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AN ASSESSMENT REPORT
FOR THE KABIRO KAWANGWARE
HEALTH CARE OUTPOST
CBD PROJECT

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1. EXECUTIVE SUMMARY

The Kabiro Kawangware Health Care Outpost CBD Project has been active since 1980. The Project serves Kawangware, one of the largest slum populations in urban Nairobi. It is truly community based with a management structure including community members and the use of community resources to build the current facilities. The Project has been through a number of serious personnel changes and has had problems with funding. Currently, the Project is funded by the GOK Treasury through NCPD, which has been unable to get payments of grant funds to Kabiro, among other CBD projects. As a result of these personnel disruptions and breaks in support, the Project has had problems maintaining continuity in services.

The Assessment was done by a team representing USAID, and the Government of Kenya. The Assessment was done to provide the required end of project review and a basis for new project development. Interviews were done with project management staff, CBD workers, and Board members at the Project's clinic site in Kawangware. Fieldwork was done in April 1992. The focus of the Assessment was to review current operations in order to provide guidelines for improved and expanded family planning services.

In general, the Assessment Team found a good CBD project with considerable potential for expansion. The funding problems and personnel changes have caused considerable laxity in operations which the Project must immediately address. CBD workers are under-producing and are clearly not aggressive in seeking clients. Not surprising, given the fact that they often go four to five months without being paid. The Project must get the workers active and attempt to penetrate the hard-to-reach segments of the community. They must also work to achieve a better method mix. If workers can not be motivated, some should be released and replaced with workers who are not hindered by the past problems of the Project.

More specific findings include:

- The active management of the Project by the community provides stability and increases the potential for expansion.
- Basic operational systems are in place and appear to be working fairly effectively. Documentation of these systems would help in future assessments and could prevent most of the personnel transition problems experienced in the past.
- It is highly unlikely that the Kabiro Project will ever be self-sustaining. The poverty of the community served, the transient nature of the residents, the sense of futility of many slum dwellers, and the age and inexperience of the

large, young population served, all clearly influence the Project's ability to raise funds from the poorest of the poor.

- The Project uses virtually no field supervision. This has resulted in a complacency and a lack of motivation on the part of the staff.
- The Kabiro Project is rapidly becoming a condom-based program serving a community at risk of AIDS. The Project should try to refocus its attention on family planning, while formalizing its AIDS efforts through improved training, IEC materials, and closer linkages to the National AIDS Control Programme and possibly, AIDSCAP.
- The Project needs to pay more attention to recruiting pill clients. Also, distribution practices should be reviewed because they are placing barriers to effective use by clients.
- The Kabiro Project needs to increase its commodity storage capacity and increase its stocks. This would eliminate periodic shortages and stock-outs.

In summary, the Kabiro Project is a good project that deserves continued funding. However, to improve performance, the Project requires continued monitoring and improved outputs as well as a reliable source of funding. The Project should also receive technical support to help it use more innovative approaches and to expand operations. The Project also has potential to serve as a trial site for pilot activities and as a training site for urban slum family planning services. Donors may wish to consider providing additional funding to allow the Project to provide these services.

2. ACKNOWLEDGEMENTS

The Assessment Team included four locally-based CBD specialists. The Team was led by Gary Lewis, SEATS Project Advisor to the Centre for African Family Studies and detailed to the USAID Mission/Kenya. Polly Mott is Family Planning Service Delivery Specialist with USAID/Kenya. Patricia Indire and Michael Mbaya are program officers with the National Council for Population and Development.

The authors wish to thank the sponsoring organizations responsible for this assessment: the National Council for Population and Development, the U.S. Agency for International Development, the Centre for African Family Studies, and the SEATS Project of John Snow Incorporated. A special thanks goes to the staff of Kabiro Kawangware Health Care Outpost for their openness and ready efforts to assist the Assessment Team.

This report represents the best efforts of the Team to look objectively at the Kabiro Kawangware CBD Project. However, the observations and opinions expressed in this paper still contain a considerable amount of subjectivity. The reader should be aware that the opinions, recommendations and observations are those of the authors and do not represent the positions or policies of their organizations or the Kabiro Kawangware CBD Project. Any errors, either factual or interpretative are the responsibility of the Team.

3. ABBREVIATIONS

CAFS	-	Centre for African Family Studies
CBD	-	Community Based Distribution
CEDPA	-	Centre for Development and Population Activities
CHW	-	Community Health Worker
CYP	-	Couple Year of Protection
FPAK	-	Family Planning Association of Kenya
FPIA	-	Family Planning International Assistance
FT	-	Foaming Tablets
GOK	-	Government of Kenya
ICA	-	Institute of Cultural Affairs
IEC	-	Information, Education & Communication
IUCD	-	Intra-Uterine Contraceptive Device
KABIRO	-	Kabiro Kawangware Health Care Outpost CBD Project
MCH	-	Maternal and Child Health Care
MOH	-	Ministry of Health
NCC	-	Nairobi City Commission
NCPD	-	National Council for Population and Development
NGO	-	Non-government Organization
PHC	-	Primary Health Care
SEATS	-	Service Expansion and Technical Support Project
STD	-	Sexually Transmitted Disease
USAID	-	U.S. Agency for International Development
VSC	-	Voluntary Surgical Contraception

