



# **COMMUNITY-BASED FAMILY PLANNING**

## **KENYA ASSESSMENT**

**MINISTRY OF PUBLIC HEALTH AND SANITATION  
DIVISION OF REPRODUCTIVE HEALTH**

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The East, Central, and Southern African Health Community (ECSA-HC) has been working with its member states, including Kenya, to address issues related to expanding access to family planning. This assessment followed a process similar to that used by ECSA in leading assessments in four other member states (Malawi, Lesotho, Uganda, and Zimbabwe).

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## **LIST OF ABBREVIATIONS AND ACRONYMS**

AMREF	African Medical and Research Foundation
ANC	Antenatal Care
AOPs	Annual Operational Plans
CAPs	Community Action Plans
CBHC	Community Based Health Care
CBHIS	Community Based Health Information System
CBOs	Community Based Organizations
CHCs	Community Health Committees
CHEWs	Community Health Extension Workers
CS	Community Strategy
CUs	Community Units
DANIDA	Danish International Development Agency
DCH	Division of Child Health
DHMT	District Health Management Team
DMOH	District Medical Officer of Health
ECN	Enrolled Community Nurse
GoK	Government of Kenya
GTZ	German Development Cooperation
HSSF	Health Sector Services Fund
IEC	Information, Education and Communication
JICA	Japan International Cooperation Agency
KDHS	Kenya Demographic Health Survey
KEPH	Kenya Essential Package for Health
MDGs	Millennium Development Goals
MoMS	Ministry of Medical Services
MoPHS	Ministry of Public Health and Sanitation
NHSSP	National Health Sector Strategic Plan
PHASE	Personal Hygiene and Sanitation Education
PHC	Primary Health Care
PHTs	Public Health Technicians
PRST	Poverty Reduction Strategy Programme
TORs	Terms of Reference
UNICEF	United Nations Children's Fund

## **EXECUTIVE SUMMARY**

Community-based family planning (CBFP) is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b; universal access to reproductive health, including family planning (FP). This approach to expanding access to FP has emerged as a major goal in sub-Saharan Africa specifically, most recently in the March 2010 meeting among 12 African nations at Kigali. At the Kigali meeting, consensus among the participating countries was that CBFP should be the priority strategy for expanding access to FP to address unmet need and accelerating progress toward the MDGs. This emphasis on CBFP resonates with earlier calls for action in the region, including the Maputo Plan of Action and the 2009 International Family Planning Conference held in Uganda.

The East, Central, and Southern African Health Community (ECSA-HC) has been working with its member states, including Kenya, to address issues related to expanding access to family planning. This assessment, funded through USAID/Kenya and led by the Kenya MOH and FHI 360, followed a process similar to that used by ECSA in leading assessments in four other member states (Malawi, Lesotho, Uganda, and Zimbabwe).

In Kenya, the key informant interviews were conducted with 31 individuals during December 2010 and February 2011 and focus groups in five districts of the country (see Appendix 1). The interviews were conducted with Directors of Public Health and Medical Services at national and provincial levels, DHMT members, officials from nongovernmental organizations and United Nation agencies working in reproductive health, and members of Parliament in the health committee.

One of the larger countries in sub-Saharan Africa at 38 million, Kenya has made substantial progress to improve the reproductive health of its citizens in the last three decades. However, major challenges remain, including a growing youth population, high unmet need for family planning, high fertility rates, and high maternal mortality. Women in rural areas of Kenya have much higher rates of unmet need for FP, unintended pregnancy, and total fertility rates than do women in urban areas.

In general, unmet need for FP and total fertility rates have stagnated in recent years, especially in rural areas. While contraceptive prevalence overall has increased, the gap between current rates and the MDG goal remains very high, with steep increases in the coming years needed. With such a large rural population, more attention is needed on improving access to contraceptives in rural areas. This can provide the incentives that Kenya needs to build on the growing attention to linking family planning to development and other broad health issues.

The national FP guidelines (2010) stipulate the FP services that can be provided by CHWs. These services include counseling and provision of condoms (male and female), pills, Lactation Amenorrhea Method (LAM), and Standard Days Method (SDM) as well as counseling and referral for all other FP methods (including longer term methods such as

injectables, implants, IUCDs and permanent methods). Emerging global evidence from other African countries and elsewhere, as well as World Health Organization technical guidance, has documented the safety, feasibility and importance of provision of Depo Provera (DMPA) by trained CHWs as a way to increase access to family planning.

In 2006, the Division of Community Health Services developed a community strategy. The process involved phasing out the CBDs and recognizing the fact that CHWs will have a balanced curriculum to provide FP and MNCH services. As a part of the assessment process on which this document is reporting, the DRH's Community-Based Task Force approved a second document called, *Family Planning: An Important Element of a Minimum Package of Community-Based Services*. This document summarized the background, rationale, policy and framework for including FP into the minimum package of activities a CHW would provide (document attached as Appendix 2).

Section 4 of this report summarizes the findings from the key informants and focus groups, and Section 5 provides first person perspectives from the CHWs on key issues. That information combined with the desk review led to the seven recommendations listed here. Section 6 provides discussion on each of the recommendations.

1. Strengthen policies and guidelines.
2. Clarify and strengthen training and supervision.
3. Address issues related to sustainability and motivation.
4. Strengthen linkages and referrals with health centres.
5. Ensure continued supply of commodities.
6. Engage the community, including men.
7. Address those resisting CHWs with global and local evidence.

Both key informants and the CHWs themselves expressed concern about the issues listed here and had ideas about addressing them. This assessment shows that CBFP has clear benefits in improving access to family planning information and services. Therefore CBFP is a powerful tool for social transformation towards improved quality of life at the community level, including improvement in the contraceptive prevalence rate and the resulting impact on maternal and child health.

