

APHIA MID-TERM REVIEW
March – April 1999

ISSUES PAPER
ON
CHILD SURVIVAL

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ACRONYMS

AFR	Africa Desk (USAID)
AFRO	Africa Regional Office (WHO)
AIDS	Acquired Immune Deficiency Syndrome
AIMI	Africa Integrated Malaria Initiative
AMREF	African Medical Research Foundation
ANC	Antenatal Care
APHIA	AIDA Population and Health Integrated Assistance
ARI	Acute Respiratory Infection
AZT	Azithromycin
BASICS	Basic Support for Institutionalizing Child Survival
BDI	Bungoma District Initiative
CA	Community Agency
CBO	Community Based Organization
CDC	Centres for Disease Control
CRC	Convention on the Rights of the Child
CS	Child Survival
DANIDA	Danish International Development Agency
DFID	Department of International Development
DHMT	District Health Medical Team
DS	Delivery Site
EANMAT	East African Network for Monitoring Anti-malarial Treatment
EPI	Expanded Program on Immunization
FINIDA	Finnish International Development Agency
GOK	Government of Kenya
HIV	Human Immuno-deficiency Virus
IEC	Information, Education Communication
IGA	Income Generating Activities
IMCI	Integrated Management of Childhood Illnesses
ITM	Insecticide Treated Material
ITN	Insect Treated Net
JICA	Japan International Cooperation Agency
KDHS	Kenya Demographic Health Survey
KEMRI	Kenya Medical Research Institute
KEPI	Kenya Expanded Program for Immunization
K-FPHCP	Kenya-Finland Primary Health Care Program
MCH	Maternal and Child Health
MoH	Ministry of Health
MTCT	Mother to Child Transmission
MTR	Mid Term Review
NASCOP	National AIDS Control Program
NID	National Immunization Day
NGO	Non Governmental Organizations
PHC	Primary Health Care
PMO	Provincial Medical Officer
QAP	Quality Assurance Project
RBM	Roll Back Malaria
SP	Sulfadoxine/Pyrimethamine
TB	Tuberculosis
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VII	Vaccine Independence Initiative
WHO	World Health Organization

CHILD SURVIVAL ISSUES PAPER

EXECUTIVE SUMMARY

The mid-term review of USAID/Kenya's APHIA project was conducted in March and April 1999. In addition to a broad view of the project activities, USAID took the decision to address five key areas of project interventions specified in the results framework as separate and free standing issues. It was hoped that designing the review in this way would offer a more detailed and contextual view of the issues.

Child survival was included within the Strategic Objective of APHIA as a response to the plateauing of child mortality rates indicated in the KDHS 1993. Despite a very marked reduction in fertility there had been no decrease in child mortality. The 1998 KDHS shows increasing child mortality rates with a greater than 12% rise in mortality during the last nine years. There has been localised reduction in mortality in certain provinces, but child mortality rates are increasing in Nyanza and Western.

USAID/APHIA is intended to contribute to child survival in the following areas of its programming.

- ? Child survival initiatives including:
 - the Vaccine Independence Initiative;
 - district-level support for the management of childhood illnesses with a focus on malaria;
- ? Improved reproductive health service delivery;
- ? Reduction of HIV/AIDS transmission;
- ? Health Sector reform

VII, after a long period of collaboration with key GOK MOH officials, has been signed and GOK funding has been released. This is an important first step in gaining GOK commitment to take responsibility for and finance its EPI programming.

A district-level initiative for addressing child survival was developed in collaboration with USAID Washington as part of the Africa Integrated Malaria Initiative (AIMI). Bungoma, a district in Western Province which had been part of a CDC research project centering on malaria control and Integrated Management of Childhood Illness (IMCI), was selected with full support from MOH as the site for a five-year project. Project objectives focus on malaria prevention and the management and treatment of febrile disease and anemia in children and pregnant women. The project has only been fully operational for a little more than a year. Project activities during this period have been concentrated on operational research and the rehabilitation of District Health Management Team facilities at the district hospital.

The arena of child survival and child health is defined and dominated by a number of key concerns which include:

- The withdrawal and/or reduction of donor support to GOK MOH (e.g. DANIDA support for KEPI) resulting from dissatisfaction with the method and rate of Health Sector reform;
- General decline in Primary Health Care including antenatal and obstetric care;
- The high rate of mortality among adults, particularly mothers, due to HIV/AIDS, depriving children of a significant family member and caregiver and resulting in general deprivation including health;
- Increasing numbers of children infected by the HIV virus (estimated number of children infected by 2000 is 153,000)
- Decline in immunization coverage resulting from a decline in immunization outreach services and breakdowns in the cold chain.
- The failure of the MOH to disseminate treatment guidelines for febrile disease and anemia in children and to ensure the inclusion of SP and iron/folate in drug kits.

Additionally, the health status of children is compromised by:

- already overburdened and under-resourced health facilities being obliged to direct resources to management of HIV/AIDS related disease;
- increasing levels of rural poverty causing unacceptably high rates of child malnutrition;
- the lack of enforcement of rights, particularly reproductive and sexual rights of women, which would offer protection and care of children.

The majority of factors that detrimentally affect child health and survival are outside the ambit of USAID/APHIA's sphere of intervention. The key recommendations of the mid-term review are:

- that the child survival component of the APHIA strategy document be rewritten to clearly focus on the child rather than on interventions, and to reflect the impact of HIV/AIDS on children's health and well-being.
- that the continuation of district-level IMCI with a focus on malaria be continued
- that the VII continues to be a focus of APHIA attention and that USAID/Kenya uses its influence with MOH KEPI to encourage the full resumption of immunization outreach services and the rehabilitation of the cold chain.
- that USAID/APHIA revisits its results framework and its strategy document to ensure that reproductive and sexual rights and specifically the gender implications of the AIDS epidemic on both adults and children be addressed systematically.

SECTION 1 INTRODUCTION

The following is a report of an assessment of USAID/APHIA interventions for Child Survival and a situation analysis of emerging child health and survival issues in Kenya. USAID/APHIA is a \$124 million five-year project, with the strategic objective of reducing fertility and risk of HIV/AIDS transmission through sustainable family planning and health services. Child Survival appears as an intermediate result under “increased use of family planning, HIV/AIDS and Child Survival services.

After a background section, there is an analysis of USAID Child Survival interventions and other donor programming in Child Survival, followed by a section covering key issues and review findings. Recommendations follow in Sections 5 and 6.

SECTION 2 BACKGROUND

Following an Assessment of Trends in Child Health and Survival in Kenya¹ undertaken prior to project design, child survival was proposed as an integral part of the APHIA project. The report noted that mortality rates had plateaued during the 80s. At that point, this trend could not be attributed to HIV/AIDS-related causes. Further, it was argued that child mortality had marked and inverse effects on child spacing. The key recommendation from the assessment was that efforts aimed at reducing fertility should also address infant and under-five mortality. It was suggested that supporting the management and prevention of common childhood illnesses in Western and Nyanza Provinces, areas of high child mortality and fertility would have a noticeable impact on national trends.

It was determined that the prime contribution of the APHIA project towards increasing child survival would be made through family planning interventions and measures to reduce HIV transmission but would support, in a limited way, other measures to address child survival. APHIA would support the establishment of a Vaccine Independence Initiative (VII) and targeted district-level activities in:

- Training in the use of WHO/UNICEF Integrated Management of Childhood Illness (IMCI)
- Field tests and other interventions in malaria prevention and treatment
- Maternal Health Services which would impact on child health

USAID would collaborate with other key donors working towards the continuation and improvement of child survival programming at the national level. Additionally, APHIA would indirectly influence child survival by improving supervisory support to provide higher quality of child health services through quality assurance and health sector reform mechanisms.

¹ Plowman, B. A. An Assessment of Trends in Child Health and Survival in Kenya – Office of Population and Health, USAID/Nairobi Jan 1995

As the APHIA project document was written, direct and indirect child survival interventions were distributed across the four intermediate results with the major interventions falling within the District focus component. In the amended APHIA, the district focus elements plus support for Kenya Expanded Programme for Immunization (KEPI) and National Immunization Days (NIDs) were absorbed within a new category of Child Survival and Infectious Diseases. The Results Framework redistributes these activities into Intermediate Result 1 and Intermediate Result 3, specifically 1.3 and 3.1 and 3.2.

The review of progress concentrates on:

- Bungoma District Initiative (B.D.I.)
- VII
- Infectious Diseases Initiative

These three activities are regarded as bearing on child health and child survival and account for approximately 25% of C.S. earmarked monies. In this section, the activities are briefly described with progress to date. As the major recommendations of the review emanate from these initiatives, some detail is given to MTR findings, particularly B.D.I.

Bungoma District Initiative

B.D.I. was designed through a collaborative process between the Bungoma District Health Medical Team, USAID/ APHIA and the African Integrated Malaria Initiative (AIMI) Washington with the overall goal of “sustainable reduction in malaria-related deaths among children under five years in Bungoma District”. The initiative is a five-year effort (1996-2000) with a US\$5 million budget jointly supported by USAID and the Government of Kenya (GOK). The district was chosen for the following reasons:

- At project design phase, Kenya-Finland Primary Health Care Program (K-FPHCP) was still in operation. In addition to supporting and rehabilitating the health sector infrastructure, the program had focused on upgrading the skills of health care providers and strengthened community-based MCH and water and sanitation services.
- The district has an extremely high malaria prevalence rate
- Malaria prevalence rate and population size were comparable to other AIMI sites in the region
- CDC had worked in the district (and also in Vihiga) to introduce and upgrade IMCI.
- The site provided opportunities to collaborate and build upon prior USAID and other donor investments in infrastructure and capacity-building;
- The Ministry of Health had granted approval for such an initiative.