4. INTRODUCTION

A. History of the Kabiro Kawangware CBD Project

The Kabiro Kawangware Health Care Outpost is one of the results of a seventeen-year collaboration between the Institute of Cultural Affairs (ICA) and the Nairobi slum community of Kawangware. In 1975, ICA sponsored a workshop to plan integrated development projects for the community. Initial activities, which started in 1978, included family planning and preventive health care, IEC, MCH and sanitation. Following a second planning workshop in 1979, community committees were set up, one of which focused on health and family planning. During this time a clinic and primary school were built to support the integrated program.

From 1980 to 1988 Kabiro Kawangware received a grant through ICA from Family Planning International Assistance (FPIA) to support clinic and community-based family planning IEC and services. At this time, CBD workers mainly provided condoms, counselled clients on other methods and referred them to clinics. In 1985, this role expanded to include resupply of pills. Then, in 1990, CBD workers began to provide pills to new clients once they were screened for contraindications. The host-country grant through the NCPD with USAID bilateral funding began in July 1989, following a six-month gap during which project activities closed down. In spite of this closure, the Project was able to retain most of its workers, volunteers and several of the project management staff. However, the program has suffered as a result of the death of its original Coordinator and also due to severe delays in receiving funds through NCPD and the Treasury.

The Project covers one sub-location, Kawangware, which consists of six villages. The estimates of the sub-location population are approximately 200,000. It is one of Nairobi's largest slums with a high level of migration. Unemployment is also high. Those who do have jobs perform casual labor, office work, street vending, prostitution and other low wage jobs. Teenage pregnancy is prevalent and HIV/AIDS is not uncommon among the population.

This Project is truly a community based program which involves community members on the level of the Board of Trustees and Board of Advisors as well as the staff.

A comparison of the performance of the Kabiro program in 1990 and 1991 is difficult to make due to the change in data definitions that took place and the fact that in 1990, Kawangware's data aggregated new clients and revisits as well as CBD and clinic clients. However, an estimate for

1990, based on available data is that about 1,600 couple years of protection were provided by CBD workers. This decreased to about 900 CYP in 1991, possibly due to low morale among the workers who were not paid regularly. In 1991, the Project reported referrals for over 260 injections, 60 IUDs and 10 VSCs by the CBD workers.

The Kabiro Kawangware Clinic is open every weekday. The CBD workers work full-time in their assigned villages. CBD workers come to the clinic daily prior to beginning their home visits. At this time, problems are discussed, questions answered, monthly reports are collected and supplies distributed. A smaller cadre of volunteers works about six hours per week usually with the CBD workers. CBD workers and volunteers reach clients through home visits, as well as contacts in local gathering places such as markets and bars. The clinic provides back-up medical services and has a full range of temporary methods available. Clients who request VSC are referred elsewhere, mostly to FPAK or Marie Stopes. These clients are counselled at the Kabiro Clinic from which they are referred to the service provider. CBD workers do not counsel VSC clients or refer them directly to the service provider.

The sub-location covered by the Kabiro Project has two clinics: the Project Clinic and the NCC Clinic at Riruta. Transportation to other referral centers, such as Kenyatta National Hospital and FPAK, is easily accessible. The two clinics' staff co-ordinate activities and share commodities if one runs short.

B. Description of Assessment

The Assessment of Kabiro was done in preparation for the development of a new project. It was designed to facilitate the transfer of the Project from a host country grant funding to CEDPA funding.

The Assessment is a donor requirement for continuation or expansion of funding. The Assessment Team was made up of Gary Lewis, who served as team leader and methodological advisor. The donor was represented by Polly Mott of USAID. The Government of Kenya provided two program officers, Patricia Indirie and Michael Mbayi from NCPD, the Government's co-ordinating agency for all family planning services.

Field work was done in April 1992. Since the Project is fairly small and operates out of a single site, field observations of operations and data collection were relatively simple to implement. The Assessment Team met

with the Project Coordinator, the Project Administrator, members of the Board of Directors, and virtually all of the CBD workers.

The Assessment focused on operations issues in an effort to provide guidelines for improved and expanded services, in light of a change of donor and a new Project Coordinator.