## **SECTION 1: INTRODUCTION**

Community-based family planning (CBFP) is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b; universal access to reproductive health, including family planning (FP). This approach to expanding access to FP has emerged as a major goal in sub-Saharan Africa specifically, most recently in the March 2010 meeting among 12 African nations at Kigali. At the Kigali meeting, consensus among the participating countries was that CBFP should be the priority strategy for expanding access to FP to address unmet need and accelerating progress toward the MDGs. This emphasis on CBFP resonates with earlier calls for action in the region, including the Maputo Plan of Action and the 2009 International Family Planning Conference held in Uganda.

Women in rural areas have a particularly high unmet need for family planning, especially during the postpartum period. A review of data from 27 Demographic and Health Surveys (DHS) found that 67 percent of women who gave birth within the previous year had an unmet need for family planning. One way to address this is through task sharing, which has been used successfully to address the critical shortage of medical professionals and to expand access to a range of health services. With task sharing, a concept endorsed by WHO, providers with less medical or paramedical training can deliver some of the same services with the same quality as providers with more training.

The East, Central, and Southern African Health Community (ECSA-HC) has been working with its member states to address issues related to expanding access to family planning. In 2008, the 46<sup>th</sup> ECSA Health Ministers conference adopted resolution HMC46/R4, which urged member states to address CBFP issues. The resolution called on member states to develop and implement policies, guidelines, and training curricula on task shifting among health care providers, so that non/less technical duties can be shifted from mid-level to lower-level cadre staff such as community based distributors of contraceptives. The resolution called for action by 2011, with the support of the ECSA secretariat.

To address this 2008 resolution, ECSA worked directly with the Ministry of Health in four member states (Lesotho, Malawi, Uganda, and Zimbabwe) to assess the current policies, guidelines, training materials, and implementation of CBFP. FHI 360 supported ECSA in that project with technical assistance. These assessments took place in Uganda in 2010 and the other countries in early 2011.

In Kenya, the Ministry of Health worked with FHI 360/Kenya to conduct a similar assessment, using the same interview instruments with key informants and focus group sessions and a similar reporting approach. The U.S. Agency for International Development (USAID) Kenya Mission supported this effort. The assessment was conducted through a Division of Reproductive Health working group, with FHI 360 providing technical assistance and working in collaboration with the other ECSA assessments. As one of the 10 ECSA member countries, Kenya's work on this topic will be referred to as part of the broad ECSA assessment project, with the important distinction of the different funding source and process

through the MOH. The Kenya assessment report includes this document and a companion short report: *Family Planning: An Important Element of a Minimum Package of Community-Based Services*.

The objectives of the five-country assessment were:

- To describe the degree to which national level policy and service delivery guidelines/standards facilitate the provision of quality FP at the community level
- To describe the challenges and opportunities in current community-level FP service delivery systems and how they could be improved to better serve the FP needs of underserved populations.
- To synthesize commonalities with regional application and identify opportunities for improved approaches to CBFP, in order to inform the development of recommendations on country and regional priorities for the improvement of CBFP programs.

The reports of each country's assessment includes material from two primary sources: 1) a desk review of related literature, including DHS data, policy documents, national guidelines, research studies, and program reports; and 2) qualitative input from key informant interviews and focus group discussions. The interviews and focus group discussions followed interview guides.

In Kenya, the key informant interviews were conducted with 31 individuals during December 2010 and February 2011 and focus groups in five districts of the country (see Appendix 1). The interviews were conducted with Directors of Public Health and Medical Services at national and provincial levels, DHMT members, officials from nongovernmental organizations and United Nation agencies working in reproductive health, and members of Parliament in the health committee.

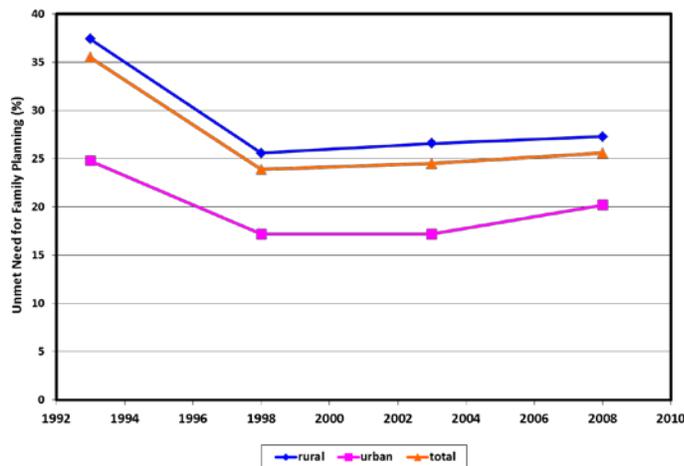
The focus group discussions were held with community health workers in five provinces to collect their views on the implementation of the community health strategy, challenges and lessons learnt. They were conducted in selected community units supported by partners namely UNICEF, FHI 360, EngenderHealth, JICA, and AMREF.

## SECTION 2: WHY COMMUNITY-BASED FAMILY PLANNING?

One of the larger countries in sub-Saharan Africa at 40 million, Kenya has made substantial progress to improve the reproductive health of its citizens in the last three decades. However, major challenges remain, including a growing youth population, high unmet need for family planning, high fertility rates, and high maternal mortality.

Women in rural areas of Kenya have much higher rates of unmet need for FP, unintended pregnancy, and total fertility rates than do women in urban areas. For more than a decade, the rate of unmet need for FP services has remained around 25% overall, with the rate a little higher in rural areas (see Figure 1).<sup>1</sup> In 2008, the contrast was 27% in rural areas, compared to 20% in urban areas. But rates were even higher in Nyanza province (32%) and Rift Valley (31%), and lower in Nairobi, North Eastern, and Central provinces (15-16%).

