complications of miscarriage and unsafe abortion, gender-based violence (GBV) and education on contraceptive methods and RH/FP. For these topics, actions required included community
education and improving access to services. With respect to services, community members proposed increasing awareness of community health care facilities, increasing knowledge of the benefits available to them, demanding services provided by the Universal Maternal and Child Health Insurance (SUMI), and working to improve quality of care at health facilities.

To evaluate the impact of the model on the community, a knowledge, attitudes and practices (KAP) survey was developed to measure changes in KAP associated with complications of miscarriage and unsafe abortion and other RH/FP health topics. Participants were surveyed before the first session of the participatory community assessment and after completing the participatory planning session. Some of the evident changes were increased knowledge of contraceptive methods and PAC services and increased use of contraceptive methods in participants’ last intercourse.

At each site, focus group discussions also were carried out with two samples (one of leaders and one of community group participants) at two points during the implementation. The results showed that the model generated changes in participants’ empowerment and social organization—for example, among neighbors and between the community and the facilities. Thus, the model facilitated the initial empowerment of the community through the identification of their RH/FP needs, the proposal of potential solutions and the development of action plans in which the communities themselves are the protagonists.

Given that the goal was to develop a model for CM, an important focus was the identification of lessons learned to facilitate the effective application of this model in other contexts. These lessons include:

- Community empowerment is not immediate; it requires sufficient time, knowledge and tools for community organization.
- Culturally-appropriate tools and instruments and trained staff are needed to facilitate community discussions.
- Communication between the community, grassroots organizations and health care personnel should be continuous to gain stakeholders’ support of the CM process, ultimately improving the health of the community.

The success of this model in terms of raising community consciousness about unintended pregnancy and complications of miscarriage and unsafe abortion and in facilitating community members’ identification of the causes of these problems validates the critical importance of CM for a broad spectrum of health initiatives. Only community members themselves can accurately describe the multiple dimensions of community problems and develop feasible, sustainable solutions. For example, through the CM process community members identified numerous shortcomings of their local health facilities that only they could identify, which empowered them to address those shortcomings because they came to understand that they are legally entitled to health care.

The results also illustrate how unintended pregnancy and complications of miscarriage and unsafe abortion are linked to broader community health problems. In Bolivia, community members identified GBV as a principal cause of unintended pregnancies, miscarriage and unsafe abortion, underscoring the importance of preparing CM teams to address GBV and other related community health problems during community meetings.
The model instruments are flexible and easy to implement and could be applied to a wide range of topics and transferred effectively to various communities in Bolivia and to other countries or regions. The model already has been validated in two different regions in Bolivia and is being implemented in Kenya and Peru.

I. Introduction

With funding and guidance from USAID/WASHINGTON and USAID/Bolivia, CATALYST/Pathfinder International (Pathfinder)-Bolivia facilitated a process of CM around complications of miscarriage and unsafe abortion in two communities in Bolivia: one served by Los Andes Hospital in the city of El Alto and the other by Metropolitana Norte Hospital in the city of Santa Cruz. The CM activity complemented the national program of Comprehensive Treatment of Hemorrhagic Complications during the First Half of Pregnancy (CTHCFHP), which is implemented at the service-delivery level by the Ministry of Health and Sports (MOH), with TA from CATALYST. The goal of this national program is to increase awareness and strengthen access to program services, which includes preventive services, such as FP counseling and the provision of contraceptive methods, and treatment services for complications of miscarriage and unsafe abortion.

In these two communities, the activity facilitated the empowerment of the community to participate actively in defining and monitoring PAC services and developing concrete action plans that contribute to the reduction of maternal morbidity and mortality rates. Through CM processes, community members identify and solve community problems. By supporting improved PAC services (including FP), community members can improve their own health and therefore their quality of life.

Reduction of maternal morbidity and mortality attributable to complications of miscarriage and unsafe abortion can be achieved through the prevention of unintended pregnancies and through the treatment of complications when they arise. Prevention can be achieved by improving the quality of information on birth spacing, contraception and access to contraceptive methods, which enables community members to make informed decisions. Increased access to treatment (CTHCFHP services) can be achieved by avoiding the three delays—(1) delay in recognizing danger signs and deciding to seek care, (2) delay in reaching appropriate care (transportation), and (3) delay in receiving care at the health facility—when complications of miscarriage and unsafe abortion occur.

This document describes the community PAC model, the implementation tools used, and the lessons learned from the experience in order to facilitate its application in other regions of the world. It is intended for national (Health Network administrators, facility directors, presidents of neighborhood boards, Social Network leaders, community leaders, the Core Groups and members of the model team) and international audiences (nongovernmental organizations (NGOs) and others that work in community health and development, such as donors (including USAID), and the general public.

20 The service is called “postabortion care (PAC)” (by USAID/Washington). It translates into Spanish as “atención postaborto (APA).” In this report, we use the term CTHCFHP in the Bolivian context and PAC in the international context.

II. Background

History of Postabortion Care at the International Level

In 1993, a group of organizations that work in the field of international RH/FP joined forces as the Postabortion Care (PAC) Consortium with the intention of addressing the impact of unsafe abortion on maternal morbidity and mortality. Since that time, member organizations have been providing PAC services in a number of countries, using a model with a dual purpose: (1) offering treatment to women who experience complications of miscarriage and unsafe abortion and (2) enabling them to use FP as a way to prevent unintended pregnancies that can lead to repeat unsafe abortions.

At the beginning of the new millennium, the PAC Consortium and USAID identified numerous barriers that can prevent women from seeking PAC services and found that it was necessary to reduce these barriers to ensure access to services for both emergency treatment and prevention. Based on the lessons learned from Safe Motherhood initiatives, they acknowledged that these barriers could only be reduced through work at the community level.

Community-level efforts take a variety of forms and achieve numerous goals, all of which ultimately increase access to services. First, community assessments obtain information from the community about their needs and perceptions of health services; this information can be used to make changes at the facility level to ensure that services meet the community’s needs. Second, community education and BCC efforts raise awareness about healthy behaviors (such as use of FP and seeking PAC services when complications arise) and the availability of FP and PAC services. Third, CM processes engender social change, which facilitates the practice of healthy behaviors, including care-seeking behaviors.

In 2003, USAID presented its new model for PAC services, which includes the following components:

- Emergency treatment;
- FP counseling, provision, STI evaluation and treatment and HIV counseling and/or referral for testing; and,
- Community empowerment through community awareness and mobilization.

After developing this model, the USAID/Washington PAC Working Group began funding projects to further define its three components. One of the least-developed components was the third one, which involved work at the community level. In collaboration with CATALYST, USAID Washington and USAID/Bolivia agreed to develop the first stage of a model for CM around PAC.

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22 AVSC International (now EngenderHealth), the International Planned Parenthood Federation, Ipas, the JHPIEGO Corporation and Pathfinder International were the agencies that established the PAC Consortium in 1993.
23 USAID has been supporting postabortion care (PAC) programs since the beginning of the 1990s.
24 The “Core Components of Postabortion Care,” first introduced in 2003, are outlined in the USAID Postabortion Care Strategy (October 2004).
History of the Bolivia Comprehensive Treatment of Hemorrhagic Complications during the First Half of Pregnancy Program

Since 2000, CATALYST/Pathfinder has provided TA to the Bolivian MOH and Sports’ CTHCFHP program in five departments: Beni, Cochabamba, La Paz, Oruro and Santa Cruz. In 2003, CATALYST adopted the USAID model for PAC services and, since then, has implemented the CTHCFHP program in accordance with this model.

One of the program’s initial achievements, a product of CATALYST’s and Ipas’s advocacy efforts, was the inclusion of CTHCFHP services within the Universal Maternal and Child Health Insurance (SUMI) package in 2002. As a result, PAC services are offered at no cost in all state hospitals in Bolivia. To date, CATALYST and Ipas have supported implementation of the clinical program in 53 secondary-level hospitals and 57 Health Centers (HCs) in Bolivia.

Not long after the introduction of the concept of community PAC, CATALYST initiated efforts at the community level. In 2002, CATALYST carried out a qualitative study, “The Opinion of Women and their Partners with respect to Postabortion Care Services and Abortion,” with the goal of collecting data to improve the CTHCFHP program. Data was collected through focus group discussions with adolescents, women of reproductive age (WRA) and married men in six departments in the country, including the five departments in which CATALYST works.

The focus group discussions revealed that there are numerous barriers, both at the community level and at the facility level. The main barriers mentioned include:

- WRA do not have access to comprehensive information about contraceptive methods or to the facilities where they can obtain these methods; however, it is generally acknowledged that pharmacies are a good source of information and contraceptive methods.
- Many women choose to terminate an unintended pregnancy. Single adolescent women hide this type of pregnancy and abortion from their families and seek help from their close female friends. Married women generally do not tell their partners about an abortion for fear of being abandoned or abused (either physically or emotionally).
- When a woman needs to seek treatment for complications of miscarriage or unsafe abortion, she does not know where to go for that treatment and/or lacks the means of transportation. Neither community leaders nor community members are aware that the basic health insurance package accessible to all Bolivian women (SUMI) covers both CTHCFHP and transportation to the facilities that offer these services.

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25 Ipas is responsible for providing TA in Bolivia’s four other departments, as well as in selected hospitals in the Department of La Paz. Both CATALYST and Ipas follow the Norms and Protocols of the Bolivian Ministry of Health and Sports for the delivery of CTHCFHP services.

26 The SUMI covers the bulk of health services needed during pregnancy, childbirth and the postpartum period as well as services for complications during those periods (e.g., PAC). For PAC, SUMI covers medical care, medicines, blood transfusions, laboratory costs, additional exams such as ultrasounds and any other exams that may be required. The SUMI also provides a mechanism for negotiation between the hospitals and the municipalities; hospitals can request that the municipalities cover specific costs associated with the SUMI services, such as transportation for obstetric emergencies.
Clients with complications of miscarriage and unsafe abortion often receive poor treatment from health care providers at the HCs. Fear of negative treatment is another barrier to seeking health care. Providers’ negative attitudes towards postabortion clients reflect the social stigma that exists in Bolivian society in general.

III. The Methodology and its Application

Target Population of the Model
The CM activity was implemented in two communities where CATALYST works: the community served by the Los Andes Hospital in the city of El Alto in the Andean Mountain region (el Altiplano) and the community served by the Metropolitana Norte Hospital in the city of Santa Cruz in the Amazon River Basin region (los Llanos).27 These two areas were selected in collaboration with USAID in Bolivia and Washington for the following reasons:

- Existence of quality CTHCFHP services in the area;
- High rates of maternal mortality28;
- Contrasting sociocultural, geographic and economic contexts, which allowed for validation of the model in two distinct settings;
- A significantly dense population, in which the number of maternal deaths due to complications of miscarriage and unsafe abortion or other obstetric emergencies was large enough so that the issue would be relevant to the members of the community.

In planning this activity, it was clear that social dynamics, including gender relationships and stigma, influence women's ability to prevent unintended pregnancies through use of contraception, their choice to seek unsafe abortion and their ability to seek treatment for complications of miscarriage and unsafe abortion by accessing CTHCFHP services. Given the impact of social inequalities on health behaviors, it is crucial to involve a wide variety of community members in the CM process.

Methodology

Theoretical Framework
Previous CM projects in Bolivia include the work conducted by Save the Children in the region of Inquisivi in the department of La Paz, which used the “Warmi” methodology. This methodology consists of four phases: a participatory community assessment, planning, implementation and a participatory evaluation. In their book How to Mobilize Communities for Health and Social Change, Howard-Grabman and Snetro refer to this same cycle of phases as the “Community Action Cycle”:

Community mobilization is a capacity-building process through which community individuals, groups or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their

27 The city of El Alto has approximately 649,958 residents and the community served by the Los Andes Network has approximately 253,867. The population of Santa Cruz is approximately 1,135,526, and the community served by the Northern Metropolitan Network has approximately 317,946 residents.

28 Per the 1994 National Demographic and Health Survey, the maternal mortality rate (MMR) in El Alto is 397 per 100,000 live births and the MMR in the Llanos is 166 per 100,000 live births. In 1994, the MMR for Bolivia as a whole was 390 per 100,000 live births. Note: A DHS was also conducted in 1998, but complete data on maternal mortality was not collected.
health and other needs, either on their own initiative or stimulated by others (Howard-Grabman and Snetro 2002:3).

The CM model was based on the Community action cycle (CAC), which is described in Appendix A.

The overall objective of the CM process is to transform relationships of power to enable and sustain the changes in behavior that are necessary to improve the physical, psychological and social health of the community. These relationships of power can be between community authorities (such as health providers) and community members, men and women, adults and youth and community members of different ethnic groups or social classes. In Bolivia, ethnicity is closely linked with social and political power; although the majority of the population is indigenous, these indigenous groups have very little power and typically have little influence on how health services are organized and delivered.

The different social categories that are marked by power dynamics often intersect; for example, a poor Aymara adolescent in El Alto may not be able to use contraception because (1) since she is poor, she may not have the economic means to pay for contraception; (2) since she is Aymara, she may fear discrimination by health providers; (3) since she is an adolescent, her parents would not approve, and she is afraid of poor treatment by health providers because she is young; (4) since she is a woman, her partner may not want her to use contraception, and she also may encounter health providers who are not gender-sensitive. It is important to note that gender power dynamics can manifest in any gendered relationship. Further, expectations defined by normative gender roles—for example, a mother’s expectations about her daughter’s actions—can influence contraceptive decisions and care-seeking behaviors, even when a female-male relationship is not directly involved.

Through the different participatory CM exercises, community members explore how social relationships impact their ability to seek health services. By involving individuals on both sides of the power relationship in the process, both viewpoints can be expressed, sensitizing each group to the situation of the other group with the hope of changing power dynamics. For example, after hearing community members’ perspectives about quality of care, providers may change how they offer services so that the client-provider relationship is more client-centered, giving the client more opportunities to discuss her health concerns. The importance of involving a broad spectrum of community members and changing power relationships was highlighted in El Alto; some female participants noted that they were unable to act in accordance with their new awareness about health behaviors because their male partners were not participating in the process and did not understand.

**Project Objectives and Instruments**

In developing the objectives, CATALYST considered the theory of CM and the steps required to achieve it.

- The general objective was to empower the community to mobilize itself with the goal of contributing to the reduction of maternal morbidity and mortality due to complications of miscarriage and unsafe abortion. *Note: Through the process of implementing the project, the team found that CM itself is an empowerment process. Therefore, community members were not empowered prior to mobilization; instead, they became increasingly empowered as they moved through the different phases of the CAC.*
The three specific objectives included the following:

1. Identify attitudinal, social, physical and financial barriers to prevention of unintended pregnancy and treatment of complications of miscarriage and unsafe abortion and educate community members about both FP (including birth spacing) and PAC services.

2. Identify and strengthen local capacity for addressing the health needs associated with prevention of unintended pregnancy and treatment of complications of miscarriage and unsafe abortion as well as other related needs such as women and adolescents' empowerment.

3. Develop community action plans to address the barriers to using both FP and PAC services.

The specific objectives correspond to three different processes: (1) a participatory community assessment (referred to as an autodiagnóstico or ADX in Bolivia), (2) an assessment of the health resources in the community, and (3) the development of community action plans. Each one of these required the application of different instruments.

To understand the problems and needs both in the community and at the facility, the three delays were a cross-cutting theme in achieving the three specific objectives. To understand the first delay, two distinct issues were addressed—whether community members recognize danger signs associated with complications of miscarriage and unsafe abortion and how they decide when and where to seek care.

**Participatory Community Assessment or “Autodiagnostico”**

An ADX is an instrument designed to guide a participatory community research process in which participants identify and prioritize their problems associated with a specific theme. This participatory approach has a theoretical grounding in both humanist philosophy and social psychology and emphasizes group dynamics. The variety of activities and research techniques that comprise the ADX allow for different groupings of people within the larger group and different forms of expression (drawings, discussions, stories, skits, mapping), all of which allow the exchange of experiences, ideas and attitudes, with the goal of developing a collective understanding about the theme. The anthropology of knowledge suggests that knowledge is dynamic, created through human interactions based on actual experiences. The ADX is a process of reflection, analysis, planning and action through which a community can improve its physical, psychological and social health.

The implementation team developed an ADX guide, the Community Needs Assessment regarding Problems during the First Half of Pregnancy, for carrying out the ADX. This guide was implemented in the communities of El Alto and Santa Cruz and included three different sessions. Each session corresponded to one of the three delays and included one or two participatory research techniques, analysis of the experiences and issues raised and prioritization of the needs identified during the session. In the first two sessions, participants were assigned “homework” for which they interviewed relatives and neighbors about their perspectives on unintended pregnancy and complications of miscarriage and unsafe abortion. The homework created awareness about the CM process in the community by generating dialogue on the issues and gave participants the opportunity to become researchers in their own communities, gathering information to better understand how the issues raised in the ADX affect the broader community.
The topic of the first session was “recognition.” The first research technique was the participatory development of imaginary life stories of community individuals (a man and a woman) focusing on RH/FP topics, including unintended pregnancy and complications of miscarriage and unsafe abortion. In the second technique, groups of approximately 25 individuals were divided into four working groups, and each one drew the “route covered” by a woman in a real-life case of unintended pregnancy or complications of miscarriage or unsafe abortion. This exercise allowed for analysis of the three delays and their causes; in each case, it was determined whether the women recognized the problem, when and how they decided what to do and how the problem was resolved (or not) at the health facility.

The second session addressed how community members decide what to do in the event of problems, such as unintended pregnancy or complications of miscarriage or unsafe abortion. A mapping research technique was used in which participants broke into groups according to the location of their homes. Each group drew a map of their community, including streets and health services (both biomedical and traditional). For homework, participants conducted interviews with health providers and clients in their communities. The results contributed to the second process of the model—identifying the communities’ health resources and their characteristics.

Finally, the third session focused on resolving the problems of unintended pregnancy and complications of miscarriage and unsafe abortion at the facility level when women seek services. The group was divided into four small groups that developed skits about two different relationships: the relationship between the members of the community and health services and the relationship between grassroots organizations and health services. At the end of this session, participants prioritized all of the needs identified in the three sessions of the ADX, resulting in the prioritization of community needs related to recognizing, deciding and resolving the problems of unintended pregnancy and complications of miscarriage and unsafe abortion.

At the end of each session, the facilitators drafted a report of the session. The quotes from the participatory needs assessment included in this document were drawn from session reports and not from a transcript based on an audio-recording of the session. It also is worth noting that some of the research techniques (specifically the life stories and skits) required participants to make up a story; therefore, it cannot be assumed that all of the stories in the ADX are true. However, some of them may contain elements of the lives of the participants or of their families. The analysis techniques help differentiate between the reality of life in the community and the ideal concepts of the community and its services. A key component in analyzing all of the research techniques was to determine whether the stories that were not real were representative.

Results were analyzed with the Ethnograph 5.0 software package, which is used for qualitative data analysis. The codes that were used are listed in Appendix B.

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29 The term “biomedical services” refers to services offered by physicians, nurses, midwives, pharmacists, etc., who have received formal training at universities, as well as community health workers. The term “traditional services” refers to services offered by traditional healers, herbalists, traditional birth attendants, etc.
Health Resources
The health resources documents were produced based on the findings of research techniques used in the second session of the ADX. Additionally, the implementation team developed an instrument for collecting data on health services and other community resources that could contribute to the reduction of maternal morbidity and mortality related to complications of miscarriage and unsafe abortion (see Appendix C). These services include FP counseling and contraceptive method provision (prevention), PAC services (treatment), community transportation systems, existing referral and counter-referral systems, general RH/FP services (detection and treatment of sexually transmitted infections (STIs) and HIV/AIDS) and other health services available in the community. The instrument was applied by the teams that implemented the model in each region and by the community leaders or “Core Group members.” The information gathered was analyzed using EpilInfo, a software package for analysis of survey data, and a document was prepared for each community.

Action Plans
A guide was developed for the participatory planning session, in which the community groups developed action plans to resolve the community needs they identified as most important. The Action Plan Matrix, shown in Table 1, allowed participants to analyze the cause of the problem in order to propose an intervention targeted specifically at the cause. In addition, the groups identified the individuals responsible for implementing each intervention (Point person).

Table 1: Action plan matrix

<table>
<thead>
<tr>
<th>Problem</th>
<th>Who does it affect?</th>
<th>What is the cause of the problem?</th>
<th>What do we want to accomplish?</th>
<th>How will we solve the problem?</th>
<th>Intervention</th>
<th>With what?</th>
<th>Point person</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To facilitate sustainability, participants were informed that the activities proposed in their action plans should be “real,” “attainable” and “feasible” in a period of three to four months. As community groups implement their action plans, they continue to receive technical and logistical support from the local teams, but the groups do not receiving funding for action plan activities. The hope is that the implementation of the action plans will facilitate improved management of existing systems (such as the SUMI and the Community Analysis and Research Committees or ARCs30) such that community groups are able to achieve their goals using these community resources.

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30 “The ARCs are part of the MOH health system, and are the mechanism designed by the MOH to encourage community participation in interpretation and analysis of health data, as well as proposing solutions to community-level health problems. The ARCs also evaluate local health services, identifying their weaknesses and strengths.” Adapted from Paz, Marcos, “Movilizacion Comunitaria por una Maternidad Segura,” SMN/JHPIEGO/USAID. La Paz, June 2002.
After each group developed its plan, they met with other groups served by the same HC to synthesize plans for each area. Through these meetings, six plans were developed in El Alto and 10 plans in Santa Cruz.

**Model Staff and Community Groups**

Implementation of the CM process was carried out by seven individuals in Bolivia who were hired for the activity. At the central level, Carmen Monasterios served as the General Coordinator in charge of the administration of the model and Kiyomi Tsuyuki, a USAID Population Fellow, served as a Technical Assistant, providing support in the coding and analysis of data and developing the matrices for collecting the data from the ADX sessions. At the regional level, there were two local Coordinators—Norma Mariaca and Marisol Heredia—responsible for coordinating the work and supporting the community leaders in carrying out the ADX and action planning sessions. There was also one Facilitator in El Alto (Judith Andrade) and two facilitators in Santa Cruz (Luis Cardozo and Carmen Quiroz), all of whom supported the local Coordinators and the community leaders and facilitated data collection.

The CATALYST/Washington team was comprised of Graciela Salvador-Dávila, Senior Reproductive Health Advisor, who managed the activity, and two consultants—Patricia Hammer and Diane Bushley. The former developed the draft of the ADX and the participatory planning guides and facilitated the training workshop for the Bolivia staff. The latter provided TA on behalf of CATALYST/Washington, supported the development of the matrices for data collection, and coordinated the documentation of the model.

At the beginning of the activity, coordinators and facilitators participated in a six-day training, which included a workshop on the principles of CM, an introduction to the ADX guide and practicum sessions, in which the local teams had an opportunity to validate the guide with community groups in El Alto. At the end of this training session, the El Alto and Santa Cruz teams worked together with the Project Coordinator to develop a detailed timeline for the implementation of the CM process (Appendix D).

Following the training, the local team members returned to their respective communities to identify groups that could participate in the CM process. Each group elected a representative as its “leader.” The group of leaders was named the Core Group. Each of the Core Groups (one for each project site) included 25 leaders. Figure 1 illustrates the relationship between the Core Group and the community groups. Although there are only 10 community groups in the diagram, the figure also reflects an approximation of the distribution of the different types of groups (women, men, mixed and adolescents) in the communities.

The role of the Core Group members was to facilitate the four sessions (ADX and participatory planning), collect relevant information and synthesize problems and needs during the development of the community action plans. All ADX sessions and the participatory planning session were carried out with the Core Group members first in order to train them in the application of the instruments for both phases.

Once they were trained to use the ADX guide, the Core Group members facilitated the ADX sessions with their respective community groups. Twenty-one community groups participated in El Alto, and 27 groups participated in Santa Cruz. At most of the sessions, there was a representative from the local team to support the Core Group leaders in conducting the sessions. It was anticipated and planned that, through the implementation of the sessions, Core Group members would become increasingly empowered and assume a leadership role in their
communities. The evaluation of the model explored the changes in sense of self-efficacy and empowerment among Core Group members.

Figure 1: Relationship between the Core Group Members and the Community Groups

Both regions had various types of community groups, including mothers’ clubs, groups of adolescents (combined male and female participants), neighborhood boards (also combined male and female participants), men’s groups and, in the case of El Alto, a group of volunteer community-based health promoters known as Manzaneras. Manzaneras educate community members about health issues and activities such as vaccinations and Pap smear campaigns.

The majority of the participants in both El Alto (92%) and Santa Cruz (80%) were women.

31 Figure 1 is only an illustration of the groups who participated in CM process. Each group had one representative in the Core Group.
32 In this CM process, “adolescent” groups were previously existing groups of adolescents/young adults who ranged from 15 to 24 years of age.
Figures 2 and 3 show the distribution of the types of groups in each community. Adolescent groups comprised 10% of the total groups in El Alto and 11% in Santa Cruz.

Figure 2: Types of groups in El Alto

![Figure 2: Types of groups in El Alto](image)

Source: Project data.

Figure 3: Types of groups in Santa Cruz

![Figure 3: Types of groups in Santa Cruz](image)

Source: Project data.
Table 2 shows the age distribution of the participants at both project sites. The bulk of the participants in El Alto were between the ages of 25 and 34; in Santa Cruz, the bulk of participants were adolescents between the ages of 15 and 19, followed by participants between the ages of 25 and 29.

<table>
<thead>
<tr>
<th>Groups</th>
<th>15–19 years</th>
<th>20–24 years</th>
<th>25–29 years</th>
<th>30–34 years</th>
<th>35–39 years</th>
<th>40–44 years</th>
<th>45–49 years</th>
<th>50–54 years</th>
<th>55–60 years</th>
<th>More than 60 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Alto</td>
<td>76</td>
<td>68</td>
<td>94</td>
<td>97</td>
<td>77</td>
<td>55</td>
<td>27</td>
<td>23</td>
<td>19</td>
<td>5</td>
<td>541</td>
</tr>
<tr>
<td>%</td>
<td>14%</td>
<td>13%</td>
<td>17%</td>
<td>18%</td>
<td>14%</td>
<td>10%</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
<td>1%</td>
<td>100%</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>208</td>
<td>81</td>
<td>82</td>
<td>66</td>
<td>67</td>
<td>62</td>
<td>43</td>
<td>30</td>
<td>34</td>
<td>32</td>
<td>705</td>
</tr>
<tr>
<td>%</td>
<td>29%</td>
<td>11%</td>
<td>12%</td>
<td>9%</td>
<td>10%</td>
<td>9%</td>
<td>6%</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Project data.

Most participants in El Alto had completed primary school (6 years) and in Santa Cruz most had completed secondary school.

IV. Results

The results of the CM process are organized based on the three specific objectives and the products that resulted from these objectives.

**Results of the Autodiagnóstico: The Most Salient Problems for the Community**

The ADX enabled participants to discuss characteristics of life in the community from the perspective of their individual experience. In some cases, they did this by developing imaginary stories about the lives of people in their communities. The life story invited participants to project aspects of their own lives into the story anonymously by creating a fictional character; therefore, the stories may have incorporated aspects from several individuals’ life experience. In the analysis of the stories, participants were offered an opportunity to discuss what happens to the characters; in doing so, they expressed attitudes, identified social norms and voiced how they wished those norms would change (how life should be).

The results of the ADX show that participants in both communities recognize the problems of unintended pregnancy and complications of miscarriage and unsafe abortion.
El Alto

In El Alto, participants attributed unintended pregnancies to the lack of use of FP and to the high prevalence of coerced sex and rape. In these cases, women do not have the option to choose to use a contraceptive method.

Participants mentioned that abortions occur as a result of the way life is in El Alto, where family finances demand that women work hard and where sometimes women and their partners resort to unsafe abortion because they lack the necessary resources to provide an education for more children.

“...In this region, it is common to see adolescents and also older women with several children, with needs and without resources for education or even food, but they continue becoming pregnant because they do not know how to use a method or do not want to use a method.” [Group of women, first session]

“Because she was so preoccupied with work, she did not use birth control and became pregnant. This is her fifth child. I advised her to go to the Health Center and practice family planning, but she does not want to listen. My brother is very chauvinist (machista), and she doesn’t seem to mind. Her children are already grown up, but they were born one right after the other. That’s the way it is; some of us worry a lot about becoming pregnant, and others don’t care how many children they have.” [Group of women, second session]

Causes of Unintended Pregnancy, Including Non-use of FP

Community members in El Alto recognize that non-use of contraceptive methods can lead to unintended pregnancies. They attribute non-use of FP to a variety of factors, including lack of information/education about FP, lack of support and love from parents and partners, lack of communication between parents and children and between partners and traditional gender roles. Interestingly, many of the participants were aware of a variety of FP methods and where to obtain them. They mentioned condoms, pills and IUDs as commonly-used methods and indicated that some methods are available at the pharmacy, while counseling and methods are available at local HCs.

“...his female partner goes to the health center when she is sick and she never had a miscarriage. They no longer want any more children and she is using an IUD...” [Group of women, third session]

She had an abortion, but “...now she takes care of herself with condoms...” [Mixed group, second session]

The initial KAP survey revealed that, in El Alto, 87.5% of participants knew about at least one contraceptive method, 78.9% knew where to obtain a method and 46.7% stated that they had used a method in their last intercourse. There was some variation among the groups in their level of knowledge. The group of men had the highest knowledge about contraceptive methods and where to obtain them (100% and 96%, respectively) and also were more likely to have used a method in their last intercourse (68%). Adolescents' knowledge was similar to the average for
all participants (87.2% knew about contraceptive methods and 85.1% knew where to obtain them).

1. Lack of information and education
According to the community members, the most common cause of unintended pregnancy is the lack of information, education or counseling about FP methods and RH/FP in general. Participants believe that, because some people do not know how their bodies function, it is difficult for them to know about or understand the concept of preventing pregnancy. It is important to note that, although participants explained the problem as lack of knowledge about their bodies, some people have cultural conceptions of bodily processes (such as pregnancy) that differ from biomedical models; they also may have culturally-defined values and perceptions about fertility and its management. In some cases, therefore, community members may not have sufficient knowledge about biomedical models; however, in others, modern contraceptives and the way they work may not coincide with community members’ cultural beliefs.

Participants noted that, due to lack of knowledge, some women go to health facilities with the intention of obtaining a contraceptive method, but they discover that they are already pregnant.

“These girls from poor families do not have many options for getting an education, and it is because of this that they often don’t finish primary school and become pregnant due to lack of information.” [Group of men, first session]

“Mainly they don’t notice when they are pregnant until the third or fourth month, because they do not know how their bodies function; when they find out, they become scared because they do not know what to do.” [Mixed group, first session]

2. Lack of support for youth
Many acknowledged that some people are more vulnerable than others to unintended pregnancy and non-use of FP; for example, adolescents, who are very young and do not foresee the consequences of their actions. Some participants believe that parents, schools and the community are not meeting their responsibility by providing support to and educating young people during the process of adolescent development, and, in doing so, reducing some of society’s taboos.