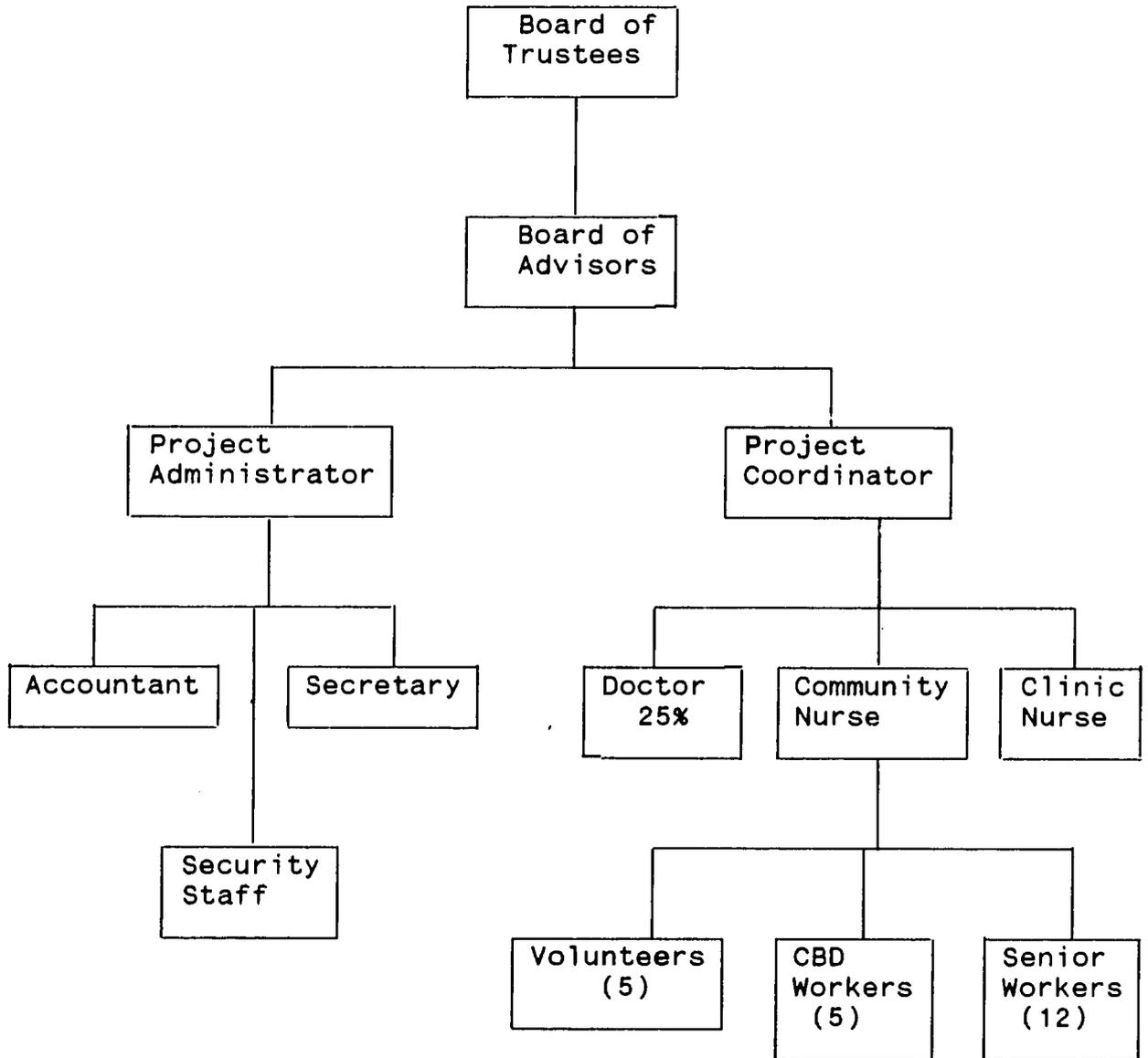
5. GENERAL PROGRAM REVIEW

A. Management

Kabiro is unusually strong in community level management. The organization was founded in response to perceived community needs nearly fifteen years ago. The Project is under a Board of Trustees with ten members. The Board also has a Sub-Board of Advisors to work more directly on the day-to-day operations of the Project. Reporting to the Board is a Project Administrator and a Project Coordinator. The Project Administrator supervises financial management, administrative matters and day-to-day operation of the facility. The Coordinator supervises the service delivery element of the Project including Clinic nurses, the part-time doctor, the CBD workers, and the youth volunteers. The lay-out of the current organizational structure is presented in the figure below.

ORGANIZATIONAL CHART

Kabiro Kawangware Health Care Outpost CBD Project



The Board is made up of four community residents, one doctor, one social worker, one consultant, and one representative from FPAK. There are currently eight members, but the Board has positions for ten. The Board of Advisors, which was designed to reduce the number of people dealing with the Project on a daily basis, has been relatively inactive. At the time of the Assessment, the Board of Advisors had not met for six months. It appears that the role of the Board is primarily implemented through two or three members who take a much more active role in operations. While one might wish greater activity on the part of the Board, it must be remembered that compared to most other CBD projects in Kenya, the community - as represented by the Board - is extremely active in project management. This situation is a credit to both the Board and the Project.

The Assessment Team had the opportunity to meet with three Board members. The Board is selected by the community during a baraza. There is no fixed term of office and most of the current directors have been in place since 1989. Members of the Board are also appointed from outside the community to broaden the base of support and management experience. Meetings are scheduled quarterly but appear to be slightly irregular in their timing. The meetings are held at the clinic. The Coordinator is also expected to attend all Board meetings.