The project was approved in March 1997, but project launch was delayed until March 1998 shortly after FINIDA (and DANIDA), after an extended period of support, withdrew from the district. The FINIDA projects were regarded as completed and there were no further plans to continue working in the district.

. B.D.I. is a complex project with five key objectives:

1. Improved management of fever and anemia, principally among children under 5 years of age, by health workers at the health facility level.
2. Improved capability of mothers and other caretakers to manage fever and anemia at the household-level.
3. Improved prevention and management of malaria in pregnancy.
4. Increased household use of insecticide-treated materials.
5. Effective collection and use of information for planning, monitoring and evaluation.

BDI is in principle implemented by the District Health Management Team (DHMT) who have since christened the project the Bungoma District Malaria Initiative

Eight of the nine proposed research/baseline activities have been completed. AMREF acts as the Project Coordinating CA and also offers technical assistance on all studies and on implementation of the insecticide treated materials (ITMs) component of the project. The DHMT wanted a local NGO to coordinate activities thus AMREF was selected. The three other collaborating agencies include CDC, BASICS, and QAP. Johns Hopkins/PCS have also conducted work in Bungoma but not in relation to project objectives.

BDI Project Achievements

At this point in the BDI, progress has successfully met its Objective 1: Improved management of fever and anemia, principally among children under 5 years of age, by health workers at the health facility level. Achievement of this objective is the result of CDC and QAP training of Bungoma nurses and clinical officers in IMCI at Kakamega hospital. There has been a strong and positive response to IMCI from service providers.

Vaccination Independence Initiative (VII)

VII is a global UNICEF program intended to encourage countries which have been wholly dependent on donors for their vaccine supply to increasingly fund their own vaccine purchases. VII has been supported and encouraged by a number of donors: DANIDA, JICA, and DFID. The three objectives of the project include:

- To give Kenya access to a stable supply of high quality vaccines
- To decrease total reliance on donors for vaccines
- To build capacity among GOK staff.

Major Achievements

From USAID/APHIA funds, US\$500,000 was deposited with UNICEF in 1996 for the purchase of vaccines for Kenya on condition that GOK signed the VII committing \$60,000 for vaccine purchase from its recurrent budget. Due to successful lobbying of GOK by USAID and other donors, GOK has recently signed the VII committing the agreed \$ 60,000 (3% of annual budget). Though this is less than 10% required, this contribution is seen by USAID as a great step forward. USAID worked closely with the MOH to develop an advocacy position paper which MOH KEPI staff used in persuading top MOH managers and Ministry of Finance to adopt VII. VII was adopted in the 1998 budget thus making possible the use of revolving funds by the MOH for vaccine purchasing.

As of May 1999, the Government status is as follows:

- ? vaccines have become a line item in the recurrent budget;
- ? a Memorandum of Understanding has been signed by GOK and UNICEF;
- ? GOK has written a cheque for \$58, 000 to UNICEF;

Infectious Disease Initiative KEMRI/CDC

With support from USAID/APHIA, CDC/KEMRI unit has begun to work with the local and central MoH to develop materials and a strategy for training peripheral health workers and private providers in the new malaria guidelines. This effort opened the door to increased linkages between research and implementation.

Other CDC studies include bednet study in Kisumu, malaria and anemia and the malaria policy

Major Achievements

The project has successfully influenced district and provincial authorities to adopt and disseminate malaria guidelines. The relationship between the researchers and the local and provincial authorities seems excellent. The appointment of the current KEMRI Kisumu Senior Researcher as national malaria consultant to the malaria control unit in Nairobi (USAID/AFR funds through WHO/AFRO for this position) offers another opportunity for linking the work in Kisumu to national policies and actions

USAID-funded programming addressing child survival

- CARE Kenya – Community-based IMCI project
- UNICEF – 2 projects
- CDC Kisumu
- PCS ARI IEC materials

Section 3. Contribution of other Donor Agencies

DFID

DFID's main contribution to child survival is its Kenya Family Health Project a ten-year project (1992 – 2002) jointly funded by the European Union. The project has three components:

- ? HIV/AIDS prevention HAPAC project. The Futures Group managed project has two elements: support for the National AIDS/STD Control Program (NAS COP) and implementation of a three-year project in Nyanza with the mandate to work with CBOs and NGOs addressing HIV/AIDS prevention and care. The activities of partner organizations receiving support from the project are diverse including syndromic management of STIs, training in home-based care, counseling, Income Generating Activities (IGAs). This is a demonstration project looking for "ideal" projects.
- ? Polio Eradication (East Africa Community) (1998 – 2000). This is divided between the three countries.
- ? Malaria Control. This component has three projects:
 - An employer-based public/private sector project managed by AMREF in Western Kenya. A public/ private sector partnership, the project carries out social marketing of bednets sourcing its netting material, dipping agents.
 - Strengthening of the Malaria Control Unit. A capacity-building project, offering policy guidance and encouraging better use of funds and better coordination. Technical assistance is given to the unit, including a malaria expert and an accountant.
 - East Africa Network for Monitoring Anti-malaria Treatment (EANMAT). Potential NGO.

Kenya is a "low-case scenario" for DFID, and there is little flexibility in funding other projects. DFID appears to share some of USAID funding priorities, albeit on a smaller scale. They have been a key funder in the area of malaria control at the district level and research (based in Kilifi), although they are now focussing their efforts on working centrally and at policy level, and are a supporter of the Roll Back Malaria Initiative.

DANIDA

Currently, all DANIDA funding has been suspended, and it is not known if or when it will resume. Until the suspension of funding, DANIDA's main support to Child Survival was support for vaccine procurement and delivery of the EPI Program, and support to the supply of essential drugs. It was a three-year \$40 million

program. Central to the program were the implementation of reform and a move from vertical to horizontal programming.

Procurement of vaccines was suspended at the end of December 1998 as a result of GOK's failure to meet all the donor conditions for progress of reform. KEPI was unable to purchase drugs; no monies were released from the Treasury. DANIDA made an *ex officio* humanitarian assistance grant of KSh 65 million to provide four-five months of vaccines.

Until 1997-98, DANIDA had a fourteen district Child Survival/Nutrition Program through the Dept. of Cultural and Social Services. Nutrition was seen as an entry point into the communities to offer preventive care and health promotion.

UNICEF

UNICEF/Kenya is winning back donor confidence, but has only a \$3 million budget to operate all of its programs. UNICEF spearheaded the VII Initiative with support from USAID/APHIA and other donors. UNICEF and WHO have supported the establishment of the IMCI Task Force to adapt WHO/UNICEF IMCI algorithms for Kenya. UNICEF Global policy now gives greater emphasis to community-based and the home care practices components of IMCI.

UNICEF's most recent project is a Mother-to-Child-Transmission (MTCT) Prevention Project, supported by USAID through the Population Council (Washington) Horizons Project. The project sites are Kwale, Migori, and Nyamira. The project will be an operational research project, including periodic presumptive treatment of malaria in pregnant women with SP, an AZT trial, intrapartum birth canal flushing, alternative infant feeding programs, and the development of training modules. UNICEF awaits confirmation of funding for a proposed community-based IMCI program in six districts, three of which will be the districts noted above in the MTCT project, the other three being Vihiga, Kajiado and Embu.

UNICEF also proposes to set up district-level pharmacies, creating a demand-driven drug system. This is predicated on the perceived failure of both the system of drug kits and the Bamako Initiative.

Section 4. ISSUES AND FINDINGS

4.1 Focus on children:

Current USAID/APHIA strategies intended to contribute to child survival are a) increasing contraceptive use, b) reducing HIV transmission, and c) increasing local funding for child survival. None of these target children *per se*.

There is a broader debate that needs to be addressed if child survival and children to be placed more firmly if not centrally within APHIA. Much of this debate is going on outside of the context of Kenya and is both an academic and development policy debate centred upon the cracks that are appearing in global population policies in the face of the HIV/AIDS pandemic and increasing or plateauing child mortality.² Long-held assumptions about fertility control and the individual health and economic benefits that would accrue to present and future generations from a reduction in fertility have not been proven. The common-and-garden logic was that once the benefits of the collective efforts of reducing family size had been realized at the individual level then the demand for family planning services would be great and would, therefore, replace the need to maintain supply from the international development purse.

However, despite dramatic decreases in fertility rates in Kenya, there has been only limited and localized improvement in associated indicators i.e. decreasing mortality and morbidity in children and adults. USAID/OPH is rightly concerned about the dissonance between apparent successful achievement of its primary objective within its Strategic Objective 1 and the relative lack of impact in the other activity areas.

A case can be made and has in fact been proven in Kenya that addressing fertility exclusively within a framework of family planning services will reduce the fertility rate. Focussing on the supply side of the equation: standards and regulations, training, supplies of contraceptives and systems have reduced the fertility rate but has not necessarily had a marked and sustainable impact in quality of reproductive health care in general and antenatal and perinatal care in particular. The question here is not the effectiveness of this approach but the its value in addressing other reproductive health issues including child survival. The shift from family planning to reproductive health may have been premature prior to a rethink of what this actually meant in the context of previous programming and the guiding principles derived from population control policy.