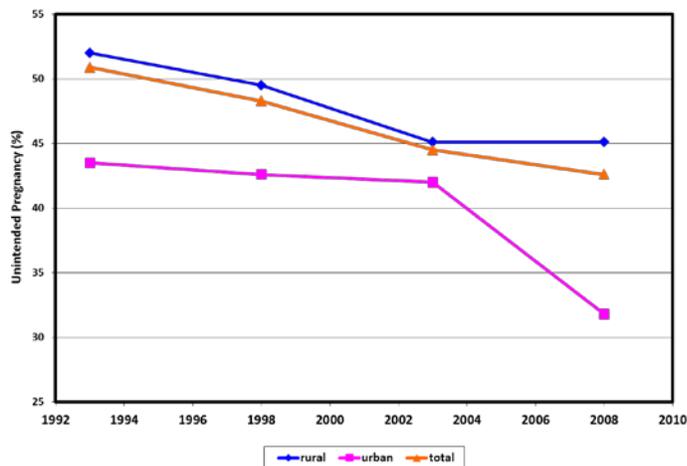
**Figure 1. Trends in Unmet Need for Family Planning**



Western province recorded the greatest improvement in unmet need, declining from 32% of married women in 2003 to 26% percent in 2009, while it increased considerably in Central and North Eastern provinces.<sup>2</sup> Married women with incomplete primary education have the highest unmet need for family planning (33%) compared with those with completed primary education (27%), no education (26%), and secondary and higher education (17%). Unmet need declines steadily as wealth increases, from 38% of married women in the lowest quintile to 19% in the highest quintile.

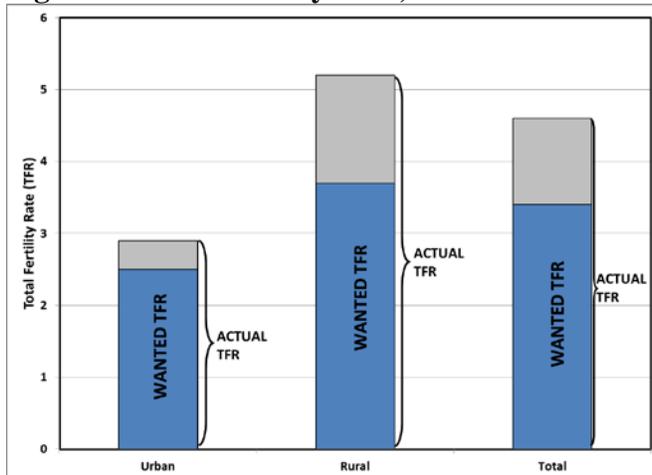
Unintended pregnancy rates in Kenya have declined from more than 50% in the early 1990s to about 42% in the latest DHS, with a 45% rate in rural areas (see Figure 2).<sup>3</sup> An unintended pregnancy is a pregnancy reported as either wanted later or not at all. If women who desired to space or limit their births had access to FP, 25% to 35% of maternal deaths could be avoided, including abortion-related mortality. Kenya's maternal mortality rate remains high at 488 deaths per 100,000 live births (KDHS).

**Figure 2. Unintended Pregnancy Trends in Kenya**



The recent Kenya DHS reports show a total fertility rate (TFR) decline from 6.7 in 1992 to 4.6 in 2009 (see Figure 3), the lowest recorded. However, the rate has been relatively stagnant since the mid-1990s. The TFR declined from 8.1 in the mid-1970s to 4.7 in the mid-1990s. The rate is much higher in rural areas, more than 5 per women compared to fewer than 3 children per woman in urban areas.

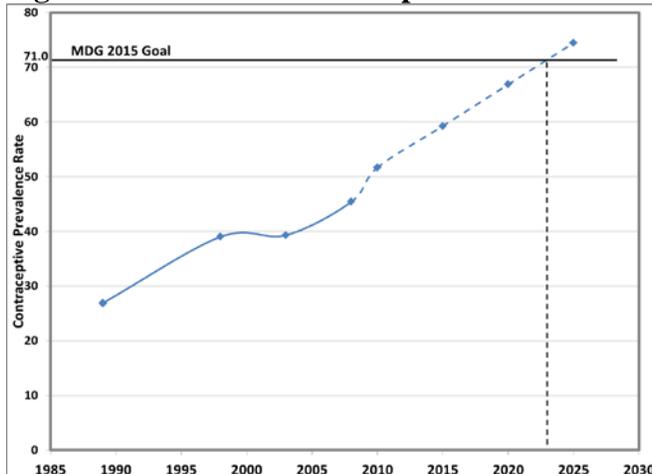
**Figure 3. Total Fertility Rate, Wanted versus Actual, Kenya, 2009**



The latest Kenya DHS (2006) reports a 39% contraceptive prevalence rate (CPR) for modern methods (including condoms) among married women of reproductive age. Another 7% use traditional methods. Of the modern methods, injectables are the most widely used. Use of male condoms is particularly high among sexually active, unmarried women. The use of

modern contraception by married women in Kenya has increased about 50% in the last 15 years, from under 30% in 1990 to about 45% in 2009.<sup>4</sup> But to achieve the Millennium Development Goal (MDG) for family planning by 2015, Malawi's CPR needs to rise to about 70% (see Figure 4). The CPR in Kenya would have to continue to rise at a steep rate to reach the MDG target, even by 2024.<sup>5</sup>

**Figure 4. Trends in Contraceptive Prevalence Rate (Married Women, All Methods)**



In Kenya, according to the 2009 KDHS, public (government) facilities provide contraceptives to more than half (57%) of modern method users, while private medical sources supply 36%, and other sources supply 6%. The WHO recommends that the health workforce (doctors, nurses, and midwives) ratio be at least 2.5 health workers per 1000 population to make progress on global health goals like the MDGs. The ratio in Kenya is 0.14 health workers per 1000 population, well below the 2.5/1000 threshold.