“She was led there based on lies so that she could work as an employee and, on top of that, so that the son could abuse her sexually. She needed information about the life she would have being far away from her parents. She would not have gone through all this.” [Group of women, first session]

“The majority think that they [young women] find themselves in these situations of pregnancy and induced abortion sometimes because of the lack of education, knowledge and the lack of love from their parents.” [Group of adolescents, second session]

“To escape abuse from her family, she marries Pedro with whom she already has three children. She is very fertile; her children (wawas) are born one right after the other and they are very thin. The last baby is eight months old and her menstruation has still not
returned. That happened to her with her second child, that while she was nursing him she did not have her period and she was already pregnant.” EA18S2 [Mixed group, second session]

Others cite the relationship between parents and their children as a cause of non-use of FP and unintended pregnancy but frame the problem as a “lack of communication”: “The lack of communication and information about [RH/FP] in their home was the cause [of the unintended pregnancy].” [Group of women].

3. Normative gender roles
There also are couples that do not plan their families even though they know about contraceptive methods. This can be attributed to the lack of communication between the couple: the man does not allow the woman to use methods or he thinks that she is responsible for choosing a method and using it. Others think that married couples do not have the right to plan their pregnancies.

“In the neighborhood there are cases like this that the responsibility of bringing children into this world is only of the women. The man only needs to bring money and he has the right to drink and to beat the woman…” [Group of women]

“Because both women and men are responsible and both should assume the responsibility, but in the majority of cases that does not happen because it is said that men belong to the streets and women in the home, and women must assume the responsibility for their children.” [Group of men, first session]

“…[W]e do not decide whether or not to have children. It is our duty as wives and for being married.” [Group of women (artisans), first session]

4. Abuse
Another reason for not using FP is violence. In some cases, men think of their wives as property and abuse them.

“Physical abuse exists because husbands feel they own their women because they are their wives or they are living together, and they abuse them [the women] sexually.” [Core (mixed) group, first session]

Consequences of Unintended Pregnancy
Participants noted a number of consequences of unintended pregnancy in cases when women decide to carry the pregnancy to term.

1. Social rejection or abandonment of mother
Women who face unintended pregnancies often suffer rejection from their partners, their families and the community, although some receive support. Many men do not become involved due to the lack of resources to support their partner or their child, and they leave the woman to assume full responsibility for the pregnancy.

2. Economic consequences
Several participants acknowledged the connection between the number of children in the family and the economic situation, relating unintended pregnancies to the family economy, which affects both parents and children. Many parents have to abandon their studies to work, and they often find it difficult to support a family due to their limited employment possibilities. Some women and partners abandon their children by leaving them with relatives or friends and, in extreme cases, leaving them in an isolated place to die.

3. Maternal health

Unintended pregnancy often affects the health of the mother. Many mothers do not know how to take care of themselves and do not have regular medical check-ups or their partners forbid it. At times, this impacts women’s emotional health. They may be afraid or worried about changes in their lives or may suffer depression because of the pregnancy and, consequently, not take care of themselves. The community acknowledged that suicide is the most serious health result of unintended pregnancy. Many times, one of the primary causes of poor health in a woman who experiences unintended pregnancy is the abuse of her partner or her family, which can manifest itself as physical or emotional violence or in forced marriage.

4. Children’s physical and emotional health

Children resulting from unintended pregnancies suffer, even if they are not abandoned. They may experience health problems, suffer malnutrition or anemia, grow up without affection, and at times be abused. Ultimately, they are victims of a “vicious circle” in which they cannot receive an education, they have many children and they do not advance economically, thus perpetuating the cycle of poverty.

“They did not know how they should educate their children, because they were not educated by their parents either.” [Group of women, first session]

“Many things happen as a result of an unintended pregnancy, such as abandonment of children. Also, before, when I lived near the Río Seco below, we knew where to find dead newborns, which have been placed in a black bag.” [Group of women, second session]

“He is an unwanted child ... due to lack of affection, communication and understanding from the parents, the children grow up without love, and this leads children to take the wrong path” [Group of women, first session]

Causes of Abortion
Participants noted that many unintended pregnancies end in abortion.

1. Couple not prepared for pregnancy
At times, this decision is made because the couple’s relationship is not very stable or due to economic reasons, including the desire to continue studying. Sometimes the choice to terminate the pregnancy is made with the partner.

2. Adolescents
Adolescents are likely to have an abortion for the same reasons as couples and also due to lack of support from their families and society.
3. Poor health
In some cases, women may resort to abortion because they know they are too young or too weak to carry the pregnancy to term. Unintended pregnancy and poor health during pregnancy also occur because women do not take care of themselves, both because they are busy caring for their children and because their husbands may prevent them from going to a doctor.

“Sometimes she buys medication to cure her children, but not for her; she only cures herself with mates [herbal infusion]. When it is serious, she could go to the doctor. She says that her husband does not want her to see a doctor. She has six children and does not use any contraceptive methods. Only her husband takes care of her.” [Core group, third session]

4. Partner encourages woman to have an abortion
In some cases, the woman’s partner asks her to have an abortion, gives her the money to do so or refers her to a place where she can receive an abortion.

“Juan, at this age, abandoned his studies. He dedicated himself to frequenting night clubs, he drank alcohol; he started romancing girls at 14 years of age, making fun of his girlfriends. But one of them became pregnant. Desperation led them to resort to a traditional healer who used herbs to perform a clandestine abortion. He encouraged her to have an abortion and threatened to leave her if she did not do it. That is how she accepted the abortion; but she died in the healer’s home.” [Group of women, second session]

5. Violence
Many abortions are the result of physical violence that causes hemorrhaging; this violence is usually perpetrated by the woman’s partner, but sometimes it is perpetrated by others. In many cases, women who experience violence lack a support network to address the violence.

“A 35-year-old woman had an abortion that was induced by her husband, who put hot cans on her stomach and threatened her if she reported that he brought on the abortion. He threatened to kill her for having lovers. Every time she gets pregnant, he does the same thing, and she does not report him out of fear and because she is all alone and does not have a family.” [Group of women, second session]

“Beatings and abuse result in hemorrhage problems and abortion in pregnant women.” [Group of women, first session]

“It involves a woman who was constantly abused by her regular partner. On one occasion, he beat her a lot, and she was three-months pregnant. As a result of the beating, she was hemorrhaging, and since the Health Center is very far from their house, they did not go to the Health Center. Due to the lack of immediate health care, she lost the baby. But she cures herself by drinking some mate at home.” [Group of men, second session]

Abortion Methods
When women terminate the pregnancy, there are a number of methods they use to do so, including consumption of herbal infusions (mates) and medications that are contraindicated for
pregnancy. According to several participants, abortions also occur when women overexert themselves (lifting heavy objects); many pregnant women do this to carry out their work duties.

**Consequences of Abortion**
Abortion may have multiple impacts on women and the community.

1. **Emotional consequences**
Many women experience emotional consequences, including fear for different reasons or feelings of guilt for having had an abortion.

2. **Physical consequences**
Other women suffer physical consequences—they are left very weak, sick or sterile. The most serious and most mentioned physical consequence is death.

“He saw her in a pool of blood.” [Group of women, first session]

**The Three Delays**
The ADX also explored how members of the community address the problems of unintended pregnancy and complications of miscarriage and unsafe abortion in terms of recognizing the problem, deciding what to do about it and resolving it (receiving care at a facility).

1. **Unintended pregnancy**
The ADX indicated that community members recognize the problem of unintended pregnancy in the following ways: (1) when women find out that they are pregnant through a pregnancy test; (2) with the help of their partners or families or when they know that they are pregnant and their economic situation does not allow them to have more children; (3) when they are pregnant and they know that they do not want the child; or (4) when the pregnancy is the result of unwanted relations, such as rape.

Once the problem has been acknowledged, women can decide not to have the child, change their mind or carry the pregnancy to term. They make this decision alone or in consultation with friends or their partner, which can lead to an abortion from a traditional provider such as a curandero, a traditional birth attendant (TBA), or a private physician. In other cases, female friends help women identify the herbs needed to induce an abortion. Women who decide to carry their pregnancy to term prefer to be cared for in their homes by a traditional provider.

2. **Complications of miscarriage and unsafe abortion**
In cases of hemorrhage, the majority of women recognize the problem by linking it to previous events, such as accidents, falls, physical efforts, beatings, taking pills, injections or mates. Other times, they recognize the problem due to bleeding during the pregnancy and knowing that it can become a serious problem if it worsens.
According to the participants, after recognizing the problem, some women drink mates in their homes while they wait for the bleeding to stop. However, most women take action with the support of their partners, relatives or friends. The majority of women seek solutions at HCs, but many also resort to traditional providers who often do not offer any solutions. Families who lack the economic resources to pay for transportation or services may request the community's support.

"Immediately the husband, because he is worried, asks for help from the neighbors so that they will loan him money to bring her to the HC but the neighbors refuse to give him a loan, and he despairs and brings her to the HC where he tells them that he doesn't have money, and the nurse tells him that he has to pay the money first before receiving services …" [Group of adolescents]

Unfortunately, the neighbors and community organizations do not always provide needed support. Inability to pay for services is therefore a barrier that is perceived and experienced by participants.

Regrettably, some women decide not to go anywhere or do not receive prompt treatment, which can lead to the death of both the mother and the baby.

"She took it as indicated, but because it had no effect on her, she took it several times. When night fell, she began bleeding heavily. Her husband asked their neighbor for help. Since he knew what was happening, he helped them take her to the Health Center, but on the way there, she died. Her face and hands were swollen, and she looked like she was nine-months pregnant." [Group of women, second session]

"He takes her to a Health Center. Upon reaching the facility, the nurse tends to her unwillingly and scolds her; she tells her that she has to come back because there are too many people, that she must wait the next turn, and that the other nurse will arrive eventually. She goes home and does not want to return to the Health Center because they treated her very poorly. Thus, she is cared for by her husband and a traditional birth attendant; the baby dies and she is left in a very delicate state." [Group of women, second session]

"When her mother takes her to the Health Center, she has to wait a long time because it is full. Although her mom explains to the nurse that she has been bleeding for many hours, the nurse does not tend to her quickly. While she waits her turn, she loses consciousness and faints; that is when they tend to her. She lost her baby and was hospitalized." [Core group, third session]

"Her partner, upon seeing her all bloody, asks the neighbor for help, who tells them to go see a female healer. But the healer, upon examining her, says that there's nothing she can do for her, that he should have brought her earlier. He then takes her to a local Health Center, where they tell him that there is no emergency care. He tries to take her to the hospital, but on the way there, she faints. When they reach the hospital, it is already too late. She had died leaving her children behind." [Group of women, first session]
Quality of Care
Participants identified several problems related to quality of care at the facilities. Although care is “generally good”, the vast majority expressed that health care staff take too long to care for women with hemorrhages: “At the Health Center, no one tended to the woman quickly because the doctor told her to wait, that he had a lot of clients to care for, and that there weren’t any nurses available to help him.” An additional problem identified was a lack of care when women do not arrive for treatment during regular facility hours; in many cases, this is because there is not a doctor on-site at night.

Finally, participants noted that they are often treated poorly by staff. To avoid this discrimination, community members delay or avoid going to health facilities and resort to alternatives. Traditional providers are the most common alternative although the community acknowledges that the care they provide is not as safe.

“She is drowsy and has anemia. As a result, she looks pale. Upon feeling so sick, she goes to the Health Center, where the staff treats her poorly, noting that she must have taken something to induce an abortion. For this reason, she returns home seeking support from her partner and tells him what is happening to her. But he proceeds to beat her so brutally that she begins to bleed without anybody to help her. She loses consciousness, faints and falls to the ground; he continues beating her until she bleeds to death.” [Group of women, first session]

Recommendations for Program Planners
The focus in responding to the ADX results – both in El Alto and Santa Cruz – should be on how to respond, rather than on specific actions. The orientation of the response is critical. The ADX generated a momentum in the community because of the participatory and dynamic nature of the sessions; the equity among participants in the sessions, which allowed for the sharing of ideas and collaborative planning among individuals who might not have otherwise had the opportunity to work together; and the fact that the goal of the activities is to develop feasible, achievable solutions to problems that the community members feel are significant. Therefore, the goal of the response should be to foster the momentum of the community. An emphasis on action by community members also increases the possibility of sustainability. According to the results of the ADX, the following issues emerge as problems of great importance to the community members:

1. Gender inequity
In El Alto, gender issues significantly influence the problems of unintended pregnancy and complications of miscarriage and unsafe abortion; these issues manifest themselves as GBV and the partner’s lack of collaboration in FP. Working with women’s partners on these issues and on gender equity would be a very effective intervention, potentially impacting all gender-related issues. The group in El Alto, primarily made up of women, also acknowledged that men’s involvement is key for this type of activity in the future.

2. Economic barriers
Another common topic in the ADX was the problem of poverty as it relates to health. While any direct intervention falls outside the model’s objective, community members could be supported in seeking avenues for community education about the benefits of citizenship and of existing programs such as the SUMI, which provides support in the form of health care for pregnant and postpartum women (including CTHCFHC) as well as other infant and child health services.
Greater awareness of the free services available through the SUMI program would presumably increase the numbers of community members who seek health services.

3. Lack of RH/FP knowledge

In general, there was a clear lack of information about FP, how to prevent complications of miscarriage and unsafe abortion, the risk involved and what to do in case it occurs. Community members should be encouraged to identify specific information needs as well as what they perceive as the most appropriate means to share this information with the community. According to the results of the ADX, collaboration between partners on issues associated with FP and the male partner’s support during pregnancy and when complications occur are important issues for community members.

4. Quality of care at facility

Finally, at the health facility level, the ADX highlights the lack of sensitization on the part of health care providers with respect to the needs of the members of El Alto, who feel that they are treated in a discriminatory manner. Collaboration between the CM participants and the facilities is a first step towards better quality care; the findings of the ADX should be presented at the HCs to serve as a means for opening the dialogue between the community and providers and will sensitize providers to community needs.

Santa Cruz

Causes of Unintended Pregnancy, Including Non-use of FP

Santa Cruz participants recognized that non-use of FP contributes to unintended pregnancies. The most commonly cited reason for not using FP was lack of information or incorrect information about FP. However, the other causes were associated with social relationships—lack of communication about FP and lack of social support, lack of values, fear of seeking services at the facility, gender norms, abuse or rape.

Participants showed an awareness of the availability of methods in general—“[She should] take care of herself with contraceptive methods.” [Group of adolescents]—and had heard some rumors about specific methods:

“Some women do not use contraceptive methods because of the rumors that the IUD causes cancer and [they have heard about] the secondary effects of Depo Provera, that it makes people fat.” [Group of women]

They cited pharmacies and HCs as places where contraceptive methods are available and where they seek their own methods. The initial KAP survey shows that, in Santa Cruz, 88.9% of participants knew about at least one contraceptive method, 85.1% knew where to obtain a method and 44.4% had used a method in their last intercourse. These numbers varied among groups. The groups of adolescents had the highest knowledge about contraceptive methods (92%) and the group of men had the lowest (80%). Men in Santa Cruz also had the lowest knowledge about where to obtain a method (84%) and, except for adolescents, were the least likely to have used a method in their last intercourse (40%).
1. Lack of information and orientation
One of the most frequently cited reasons for non-use of FP was lack of information about FP. “Some men and women don’t want to use FP because they don’t have complete information.” [Mixed group].

“Nowadays we see more often women who become pregnant very young and who do not know how to protect themselves; perhaps because they don’t receive appropriate counseling from their parents” SC21S1 [Mixed group, first session]

“She became pregnant because she did not know how to take care of herself, she did not know about contraceptive methods …” [Group of adolescents]

2. Lack of communication
Another commonly-cited reason for non-use of FP was the lack of communication, primarily between parents and adolescents but also between partners:

“The couple should have better communication to plan their family, participating in courses like these men and women.” [Mixed group]

“Bad education in the house [for adolescents], there is no dialogue with the parents …” [Mixed group]

The following quote also suggests one of the functions of communication according to the participants—to instill values in adolescents so that they can take care of themselves:

“Some people like Maria have the luck of finding people that give them values, principles through which they don’t rush to have premarital sexual relations and avoid being a single mom.” [Mixed group].

The groups also offered shame as a reason for the lack of communication about FP between partners. Referring to one adolescent, they noted

“She did not do this because she was ashamed to talk about condoms with her partner.” [Group of women]

3. Gender relationships
Non-use of FP also was attributed to gender relationships, either because the man or the woman did not want to use FP. For the most part, participants stressed that men did not want to use FP because of machismo.

“[Unintended pregnancy occurs because of] lack of agreement within the couple [about FP use], primarily the man.” [Group of men]

“[S]ome women do not want to use FP because they don’t want their partner to leave the house (abandon them).” [Mixed Group]

“[Unintended pregnancy occurs] due to carelessness, forgetting to take the pill. He will not agree to use condoms.” [Core group, second session]
4. Abuse and rape
Another barrier to using FP is because women do not have control over when they have intercourse, either because they are forced to have sex or because they are raped:

“Some men obligate their wives to have sexual relationships with them and they become pregnant.” [Group of women]

“Unintended pregnancies also occur because of rape, and they aren’t denounced for fear or shame of what people will say.” [Group of adolescents]

Consequences of Unintended Pregnancy
Like participants in El Alto, Santa Cruz participants believe that unintended pregnancy can have a profound impact on the family. Often women or men have to abandon their studies, which affects the family’s finances. Women or the children resulting from this type of pregnancy may suffer psychological consequences, such as rejection. It also was acknowledged that it is very common to resort to abortion in these circumstances and that abortion can lead to severe consequences, including emotional problems, diseases and infections, and even death.

“In this case, the male’s responsibility increases because, whereas before he worked to help his family, now he will also have to work to support his wife and child. Such a situation is very hard to deal with because it is difficult to find a job and much worse if one does not have an education or a profession.” [Group of women, first session]

“When the pregnancy is not planned, the woman does not take care of herself, she does not give affection to the baby inside her, she lifts heavy objects, she takes medications without prescriptions, she does not eat well during pregnancy, risking her life, and she does not go to her prenatal care check-ups. For this reason, she has a complicated delivery during which the baby suffers.” [Mixed group, first session]

Economic and/or educational inequalities among the members of the community imply that problems such as unintended pregnancy and complications of miscarriage and unsafe abortion affect some individuals more than others. Participants identified a relationship between the lack of information about contraceptive methods and lack of economic resources.

“It is something that still happens in the neighborhood. There are families that are very poor and whose children do not have sufficient education to use protection and prevent an unwanted pregnancy. Children must work to help their families.” [Group of women, first session]

Causes of Abortion

1. Social rejection of the woman
When there is an unintended pregnancy, sometimes the woman is rejected by her partner, her family, her friends or the community. It is possible that the pregnancy does not fall within the couple’s plans, and that is why the partner abandons the woman or that her family or her community will punish her for ruining her life.

“Families worry about society primarily because the woman’s reputation is affected, and, if she is not married, it is even worse, and they are ashamed by what others might say.
For example, men say that that woman must have several boyfriends and that she is lost [a prostitute].” [Mixed group, first session]

“Primarily, the man considers abandoning the pregnant woman to avoid responsibility for the pregnancy. First, because he does not feel prepared to assume this responsibility, and second, because he also does not have the support of his parents, who instead of advising him to own up to his responsibility, advise him to leave her.” [Mixed group, first session]

“The woman may also suffer aggression perpetrated by her male partner if she does not want to have an abortion and the man wants her to abort.” [Mixed group, first session]

2. Physical/emotional violence
In extreme cases, she is a victim of physical or emotional violence perpetrated by her father or her partner. Sometimes, the woman’s partner or her family asks her to have an abortion.

“Women who have unintended pregnancies may suffer physical aggression from their parents, who unleash their frustration and rage in this manner. In married couples, it is the husbands who beat their wives to cause an abortion.” [Group of women, first session]

“There are some men who ask their partners to have an abortion and even accompany them to clandestine providers. Men do this to avoid losing their freedom. What’s more, they do not feel able to assume the responsibility and are afraid that their families will find out.” [Group of women, first session]

“[Abortion] is a typical occurrence in the community, because some parents force their daughters to have an abortion so they can continue studying and because they are afraid of what the neighbors may say. Only a few parents support their pregnant daughters. This happens when they have the economic resources.” [Group of women, first session]

3. Self-induced abortion and miscarriage
In some cases, the woman self-induces an abortion by taking medications, going to a herbalist, lifting heavy objects or beating herself. In other cases, an abortion occurs because women cannot stop working to take care of themselves.

“When the abortion is induced, it occurs by means of taking medication that is contraindicated during pregnancy or by inserting instruments such as sharp objects like knitting needles, or taking home remedies such as abortifacients. Miscarriages may occur due to weakness in the cervix, detachment of the placenta, lifting heavy objects, jumping.” [Homework]

“She should not lift heavy objects. She behaves like that because she has no other alternative, since her husband works and she does not have anyone to help her with her house chores. She did the right thing in light of the problem—she sought immediate help at the Health Center and thus was able to save her baby’s life.” [Mixed group, first session]
“[She had a miscarriage] because she did not have medical follow-up during the first months of her pregnancy. They don’t take care of themselves; they lift heavy objects; and then they realize that they are bleeding, and, because they are ashamed, they won’t see a physician. They do not communicate with anybody. They go to the doctor too late.” [Homework]

Adolescents and Abortion
Participants believe that adolescents are very vulnerable to unintended pregnancy and complications of miscarriage and unsafe abortion. This is due to their lack of information and knowledge about FP, lack of self-efficacy (inability to use FP when required even when they are aware of it), lack of reflection on the consequences of sex and unintended pregnancy, and lack of parent-child communication and understanding about RH/FP. They also believe that adolescents’ bodies are not prepared for pregnancy. Parents force them or encourage them to have an abortion, or the young women themselves decide to do so due to their individual circumstances.

“Young people have sex only for the physical pleasure and do not think about the consequences of an unintended pregnancy. They hear that there are contraceptive methods, but when the time comes to use them, they don’t.” [Mixed group, first session]

“Young people don’t use protection when they have sex. They fall in love blindly and do not think about the consequences of an unintended pregnancy and choose to have an abortion. Often, the man will find a place that provides abortions and will give the woman money for this, or, in other cases, the man avoids his responsibility because he does not feel able to support his child and also considers his freedom. The woman is saddled with the responsibility.” [Mixed group, first session]

“[Unintended pregnancy] occurs because parents do not communicate with their children and do not counsel them on sexuality. They are more dedicated to their jobs.....They do not ask their children how they are, and the children don’t look for an opportunity to talk about these topics either.” [Mixed group, first session]

The Three Delays
The ADX in Santa Cruz explored the community’s response to the problem of complications of miscarriage and unsafe abortion in relation to the three delays: recognizing the problem, deciding what to do and resolving it (receiving care at a facility).

Women recognize the problem of complications of miscarriage or unsafe abortion when they experience bleeding during pregnancy, especially if it worsens or does not stop. They may acknowledge it on their own or with the help of their husbands, female friends, neighbors or their parents. In many cases, they identify a relationship between the complications and some previous event, such as an accident, taking pills or injections. While they do recognize the problem, they sometimes do not recognize the urgency of the situation and act accordingly.

“It takes her a while to recognize that she has a problem because she thinks that her bleeding is her menstruation, which is three months late, and that is why it was heavier.” [Mixed group, first session]
Once the problem is recognized, many women seek care—whether at a HC, maternity hospital, private clinic, pharmacy or from a traditional provider—with the help of someone, or they wait for someone to come help them. Other women act alone or do nothing out of fear or shame.

At times, women take too long to seek care, because they wait to see whether the problem will go away, or they resort to facilities that do not provide appropriate care. Both delays and the quality of care can determine whether the lives of the mother and the baby will be saved when they reach the facility.

“She arrives alone at the maternity hospital, where they hospitalize her to treat the hemorrhage with an injection, and after a few days they discharge her and ask her to rest and follow the medical indications. She is very worried because she must continue working to survive.” [Group of women, first session]

“The physician tells her at the Center that her bleeding is from her menstruation. She returns home at ease, but she gets worried when she sees that the bleeding is lasting longer than normal. She returns to the health center where they perform an ultrasound, which helps them diagnose that the bleeding is the result of an abortion, and they perform a scraping (curettage). The woman returns to her home saddened due to the loss of her baby.” [Mixed group, first session]

“The nurse at the health center does not attend to her rapidly. She tells the patient that the physician had important things to do in his office and asks her whether she wants to wait awhile or, otherwise, return in the afternoon. She makes her wait more than an hour. After a long wait, the physician comes out; upon seeing the patient in poor condition, he refers her to Hospital Japonés saying that at his center they have neither the equipment nor the medications necessary to treat her.” [Group of women, third session]

“She returns to the herbalist, who this time gives her stronger herbs that work. But the problem now is that the bleeding does not stop, and another friend recommends that she go to the health center, where she can be treated at no cost. However, she is afraid to go there because she knows that they will ask her a thousand questions, and she was already threatened by the herbalist that, if something went wrong, she could not say where she obtained the herbs. But, since she was already very weak, she decided to go to the medical center, where they solved her problem.” [Group of women, first session]

Quality of Care

Participants made many comments about the care they receive to solve problems associated with complications of miscarriage and unsafe abortion. While some believe that the quality of care is good, the majority thinks that it is terrible, because providers take too long or treat clients poorly or because there is no physician and the client must be transferred to another facility. They attribute the poor treatment from nurses and physicians to the fact that their services are not well compensated. Generally, poor treatment is not reported because clients are afraid or they are not familiar with the procedure.

“The health care staff cannot do anything if it does not have the necessary equipment and because of this they become discouraged and also because their salaries are low and they are not compensated for the work that they do. In addition, the gynecologist
only sees patients during the morning shift, which means that women who can only go to the facility in the afternoon are not treated.” [Mixed group, third session]

**Recommendations for Program Planners**

The results of the ADX in Santa Cruz show that there are problems that interfere with the use of contraceptive methods to prevent unintended pregnancies, which can lead women or adolescents to resort to abortion and affect their search for help in the event of complications. Community participants should be supported in the implementation of community-designed activities to address these problems.

1. **Lack of information about contraceptive methods**

   Clearly, there is lack of information about contraceptive methods, and community members perceive the need for training and education about contraception in their communities. Another problem identified is that some men do not allow their partners to use contraceptive methods, or the partners do not use them when they are having sex. Community participants have started—and should continue to do so—to generate ideas involving men in FP decisions. In replicating this model, implementation teams also should consider inviting more men to participate.

2. **Lack of recognition of the gravity of bleeding during pregnancy**

   Through the ADX discussion, participants noted that sometimes women, their partners and their families do not recognize when bleeding during pregnancy requires medical attention; nonetheless, the ADX findings did not suggest why this was the case. It is possible that bleeding is perceived as something that is “normal,” that there is a cultural understanding of bleeding that does not define it as “dangerous” or that women and their families are too preoccupied with meeting their basic needs through work and household chores to attend to their health needs. Future replications of this activity should further explore the topic of why bleeding during pregnancy may not be considered an emergency.

3. **Social rejection**

   Community members recognize that unintended pregnancies can result in the rejection of women or adolescent girls by their partners, families or communities. This rejection is sometimes manifested as physical or psychological violence, which can lead to abortion. Community participants should be taught to develop solutions to these problems and be supported in the implementation of those solutions. Again, from the perspective of the implementation team, involving more partners and family members in the process also may sensitize them to the dire situations faced by women and adolescents.

4. **Quality of care at facilities**

   Community members should discuss their most common complaints about the facilities (delay in providing care and poor treatment on the part of health care providers) with providers and health care managers. As a means for initiating this discussion, the results of the ADX should be presented.

**Results of the Health Resources Directory**

A summary document for each community was prepared using data from (1) the mapping exercise in the second ADX session; (2) the group homework conducted after the second session of the ADX; (3) the MOH, including the Decentralized Health Unit in El Alto (UDSEA)
and the Local Health District (DILOS) in Santa Cruz; and (4) the application of the survey instrument developed by the project team.

Data was not available for all facilities from all sources. The mapping and the homework were not systematic and did not cover all of the facilities in the communities; in contrast, the DISA and survey data were collected in a systematic fashion, and therefore present more complete information about the facilities and services available in the communities. Community members provided important data that was not available from UDSEA and the DILOS; for example, from community-based providers that are not linked with a specific facility, such as pharmacists, traditional healers, etc. They also provided information their perspectives on the quality of care at the facilities. Data for each project site was analyzed and compiled using Epilinfo and was prepared in the form of a health resources directory.

The directories include the following information (Depending upon the data sources available, data is more complete for some facilities than for others):

- Address of the facility, neighborhoods served by the facility, approximate distance from each neighborhood to the facility and official facility hours.
- Number of personnel at each facility, including doctors, nurses, auxiliary nurses, technicians, pharmacists, receptionists, cleaning staff, guards, etc.
- Types of services offered, including general medicine, pediatrics, obstetrics and gynecology, nursing, pharmaceutical, and whether services are covered by the SUMI.
- Specialized services related to PAC, including FP and PAC counseling and services, and counseling, treatment and referral for STIs and HIV/AIDS.
- Existence of referral and counter referral systems.
- Information on transportation, including how community members reach the facility and transportation available for referrals.
- From the group homework interviews with clients and providers, perceptions about quality, reasons why clients seek care at specific facilities and clients’ and providers’ knowledge about the SUMI.
- From the mapping exercise, community members’ perceptions about quality of care, including facility personnel, hours, costs, etc. In some cases, these perceptions differ from the information offered by the MOH and providers as well as the information collected through the facility survey.

The discussion of transportation issues has been included in this section because transportation was directly addressed in the mapping exercise. It also could have been addressed indirectly in several research techniques used in the other sessions: the life story and the “route covered” exercises in the first session and the skits in the third, as community members could have addressed how they sought or obtained transportation in their narratives. In most of the community groups, the topic of transportation did not emerge as a priority problem for community members through these other techniques. For example, during the “routes covered” techniques and the sociodramas, most groups simply indicated that the women experiencing hemorrhage went directly to the facility, usually with the help of others.

“Upon seeing the hemorrhage that she has, her husband takes her directly to the HC.”
[Group of women]
“She calls her husband to go to the HC because she does not want to lose her baby.”
[Mixed group]

The lack of discussion of transportation may be partially because the project was carried out in two large, urban areas that have relatively reliable public transportation systems. In both El Alto and Santa Cruz, there is a fairly extensive system of microbuses or minibuses, which are mini-vans that have regular routes. In future replications of the model, implementation teams may want to consider focusing directly on transportation issues.