The decision to move to Reproductive Health was determined by both dissatisfaction with vertical contraceptive delivery systems³ and the need to address rapidly and systematically the increasing and alarming rate of HIV/AIDS transmission in the country. The Reproductive Health approach, (which implicitly includes sexual health) however, has a very broad definition and scope⁴. It refers to clusters of health problems that impede healthy sexual and reproductive

² Gita Sen et alia Population Policies Reconsidered: Health Empowerment and Rights. Harvard School of Public Health 1994

³ The Safe Motherhood initiative, the Child Survival movement and the United Nation's Decade of Women were agents in promoting integration of family planning into broader reproductive health programs.

⁴ Germain and Ordway define a reproductive health approach that enables women and men, including adolescents, everywhere to regulate their own fertility safely and effectively..., terminating unwanted pregnancies and carrying wanted pregnancies to term; to remain free from disease, disability, or death associated with reproduction or sexuality and **to bear and raise healthy children.**

function and vary according to the health circumstances of a given population. Further, a reproductive health approach has major social, political and developmental aspects beyond the medical and technical challenges it presents. It is fundamentally highly associated with rights particularly the rights and responsibilities of men and women to each other's and their children's health.

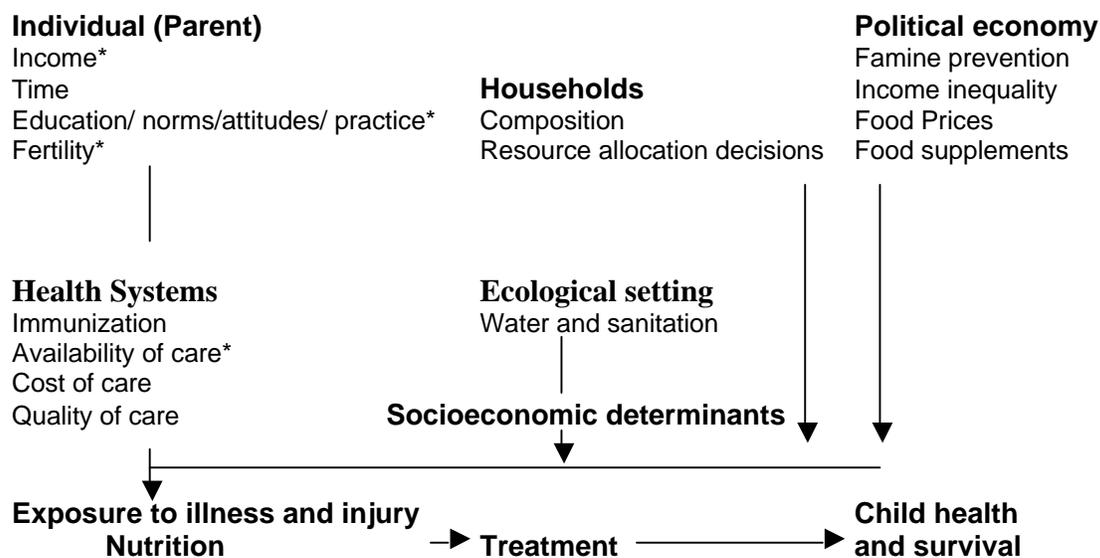
It is clearly not possible for USAID/APHIA to address all aspects suggested by a reproductive health approach but a recognition of the current limits imposed by the somewhat competing priorities of a reproductive health approach overlaid upon a traditional population control program would help organize program thinking in relation to what is possible, achievable and measurable in relation to child survival. The attainment of satisfactory reproductive health as suggested by the Cairo Conference is premised on the attainment of reproductive and sexual rights which are, of themselves, contingent on a myriad of other factors requiring multiple interventions and immense political will.

It is an expressed concern that the emerging notions of what constitutes reproductive health may be too broad to be addressed in a strategic and comprehensive fashion by APHIA. Indeed, a comprehensive intervention program in reproductive health may not be possible within the confines of one donor project unless it were closely linked through government to the various ministries, agencies and organizations who would need to be involved. For example, significantly improved antenatal and obstetric services (just one component of RH which has a direct bearing on child survival) will not be possible without concurrent progress in health reform. Therefore if systemic reproductive health programming requiring synergy at the economic, political and social levels is not realizable, then the placement of child survival within the RH intermediate results may compromise what is actually achievable in child health.

Any progress to improving child survival (children under-five) that may have resulted from reproductive health interventions will have been diminished by the growing impact of HIV/AIDS on children and under-fives in particular (See 4.4) Thus USAID/APHIA may need to review not **what** it is doing in relation to child health but rather **where** it places these interventions in its results framework and how it defines its target group.

Table I gives a model of child health and survival.

A Model of Child Health and Survival*



Source: Abstracted from Mosley and Chen 1984. *Stressed by UNICEF and by the World Bank

If this model is regarded as a comprehensive one⁵, then it can be readily seen that those components of child health which are part of the APHIA project (Family Planning, Immunization, district-level treatment etc) represent only a small part of a strategic approach. It is also no longer clear to what extent these are infant and under-five child survival interventions, they are more accurately child health and survival interventions targeting an undefined-age group of children. If USAID/APHIA continues with its focus on IMCI both at district-level programming and at influencing GOK policy – child health interventions – this should be reflected in the program strategy along with an age definition of target group.

4.2 Significant and severe rises in infant and child mortality:

While neonatal mortality rates remained the same since the KDHS 1993, post-neonatal and child mortality rates have risen by more than one third between the late 1980's and mid-90s.

⁵ Albeit somewhat out of date, for example, "health status" of the parent could be included under the "Individual" category to include HIV.

Table 2 Rates of Early Childhood Mortality – KDHS 1998

Rates of Early Childhood Mortality*					
Neonatal, postneonatal, infant child and under-five mortality by five-year periods preceding the survey, Kenya 1998					
Years preceding survey	Neonatal mortality (NN)	Postneonatal mortality (PNN)	Infant mortality (1q0)	Child mortality (4q1)	Under-five mortality (5q0)
0-4	28.4	45.3	73.7	40.8	111.5
5-9	25.5	42.1	67.7	33.5	98.9
10-14	28.8	33.2	61.9	29.5	89.6

* KDHS 1998

Gains made in reducing neonatal mortality could be ascribed to family planning and antenatal care but this has been more than offset by rise in under five mortality (U5 mortality has increased from 98.9 in 1993 to 111.5 in 1998 per 1000) thus demonstrating that the main immediate **causes** (malaria, ARIs, diarrhoeal disease) of child mortality require interventions beyond reproductive health interventions. There is currently no data as to the relationship between HIV/AIDS prevalence and child mortality in Kenya, however, it is estimated that 153,000 Kenyan children will be carrying the virus by 2000⁶. Most children who are infected at birth develop AIDS and die within two years. Few survive past the age of five.⁷ AIDS is regarded by NASCOP as the defining cause of increased child mortality

However, significant regional differences in mortality rates exist with Nyanza and Western Provinces skewing national rate with rates of 199 and 123 per 1000 respectively suggesting multifactoral causation. HIV/AIDS prevalence in Central and Rift Valley provinces (based on recent sentinel site surveillance in Nyeri and Nakuru) suggest that other areas of Kenya are beginning to approach the high prevalence rates found in the west.

⁶ Orphan Programming in Kenya: Building Community Capacity to Manage Comprehensive Programmes for Prevention, Care and Support. Draft Report USAID/UNICEF April 1999

⁷ AIDS in Kenya NASCOP 1998

Table 3

Neonatal, postnatal, infant child, and under-five mortality by socioeconomic characteristics					
Neonatal, postnatal, infant child, and under-five mortality for the ten-year period preceding the survey, by socioeconomic characteristics, Kenya 1998					
Socioeconomic Characteristic	Neonatal mortality (NN)	Post-neonatal mortality (PNN)	Infant mortality ($1Q_0$)	Child mortality ($4Q_1$)	Under-five mortality ($5Q_0$)
Residence					
Urban	20.3	35.1	55.4	34.8	88.3
Rural	28.4	45.4	73.8	37.6	108.6
Province					
Nairobi	19.5	21.6	41.1	26.1	66.1
Central	17.7	9.7	27.3	6.3	33.5
Coast	27.7	42.1	69.8	27.9	95.8
Eastern	22.6	30.5	53.1	26.1	77.8
Nyanza	38.1	97.3	135.3	73.4	198.8
Rift Valley	28.3	22.0	50.3	18.5	67.8
Western	20.1	43.8	63.9	62.5	122.5
Education					
No education	27.5	54.7	82.2	43.9	122.5
Primary incomplete	31.7	59.7	91.4	51.5	138.1
Primary complete	29.7	31.7	61.4	27.2	86.9
Secondary+	16.7	23.4	40.0	20.7	59.9
Total	27.0	43.7	70.7	37.1	105.2
KDHS 1998					

Field Visit Findings

- ? The main recorded cause of death in children under 5 in Central Province is ARIs.

4.3 Integrated Management of Childhood Illness:

The Integrated Management of Childhood Illness (IMCI) is an initiative of WHO and UNICEF started in 1992 as a strategy for reducing the mortality and morbidity

associated with the major causes of childhood illness. The principle governing IMCI is managing the health of the child rather than the prevention and treatment of disease i.e. it is a radical shift away from vertical programming and prevention and treatment of individual diseases which affect children. The focus of attention is the child and IMCI is based on a rights approach to access to quality child care.