In general, unmet need for FP and total fertility rates have stagnated in recent years, especially in rural areas. While contraceptive prevalence overall has increased, the gap between current rates and the MDG goal remains very high, with steep increases in the coming years needed. With such a large rural population, more attention is needed on improving access to contraceptives in rural areas. This can provide the incentives that Kenya needs to build on the growing attention to linking family planning to development and other broad health issues.

### **SECTION 3: POLICIES, GUIDELINES, AND STRATEGIES**

Communities are at the foundation of affordable, equitable, and effective health care, and are the core of the Kenya Essential Package for Health (KEPH) proposed in the second National Health Sector Strategic Plan 2005– 2010 (NHSSP II). This strategy document sets out the approach to be taken to ensure that Kenyan communities have the capacity and motivation to take up their essential role in health care delivery. It discusses the norms and services at level one, including the need for supportive supervision and a communication strategy among other issues. The strategy outlines that the community health worker (CHW) will provide family health services to expand FP, maternal, child, and youth services. The CHWs would also be involved in disease prevention and control to reduce morbidity, disability, and mortality through environmental sanitation, safe water supply and good personal hygiene.

The national FP guidelines (2010) stipulate the FP services that can be provided by CHWs. These services include counseling and provision of condoms (male and female), pills, Lactation Amenorrhea Method (LAM), and Standard Days Method (SDM) as well as counseling and referral for all other FP methods (including longer term methods such as injectables, implants, IUCDs and permanent methods).

Emerging global evidence from other African countries and elsewhere, as well as World Health Organization technical guidance, has documented the safety, feasibility and importance of provision of Depo Provera (DMPA) by trained CHWs as a way to increase access to family planning. A recently completed pilot project in Tharaka District, Eastern Province has generated Kenyan evidence that confirms the global evidence. The Division of Reproductive Health is exploring options for creating a policy environment that will allow provision of DMPA at the community level. This strategy will expand the range and options of services available to women.

In the past, Community Based Distributors provided information about FP as well as pills and condoms. Now, the approach to CBFP is shifting so that the CHWs incorporate FP into the larger array of services they provide. This shift is documented in recent national documents, including:

- Taking the Essential Package for Health to the COMMUNITY: A Strategy for the Delivery of LEVEL ONE SERVICES
- National Family Planning Guidelines for Service Providers: 2010
- Job aids including FP checklists for ruling out pregnancy and combined oral contraceptive (COC) pills
- CHW revised training manual
- Community Health Workers' Standard Referral Form

In 2006, the Division of Community Health Services developed a community strategy. This process involved phasing out the CBDs and recognizing the fact that CHWs will have a balanced curriculum to provide FP and MNCH services. As a part of the assessment process on which this document is reporting, the Technical Working Group approved a second

document called, *Family Planning: An Important Element of a Minimum Package of Community-Based Services*. This document summarized the background, rationale, policy and framework for including FP into the minimum package of activities a CHW would provide (document attached as Appendix 2).

This assessment found that generally, a CHW reports to a community health extension worker (CHEW), who in turn reports to the District Health Management Team (DHMT). Some person interviewed reported that the CHWs integrate FP messages with HIV/AIDs since initially they were trained to offer home based care services. The community strategy is in the process of consolidating the duties of what have been the CBDs, home-based care providers, and those providing TB and other services.

The CHWs in the focus group discussion mentioned providing the following duties:

- Create awareness on FP methods and services
- Promote health seeking behaviour, including to encourage pregnant mothers to seek antenatal services and HIV testing services, to remind them to take their children for immunization, and to advise mothers on breast feeding
- Provide education on environmental hygiene (boiling drinking water, using pit latrines, proper waste disposal, use of insecticide treated nets to prevent malaria), nutrition, and safe sex for youth who do not abstain from sex
- Provide education on other issues such as PMTCT
- Provide FP methods such as pills and condoms
- Carry out home based care including TB defaulter tracing
- Make referrals to health facilities including for FP methods not provided by the CHW such as DMPA, implants, IUCD; for HIV counseling and testing; and for other health issues including child health clinic, ante and postnatal care, diarrhea, malaria and other illnesses.
- Most participants reported using a referral form to ensure effectiveness

All of those interviewed in the assessment said they appreciated the role played by the CHWs. As one said, “If someone can bring commodities just next to the door you are more likely to use it, more likely to engage with him than when it is at a health centre that’s five km away and you may not make an effort to go there. And when you go there you even find workers are overwhelmed.”

## SECTION 4: ASSESSMENT FINDINGS

This section synthesizes information obtained during the key informant interviews and focus group discussions. The material is grouped according to challenges to CBFP and responses to those challenges.

### Challenges to Community-Based Family Planning

A wide range of challenges arose during the assessment that could hinder the adoption of CBFP. These include the following areas.

***Low motivation of CHWs and reduced retention rate.*** Although the CHWs undertook their responsibilities with an understanding that it was on a voluntary basis, they had their own expectations regarding rewards and incentives that should be provided by the programme. They reported that voluntarism was quite challenging given that some of them are breadwinners. Also, the young and better educated people are not as willing to engage in voluntary work, are mobile and less committed as they are looking for jobs. Hence, when they are CHWs, they have higher rates of attrition. CFP could be hampered by inadequate government commitment in terms of resource allocation towards supporting any payments for the community health workers.

***Weak community based health system.*** The community health system is not well structured and there is lack of data collection materials. Hence, timely collection and delivery of information to the higher levels of the health system is delayed.

***Resistance by some health staff.*** Health facility staff expressed resistance to some aspects of CBFP services, especially the nurses, who are opposed to using the CHWs to providing injectables. The nursing council in particular favors increased use of nurses to provide injectables, rather than CHWs.