The scope of work for the Board as defined by the Board includes:

- Advice on clinic operations
- Financial management
- Overall project supervision
- Fund-raising (Board identified major problem as their current single donor status)
- Community liaison
- Liaison with other NGOs and organizations in the community.

A few Board members regularly visit the clinic and are updated by the Coordinator and the Administrator. Board members also indicated that there is a considerable amount of community feedback. Because Board members live in Kabiro Kawangware, if there any problems or complaints, Board members are often the first to hear from the community. As a consequence, there appears to be a dynamic communications environment involving the Board, the community and the Project.

The day-to-day management of the Project is handled by the Coordinator and the Administrator. At the time of the Assessment, the management structure in terms of lines of authority and responsibility was a little confused, because of the recent recruitment of a new Coordinator. The organizational chart suggests that these two positions are equal. This is an unusual situation, and the Project may wish to consider the more traditional role of Project Leader or Director, usually filled by the equivalent of the Project Coordinator.

Because of the long history of the Project, management systems appear to be in place, although somewhat informal. The various functions of management including financial, supervision, personnel and community relations seem to be well in hand. The Project would benefit, but only slightly, from improved conceptualization and documentation of its management systems. However, in the short run, the Assessment Team could identify no serious management problems.

B. Community Based Context of the Project

The Kabiro Project, even by the standards of community-based family planning services, has unusually strongly ties to the community. Many of the Board members come from the community. The clinical facilities are physically in the community. The Project undertakes a variety of community service activities (education, income generating projects, community organization), in addition to its family planning work. The Project also clearly is well known and respected in the community. CBD workers are often recognized and acknowledged even in the streets. One product of the close ties to the community is that the Project has an unusually good sense of the problems of the community. The problems are very frequently seen in urban-slum areas: lack of adequate shelter, inadequate and poor quality nutrition, unavailability of good roads, potable water and sanitation, high levels of unemployment, crime, and apathy on the part of frustrated community members and an unusually young and marginalized population involved in prostitution, brewing liquor and similar activities.

The Assessment Team made no direct contact with community members. However, the Board and some of the CBD workers indicated fairly high levels of community support for the Project. As might be expected, the close proximity of the clinical facilities and the reputation for high quality services contributed substantially to the community's acceptance of the services. There is apparently considerable pressure on the clinic to expand their curative services, because of the poor quality of other clinical

services in the community. The NCC facility requires clients to wait before receiving services, and then often does not have drugs for treatment. Apparently, they also lack some of the necessary equipment and supplies to do physical exams required for both family planning and curative clients.

It is clear that Kabiro is a community-based Project. Its size, management structure, the nature of services and the unique requirements of urban slums indicate that urban CBD projects are feasible, and can be incorporated into the community structure. But, it is also clear that Kabiro could not operate using only community resources. The poverty of the community, the lack of infrastructure, the transient status of many of the residents, the negative attitude of many slum dwellers, and the age and inexperience of the population clearly suggests that the community is unlikely to generate adequate resources to operate an integrated family planning project. To continue to provide high quality family planning services and some primary health care services, Kabiro must have external resources.

The Project has been conscientious about seeking ways of achieving a higher level of self sustainability. The Assessment Team found no evidence that these activities generated enough income to the Project to justify the cost of management. Income generating activities, fees for services and the annual fee for membership were efforts to expand the resource base of the Project. It is unlikely that the Kabiro will ever be self-sufficient. Given the characteristics of the high risk population served by the Project, it is not appropriate to force unrealistic sustainability criteria on the Project.

C. Recruitment and Training

CBD workers were recruited among community members. Most have been involved in the program for so long that it was difficult to elicit comments on the recruitment procedures. However, it is clear that the workers are all well established, and well respected members of the community they serve.

Training for CBD workers is carried out as soon as they join the Project. There have been four groups of entering CBD workers, all of whom received CBD and primary health care training. Currently, the course is three-months of on-the-job training, with a focus on: hygiene, family planning methods, simple first-aid, breastfeeding, and public health issues. The three-month course has two months of classroom followed by one month of applied field work. After the initial training, one-day refresher courses are held, about

two or three months after the original orientation. This is to help reinforce the learning and resolve issues arising from the field.

The initial training stressed nutrition, hygiene and sanitation because the slums were dirty and beset by a number of hygiene related diseases. The residents of the area also had very poor nutritional habits. As the situation improved and community awareness of these issues increased, the focus of the CBD workers and the orientation of training shifted to family life education and community-based distribution of contraceptives. However, the family planning component of the training is still only a little more than one week. While staff are reasonably skilled, the training curriculum sends a message to CBD workers that family planning is only one of many activities and it is less important than other primary health activities. Future training should place greater emphasis on family planning.

Subsequently, Kabiro CBD workers have received a two-week refresher course at Kenyatta National Hospital, and in 1991 were given a course on new family planning methods and approaches. The course stressed development of interpersonal skills, counselling for youth and recruitment techniques. The Project continues to carry out monthly on-the-job training through a series of CBD worker/Coordinator meetings. These meetings serve as a forum to allow CBD workers to share experiences, identify new problems and get guidance on solutions. Recent issues in these forums have included: services to HIV Positive and AIDS clients, and overcoming strong resistance to family planning by selected couples.