Existing vertical programs force resource-poor districts and service providers to make difficult if not impossible choices as to what and who to treat. IMCI inhibits the default choice not to systematically address child health.

WHO/UNICEF designed IMCI generic clinical training and treatment protocols for first line treatment. These were completed in 1996 and are starting to be used as a basis for treatment in a number of countries. An IMCI approach at referral centre level, requires the clinician to take a full case history of the patient and, in addition to treating the presenting disease, to check the overall health of the child, to treat any other diagnosed illness and counsel the caregiver on treatment or prevention measures.

From a public health perspective, this approach can considerably reduce the numbers of repeat attendees at clinics. The extended length of time of initial consultation is offset by the overall reduction in repeat attendance over time. In areas which have adopted an IMCI approach, it has been found very popular by caregivers/mothers as it both reassures them that their children's health needs are being fully addressed and reduces the amount of time they have to spend in taking their children for treatment.

IMCI has its drawbacks. It is costly and time-consuming to introduce and maintain. IMCI requires a large investment in training and its success, as an effective clinical approach, is dependent upon a reliable supply of appropriate drugs and health facilities which are well equipped and functional.

In response to criticisms of IMCI, UNICEF Headquarters are reviewing the protocols and placing greater emphasis on the community and household level components of IMCI. It is intended that the algorithms will be adapted for caregiver/parent use which will provide parents with the necessary information to give appropriate treatment of the child when necessary and to determine when and if they need to take their child to a referral centre. (To support the availability of necessary drugs in the appropriate dosages, UNICEF wants to encourage the establishment of district pharmacies.) Child nutrition and infant feeding also falls within IMCI. For the districts for UNICEF's proposed community-based IMCI program, IEC materials are being developed for communities and households.

IMCI is still in its infancy in Kenya. WHO has been instrumental in striking a national IMCI Taskforce but the adaptation of WHO/UNICEF IMCI algorithms to Kenya is unlikely to be finalized before 2000. For Kenya, UNICEF is arguing for the adaptation and adoption of IMCI algorithms for utilization by primary caregivers.

The Taskforce could benefit from the research and the lessons learnt deriving from the USAID supported activities in Siaya, Bungoma and Vihiga. A representative from Bungoma DHMT is sitting on the technical committee of the Taskforce. Equally important, would be formal links between USAID/APHIA and the Taskforce to share IMCI research and experience.

ARIs, TB, diarrheal disease, parasitic worms, in general terms, contribute more to morbidity than mortality but their management has been adversely affected by the decline of PHC. IMCI with a broad scope i.e. inclusive of HIV/AIDS related diseases could potentially address these endemic health issues. However, the greatest burden of childhood mortality and morbidity in Kenya remains febrile illnesses mainly malaria⁸, and so it is reasonable to presume that any IMCI programming in malaria-endemic areas would be centered, but not exclusively focussed around issues of malaria prevention and control (see section 4.9).

4.4 HIV/AIDS:

It is known that increasing numbers of children are both infected and affected by HIV/AIDS. The 1998 KDHS suggests that over 530,000 children are either single or double orphans but other agencies suggest that the numbers of children orphaned or affected may be as high as 1 million. Currently the proportion of the above group believed to be infected is approximately 10% but again this may be an underestimate. All figures are based on HIV/AIDS prevalence rates in antenatal clinics.

The two principal areas of overlap between child health and welfare and HIV are: (1) HIV infection of children through vertical transmission in the perinatal period; and (2) Orphanhood and the experience of loss of significant family members. Mother to child transmission of HIV is presently receiving much attention and there is pressure on international agencies to help reduce perinatal infection and

Field Visit Findings

- ? IMCI was well understood in Western and Nyanza. Clinicians had been trained in IMCI from Vihiga, Kakamega, Busia and Bungoma. IMCI was practiced in a number of H.C.s in Vihiga, Bungoma and Busia.
- ? IMCI was known by health staff in Central but not fully understood as an approach.
- ? In Coast Province, the concept is currently unknown even among key health staff

⁸ There is some evidence, including work being done by Kemri/CDC in Kisumu that there is a synergistic relationship between HIV infection and malaria., the presence of one increasing the susceptibility to and severity of the other and influencing the rate of MTCT.

increase child survival. It should, however, be quite clear that any success of these efforts will translate directly into increasing demand for a response to the second issue, the number of orphans caused by the HIV epidemic in Africa.

Although there is a qualitative difference between the childhood experience of family illness, death, or economic hardship, and the experience of orphanhood, the death of the mother can be considered the extreme of a spectrum of the impact of HIV on children. Earlier studies in Africa found that orphaned children were well absorbed into extended family units. But countries with high HIV prevalence soon reached a saturation point and traditional systems of orphan care came under strain. Differences in nutritional and health status as well as access to education have been noted between natural children and fostered/adopted children, with girls being more affected than boys (Meeghan 1998).

The number of orphans in the 19 worst affected countries of Africa including Kenya is twice the number these countries traditionally had to support. At this level, existing support structures are no longer able to absorb the increased demand. In some countries this point was reached some years ago, in other countries it is still not reached. In general, the peak numbers in orphanhood are reached about ten years after peaks in HIV sero-prevalence. This means that even countries like Uganda that have now recorded a five year decline in HIV infection, have not yet reached the peak demand for orphan care.

In the instance of HIV/AIDS, there is a clear and intimate relationship between the reproductive rights of women, the right to control their sexuality, and the rights of their children. One of the most difficult barriers to individual HIV prevention in the HIV epidemic observed in sub-Saharan Africa is the paradoxical division between vulnerability and locus of control among men and women. In the context of a heterosexual relationship, women run about twice the risk of infection during sexual intercourse with an infected partner than men, yet their means of protection are grossly inferior. This is coupled with the widely held belief that women are the carriers and transmitters of infection. As most women in Kenya are a long way from attaining even minimal reproductive and sexual rights, they are unable to systematically and autonomously protect themselves or their unborn children from infection or consequently their children from orphanhood .

The National AIDS Policy, while mentioning women's vulnerability to HIV/AIDS "due to a variety of social and biological factors", does not assert or identify gender relations as a key issue and is vague in its policy guideline: "The Government will work with community agenciesempowering women on matters pertaining to access to information and economic and social recognition." The Policy does not refer to women's primary role as mothers/caregivers and thus the impact of their disease and their deaths on their children.

Policy guidelines to ensure protection of infected and affected children from discrimination and exploitation, is equally as amorphous, not taking into account that like women any rights they have are contingent, marginal and unlikely to be applied.

Field Visit Findings

- ? There was no evidence of any programs addressing children infected or affected by HIV/AIDS in the provinces visited.
- ? HIV rate is now 30-40 percent in a number of antenatal clinics in Central and Western.
- ? No records exist of the number of children infected. Health professionals, in the main, do not regard HIV/AIDS infection in children as an important PH issue.
- ? It is estimated that as many as 50% of U3's of infected mothers are dying irrespective of their HIV status.
- ? All provincial towns are witnessing rapidly increasing numbers of children living (and dying on the streets)

A final point for consideration is a recommendation made in the USAID/UNICEF Assessment of Orphan Programming which is specifically a child survival intervention. It is suggested that to minimise the likelihood of sub-optimal care by professional health or child care workers, or abandonment by mothers⁹, of presumed HIV+ infants, support be given for the purchase of PCR's to be shared by hospitals, orphanages, for encouraging better understanding of the results of antibody test versus PCR testing, and for encouraging generally better care of infants regardless of HIV status.

This recommendation appears both costly and impractical. PCR equipment is delicate, requiring sterile housing and a dedicated technician. Attitudinal change and optimal care are not likely to result from more sophisticated testing and a better understanding of test results. Further, the recommendation side-steps the question that is raised earlier in this section, that a child survival response in MTCT requires a response to orphanhood and the loss of the primary caregiver.

4.4 Immunization:

KDHS 1998 notes that full coverage (all vaccines, ages 12 –23months) has fallen from 79% in 1993 to 65%. Provincial variations in vaccination coverage are marked: Nyanza Province 47% , Western Province 56%, Rift Valley 69% and Central Province 71%. Immunization rates are higher than the national average in Central Province but there remain areas where children are still getting sick and even dying of immunizable diseases, especially measles.

⁹ Do mothers abandon children because of the child's or their own HIV status? Is this well understood?

Nyanza, which had a 65% coverage rate in 1989, has suffered a proportionally greater decline in full coverage than other provinces.

Although districts visited in Western Province and Nyanza claimed that there had been no significant drop in coverage within their districts, reports varied between health professionals. The MTR teams were told that:

- ? logistical support for the transport of vaccines was sporadic
- ? the cold chain appears to have broken down, (the visit to the KEPI depot in Mombasa coincided with a ten hour power cut, the depot having no backup generator),
- ? several teams noted that the areas they visited were characterised by not-infrequent measles outbreaks, many occurring within a five kilometer radius of a service point,
- ? cost recovery on syringes and needles and occasionally record cards put vaccination beyond the pocket of some households,
- ? as a result of the AIDS epidemic, many mothers are suspicious that the needles are not sterilised.