El Alto
The directory for the Los Andes Network in El Alto includes a total of 24 health facilities: one referral hospital (Hospital Los Andes), eight first-level public-sector HCs, three private HCs, three church HCs and 10 NGO HCs (five operated by PROSALUD, three by PROMUJER, one by CIES and one by Asociación XXI). More detailed information is available for 16 of these facilities and can be found in Appendices E and F.

Additionally, the directory includes information on other traditional and biomedical community health resources, the bulk of which were identified by the participants during the mapping. These included one curandero/a (traditional healer), two yerbero/as (herbalists) and one pharmacy. The participants indicated that both the curandera and yerbero/as sell herbs, and that the curandera also provides care to women during labor and delivery. The yerbero/as also treat other ailments, such as kidney problems. Participants indicated that they sought care at the pharmacy primarily for colds and pregnancy tests and that it was unlikely that they would go there if they were hemorrhaging.

Costs
Costs for a consultation at the various facilities range from 3.5 bolivianos (Bs) at some public-sector facilities to 25Bs at one private-sector facility. Public-sector facility costs range from 3.5 bolivianos at three primary-level HCs to 10 to 15 bolivianos at the Los Andes Hospital.

FP and PAC Services
All of the facilities offer FP counseling and method provision. The majority have trained personnel, dedicated spaces and established hours for counseling. One facility does not have a dedicated space and provides counseling in the exam room; another does not have personnel for counseling; and in a third, church volunteers provide counseling services. The majority of the facilities have specialized counseling for adolescents, and one has a psychologist who provides this counseling.

All facilities provide the following FP methods: oral contraceptive pills, condoms, IUDs and the rhythm or calendar method. Most provide Depo Provera (injectables), several provide tubal ligation and one provides vasectomy services.

One of the public-sector HCs does not provide complete PAC services that include emergency treatment. Complete information for two others is not available. The remainder of the HCs provide emergency treatment, many of them using manual vacuum aspiration (MVA). In HCs that do not provide emergency treatment or in cases of severe postabortion complications, clients are referred to the Hospital Los Andes for treatment. The directory data reveals that most facilities provide PAC counseling. In many cases, this counseling is provided by the ob/gyn.

2-33
**STIs and HIV/AIDS**
The directory information indicates that almost all of the facilities provide counseling for STIs and HIV/AIDS. Some facilities have a system for detection of STIs, one specifically has a lab available, and about half of the facilities have medicines available for STI treatment. Information on approximately one-third of the facilities indicated that they have a system for follow-up with clients who test positive for STIs or HIV/AIDS. Almost all facilities provide counseling on HIV/AIDS, and at least half know how to make a referral for voluntary counseling and testing (VCT) for HIV/AIDS.

**Other Services**
Almost every facility in El Alto indicated that they have a women’s empowerment program, although they did not provide more specific details on these programs.

**Referral and Counter-referral**
All of the facilities indicated that they have a system for referral and counter-referral in accordance with the standards of the Bolivian MOH. Referrals are made in writing, and all facilities have the materials necessary for making this referral. Since all facilities are located within the Los Andes Network, the Los Andes Hospital is the referral hospital. Nonetheless, some facilities sometimes make referrals to other hospitals because the Los Andes Hospital is very crowded.

**Transportation and access**
Almost all of the facilities have an ambulance available for emergencies. One public-sector facility and one NGO facility do not have an emergency vehicle available, and referred clients are sent by taxi or microbus to the referral facility. In four facilities, their correspondent communities also have vehicles available for transportation; these vehicles may be the same in some cases.

At the community level, most community members get to the health care facility on foot (if they are well enough), by minibus or in taxis in cases of emergencies.

“To get to the Los Andes Hospital you can take whatever public transportation is available on Juan Pablo II Avenue.” [Group of men]

Participants also recognized distance to the facility or a lack of facilities in their neighborhood as a major challenge in seeking care:

“The hospital is in Los Andes, the last neighborhood. We have to go through four neighborhoods to get there. And we arrive by public transportation and when there is no public transportation we hire a car or look for the neighbors who have private vehicles in order to get there quickly.” [Group of women]

“Those who live close to the Avenue [Juan Pablo II] arrive at the Los Andes Hospital quickly, but for those who live farther away, most of them find it difficult to get to the hospital or the health center …” [Group of men]

“In the “Estrellas de Belen” neighborhood there should be a public health center. To go to the health center we have to go viviendas [very far].” [Mixed group]
Participants also cited lack of or limitations in transportation as barriers to seeking care:

“We only have two minibus stops in our neighborhood and it is big.” [Group of women]

“We don’t have an ambulance.” EA18S3 [Mixed Group]

“[There is a] lack of [public] transportation available at night.” [Group of adolescents]

“Unfortunately the only way to get there is to walk, because there is no public transportation that goes by the HC.” [Group of women]

El Alto participants addressed some of these issues in their action plans.

Why clients seek care at specific facilities

The directory information indicates that clients often choose to go to the facilities closest to them and that they often seek care at public-sector facilities because sometimes the services are free: “They go because they lack money and it is free and good.” [Group of adolescents]. Others noted that services at public-sector facilities are covered by the SUMI.

“Some people go to the HC, because it is the only one in the neighborhood; they say that the doctor is good because he tells them how to take their medicine and gives them medications that are covered by the SUMI.” [Mixed group]

“I go to the Los Andes Hospital, because it is close to my house. It is full and they treat people poorly but I don’t know where to go. I don’t know of another health center.” [Group of men]

Finally, one respondent from the group homework indicated that they sought care at a particular facility because the services are comprehensive.

“Because there are a lot of people, they have general medicine, orthodontics, nursing, curative care, vaccinations, weight and height, and they have a small stock of medicines and offer 24-hour care in emergency cases.” [Group homework]

With regard to the quality of care, participants had both positive and negative comments about the HCs.

“[The woman interviewed] commented to us that the care provided is now okay because they changed the personnel and the treatment also improved, only that they make us wait to be seen, because sometimes there are a lot of patients, or in other cases there is no care because of the doctors’ strikes.” [Homework]

“The care is very slow and they do not treat people very well because the administration of the HC does not let us understand, and when he asks us something and we don’t respond he yells at the patients and offers bad care and we wait a long time.” [Group of adolescents]

“One time they treated a woman with a hemorrhage, avoiding greater consequences, and she says that the care offered is fast and good.” [Group of women]
Santa Cruz
The directory for the Northern Metropolitan Network in Santa Cruz includes a total of 24 health facilities: one reference hospital (Hospital Japonés), nine first-level public-sector HCs, two secondary-level social security HCs, five private HCs, two first-level health posts operated by the church and one church hospital and five NGO HCs (three operated by the Bolivian NGO Prosalud and two operated by Kolping, a German NGO). Five of the 10 public-sector facilities did not appear in the mapping exercise. This could be because participants did not live near those facilities, because they rarely use them or for some other reason. For more detailed information about each of the facilities included in the directory (a total of 18 have more detailed information), see Appendices G and H.

Other community health resources identified included three curanderos (traditional healers), one private nurse, two pharmacies, two hueseros (bonesetters), two naturopathic doctors, two parterro/as (TBAs), and three yerbero/as (herbalists).

Costs
Costs for consultations in all public-sector facilities are 10Bs. In one private-sector facility, the cost for a consultation is 20Bs. In one group, participants indicated that, even though labor and delivery are covered by the SUMI, they still have to purchase some items:

“In the [HC] when the woman goes so that they will provide care for her during her labor and delivery, the make her buy soap … needle and thread, cotton, syringes, dioxadol, and a black bag.” [Mixed group]

FP and PAC Services
All of the facilities offer FP counseling and method provision. They also have a dedicated space for this counseling. The most commonly available FP methods are Depo Provera (injectables), IUD, oral contraceptive pills, condoms and counseling for the rhythm or calendar method. One public-sector HC (Santa Isabel) noted that, although they do not provide tubal ligation, they do provide counseling and referral for that method.

Three of the public-sector HCs do not provide complete PAC services that include emergency treatment so they refer clients to another HC where that treatment is available or to Hospital Japonés. The remainder of the HCs provide treatment for uncomplicated cases, referring clients to Hospital Japonés only for the more complicated cases. Despite how most HCs can provide emergency treatment and are officially open 24-hours-a-day for emergencies, emergency treatment is not always available. According to the participants, the main reason for this is that there are no doctors available at the HCs at night; unfortunately, the system also prohibits clients from going directly to the hospital for PAC services, because they need a referral from their local HC. The result is that clients often have to wait over twelve hours to receive PAC services. The directory data also reveals that PAC counseling can be problematic. In some cases, all providers in the HC are trained to provide counseling; in others, there is a dedicated provider for counseling, which can be a problem if that provider is unavailable or busy. In one facility (Santa Isabel), only the gynecologist was trained to provide PAC counseling.
**STIs and HIV/AIDS**

The directory information indicates that almost all of the facilities provide counseling for STIs and HIV/AIDS and have a system for detecting these infections. Many of the facilities use either syndromic or symptomatic detection and a few have laboratory services. For STIs, all facilities try to treat couples, although one HC (Lazareto) noted that many women do not return when they are told that their partner must be treated as well. Some facilities have the medicines needed for STI treatment and carry out follow-up visits with the clients. In one case, the survey did not yield information about whether the facility had a system for detection of STIs and HIV/AIDS because the gynecologist did not respond. Several of the facilities indicated that they know how and where to make a referral for VCT for HIV/AIDS.

**Referral and Counter-referral**

All of the facilities have a system for referral and counter-referral in accordance with the standards of the Bolivian MOH. Referrals are made in writing, and all facilities have the materials necessary for making a referral. Since all facilities are located within the Northern Metropolitan Network, the Hospital Japonés is the referral hospital.

**Transportation and access**

Two public-sector HCs, one private sector and one church facility have a vehicle available for emergency transport if a referral is necessary. In two other public-sector HCs, referred clients take a taxi for which they must pay to arrive at the referral facility. See Appendix G for the distance from clients’ homes to health facilities.

Clients arrive at the HC on foot, by microbus or taxi. Community members indicate that clients often take taxis in the event of an emergency.

“One arrives by walking because it is close to the neighborhood, or sometimes we go in a micro[bus] or in taxi.” [Group of adolescents]

“We get to the 10 de octubre Health Center on foot, but when we have to go to the maternity hospital or to the Japonés we have to go by bus (public transportation) or taxi.” [Mixed group]

In most of the stories discussed in the sessions, clients went directly to the facility, often with the help of a partner or family member. However, in some cases there was a delay in seeking care because the female clients were dependent upon others for transportation, although this dependence was not identified by the community members as a priority problem.

“…her husband was not at home and she calls the neighbor who says he will bring her when he finishes what he is doing, the neighbor brings her to the health center.” [Group of adolescents]

In some groups, the lack of a health facility was perceived as a greater problem than the lack of transportation to reach the facility:

“[The] 10 de octubre Health Center is not in the neighborhood and it is about 20 blocks from the house of the person who lives farthest” [Mixed Group][33]

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[33] The blocks in Santa Cruz are between approximately 200 and 400 meters long.
Finally, some groups indicated that there was no ambulance available.

**Why clients seek care at specific facilities**

The results of the mapping and the client interviews suggest that most clients go to facilities that are closest to them. They also appreciate that public-sector facilities are economical or free, as are some of the other types of facilities, e.g., church and NGO facilities. Clients often choose to go to facilities that accept the SUMI insurance due to cost concerns. Others indicated that quality of care was a factor in their choice.

"Why do I go to this facility? Because I receive excellent care and it is closest to me in case of an emergency." [Group of women]

The most commonly-mentioned reason for seeking care at private-sector facilities, particularly in the context of PAC, is that those facilities are open 24 hours and there are doctors available at night. As noted above, this is often not the case with public-sector facilities. One community member noted why they might choose UCEBOL, a hospital run by the church: “If one is in pain and it is nighttime, the care is good.”

In general, convenient hours are one of the most highly valued aspects of facilities. The following quotes illustrate both positive and negative evaluations of facility hours:

"The participants indicate that the hours are really 8:00 a.m. to 1:30 p.m. and from 3:30 p.m. to 5:00 p.m. and at night sometimes there is no doctor available, principally on Wednesdays." [Group of women, discussing a public-sector facility]

"The care is the same as all of the health centers, normal, but luckily this health center offers 24-hour care. [Mixed group]

**Other providers**

Among the other providers in the community, community members seek care from different providers for different reasons. The community members conducted homework and interviewed providers, yielding the data shown in Table 3. The comments cited in the table are illustrative of many of the comments given. It is notable that most of the providers say that they have some contact with pregnant women and with women who wish to induce an abortion; however, many of the providers stated that they did not provide women with medicines or herbs to induce abortion because it is illegal and therefore could cause trouble for them as providers.
Table 3. Other providers in Santa Cruz

<table>
<thead>
<tr>
<th>Provider</th>
<th>Services sought</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curandero/a</td>
<td>1. Adjustment of the position of the baby.</td>
<td>- “They [the clients] come because they have lower abdominal pain, are dizzy, or to stop bleeding or vaginal discharge. Sometimes they want some very strong herbs for abortions.” [Group of women, homework]</td>
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<tr>
<td></td>
<td>2. Treatment for nausea, headaches and vomiting</td>
<td>- “Many pregnant women, especially young women with unwanted pregnancies that want abortions come to me, but I don’t prescribe anything for them, because if a problem occurs then I am in trouble.” [Group of women, homework]</td>
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<tr>
<td></td>
<td>3. Treatment of lower abdominal pain and dizziness</td>
<td>- “They [curandero/as] have faith in natural medicine and offer services between 2:00 and 8:00 p.m.” [Group of adolescents]</td>
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<tr>
<td></td>
<td>4. Herbs for abortions</td>
<td></td>
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<tr>
<td></td>
<td>5. Natural medicine</td>
<td></td>
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<tr>
<td></td>
<td>6. Injections</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1. Pregnancy tests</td>
<td>- “They come here for tranquilizers, or they come for a pregnancy test because they are vomiting; they have ovarian pain, headaches, vaginal infections, but usually I advise them to go to a doctor.” [Mixed Group, homework]</td>
</tr>
<tr>
<td></td>
<td>2. Pregnancy problems</td>
<td></td>
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<tr>
<td></td>
<td>3. Medicines</td>
<td></td>
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<tr>
<td></td>
<td>4. Pregnancy danger signs</td>
<td>- “They are looking for prenatal vitamins.” [Group of women, homework]</td>
</tr>
<tr>
<td></td>
<td>5. Abortion</td>
<td>- “Many women come to my pharmacy to look for medicine that will cause an abortion. They arrive desperate to ask me to please sell them some medicine, and I tell them that I can’t because it is prohibited.” [Group of women, homework]</td>
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<tr>
<td></td>
<td>6. Colds and fevers</td>
<td></td>
</tr>
<tr>
<td>Naturista</td>
<td>1. Hemorrhage and pain in the lower abdomen</td>
<td>- “Yes the [women experiencing hemorrhage] come but not very frequently. They are vomiting and are poorly nourished. I prescribe them herbs but not strong remedies.” [Mixed group, homework]</td>
</tr>
<tr>
<td></td>
<td>2. Vomiting and poor nutrition</td>
<td>- “Vomiting, urinary tract, problems with the spine or liver.” [Mixed group, homework]</td>
</tr>
<tr>
<td></td>
<td>3. Problems with urinary tract, liver and other conditions</td>
<td></td>
</tr>
<tr>
<td>Partera/o</td>
<td>1. Adjustment of the position of the baby</td>
<td>- “They come, so that I can adjust the position of the baby when it is crossed.” [Mixed group, homework]</td>
</tr>
<tr>
<td></td>
<td>2. Abdominal pain</td>
<td>- “I help women when they give birth.” [Group of women, homework]</td>
</tr>
<tr>
<td></td>
<td>3. Birth</td>
<td>- “[I am a] partera and an auxiliary nurse, I offer services 24 hours. Before the SUMI existed, they [women] came to me because they had few resources and they did not have money for transport or they were afraid of the doctors. The care I offer is in their own house and is very hygienic …” [Group of women, homework]</td>
</tr>
<tr>
<td></td>
<td>4. Postpartum conditions</td>
<td></td>
</tr>
<tr>
<td>Yerbera/o</td>
<td>1. Abdominal pain or labor pain</td>
<td>- “Principally pregnant women come when the baby is not moving or is in a bad position” [Group of women, homework]</td>
</tr>
<tr>
<td></td>
<td>2. Bad position of the baby</td>
<td>- “The majority [come] because [they want me to] bless their child.” SC16 [Group of adolescents, homework]</td>
</tr>
<tr>
<td></td>
<td>3. Bless (sanctify) a child</td>
<td></td>
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<tr>
<td></td>
<td>4. Hemorrhage</td>
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</table>

Results of the Participatory Planning Sessions

To develop the community action plans, three to four-hour sessions were carried out with each group in the community. The vast majority of the participants were the same ones from the ADX. Core Group members facilitated the participatory action planning sessions using the guide provided and with the help of another member of their community group or a member of the implementation team.
Once the plans were completed, the Core Groups held meetings to synthesize the action plans of the different community groups according to the communities served by each HC. A matrix, which served as a basis for this synthesis, was organized based on the main topics identified in the ADX: problems or needs of the HCs, the SUMI, training and the community. In El Alto, violence was also identified as a priority topic. Table 4 summarizes the problems addressed in the action plans at both project sites.

Table 4: Summary of community needs addressed in action plans

<table>
<thead>
<tr>
<th></th>
<th>El Alto</th>
<th>Santa Cruz</th>
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<tbody>
<tr>
<td>HCs</td>
<td>• Quality of care</td>
<td>• Quality of care</td>
</tr>
<tr>
<td>SUMI</td>
<td>• Lack of knowledge about services or benefits</td>
<td>• Lack of knowledge about services or benefits</td>
</tr>
<tr>
<td></td>
<td>• Lack of medications</td>
<td>• SUMI management of health care and medications</td>
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<tr>
<td>Training</td>
<td>• Contraceptive methods</td>
<td>• RH/FP issues</td>
</tr>
<tr>
<td></td>
<td>• Recognizing hemorrhage and what to do when it occurs</td>
<td>• Prevention of unintended pregnancy and complications of miscarriage and unsafe abortion</td>
</tr>
<tr>
<td></td>
<td>• Causes of hemorrhage</td>
<td>• Contraceptive methods</td>
</tr>
<tr>
<td></td>
<td>• Communication within the family</td>
<td></td>
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<tr>
<td></td>
<td>• Gender, training men on comprehensive health at their workplaces and creating men’s groups</td>
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<tr>
<td></td>
<td>• Domestic violence</td>
<td></td>
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<tr>
<td></td>
<td>• Awareness of the HC services and hours of operation</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>• Lack of coordination between the community and the HCs</td>
<td>• Lack of awareness of the existence of grassroots organizations</td>
</tr>
<tr>
<td></td>
<td>• Lack of infrastructure in the community, such as transportation</td>
<td>• Lack of community access to grassroots organizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Failure to coordinate activities between the HCs and the community</td>
</tr>
<tr>
<td>Violence</td>
<td>• Physical abuse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rape</td>
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</tbody>
</table>

Summary of Action Plans in El Alto
The community of El Alto developed six action plans: five of them were developed by aggregations of community groups according to the HCs where they seek care\textsuperscript{34} and the sixth by the Core Group in El Alto.

\textsuperscript{34} The communities in which the action plans were carried out include areas of referral for the following HCs: Puerto Mejillones and PROSALUD, PROSALUD-Cooperativa, Los Andes-PROSALUD Health Center, Lotes and Servicios-PROSALUD, and PROSALUD-Health Center Alto Lima, 4\textsuperscript{th} Section.
Action plan activities can be grouped into five main topics (four of which were also found in Santa Cruz): (1) HCs, (2) the SUMI, (3) RH/FP training of community members, and (4) the community. The fifth topic in El Alto is violence—both domestic and GBV, which emerged as an “umbrella” theme of the ADX in El Alto.

**HCs**
Problems identified with the HCs include:

1. **Hours of operation and delays**
   In the communities in El Alto, there are no medical centers that are open 24 hours a day. Those that do offer these services may not have a physician on call at night, weekends or holidays. Likewise, there are no pharmacies open 24 hours a day. When clients arrive at the HC, they do not receive timely care, especially in cases of hemorrhage. Both health care staff and the community attribute this delay to the lack of qualified personnel (i.e., there are no specialists, there are only nurses, or the staff is not proportional to the caseload) or to the fact that the health care staff does not treat women in a timely manner even if they are hemorrhaging. To solve these problems, the different groups plan to meet with neighborhood boards, HCs and other grassroots organizations in their communities to demand that treatment be made available and provided in a timely manner, that HCs have more staff members and that staff be qualified.

2. **Quality of care**
   The majority of the groups agreed that quality of care at the HCs could be improved. They indicated that, due to their socioeconomic situation, the members of the community are victims of poor treatment and discrimination. This discrimination manifests itself in providers’ lack of patience with clients or, at times, in their failure to counsel them about FP. One of the most serious consequences is that the clients will not go to the facilities. To solve these problems with respect to quality, the groups plan to partner with other community groups with the goal of submitting complaints to the HC directors. Also, they suggest training the health care staff in human relations and FP counseling and making the community members aware of the type of care they are entitled to receive.

3. **Infrastructure and transportation**
   For the community, the infrastructure constitutes a barrier to access to quality services. For example, some communities have no state HCs or pharmacies. Another common problem is the lack of ambulances, instruments, equipment and specialists. The groups suggest that a meeting with the neighborhood boards, school boards and HCs is necessary to alleviate these problems; in this meeting they plan to request ambulances and equipment for the facilities. Finally, the groups plan to work with the MOH and other authorities in their respective communities with the objective of requesting that new health facilities be established.

4. **High health care costs and lack of community awareness of the SUMI**
   The last two problems identified by the community groups are the high cost of services and medications and the lack of knowledge about the HCs, the HCs covered by the SUMI, and services and hours of operation. Both barriers affect clients’ access to services. To solve these problems, the groups plan to coordinate information dissemination activities with the HCs and the neighborhood boards. Another suggestion is that the MOH reach agreements with pharmaceutical companies that manufacture medications to lower the prices of those medications.
**SUMI**

The community’s lack of knowledge about the SUMI negatively impacts access to services. The difficulty in accessing services is compounded due to the administrative problems of the SUMI and to poor-quality services or shortage of medications. Many participants also mentioned that there are few state HCs covered by the SUMI. According to the groups’ suggestions, such problems could be resolved by coordinating with the HCs to educate the community about the benefits of the SUMI. If community members are aware that PAC-related services are available at no cost, they may be more likely to seek those services in a timely manner or at all.

**Training**

The training needs identified range from insufficient information about FP to the lack of knowledge about how to recognize the problem and what to do in case of complications of miscarriage and unsafe abortion. In many cases, the proposed activities address the causes of the problems of unintended pregnancy and complications of miscarriage and unsafe abortion.

1. **RH/FP and why pregnancy occurs**

According to the members of the community, unintended pregnancy occurs for many reasons, perhaps related to the couple’s lack of knowledge or coordination in planning a family. In some cases, women do not believe that they can become pregnant; for example, if they are nursing or if they have stopped menstruating and are menopausal. In others, pregnancy occurs due to the lack of information, FP and contraceptive methods. Another problem is the lack of communication within the family, whether within the couple or between parents and their children.

The groups in the community plan to request the support of the HCs to conduct workshops and information, education and communication (IEC) campaigns through the media, such as radio and television, as well as educational talks, health fairs, posters and flyers, and home visits. They also suggest requesting the support of professional psychologists to improve communication within the family. All of the proposed activities seek to convert FP into a topic that is commonly discussed in the communities.

2. **Prevention of hemorrhage**

The causes of hemorrhages are another important topic. Due to their economic situation, many women have to work very hard, at times lifting heavy objects or experiencing work-related accidents. For others, the lack of FP and the number of children, one right after the other, may be indirect causes of infant malnutrition or miscarriage. Lastly, others mentioned that some women do not take care of themselves or eat well during pregnancy, which could be because they are not aware of their pregnancy, they do not know how to take care of themselves (poor nutrition, alcohol consumption) or they lack the economic resources to do so.

To alleviate these problems, the groups suggest organizing IEC campaigns through the media. Additionally, given that it is important for the women’s partners to understand how women can take care of themselves during pregnancy, they suggest that men accompany women during prenatal care visits. Finally, they suggest that an improved economic situation will enable women to take care of themselves during pregnancy.
3. Dangers of over-the-counter drugs and traditional methods for abortion
The groups acknowledge that unintended pregnancy can lead to domestic problems; thus, many couples and/or women resort to abortions using unsafe methods. These include mates, herbs, injections and pills that are sold over the counter in pharmacies or the market as well as by traditional providers, including TBAs and healers. The groups agree that none of these methods are safe and they can be fatal for women. In their action plans, the groups include educational activities to prevent women from resorting to traditional providers or pharmacists, and they suggest, instead, that these providers refer women to HCs.

4. Signs of hemorrhaging
Many individuals in the community indicated that neither they nor their neighbors would know how to identify the signs of a hemorrhage or what to do if a woman was hemorrhaging. Some women resort to TBAs, who do not know how to help the women either. To breach this gap, the groups include educational activities (home visits, health fairs and media messages) in their action plans to disseminate information about the danger signs associated with hemorrhage and the action that should be taken. The goal is to inform the community about the danger of resorting to TBAs and about free health care provided by the SUMI if they seek care at an MOH HC.

5. Couples’ communication
Concerns regarding couple’s relations emerged as a general problem in many of the training topics. For example, one group mentioned that women do not participate in educational programs for fear of their husbands’ reaction. They also point out that partners’ lack of communication and understanding (specifically with respect to sex) is one of the causes of unintended pregnancy. Participants associated GBV—mainly physical and psychological abuse perpetrated by the woman’s partner—with miscarriage. To reduce these problems, the activities proposed in the groups’ plans include inviting men to the HCs, forming men’s groups for training and giving talks to couples at the HCs.

Community
1. Lack of organization
At the community level, the groups acknowledged problems related to collaboration between local organizations and the HCs as well as a lack of infrastructure. The former is attributed to how the authorities are not interested in disseminating the benefits of health care or helping out with emergencies, which is evident because the director of the HC, the president of the community and the local organizations do not meet regularly to coordinate activities. The groups suggest submitting requests to the neighborhood boards, school boards, grassroots organizations and HCs to initiate meetings, including trainings and orientations, that will lead to solving some problems.

2. Lack of transportation
With respect to the infrastructure, one of the most serious problems is the lack of transportation to reach the health facilities in emergency situations. Often there is no transportation at night or there are few bus stops in large communities, resulting in the deaths of many women. To resolve this problem, the communities propose grassroots organization in order to ask for the help of the transportation lines in their respective communities.
Violence
In El Alto, the problem of violence was one of the most mentioned. The members of the community acknowledged that physical abuse has a significant impact both on unintended pregnancy and abortion and attribute this to the living conditions in the community. They indicated that, in some way, poverty leads to abuse perpetrated by the husband when the woman becomes pregnant without planning it. Unintended pregnancies also may be the result of rape. Other groups mentioned that both abuse and rape are often associated with alcohol consumption.\textsuperscript{35}

Suggested solutions proposed by the groups include orientation and education on what constitutes gender-based violence and that women should not have to be victims of GBV. They also suggested that there be psychological help for couples and that the abuse be reported to battered women's shelters. In cases of abuse of adolescents, they propose similar actions. Finally, to break the cycle of alcoholism and violence, some groups plan to conduct activities intended to combat alcoholism in couples and the communities.

Summary of the Action Plans in Santa Cruz
In the community of Santa Cruz, 10 action plans were developed. Eight of them were developed by constituents of the community groups in accordance with the HCs where community members seek treatment, and the remaining two were developed, respectively, by a group of adolescents and a group of traditional providers who are part of the Bolivian Society of Traditional Medicine (SOBOMETRA).

HCs
Problems identified with the HCs include:

1. \textit{Hours of operation}
Several centers do not comply with the hours of operation established or offer immediate care. Many groups mentioned the lack of physicians or services in the afternoon, at night or on weekends. Sometimes physicians do not comply with their schedules, which results in a lack of timely or immediate care. In this regard, the groups plan to meet with the HC directors to find out about the causes of these problems and try to find solutions.

2. \textit{Quality of care}
Many of the problems are linked to the quality of care. The members of the community noted that in some centers services are “awful” and poor treatment of clients is common. They attribute this to the staff being bored with their jobs and not receiving good compensation. To alleviate the situation, they propose holding meetings with the HC directors to ask them to train their staff in human relations and support the health committees to uphold clients’ right to receive quality care.

3. \textit{Infrastructure}
Lastly, a specific HC problem is the lack of infrastructure and equipment and lack of state HCs (for example, in the neighborhood of Tusequis). There also is a lack of a private place to provide counseling, lack of ambulances and lack of equipment and materials, primarily ultrasound equipment and incubators to treat pregnancy complications. All the groups are planning to

\textsuperscript{35} One group also identified women's alcohol consumption as a problem in the community.
coordinate activities with their grassroots organizations, their churches and their HCs to resolve these problems together.

**SUMI**

1. Awareness of SUMI
The vast majority of the action plans address the problem that the community groups are not familiar with the services and general benefits of the SUMI, particularly those specific to hemorrhages during the first half of pregnancy. This lack of knowledge, according to the groups, affects decision-making with respect to FP and hemorrhages; some women seek care in pharmacies rather than HCs because they are not aware of the SUMI. Actions proposed to resolve this problem include requesting that HCs organize workshops to inform women and adolescents about the SUMI and that they place posters in public places.

2. Administrative problems with SUMI
The groups also identified administrative problems with respect to the SUMI, specifically improving the services delivered by addressing human resources needs and ensuring that medications are available in the SUMI pharmacies. The community groups are planning to meet with the HC directors to demand that they disclose the causes of these problems and look for better ways to organize and manage the SUMI.

**Training**
The groups’ action plans incorporate activities directed towards training the community in topics such as RH/FP, the prevention of unintended pregnancy and complications of miscarriage and unsafe abortion, including recognizing these complications and making appropriate decisions once they have been recognized.

1. RH/FP
The majority of the groups believed there was insufficient knowledge among community members about RH/FP, and that this lack of knowledge influences the use of FP and the knowledge about the importance of the quality of services at the HCs. To resolve this problem, they propose developing informational posters and wallcharts and posting them at the HCs, conducting orientation workshops for the participating groups and mothers’ clubs and organizing IEC campaigns for students, so they can disseminate the information about RH/FP in their family settings. Other activities proposed to raise awareness of these issues include informing community members about how and where to report poor service or the lack of respect towards them at the HCs. To this end, suggestion and complaint boxes and posters with information (including phone numbers) about how to report poor quality of care will be placed in facilities.