Issues identified by CBD workers as influencing Kabiro training include:

- Contraceptive technology improvements
- Changes in social systems, societal attitudes and demand for services related to changes in the medical environment (specifically HIV/AIDS)
- Improvements in counselling techniques
- Changes in the socio-economic environment of Kenya, which call for a modification in individual, community and national policies influencing fertility and family planning decision making
- The increased need and demand for effective IEC materials to create, motivate and sustain awareness of the benefits of family planning to the general public.

In summary, the long involvement of CBD workers in the Kabiro Project has resulted in relatively sophisticated CBD workers. While it is difficult to tell the original quality of the training, it is clear that the staff can provide high quality family planning services. The duration of training and the heavy focus on primary health care issues are, to some extent, inconsistent with the family planning nature of the program. However, since workers are already trained, it is not a problem for the on-going Project. Any training of new CBD workers by Kabiro should be done using the national CBD training manual. Staff should also be reminded through supervision and training that the Project is primarily a family planning project.

D. Supervision

Supervision in the Kabiro Project is provided by the Coordinator and to a very limited extent by the Administrator. As befits a fairly mature project with well established CBD workers, the level of supervision is fairly low. At the field work level, CBD workers are virtually self-supervised. The Administrator spends no time in the field and the Coordinator or clinic nurses spend about four hours per week. Most of the field time of the clinic staff is focused on service provision and community co-ordination, with relatively little direct supervision. What supervision does come to the CBD workers is done during daily and monthly staff meetings at the clinic facility. The CBD workers also report that any special problem needing guidance or higher levels of intervention will bring them back to the clinic. In the past, the Project attempted to use team leaders, CBD workers who rotated in and out of the role to provide some supervision. This approach did not prove effective, because the CBD workers did not seem to take supervision responsibilities seriously.

The Assessment Team basically found that overall supervision was adequate, given the experience level of the CBD workers. The one issue which may concern the Project is the reliance on group supervision at the clinic and a complete lack of active field supervision. CBD workers are not and do not expect to be supervised as they do jobs. The Kabiro Project may wish to take a more active role in supervision with periodic spot checks and a general effort to reduce the complacency about supervision.

The nurses are supervised by the Coordinator who is a nurse herself, and the Assessment Team could identify no problems in this relationship. The fact that these individuals work together so much and share some responsibilities virtually

ensures good communication, mutual understanding of problems and a relatively supportive working environment for the nurses being supervised.

It appears that the Administrator is relatively unsupervised in the current project structure. This may be a historical anomaly because of the long interval when a Coordinator was lacking. In future, more direct supervision of the Administrator is advisable. The Coordinator and Administrator are technically supervised by the Board. As might be expected, the actual level of supervision is minimal and spotty. However, the continuous oversight role that the Board plays in the Project ensures that even though not actively involved in supervision, the Board will eventually identify problems and precipitate change.

In summary, the current supervision structure of the Kabiro Project is adequate to meet current operational needs. This adequacy is the result of the age of the Project and the maturity of staff at all levels. While no major changes in the supervisory structure or operations are recommended, senior project staff should be concerned about not abdicating their supervisory responsibilities. For this reason, it is recommended that supervision structures be documented and supervision activities be undertaken on a periodic basis.

E. Coverage

Since the Kabiro Project covers a relatively small, densely populated geographic area, CBD workers have been assigned specific villages in the community. The workers have roughly delineated catchment areas. On average, a CBD worker covers about 2,000 households.

In terms of commodities provided to clients, the level varies considerably among CBD workers and between the two primary methods, as shown below:

Commodities Provided by CBD Workers

	<u>Pill Cycles</u>	<u>Condoms</u>
	15	40
	10	1,000
	8	900
	7	300
	7	800
	0	200*
	2	80*
	7	800
	9	900
	10	1,200
	8	900
	13	1,000
	10	1,000
	11	700
	12	400
	9	400
	13	1,350

* Volunteers

In the above list, the condom clients obviously must be counted with some skepticism, since it is a highly mobile population and men are the primary consumers. The CBD workers explained that condom demand varies between areas based on the characteristics of the population in that community. Some areas are more stable with less commercial sex, while others are more likely to have behaviors that would generate considerable demand for condoms. In terms of coverage, the Kabiro Project has done well in delineating areas of responsibility. However, the heavy density of the population, the case load of the CBD workers and their own statements suggest that the work is not demanding and that there is considerable potential for expansion. The CBD workers use primarily home visits to provide contraceptives and generate clinic referrals. As a consequence, none of the less time consuming techniques like depot operations are used. If more efficient distribution techniques were used, CBD workers could probably cover larger areas or cover the areas that they are managing more intensively.