KEPI has been and remains in crisis as a result of withdrawal of donor support (DANIDA) for purchase of vaccines. The failure of GOK to commit its own resources to both purchase of vaccines and immunization program operations has contributed to fall in immunization coverage. GOK has only just signed off on its commitment to VII, and is currently using cost-recovery monies to fund the operation of vaccine program. Reports vary but of the 4 million KSH budgeted for operations, less than a third, if any, has been disbursed.

As a result of above issues and constraints, it is believed that breakdowns in cold chain are occurring widely. There is a suggestion that NIDS (USAID supported) may be having a negative impact on immunization completion as parents/guardians may regard this initiative as offering complete coverage.

The success in gaining GOK commitment to VII may be a pyrrhic victory in the face of DANIDA's suspension of activities and likely withdrawal. USAID/APHIA may need to play a strong advocacy role at senior level and exert its influence in compelling MoH to use its resources for improving/rehabilitating the cold chain and ensuring the reinstatement of immunization outreach services.

4.6 Reduction in foreign aid to health sector:

In the current political and economic climate, the reduction of foreign aid and the reliance on loans for MOH financing has undoubtedly affected child health and survival. Aid money for health sector financing is diminishing and traditional donors are withdrawing as a result of frustration with the pace of reform. Unfortunately, it is the donors who traditionally gave priority to children's health

who have withdrawn in the recent period. In the context of the region, many donors regard Kenya as a low priority for health.

4.7 Health data, HMIS and research:

The severe lack of reliable data on childhood morbidity and mortality hinders analysis of health risks and burden of disease and consequently affects policy planning and programming. Only 30% of district health returns are available at MOH. The lack of response and feedback from the MOH and DHMTs to health facilities acts as a disincentive to record keeping and submitting returns, and the lack of adequate records and HMIS make it problematic to assess extent of morbidity and mortality among children and to design appropriate programming.

The large amounts of money put into the MOH HMIS does not appear to have had any significant impact on record-keeping at all levels. The field visits confirmed the lack of disaggregated data by age and sex in district level outpatient records. This lack of capacity and will to collect, disaggregate and analyze health records at all levels over time makes it impossible to attribute childhood mortality to any one of several possible causes (malaria, HIV/AIDS, ARI, diarrhea etc.) e.g. Are the respective decrease and increase of child mortality in the Coast and Nyanza the result of successful malaria control at the Coast and effects of HIV in Nyanza, worsening malaria in Nyanza or a combination of Malaria and HIV in Nyanza?

4.8 Health Sector reform:

Health Sector reform has been slow and partial, and has yet to translate into adequate delivery of PHC at community-level, negatively affecting children and women. Increasing levels of poverty in parts of the country and sectors of the population have placed most child health care options including purchase of drugs beyond the pocket of many households. The desire of many mothers to find resources to cover healthcare costs for the children means that other essential household expenditures may suffer.¹⁰

4.9 Malaria Control, prevention and treatment:

KDHS 1998 data pointing to higher than average infant and child mortality suggests that malaria and malaria-related illness remain major contributors to increases in child mortality. The conclusion of the recent Durban conference on malaria and all recent research is that malaria is the dominant child survival component in the burden of the disease in Africa and will be for some time to

¹⁰ CDC/Kemri in Kisumu has conducted research which demonstrates the extraordinary lengths mothers/caregivers will go to find and pay for treatment for their children.

come. It continues to swamp most health systems accounting for 30% of all health facility attendances.

There are three well-recognized means for addressing the burden of malaria: early and effective treatment of febrile episodes, use of insecticide-impregnated nets and materials, and reduction in placental malaria infection by intermittent treatment of pregnant women with an effective antimalarial:

Early and effective treatment of febrile episodes and treatment of pregnant women

Recent development of revised treatment guidelines for treatment of malaria in Kenya facilitate effective treatment in children and pregnant women. However, the guidelines have yet to be widely disseminated or supported by health worker training, and the provision of the required drugs is inadequate to enable health workers to follow the guidelines in much of the country. SP is only available in areas with external project support, and chloroquine is still prescribed in most GOK facilities despite 80% resistance. Under treatment of childhood anemia occurs as a result of limited recognition of anemia by health workers.

Effective implementation of these two interventions: early and effective treatment in households (where it has been demonstrated that 70-80% of febrile illness in Kenya is treated) and facilities and presumptive treatment with SP in pregnancy would greatly reduce malaria-related morbidity and mortality including the effects of anemia, maternal anemia, low birth weight and its attendant infant mortality, and perhaps (the research findings are not yet definitive) vertical HIV transmission.

ITNs

Insecticide-treated nets have been proven in virtually every type of malaria transmission zone to reduce overall child mortality by 20-30%. Evidence from western Kenya suggests that as much as 25% of child death and a major part of child anemia can be averted by use of ITNs. Reduction in numbers and severity of febrile episodes in children has been shown to substantially reduce household expenditures on child illness. However, the MOH has no overall strategy for implementation of ITNs in the country. Kenya has a lively private sector eager to enter this market. There have been a number of successful research and NGO projects using ITNs and the UNICEF Bamako Initiative revolving funds were successful for a period in providing subsidized ITN coverage in Kenya. None of these efforts has yet to be brought to scale over the long haul.

One unifying mechanism for providing effective treatment and prevention with ITNs is the expanded IMCI, meaning both provision of integrated management in facilities but also selected interventions (including recognition and treatment of malaria and ITNs) in communities. Kenya has only just begun the process of introduction of IMCI with the formation of a Task Force. As discussed above,

adaptation of the IMCI, definition of the community elements for Kenya, and gearing up for training and implementation will take several years at best, and will require substantial financial commitment from government and donors.

The experience of facility-based IMCI in Vihiga and Bungoma Districts, carried out by CDC with minimal engagement of central MoH, has been positive. The districts continue to train, supervise and logistically support facility-based health workers in IMCI. There has not been as yet, any development in these districts of community-based IMCI. The relevant community work has focussed on malaria. Even the malaria work in communities has emphasized IEC for recognition and treatment and not ITNs.

Roll Back Malaria

The global movement to Roll Back Malaria offers another opportunity to use a malaria-specific focus to improve child survival and in the long term support integrated interventions such as IMCI. USAID/Washington has made a firm commitment to (Roll Back Malaria) RBM partners to continue support for regional leadership for RBM and to facilitate bilateral coordination and mobilization of resources locally. The level of USAID/Kenya resources which can be brought to bear on malaria (and IMCI as the major vehicle for malaria intervention) is significant. Both child survival and infectious disease funds can be coordinated with those of other donors and partners in Kenya. This coordination already takes place through existing mechanisms in Kenya but must be strengthened.

Focus for USAID/Kenya

The three arenas of action outside Vihiga and Bungoma which offer the greatest potential for effective USAID/Kenya intervention are:

- 1) the national Task Force on IMCI (relating district experience to policy),
- 2) the national malaria discussions (policy, RBM), and
- 3) Nyanza Province (treatment, pregnancy, research).

These arenas, together with a focus on malaria and IMCI, can provide direction for child health and child survival activities in the future.

Field visit findings

? In the Coast, all senior staff was aware of the new National Malaria Guidelines although not all of them had seen the guidelines. Concerns were raised in that even though the malaria policy has changed, the drug kit had not changed to support the policy

? In certain districts in Central such as Muranga, the most common cause of mortality in all age groups, including under 5, is malaria although in the province as a whole there are very few cases.

4.10 Maternal Child Health and links to Safe Motherhood:

GOK policy and practice on safe motherhood only addresses neonatal health and does not include infant and child health. MCH/reproductive health approaches tend to collapse women and children's health into a unity and do not take a broad view of either women or children's health. In this context adolescent girl children tend to be viewed and addressed only in relation to their reproductive health and not as children with other health and developmental needs.

As well, poor facilities at ANCs and Delivery Sites (DSs,) lack of diagnostic and birth delivery skills and lack of drug kits all act as disincentives to utilization and negatively affect child survival. Despite the research and evidence that presumptive treatment of malaria in pregnancy reduces risk of low birth weight (and hypothetically MTCT), this information has not been disseminated nor included in clinical protocols. Limited treatment of anemia in pregnant women results in anemic children (only 1/3 of pregnant women attending ante-natal clinics receive iron supplements¹¹).

Trials are underway in Kenya (See Section 2.2) and elsewhere which will inform preparation of guidelines for weaning in relation to vertical transmission of HIV (MTCT), and infant feeding practice and guidelines will need development in relation to changing policy on weaning.

Adolescent pregnancy is a growing high risk factor in child survival, although the extent of risk is not clear from currently available data. It is known, however, that adolescent girls are six times more likely to contract HIV/AIDS than adolescent boys. Their vulnerability to infection places their children in a very high risk group as mothers in this category are the least likely to receive antenatal care or interventions to reduce MTCT.

4.11 Nutrition

The 1998 KDHS estimate of the prevalence of chronic under nutrition or stunting is 33%, about one third of these are severely stunted. These estimates of stunting closely parallel those based on the 1993 KDHS data, suggesting no improvement in the nutritional situation of young children over the last 5 years.