***Lack of harmonized FP focused training.*** The CHWs have been undergoing different types of training modules by partners based on their particular project needs, including nutrition, home based care, HIV/AIDS, FP, or maternal and child health.

***Limited logistical support.*** A limited supply of logistical resources was evident such as bicycles, umbrellas (during rainy seasons), bags, identification materials (badges), CHW kits and IEC materials.

***Lack of male involvement with FP in general.*** FP programs have focused mostly on women and left out men who are the main decision makers. Meanwhile, many men in the community are opposed to the use of family planning, the assessment respondents said. Consequently, many women secretly use FP. In Korogocho slums for example, a respondent said, most women resort to hiding contraceptives to avoid the wrath of their husbands. The lack of male support affects the CHWs as well as the clients. As a female CHW from Siaya said, “The most hurting thing is that men despise our work. The community looks down upon us,

especially some men of the homesteads. When we do home visits to talk to them they feel like whatever we are talking about is not important to them.”

***Weak policy implementation.*** Implementation of CBFPP often does not match what the policies say. For example, supervision is still weak. Further, lack of clear guidance from the community strategy makes each partner to implement activities in the way they choose and from experience.

***Inadequate financial resources.*** Community family planning requires a huge financial base to ensure uninterrupted supply of commodities and human resources. Even though the supply chain is clear, there are frequent stock-outs of some commodities. Although the government has increased resource allocation for FP commodities, there is still the need for donor support to fill the remaining gap.

***Cultural and religious diversities.*** Certain myths about FP are still rampant and can undermine efforts geared towards expanding access to services. Several examples are in Section 5, where the CHWs report on these in their own words. Also, some groups in Kenya support having many children, which does not allow for family planning. Some religions do not support all methods of family planning and in most cases; these are the more effective FP methods. The wakorino sect, for example, does not promote FP methods or delivering in hospitals among their members. Another concept called Turkana supports continuing pregnancies “until all the children are exhausted from the stomach.” Finally, some politicians argue in favor of an *increased* birth rate so as to attract enhanced national resource allocation to their constituents.

## **Opportunities for Community-Based Family Planning**

***Community participation.*** Because CHWs are drawn from the communities that they serve, the level of community participation in the program is high, respondents said. CHWs are selected because they are well respected, informed, and often lead a community group. With good messaging and training, and when they are themselves users, they are well received by their communities. The participatory approach outlined in community strategy can help ensure that the communities sustain the program. “Sustainability can be achieved if community ownership is promoted,” said one informant. “The Community Health Strategy is a flagship of vision 2030, but resources were not put there.”

***Support CHW retention, motivation, and sustainability.*** The Division of Community Health Services has proposed a payment of Ksh 2000 per CHW per month. This payment being proposed is not a salary but a token /stipend to the CHW as a sign of appreciation of their work . The importance of this was reiterated by a key informant: “The government should think of how to raise or improve the career of CHWs, which can be a motivation. Supervision of CHWs becomes a challenge because there is no incentive. What messages can you give if you don’t find a CHW at their place of work? How can you reprimand/ask them for results without any incentive to motivate them?”

Others ways of compensating and motivating CHWs were discussed, including:

- Sustainability of compensation of CHWs should be through community ownership, said an informant. “They have to see that it is a service for them and come up with systems to award CHWs, such as income generating activities.”
- Monthly remuneration for CHWs is needed under the Community Health Strategy.
- The culture of volunteerism has to be dealt with because it is not working well.
- Communities could train CHWs on other areas of livelihoods, involving income generating activities, perhaps linked with microfinance projects. They could link CHWs to financial institutions for loans to fund their businesses.
- In innovative income activities, funds generated within the community could be managed by a funding court and not owned by the government as such, but be owned by the people from that area to help sustain the CHWs.
- Selecting CHWs according to the community strategy is important, with the ones working to be remunerated reasonably.
- CHW selection should focus on those who are more likely to be committed and not leave for other job opportunities, like talented youth who have just finished school.
- Providing recognition, such as certificates of merit.
- Recognizing the champions and rewarding best practices and innovative approaches by way of trophies
- Organizing exchange programs so that they can learn from each other

***Involve men, couples.*** Participants pointed out the importance of CBFP trying to involve men in discussing contraception. A couple needs to discuss the FP issues and make a joint decision, informants said.

***Sustain CHW programs in the health system.*** Here are key points that arose in interviews.

- Representatives of the MoPHS indicated that measures have been put in place to enhance sustainability including forged linkages between existing government and community units through the community strategy, the public health medical technicians, and the district health management team.
- Capacity building through the training of CHEW, CHWs, and community health committees on more methods of family planning will ensure continuity of the CBFP activities. For example, CHWs can be trained to provide DMPA. Also, nurses and clinical officers could be trained to provide vasectomy and tubal ligation. Refresher trainings should also be provided.
- Regular monitoring and evaluation by MoPHS through DRH as well as all partners and stakeholders can help ensure that the community units continue accessing support from the Government.
- Activities need to main streamed within sustainable community unit structures such as the national health system. This will help through actual provision and allocation of resources to run the unit without relying on external donors or partners’ support.
- The health sector strategic fund (HSSF) for performance could be used to reward the facility that performs better, so that they are reimbursed with funds to be used for demand creation.

***Partners support CBFP.*** The assessment revealed that there are many partners who are willing to support CBFP, including UNICEF, AMREF, NCAPD, GTZ, and others.

***Champions can help.*** The best ways of engaging those who oppose CHWs providing FP services is to identify champions at all levels (community, health facility, and local administrators) to reach out to all community members, using available local structures.