The Kabiro Project does not include in its population coverage, adolescents who are sexually active. Girls under 15 years of age are not served. Slightly older girls are served, but only after extensive counselling. The rules with regard to providing contraceptives to boys are less clear, but services are also restricted in most cases. These same clients would be served if brought in to the

clinic by a parent. The burden of the policy tends to fall more heavily on girls. Since girls must visit the clinic before they can get the most effective methods, they are effectively screened out. Boys can get condoms relatively easily from the community distribution activities. Kabiro offers an active counselling program for youth seeking services, but in the end, many who are sexually active will not receive contraception. The unique nature of the urban slum environment suggests that the definition of "youth" be modified to reflect the fact that pregnant 14 year old girls are a common phenomena.

F. Field Operations

The Kabiro CBD Project provides services to its clients through the use of home visits and group meetings. The Project is very active in distributing contraceptives, specifically condoms, in bars and other places where there are large numbers of people. The Project is commendable and notable for the acceptability of its public distribution of contraceptives.

Since the Kabiro Project has focused heavily on condom distribution, the Assessment Team examined the issues of distribution. The observations of the CBD workers and staff on the use of condoms in urban slum are very interesting:

- The prevalence of STDs has raised awareness of condoms, resulting in their widespread acceptance both for their protective and family planning capabilities.
- The demand for condoms is high and rapidly increasing.
- Awareness of HIV/AIDS and the need for condom use is widespread in the community.
- Kabiro CBD workers have found that young people are especially receptive to condom use to prevent STDs and early pregnancy.
- Condoms are also popular because they are simple to use, require no medical examination and have no side effects.
- CBD workers report that there is virtually no stigma attached to condom use any more in Kabiro.
- Men are the major procurers of condoms.

- The Kabiro CBD Project puts no age limits on providing contraceptives to men if they are sexually active. However, for younger men they do strongly recommend counselling services to raise knowledge levels.
- It is not unusual to have CBD workers approached by mothers seeking condoms for their children. Some parents also seek counselling to help them deal with their children's sexuality.
- An AIDS death in the community causes a panic for a few days. The results of this panic is reduced activity for commercial sex workers and increased demands for condoms. However, the CBD workers report that this panic usually lasts for less than a week.
- The CBD workers report that their job has been made considerably easier because of the HIV/AIDS epidemic.
- There have been problems with disposal of used condoms and CBD workers now try to inform clients of appropriate techniques for disposal.
- The Project currently distributes 20 condoms to a new client and 50 to a continuing client. Given the high mobility of the population and the distribution techniques, it is difficult to determine who is new and who is continuing. It appears that new is defined as new to the CBD worker.
- The CBD workers have had very few complaints about condoms. The one piece of negative information is that a brand called "Million Gold" breaks easily.
- The Project's efforts to distribute in places where men gather has made it very popular in clubs, bars and gambling houses. A visit to one of these facilities will virtually guarantee a CBD worker distribution of her entire stock of condoms.
- Commercial sex workers in the Kabiro area have also become very pro-active in seeking out CBD workers to get supplies.

The Assessment Team attempted to identify the constraints experienced by the CBD workers in doing their field work. Briefly described below are the constraints identified:

- CBD workers report that the medical examination "required" for contraceptive use is a constraint. Many women are unwilling to be examined. Also many have

heard of the contraindications for pill use, and correctly or incorrectly assumed that they are not acceptable candidates for the method.

- The high mobility of clients means that they are educated, motivated and possibly supplied once by the CBD worker and then are gone.
- Many clients want hormonal methods, and refuse other available methods. In order to get pills or injection without physical exam or problems, they go to non-project sources like private clinics or dispensaries.
- The low levels of use of permanent methods, is a consequence of the unmarried status of most of the women in the community, who wish to keep their child bearing options open. There is also some fear of a surgical procedure because many of the women are involved in heavy manual labor and fear being disabled. However, for those older women who have completed fertility, the CBD workers report a generally positive attitude towards the method.
- The constraints to increased IUCD use are the attitudes of men who claim to be able to feel the string of the device, the popular perception that it is a less effective method, the practice of having multiple partners raises fears of STDs and the associated vaginal discharge is perceived to be harmful to relationships. There is also a considerable amount of negative information (It can migrate to other parts of the body, it is easily expelled or the user bleeds constantly).

The Kabiro CBD Project is primarily a home visit program with active distribution in group meetings. However, the CBD workers do indicate some use of their homes as depots. Clients contact the CBD workers for supplies most frequently on weekends. According to the CBD workers, most active clients know the CBD worker's home. If they do not know the location but are anywhere in the area, the neighbors know and will direct them to the worker's home.

The IEC component of the Kabiro Project is virtually all interpersonal communication. The CBD workers have had specialized training in counselling and interpersonal communication and can be expected to be reasonably good at it. However, the other forms of communicating with clients: posters, hand-outs are in short supplies. Most CBD workers had copies of the NCPD pamphlets to show clients, but none

to distribute. As with most CBD projects in Kenya, more IEC materials, both on the services and on family planning, would be useful to CBD and clinic workers.