2. Lack of information about contraception
With respect to the use of FP, the action plans identified problems such as lack of information about contraceptive methods, fear of their side effects and lack of discussion between the couple regarding the number of children they wish to have. Another problem is the lack of training workshops on FP topics. To address these needs, community groups propose asking HCs to carry out educational activities such as workshops, distribution of informational brochures and sponsorship of health fairs.

3. Adolescents
All the groups identified adolescents as the group most likely to not use FP and to have unintended pregnancies, primarily because they lack sufficient guidance on RH/FP and because
their parents do not talk to them about these issues. Community members believe this lack of communication between parents and children is due to the fact that the former are ashamed and the latter are afraid to address these topics. The majority of the groups suggested that this interaction needs to be improved through workshops facilitated by professional psychologists. Some groups’ action plans include training adolescents so they can disseminate the information within their schools, families and communities.

4. Prevention of complications and recognition of danger signs
The failure to recognize the danger signs associated with complications of miscarriage and unsafe abortion indicates a lack of knowledge about these danger signs and difficulty in taking action in the event of these complications. Regarding prevention, both adults and youth lack information on how to prevent abortion. Also, women do not foresee abortion’s physical or psychological consequences. For example, some pregnant women do not seek prenatal care, which can sometimes prevent miscarriage. With respect to complications of miscarriage and unsafe abortion, women, men and adolescents are not aware of or do not consider the risks of unintended pregnancy or do not know the danger signs. Activities proposed for solving these problems include counseling and workshops on the prevention of unintended pregnancy and potential pregnancy problems and how to recognize danger signs. To strengthen these efforts, community groups will request the support of the HCs, the people’s committees and the neighborhood boards.

Community
Local problems include lack of community organization in general as well as lack of community members’ information about and access to community organizations. To resolve these problems, community members propose (1) electing a community leader to organize the community, serving as a liaison among community organizations, and (2) forming a mothers’ club so they can initiate community organization activities as two ways of resolving these problems.

1. Lack of coordination
With respect to existing grassroots organizations, many members of the community feel that they are not successful or do not work in a coordinated fashion. One of the groups attributed the lack of unity to the divisions created by political interests. The action plans propose coordination meetings to inform these organizations that the community groups would like them to work together.

2. Community organizations lack support from community members
The participants acknowledged that they too could give more support or show more interest in becoming more familiar with the grassroots organizations. Generally, the lack of community support can be attributed to how the members of the community do not know the local representatives or that the latter do not share information about their activities with the broader community. To address the problem, the community groups propose encouraging community member involvement at meetings, where they can discuss the importance of coordinating activities with the grassroots organizations and raise community awareness of the activities undertaken by those organizations.36

36 Grassroots organizations include neighborhood boards, one of the community organizations most mentioned by the community.
3. Lack of coordination between the community and HCs
The lack of coordination between the community and the HCs is often due to the fact that the local health committees are not active or the lack of communication between the grassroots organizations and the HCs. The lack of coordination is reflected in how, in some districts, health issues are not addressed, and the members of the communities do not know what the HCs' Annual Operational Plans (AOPs) are or what they include. The community groups propose solving these problems by inviting HC directors to participate in community meetings and by developing AOPs in conjunction with the HCs to ensure that they include the needs of the community.

IV. Process Evaluation
A qualitative process evaluation was carried out to understand how the model was implemented, to identify lessons learned and to assess the impact of the project. Additionally, a quantitative evaluation was implemented in the form of a KAP Survey, which was implemented with participants prior to the first ADX session and after the participatory planning session. Its purpose was to assess whether the sharing of experiences among the participants generated an increase in knowledge and changes in attitudes and practices.

Research Methods
A variety of research methods were used to gather qualitative information, with two main goals: (1) measuring qualitative changes in the communities and 2) evaluating the implementation of the model to identify challenges, successes and lessons learned. To measure changes in the participants and in the community, focus group discussions were conducted with two groups in each community: a sample of Core Group individuals and another of individuals from community groups in each of the two regions. The groups met after completing the three ADX sessions and after completing the participatory planning sessions.

In El Alto, the midterm and end-of-project focus groups with Core Group members were comprised of 12 and 13 women, respectively. The correspondent focus groups conducted with community group members were comprised of 11 participants (eight women and three men) and eight participants (seven women and one man). In Santa Cruz, the midterm and end-of-project focus groups with Core Group members were comprised of eight participants (six women and two men) and 13 participants (10 women and three men), respectively. The correspondent community group focus groups were comprised of 10 participants (seven women and three men) and eight participants (six women and two men).

To supplement the information gathered from the members of the community, in-depth interviews were conducted with local authorities. These interviews were carried out with eight authorities in each community—four at the community level and four health care providers. In Santa Cruz, both the samples of community authorities and health authorities were comprised of three women and one man; two of the health authorities were doctors and two were nurses. In El Alto, both samples of community authorities were comprised of one woman and three men; all of the health authorities were doctors. All authorities were between 35 and 45 years of age. Implementation of the action plans will require coordination with these same authorities; this coordination was one of the long-term objectives of the CM model.
Information from the two local teams also was collected using other qualitative methods and data sources. In semimonthly reports, local staff detailed their impressions of the process. Two participatory evaluations—a midterm evaluation after completion of the ADX and a final evaluation—also were conducted with the teams. These evaluations provided an opportunity to solicit their feedback about the process of developing the model as well as the changes that they observed in their respective communities.

The findings of the KAP Survey, the focus group discussions, interviews and other qualitative data has been integrated, with the objective of illustrating results in four main areas: (1) changes in KAP, (2) other topics that emerged through the ADX process, (3) empowerment and (4) social organization.

**Changes in RH/FP KAP**

The 22-question KAP survey questionnaire was developed to determine whether the sharing of experiences generated changes in participants’ KAP with regard to RH/FP issues (see Appendix I for a copy of this questionnaire). The questionnaire was administered to participants prior to the ADX (1,076 respondents) and after the participatory action planning phase (888 respondents). Comparison of the initial analysis with the final analysis of the KAP Survey allowed for measurement of the change in these issues (see Table 5).

With respect to knowledge, there was a significant increase in the percentage of participants who knew about at least one contraceptive method (88.3% to 94%) and about PAC services (64.8% to 71.3%). There also was a slight increase in the percentage of participants who knew that treatment for hemorrhagic complications during the first half of pregnancy are covered by the SUMI, although this increase was not statistically significant (67.7% to 71.5%). There was a slight decrease in the percentage of participants who knew about danger signs following an abortion, although it is not statistically significant (58.6% to 58.2%).

As for changes in attitudes, there was a slight (not statistically significant) increase in the percentage of participants who said that people can decide the number of children they would like to have (87.5% to 89.5%). The percentage of participants who believed that unintended pregnancies could bring negative consequences increased significantly (from 82.4% to 84.8%). There was a slight decrease in the percentage of participants who said they would immediately seek health care in the event of complications of miscarriage or unsafe abortion (91.3% to 90.5%).

In terms of practices, there was a significant increase in the percentage of participants who stated that they had used a contraceptive method in the last intercourse (45.6% to 54.2%), and a slight increase in the percentage who said they were able to prevent unintended pregnancy by using a contraceptive method (75.2% to 77.5%). There was a significant decrease in the percentage of participants who indicated that their health problem had been resolved the last time they visited a health facility (53.2% to 50.7%). While this could be a reflection of poor quality of care, it also may indicate that the CM process enabled participants to think more critically about the quality of care at the health facilities.

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For the purposes of this report, statistics with p-values below .05 are considered statistically significant.

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2-48
<table>
<thead>
<tr>
<th>#</th>
<th>Question</th>
<th>Pre-test (%/numerator)</th>
<th>Post-test (%/numerator)</th>
<th>P-value</th>
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<tr>
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<tr>
<td><strong>Knowledge</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>Do you know of any FP methods?</td>
<td>88.3/950</td>
<td>94.0/835</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>2</td>
<td>Do you know where to obtain a contraceptive method?</td>
<td>82.2/884</td>
<td>83.7/743</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>3</td>
<td>Is there a method that also protects you from sexually transmitted infections?</td>
<td>80.7/868</td>
<td>79.8/709</td>
<td>&lt;.01*</td>
</tr>
<tr>
<td>4</td>
<td>Is the rhythm/calendar method based on not having sex during menstruation?</td>
<td>47.3/509</td>
<td>43.6/389</td>
<td>&lt;.01*</td>
</tr>
<tr>
<td>5</td>
<td>Is it recommended that women wait at least 3 years before becoming pregnant again?</td>
<td>85.3/918</td>
<td>77.8/691</td>
<td>&lt;.01*</td>
</tr>
<tr>
<td>6</td>
<td>Do you recognize the warning signs that indicate that there is a problem during pregnancy?</td>
<td>71.6/770</td>
<td>65.3/580</td>
<td>&lt;.05*</td>
</tr>
<tr>
<td>7</td>
<td>Do you know of any warning signs that occur after a failed pregnancy (fracaso)?</td>
<td>58.6/630</td>
<td>58.2/517</td>
<td>**</td>
</tr>
<tr>
<td>8</td>
<td>Do you know of any health facility where they take care of people without any problems when they experience discomforts due to a failed pregnancy?</td>
<td>64.8/697</td>
<td>71.3/633</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>9</td>
<td>Is treatment of bleeding during pregnancy part of the SUMI?</td>
<td>67.7/728</td>
<td>71.5/635</td>
<td>**</td>
</tr>
<tr>
<td>10</td>
<td>After experiencing a failed pregnancy, is it appropriate to use a FP method?</td>
<td>83.1/1,076</td>
<td>78.5/888</td>
<td>&lt;.05*</td>
</tr>
<tr>
<td>11</td>
<td>Do you know where to go to report a rape or other physical or emotional abuse?</td>
<td>78.4/844</td>
<td>80.3/713</td>
<td>&lt;.01*</td>
</tr>
<tr>
<td><strong>Attitudes</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1</td>
<td>Can a woman decide how many children to have?</td>
<td>87.5/941</td>
<td>89.5/795</td>
<td>**</td>
</tr>
<tr>
<td>2</td>
<td>When a woman becomes pregnant without planning, could she suffer a negative consequence?</td>
<td>82.4/887</td>
<td>84.8/753</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>3</td>
<td>If a woman has a failed pregnancy, should she report immediately to a health facility?</td>
<td>91.3/982</td>
<td>90.5/804</td>
<td>**</td>
</tr>
<tr>
<td>4</td>
<td>Does the use of FP methods prevent having to resort to abortion?</td>
<td>78.3/842</td>
<td>78.3/695</td>
<td>**</td>
</tr>
<tr>
<td>5</td>
<td>If you suffered some type of violence (physical, psychological, sexual), would you report it?</td>
<td>90.1/970</td>
<td>85.8/762</td>
<td>&lt;.05</td>
</tr>
<tr>
<td><strong>Practices</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>The last time that you or your partner (or any other person you know) experienced a pregnancy-related problem, did you go to a health facility?</td>
<td>68.5/737</td>
<td>61.4/545</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>2</td>
<td>In your last sexual relation, did you or your partner use a FP method?</td>
<td>45.6/491</td>
<td>54.2/481</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>3</td>
<td>In your last visit to the health facility, did they clarify all your doubts with respect to your health problem?</td>
<td>51.4/553</td>
<td>48.4/430</td>
<td>**</td>
</tr>
<tr>
<td>4</td>
<td>In your last visit to the health facility, did they solve your problem?</td>
<td>53.2/572</td>
<td>50.7/450</td>
<td>&lt;.05*</td>
</tr>
<tr>
<td>5</td>
<td>Are you and your partner able to prevent unintended pregnancies with the use of FP methods?</td>
<td>75.2/809</td>
<td>77.5/688</td>
<td>**</td>
</tr>
<tr>
<td>6</td>
<td>Where do you go to obtain a FP method?</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td></td>
<td>1,076</td>
<td>888</td>
<td></td>
</tr>
</tbody>
</table>
Focus group results reinforce the findings of the KAP Survey, specifically in that the model has been a learning process for the participants. One Core Group participant in the mid-term focus groups commented about the meetings:

“...Well, for me they have been very good because we have received opinions from our entire group, and we have learned things one does not know; other people know one or another thing. From different people, we learned everything…” [Woman, Santa Cruz]

Regarding changes in attitudes, another participant in the Core Group noted during the mid-term focus group meetings: “...It helped me have a more open mind because it is one way of being able to help in an emergency situation, both for men and women…” [Woman, Santa Cruz]

**Other Topics Identified by the Community**

Because of the community-driven nature of the ADX, it was anticipated that community members would discuss other topics related to RH/FP in addition to complications of miscarriage and unsafe abortion. In El Alto, the themes that arose have to do with sociocultural factors in the community, such as RH/FP, domestic violence, legal processes, negotiating with partners and training men about women’s health.

In Santa Cruz, on the other hand, the majority of the topics that emerged are associated with general quality of care at the health facilities and with the coordination between the community and service providers. These topics include what type of care clients are entitled to receive (those who use a HC), service delivery (poor treatment given by the health care providers, absence from work, lack of medications and organization, lack of coordination with the HC) and the AOP of the services. At the community level, two other issues emerged: the lack of communication about RH/FP, primarily between parents and children, and the lack of contraceptive counseling.38

**Empowerment**

**Core Group Members**

From the perspective of the local teams, Core Group representatives have become empowered during the process in that they now have expertise that they can use to solve other problems in the community. They are competent in both the ADX and participatory planning instruments, and they now realize that they can use them to analyze and find solutions to other needs.

Local teams reported that the representatives feel able to organize meetings with the community and that they have their groups’ support to conduct the activities scheduled in the action plans. They are now aware of the organizations in the community and how to obtain the community authorities’ support (for example, by writing a letter to request a meeting). When they meet with the authorities, they demonstrate confidence and self-assurance and are prepared to present their needs and problems.

The focus group results also indicate success in empowering the Core Group members. One participant agreed with another member of her group when she stated:

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38 The lists of additional topics were developed by the local teams from each project site.

2-50
“...I too thought that I would not be able to do this. Before coming here, I couldn’t talk [in public]. In these courses I have learned, and for that, I would like to thank the ladies. They told me: ‘Don’t be afraid; you can do it’ and I’ve done it. I’m happy.” [Woman, El Alto]

**Community Group Members**

According to the local teams, it also is evident that the community group members have become empowered by acquiring more information about the HCs, institutions and organizations in the community and entities with which they coordinate training activities on topics such as violence and legal processes. Like their leaders, they have learned to identify the community’s problems and seek solutions.

The focus group results also showed that the participants experienced a learning process. For example, some learned how to take care of themselves during pregnancy:

“Before, I did not know how to take care of myself. I lifted heavy objects. Now that I’m expecting, this time it is different. I no longer do the things I used to do when I was pregnant with my other children. In addition, we have also realized that women must always learn to better themselves; otherwise, men do as they wish with us. They beat us. They demand things of us, even when we’re pregnant. And we women, to fulfill our duty, we do things that we shouldn’t do and we do not take care of our pregnancy. We must be conscious of the fact that women are not objects, but that we have feelings and that we must better ourselves. Men are very chauvinistic and they always want us to do as they say, even when they’re not right. They do not take care of us, and we have to be better than them, right? But that’s good for us, that way no one will step on us.” [Woman, El Alto]

Some participants also indicated that they have learned a lot and that they share this information with other people in the community. This shows that, although not all the women can participate, the activity and its messages reach the community at large:

“...this is like a thread. We initiate it and then we pass it on [to others]. The information continues and they [community members] begin to know more. Whereas before they did not know where to go in an emergency, now they do and they receive quality care; they are finding out through us.” [Woman, Santa Cruz]

The focus group results also showed a change in the community with respect to individuals’ interest in the CM process and in conducting community activities, which indicates that there is strong motivation to continue with the activities. The presence of a population that is willing to carry out activities for its community implies that there are greater human resources available, suggesting that the community was empowered as a unit.

**Actions Taken by the Communities**

The different groups in both regions are ready and willing to carry out the activities detailed in their action plans. Some of the activities that have already begun include:
In El Alto
- Partnerships with HCs, institutions and organizations to address some of the problems included in the action plans
- Activities such as fairs, pap smear campaigns and screening of educational videos at the HCs on different SRH topics
- Involvement in the Community ARC and neighborhood board meetings
- CM with the group members
- Home visits to identify pregnant women and physical abuse of pregnant women and children

In Santa Cruz
- Coordination meetings between the neighborhood authorities and health authorities
- Formation of adolescent groups
- Training workshops with psychologists at the Bolivian Evangelical University (UEB)
- Writing letters to local authorities
- Blackboards with information regarding services and hours of operation
- Development of posters on what type of care clients are entitled to receive to be posted in health facilities
- Identification tags for health care staff, to be provided by the Health Network Management
- Involvement of the community and each HC in the development of the AOPs
- Improved organization at the network level to prevent a lack of supply of medications from the SUMI

Social Organization
During the development of the model, it was anticipated that there would be changes in the communities’ social organization since there was constant collaboration among the Core Group members.

Coordination within the Communities

El Alto
The local team noted that, before the model was implemented in El Alto, the topics of unintended pregnancy and complications of miscarriage and unsafe abortion were not discussed in community and family settings. Upon presenting the action plans to the local authorities, the Core Group members underscored this point, stating that the CM process had been very useful in improving communication. Previously, they had no power to communicate with other people about these topics, but now not only can they communicate with women but also with adolescents.

At this site, there is greater coordination and communication among individuals in the community. The Core Group members support each other in carrying out the ADX sessions; they meet more often to coordinate their efforts, and they have a work plan with concrete objectives, for which they are completely responsible.

In the midterm focus groups, a member of the Core Group stated the following with respect to the changes she observed in the community:
“In the community, there is also more participation, more collaboration and more understanding. I think that we now live in greater harmony; we understand each other better because we understand the things that have happened and what each one goes through, and we are supportive of each other somehow.” [Woman, El Alto]

**Santa Cruz**

In Santa Cruz, plans are more focused on the relationship between the community and the service providers, instead of community support. However, the local team indicated that, prior to initiating the CM process, “some [leaders] felt let down because they were not involved in the decision making, or if they tried to take action, they were not taken into account or they did not obtain answers to their questions.” Failure to acknowledge their concerns may have occurred, because the leaders took isolated actions instead of working together.

Currently, the leaders and members of the community in Santa Cruz are “getting into the habit of meeting and coordinating actions to carry out the activities in the action plan.” Consolidation of the action plans has facilitated these coordinated actions in order to strengthen their efforts and achieve better results.

**Coordination with Community Organizations**

In the process of developing the model and in the current implementation of the action plan activities, the community groups had the support of some NGOs and institutions that were already working in their communities. They include the following:

**El Alto**
- UDSEA—Provision of information about health resources (by HC) and statistical data
- CESIM—Organization of groups, support to the local team, site for carrying out the ADX sessions, training on domestic violence and the legal process, health services offered by the institution
- Christian Children’s Center (*Centro Cristiano Wawa*)—Site for carrying out sessions, training for couples with family problems
- Puerto Mejillones HC—Educational videos, trainings for community groups conducted by the health care staff, work space, community ARC involvement
- Alto Lima 4th Section HC—Dr. Raúl Sunagua has accompanied community group participants on home visits and provided support in other community activities, work space, trainings for community groups conducted by the health care staff, community ARC involvement
- Pro Salud Huayna Potosí—Community activities, dissemination of information about HC services, trainings for community groups conducted by the health care staff
- Cooperative HC—Work space, community ARC involvement, trainings for community groups conducted by the health care staff

**Santa Cruz**
- FORSA JICA (project of the Japanese International Cooperation Agency)—Participation in meetings with the community and the HCs to bring together the activities, commitment to collaborate on trainings and health fairs
• Gender and Violence Program of the SEDES—A coordination meeting with the Program Manager to strengthen Core Group activities
• UEB—Ongoing work agreement with advanced Psychology students to improve parent-child communication
• Adolescent Program of the SEDES—ADX was carried out with two affiliated groups
• Lazareto Cultural Center (Centro Cultural Lazareto)—Meeting and workshop sites
• Social Networks—Support of Social Networks representatives to identify community leaders and motivate and train those leaders
• Health care Unit—Expressed availability to collaborate on the model
• The administration of the Northern Metropolitan Health Network (Gerencia de Salud de la Red Metropolitana Norte)—Participation in meetings regarding the CM process (three meetings), use of action plans to resolve some of the problems in the HCs that they can easily resolve
• Care International—Loan of an overhead projector for presentations

Coordination with the Facilities
The model has strengthened the links between the communities and the facilities, both in terms of the knowledge about services provided and the coordination that takes place among these facilities.

El Alto
According to the team from El Alto, prior to initiating the CM process, the members of the community did not know the authorities or the area’s health resources and were not aware that these authorities could support them in solving their health problems. Now, the leaders have the support of some HCs and know their directors and medical staff. The HC also has the “support of the leaders and groups so that, in community activities, they can serve as spokespeople of the services offered by the HC in their community.” [Team in El Alto]

Santa Cruz
As mentioned previously, in Santa Cruz there was greater focus on the relationship between the facilities and the community throughout the CM process. Developing the action plans and presenting them to the health facilities improved communication with the staff and other authorities, who now acknowledge the leaders and take them into account when seeking to collaborate with the community on activities.

The Perspective of Local Authorities
In-depth interviews with local authorities also were conducted with the objective of finding out their perception of the model. The results of these interviews include:
• The health care staff found out about the CM process through the homework (interviews) conducted as part of the ADX and in subsequent introduction and coordination meetings, which were carried out according to the activities in the community groups’ action plans.
• The lack of coordination of activities between the HCs and the community is due to the lack of policies that outline such collaborative work.

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39 A vast majority of the sessions in Santa Cruz were conducted in a meeting room at one of the HCs. This setting may have influenced the results of the ADX.
• The community and the health care providers do not understand the purpose of community monitoring of health services, which can damage the good relationship and work efforts between the HCs and the community.
• The patient referral and counter-referral system should be the shared responsibility of the community and the HC in order to achieve greater efficiency.

VI. Challenges
During the implementation of the model, several challenges were identified that were common to both communities.

Both local teams thought that the timeframe for implementing the model was too short; however, they also indicated that it is important not to let too much time elapse between the different sessions of the ADX or between completion of the ADX and the participatory planning, because the participants could lose their motivation. The Santa Cruz team found that a very long lapse often implied that new people attended the participatory planning sessions without having participated in the ADX process, which made it more difficult to conduct the sessions.

The implementation team recommends that the project timeframe be lengthened. Specifically, more time is required to train the local project teams and carry out team-building activities with them. The teams should have time for practice sessions and coordination of those sessions, which will require patience and flexibility to respond to people’s schedules. Allocating time for training follow-up, corrective and practice exercises and team-building activities would enhance team skills and strengthen the CM process. More time also would allow for ongoing updates about the project to community authorities such as political and MOH figures, HC personnel, teachers, clergy and others who are affected by or may be influential in resolving the problem. Such meetings, consensus forums and presentations take time to coordinate and implement and should be held throughout the CM process; influential groups and individuals should participate in the validation of the action plan to provide input and concretize their commitments. The consensus and commitment process throughout the CM activity can take between one and three years, depending upon the size and previous organizational experience of the population and support institutions. These updates also would resolve the problem of lack of continuity mentioned by the local teams above.

Participants in both types of focus groups (Core Group members and community group members) in both communities mentioned that it was difficult to limit the number of participants in each group. Some individuals who were interested were not able to participate due to the fact that the number of participants in each group could not exceed 25. All groups requested that this number be increased. It would be possible to increase the number of participants, but the number of participants per group should be limited to approximately 25 to appropriately facilitate group participation. Additionally, in replications of this model, it is suggested that implementation teams allow for at least three facilitators for each group of 25. During plenary discussions, one member of the facilitation team guides discussion, the second ensures participation and the third observes to monitor overall group interest, comprehension or particular dynamics, such as oppositional attitudes, disagreement, misunderstandings, power plays, etc. Experience has shown that it is not advisable to have more than 25 participants in a meeting, as this can limit participation.
As for sustainability, the teams in both El Alto and Santa Cruz had difficulty in counting on the willingness and commitment of the HCs and the community organizations throughout the CM process, both of which are considered key elements for achieving the best results. To ensure the commitment of these entities to the project, implementation teams should make authorities aware of the project from the beginning and provide them with continuous updates about project progress.

The team in Santa Cruz mentioned the difficulty in strengthening the leaders’ skills, particularly in ensuring that they are able to appropriate the methodology and carry out their activities in an increasingly independent manner. Santa Cruz also noted the challenge of normalizing the practice of community members’ meeting to analyze their problems and look for solutions based on resources available to them.

*Challenges specific to El Alto*

El Alto identified some challenges that were not mentioned in Santa Cruz.

First, there were challenges related to illiteracy of participants and the fact that some participants spoke only Aymara. This made it difficult to carry out the exercises and the documentation process for some leaders, who sought the help of adolescents and children. Relatives and neighbors also served as translators and interpreters for those who spoke Aymara. Although they could write, Core Group members found it difficult to capture all the information discussed in the sessions; there was only one leader in each session, and s/he could not facilitate and take notes at the same time.

Secondly, many of the participants in the El Alto groups mentioned that, while there were male participants, they were not the husbands or partners of the women who participated. Both the local team and the participants believe that it will be difficult to achieve changes in the homes without the partner’s involvement and support.

**VII. Lessons Learned**

The team began identifying lessons learned from the outset, beginning with the proposal development and hiring of personnel. The lessons learned were identified by the local teams, the team in La Paz and the CATALYST/Washington team who synthesized common issues in the responses of the two communities. Appendix J contains a summary chart with all the lessons learned identified by the local teams.

One of the most important lessons learned was that the model should be understood clearly as a CM activity rather than a PAC project. When the model is perceived primarily as a PAC project, team members may assume that they should teach the community about the problem of unsafe abortion when carrying out the ADX sessions. In fact, the goal of the assessment is to understand the participants’ perspectives about the unsafe abortion problem, their needs and facilitate the community members’ development of appropriate solutions to those needs. Solutions identified by community members also are more likely to be sustainable, since they will feel a sense of ownership of those solutions. Working within this framework requires an appropriate methodology and personnel trained in facilitation skills. It is important to carry out a sensitization and training workshop prior to working with the communities, which allows the model team to reach a common understanding with respect to the theory, methodology and instruments.
Regarding work with the community members, it is important to maintain continuity of activities so the participants continue their commitment to the CM process. However, the implementation team also should understand that empowering the community is not immediate and that it requires sufficient time and the support of the knowledge and tools needed for community organization. Including frequent updates would maintain continuity of the project even if the timeline is extended. The implementation team also noted that leaders’ commitment to the process can be strengthened if the entire model process, from the trainings to the implementation of the action plans, is explained to them prior to initiating activities.

Finally, if the goal is to improve the health of the community, it is necessary to strengthen communication efforts among the community, grassroots organizations and health care providers to garner support, which is critical to the sustainability of the CM activities.

**Core Groups**

From a logistics perspective, the lessons learned about working with the Core Groups include:

- Core Group members should be invited in writing, specifying the place and time of the meeting and emphasizing that the invitation is personal (only the leader, not her entire group, will participate at this meeting).
- The Core Group should be asked to provide their telephone numbers and personal cell phone numbers to improve communication. In Bolivia, when women Core Group members provided their husband’s or partner’s phone numbers, the women never received messages regarding CM meetings.
- In planning meetings, it is important to consider the workdays and schedules of all of the community participants.
- A site should be made available to conduct Core Group meeting activities.

In general, both teams indicated that more training for Core Group members is necessary so that they will be more independent in implementing the ADX sessions.

- Core Group members should be better trained and prepared in how to complete the matrices (for data collection).
- Santa Cruz suggested preparing the analysis matrices for the sessions beforehand in order to facilitate the work of the Core Groups and that the leader should be prepared to use those matrices.

They also suggested working with existing (experienced) leaders, who already are knowledgeable and have connections in the community, to facilitate the process of conducting the ADX in the community.

**Autodiagnóstico**

The following lessons learned were identified with respect to the implementation of the ADX sessions:
• Given the large number of groups, the facilitators should develop a timeline for monitoring the sessions according to the physical distances between the meeting sites for each of the groups.  

• Working with participants who live in the same neighborhood would most likely increase participants’ attendance.

• Both teams mentioned that it is important to understand that results of the model occur gradually and that the teams implementing the model should not become discouraged during the first sessions.

• The ADX guide needs to be modified according to the characteristics of the different groups.

Focus group participants advised that two facilitators carry out each session:

“I think that it would be good [to have] two people, because I didn’t know how to split myself in two: whether to note what the women were saying or to look at my guide. At times, my daughter helped me.” [Woman, Core Group, El Alto]  

As noted previously, the project team suggests that replications of this model should consider a minimum of three facilitators for each session.

**Plans**

As for developing the plans, the lessons learned indicate that the process can be easier by taking into account the following aspects:

• Leaders must have basic theoretical knowledge of RH/FP topics.

• At least four hours are necessary to develop the group plans.

Other lessons learned had to do with the relationship between the action plans and local authorities:

• It may be beneficial to invite the local authorities to participate in developing the plan in order to obtain their support of and commitment to the participants, at least on issues related to the HCs.

• The plans serve as an opportunity for community leaders to interact with the health care authorities.

**Community**

From a logistics perspective, the lessons learned include taking into account the participants’ schedules:

• It is necessary to take into account when participants can attend the meetings without having to leave before the session is over.

• The community is not accustomed to meeting regularly (and this needs to be considered when planning meetings).

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40 Since this was not originally considered in the scheduling of the sessions, the local teams found it difficult to reach all of the community meetings because of the great distances between them. This was a greater challenge in El Alto, since there were only two local team members at that site.

41 By having more than one leader per group, it is possible that they will be more self-sufficient, and they also may feel more empowered.

42 It was anticipated that the action planning sessions would be three hours long.
It is also important to sensitize the local team and leaders:

- They should know how to discuss problems of domestic violence and unintended pregnancies with individuals who are confronting these issues.
- It is important to respect the values and customs of the community because sometimes the language [used] may conflict with these.

The team in Santa Cruz stressed the community members’ ability to learn among themselves and to empower themselves:

- The community is able to transmit knowledge through their life experiences.
- The more the community knows, the more empowered its members feel to carry out joint activities.

**Local Authorities**

The lessons learned with respect to the work with local authorities refers to how to involve them in the model:

- It is important to know the roles these authorities play in the community, their schedules and the support they could provide to community activities.
- Authorities should be invited to participate in the ADX meeting and the community action plan session to increase their level of commitment.
- When authorities are knowledgeable about the model and participate in meetings, the model will have a greater impact.