Children living in rural areas are 30% more likely to have a low height-for-age (stunting) and 22% more likely to be low weight-for-age (wasting) than their urban counterparts. Field visits in Western and Central, found that the prevalence of stunting was significantly higher than the national average (45-50%)in areas of commercial agriculture (sugar and coffee growing areas)

Child nutrition programs have suffered from the reduction in donor funding and health sector reform. Field visits confirmed that growth monitoring programs have

¹¹ Kirinyaga 1996

all but stopped in most districts. Surveys undertaken under the auspices of DANIDA and other donors demonstrating prevalence of malnutrition have not been followed by any systematic interventions. The lack of focussed interventions appears to be partly the result of unclear lines of responsibility between district departments. Nutrition surveys were carried out through the social development departments but programming follow-up would need to be conducted as a joint effort with the DHMT and the agriculture department.

The poor nutritional status of infants and children is well-understood to be a major contributor to morbidity and mortality in childhood and under performance in school. It will be valuable for USAID/Kenya to observe the progress and impact of UNICEF's 6 district community-based IMCI and nutrition project to determine whether this is an intervention area it might want to consider at a later date.

4.12 Health Promotion and Disease Prevention:

Health promotion and disease prevention in children is largely neglected outside of malaria prevention and water and sanitation programming and EPI. Infant and child nutrition programs represent the only GOK health promotion intervention.

Stakeholders/key informants believe that there is a major need to address the whole child and to support and encourage community-based well baby and well child programs. The various reasons for such programming included: the breakdown of PHC, the limitations of disease-based approach to health i.e. psychosocial development and well-being of children is inseparable from physical health (Neumann and Bwibo Embu study), and limits on the capacity of women to be responsible and held accountable for child health.

Involvement of men both as fathers/caregivers and as community leaders is regarded as critical to systematically addressing health promotion and well being in children. Informants cited examples of successful well baby and child programs in Egypt and Nigeria where community elders took responsibility for health status of the children in their communities.

Valorizing children *qua* children rather than as symbols of status and fertility or future economic value may be key to future IEC campaigns.

4.13 Bungoma District Initiative:

The project has been hampered and complicated by the somewhat competing objectives of USAID/APHIA and AIMI Washington. As a consequence, B.D.I. was baptized B.D.M.I. by the DHMT who view the project in the first instance as a malaria control project which should more strictly adhere to the traditional model of malaria control including vector control. The child focus has apparently lost its centrality. There is a strong sense of unease both within USAID and other

stakeholders that the initiative may have an inappropriate funding mechanism. It is thought that the DHMT, when agreeing to be the implementer, did not at that time fully comprehend the funding mechanism..

The initial round of interviews with stakeholders in Nairobi suggested a level of dissatisfaction with the current state of the project and pointed to difficulties with the project design. Although in theory iterative and flexible, there is currently little room for flexibility and refocus within the strategy document.

The DHMT although appreciative of the infrastructural support by way of office rehabilitation, vehicle purchase and repair and computer purchase, has explicitly expressed strong dissatisfaction with the project for the following reasons:

- Too much research resulting in communities becoming fatigued by being too frequently subjects/objects of research and frustrated at the absence of any tangible interventions or inputs;
- No sense of ownership of the research nor the sense that they are full partners in the project.
- Lack of transparency vis. proportion of budget going to non-Kenyan CAs;
- Lack of allowances and/or incentives for conducting additional tasks associated with BDMI;

AMREF both at headquarter and at district level is concerned by the frequently difficult relationship with the DHMT resulting from the above. AMREF believes it is in an ambiguous position in its project coordinator role putting in question team-building and mutual respect and trust necessary for effective implementation.

The operational research component has largely dominated project activities since project launch. As none of the CAs, apart from AMREF, had a permanent presence in the district, logistical support and organisation for the research operations was demanding and occasionally problematic. Staff persons from the respective organisations have come in and out of the district for short periods to manage the various stages of research studies (establishing research protocols, setting up data collection systems etc.) but frequently leaving the DHMT members to conduct the research. This combined with much of the data analysis being done elsewhere has left the DHMT feeling (probably justifiably) ill-used.

A further criticism emanating from both the DHMT and health facilities involved in the research is the lack of adequate dissemination of the research findings and recommendations. At the DHMT-level, it is clear that in the light of CA personnel only coming for short periods intermittently there is now resistance to being called to dissemination meetings to suit CA schedules. It is less clear as to why dissemination of findings is not occurring with research site staff or key public health officials. At Webuye Hospital, a study site for CDCs Malaria in Pregnancy Research, neither the matron nor the Public Health Officer had heard about the findings.

Mid Term Review (MTR) team members witnessed diagnosis and treatment of fever and anemia in three health facilities in the district..

Clinical officers and nurses in three health facilities visited by the MTR team were using IMCI diagnostic approaches and recommended treatment for fever and anemia. Sulfadoxine-pyrimethamine (SP) was always prescribed although not routinely found in the drug kits. Two of the three facilities were able to show adequate stocks of Sulfadoxine/Pyrimethamine (SP) and iron and folate SP was, however, prescribed jointly with chloroquine (CQ) in the hospital facility despite it being generally well understood that CQ was ineffective.

In considering the findings it is important to note that the project is very young and very ambitious. Therefore, the brief review of project activities permitted within the APHIA MTR can only offer a thumbnail sketch. It also needs to be noted that teething problems are to be expected at this stage of any large and complex project.

4.14 Information, Education, Communication (IEC)

Child survival and child health receives little direct or exclusive attention at provincial or district level. District health staff who have received IMCI training are more conscious of the need to provide counselling to caregivers but this is conducted at an individual level. PH officers and technicians will take action at the community-level only in response to outbreaks of measles or cholera.

It is apparent that the focus of PH energy and resources is currently and importantly the prevention of HIV/AIDS. However, an IEC campaign promoting the healthy child is an important component of national health and was an effective strategy in post-war Europe and North America in improving child health on both continents.

5. RECOMMENDATIONS TO USAID KENYA

- 5.1** It is recommended that the child survival component of the APHIA strategy document be rewritten to clearly focus on the child rather than on interventions, and to reflect the impact of HIV/AIDS on children's health and well-being. This can then be used to form the basis for USAID Kenya to assess and document the changing environment for children as the AIDS pandemic matures. This will ensure that USAID has a voice in the policy and programmatic fora that will take place in the coming months.

- 5.2** It is recommended that the continuation of district-level IMCI with a focus on malaria is continued. Expansion of any IMCI initiatives into districts without existing facility-based IMCI would be inappropriate until such time as the IMCI national Taskforce has adapted the UNICEF/WHO algorithms, planned training and budgeting strategies and gained necessary GOK approval. Further training of service providers in IMCI, careful supervision and monitoring, an assessment of impact, and greater community involvement is required in Vihiga and Bungoma where IMCI is being done. USAID/Kenya support to the IMCI work in the two districts should continue, both in expanding and strengthening IMCI in facilities and in developing the strategy for IMCI in communities. This would certainly be reinforced by USAID/Washington's strong emphasis on IMCI as the vehicle for delivering child survival interventions. The lessons learned from the experiences of IMCI in the two districts can continue to inform the taskforce and be usefully disseminated among interested parties at provincial as well as at national and regional level. A continued focus on malaria is called for in the light of the global Roll Back Malaria WHO initiative.
- 5.3** It is recommended that the VII continues to be a focus of APHIA attention and that USAID/Kenya uses its influence with MOH KEPI to encourage the full resumption of immunization outreach services and the rehabilitation of the cold chain.
- 5.4** It is recommended that options be explored to continue the research collaboration between CDC and KEMRI in Kisumu, particularly in the areas of outstanding questions which will expand and improve interventions in child survival, such as caretaker recognition and response to anemia, development of anemia and immunity in children, malaria and HIV vertical transmission, optimal strategies for breast-feeding to minimize vertical transmission, etc. As a consequence of the high quality of research, the collaboration could utilise existing data to answer more general questions on child survival which would have applicability to the rest of the country.
- 5.5** It is recommended that USAID/APHIA explore the possibility of one of its existing CAs developing a low cost community-based health child programme using community skills and resources. This might be initiated in one of the six UNICEF project sites.
- 5.6** It is recommended that USAID/APHIA revisits its results framework and its strategy document to ensure that reproductive and sexual rights and

specifically the gender implications of the AIDS epidemic on both adults and children be addressed systematically.

6. RECOMMENDATIONS TO USAID WASHINGTON

- 6.1** It is recommended that the current system of budget allocation for APHIA be reviewed. In recent years, significant changes made to the annual budgeting from Washington for APHIA programming has been a cause of limited monies going to child survival activities.