While traditional IEC is limited, the youth program is nothing but a series of IEC activities. Movies, videos, group talks and individual counselling are all channels used by the Project for dealing with young people. The same efforts could go into dealing with potential contraceptive users. IEC materials specifically for CBD projects are currently under development and should contribute significantly to Kabiro IEC efforts. However, the Project would benefit from the development of its own IEC strategy to target specific populations, like commercial sex workers, young adults, highly mobile women and other community residents who are less likely to be reached by conventional IEC efforts.

A review of CBD worker records provided some interesting insights into field operations (Quarter 1, 1992).

CBD Worker A

New Clients of Pill - 12
Resupplied Pill Clients - 11
Referrals (for anything) - 28
Condoms distributed - 39,000

CBD Worker B

Condoms distributed - 3,000
VFTs distributed - 200
Referrals - 77+
Resupplied Pill Clients - 5

CBD Worker C

Condoms distributed - 900
Resupplied Pill Clients - 1

In reviewing the records, several facts are notable. The number of pill clients being given one cycle is larger than one would expect or consider desirable. The potential to distribute large quantities of condoms is obvious from the outputs of CBD Worker A above. The low performance of CBD worker C is in part due to only working 1.5 months during the quarter, suggesting problems in continuity of client services. CBD workers are keeping records and the Project does have the information necessary for evaluation of individual performance.

In summary, the field operations of the Kabiro Project are fairly effective and comprehensive. The quality of service appears to be high compared to other CBD programmes in Kenya. The only major problems identified are the

consistency of service due to absenteeism. This absenteeism is in large part stimulated by the irregularity of salary payments. It is also clear that workloads could be expanded and outputs dramatically raised with appropriate efforts on the part of project management. One concern of the Assessment Team was the fairly significant differentials in performance among CBD workers. The volunteers have lower levels of performance, as might be expected. However, among the full time CBD workers there was still a considerable amount of variation. Project management should review its supervision and field operations activities and focus on raising the performance levels of under producing CBD workers.

The Kabiro CBD workers do a considerable number of referrals. As would be expected, most referrals go to the Project clinic. For VSC or serious complications clients are traditionally referred to Marie Stopes or FPAK facilities. The CBD workers had no complaints about the quality of services their clients received. However, it is interesting to note that virtually none had ever visited their referral sites and, as a consequence, had no relationship or confidence in their referral sites. Some referrals are made to Kenyatta Hospital, but the level of client satisfaction is so low that these referrals are kept to a minimum.

G. Logistics

The Kabiro Project has not yet experienced a major stock-out, because of its close proximity to the Ministry of Health Central Medical Stores. However, there are some logistics problems that need to be addressed to prevent problems in the future.

The lack of gloves to allow pelvic examinations and IUCD insertion is widespread throughout Kenya and is especially problematic for government facilities. Kabiro has been able to purchase disposable gloves on the commercial market using the small amount of money available through the fee structure. Because of the availability of gloves, government facilities have been referring IUCD clients to Kabiro. For clients needing services in government medical facilities like Kenyatta Hospital, Kabiro has been giving clients gloves to take with them to ensure receiving an adequate examination. The disparity in resources and commodities between NGO and government sectors is creating both benefits and costs for Kabiro. While Kabiro gets more referral clients, the population is less willing to use health facilities and family planning methods that require a physical examination. However, the point is that while Kabiro has been able to overcome the problem of getting

gloves, it is clear that government facilities are limiting access to family planning in their facilities because of the lack of necessary equipment.

Another non-family planning logistic problem experienced by the Kabiro Project clinic is in its dealings with the KEPI Programme of the Ministry of Health. The Kabiro clinic can do immunizations, but this service has been curtailed due to lack of vaccines. While vaccines are not in short supply, KEPI has not been able to provide the gas cylinder for the refrigerator to protect the cold chain.

The problem of inadequate drug supplies in the government sector was also a problem mentioned by Kabiro staff. The complaint is that if you go to a government facility for family planning or health service, you may wait all day to be seen and then find there are no drugs available. According to the staff of the Kabiro Project, this has created considerable resistance to seeking services of any sort in government facilities.

In reviewing the contraceptive stocks for the clinic and the CBD workers, the storage facilities were adequate for the amounts kept. Unfortunately, the amounts kept are insufficient for good logistics management. The Kabiro Project had about a one month supply of pills, a four to five day supply of injectables, and virtually no stock of vaginal foaming tablets (there was a national level stock out at the time of the Assessment). Because they visit the clinic everyday and lack storage facilities, the CBD workers also keep about a one month's supply of commodities. The lack of stock puts the Kabiro Project at risk of stock-outs if there should be any problems. It is clear that the Kabiro Clinic should expand its storage capacity and increase its reserve stocks very substantially.

The Kabiro Project's distribution levels for condoms are impressive. Discussions with CBD workers and project management suggest that they could be even higher. At the time of the Assessment the Kabiro Project was rationing condoms. During a rationing period, the usual 20 pieces for a new client is reduced to 10, and the 50 pieces for continuing users is reduced to 30. Kabiro is rationing because the MOH medical stores is limiting the quantities provided. The Project could not explain why they were being given limited number of condoms. However, this issue should be examined by the donors and NCPD to determine what the problem is at the medical stores level. All of the CBD workers indicated that their distribution is based on the number they have available and not demand. If more supplies

are available, more supplies could be distributed. They reported no evidence of waste of condoms in their communities.