**VIII. Conclusions**

To develop a model of CM around complications of miscarriage and unsafe abortion, the same methodology was implemented in two different communities in Bolivia—El Alto and Santa Cruz. The model achieved results at both sites, but the results varied due to differences in the implementation and sociocultural differences between the two communities.

**El Alto**

One of the most notable differences between the two communities that impacted results was the fact that previous CM projects had been carried out in El Alto. As is evident from the ADX results, the El Alto findings also were richer than the findings from Santa Cruz. Nonetheless, participants expressed that the PAC CM project—and particularly the ADX—was a “new” experience for them and that it increased community awareness about a number of issues.

**Emphasis on Community-level Actions**

The El Alto action plans were more community-oriented in their scope. This could be attributed to the community’s previous experiences with community-based maternal mortality projects in which similar ADXs were carried out. However, this could reflect El Alto participants’ perceptions about their role in their community and about the community’s role in health care.

**Increased Community Awareness**

One of the most profound impacts is that it is now possible to discuss the topics of unintended pregnancy and complications of miscarriage and unsafe abortion in El Alto. Additionally, it is extremely significant that the El Alto participants recognized the cyclical patterns of behaviors;
for example, cycles of unintended pregnancy in which the child born from an unintended pregnancy (1) feels unwanted, (2) may run away with a partner (who offers affection) and (3) end up having children who also may feel unwanted, ultimately repeating the cycle. Once consciousness is raised about these cycles, participants can consider ways to break the cycle. Action plan activities focus on community education and neighborhood health information activities.

Santa Cruz
The results in Santa Cruz differ from those in El Alto. Action plans focus more heavily on facility-level interventions. Additionally, Santa Cruz participants did not have the same type of previous experience with community-level interventions as in El Alto; therefore, one of the major accomplishments of the activity was the strengthening of the overall level of community organization.

Coordination with Health Facilities
Action plans focus on collaborating with the health facilities to improve the quality of care. The community is now coordinating with health facilities, which is something that they had not done previously.

Community Organization
Santa Cruz team members stressed that accomplishments to date are “the beginning of a journey to empower the community,” noting that this type of model should not be implemented in a short period of time and that the institutional support must be ongoing if the goal is to fully empower the community and achieve a sustainable intervention.

Both the facility-based orientation of the action plans and the feedback regarding the relative fragility of the community groups from Santa Cruz could be attributed to the lack of experience in Santa Cruz with this type of CM project.

Next Steps
The motivation to continue the work is very strong, and there is a sense of ownership and empowerment among all the representatives of the Core Groups at both sites. The community groups also feel motivated to continue meeting, because they believe that their leaders still need their support. In all of the final focus groups, participants expressed their wish that the activities continue. Finally, the model has generated interest in individuals who have not yet participated; it could therefore easily be replicated within the same communities or in neighboring communities to reach more people and have greater impact in generating social change in the community at large.

In both communities, the most significant achievement has been the mobilization of the communities to undertake activities without the support of the project team. The local teams at both sites believe that they have taken the first step towards empowering the community by helping them identify their problems and needs. This was the basis for the development of solutions in the action plans, which the community members themselves are responsible for implementing.

It is critical to ensure that the participatory approach continues once action plan implementation begins. The CM methodology should be incorporated into action plan activities that involve education and information dissemination. Some of the most effective behavior change
approaches are participatory workshops (like the ADX sessions) that create a safe atmosphere for human interaction about RH/FP in which people can discuss, share and analyze real experiences, pose questions and suggest solutions that are feasible within their particular context. To ensure that they are culturally relevant and compelling, BCC messages also should be developed in collaboration with community members.

**General**
The success of this model validates the critical importance of CM for a broad spectrum of health initiatives. Only community members themselves can accurately describe the multiple dimensions of community problems and develop feasible, sustainable solutions. For example, through the CM process, community members identified numerous shortcomings of their local health facilities that only they could identify, which empowered them to address those shortcomings because they came to understand that they are legally entitled to health care.

The results of this activity also illustrate how unintended pregnancy and complications of miscarriage and unsafe abortion are linked to broader community health problems. In Bolivia, community members identified GBV as one of the principal causes of unintended pregnancies, miscarriage and unsafe abortion, underscoring the importance of preparing CM teams to address GBV and other related community health problems during community meetings.

At the international level, the most important lesson learned is that it is possible to carry out a CM activity about a sensitive subject like PAC. The results in these two Bolivian communities show that unintended pregnancies and complications of miscarriage and unsafe abortion are problems that are experienced and felt by a variety of community members, and that, with the help of a team that will facilitate the process, the communities can motivate themselves to solve these problems. It is likely that similar results would be obtained in other regions of Bolivia and in other countries of the world. In addition, given that the model is implemented using flexible instruments (e.g. the ADX and participatory planning guides), it can easily be applied in other contexts and to other topics. The model is currently being replicated in Kenya and Peru.
Appendix A: Community Action Cycle

Select an issue and define the community. Put together a Community Mobilization team. Gather information about the health issue and the community. Develop a Community Mobilization plan. Identify resources and constraints. Define your team’s role. Develop your team.

Orient the community with respect to the community mobilization project. Encourage individuals most affected or most interested in the issue to participate in developing a solution. Develop a core group of community members to work together.

The community evaluates the results of its actions. Based on the evaluation, they may decide to continue working on the same problem, or identify another problem and establish new priorities. A new Action Cycle begins.

Explore the issue with the core group. Plan and carry out community research. Analyze the data collected and set priorities for action.

Define the role of the project team in accompanying community action. Support the community and strengthen its capacity to implement its action plan. Monitor progress within the community and the institutions involved. Solve problems and facilitate conflict resolution.

Determine the objectives of the planning process. Determine who will be involved in the planning and their roles and responsibilities. Design the planning process. Conduct/facilitate the planning process to create a community action plan.

Adapted from “How to Mobilize Communities for Health and Social Change” a Health Communication Partnership Field Guide by Lisa Howard-Grabman and Gail Snetro. Published by the Health Communication Partnership (HCP) with support from the United States Agency for International Development (USAID).
Appendix B: Codes for Analysis of the Autodiagnostico Data

<table>
<thead>
<tr>
<th>Recognize</th>
<th>Recognize</th>
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<tbody>
<tr>
<td>Decide</td>
<td>Decide</td>
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<td>Resolve</td>
<td>Resolve</td>
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<tr>
<th>Final prioritization</th>
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<tr>
<td>Greatest importance</td>
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<tr>
<td>Medium importance</td>
<td>Medium</td>
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<tr>
<td>Least importance</td>
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<table>
<thead>
<tr>
<th>Bridge of possibilities</th>
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<tbody>
<tr>
<td>Reality within the community</td>
<td>Reality</td>
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<tr>
<td>How should it be</td>
<td>How should</td>
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<table>
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<tr>
<th>Expectations</th>
<th>Expect</th>
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<td>Observations</td>
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<tr>
<td>Better</td>
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<tr>
<td>Difficult</td>
<td>Difficult</td>
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</table>

Topics

1. Abortion (hemorrhage, bleeding, blood [associated with abortion], NOT menstruation) | Abortion
2. Adolescents (young people, youth, schools) | Adolescent
3. Friends (neighbors) | Friend
4. Health care (competency/technical ability, training, specialist, schedule, waiting time, availability [access, in the community], conditions, ability/inability to solve the problem, they take good care of me, attending physician, services) | Care
5. Help (support, someone’s help, through someone, should support, aid) | Help
6. Cause/Consequence (influences, that is why, cause, consequence) | Causeconse
7. Complications (risks, pregnancy problems, premature, sterile) | Complica
8. Communication (talks, does not talk, media, conversation, recounting, NOT television) | Communica
9. Community (organizations, social, sociable, people, society, community, district/neighborhood) | Community
10. Drugs (alcoholism, drug addiction) | Drugs
11. Economic (poor, lack of resources, we pay, free, money) | Economic
12. Pregnancy (pregnant) | Pregnancy
13. Study (abandons her studies, cannot study, school, student, education, pays little attention to her homework) | Study
14. Physical (heavy objects, overexerting oneself, physical weakness, nutrition [good, does not eat well], accident, weakening) | Physical
15. Relatives (parents, uncle/aunt, cousin, family, home) | Relatives
16. Gender (e.g., husband does not want his wife to use a method, boyfriend decided that she should have an abortion, machismo, husband does not become involved in the pregnancy, husband does not want to assume his responsibility or paternity, woman takes care of her baby by herself)

17. Men

18. Child (wawa, baby, child, NOT fetus)

19. Infrastructure (transportation [public mobility, transfer] or public telephone)

20. Ingestion of medications (natural [mates], pills, drugs [volatile])

21. Information (lack of knowledge or information, guidance, not knowing, inform, know, lack of dissemination, aware of, does not know)

22. Mental (depression, low self-esteem, suffering, sadness, emotionally, frustration, trauma)

23. Contraceptive methods (FP, using protection, any contraceptive method [e.g., Copper T], condom)

24. Women

25. Death (passes away, might lose, dead, die, mortal, fatal)

26. Unplanned (unintended, unwanted, unplanned)

27. Partner (husband, boyfriend/girlfriend, spouse, “concubine”)

28. Rejection (relatives, social, partner, friends, abandonment, throw out of the house, bad reputation as social rejection)

29. Health resources (medications, commodities, beds, space, ambulance, remedies, vaccines)

30. Reproductive health and family planning (RH/FP, reproduction, relations, information)

31. Health services (health center, healthcare staff, institution, pharmacies, hospitals, CNS, ProSalud, private HC)

32. SUMI

33. Traditional healers (yatiri, healer, TBA, naturalist)

34. Treatment at facilities (good human relations, bad, scolding, judging, insensitivity, trust, ashamed to go to the HC, afraid of the physician)

35. Violence (physical, sexual and psychological, others scold the woman because of her situation)
Appendix C: Guide for Data Collection Regarding Health Services

Note: Information needs to be collected for each one of the health resources.

Total Number of Facilities
From Health Posts to tertiary-level hospitals

a) Public sector
b) Private sector
c) NGOs
d) Other community resources

Providers (Total number and number that are available):
a) SRH service providers
b) PAC service providers
c) General practitioners
d) Pharmacies
e) Community Health Workers

List of Types of Services Available:
a) Social Services:
   • Family planning counseling
   • Women’s empowerment programs (e.g., education) Programas de potenciación de las mujeres (Ej: educación)
b) Family planning methods
c) PAC services
d) General SRH:
   • Systematic testing for STIs and HIV/AIDS
   • Voluntary Counseling and Testing (VCT) for HIV
   • Treatment for STIs, HIV/AIDS
   • Other services provided in the community

Access:
a) Community transport system for health care services
b) Distance to health care services
c) Established referral and counterreferral systems
d) Cost of services

Recommendations:
E.g.: Information regarding deficiencies in the types or hours of services (this information can be included in the Action Plans)

Note: Items that are underlined should be emphasized.
## Appendix D: Timeline of Activities

<table>
<thead>
<tr>
<th>Phase 1 (April and May)</th>
<th>Model</th>
<th>Process Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify and contact target population</td>
<td>• Train facilitators on bimonthly reports</td>
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<tr>
<td>• Select and hire staff</td>
<td>• Implement initial KAP Survey with community participants</td>
<td></td>
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<tr>
<td>• Describe the ADX instrument. Process with the model team</td>
<td></td>
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<tr>
<td>• Train in the ADX methodology for staff (the guide)</td>
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<tr>
<td>• Validate the ADX Guide</td>
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<table>
<thead>
<tr>
<th>Phase 2 (May, June and July)</th>
<th>Model</th>
<th>Process Evaluation</th>
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</thead>
<tbody>
<tr>
<td>• Identify organized groups in the community</td>
<td>• Focus group sessions with members of Core Groups and community groups</td>
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<tr>
<td>• Select Core Group representatives</td>
<td>• Process data from initial KAP survey</td>
<td></td>
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<tr>
<td>• Train Core Group on the methodology for the ADX</td>
<td></td>
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<tr>
<td>• Core Group facilitates community groups in the methodology of the ADX</td>
<td></td>
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<tr>
<td>• Core group fills out data collection matrices</td>
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<thead>
<tr>
<th>Phase 3 (June and July)</th>
<th>Model</th>
<th>Process Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Process data at CATALYST/Pathfinder headquarters</td>
<td>• Mid-term evaluation</td>
<td></td>
</tr>
<tr>
<td>• Coding and analysis of qualitative data</td>
<td>• Following development of plans, implement the final KAP survey</td>
<td></td>
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<tr>
<td>• Development of the preliminary report of ADX findings</td>
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<thead>
<tr>
<th>Phase 4 (July, August and September)</th>
<th>Model</th>
<th>Process Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Define the participatory planning sessions with the model team and train Core Group to carry out the session</td>
<td>• Second round of focus group discussions with Core Group and community group members</td>
<td></td>
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<tr>
<td>• Definition of the next steps after the participatory planning with the local model teams</td>
<td>• In-depth interviews with local authorities</td>
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<tr>
<td>• Present preliminary results to the local authorities in the community</td>
<td>• Final evaluation</td>
<td></td>
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<tr>
<td>• Finalization of monitoring and evaluation plan (including focus group instruments) by headquarters staff and local teams</td>
<td>• Process data of the final KAP survey and develop the report</td>
<td></td>
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<tr>
<td>• Evaluations</td>
<td>• Develop documentation of the process, based on the evaluation methods mentioned above and the reports of the local coordinators</td>
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<tr>
<td>• Core Group facilitates community groups in developing the participatory action plans</td>
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<tr>
<th>Phase 5 (September and October)</th>
<th>Model</th>
<th>Process Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Process data at CATALYST/Pathfinder headquarters</td>
<td>• Second round of focus group discussions with Core Group and community group members</td>
<td></td>
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<tr>
<td>• Document development processes</td>
<td>• In-depth interviews with local authorities</td>
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</tr>
<tr>
<td>1) Document participatory research (reports of the ADX sessions); 2) Community health resources; 3) KAP Survey (quantitative evaluation); 4) Compilation of community action plans for each site</td>
<td>• Final evaluation</td>
<td></td>
</tr>
<tr>
<td>• Develop documentation of the process, based on the evaluation methods mentioned above and the reports of the local coordinators</td>
<td>• Process data of the final KAP survey and develop the report</td>
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2-66
# Appendix E: El Alto Facilities

<table>
<thead>
<tr>
<th>#</th>
<th>Facility Name</th>
<th>Type</th>
<th>Level of Care</th>
<th>Personnel (Only doctors/nurses/auxiliary nurses listed)</th>
<th>Facility Hours</th>
<th>Catchment area population (# of neighborhoods)</th>
<th>Longest Distance*</th>
<th>Transport for referrals available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Materno Infantil Los Andes</td>
<td>Public</td>
<td>Secondary</td>
<td>15 (6 doctors, 1 nurse)</td>
<td>24 hours</td>
<td>253,867</td>
<td>Not available (n/a)</td>
<td>Yes (Women who are referred to the hospital are transported by the hospital ambulance)</td>
</tr>
<tr>
<td>2</td>
<td>CRA</td>
<td>Public</td>
<td>Primary</td>
<td>4 (3 doctors)</td>
<td>12 hours</td>
<td>n/a</td>
<td>n/a</td>
<td>- Yes</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Note: These data are incomplete.</td>
<td></td>
<td></td>
<td></td>
<td>- The community has a vehicle</td>
</tr>
<tr>
<td>3</td>
<td>Alto Lima</td>
<td>Public</td>
<td>Primary</td>
<td>5 (2 doctors, 2 community health workers)</td>
<td>12 hours</td>
<td>n/a</td>
<td>n/a</td>
<td>- Yes</td>
</tr>
<tr>
<td>4</td>
<td>German Busch</td>
<td>Public</td>
<td>Primary</td>
<td>11 (6 doctors, 1 nurse)</td>
<td>24 hours</td>
<td>n/a</td>
<td>n/a</td>
<td>- The community also has a vehicle</td>
</tr>
<tr>
<td>5</td>
<td>Puerto Mejillones</td>
<td>Public</td>
<td>Primary</td>
<td>? (3 doctors, 2 nurses, 2 auxiliary nurses)</td>
<td>12 hours</td>
<td>30 min.</td>
<td></td>
<td>- Yes</td>
</tr>
<tr>
<td>6</td>
<td>Villa Cooperativa</td>
<td>Public</td>
<td>Primary</td>
<td>7 (2 doctors, 1 nurse, 3 auxiliary nurses)</td>
<td>12 hours</td>
<td>30 min. to one hour</td>
<td></td>
<td>- No (Patients are sent by taxi, microbus or minibus)</td>
</tr>
<tr>
<td>7</td>
<td>San Roque</td>
<td>Public</td>
<td>Primary</td>
<td>6 (2 doctors, 3 auxiliary nurses)</td>
<td>12 hours</td>
<td>80 blocks</td>
<td></td>
<td>Yes (patients are sent for referrals by ambulance)</td>
</tr>
<tr>
<td>8</td>
<td>CESIM</td>
<td>Public</td>
<td>Primary</td>
<td>? (2 doctors, 1 auxiliary nurse)</td>
<td>8 hours</td>
<td>6 blocks</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>El Alto*</td>
<td>Private</td>
<td>Primary</td>
<td>14 (7 doctors, 4 auxiliary nurses)</td>
<td>24 hours</td>
<td>One to two hours</td>
<td></td>
<td>- Yes (The community also has an emergency vehicle)</td>
</tr>
<tr>
<td>10</td>
<td>San Martin de Porres*</td>
<td>Private</td>
<td>Primary</td>
<td>13 (8 doctors, 2 auxiliary nurses)</td>
<td>24 hours</td>
<td>12 blocks</td>
<td></td>
<td>Yes (ambulance for referrals)</td>
</tr>
<tr>
<td>11</td>
<td>Virgen de la Candelaria*</td>
<td>Private</td>
<td>Primary</td>
<td>7 (3 doctors, 2 auxiliary nurses)</td>
<td>24 hours</td>
<td>n/a</td>
<td></td>
<td>Yes (ambulance for referrals)</td>
</tr>
<tr>
<td>12</td>
<td>Fides*</td>
<td>Church</td>
<td>Primary</td>
<td>10 (5 doctors, 4 auxiliary nurses)</td>
<td>24 hours</td>
<td>n/a</td>
<td></td>
<td>Yes (both for emergency and for referrals)</td>
</tr>
<tr>
<td>13</td>
<td>Espiritu Santo*</td>
<td>Church</td>
<td>Primary</td>
<td>6 (3 doctors, 2 auxiliary nurses)</td>
<td>8 hours</td>
<td>15 blocks</td>
<td></td>
<td>- Yes (Community also has an emergency vehicle)</td>
</tr>
<tr>
<td>14</td>
<td>PROSALUD Huayna Potosi*</td>
<td>NGO</td>
<td>Primary</td>
<td>8 (4 doctors, 1 nurse, 3 auxiliary nurses)</td>
<td>24 hours</td>
<td>n/a</td>
<td></td>
<td>- No (Community does not have a vehicle either)</td>
</tr>
<tr>
<td>15</td>
<td>CIES*</td>
<td>NGO</td>
<td>Primary</td>
<td>- 10 (6 doctors, 3 auxiliary nurses)</td>
<td>24 hours</td>
<td>One hour</td>
<td></td>
<td>- Yes (The means of transport for referrals is an)</td>
</tr>
</tbody>
</table>

2-67
<table>
<thead>
<tr>
<th>No.</th>
<th>Facility Name</th>
<th>Type</th>
<th>Promoters and Community Leaders</th>
<th>Contact Information</th>
<th>Ambulance or Taxi</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>PROMUJER Juan Pablo II*</td>
<td>NGO Primary</td>
<td>- 3 (1 doctor, 1 nurse, 1 auxiliary nurse) &lt;br&gt; - 105 community health workers***</td>
<td>- Obtain an ambulance for referrals by calling 911 &lt;br&gt; - Community has a vehicle</td>
<td>n/a</td>
</tr>
</tbody>
</table>

* Indicates that the facility was not identified in the mapping exercise in Session 2.  
**Information on longest distance is only available for selected communities.  
***These community health workers are known as responsables populares de salud (responsible for the people’s health). They are elected by community members, receive basic training from health providers and provide community health education talks about preventive health and basic curative care. They also refer clients who need emergency care to facilities.
Appendix F: Type and Quality of El Alto Services

<table>
<thead>
<tr>
<th>Facility</th>
<th>Counseling Services</th>
<th>Comments (Comments in italics are from clients and from the autodiagnostico sessions)</th>
</tr>
</thead>
</table>
| Materno Infantil Los Andes | PAC X FP X PAC X | - If there are too many clients at Los Andes, they refer them to the Hospital General [Group of men]  
- “To arrive at the Los Andes Hospital you can take any bus on the Juan Pablo II Avenue.” [Group of men]  
- “The Los Andes Hospital is located in the last zone Los Andes, we have to go through four zones to get there and we arrive by microbus and when there is no microbus we have to hire a car or we ask the neighbors who have private vehicles in order to arrive quickly.” [Group of women]  
- “Those who live close to the avenue (Juan Pablo II) arrive at the Los Andes Hospital quickly, but those who live in the far-away zones for most of them it is more complicated to get to the Hospital and they don’t have a health center in the community.” [Group of men] |
| CRA                 | X X X X            | - There are dedicated personnel for counseling  
- Know where to refer for VCT for HIV/AIDS  
- They use MVA |
| Alto Lima           | X X X X            | - Special services for youth  
- Know where to refer for VCT  
- They use MVA |
| German Busch        | X X X X            | - Special services for youth  
- There are designated people who provide counseling and they are volunteers from the church  
- “The majority of the clients who go to this center arrive on foot and very few arrive by public transport.”  
- “The German Busch health center is a little far from where we live, we get there by minibus such as 252 and 287.” [Mixed group]  
- “They go because they lack money and the services are free and good.” [Group of adolescents]  
- “.... they make us wait for treatment because sometimes there are a lot of patients, or in other cases there are no services because the doctors are on strike.” [Homework, Mixed group] |
| Puerto Mejillones   | X X X X            | - If it is not a normal delivery, they send clients to the Los Andes Hospital, communicating with the hospital by radio. [Group of women]  
- “The care is very slow and the treatment is not very good because the administrators at the center don’t explain so that [clients] can understand, and when they ask us something and we don’t respond to them they yell at the clients ....” [Group of mixed adolescents]  
- “The health center only provides services 8 hours a day.” |
| Villa Cooperativa   | X X X X            | - Know where to refer for VCT  
- “Some people come to the center, because this is the only one in the zone, indicating that the doctor is good because he tells us how to take the medicines and also gives us SUMI medicines.” [Mixed group]  
- “The offer emergency care 24 hours a day and at any moment we can receive emergency care and there is also an ambulance that is available through a phone call.” [Group of women] |
| San Roque           | X X n/a X          | - Counseling services for adolescents  
- Know where to refer for VCT  
- The distance from the neighborhood that is farthest from the San Roque health center is more or less 80 blocks  
- “They knew that the Puerto Mejillones health center offers SUMI services.” [Group of women] |
| CESIM               | X X X X            | - The distance from the neighborhood that is farthest from the CESIM health center is six blocks |
| El Alto*            | X X X X            | - The distance from the neighborhood that is farthest from the El Alto clinic is from one to two hours |
| San Martin de Porres* | X X X X          | - Special services for adolescents |
| Virgen de la Candelaria* | X X X X        | - Know where to refer people for VCT  
- Receive counter-referral for follow-up with clients |
| Fides*              | X X X X            | - No special counseling for adolescents available  
- No personnel available who have received training in PAC counseling |
<p>| Espiritu Santo*     | n/a X n/a n/a n/a | - Program for women’s empowerment |</p>
<table>
<thead>
<tr>
<th>Facility</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRO SALUD</td>
<td>- Clients with postabortion complications are referred to the hospital</td>
</tr>
<tr>
<td>Huayna Potosí</td>
<td>- Program for women’s empowerment</td>
</tr>
<tr>
<td></td>
<td>- They perform MVA</td>
</tr>
<tr>
<td></td>
<td>- Know where to refer for VCT</td>
</tr>
<tr>
<td></td>
<td>- Special program for adolescents</td>
</tr>
<tr>
<td></td>
<td>- No system available for follow-up of clients with STIs</td>
</tr>
<tr>
<td>CIES*</td>
<td>- Know where to refer for VCT</td>
</tr>
<tr>
<td></td>
<td>- Use MVA</td>
</tr>
<tr>
<td>PROMUJER</td>
<td>- Use MVA</td>
</tr>
<tr>
<td>Juan Pablo II*</td>
<td>- Special services for adolescents</td>
</tr>
<tr>
<td></td>
<td>- System for follow-up for patients with STIs and HIV/AIDS</td>
</tr>
</tbody>
</table>

* Indicates that the facility was *not* identified in the mapping exercise in Session 2.
<table>
<thead>
<tr>
<th>#</th>
<th>Facility Name</th>
<th>Type</th>
<th>Level of Care</th>
<th>Personnel (Only doctors, nurses and auxiliary nurses are listed)</th>
<th>Facility Hours</th>
<th>Catchment area population (# of neighborhoods)</th>
<th>Average/Longest Distance**</th>
<th>Transport for referrals available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hospital Japonés</td>
<td>Public</td>
<td>Tertiary</td>
<td>10 ob/gyns, 3 auxiliary nurses</td>
<td>24 hours</td>
<td>317,946</td>
<td>n/a</td>
<td>Yes (one health center uses the hospitals system) n/a</td>
</tr>
<tr>
<td>2</td>
<td>HC – 10 de Octubre</td>
<td>Public</td>
<td>Primary</td>
<td>26 (7 doctors, 1 nurse, 10 auxiliary nurses)</td>
<td>24 hours</td>
<td>14,600 (9)</td>
<td>5.5 blocks</td>
<td>n/a</td>
</tr>
<tr>
<td>3</td>
<td>HC – San Antonio</td>
<td>Public</td>
<td>Primary</td>
<td>21 (7 doctors, 1 nurse, 7 auxiliary nurses)</td>
<td>24 hours</td>
<td>32,820 (7)</td>
<td>1.24 kilometers (km)</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>HC – Lazareto</td>
<td>Public</td>
<td>Primary</td>
<td>20 (5 doctors, 1 nurse, 7 auxiliary nurses)</td>
<td>24 hours</td>
<td>n/a (4)</td>
<td>4.5 blocks/5 to 7 km</td>
<td>No (clients pay for taxi)</td>
</tr>
<tr>
<td>5</td>
<td>HC – Norte*</td>
<td>Public</td>
<td>Primary</td>
<td>22 (7 doctors, 1 nurse, 8 auxiliary nurses)</td>
<td>24 hours</td>
<td>n/a (8)</td>
<td>5.875 blocks/10 km</td>
<td>No (clients pay for taxi)</td>
</tr>
<tr>
<td>6</td>
<td>HC – Pochola Trapero*</td>
<td>Public</td>
<td>Primary</td>
<td>11 (3 doctors, 1 nurse, 3 auxiliary nurses)</td>
<td>12 hours (7:30 a.m. to 7:30 p.m.)</td>
<td>n/a (8)</td>
<td>3.44 blocks</td>
<td>No (clients pay for taxis)</td>
</tr>
<tr>
<td>7</td>
<td>HC – Hamacas*</td>
<td>Public</td>
<td>Primary</td>
<td>17 (4 doctors, 1 nurse, 3 auxiliary nurses)</td>
<td>12 hours</td>
<td>n/a (7)</td>
<td>10.57 blocks</td>
<td>n/a</td>
</tr>
<tr>
<td>8</td>
<td>HC – Anita Leigue*</td>
<td>Public</td>
<td>Primary</td>
<td>14 (5 doctors, 1 nurse, 3 auxiliary nurses)</td>
<td>12 hours</td>
<td>20,816 (8)</td>
<td>1.56 km/3 km</td>
<td>No (clients pay for referrals in taxis)</td>
</tr>
<tr>
<td>9</td>
<td>HC – Santa Isabel*</td>
<td>Public</td>
<td>Primary</td>
<td>12 (3 doctors, 1 nurse, 4 auxiliary nurses)</td>
<td>12 hours</td>
<td>34,300 (8)</td>
<td>8.75 blocks/3 km</td>
<td>Yes (belongs to Hospital Japonés)</td>
</tr>
<tr>
<td>10</td>
<td>Mayo</td>
<td>Private</td>
<td>***</td>
<td>n/a</td>
<td>24 hours</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>11</td>
<td>Quiroz</td>
<td>Private</td>
<td>***</td>
<td>n/a</td>
<td>24 hours</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>12</td>
<td>HC – San Martin</td>
<td>Private</td>
<td>Primary</td>
<td>13 (7 doctors, 3 doctors who have completed their coursework but have not completed their thesis)</td>
<td>24 (gynecology)</td>
<td>n/a</td>
<td>n/a</td>
<td>- Yes - Community also has a vehicle for emergencies.</td>
</tr>
<tr>
<td>13</td>
<td>HC – Clinica Universitaria* (UCEBOL)</td>
<td>Church</td>
<td>***</td>
<td>47 (39 doctors and 8 nurses)</td>
<td>24</td>
<td>n/a</td>
<td>n/a</td>
<td>Yes</td>
</tr>
<tr>
<td>14</td>
<td>Hospital San Juan de Dios</td>
<td>Private</td>
<td>***</td>
<td>n/a</td>
<td>24</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>Facility Name</td>
<td>Type</td>
<td>Level</td>
<td>Distance (km)</td>
<td>Type of Care</td>
<td>Level of Care</td>
<td>Population</td>
<td>District</td>
</tr>
<tr>
<td>----</td>
<td>------------------</td>
<td>--------------</td>
<td>-------</td>
<td>---------------</td>
<td>--------------</td>
<td>--------------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>15</td>
<td>Kolping Los Chacos</td>
<td>NGO</td>
<td>n/a</td>
<td>24</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Santa Rita</td>
<td>Private</td>
<td>***</td>
<td>n/a</td>
<td>24</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>San Martin</td>
<td>Private</td>
<td>***</td>
<td>n/a</td>
<td>24</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>PROSALUD Las Pampitas</td>
<td>NGO</td>
<td>***</td>
<td>n/a</td>
<td>24</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
</tbody>
</table>

* Indicates that the facility was not identified in the mapping exercise in Session 2.

** Average distance has been calculated using the number of neighborhoods as the denominator since the population of all neighborhoods is not available.