List of Interviewees for Child Survival Assessment

Central Province

1. Provincial Medical Officer
2. Deputy PMO and Provincial Pediatrician
3. District Development Officer
4. District Children's Officer
5. District Public Health Officer
6. Regional Depot Officer (in charge of vaccines)
7. Health Development Coordinator, Consolata (Catholic) Hospital
8. Project Director, Karatina Home Based Care and Counseling Medical Clinic
9. District Health and Management team, Muranga District
10. Clinical Officer, Marie Stopes RH Clinic and birthing center
11. Nurse, Self-help Dispensary

Coast Province

1. Dr. Adongosi, Deputy PMO, Coast
2. Mr. Komora, In-charge KEPI Depot Coast
3. Mr. Macharia, Provincial Health Administration Officer
4. Dr. Getambo, Administrator, Coast general Hospital
5. Mr. Haro, Social Worker, Coast general
6. Mrs. Ali. In-charge MCH/FP, Coast general
7. Mr. Mutinda, Clinical Officer, Tiwi Rural Health Training center
8. Dr. Tsuma and the Kwale District DHMT
9. Mr. Salim ... Aga Khan health services
10. Mrs. Margaret Mwiti, AMREF Kaloleni RH Care program, Kilifi
11. Mrs. Margaret Nyoka, AMREF Kaloleni RH Care Program

Nyanza Province

1. Administrator, Marie Stopes Clinic
2. Nurse Counsellor, Marie Stopes Clinic
3. Director, Family Planning Association of Kenya
4. Nurse, Family Planning Association of Kenya
5. Dr. Muzore, acting Medical Supervisor for the New Nyanza Provincial Hospital
6. Programme Officer for EU-FHP, CARE, Kisumu
7. Dr. Ochola, Medical Officer of Health
8. District Officer, Siaya
9. Nurse, Ting' Wangi Dispensary, Siaya
10. CBDs, Siaya
11. Bishop
12. Bernad Nahlen, head of CDC part of CDC/KEMRI
13. Penny Phillips-Howard, CDC/KEMRI
14. Feiko ter Kule, CDC/KEMRI

Western Province

Veronica Okoti Provincial Matron
Dr. Quido Ahindikha, Kakamega MOH
Clement Were Kakamega District Health Education Officer
James Kuya D.H. Records Officer Kakamega
Enid Washika DPHM Kakamega
Jackson Shiyuka District PH Officer
Joyce Lungaphar District Public Health Nurse Vihiga
DPHO Vihiga
Gekonge Gesage District Social Development Officer Busia
DHMT Bungoma
Hezron Ngugi AMREF
Steve Mukoma BDI DHMT Counterpart
Prisca Nyanguka Odityo Matron Webuye District Hospital
Mr Kwoba PH Officer Webuye District Hospital

Nairobi

1. Dr. M. Hassan, Director, Division of Primary Health Care
2. Dr. Sarah Onyango, Manager, KEPI, Division of Primary Health Care
3. Ms. Joy Opumbi, Program for Integrated Management of Childhood Illnesses, Division of Primary Health Care,
4. Ms. Benta Shako, Chief Nutritionist, Division of Primary Health Care\
5. Earling Larson, Advisor to KEPI, DANIDA
6. Alberto Gallacchi, Advisor, Health Sector Support Programme
7. Ian Sliney, Chief of Party, Management Sciences for Health
8. Dr. Alistan Unwin, Dfid
9. Jason Lane, Programme Officer, DFID
10. Dr. Kariuki, Health Planning Management Unit, AMREF
11. Dr. John Ndube, Health Planning Management Unit, AMREF
12. Ms. Jane Gitonga, Division of Primary Health Care
13. Mrs. Margaret Muiva, Chairman Department of Nursing, University of Nairobi
14. Mr. Ole Kiu, Chairman, Clinical Officers Association
15. Chairman, University of Nairobi Community Health Department
16. Dr. Muge, Infectious and Communicable Diseases, WHO
17. Dr. Tabitha Oduori, WHO
18. Don Dickerson, HAFAG Project, Futures
19. Swaleh Karanja, CARE-Kenya
20. Dr. Grace Miheso, CARE-Kenya
21. Dr. Marinus Gotink, Health and Nutrition Officer, UNICEF
22. Jane Kariuki, Nutritionist, UNICEF Kenya
23. Helena Eversole, UNICEF Kenya
24. Kimberley Gamble-Payne, Senior Rights Officer UNICEF Regional Officer
25. Francis Farmer, Director of Programming, Pathfinder

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INTERVIEW GUIDELINES

District level – DHMT, private and mission hospitals, and GOK hospital administrators

DHMT

IMCI – Integrated Management of Childhood Illness

General

What are regarded to be the critical issues facing children's health and well being in this area (geographic)?

How are children targeted in this area for:

Preventive/ promotion health care?

Curative care?

What preventive/ promotion and curative are being taken with regard to

0 – 12 months

12 mths – 5 years

5 – 12 years

12 – 18 years

What initiatives/programmes/projects have addressed child health and well being during the last 10 years?

To what extent have these been effective?

Are Safe Motherhood initiatives regarded as addressing childhood survival and to what extent have these been effective in reducing childhood mortality?

Have you heard of the IMCI programming approach?

If yes, what is your understanding of IMCI?

(explain IMCI if not known)

Are you or have you initiated any IMCI strategies in the district? (if no known IMCI projects in the area)

What do you see to be the potential advantages and constraints to implementation?

At district and provincial level

At health center/ dispensaries level

Resource allocation

What resources in terms of skills, equipment, budgetary allocations and personnel (trained and untrained) do you have available for primary health care?

What percentage of those resources benefit children's health either directly and indirectly

What measures are being taken to address this?

With limited resources what could be done to promote child health and well being at the district-level?

Community- level ?

If you had limited resources and wanted to prioritize where to put money to help reduce child mortality, where would you put it?

Drug Supply (may not be necessary, depending on questions of H.S. reform)

To what extent are you satisfied with the supply and composition of drug kits?

Do you have drug kits for all service delivery points?

How do you get your drugs out to the dispensaries? Do you have a delivery schedule?

Immunization

In general terms, why do you think immunization rates are going down in your area?
How many children are you immunizing per month (immunization records per health unit)?

Do you think you are capturing most of the children in the district? If no, why? If yes, why?

Additional prompts

- Why do you think parents/caretakers are not bringing in children for immunization?
- Why do you think some the children are not completing their immunization schedules?
- What are some of the reasons that people are not bringing in for vaccination?

How are you promoting immunization activities in your area?

To what extent do you think the district is feeling the impact of declining immunization rates?

What are your proposed strategies for addressing declining immunization?

Nutrition

Do you have any sense of the overall nutritional status of children in the district? How would you characterize it?

How are you monitoring nutritional status for

0 – 12 months

12 months – 5 years

5 years – 12 years

What initiatives and programmes addressing child nutrition are in place?

How are promoting good nutrition?

Who is currently supporting nutrition programmes in your district and to what extent?

What was the effectiveness of the government's nutrition Programme for Action in the 1990's?

Given existing resources, how could nutritional status of under 12's be improved in your area?

HIV/AIDS/ TB

What do you estimate the HIV/AIDS prevalence rate in your area to be?

How are you monitoring infection rates?

What would you estimate the mortality rate is from HIV/AIDS in your area?

What is the direct/ indirect impact of HIV/ AIDS prevalence on children's health and well being in the district?

How are you monitoring this?

To what extent and scale have children been affected by HIV/AIDS in this area? Please be specific.

What initiatives (GOK or other agencies) are in place in this area for addressing the needs of affected and infected children.

Are you aware of an HIV/AIDS and breastfeeding policy in your area? What is it?

How are you monitoring TB prevalence among children, particularly those affected by AIDS?

Malaria

Do you regard this district as a hyperendemic area for malaria?

How are you addressing malaria in the area? What interventions are in place (be specific)

Who is supporting these interventions?

Are you aware of the Malaria Control Unit policies?

If yes, are you implementing them? What are the constraints?

How do you think children are affected by malaria in the area?

How specifically are you targeting the effects of malaria in the area.

Malaria related conditions:

Are you monitoring ARI among children? If so, how?

Are you monitoring anaemia among children? If so, how?

Do you have protocols in use for treatment of anaemia , ARI's in children.

Research and record-keeping

Are you receiving health records from all facilities in the district, public and private?

What are you doing to ensure returns are made?

How are you currently using health returns?

Are returns disaggregated by age and sex?

Are you able to analyse health status of children up to 18? If so, how?

For Siaya, Bungoma, Vihiga

IMCI initiatives are being piloted in your area. To what extent are you aware of these initiatives and monitoring their implementation?

What do you consider to be the benefits and strengths of these project models?

Do you think it would be possible for the district to continue with these projects at the end of the project life? What would be constraints (please be specific)?

Dispensary and Health Centres

How many children do you estimate you treat per day?

0 – 12 months

12 months – 5 years

5 years – 12 years

What symptoms are you treating in these 3 age groups on average?

What symptoms do you see and how do you treat these symptoms?

How do you follow up on treatment?

On average, how many children do you refer per day? Where do you refer them to and what is the average distance to the nearest referral centers?
 What do you feel are the critical issues regarding children's health and well-being in this area?
 What are the constraints to treating children?
 What childhood health promotion and disease prevention is being undertaken in the community? By whom?
 What equipment do you have available – prescription books, torch, tongue depressor, thermometer, pressure cuff, weighing scale, fridge
 When did you receive your last drug supply?
 Is it a full kit as per specification?
 Are you receiving SP, iron supplements, erythromycin? In what dosages?
 Is the supply adequate
 What other sources do you have for drugs?
 On average, when does the drug kit run out?
 What happens when you run out?
 (Check of records for a couple of days – Are ages and sex of children recorded?)
 How are you managing your record keeping?
 Are you able to make returns on a monthly basis?
 Do you receive any response from the DHMT on the basis of your returns?
 Given the limitations on means and resources, what kinds of initiatives would you suggest to address child health and well-being in this community? Be specific in relation to age groups?