This assessment shows that CBFP has clear benefits in improving access to family planning information and services. Therefore CBFP is a powerful tool for social transformation towards improved quality of life at the community level, including improvement in the contraceptive prevalence rate and the resulting impact on maternal and child health.

At the same time, both key informants and the CHWs themselves expressed concern about a number of issues and had ideas about addressing them. These include issues related to policies and guidelines, training and supervision, motivation and sustainability, and linkages with health centres. The next section provides some of the CHWs thoughts in their own words, and the report concludes with recommendations.

## **SECTION 5. IN THEIR OWN WORDS: CHWs SPEAK**

*As part of the assessment, focus groups were held in five different provinces with CHWs (see Appendix 1). The summary below is in the words of the CHWs from these discussions.*

### ***What type of problems to the CHWs face?***

Husbands say that giving birth is a blessing from God so their wives should give birth. Their husbands bring up issues like, they might forget to take the pills, injection makes one bleed throughout, or sex is no longer interesting.

We have problems in the community when we are teaching people about family planning. There is this household I went to that a woman had a three-month old baby. I informed her of family planning and breastfeeding, together with the husband. After giving them the information the man refused and said not in my home, because his wife will be cold.

### **What do CHWs think about sustainability, incentives, and training?**

For sustainability, CHWs should be paid some money to motivate them. There should also be the provision of the commodities in adequate amounts to avoid stock-outs. We should also be allowed to give more methods such as injectables.

To keep the programme going, CHWs should be remunerated so that they keep teaching, should be given transport bikes and uniforms, and be trained more. The CHWs should also be given kits that are fully equipped with commodities. And, we need more CHWs to reduce burnout caused by being overworked.

We should be trained a lot on family planning and at least be shown videos so that it shows the importance of FP and at least see the side effects in the video. We need refresher courses for our community.

## SECTION 6: RECOMMENDATIONS

This assessment leads to seven key recommendations to expand access to FP through community based services.

1. ***Strengthen policies and guidelines.*** Respondents recognized that while guidelines and strategies exist to guide provision of CBFP, these need to be strengthened and clarified. For example, the community strategy supports provision of FP at the community level but the strategy needs to be clearer on what range of FP services CHWs ought to provide.
2. ***Clarify and strengthen training and supervision.*** Discrepancies exist between the content of training for CHWs by different partners who have different programme goals and objectives. Equip the CHWs with more knowledge and information on family planning, covering how FP methods work, their advantages and disadvantages, and other information. This can be done through the inclusion of a separate FP module in the CHW Manual.

In addition, the current structure of reporting presents challenges. Most CHWs are supervised by the CHEW, who in turn reports to a selected member of the DHMT. But the CHWs in this assessment generally reported they were not being visited by the CHEW due to lack of transport. Others reported minimal visits. CHWs should be visited at least four times in a year by the right cadre (i.e., CHEW) to ensure provision of quality services.

3. ***Address issues related to sustainability and motivation.*** Successful implementation of CBFP requires more attention to sustaining and motivating CHWs. A number of options for ensuring sustainability should be explored and recommended within the policy to allow for flexibility. Suggestions that arose in the assessment included:
  - Paying CHWs and developing some system of sustaining the remuneration system. Some programmes implemented outside of the public sector funding have structured remuneration packages for their CHWs that have had positive outcomes.
  - Provide incentives such as bikes and uniforms
  - Explore non-monetary incentives such as initiating income generating activities.
  - Provide performance based incentives.
  - Provide non-financial incentives such exchange tours, badges, recommendations letters, and certificates of attendance.
4. ***Strengthen linkages and referrals with health centres.*** A standard referral form should be used to track referrals. CHWs currently refer clients for long-term and permanent methods, including injectables, to the nearest health facility. They are supposed to use a form to track the referrals. However, some providers do not recognize the forms, so referred clients are not adequately supported.

5. ***Ensure continued supply of commodities.*** Issues related to stock outs go beyond the CHW and CBFP delivery system, including good coordination within the overall supply chain. Without commodities, CHWs cannot provide FP services effectively.
6. ***Engage the community, including men.*** The greater the community participation in supporting the CHWs and provision of FP, the greater chances of success. This approach includes discussing FP among men's groups in villages and supporting conversations about FP with couples. Open discussions can help address myths and can approach the positive angles of having more money to keep children in school and provide a better life for all family members.
7. ***Address those resisting CHWs with global and local evidence.*** Some sectors, particularly nurse advocacy groups, resist CHWs providing injectables in particular. Scientific evidence shows that CHWs can provide injectables safely and effectively, with high acceptance by women and the community. This can expand access to FP and hence lead to fewer maternal deaths and abortions and support better MCH indicators as well as other Millenium Development Goals. At the same time, recent experience in Kenya has found that unemployed nurses do not seek employment in the rural areas where CHWs work. Moreover, nurses can and should be involved in supervising CHWs through the district health office.

## Annex 1. Districts Selected for Focus Groups and Key Informants

In the districts below, both focus groups and key informant interviews were conducted.