*** Information on the level of care is not available for all private facilities.
### Appendix H: Type and Quality of Santa Cruz Services

<table>
<thead>
<tr>
<th>Facility</th>
<th>Counseling</th>
<th>Services</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAC</td>
<td>F</td>
<td>PAC</td>
<td>FP</td>
</tr>
</tbody>
</table>
| **1** Hospital Japonés | X          | X        | X        | - Psychologist for PAC counseling  
- Laboratory for STI testing  
- Know where to refer for VCT  
- "The care provided is friendly. I am here for the second time.” [Group of women]  
- "Some women go to the HC 10 de octubre because they don’t have money to go to another center.” [Group of women] |
| **2** HC – 10 de Octubre | X          | X        | X        | - Laboratory for STI testing  
- Know where to refer for VCT  
- "The care provided is friendly. I am here for the second time.” [Group of women]  
- "Some women go to the HC 10 de octubre because they don’t have money to go to another center.” [Group of women] |
| **3** HC – San Antonio | X          | X        | X        | - Use MVA for PAC  
- Emergency transport available; many clients arrive via microbus  
- "[The care is] like the care in all of the HCs, sometimes a little bit slow.” [Group of women] |
| **4** HC – Lazareto | X          | X        | X        | - Laboratory for STI testing  
- Most clients arrive at the facility by taxi.  
- "They say that there is 24-hour care, but it is not true.” [Group of women]  
- "The care is average. They make us wait a long time.” [Group of women] |
| **5** HC – Norte* | X          | X        | X        | - Not everyone has the materials/equipment to resolve postabortion complications  
- Clients who need to be referred must pay for their taxis to arrive at the referral facility.  
- "[The care is] good, but there are no specialists.” [Group of women] |
| **6** HC – Pochola Trapero* | X          | X        | X        | - Know where to refer for VCT  
- Clients who need to be referred must pay for their taxis to arrive at the referral facility. |
| **7** HC – Hamacas* | X          | X        | X        | - There is not a designated person to provide counseling; providers who are available provide counseling |
| **8** HC – Anita Leigue* | X          | X        | n/a      | - Everyone is trained to provide PAC counseling, including the cleaning staff  
- Know where to refer people for VCT  
- Clients who need to be referred must pay for their taxis to arrive at the referral facility |
| **9** HC – Santa Isabel* | X          | X        | X        | - Only the gynecologist is trained to provide PAC counseling.  
All personnel at the facility provide general counseling.  
- They have a women’s empowerment program.  
- Clients usually arrive at the facility on foot, in a microbus or by taxi if it is an emergency.  
- "It is [the] closest [facility] to me and they provide me with good care. ” [Mixed group] |
| **10** HC - Mayo | n/a        | n/a      | n/a      | "The care provided is good because the nurse is very nice.” [Mixed group] |
| **11** HC - Quiroz | n/a        | n/a      | n/a      | "There are no strikes and it is better” [Group of women] |
| **12** HC – San Martin | X          | X        | X        | - Counseling provided by the nurse.  
- Laboratory for STI testing  
- Providers are trained to use MVA but do not use the technique. |
| **13** HC – Clinica Universitaria | X          | X        | X        | - Offer tubal ligation and vasectomy  
- Know where to refer for VCT |

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(UCEBOL)*

<table>
<thead>
<tr>
<th>ID</th>
<th>Facility</th>
<th>Distance (n/a)</th>
<th>Type (n/a)</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Hospital San Juan de Dios</td>
<td>n/a</td>
<td>a</td>
<td>Note: Since this is a hospital, it can be assumed that both FP and PAC services are provided.</td>
</tr>
<tr>
<td>15</td>
<td>Kolping Los Chacos</td>
<td>n/a</td>
<td>a</td>
<td>&quot;In case of pain if it is at night the care is good.&quot; [Mixed group]</td>
</tr>
<tr>
<td>16</td>
<td>Santa Rita</td>
<td>n/a</td>
<td>a</td>
<td>&quot;It is the closest to my neighborhood.&quot; [Group of women]</td>
</tr>
<tr>
<td>17</td>
<td>San Martin</td>
<td>n/a</td>
<td>a</td>
<td>&quot;Gynecology services are available 24 hours.&quot; [Client interview, Mixed group, 1)</td>
</tr>
<tr>
<td>18</td>
<td>PROSALUD Las Pampitas</td>
<td>n/a</td>
<td>a</td>
<td>&quot;Laboratory' [Client interview, Mixed group, 1)</td>
</tr>
</tbody>
</table>

* Indicates that the facility was *not* identified in the mapping exercise in Session 2.
### Questionnaire

#### Knowledge

<table>
<thead>
<tr>
<th>#</th>
<th>Questions</th>
<th>True Yes</th>
<th>False No</th>
<th>Does not know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you know of any family planning methods?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Do you know where to obtain a contraceptive method?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Is there a method that also protects you from sexually transmitted infections?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Is the rhythm/calendar method based on not having sex during menstruation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Is it recommended that women wait at least 3 years before becoming pregnant again?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Do you recognize the warning signs that indicate that there is a problem during pregnancy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Do you know of any warning signs that occur after a failed pregnancy (fracaso)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do you know any health facility where they take care of people without any problems when they experience discomforts due to a failed pregnancy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Is treatment of bleeding during pregnancy part of the SUMI?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>After experiencing a failed pregnancy, is it appropriate to use a family planning method?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Do you know where to go to report a rape or other physical or emotional abuse?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Attitudes

<table>
<thead>
<tr>
<th>No.</th>
<th>Questions</th>
<th>True Yes</th>
<th>False No</th>
<th>Does not know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Can a woman decide how many children to have?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>When a woman becomes pregnant without planning, could she suffer a negative consequence?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>If a woman has a failed pregnancy, should she resort immediately to a health facility?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Does the use of family planning methods prevent having to resort to abortion?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>If you suffered some type of violence (physical, psychological, sexual), would you report it?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Questions</td>
<td>True</td>
<td>False</td>
<td>Does not know</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------</td>
<td>------</td>
<td>-------</td>
<td>---------------</td>
</tr>
<tr>
<td>1</td>
<td>The last time that you or your partner (or any other person you know) experienced a pregnancy-related problem, did you go to a health facility?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>In your last sexual relation, did you or your partner use a family planning method?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>In your last visit to the health facility, did they clarify all your doubts with respect to your health problem?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>In your last visit to the health facility, did they solve your problem?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Are you and your partner able to prevent unintended pregnancies with the use of family planning methods?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Where do you go to obtain a family planning method?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix J: Lessons Learned: Responses From The Teams in El Alto and Santa Cruz

<table>
<thead>
<tr>
<th>Core Group</th>
<th>El Alto</th>
<th>Santa Cruz</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Take into account the setting available to conduct the Core Group meetings.</td>
<td>• Instruments (matrices) for analysis need to be prepared ahead of time for the leaders.</td>
</tr>
<tr>
<td></td>
<td>• Ask the Core Group to provide telephone numbers and cell phone numbers that they control to improve communication. (For example, not their husband’s cell phone numbers.)</td>
<td>• It is important that the leaders become familiar with the action plan matrices before conducting the activity in their groups.</td>
</tr>
<tr>
<td></td>
<td>• Instruments (matrices) for analysis need to be prepared ahead of time for the leaders.</td>
<td>• The plans serve as a link between the leaders and the health care authorities.</td>
</tr>
<tr>
<td></td>
<td>• It is important that the leaders become familiar with the action plan matrices before conducting the activity in their groups.</td>
<td>• It is important that the leader is prepared to support the group in responding to the questions found in the matrix and thus schedule feasible activities.</td>
</tr>
<tr>
<td></td>
<td>• The plans serve as a link between the leaders and the health care authorities.</td>
<td>• The plans serve as a link between the leaders and the health care authorities.</td>
</tr>
<tr>
<td></td>
<td>• It is important that the leader is prepared to support the group in responding to the questions found in the matrix and thus schedule feasible activities.</td>
<td>• The plans serve as a link between the leaders and the health care authorities.</td>
</tr>
<tr>
<td>Autodiagnostico</td>
<td>• The Core Group training in how to fill out the matrices for the session reports was inadequate due to time constraints, since they were supposed to fill out the matrices of the three sessions within their respective groups.</td>
<td>• Results come gradually and one should not become discouraged with the first negative impressions that emerge during the process.</td>
</tr>
<tr>
<td></td>
<td>• Keep in mind the work days and schedule of the women.</td>
<td>• We should begin by identifying the leaders and groups with the support of the local authorities.</td>
</tr>
<tr>
<td></td>
<td>• Develop the timeline for the local team based on the distance between group meeting sites.</td>
<td>• Tools (such as the ADX guide) are modified along the way according to the characteristics of the different groups.</td>
</tr>
<tr>
<td></td>
<td>• Develop the timeline for the local team based on the distance between group meeting sites.</td>
<td>• We have learned that we should work with participants who live close to one another to improve attendance in the 4 sessions and in implementing the action plans.</td>
</tr>
<tr>
<td>Plans</td>
<td>• Encourage the local authorities to become involved in development of the action plans to obtain their support of and commitment to the participants, at least in the part that refers to the HCs.</td>
<td>• The leaders should have basic theoretical knowledge of RH/FP topics.</td>
</tr>
<tr>
<td></td>
<td>• More time – at one additional hour – is necessary to develop the Plans within the groups.</td>
<td>• It is important to work with existing (experienced) leaders, as they facilitate the community ADX process.</td>
</tr>
<tr>
<td></td>
<td>• The entire model process, from the training to the implementation of the action plans, should be explained to the leaders to encourage their</td>
<td>• The entire model process, from the training to the implementation of the action plans, should be explained to the leaders to encourage their</td>
</tr>
<tr>
<td></td>
<td>El Alto</td>
<td>Santa Cruz</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Community        | - Take into account that Core Group members will need to know how to address issues of domestic violence and unintended pregnancy with individuals who are facing those problems.  
                  | - Keep in mind the schedule of community members when planning meetings meetings so that they can attend without having to leave before the scheduled ending time. | - The community is not accustomed to meeting periodically.  
                  | - The community members are able to transfer knowledge through their life experiences.  
                  | - It is important to respect the values and customs of the community; sometimes the language used may conflict with these. | - The more knowledgeable they are about the model, the more coordination meetings there are, the more improved the results will be. |
| Authorities      | - Know the roles the local authorities play in the community, their schedules and the support they could provide to community activities.  
                  | - Invite them to participate at a meeting of the ADX and in the community action plan to achieve a greater commitment from them. Actually, we are considering inviting the local authorities and ensuring their participation at the presentations of the results. | - The more knowledgeable they are about the model, the more coordination meetings there are, the more improved the results will be. |
# Chapter 3: A Model for Scale-up of Postabortion Care: Implementing Public-sector Services in Bolivia, Egypt and Peru

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<tr>
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</tbody>
</table>
Executive Summary

Each year, more than 500,000 women die due to complications associated with pregnancy and childbirth (World Health Organization [WHO] 2004). Approximately 68,000 deaths (13% of all maternal deaths) can be attributed to unsafe abortion, and still others to spontaneous abortion or miscarriage. Complications of spontaneous and induced abortion are a significant cause of both maternal mortality and morbidity, and can also have a profound impact on the lives of women and their families. Further, the cost of treating these complications takes a tremendous toll on health care systems, particularly in resource-poor settings.

For more than a decade, various nongovernmental organizations and donors, including USAID, have sought to reduce the public health impact of complications of spontaneous and induced abortion around the world through the provision of a package of services called postabortion care (PAC). At minimum, these services include treatment for women who experience complications of spontaneous or induced abortion, and FP counseling and provision of a contraceptive method to prevent unintended pregnancies that can lead to repeat abortions. Often the scope of these services is much broader. For example, the USAID PAC model (2003) includes three Core Components: (1) emergency treatment; (2) family planning (FP) counseling, provision, STI evaluation and treatment, and HIV counseling and/or referral for testing; and (3) community empowerment through community awareness and mobilization.

This document describes the experience of the CATALYST Consortium (CATALYST), a global reproductive health and family planning project of the U.S. Agency for International Development (USAID), in scaling-up PAC services in three countries—Bolivia, Egypt and Peru. Scale-up, as defined by CATALYST, is the process of expanding services to reach more people in more places. Given the political and cultural sensitivity of PAC in many countries around the world, scale-up of PAC services can be particularly challenging; numerous programs become vulnerable due to national or regional political changes or even changes in hospital personnel. This document focuses on how the three CATALYST programs were scaled-up and what made scale-up possible, synthesizing the experiences to identify key elements that contributed to successful scale-up.

In all country programs, PAC training is tailored according to the type of facility in which the provider works. Providers at primary care facilities are trained to recognize danger signs and stabilize and refer clients to a higher-level facility where emergency treatment can be performed. These providers are also trained to provide follow-up care for PAC clients, including FP counseling and contraceptive method provision.

In Peru, health providers from 65 tertiary, secondary and primary facilities in five of Peru’s 24 departments were trained directly by CATALYST between July 2002 and December 2004; an additional 241 health facilities in these same departments received cascade training during the same time period. CATALYST piloted a community mobilization activity in one site, working with 373 participants (primarily women and adolescents) from 11 communities (urban, peri-urban and rural). Participants developed and implemented 11 actions plans and also collaborated with local hospital authorities to establish a quality of care committee (comprised of community leaders and hospital workers) focused on PAC and women’s health; a twelfth action plan was created for that committee.
In Bolivia, CATALYST trained providers at 166 tertiary, secondary, and primary facilities in five of the nine departments of the country between July 2000 and May 2005. Through a PAC community mobilization activity in two sites, CATALYST supported a total of 1,206 community members (women, men and adolescents) in developing and implementing a total of 16 action plans that aimed to increase access to and quality of PAC services.

The Egypt program is unique in that PAC was introduced as part of a broader, integrated family health program; therefore, PAC program stakeholders were the same as the stakeholders for the entire program. Staff at 14 hospitals in five of the country’s 26 governorates were trained in PAC between March 2004 and June 2005; providers at primary care facilities within these hospitals’ referral networks were also trained. Because of the integrated approach in Egypt, the program initiated community PAC activities simultaneously with clinical activities; groups of trained community leaders—including religious leaders—carried out community awareness sessions to increase knowledge about PAC in their communities. By June 2005, more than 12,600 people had participated in these sessions. A pre-post test carried out with 1,474 session participants showed that knowledge about when fertility returns postabortion increased from .7% to 99.7%; the percentage of participants who knew which FP methods could be used postabortion increased from 0% to 99%.

In all three countries, the creation and maintenance of a supportive policy environment at the national, regional and local levels has been fundamental to program scale-up. These efforts led to inclusion of the PAC programs in national policy. In Peru, PAC was successfully integrated into national policy only when programming centered on a broader package of maternal health services (emergency obstetric care or EmOC). Because EmOC addresses women’s health in general, integration of PAC into such programs can make it more politically acceptable and less vulnerable to changes in national and local politics. Nonetheless, even within such integrated programs, it is important to include the complete package of PAC services, and to sensitize providers to the situations of women who experience complications of spontaneous and induced abortion.

In Bolivia, the program has been implemented for over five years; CATALYST has provided support in the development of numerous policy documents that support PAC, including the *Manual of Norms, Rules, Protocols, and Technical Procedures for Management of Hemorrhagic Complications During the First Half of Pregnancy* and the National Sexual and Reproductive Health Program. PAC is also covered by the national maternal and infant health insurance package in Bolivia, making it available free of charge to all Bolivian women in public-sector facilities.

In Egypt, collaboration with national-level stakeholders has resulted in the inclusion of PAC in the updated *Clinical Standards of Practice for RH and FP Clinical Service Provision*, which were approved in early 2005. Further, the Egypt office has developed a comprehensive PAC package that includes tools for working with all program stakeholders—communities, Safe Motherhood Committees, primary care providers and hospitals.

The three CATALYST experiences demonstrate that the greatest challenge to scale-up is program sustainability. To achieve sustainability, all components of the scale-up model should be transferred to the local government, including systems for service implementation, community involvement, and monitoring and evaluation. It is also critical that responsibility for
maintaining the policy environment be transferred. The active involvement of stakeholders at all levels throughout the process will help ensure political commitment and facilitate this transfer.
I. Introduction

The Global Need for Postabortion Care

Each year, more than 500,000 women die due to complications associated with pregnancy and childbirth (World Health Organization [WHO] 2004). Approximately 68,000 deaths (13% of all maternal deaths) can be attributed to unsafe abortion, and still others to spontaneous abortion or miscarriage. Complications of spontaneous and induced abortion are a significant cause of both maternal mortality and morbidity (including infections, damage to internal organs, and long term morbidity such as chronic pain and infertility), and can also have a profound impact on the lives of women and their families. Furthermore, the cost of treating these complications takes a tremendous toll on health care systems, particularly in resource-poor settings.

In 1993, a group of international health organizations joined forces as the Postabortion Care (PAC) Consortium with the intention of addressing the impact of unsafe abortion on maternal morbidity and mortality. The Consortium coined the term PAC to refer to a package of services for women who experience complications of spontaneous or induced abortion. At minimum, these services aim to provide treatment for women who experience these complications, and FP counseling and a contraceptive method to prevent unintended pregnancies that can lead to repeat abortions. There have been several PAC models introduced over the years, the most recent being the USAID PAC Model (2003), which includes three Core Components:

- Emergency treatment;
- Family planning (FP) counseling, provision, STI evaluation and treatment, and HIV counseling and/or referral for testing; and
- Community empowerment through community awareness and mobilization.

Since the formation of the PAC Consortium, member organizations have provided technical support to implement PAC services globally. USAID and other donors have also provided financial and technical support to numerous PAC programs, including the three programs described in this document.

The CATALYST PAC Programs

The CATALYST Consortium is a global reproductive health and family planning project sponsored by the U.S. Agency for International Development (USAID), and is implemented by five partners: Pathfinder International, the Academy for Educational Development, the Centre for Development and Population Activities, Meridian Group International, Inc. and PROFAMILIA/Colombia. This document describes the CATALYST Consortium’s (CATALYST) experience of implementing and scaling up PAC services in three countries: Bolivia, Egypt, and Peru.

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44 Because complications of induced abortion are often unreported, it is often difficult to determine the exact extent to which they contribute to maternal mortality.

45 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.”

46 AVSC International (now EngenderHealth), the International Planned Parenthood Federation, Ipas, the JHPIEGO Corporation and Pathfinder International established the PAC Consortium in 1993.

47 CATALYST does not perform or actively promote abortions.
Scale-up, as defined by CATALYST, is the process of expanding services to reach more people in more places. As illustrated in this document, CATALYST has scaled up PAC in a variety of ways. Within the three countries, services have been scaled up not only in the more commonly understood sense, by expanding comprehensive PAC services to additional secondary and tertiary-level hospitals (after piloting services in one hospital). They have also been scaled up by providing selected components of PAC—such as identification of danger signs, stabilization, and referral to a hospital—at primary care facilities such as health centers and health posts. Offering PAC at lower-level facilities can make the service more accessible, particularly for clients living in rural areas. Similarly, community-level initiatives that create awareness about the health risks of complications of spontaneous and induced abortion can also increase access to both PAC and FP, making those initiatives an important component of scale-up.

The Peru and Bolivia programs were initiated by Pathfinder International in 1997 and 1999 respectively, and expanded significantly under CATALYST. The Egypt program, which is the youngest of the three, drew upon the Peru model to quickly scale-up a public-sector program. The three country experiences are similar in a variety of ways: they are all public-sector programs, they all have been developed in a participatory fashion with national, regional, and local-level stakeholders, and they all focus on PAC programming at all levels of facilities (tertiary, secondary and primary) and in communities.

Another major commonality between the three programs is the fact that, because PAC provides treatment for women who experience complications after an unsafe abortion, it is a sensitive topic in all three countries. This is because abortion is legally restricted in these countries and also contradicts the dominant religion (Catholicism in the case of Bolivia and Peru and Islam in the case of Egypt). From the beginning of the programs in the three countries, it was important to clarify to authorities that PAC is provided after an abortion has already occurred, and that, because PAC includes provision of contraception, it can also prevent unintended pregnancies and repeat abortions. The challenge of confronting political barriers and religious and cultural sensitivities was addressed in a different way in each of the three countries.

All three of the PAC programs have also involved the introduction of manual vacuum aspiration (MVA) technology for treatment of complications of spontaneous and induced abortions that occur in pregnancies of less than 12 weeks gestational age. In contrast to dilation and curettage (D&C), MVA can (1) be safer for the client because of the reduced risk of uterine perforation; (2) be performed effectively by mid-level providers, i.e., nurse-midwives, and in low-resource settings; and (3) reduce costs for both the client and facility. D&C requires general anesthesia, and therefore a longer hospital stay, sometimes as long as two or three days. In contrast, MVA can be provided using local anesthesia, therefore recovery time is very short and clients can safely leave the hospital within a matter of hours. Because they require fewer hospital resources, these shorter hospital stays are less expensive.

It should be noted that this report is not intended to serve as an evaluation of the three programs; instead, it seeks to describe how the programs were scaled up and what made scale-up.

CATALYST uses the term “scaling-up” to refer to taking a process or technique and spreading it to more sites. A program that extends services to more people in more places is said to be scaling-up. The term can also include extending a tool, approach or methodology to cover a larger portion of a specific target group.
up possible. It begins by describing the experiences of program implementation in the three countries. Next, the key components common to the programs are described. In the final section, four issues highlighted by the program experiences are addressed—provision of contraceptive methods, linking MVA with PAC, integration of PAC into EmOC, and sustainability.

II. The Three Country Experiences
CATALYST partner Pathfinder International initiated PAC programs in Peru and Bolivia prior to the CATALYST activity. Peru was the first country in which PAC services were scaled up, beginning in 1997 with support from the United Kingdom’s Department for International Development (DfID). The Peru team later provided technical assistance to both the Bolivia and Egypt offices as they were implementing their programs.

Peru
The population of Peru is 27,547,000 (PRB, 2004), with nearly 6.7 million women of reproductive age. More than half of those women (56%), and more than 31% of women in unions do not use FP methods, or use methods incorrectly. Lack of access to care due to geographic, economic, or cultural barriers contributes to low rates of contraceptive prevalence in Peru (unless otherwise noted, all data from DHS, 2000).

Low rates of family planning use contribute to high rates of unsafe abortion. Data show that approximately one million pregnancies occur in Peru each year. Among these, 35% end in induced abortion. Because the procedure is legally restricted, exact figures are difficult to find, but 2001 estimates reveal that approximately 352,000 abortions are performed each year, up from 271,000 in 1994.49

Complications of spontaneous and induced abortion are among the principal causes of maternal mortality in the country. In 2003, the maternal mortality ratio in Peru was 188/100,000 live births (DHS). This figure does not reflect the variation in maternal mortality caused by social inequalities, including gender inequalities such as women’s limited access to education, work and health care.

With technical support from Pathfinder International and funding from DfID, the Peruvian Ministry of Health (Ministerio de Salud or MINSA) implemented a national “Comprehensive Postabortion Care Project” between 1997 and 2002. Over the five years of the project, Pathfinder supported the initiation of services in 50 hospitals located in all 24 departments of Peru.

In 2002, with funding from USAID/Peru through the CATALYST project, Pathfinder built on the PAC program model to implement an Emergency Obstetric Care (EmOC) program, developing a model for Comprehensive Maternal Health Care.50 The program focused on EmOC because USAID preferred a more holistic approach to maternal health programming; nonetheless, there is a continued emphasis on the importance of comprehensive care for complications of


50 The CATALYST/Peru program also includes emergency neonatal care services, but this document focuses on the emergency obstetric care component of the program.
spontaneous and induced abortion. Between July 2002 and June 2005, CATALYST/Peru implemented the program in seven departments in the Amazon basin region of the country (Ayacucho, Cusco, Huanuco, Junin, Pasco, San Martin and Ucayali).

The mandate of the Peru program is to build capacity in all levels of public-sector facilities in the seven departments. The CATALYST team works in close collaboration with stakeholders and the regional (departmental), district, and subdistrict levels to develop the plan for program implementation. By the end of December 2004, providers at 65 facilities in five departments had been directly trained by CATALYST (see Table 1). An additional 241 health facilities in the five departments (107 in Huanuco, five in Junin, seven in Pasco, seven in San Martin, and 115 in Ucayali) had participated in cascade trainings. Training in the remaining two departments (Ayacucho and Cusco) will be carried out by regional training centers that were established with CATALYST support in 2005.

Table 1. Facilities trained directly by CATALYST (July 2002 to December 2004)

<table>
<thead>
<tr>
<th>DISA</th>
<th>Type of Health Facility</th>
<th>Number of Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Huanuco</td>
<td>Hospital</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Health Center</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Health Post</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>32</td>
</tr>
<tr>
<td>Junin</td>
<td>Hospital</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Health Center</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Health Post</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6</td>
</tr>
<tr>
<td>Pasco</td>
<td>Hospital</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Health Center</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Health Post</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4</td>
</tr>
<tr>
<td>San Martin</td>
<td>Hospital</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Health Center</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Health Post</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
</tr>
<tr>
<td>Ucayali</td>
<td>Hospital</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Health Center</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Health Post</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>18</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>65</td>
</tr>
</tbody>
</table>

Between July 2003 and June 2005, 15,008 PAC clients were served at facilities in the CATALYST EmOC program region. Between January and June of 2004, 2,793 clients were served; 97% (2,703) received counseling and 29% chose to contracept at the point of service. Between July 2004 and June 2005, 9,298 clients were served; 97% (9,019) received counseling and 29% (2,745) chose to contracept at the point of service.

There are some cultural barriers to contraceptive uptake among clients; for example, qualitative studies have shown that some women believe IUDs cause cancer. However, the most significant barrier to provision of contraceptives is a lack of availability of contraceptives (or a complete method mix) in many facilities. The Peruvian government is no longer receiving
donated contraceptives, and therefore the MINSA is working to set up contraceptive supply systems. Once these systems are established, it is hoped that contraceptive uptake among PAC clients will increase.

Bolivia

Bolivia has a population of 8,766,000 (PRB, 2004), which is dispersed throughout the three main geographic regions of the country: the altiplano (Andean Mountain Region); the valle (valleys between the mountains and the Amazon River Basin) and the llanos (the Amazon River Basin). Together, the Quechua and Aymara ethnic groups (the two largest indigenous groups in the country) comprise 55% of the total population. Geographic and sociocultural barriers significantly impact access to services for both indigenous and non-indigenous groups.

Reproductive health in Bolivia is poor, and basic indicators reveal that the RH status is among the lowest in Latin America. Modern contraceptive prevalence among women aged 15-49 who are married or in union is 27.2%, and unmet need among this same group is 26.1% (DHS, 1998). As is the case in Peru, many unintended pregnancies lead to clandestine, unsafe abortion, which in turn impacts maternal mortality. The Ministry of Health and Sports (MHS) estimates that complications of abortion account for 27% to 35% of maternal mortality. Data from the CATALYST community PAC activity (see Involving the Community in Section 3) in Bolivia also suggests that some miscarriages are caused by violence perpetrated by an intimate partner or a family member.

The maternal mortality ratio in Bolivia has declined significantly in recent years, from 390 in 1994 (DHS) to 230 in 2003 (preliminary data from DHS, 2003), although this number varies widely in the different regions of the country, with the highest rates of mortality among indigenous groups in the Andean mountain regions.

Bolivia initiated a National Reproductive Health Program in 1989, and continued to develop the program throughout the 1990s. In the latter part of that decade, Pathfinder joined forces with other NGOs (including the U.S-based NGO Ipas) to form the Inter-Institutional Committee for the Coordination of Postabortion Care (ICCPAC), and began advocating with the Bolivian Ministry of Health and Sports (MHS) to launch the national PAC program. At the beginning, the ICCPAC encountered strong resistance from the Catholic Church. To ensure that the program intent was clearly understood as providing treatment for women with complications, the ICCPAC selected the term Comprehensive Care for Hemorrhagic Complications during the First Half of Pregnancy for the program rather than the Spanish translation for PAC (Atención Postaborto).

In 2000, after a pilot phase that will be discussed further below, USAID/Bolivia selected Pathfinder/CACTALYST as one of the implementing agencies of the National PAC Program. Ipas was selected as the other implementing agency. The two agencies worked together to develop national guidelines and training curricula, and were each responsible for supporting program implementation in MHS facilities in different regions of the country. CATALYST was responsible for the departments of Beni, Cochabamba, Oruro, and Santa Cruz, and Ipas was responsible for

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51 These data were provided by the Interagency Group for the Reduction of Maternal Morbidity and Mortality, comprised of the Pan-American Health Organization (PAHO), UNFPA, UNICEF, Family Care International, the Population Council, the Inter-American Development Bank, and the World Bank. From “La Experiencia en Bolivia de la Atencion Postabortal” (The Bolivian PAC Experience) (2004), a document developed by stakeholders of the Bolivian PAC program.
Chuquisaca, Pando, Potosi, and Tarija. The two shared responsibility for La Paz, the country’s ninth department.

Table 2 shows the number of facilities at which providers were trained during each year of program implementation. Providers at 166 facilities were trained during the five years of the program: 23 in Beni, one in Chuquisaca, 44 in Cochabamba, 47 in La Paz, 20 in Oruro, one in Potosi, 29 in Santa Cruz, and one in Tarija.

Table 2. Facilities trained through CATALYST PAC Program

<table>
<thead>
<tr>
<th></th>
<th>2000*</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005*</th>
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<td>9</td>
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<td>5</td>
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<td>51</td>
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<tr>
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<td>7</td>
<td>20</td>
<td>28</td>
<td>23</td>
<td>106</td>
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<tr>
<td>Other**</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>7</td>
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<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>54</td>
<td>16</td>
<td>23</td>
<td>40</td>
<td>28</td>
<td>166</td>
</tr>
</tbody>
</table>

*2000 data are from June through December and 2005 data are from January through May.
**The “other” includes NGOs for all years except 2005, in which it represents the Riberalta health network in the department of Beni.

Over the five-year period, 44,485 PAC clients were served. The percentage of clients counseled for FP during the fiscal year (June through July) increased from 59.4% (3,869/6,508) in FY 2000-2001 to 77.9% (7,160/9,186) in FY 2004-2005. In the same time period, the contraceptive acceptance among PAC clients doubled, increasing from 21.4% (1,396/6,508) to 45.7% (4,195/9,186). Figure 1 shows the percentage of PAC clients who received counseling, chose to contracept and received a referral for other RH/FP services during the five fiscal years.

Figure 1. PAC service data for 44,485 clients (July 2000-2005)

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52 One of the “facilities” in Beni is the Riberalta health network.
53 Although Chuquisaca, Potosi and Tarija were not in the CATALYST program area, CATALYST was asked to train one NGO facility in each of these departments.
Egypt

Egypt has a population of 73,390,000 (PRB, 2004). Religion plays an important role in Egyptian society, and the majority of Egyptians are Muslim (approximately 94%); the remainder is Coptic (Orthodox) Christian. Between 1980 and 2003, use of modern contraception among married women increased from 24% to 57%, and the total fertility rate decreased from 5.3 to 3.2. A focused effort to improve the quality of maternal health care that began in 1992 resulted in a dramatic drop in maternal mortality, from 174/100,000 live births in 1992-3 to 84/100,000 live births in 2000.