H. Donor Relations

The Kabiro CBD Project is funded by USAID through NCPD. The only major problem in this relationship has been delays in payment of operating funds. This problem is not unique to the Kabiro Project, but extends through all NCPD/GOK Treasury-funded family planning projects. It appears that the problem rests in the Treasury and not NCPD. The best efforts of the donors and NCPD have not been able to resolve these problems. As a consequence, Kabiro has and will continue to suffer until an alternate funding source can be developed.

6. PROJECT OUTPUTS

Keeping in mind that the Kabiro CBD Project is a family planning project with some primary health care activities, this assessment addresses only the family planning outputs. The reference period for this assessment is 1991, since there was little activity previously and the reports for Quarter 1, 1992 were not available at the time of the Assessment.

- At the end of 1991, the Project was halfway to completion. In terms of meeting the performance objectives set in the original project design: New client targets were 39% met. Condom distribution targets were over-achieved by 140%. Pill distribution achieved only 25% of the target. These results suggest that original condom objectives failed to consider the rapid change in behavior associated with AIDS.
- For 1991, 908 CYP were provided. This means that on average each CBD worker provided 41 CYP. Based on an average salary (adjusted for varying pay scales), CBD workers are paid Kshs 329 (about \$10) per CYP. This covers only CBD remuneration, and not management, operational or commodity costs.
- On average, each CBD worker has about nine Pill clients. If these clients are visited quarterly, it means that each CBD worker would visit one pill client per month (9 clients x 4 visits - 12 months), not a particularly high level of activity.

- With the budget divided proportionally over the three year life of the Project, it can be roughly estimated that each CYP generated in 1991 costs about Kshs 1,200 (US\$40).
- It should be noted that while performance was less than should be desired, the trend in contraceptives distributed and new clients suggested substantial increases in outputs.

7. RECOMMENDATIONS

Community level management of Kabiro is apparently effective and should be supported and encouraged in any new project. The concerns of the Board over single donor funding are legitimate and donors may wish to work with the project and Board to seek alternate sources of resources.

The Project should attempt to do more spot inspection and supervision to establish both the right of supervision and the necessity for high levels of performance on the part of CBD workers.

No major changes in the supervision structure are recommended. However, senior level staff should maintain their credibility as supervisors by increasing periodic inspection of operations and establishing a time for direct supervision of CBD operations.

AID and NCPD should consider alternate strategies for funding Kabiro to avoid the delays experienced due to current Government of Kenya fiscal management problems.

The Project is well established and operating on a regular basis. However, it is under producing in terms of contraceptive outputs given the maturity of the Project, the size and density of the population, the level of demand and the full time status of CBD workers. It is suggested that the Project make a major assessment of its field operations with a specific objective of expanding outputs.

One anomaly in the Project is the incentive or salary differential between different levels of CBD workers. The levels of CBD workers have to do with the time they joined the Project and not their skill levels or effectiveness. It is recommended in the new phase of the Project that salaries be equalized.

The Kabiro may wish to consider performance-based management, with rewards or incentives linked to output. Currently CBD workers have little concern about their level of performance. As a consequence, there is tremendous variability in outputs. This problem could be solved by a more focused emphasis on services delivered.

If there should be any expansion into new areas, the training programme should focus more on family planning and less on primary health care.

Kabiro should make arrangements with Marie Stopes clinics and FPAK to send in CBD workers to observe VSCs for at least two days per CBD worker.

It is unlikely that community resources will ever be a major factor in the operations of the Kabiro Project. Sustainability and self sufficiency are issues which should not be seriously considered in future projects.

The Project has achieved community acceptance of its condom distribution activities. However, very serious efforts should be made to increase pill use and distribution.

Kabiro should increase its storage capacity with a lockable store room. It should also increase its buffer stock of commodities significantly.

Special efforts should be made to improve the method mix. Specifically, there should be greater numbers of pill and long term method users. Such efforts as quotas, special programs, and recruitment drives are a few of the efforts which can be tried.

The Kabiro Project should be more innovative. A mature project with an unusual client base should be experimenting with new approaches, better IEC and special programs. The potential of Kabiro to be experimental could also be a major selling point for new donors.

The condom bias of the Project clearly suggests that what started as a family planning activity is becoming an AIDS prevention program. Kabiro may wish to seek new funding from AIDS sources.

Kabiro is an ideal site for operations research activities focusing on delivering services to urban slum populations.

Kabiro should develop its own IEC strategy to give focus to its efforts to educate its community.

The use of depots to distribute condoms could save CBD workers time. Bars, kiosks and guest houses might be good sites to set up depots. The Kabiro Project should consider alternate approaches to distributing and recruiting clients. Alternate distributors could include community leaders, traditional birth attendants, traditional healers and shop keepers.

PERSONS CONTACTED

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Sister Eroni Nakagwa, Enrolled Community Nurse

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