District	Province	Community Unit
Siaya	Nyanza	Sega
Nakuru	Rift Valley	Kaptebwo
Naivasha	Rift Valley	Karunga
Taita	Coast	Mwatate
Kibwezi	Eastern	Kalii

### Key Informant Interviews

1. Dr Annah Wamae Head, Department of Family Health
2. Dr. Shiprah Kuria Head, Division of Reproductive Health
3. Dr James Mwitari Head, Division of Community Health Services
4. Dr Rono PMO , Rift Valley
5. Dr Onditi DMOH, Siaya
6. Dr Gerald Munga DMOH, Gilgil
7. Mr Wangi DDPHO, Nakuru
8. Constance Mwandaso District CS FPP, Wundanyi
9. Mr. Ngatia Karugu Manager Program Coord. and Monitoring, NCAPD
10. Dr Chris Ouma Head, Health Section, UNICEF
11. Dr Stephen Seif Wanyee Assistant Representative, UNFPA
12. Dr Lawrence Mbae Deputy Director, PSI
13. Dr. Othigo Jennifer Provincial RH Coordinator, Coast Province
14. Dr. Simiyu Maurice PDMS - PGH
15. Dr Makumi Pathfinder International
16. Dr. Victor Wanjui DMOH, Kibwezi
17. Dr. David Simiyu Eseli MP, Kimili, Parliament
18. Dr Nancy Kidula Jphiego
19. Mercy Wahome EngenderHealth
20. Wendy Cherop DPHN, NAKURU
21. Dr. Joyce Lavussa WHO
22. Dr. Solomon Marsden Reproductive Health Advisor, FHI 360
23. Paul Kuria Country Manager, M&E, APHRC
24. George Kahuthia AED
25. Dr. Patricia Odero GTZ
26. Dr Caroline Tatua FHOK
27. June Omollo PATH
28. Pharis Nkari Division of Health Promotion
29. Dr. Jona Mwangi Maina Program Manager, Department of Family Planning
30. Mr. Peter O. Ofware AMREF
31. Zebedee Mkala DSW

## **Annex 2. Family Planning: An Important Element of a Minimum Package of Community-Based Services**

### **1.0 Background and Rationale**

The family planning program in Kenya is characterized by a low contraceptive prevalence rate (CPR), high unmet need for family planning and a total fertility rate of 4.6 births per woman according to the 2008/09 Kenya Demographic and Health Survey (KDHS). In addition, the maternal mortality rate is high and a substantial proportion of births are either unwanted or mistimed. Against this background, interventions to improve knowledge of and access to contraceptive methods can have a significant impact on the reproductive health outcomes of women in Kenya.

Over 70 percent of Kenya's population live in underserved rural areas, thus many women do not have adequate access to family planning services. For this reason, there is need to develop innovative methods to bring family planning services to rural communities. Community health workers (CHWs) are an important mechanism for expanding contraceptive distribution in these communities. Indeed, the role played by the CHWs is critical and appreciated by the community as described by a key informant:

*If someone can bring commodities just next to the door, you are more likely to use it, more likely to engage with him than when it is at a health centre that's 5 km away. You may not make an effort to go there. And, when you go there, you even find workers are overwhelmed".*

A series of major international, regional, and Kenya meetings have focused on how family planning can assist in addressing broader development goals. These include the International Conference on Family Planning convened in Kampala, Uganda in 2009, a follow on meeting held in Kigali, Rwanda in 2010, and a national leaders conference on population and development held in Nairobi in 2010. Following these meetings, Kenya has increased efforts to build the capacity of the community to provide basic health services including family planning. Initial steps taken include review and revision of the community strategy as well as the CHW national training curriculum. Further, Kenya has set a target of increasing the CPR from 46 to 56% by 2015. Every effort is needed to achieve this goal. Hence, developing a framework within which the CHW will provide family planning services can provide an essential element to increase access to contraception, avert unintended pregnancies and reduce maternal mortality.

### **2.0 Policy Framework**

Communities are at the foundation of affordable, equitable and effective health care, and are the core of the Kenya Essential Package for Health (KEPH) proposed in the second National Health Sector Strategic Plan 2005– 2010 (NHSSP II). This strategy document sets out the approach to be taken to ensure that Kenyan communities have the capacity and motivation to take up their essential role in health care delivery. It discusses the norms and services at level 1, including the need for supportive supervision and a communication strategy among other

issues. The strategy outlines that the CHW will provide family health services to expand FP, maternal, child and youth services. The CHWs would also be involved in disease prevention and control to reduce morbidity, disability and mortality through environmental sanitation, safe water supply and good personal hygiene.

The national FP guidelines (2010) stipulate the FP services that can be provided by CHWs. These services include counseling and provision of condoms (male & female), pills, Lactation Amenorrhea Method (LAM), and Standard Days Method (SDM) as well as counseling and referral for all other FP methods (including longer term methods such as injectables, implants, IUCDs and permanent methods).

Emerging global evidence from other African countries and elsewhere, as well as World Health Organization technical guidance, have documented the safety, feasibility and importance of provision of Depo Provera (DMPA) by trained CHWs to increasing access to family planning. A recently completed pilot project in Tharaka District, Eastern Province has generated local [Kenyan] evidence that confirms the global evidence. It is worth exploring scaling up this approach and creating a policy environment that will allow provision of DMPA at the community level. This strategy will expand the range and options of services available to women.

### **3.0 Family Planning as Part of a Minimum Package of Community Services**

This document provides a framework for the implementation of family planning services at the community level. It describes the FP services and the supportive structures /systems that must be in place at the community level for FP service provision. It highlights the current policy environment and recommends the actual services that should be provided by a CHW; the supportive structures; and the supportive/reference materials that will enrich the quality of services provided.

This package was mainly informed by an assessment of the current FP situation recently conducted by the Division of Reproductive Health (DRH) and Division of Community Strategy of the MOPH&S, supported by FHI 360, with additional guidance from other regional and global community FP models. Providing guidelines for provision of community-based family planning (CBFP) is essential to assure that key players provide similar and harmonized services.

#### **3.1 Family Planning Services provided by Community Health Workers**

The basic functions of the CHW are broadly categorized as advocacy and service delivery. Advocacy activities involve creation of awareness about FP among community members. This includes advocacy for FP and making referrals to health facilities for FP methods that the CHW cannot provide. Service delivery activities mainly involve actual provision of FP methods. Education activities can be incorporated into both advocacy and service delivery. The following specific duties should be undertaken by the CHW:

- 1) Provision of information and/or education;

- 2) Provision of prescribed FP methods;
- 3) Referrals for other methods.