Despite these gains in contraceptive prevalence and the reduction in fertility, the incidence of unintended pregnancy—and therefore of unsafe, illegal abortion—is still high. A 1993 study carried out by the National Population Council/Research Management Unit and Suez Canal University found that approximately 26 percent of all women aged 35-60 in Egypt have had one or more abortions (either spontaneous or induced). A 1997 study of public hospitals also revealed the profound impact that complications of spontaneous and induced abortions have on the health care system; these complications accounted for 19% of all admissions in the 89 hospitals included in the study, or a total of 340,000 clients annually. This same study found that only 47% of the PAC clients had ever used a contraceptive method and that only 20% of them had received a contraceptive method prior to being discharged from the facility.

Prior to the initiation of the CATALYST program, several organizations had implemented PAC activities in Egypt. In the 1990s, the Egyptian Fertility Care Society (EFCS) and the Population Council introduced pilot projects in a number of hospitals. By 2000, the EFCS extended the trial to three years and succeeded in establishing PAC services in three university clinics in the cities of Alexandria, Cairo and Mansoura.

Through its TAHSEEN project, which is funded by USAID/Egypt, CATALYST launched a PAC program in Upper Egypt in March 2004, making the Egypt program the newest of the three programs described in this document. The program is designed to address the “three delays” that can inhibit women from receiving timely PAC—(1) delay in recognizing danger signs and deciding to seek care, (2) delay in reaching appropriate care (transportation), and (3) delay in receiving care at the health facility—and includes interventions at the community, primary care, and hospital levels to minimize these delays. Community leaders are trained to disseminate messages that aim to minimize the three delays in their communities; primary care providers are trained to immediately stabilize and refer women who experience complications of spontaneous and induced abortions to the nearest hospital; and hospital providers are trained to provide

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timely, good-quality, and humane care to PAC clients, which includes FP services and use of MVA for treating incomplete abortion when appropriate.

TAHSEEN/CATALYST conducted its first PAC training in March 2004. By June 2005, 241 physicians and 178 nurses working in the OB/GYN wards in 14 public-sector hospitals had participated in PAC training. Some 239 primary care doctors and 213 primary care nurses had been trained to identify women who need emergency care and refer them to the hospital immediately. Groups of trained community leaders—including religious leaders—increased awareness in communities they serve.

Between July 2004 and June 2005, 3,495 clients received PAC services at 12 of the program hospitals. Sixty-six percent (2,290) received counseling on FP. Ten percent (348) received an FP method prior to discharge and 42% (1,461) received a referral for FP services upon discharge. The percentage of clients receiving methods upon discharge has also increased considerably during the first year of programming. In July 2004, 14% of clients (11/77) received a method prior to discharge at three hospitals; in June 2005, 24% (99/420) received methods at 11 hospitals.

It should be noted that provision of contraception at the point of service is particularly challenging in Egypt, given that PAC and FP services are provided through two different divisions of the Egyptian Ministry of Health and Population (MOHP). TAHSEEN/CATALYST is currently carrying out operations research (OR) in collaboration with the Population Council to determine the most effective means for providing postabortion contraception. If the results show that contraceptive uptake increases when contraception is provided at the time of PAC services, the MOHP has agreed to make contraception available at PAC service delivery points. It is hoped that the results of the OR will facilitate institutional change and increase postabortion contraceptive uptake.

The next section explores the factors that made scale-up possible, highlighting the components that were common to all of the country experiences, as well as aspects that are unique to each.

III. The PAC Scale-up Model

Many of the PAC models that were developed in the 1990s focused on the elements that were essential to quality postabortion care, providers’ technical capacity, and comprehensive counseling, but did not consider the fundamental managerial and infrastructural elements that improve the capacity of the facility to respond to complications of spontaneous and induced abortion and simultaneously contribute to program sustainability.

In the case of all three CATALYST programs, the development of a program model, including nationally-applicable systems for needs assessments, training, supervision, and monitoring and evaluation, facilitated rapid scale-up of the program. Innovative community-level activities in all three countries also contributed to scale-up where implemented (see Involving the Community

59 Hospitals were located in five governorates, one in each of eleven districts in the Minia, Fayoum and Beni Suef governorates, in two urban areas in Giza Governorate and one in an urban area of Cairo.
60 The percentages were lower during some of the interim months, particularly immediately after services had been scaled up to additional facilities.
for more information). The success of the systems that facilitated scale-up can largely be attributed to the fact that they were developed in collaboration with representatives from the Ministries of Health (MOHs) in each country, ensuring that they were locally relevant and feasible. To achieve this collaboration, the creation and maintenance of a supportive policy environment was the foundation of all three programs.

**Creating and Maintaining a Supportive Policy Environment**

**National Level**

To launch the programs, CATALYST began by working with national-level decision-makers to garner political commitment to PAC. The messages and methodology used to gain their commitment varied from country to country; however, in all countries, the messages focused on PAC programming (or in the case of Peru, EmOC) as an initiative that would contribute to the reduction of maternal morbidity and mortality.

Because of the broader scope of the emergency obstetric care program in Peru, messages centered on reduction of maternal morbidity and mortality. The Peruvian government has national and international commitments to reduce maternal mortality, for example, through the Millennium Development Goals, and therefore the process of obtaining political support was not difficult. Further, the MINSA’s previous experience with the Pathfinder PAC program strengthened CATALYST’s position, because the EmOC program was viewed as an expansion of the earlier PAC program. In addition to the persuasiveness of the message, building policy support in Peru was more focused at the regional and district levels, since the Peruvian MOH has undergone a process of decentralization in recent years.

In Bolivia, the PAC program has been closely linked to the introduction of manual vacuum aspiration (MVA). Ipas, an international NGO that manufactures MVA equipment, began advocating for the introduction of MVA in the early 1990s, and carried out a number of pilot activities and studies. In collaboration with Ipas through the ICCPAC mentioned previously, Pathfinder advocated with MHS authorities, including the Minister of Health and the Head of the National Sexual and Reproductive Health Program. At the time, both Pathfinder and Ipas had PAC initiatives in Peru, and the Peruvian offices of both NGOs provided technical assistance, sharing the Peruvian experiences to demonstrate the benefits of the PAC program to the MHS.

As a result of these efforts, in March 1999, the MHS issued Ministerial Resolution 133: “Organize emergency obstetric services to improve the quality of services, reducing treatment costs and time spent at the facility, through the introduction of MVA for postabortion care services.” This resolution paved the way for the introduction of PAC services, and both Pathfinder and Ipas carried out and evaluated pilot activities. When the results of these evaluations were presented to the MHS, it chose to launch a national program in 2000.

Interviews with MHS authorities showed that they chose to initiate the PAC program because of the high rates of maternal mortality associated with PAC, and that they endorsed MVA primarily because of the cost-effectiveness of the technique due to the reduction in time clients spend at the facility. An additional clinical reason cited for the endorsement of MVA was the reduced risk of uterine perforation (as compared to D&C). Finally, the MHS noted that use of MVA for PAC provides a social benefit for the client because it allows her to return home quickly. Many women have children they need to care for and some women seek care without their husband’s knowledge; therefore, a shorter hospital stay increases the likelihood that their visit will remain confidential.
In Egypt, national-level policy support was garnered through two workshops. In March 2004, TAHSEEN held a workshop with the Ministry of Health and Population (MOHP) and other national stakeholders—including the curative, maternal and child health (MCH) and family planning sectors of the MOHP, USAID, universities and the Egyptian Fertility Care Society (EFCS)—to determine how and with whom the PAC program would be implemented. Representatives from the CATALYST/Peru office also participated in the workshop and provided technical insight based on their years of program experience. Workshop participants identified Safe Motherhood Committees (SMCs), district hospitals, primary care providers, and community members as local program stakeholders, each of whom has a unique role in the PAC program. Following this initial workshop, TAHSEEN developed a National PAC Package that included tools for working with each group of stakeholders. The package was presented to stakeholders during a second workshop in May 2004. In September 2004, the training team from the MOHP took a study tour to Peru for additional training in PAC at the Peruvian National Training Center in Lima and also visited PAC program sites.

**National Policy Support for PAC Programs**

The initial efforts to garner policy support for PAC resulted in actions in all three countries. In Peru, CATALYST participated in the development of the 2004 *National Guidelines for Integrated Sexual and Reproductive Health Care*, incorporating fundamental changes to strengthen PAC services. Complications of spontaneous and induced abortion are explicitly included in these guidelines, and the PAC service model (including counseling and contraceptive method provision) is included as a strategy for providing care to women who experience these complications. Further, MVA is included in the PAC model at secondary-level facilities. This explicit inclusion of PAC is important; many EmOC programs include complications of spontaneous and induced abortion as “bleeding in the first half of pregnancy,” but focus only on treating the obstetric emergency rather than providing comprehensive RH/FP services.

The Bolivia program has been established for more than five years, and therefore CATALYST has helped to incorporate PAC into numerous policy documents, including the Bolivian *Norms for Maternal and Newborn Care*, the *Manual of Norms, Rules, Protocols, and Technical Procedures for the Management of Hemorrhagic Complications during the First Half of Pregnancy* (updated in 2004), and the *National Sexual and Reproductive Health Program*. Since 1998, PAC has been included in the national health insurance package, currently called the Universal Maternal and Child Health Services (SUMI, for the Spanish acronym), making PAC services free of charge for Bolivian women in all public-sector facilities in Bolivia. In addition to these policy guidelines, CATALYST, Ipas, and other CAs and NGOs in Bolivia have worked together to develop essential program tools that are used nationwide, including the Training of Trainers (TOT) module, a supervision guide, verification checklists (for supervision), and an information system for monitoring and evaluation.

In Egypt, collaboration with national-level stakeholders has resulted in the inclusion of PAC in the updated *Clinical Standards of Practice for RH and FP Clinical Service Provision*, which was approved in early 2005. Further, the Egypt office has developed a Comprehensive PAC Package that includes tools for working with each group of program stakeholders—communities, Safe Motherhood Committees, primary care providers, and hospitals.
**Regional/local Level**

In all three countries, once the necessary national support was obtained, CATALYST began negotiating at the local level to gain support for the program and reach consensus with regional authorities about where interventions should be implemented.

In Peru, regional-level support for the program was critical due to the decentralized nature of the country’s health system. The CATALYST team collaborated with the regional health authorities (DISAs) to match the objectives of the EmOC program with the objectives of the DISAs and develop a plan. Concrete national-level results, like the integration of PAC into the National Guidelines mentioned previously, came several years after the program was first implemented.

In Bolivia, many of the strategies used at the national level were applied at the local level. The first step was to create awareness about complications of spontaneous and induced abortion as a public health problem and about the benefits—for the MHS, facilities, providers, and clients—of using MVA for uterine evacuation. Once regional authorities agreed to implement PAC in their departments, CATALYST began working with district and facility authorities to reach consensus about implementing PAC.

In Egypt, negotiations were carried out first with Safe Motherhood committees, local authorities (e.g., governors and other political figures) and then with facility authorities. The Egypt program is unique in that, unlike Bolivia and Peru, community PAC activities were initiated simultaneously with clinical activities. Therefore, negotiations were also carried out with community leaders from various social sectors—including Muslim and Christian religious leaders, community educators, agricultural workers, primary care physicians and nurses, community development associations (CDAs), dayat (traditional birth attendants) and the media—to sensitze them to the issue and seek their input on how the program should be implemented. It should also be noted that TAHSEEN/CATALYST credits the success of the community PAC approach in Egypt to the fact that the program was introduced as part of a broader family health package. Prior to introducing the PAC program, TAHSEEN/CATALYST had gained community members’ trust through earlier family health activities that showed results and demonstrated TAHSEEN’s collaborative approach.

2. Implementing Clinical Services

Once political support had been gained at the national and regional levels, CATALYST worked with facilities to implement clinical services. In each site, this included three basic stages—needs assessment, training, and supervision.

**Needs Assessment**

Tools and methodologies for facility needs assessments were developed in all countries. These tools are used to analyze the infrastructure of the health facilities (including information on organization of services and procedure rooms, condition of the facility, numbers and cadres and specialties of medical staff), whether essential basic equipment and supplies for PAC are available, demand for PAC services and providers’ knowledge and training. Results of the assessment help CATALYST determine the capacity of the facility. CATALYST/Peru uses a software system called “Obstetrics and Neonatal Functions” (FON, for its Spanish acronym) to carry out the needs assessment. (See Box 1).

Needs assessments often reveal deficiencies in the infrastructure, equipment, or commodity supply that need to be addressed in order to ensure that quality PAC services can be provided.
To the greatest extent possible, CATALYST provides support to facility and other local managers in resolving these problems.

**Training**

Each country has developed a training manual for PAC (the EmOC training manual in Peru includes a module on “Prevention and Management of Hemorrhagic Obstetric Emergencies,” which includes PAC). Training sessions are five or six days long, depending upon the program. The length of the training sessions in Peru varies because training is tailored based on the results of the initial needs assessment; average training length is five days.

All trainings begin with a sensitization, allowing providers and facility managers to reflect on the problem of unsafe abortion and why it occurs. The goal of this sensitization is to enable providers to offer comprehensive, empathetic counseling to PAC clients. TAHSEEN/CATALYST carries out focus group discussions (FGDs) with recent clients in Egypt before initiating program activities so providers can learn what clients think about the quality of PAC at that facility.

In all three programs, physicians, nurse-midwives, and nurses are trained to provide PAC as a team. The physician performs the MVA or D&C procedure, taking appropriate infection control measures, and the nurse-midwife or nurse counsels the client before, during and after the procedure. In all countries, training includes both theoretical and practical training in MVA. Because the Peru training focuses on all obstetric emergencies, MVA training during the initial workshops is more limited. However, providers can complete their practical MVA training through an internship program at the National Training Center in Lima in a relatively short time period due to the high PAC caseload at the Training Center. Training in counseling is a central component of PAC. Counseling serves to calm the client for pain management, answer the clients’ questions, and provide information about essential follow-up care. It also focuses on ensuring that the client has the information she needs to choose a family planning method.

In all countries, providers at primary care facilities are trained to offer components of PAC that are appropriate to their level of service provision. Since these facilities can often be the first point of contact between PAC clients and providers, especially in remote or rural areas, primary care providers are trained to recognize danger signs associated with complications of spontaneous or induced abortion, stabilize the client, and immediately refer her to a hospital where treatment of complications is provided. These providers are also trained to provide follow-up care for PAC clients, including FP counseling and method provision.

CATALYST has used a variety of methodologies to scale-up training. In Bolivia, both cascade training and peer training (a form of on-the-job training in which a non-trained peer learns from a trained peer) have been used. In Peru, cascade training is carried out. Typically, referral-level facilities are trained by CATALYST and then are responsible for training the providers at lower-level facilities within their referral network. In Peru, the development of regional training capacity was also identified as a strategy for program sustainability, and CATALYST is helping the MINSA establish regional Centers for Competency Development (CDCs, for its Spanish acronym) in each program department. In Egypt, Training of Trainers courses have been conducted, building the capacity of local providers to train new colleagues at their hospitals; this helps ameliorate the challenge of the high provider turnover rate.
Supervision

Five or six days is a relatively short period of time in which to gain complete competency in the skills necessary for PAC services, particularly the MVA procedure. The internship component of the CATALYST/Peru program mentioned previously, in which providers are certified after performing between five and six procedures under the supervision of a master trainer in Lima, has proven an effective means for strengthening providers’ skills. In all cases, however, ongoing supervision is critical to help ensure that providers apply the knowledge and skills they acquire during training in their daily work.

All three programs have developed tools for supervision. In Bolivia and Egypt, checklists are used. The Peru program has developed a software package called “Supervision of Obstetric and Neonatal Functions” (FONSUP, for its Spanish acronym), and therefore has an “electronic” checklist through which they can easily “score” providers’ performance (see Box 1 for more information). Supervision visits apply the “training supervision” methodology, in which MOH professionals accompany the CATALYST teams on semi-annual supervision visits; this process facilitates the transfer of the supervision responsibility to the MOH and supports sustainability.

Qualitative data from both Bolivia and Peru indicate that many stakeholders recognize supervision as a program area that could be improved. Strengthening supervision in scaled-up settings remains a challenge for PAC programs.
Box 1. FON and FONSUP: Software for Needs Assessment, Monitoring and Supervision

The FON (Funciones Obstetricas y Neonatales or Obstetric and Neonatal Functions) was developed through Project 2000, a USAID/Peru cooperative agreement implemented by Pathfinder and its partners between 1995 and 2002. During Project 2000, the FON was validated in 12 regions of the country, but it was not institutionalized until the CATALYST EmOC program.

The FON is software that serves as a tool for measuring health facilities’ capacity to resolve obstetric and neonatal health problems. In Peru, there are three types of facilities, each of which has a different level of resolution capacity: health posts, which are often only staffed by a nurse technician, can perform “primary” obstetric and neonatal functions; health centers, which are usually staffed by a physician, can perform “basic” obstetric and neonatal functions; and hospitals can perform emergency obstetric and neonatal functions.

The FON is tailored for each level of resolution capacity, so that facilities are “scored” based on their ability to perform their essential clinical functions. To calculate this score, the FON incorporates a simple survey to assess the infrastructure, equipment, hospital beds and medicines available in facilities, as well as the number and type of staff, the skills and competencies of this staff, and the staff coverage during facility hours. The FON is applied periodically (every six months), and serves as a means for measuring overall improvements in the resolution capacity in the facility. Using the results of the FON, health facilities and regional health authorities are able to determine resources they lack and ways in which they could improve the distribution of existing resources, for example, by reorganizing services or storing medications in the areas of the hospital where they are most needed.

CATALYST has also developed and introduced a software package for supervision (FONSUP). This system is similar to the FON, using a computerized checklist system to “score” providers’ performance. As part of the capacity-building and sustainability plan CATALYST has trained local health professionals to apply the FON and FONSUP.

3. Involving the Community

After nearly a decade of PAC programming using a service-delivery-oriented model, organizations working in PAC identified numerous sociocultural barriers that prevent women from seeking PAC services, and concluded that these barriers could only be reduced through work at the community level. In response, CATALYST worked with USAID funding to develop community PAC activities in Bolivia, Egypt, and Peru in 2004. The goal of these activities was to facilitate access to and increase quality of FP and PAC services, ultimately achieving the goal of scale-up by reaching more clients. Community PAC activities can take a variety of forms, all of which can increase access. First, community assessments can be used to obtain information from the community about their needs and perceptions of health services; this information can then be used to make changes at the facility level to help ensure that services meet the community’s needs. Second, community education and behavior change communication (BCC) efforts can raise awareness about healthy behaviors (such as use of FP and seeking PAC services when complications arise) and the availability of FP and PAC services.

CATALYST’s community PAC initiatives are community mobilization (CM) activities, which engage a wide variety of community members—including educators, community leaders, health
professionals, women’s groups, and adolescents—in a participatory process of (1) reflection on and assessment of the problems of unintended pregnancy in their communities; (2) development of action plans based on the results of the assessment; (3) implementation of the action plans; and (4) evaluation of action plan implementation. The CM process is designed such that, using the results of the evaluation, community members can begin the four-step cycle again, giving them an opportunity to continue to work to resolve problems that may not have been resolved in the first cycle or identify and tackle new problems. Qualitative results reveal that the activities were effective in “breaking the silence” about the problems of unintended pregnancy and complications of spontaneous abortion in the communities, and the action plans have yielded different results in different countries. In some cases, these results extended beyond results specific to PAC.

In Peru, community leaders from a local women’s organization carried out a process similar to Bolivia’s. Three hundred and seventy three participants comprised of women and adolescents from 11 communities (urban, peri-urban and rural) participated in the process. As a result of the project, community members developed and implemented 11 actions plans. The women’s organization also worked together with hospital authorities to establish a quality of care committee (comprised of community leaders and hospital workers) focused on PAC and women’s health; a twelfth action plan was created for that committee.

In Bolivia, a total of 1,206 community members (women, men and adolescents) participated in two project sites and developed and implemented a total of 16 action plans. Participants in both communities recognized that their local community organizations did not work together, and that this would be a barrier to implementation of their action plans. Therefore, they designed activities to strengthen community organizations, building the capacity of those organizations to resolve community problems.

In Egypt, community leaders’ action plans included conducting community awareness sessions about unintended pregnancy and PAC. More than 12,600 people participated in 246 awareness sessions organized by community leaders on PAC. A pre-post test carried out with 1,474 awareness session participants showed that knowledge about when fertility returns postabortion increased from 7% to 99.7%; the percentage of participants who knew which FP methods could be used postabortion increased from 0% to 99%.

It should be noted that these community activities are designed to bring about social change, which is a long process. As of August 2005, the Bolivia and Egypt activities had been implemented for just over a year, and the Peru activity for less than a year. The preliminary results described above are promising. However, ongoing monitoring and evaluation will help determine whether anticipated long-term outcomes are achieved.

4. Monitoring and Evaluating the Program
Monitoring and evaluation (M&E) of all aspects of the program, including the policy environment, implementation of services and community involvement is essential to ensure that program goals are met. Program results can also provide information that can be used to gain policy support in the future, facilitating scale-up and sustainability. In terms of the policy environment, the most critical goal of monitoring is to maintain a supportive policy environment by sharing new results with program stakeholders and collaborating with them on program decisions.
At the service delivery level, M&E helps ensure that quality services are provided according to national standards, and can also yield important information about service gaps. Program information systems (such as the FON and other data collection systems) support data collection for M&E. For example, by reviewing service data, a facility manager may note that the percentage of clients treated with MVA has dropped. In some cases, this could be caused by staff turnover if a trained professional has left and his/her replacement has not received training in MVA. Alternately, this could indicate a lack of available MVA kits or a problem with cleaning the kits and making them available for re-use. Another revealing statistic could be a drop in the percentage of PAC clients leaving the facility with a contraceptive method. This could indicate poor counseling, a lack of contraceptive methods, a poor method mix, or another problem, such as the lack of providers authorized to provide methods at the time of the clients’ discharge, which may occur if the hospital's FP clinic or pharmacy is closed. Another important means for monitoring services is through client satisfaction surveys. These have been carried out in both Bolivia and Peru, and can reveal whether services respond to clients’ needs. Ongoing monitoring of service data, stakeholders’ perspectives, and clients’ views on services can help reveal problems and gaps that can then be resolved.

M&E at the community level is similar to M&E of policy support activities. Program managers need to monitor continuity and impact of community initiatives. As noted previously, impact at the community-level can be a lengthy process, so managers need to ensure that community interest is sustained throughout this process. Particularly since these initiatives are relatively new, measuring impact could increase global learning by showing how community initiatives contribute to PAC program results.

IV. Conclusions

This section highlights some of the key issues addressed in this report, and also offers some general conclusions and recommendations for scale-up of PAC services.

The FP Component of PAC

Provision of FP counseling and contraceptive methods is central to quality PAC, and the experiences from these three programs show that provision of contraception can be impeded for a variety of reasons.

In some cases, contraceptive provision has been impeded because of a lack of available commodities due to supply problems or stockouts, or a lack of commodities at the right place at the right time. Commodities may not be available when needed because of the way services are organized. The Egypt example mentioned previously, in which PAC and FP services are provided through different sectors of the MOHP, is a barrier to providing contraception to clients upon discharge. In some hospitals in Bolivia, clients did not receive contraceptive methods because they were stored in a pharmacy that was closed when the clients were discharged. International experience suggests that contraceptive uptake among PAC clients can be increased when commodities are stored in the area where PAC services are provided.

Contraceptive provision can also be limited by providers. Although many providers recognize the importance of FP services for PAC clients, some may be unmotivated to provide counseling for a variety of reasons, or they may not be trained or be misinformed. In some facilities, counseling staff may have numerous other responsibilities, and simply may not be available
when they are needed. To help ameliorate these provider-level barriers, facility managers and programs should seek to train and motivate staff and designate a dedicated professional for FP counseling.

Finally, sociocultural factors that impact the client can also be a barrier. Some clients may have beliefs or concerns about contraceptive methods that prevent them from using those methods. These may be medically accurate, e.g., that injectables can cause weight gain; influenced by religion, e.g., concerns among Muslims that oral contraception may interfere with religiously-mandated fasting; or they may be culturally-constructed beliefs, e.g., that IUDs cause cancer. In all cases, FP counseling should address these beliefs, answer the client’s questions, and help her make a decision about FP. Another social barrier is gender relationships; in all three countries, male partners sometimes oppose contraceptive use, and some women do not feel they can decide to use contraception on their own. In some countries, involving the male partner in FP counseling has proven effective in increasing contraceptive uptake among PAC clients. Community-level PAC initiatives can also address many sociocultural factors that influence clients’ FP decisions.

**MVA and Scale-up**

In the Bolivia experience, there were advantages and disadvantages to the fact that the PAC program was introduced as an MVA PAC program. Clearly, MVA can be safer than D&C because of the reduced risk of uterine perforation. It can also dramatically reduce the amount of time PAC clients spend at the facility, which in turn reduces financial costs for the health system and social (opportunity) costs for the client. Evidence from around the world also shows that MVA can facilitate scale-up to primary care facilities that may not be able to provide D&C. In fact, Ipas introduced MVA in primary care facilities in the departments of Bolivia in which it worked.

However, both political and individual commitment to MVA is essential to reap these benefits. In some cases in Bolivia linking PAC to MVA was a barrier to the implementation of the program. When first introduced to the program, some providers resisted the concept of PAC altogether because they did not support the MVA technology. Other providers were concerned that, with MVA, women are awake during the procedure. They were primarily concerned about pain management; as one national-level MHS authority noted, the providers thought “why should we make the woman cry if she can be anesthetized.” Still other providers are simply uncomfortable with the technique because they do not feel competent, suggesting that training and supervision should be strengthened.

A final problem with MVA is inconsistent commodity supply. The program donates equipment to the hospital at the beginning of the program, and, by law, hospitals should include MVA equipment in their budgets, but adding MVA to hospital budgets has been a slow process. In all of these cases in which MVA is not used, providers sometimes neglect the other core components of PAC, particularly counseling and contraceptive method provision; this is partially due to the fact that general anesthesia limits counseling opportunities. Nonetheless, it is important to ensure that providers understand that all components of PAC, including FP counseling and method provision, should be provided, regardless of whether MVA or D&C is used for treatment. For the future, it is promising that younger providers (in Bolivia) were more

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61 In accordance with USAID regulations, MVA equipment is not purchased with USAID funds; funds for the equipment have been provided by another donor (the Packard Foundation).
easily convinced of the benefits of MVA and more comfortable with the technique, suggesting that support for the technique may continue to increase.

Integration of PAC into EmOC
The Bolivia and Peru experiences provide an opportunity to compare vertical and integrated PAC programs. In contrast to the Bolivia experience, the Peru program focused on an expanded model of EmOC, which also has advantages and disadvantages. First, the EmOC approach facilitated the initiation of services. Second, since PAC and other EmOC services require many of the same skills, commodities, equipment, and infrastructure, EmOC services can be more cost effective for health systems. The final advantage is that, because EmOC is less sensitive than PAC and is likely to remain a political priority, integration of PAC into EmOC facilitates institutionalization and sustainability of the program.

The major disadvantage of the integration of PAC into EmOC is that, given the broader range of programming, there may be decreased emphasis on the unique circumstances PAC clients face. Nonetheless, in Peru, the EmOC training continues to focus on humane care for all emergencies, which has actually improved the quality of all EmOC services. In Peru, CATALYST had the added advantage of working in some of the same facilities in which the DFID-funded PAC program had been implemented. Therefore, many of the providers had previously been exposed to the PAC sensitization activities. Finally, after the program had been established, CATALYST had the opportunity to integrate the comprehensive model for PAC (including counseling and FP method provision) into training materials and the National Norms.

Conclusions
One of the most significant contributing factors to both scale-up and sustainability in the three country programs was the policy support for the programs. Program stakeholders in all three places recognized the importance of this support. MHS authorities in Bolivia even noted that they seek to strengthen the sustainability of documents and instruments by issuing “Ministerial Resolutions” so that new personnel cannot easily change MHS policy. This statement by the MHS reflects one of the greatest points of vulnerability of vertical PAC programs. New MOH personnel, whether hospital directors or Ministers of Health, can easily modify decisions or policies made by their predecessors, particularly regarding a sensitive issue such as PAC, and they may cut the program’s human or financial resources. This problem can be exacerbated by high rates of staff turnover.

Despite the fact that vertical programs can be vulnerable, program successes have been achieved in terms of sensitization to the issue of complications of spontaneous and induced abortion. In hospitals, the improvement in quality of care resulting from provider sensitization has resulted in an increase in client satisfaction. Additionally, the involvement of a broad spectrum of community members in all countries has built a critical mass of support for women who experience complications of spontaneous and induced abortions in the project sites.

All of the programs yield important lessons learned in terms of the need for flexibility in program design. In Bolivia, the name of the program was changed to respond to the national political climate. In Peru, the program design was amplified; CATALYST and the MINSA, after the experience of implementing a five-year PAC program, made this change with the intention of improving the possibilities for program sustainability. As one national MINSA authority noted about the shift:

3-22
The PAC [Program] was focused on a particular theme and then the EmOC program is something more organic, something that it would be difficult for people to oppose, whatever their [view], probably for the PAC program they would have a comment, but for an EmOC program, that has to do with all of the circumstances that can affect women’s health, and health in general, I think it would be difficult to find people who oppose this [program], one would have to be crazy to oppose this.

When policy support exists, program systems for needs assessments, training, supervision, community involvement, and M&E can be developed. With the endorsement of the MOH at the national level, these systems facilitate scale-up. The CATALYST experience demonstrates that systems that show results can even be scaled up by the MOH with minimal CATALYST involvement. For example, the MINSA in Peru requested that CATALYST carry out a series of workshops so that the FON software can be applied nationwide. In Egypt, trainers expanded the program to four additional hospitals in one governorate. One non-intervention governorate has also started implementing the PAC model (clinical, primary health care, and community) in four district hospitals and one teaching hospital with minimal technical assistance from TAHSEEN/CATALYST.