### **3.1.1 Provision of Information and/or Education**

CHWs need to be adequately trained to provide information on all FP methods so that they can address the rumors and myths that still exist and also refer as appropriate. Provision of information and/or education includes:

- Create awareness on FP methods and services
- Advocate for FP
- Counsel clients on all FP methods

### **3.1.2 Provision of Family Planning Methods**

The following FP methods should be provided by the CHW:

- Condoms (both male and female)
- Pills
- Lactation Amenorrhea Method (LAM)
- Standard Days Method (SDM)
- Injectables/DMPA (in selected regions building on a successful 2009-10 Kenyan pilot, per policy changes)

### **3.1.3 Referrals and the Referral System**

CHWs should refer clients for FP methods that they do not provide. These include the following:

- Injectables/DMPA (in areas where policy does not allow for provision)
- Implants
- IUCD
- Female and male sterilization

A referral form should be used to increase the effectiveness of referrals. (Note: MOH has a standard referral form for CHW which is provided in the appendix.) It is imperative that linkages between the CHW and the health facilities are strengthened to achieve an effective referral system. (NOTE: CHW should also refer clients when they are in doubt. Also, a community desk can be established at the health facility to manage referrals and to strengthen community and health facility linkages.)

***NOTE: WHERE THEY EXIST AND ARE TRAINED IN FP, MIDWIVES (NURSES) BASED WITHIN THE COMMUNITY CAN ALSO PROVIDE COMMUNITY-BASED FP SERVICES WHICH SHOULD INCLUDE ALL THE ABOVE MENTIONED FP SERVICES AS WELL AS PROVISION OF DMPA.***

The array of services provided above is in line with the provisions of the community strategy as well as the *National FP Guidelines for Service Providers*. According to these two

documents, CHWs provide information for all FP methods and further provide selected methods and refer for the rest as discussed above.

It is important to note that the services prescribed above are specific to FP. How this fits into the broader duties of the CHW is an area that needs to be explored further and additional evidence provided on whether one CHW is able to provide the broad range of health services at the community or whether there is need for specialized CHWs.

## **3.2 Supportive Structures/Systems**

### **3.2.1 Support Supervision**

The CHW should report to the Community Health Extension Worker (CHEW) and obtain the necessary support including restock of supplies and commodities. The CHEW should in turn be answerable to the District Health Management Team (DHMT). This supervision structure is well defined in the community strategy. (*Refer to “Taking the Essential Package for Health to the COMMUNITY: A Strategy for the Delivery of LEVEL ONE SERVICES.”*)

Support supervision is key to ensure provision of quality services. It, therefore, needs to be strengthened to ensure the necessary support to CHWs including a constant supply of commodities.

The recent CBFPS situational analysis identified a weak supervision system. This critical area needs further exploration and additional strategies/suggestions are needed to strengthen support supervision for CHWs. Use of a standard supervision checklist is one recommended strategy.

## **4.0 Community Health Worker Training**

The National CHW Training Curriculum provides an outline for the training that CHWs should undergo and it contains a module specific to FP. However, there is need to refer to other appropriate FP resource to provide additional content to enrich CHW FP training and skills. In line with the training curriculum, the following FP content should be covered during training:

- *Basic content:* Benefits of family planning, things to consider before initiating FP, signs of pregnancy, available FP methods, use of the FP choice checklist, and importance of adherence to FP methods
- *Method-specific information:* For each family planning method, discuss what the method is, who can use, who cannot use, non contraceptive benefits , advantages, disadvantages, effectiveness and how to use as well as problems that can be encountered
- *FP and HIV:* Appropriate use of FP in the context of HIV and dual protection
- *Counseling:* Provide definitions of communication and counseling, discuss benefits of counseling and the counseling process
- *Misinformation:* FP rumors and misconceptions

- *Logistics:* Commodity supply chain
- *Record keeping:* Overview of community based health information system
- *Supervision:* Supervision and reporting structure as defined in the community strategy.

### **5.0 Supportive Reference Materials**

- Taking the Essential Package for Health to the COMMUNITY: A Strategy for the Delivery of LEVEL ONE SERVICES
- National Family Planning Guidelines for Service Providers: 2010
- Job aids including FP checklists for ruling out pregnancy and combined oral contraceptive (COC) pills
- CHW training manual [Revised]
- Community Health Workers' Standard Referral Form
- Information, education and communication (IEC) materials

### **5.0 Conclusions**

This document provides a framework for CHW provision of a minimum set of FP services including the supportive systems that need to be in place. It also acknowledges the variety of supportive reference materials available to build the capacity of the CHWs to provide quality FP services. It is the hope of DRH that this minimum package will become the standard reference document to ensure uniformity of FP service provision among various programs.

## Endnotes

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<sup>1</sup> MEASURE DHS. STAT Compiler. Available from: <http://www.statcompiler.com/>

<sup>2</sup> KDHS 2008-09

<sup>3</sup> MEASURE DHS. STAT Compiler. Available from: <http://www.statcompiler.com/>

<sup>4</sup> MEASURE DHS. STAT Compiler; Moreland S, Smith E, Sharma S. *World Population Prospects and Unmet Need for Family Planning*. (Washington, DC: Futures Group, 2010). Available from: <http://www.futuresgroup.com/wp-content/uploads/2010/04/World-Population-Prospects-and-Unmet-Need-for-Family-Planning.pdf>

<sup>5</sup> The data from 1992, 2000, and 2004 come from the DHS, while the data from 2006 come from the 2006 Malawi Multiple Indicator Cluster Survey. The data on the dotted line comes from the modeling of the study by Moreland et al, which used two key assumptions to calculate the projected CPR for married women: 1. The total CPR and the CPR for married women will change at the same rate; 2. The proportion of married and unmarried women stays constant over time.