This document has highlighted a number of issues that will remain a challenge for those who scale-up PAC programs: (1) helping to ensure that the system (including commodity supply, facility management, providers, infrastructure, etc.) supports the provision of FP counseling and contraceptive methods for PAC clients and (2) strengthening supervision systems to help monitor and maintain quality of care. Nonetheless, the greatest challenge to scale-up is program sustainability. The CATALYST experiences suggest that, to achieve sustainability, all components of the scale-up model should be transferred to the local government, including systems for service delivery implementation, community involvement, and monitoring and evaluation. It is also critical that the responsibility for maintaining the policy environment be transferred. The active involvement of stakeholders at all levels throughout the process will help ensure political commitment and facilitate this transfer.
# Chapter 4: PAC Small Grants

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Acknowledgements

This report would not be possible without the hard work and dedication of our nongovernmental organization grant partners in Cambodia and Romania. The CATALYST Consortium would like to thank the Reproductive and Child Health Alliance (RACHA) and the Society for Education on Contraception and Sexuality (SECS) and their committed staff members. We would also like to thank the United States Agency for International Development (USAID) for their support and involvement throughout the entire grants intervention period.

Clarification

The term Postabortion care (PAC), as used in this document, refers to the strengthening of family planning counseling and method provision to postabortion care clients. In Romania and Cambodia, CATALYST focused on raising community awareness of postabortion care clients to seek family planning services and methods at appropriate health care facilities. The NGOs that CATALYST supported through these grants have certified that they are in compliance with the Mexico City Policy.

Executive Summary

Postabortion care (PAC) is a critical health care service that can save millions of women’s lives. To scale-up PAC services in countries where the CATALYST Consortium did not have a presence, CATALYST designed a grants programs to collaborate with local nongovernmental organizations (NGOs) in specific countries. The use of grants allowed local NGOs to identify their needs regarding PAC and to provide solutions that are socially and culturally adapted to their specific situations. CATALYST also used the grants program to gather data and lessons learned.

In the second half of 2004, PAC grants were awarded to local NGOs in Romania and Cambodia. The PAC grants program achieved many of the objectives CATALYST had outlined. CATALYST managed to link the target populations with community-level service providers and health institutions to foster greater lines of communication and awareness regarding PAC. Community members were informed of PAC issues and were taught the benefits of seeking care from trained health professionals. FP counseling also was emphasized as a way to prevent unwanted pregnancies and repeat abortions. The activities made possible by the grants in Cambodia and Romania reached sizeable populations.
I. Introduction

It is estimated that 19 million women undergo unsafe abortions each year; 18.4 million of those women live in developing countries, and the remainder primarily live in Eastern Europe. One third of these women will suffer serious complications but less than half of them will receive the hospital treatment they need.

Globally, nearly 68,000 women die from complications due to unsafe abortions each year, accounting for about 13% of maternal mortality. Countless other women suffer long-term health consequences, including infertility.

PAC services that are comprehensive, accessible and empathetic are crucial to meet the physical and emotional needs of women. Ultimately, the goal of comprehensive PAC services is to treat the complications of incomplete and unsafe abortions when they occur and prevent both unwanted pregnancies and complications of unsafe abortion.

CATALYST PAC activities are based on the USAID Postabortion Care Model, which facilitates access to PAC services. The model consists of three core components:

1. Emergency treatment for complications of spontaneous or induced abortion.
2. FP counseling and service provision, sexually transmitted infection (STI) evaluation and treatment and HIV counseling and/or referral for HIV testing.
3. Community empowerment through community awareness and mobilization.

II. Background

The use of grants was chosen as an approach to scale-up PAC services to countries where CATALYST did not have a presence. By responding to the request for proposals (RFP), local NGOs were given the opportunity to explore local solutions that took into consideration specific cultural and social aspects that fostered ownership and contributed to the subsequent sustainability of the programs. At the same time, grants permitted the transfer of international evidence-based practices to the local settings through technical assistance (TA) provided by CATALYST. New research findings were to be shared with the grantees and target groups of the interventions, such as the recommendation that women who received PAC services wait at least six months before becoming pregnant again to avoid adverse complications. Through the grants, CATALYST also hoped to increase the number of lessons learned for the third component of the PAC strategy: “community empowerment via community awareness and mobilization.”

The countries of intervention were chosen based upon CATALYST’s ability to receive approvals from the local USAID missions on the PAC activities and interventions proposed by the local NGOs. Selection of the NGO grantees was based upon the extent to which proposed activities...

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63 Unsafe abortion: 2004, p. 16.  
64 USAID Postabortion Care Strategy. USAID, October 2004.  
65 Scale-up is defined by CATALYST as expanding programs within one country (e.g. geographically, increasing the number of facilities where services are offered, offering selected services at primary care facilities, etc.) or as implementing programmatic models developed in one country in another country setting.
applied or scaled-up PAC services. Another selection criterion was the integration of gender components.

In the second half of 2004, the PAC grants were implemented in Romania and Cambodia. The grant monies ranged from $40,000 to $45,000 and were granted from CATALYST Core funds. The programs focused on generating awareness among the community and improving the skills of providers who provide correct and appropriate counseling on FP services for women with abortion complications.

This report will outline the intervention in each country separately and then synthesize the overall lessons learned through the grants project.

III. Cambodia

Background
Cambodia’s Health Sector Strategic Plan for 2003-2007 identifies reducing high maternal mortality, including deaths from obstetric trauma, as a high priority. Also, one of the Millennium Development Goals for Cambodia is the reduction of the ratio of maternal mortality from 437 to 305 deaths per 100,000 live births.66

An estimated one third of maternal deaths are caused by unsafe/septic abortions67, even though abortion is legal in Cambodia. Presently, the contraceptive prevalence rate of married women ages 15-49 is 23.8%.68 Still, there remains a very high number of unsafe abortions and a great need for PAC and FP services.

Due to poverty and lack of information, most clients first seek care from traditional providers, such as traditional birth attendants (TBAs) or village drugs sellers for abortions or miscarriages. These providers often use dangerous and inadequate techniques to provoke pregnancy termination. Many women experiencing postabortion complications arrive late, too late or not at all to appropriate health centers (HCs) or referral hospitals. Some die as a result of infections and hemorrhage, and those who survive may live with permanent disabilities. This situation could be greatly minimized with timely use of effective contraceptive methods to avoid unintended pregnancies.

Intervention
From June 1, 2004 to June 30, 2005, CATALYST worked with the Reproductive and Child Health Alliance (RACHA) in Cambodia, with an objective of raising awareness about unsafe abortions and health risks, providing counseling on prevention of unwanted pregnancies and treating complications. RACHA is one of the largest RH/FP NGO in Cambodia and partners with the MOH in national health programs. The interventions for the PAC grant were conducted in six operational districts (ODs): Anchorchey (Kampot province), Saompoa Meas (Pursat province),

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Maung Russey (Battambang province), and Siem Reap, Kralanh and Angkor Choum (Siem Reap province). All of these ODs are served by the MOH.

The CATALYST-supported PAC grant project in Cambodia strengthens the existing services by helping communities recognize the signs and symptoms of abortion complications and the need for immediate referral to health facilities. Further, travel compensation has been established for women suffering complications of abortion, who arrive at health facilities for treatment. This resulted from an effort to increase access to care as well as to set a precedent for communities to inculcate health-seeking behavior, especially when related to women’s health.

PAC flyers also were designed for the communities to outline the danger signs of abortion and its complications. One consistent message that was reflected in the flyers and the trainings was that as soon as a complication is detected, it is necessary to refer the woman to the nearest health facility for treatment. The flyer used local themes and images to make it user-friendly (see Appendix for example leaflet).

Working in partnership with the MOH, RACHA implemented a series of training events at the district level to update the knowledge of community health volunteers and providers, such as TBAs, traditional healers and village health support groups (VHSGs), to recognize the complications of abortion and refer clients to health facilities. In addition, the service providers from the health centers also were trained and informed that referrals would be an important component of the activity. Additionally, service providers were trained in FP counseling skills.

In summary, the main activities of the intervention include:

- Development of training curriculum to educate the community on danger signs of abortion complications.
- Training sessions with community health workers and community to educate on danger signs and to refer clients to health facilities.
- Distribution of flyers to reiterate the messages to seek appropriate care when dealing with danger signs of abortion complications.

**Baseline Study**

A baseline survey was conducted to collect data on community members’ knowledge of miscarriage, abortions and FP before the start of the project activities. In-depth interviews were conducted with specific target groups, which included: midwives, TBAs, VHSGs and women of reproductive age (WRA). In total, 40 midwives, 132 TBAs, 270 VHSGs and 4,224 WRA were interviewed. The main finding from the baseline survey was that FP knowledge is high among both users and providers; however, variances exist as to the knowledge of different methods of contraception, especially permanent methods for men.

**Endline**

RACHA conducted an endline study at the end of the intervention. The study was comprised of in-depth interviews with the same target groups addressed at baseline. A comparison between the baseline and endline studies was conducted to compare changes in knowledge before and after the intervention.

Change in knowledge of PAC danger signs increased with all of the target groups. Midwives had the highest knowledge level at the baseline, however, their knowledge also showed increase in the endline. The percentage of respondents who knew danger signs such as
bleeding, fever and lower abdominal pain/strong abdominal pain increased while the percentage of respondents who answered “Other” or “Don’t know” decreased.69

A comparison of the baseline and endline found that the number of TBAs who referred clients to the health facilities increased from 73% to 94%. Also, the percentage of midwives who referred PAC clients to higher level facilities decreased after receiving training on how to better manage PAC cases.

All of the target groups showed increase in their knowledge of different types of FP methods as seen in the table below:

**Table 1: Knowledge of FP Methods (Baseline vs. Endline)**

<table>
<thead>
<tr>
<th>Methods of Family Planning</th>
<th>WRA</th>
<th>TBA</th>
<th>VHSG</th>
<th>Midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BL</td>
<td>EL</td>
<td>BL</td>
<td>EL</td>
</tr>
<tr>
<td></td>
<td>N=422</td>
<td>n=421</td>
<td>N=132</td>
<td>n=88</td>
</tr>
<tr>
<td>Natural family planning</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Condom</td>
<td>69</td>
<td>77</td>
<td>61</td>
<td>85</td>
</tr>
<tr>
<td>Pill</td>
<td>92</td>
<td>94</td>
<td>86</td>
<td>98</td>
</tr>
<tr>
<td>Injectable</td>
<td>78</td>
<td>82</td>
<td>73</td>
<td>90</td>
</tr>
<tr>
<td>IUD</td>
<td>48</td>
<td>54</td>
<td>40</td>
<td>76</td>
</tr>
<tr>
<td>Norplant</td>
<td>5</td>
<td>26</td>
<td>5</td>
<td>49</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>5</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>23</td>
<td>33</td>
<td>19</td>
<td>44</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4</td>
<td>4</td>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>

*BL = Baseline; EL = Endline

When interviewed about their knowledge of where FP methods can be obtained, the health center was the most common place respondents mentioned. Other places that were mentioned include the provincial hospital, VHSG’s houses, pharmacies, private clinics, and the RACHA Maternal and Child Health Center.

69 See Table B in Appendix for complete results.
Results
A total of 383 villages were reached with PAC messages during the project intervention period. This covered a population of approximately 342,166 people, of which 26% were WRA. The project intervention also trained 268 TBAs, 625 VHSGs and 48 health center staff in PAC messages, service provision and the referral system.70

RACHA also developed information and education campaign (IEC) materials to provide health education to the community members, community health workers and health center staff. In total, 90,000 leaflets71, 2,000 posters and 900 education materials were printed and distributed. Leaflets were distributed to villagers to remind them of the health messages they had received, and posters were put up in high traffic areas to inform community members that PAC services are available at the health centers. The education materials also were used by community workers as visual aids during their information sessions with the communities.

During the intervention period, 259 PAC clients came to the 24 health centers participating in the project. Two of those PAC clients were referred to higher level care. The referral system brought 163 PAC clients to the health centers. Of these, 53 were referred by TBAs and 52 by VHSGs, who were reimbursed for their transportation costs; the remaining 58 were referred by other women or by their families. The number of clients coming to the health centers for PAC services increased considerably during the project. The average number of PAC clients per month prior to the intervention in the second half of 2004 was 18; this increased to 22 clients per month for the first half of 2005.

Challenges
One challenge was in the coordination of activities. RACHA found that due to conflicting schedules and other commitments, it was difficult to organize staff from the ODs and HCs to participate in training, monitoring and follow-up of the PAC community program. The same difficulties and delays also were encountered when working with the community health providers and community members.

A second challenge RACHA reported was the difficulties encountered by health providers in spreading the PAC messages to the community members. RACHA found it difficult to obtain community members’ participation in information sessions due to conflicting schedules. Also, some villagers were not able to completely grasp the PAC messages. Others did not find the information important enough to pay close attention to the providers during the sessions.

Lessons Learned
The referral system can improve the linkage between community workers, community members and the health centers, which results in more referrals of women who show danger signs of incomplete abortion to health centers. The project also built awareness in the community to the point where family members and relatives were sufficiently aware of the danger signs, so that they too could refer women directly to health facilities.

A second important lesson learned was that it is always necessary to emphasize and look for ways to motivate technical staff at the health centers and ensure they are available to provide

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70 See Table A in Appendix for more detailed information on coverage area of the project and providers trained.
71 See Appendix for a copy of the produced leaflets.
quality care. Through education and encouragement, the staff members were given the motivation they needed to provide high quality services to their clients.

**Conclusion**
The intervention in Cambodia has increased awareness in 383 villages in six ODs on the complications of abortion and the need to seek early treatment and care. The grant project reached a large rural population of approximately 342,166 people in order to increase awareness of PAC and increase health seeking behaviors by reducing the gap between providers and clients. Preventing unwanted pregnancies through use of effective FP methods will reduce the incidence of unsafe abortions and result in better health outcomes for women and children in Cambodia.

**IV. Romania**

**Background**
Romania has the highest maternal mortality ratio (58 per 100,000 live births) and infant mortality rate (19 per 1,000 live births) in Europe. The country has undergone several political upheavals in the last four decades. With each change in political system, there have been dramatic changes in the country’s population policies.

In the 1960s and up until 1989, the Ceausescu government tried to reverse the country’s population decline by introducing a strong pronatalist approach that strictly prohibited abortion. Further, FP services were severely restricted, and incentives were introduced to encourage women to have more children.

In the early 1990s, policymakers quickly lifted the restrictions on contraception and abortion and helped implement the nation’s FP program. More recently, the Romanian government developed a national RH/FP strategy and expanded access to modern contraceptive methods through cooperation with international development agencies. Although the contraceptive prevalence rate is 64%, the use of modern contraceptives only accounts for 30%.

In 2003, the National Strategy in Reproductive Health recognized that FP was “a major concern for the Romanian Government.” The Romanian MOH is responsible for the supply and distribution of contraceptives in the country. The Ministry distributes FP methods free of charge to the public, resulting in over 200 FP clinics distributing free contraceptives. Facilities report to the local health authorities and the MOH regarding contraceptive uptake. The MOH also requires that all medical staff be trained through a continuous medical education system. FP and PAC training recently have been added to the training curriculum.

In the last decade, considerable progress has been made in Romania in the field of RH/FP; however, much still needs to be done to counter misinformation on contraceptive methods. Few health personnel are trained in the provision of FP methods and the availability of modern contraceptives also is not adequate. While access to free contraceptives is available to a large segment of the population, the use of contraceptives among the disadvantaged population and those living in rural areas is low. Abortion is still the main method of fertility regulation for these

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populations. The number of abortions each year exceeds the number of live births.\textsuperscript{74} Although maternal deaths have fallen substantially, from 170 deaths per 100,000 live births in 1989 to 58 per 100,000 in 2000, complications from abortions still account for almost one half of women’s deaths related to pregnancy and childbirth.\textsuperscript{75}

**Needs Assessment**

Five focus groups were conducted with medical professionals and 77 semi-structured interviews were conducted with three OB/GYNs, 53 women (25 from urban areas and 28 from rural areas) and 21 male partners (10 from urban areas and 11 from rural areas).

One of the main findings was that misconceptions and myths surrounding modern contraceptive methods was the reason that prevented many couples from using them. This misinformation about contraceptives is propagated not only by the population but also by health professionals.

It was found that almost 50\% of the medical providers at primary health care facilities had been trained in FP and were distributing free contraceptives. Yet none of the OB/GYNs or nurses at the municipal hospital or the community nurses had been trained in FP. No initial supply of contraceptives in the abortion department is provided to women who have undergone abortions because the hospital and policlinic do not distribute free contraceptives. The survey also found that no postabortion counseling was provided at any level of the medical system. Women rarely, if ever, consulted their family doctors for FP after an abortion.

**Activities**

Based on the findings of the needs assessment as well as the situation encountered with the clients at the abortion departments, two main areas of intervention were designed:

1. Improve PAC counseling and FP service provision:
   a. Improve the PAC and FP counseling skills of medical providers through training sessions.
   b. Ensure access to FP services, including distribution of free contraceptives.
   c. Strengthen relations among different categories of medical providers to improve referrals and communications between different levels of providers.

2. Community involvement:
   a. Develop a comprehensive BCC materials package, including posters, brochures and other materials, to introduce PAC and FP concepts to the community.
   b. Train nurses to conduct BCC informational sessions.
   c. Launch a communications campaign about the dangers of abortion and the need for FP.

SECS trained service providers such as OB/GYNs, community nurses and family doctors in a number of training sessions on topics related to PAC and FP counseling (see Table 6).

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\textsuperscript{74} 1999 Romania Reproductive Health Survey. Center for Disease Control.

Table 6: Participants of Training Sessions

<table>
<thead>
<tr>
<th>Training Activity</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP: Basic Training</td>
<td>17</td>
</tr>
<tr>
<td>Optimal Birth Spacing Interval: Advanced Counseling</td>
<td>44</td>
</tr>
<tr>
<td>Myths and Management of Side Effects Related to Contraception</td>
<td>44</td>
</tr>
<tr>
<td>PAC Concepts</td>
<td>44</td>
</tr>
</tbody>
</table>

SECS held meetings with the local health authority to include the abortion departments at the municipal hospital and the policlinic as a part of the national network system for distribution of free contraceptives. Beginning in October 2004, free contraceptives were distributed from the municipal hospital and policlinic in Orastie.

At the end of the project, SECS held a national conference in Bucharest entitled “New Approaches in Reproductive Health: Optimal Birth Spacing Interval (OBSI) and PAC,” which presented the PAC project along with another project on OBSI funded by a separate CATALYST grant. Ninety-six participants attended the conference; these included health care providers, local authorities and international donors.

Results

SECS worked with the National Center for Post-Graduate Education of Health Providers to accredit providers who participated in the PAC trainings. The providers earned 30 credits for their participation in the 5 days of training.

Table 7: Indicators as Reported by SECS (November 2004 – June 2005)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of PAC clients who received services at the hospital</td>
<td>96</td>
</tr>
<tr>
<td>% of PAC clients who received FP counseling at the hospital</td>
<td>100%</td>
</tr>
<tr>
<td>% of PAC clients who received an FP method at the hospital</td>
<td>47.9%</td>
</tr>
<tr>
<td>% of PAC clients referred by the hospital to community nurses or health</td>
<td>100%</td>
</tr>
<tr>
<td>facilities</td>
<td></td>
</tr>
<tr>
<td># of PAC clients who interacted with family doctors</td>
<td>29.1%</td>
</tr>
<tr>
<td>% of the referred PAC clients who received FP counseling</td>
<td>100%</td>
</tr>
<tr>
<td>% of referred PAC clients who received an FP method</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Local Health Authority – Orastie, Romania

Seventeen nurses and one family doctor were trained in facilitative skills, the use of BCC materials and how to conduct informational sessions with the community. Once trained, nurses launched a campaign and held more than 100 informational sessions with 1,117 women from Orastie to inform them about contraceptives and the risks of abortion.

Challenges

Lack of time was a challenge that SECS faced throughout the implementation. The SECS teams continuously kept tight deadlines in order to complete all activities. SECS conducted several activities at the same time or back to back in order to meet their deadlines.
Privacy and confidentiality issues were a challenge at the beginning of the project when it was discovered that PAC clients were providing false contact information to the health facilities to avoid follow up with the community nurses at home. This indicated that despite the fact that abortions are legal in Romania, it is still highly stigmatized. Thus, the project activities had to be modified to change the focus from follow up at the home with community nurses to reaching out to PAC clients through providers, such as OB/GYNs, nurses and family doctors at the facilities.

SECS also had difficulty establishing communication links between the medical structures and health care providers.

One weakness of the NGO was its monitoring and evaluation skills. SECS encountered challenges in keeping track of health indicators. A substantial amount of TA was provided by CATALYST to strengthen these skills.

**Lessons Learned**

Involving community-based nurses in providing PAC and FP counseling is an effective way to increase awareness. Since these nurses are a part of the community, they are very familiar with the problems the population faces and are able to adapt to the groups they work with. They also are able to organize activities based on the community’s needs and reach larger numbers of people.

Working with service providers in the community created sustainability since these providers will remain long after the project ends. They will continue to provide information and services utilizing the skills that they have been taught. The service providers also can use their new skills to inform clients on other issues, not just those related to PAC.

**Conclusion**

Through provider training and dissemination of BCC materials to the community, SECS spread awareness on the dangers of abortion and repeat abortion and lifted misconceptions of FP methods. Involving the local health authorities also created incentives for sustaining the program’s achievements after the CATALYST grant was over. Involving other stakeholders to scale-up PAC activities resulted in a USAID-supported bilateral grant incorporating the PAC model. During the national conference in Bucharest held at the end of the project, a representative from John Snow Inc. stated that they have accepted the model and activities started by CATALYST and will be replicating them in other districts in Romania.

**V. Overall Challenges & Lessons Learned**

Delays were encountered throughout the entire project implementation with the three grantees due to the tight deadlines and the unexpected length of time it took to process paperwork. At the start-up, finalization of the grantees proposal as well as the transfer of the initial grant payments took more time than expected.

Lessons learned from these early delays are that adequate time must be set aside to receive approval from USAID missions, finalize proposals and allow time for the processing of grant award documentation. In general, once the grantees have been selected, it takes between two to three months before grants are officially awarded and funds transferred.
Regardless of the amount of experience the local NGO has in implementing projects with USAID, a certain level of TA from CATALYST is required to ensure that activities are done according to schedule. Close communications must be maintained with the grantees via email and telephone. This continuous communication and follow-up establishes where the project is moving and can allow for timely revisions to the activities as necessary. For future reference, it may be helpful to establish a regular means of communications and reporting with the grantees at the beginning of the project.

Due to the Mexico City Policy compliance, CATALYST was required to perform monitoring visits to the grantees and the project intervention facilities and sites. Funds had not been previously set aside for these trips since they became new requirements after the grants’ funding had been budgeted. CATALYST was able to combine technical visits to the grantees with the monitoring visits. If monitoring visits continue to be required to comply with the Mexico City Policy, it is highly advisable that separate funds be allocated for these visits.

Utilizing similar amounts of grant funding, Romania and Cambodia achieved very different interventions and results. In Romania, the project involved training of higher level health care providers. They were informed and educated on PAC and FP counseling and were able to counsel their clients on these issues within the town of Orastie. In Cambodia, the project worked with community level health providers and traditional health workers. Although not as highly trained as the health providers involved in the Romanian project, the community and traditional health workers in Cambodia were able to reach populations living in six ODs and inform them of PAC danger signs and messages. The differences in the health care workers involved as well as the populations reached with messages indicate the flexibility of utilizing grants to scale-up PAC. The use of different methods of intervention addressed the unique issues in the intervention areas. While misconception of FP methods and lack of understanding of the dangers of repeat abortion were the issues in Romania, underutilization of health facilities and misunderstanding the importance of receiving appropriate care were the problems in Cambodia.

VII. Conclusion

The PAC grants program achieved many of the objectives CATALYST had outlined. The grants allowed CATALYST to work with grantees in countries where the organization did not previously have a presence. The program also helped spread new, state-of-the-art technical information to the grantees and build their capacity. CATALYST also garnered further data and lessons learned on “community empowerment via community awareness and mobilization.”

CATALYST linked the target populations with community-level service providers and health institutions to foster greater lines of communication and awareness regarding PAC. Community members were informed of PAC issues and began to seek care from trained health professionals. FP counseling also was emphasized to help prevent unwanted pregnancies and repeat abortions. The grants in Cambodia and Romania reached sizeable populations through the dissemination of carefully produced BCC materials and the holding of information sessions with the community members. Approximately 342,166 community members were reached in Cambodia, while 1,117 women were reached with messages in Romania.
Table A: Coverage Area of PAC Community Project and Numbers of Providers Trained

<table>
<thead>
<tr>
<th>Province</th>
<th>RH or HCs</th>
<th># Villages</th>
<th>Total Pop.</th>
<th>WRA (26%)</th>
<th># TBAs Oriented in PAC</th>
<th># VHSG Oriented PAC</th>
<th># of HC Staff Oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kampot/ Angkorchey OD</td>
<td>1- Champey</td>
<td>15</td>
<td>15,827</td>
<td>4,115</td>
<td>9</td>
<td>28</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2- Dankom</td>
<td>9</td>
<td>10,094</td>
<td>2,624</td>
<td>3</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3- Tany</td>
<td>13</td>
<td>16,248</td>
<td>4,224</td>
<td>8</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4- Tropaingsala</td>
<td>10</td>
<td>9,726</td>
<td>2,529</td>
<td>3</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>5- Dambokpous</td>
<td>8</td>
<td>11,062</td>
<td>2,876</td>
<td>7</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Pursat/ Sampov Meas OD</td>
<td>1- Prey Nhy</td>
<td>21</td>
<td>13,430</td>
<td>3,492</td>
<td>9</td>
<td>36</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2- Sya</td>
<td>23</td>
<td>15,067</td>
<td>3,917</td>
<td>5</td>
<td>36</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3- Kampongloung</td>
<td>5</td>
<td>9,558</td>
<td>2,485</td>
<td>6</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4- Boeungkantout</td>
<td>27</td>
<td>15,888</td>
<td>4,131</td>
<td>17</td>
<td>52</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>5- Preknout</td>
<td>16</td>
<td>12,912</td>
<td>3,357</td>
<td>10</td>
<td>25</td>
<td>2</td>
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<tr>
<td></td>
<td>6- Samrong</td>
<td>14</td>
<td>11,428</td>
<td>2,971</td>
<td>12</td>
<td>24</td>
<td>2</td>
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<tr>
<td></td>
<td>7- Kravanh</td>
<td>17</td>
<td>19,247</td>
<td>5,004</td>
<td>11</td>
<td>31</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>8- Krokor</td>
<td>32</td>
<td>19,419</td>
<td>5,049</td>
<td>12</td>
<td>56</td>
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<tr>
<td>Battamban/ Mung Russey OD</td>
<td>1- Kakoh</td>
<td>7</td>
<td>10,816</td>
<td>2,812</td>
<td>11</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2- Kea</td>
<td>12</td>
<td>18,044</td>
<td>4,236</td>
<td>16</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>Siem Reap/ Siem Reap OD</td>
<td>1- Mondol Muy*</td>
<td>10</td>
<td>34,400</td>
<td>8,944</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2- Pouk</td>
<td>23</td>
<td>23,281</td>
<td>6,053</td>
<td>17</td>
<td>44</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>3- Banteysrey</td>
<td>18</td>
<td>14,732</td>
<td>3,830</td>
<td>17</td>
<td>12</td>
<td>1</td>
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<tr>
<td></td>
<td>4- Sarsarsdom</td>
<td>27</td>
<td>22,938</td>
<td>5,964</td>
<td>14</td>
<td>38</td>
<td>3</td>
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<tr>
<td></td>
<td>5- Roeul</td>
<td>24</td>
<td>21,304</td>
<td>5,539</td>
<td>21</td>
<td>32</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6- Korkdong</td>
<td>15</td>
<td>11,446</td>
<td>2,976</td>
<td>16</td>
<td>26</td>
<td>2</td>
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<tr>
<td></td>
<td>7- Chongkneas</td>
<td>7</td>
<td>5,327</td>
<td>1,385</td>
<td>6</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>8- Preah Dak</td>
<td>9</td>
<td>9,594</td>
<td>2,494</td>
<td>12</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>9- Doun Keo</td>
<td>13</td>
<td>11,711</td>
<td>3,045</td>
<td>14</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>Siem Reap/ Krolanh OD</td>
<td>10- Preychrouk</td>
<td>18</td>
<td>13,067</td>
<td>3,397</td>
<td>12</td>
<td>35</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>383</td>
<td>342,166</td>
<td>88,505</td>
<td>268</td>
<td>625</td>
<td>48</td>
<td></td>
</tr>
</tbody>
</table>

*Mondol Muy health center is located in the town of Siem Reap, therefore it does not have any TBAs or VHSGs.*
Table B: Knowledge of PAC Danger Signs (Baseline vs. Endline)

<table>
<thead>
<tr>
<th>Reported Signs of Spontaneous/Induced Abortion</th>
<th>WRA</th>
<th>TBA</th>
<th>VHSG</th>
<th>Midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BL N=4224</td>
<td>EL n=4217</td>
<td>BL n=13</td>
<td>EL n=88</td>
</tr>
<tr>
<td></td>
<td>EL n=27</td>
<td>EL n=2350</td>
<td>BL n=40</td>
<td>EL n=34</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Bleeding</td>
<td>53</td>
<td>75</td>
<td>71</td>
<td>93</td>
</tr>
<tr>
<td></td>
<td>60 *</td>
<td>91 *</td>
<td>92 *</td>
<td>88 ***</td>
</tr>
<tr>
<td>Fever</td>
<td>10</td>
<td>31</td>
<td>19</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>15 *</td>
<td>66 *</td>
<td>68 *</td>
<td>100 *</td>
</tr>
<tr>
<td>Lower abdominal pain / strong abdominal pain</td>
<td>20</td>
<td>29</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>30 *</td>
<td>58 *</td>
<td>71 *</td>
<td>82 *</td>
</tr>
<tr>
<td>Others(^{76})</td>
<td>10</td>
<td>24</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>7 *</td>
<td>11 **</td>
<td>10 *</td>
<td>9 ***</td>
</tr>
<tr>
<td>Don’t know</td>
<td>41</td>
<td>15</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>35 *</td>
<td>3 *</td>
<td>4 *</td>
<td>0</td>
</tr>
</tbody>
</table>

BL = Baseline; EL = Endline
* p < 0.01
** p < 0.05
*** Not statistically significant

\(^{76}\) Other danger signs reported include: swelling, dizziness, headache, membrane rupture, shivering, weight loss, shock, anemia, asthenia, body pain, bone pain, chest ache, chronic illness, convulsions, cold feet and hands, death, difficulty breathing, discharge, dyspnea, endometritis, fainting, heart failure, itchiness, leucorrhea, numbness, loss of memory, oedema, paleness, palpitations, stiff neck, unconsciousness, burning uterus, swollen uterus, waist pain, vaginal laceration, vomiting, and weakness.
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Dacă te întreiazi cu privire la planificarea familiei sau daca te îngrij ori daca trebuie să te-i îngrijori,
Arăta să găsești metode de contracepție pe care acestea să iată eficace.