Community Development Officer

What do you regard to be the key issues facing child health and well-being in the district?
 (Press for more than HIV/AIDs)
 Which age group, in your opinion, receives most attention in terms of services and why?
 0 – 12 months
 12 months – 5 years
 5 years – 12 years
 12 – 18 years
 Which age group receives least attention and why?
 Which age group do you believe to be most at risk/neglected?
 Which group of children (not necessarily age cohort) are the most vulnerable at present?
 Why?
 What is being done within the district to address childrens' needs (social, and emotional as well as educational and physical)?
 To what extent are children affected by HIV/AIDs rates in the district?
 How is the district addressing rising numbers of orphans and street children?
 Are there systems in place to monitor numbers and status of children affected by HIV/AIDs?
 How, in your opinion, are communities managing growing numbers of orphans?

ISSUES PAPER ON HIV/AIDS

Prepared for the APHIA Mid-term Review

May 1999

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ACRONYMS

AIDS	Acquired immune deficiency syndrome
AIMI	Africa Integrated Malaria Initiative
APHIA	AIDS, Population and Health Integrated Assistance (Project)
BCC	Behavior change communications
BDI	Bungoma District Initiative
CA	Cooperating agency
CDC	Centers for Disease Control
FHI	Family Health International
FP	Family planning
FPAK	Family Planning Association of Kenya
FPSP	Family Planning Private Sector
GOK	Government of Kenya
HIV	Human immune deficiency virus
IEC	Information, education, communication
IUD	Intra-uterine device
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
MCH	Maternal and child health
MOH	Ministry of Health
MTR	Mid-term review
NASCOP	National AIDS and STD Control Programme
NGO	Non-government organization
OPH	(USAID/Kenya) Office of Population and Health
PCS	Population Communication Services
PLWA	Persons living with AIDS
PSI	Population Services International
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TB	Tuberculosis
UNICEF	United Nations Childrens Fund
VCT	Voluntary counseling and testing
WHO	World Health Organization

I. Purpose

A complete review of HIV/AIDS was not proposed under the AIDS, Population and Health Integrated Assistance (APHIA) mid-term review (MTR) since the Kenya program strategy was completely revised in May 1998, with large stakeholder input. Since that time, the USAID/Kenya Office of Population and Health (OPH) has begun to orchestrate the implementation of that strategy by working closely with our cooperating agency partners, both old and new, to make sure that their implementation plans and workplans fit the new vision proposed under the strategy. Therefore, the purpose of this issues paper on HIV/AIDS is to:

- give an overview of USAID's assistance to the HIV/AIDS sector during APHIA, comparing APHIA's original vision with the actual accomplishments;
- review the needs identified during USAID/Kenya's 1998 HIV/AIDS design and outline the approaches proposed;
- summarize ongoing and planned HIV/AIDS activities;
- highlight findings of the MTR team related to HIV/AIDS which may call for adjustments in APHIA's current HIV/AIDS strategy.

A cautionary note to suggestions made in this and other issues papers developed under the MTR is that USAID/Kenya's level of funding for HIV/AIDS programming for the foreseeable future is unlikely to be increased. Therefore, priorities will need to be set and difficult choices will continue to be necessary in terms of selecting one critical activity over another.

II. APHIA's vision and accomplishments

APHIA proposed to rely on a number of strategies and interventions in undertaking its HIV/AIDS program. While many strategies met or exceeded their proposed objectives, others were less than successful. A summary of APHIA's 1995 vision as compared to its achievements follows:

- **Donor coordination and dialogue**

Vision: APHIA was to have supported the development of mechanisms to coordinate Ministry of Health (MOH) and donor activities, explicitly in the area of condoms (both to assure sufficient condom procurement and explore potential for cost recovery) and other proposed social marketing activities. Proposed fora included the Population and Health Donors' Group, the Kenya AIDS NGOs' Consortium, and the Integration Working Group.

Achieved: OPH staff participated actively in the Population and Health Donors' Group since 1994. In addition, with the advent of UNAIDS in January 1995, USAID was the lead donor in developing the AIDS/STD Working Group in an effort to assure an additional forum for discussion of technical issues related to HIV. In both 1995

and 1997, USAID researched and published a donor inventory which outlined all the activities of the other donors in the health, population and AIDS sector. The Integration Working Group, begun in 1994 through USAID funding to Pathfinder, worked for a total of 3 years through 1997, and played a valuable role in clarifying family planning (FP) and HIV/AIDS integration issues. The Kenya AIDS NGOs' Consortium, with USAID funding remained a key player in assuring collaboration particularly among Kenyan NGOs. Assuring condom procurement and cost recovery, although not yet resolved, has been a consistent concern during the entire period. At present, USAID is prepared to assist the MOH to develop a contraceptive strategy which includes condoms.

- **Policy dialogue/advocacy to assure resources are available and to create a supportive public and private sector environment.**

Vision: Under APHIA, USAID was to continue to support selected HIV/AIDS policy dialogue and advocacy activities including assistance to the Kenya AIDS NGOS Consortium and improving advocacy capacity among political, religious, educational and other opinion leaders and private sector employers through training in the AIDS Impact Model, improved capacity to write and disseminate HIV policy reviews, articles, analyses to describe socio-economic impacts of HIV/AIDS in Kenya and other issues related to the evolution of the epidemic. APHIA was to continue providing financial assistance for the rural sentinel surveillance sites and technical support and training for the NASCOP staff. Finally, APHIA was to have assisted in establishing a sexually transmitted disease (STD) surveillance system.

Achieved: With the exception of establishment of an STD surveillance system, which was deemed too expensive and of uncertain utility, USAID's assistance in the policy arena exceeded expectations. USAID supported the government of Kenya (GOK) to collect surveillance data from rural and periurban sites and provided technical assistance in analyzing and publishing the surveillance data. USAID supported training for planners and policy makers in the public and private sector to increase awareness of the impact of HIV and to anticipate and plan for the impact of AIDS on the public sector budgets. USAID, with its host country partners, also undertook studies and assessments which reviewed policy implications of the AIDS epidemic at the household, sector and macroeconomic level. These studies resulted in a much-acclaimed book on the *AIDS in Kenya: Socioeconomic Impact and Policy Implications* which was widely quoted in and thought to have contributed to the passage of the *Sessional Paper on AIDS in Kenya* in 1997. Other policy interventions included support for workplace programs and institutional strengthening of selected umbrella NGOs and religious organizations to promote a policy agenda within their respective constituencies.

- **Increased access to condoms and improved management of STDs.**

Vision: Condom social marketing activities under APHIA were to have been carried out in three different settings: at the national level, in USAID-funded non-governmental integrated service delivery settings and in selected focus districts. At the national level the project was to work in all provinces; focussing marketing and sales efforts in urban areas selected during the project planning phase. Population Services International (PSI), the contractor, was to have worked closely with USAID-funded NGOs and community-based distributors to increase sales of condoms in private sector settings and to progressively attempt to move from "free to fee" in settings such as worksites where people can afford to pay for condoms. In the geographic focus districts, the contractor was to have undertaken an intensified program in order to show increased impact. The APHIA project paper envisioned USAID would support the condom social marketing through December 1997 at which time other donors would begin to assist with financing. At the end of the 2001, USAID anticipated that a sustainable mechanism would be in place to enable private sector sales of condoms to be continued without additional donor funding.

Achieved: The quantifiable success of the condom social marketing program is outlined in the MTR issues paper on social marketing. The sales of *Trust* condoms have exceeded expectations countrywide with 1999 sales at about 1 million per month. In addition, since the beginning of APHIA, PSI has made important progress in pioneering the placement of high quality anti-AIDS campaigns in the media. The areas which were not completely successful were in moving from "fee to free" condoms among USAID-funded private sector grantees and in development of a private sector entity, which is only now becoming a reality. In the one geographic focus district of Bungoma, intensified programming is also just beginning.

- **Integration of HIV/AIDS/STD prevention activities into the nationwide USAID-funded FP/MCH service delivery network.**

Vision: APHIA's HIV/AIDS strategy was to accelerate and scale up the integration of HIV/AIDS prevention activities into the nationwide USAID-funded FP/Maternal and Child Health (MCH) service delivery network, with a particular emphasis on improving the diagnosis, treatment and prevention of STDs. All APHIA HIV/AIDS activities were to have specifically targeted women and adolescents.

Achieved: USAID has promoted integration of HIV/AIDS/STI prevention into traditional MCH/FP service sites through information sharing, training and research. USAID's ongoing programs in logistics management, district based training, quality assurance and clinic based and community based service delivery are important elements that contributed to the overall results in HIV/AIDS. In addition, USAID has provided support for innovative research which included studies on counseling and testing efficacy, acceptability and efficacy of female condoms, vertical transmission of HIV in pregnant women with malaria, HIV transmission among users of intra-uterine devices (IUDs), dual method use and many others. USAID has also supported various modeling

programs which are designed to help GOK planners make decisions based on data.

- **Communications focused on behavior change and including behavioral research to refine the targeting of appropriate messages.**

Vision: Behavior change communications (BCC) at the national level under APHIA were to have been done in an integrated format, emphasizing the intimate links among HIV/AIDS, STDs, family planning and child health. Development, field-testing and evaluation of integrated messages were to have been developed and a mass media campaign undertaken. Also, under the district focus, BCC was to have been a cornerstone with APHIA supporting a pilot counseling and testing center and selective, innovative, participatory education and communication activities, with appropriate cultural and language considerations.

Achieved: The Family Health International (FHI) AIDSCAP project, which ended in September 1997, two years into the APHIA project, undertook many BCC interventions. Evaluations of over 20 FHI subprojects showed impressive results in the areas of numerous behavior change interventions including mass media, theater troupes, peer education programs in universities and worksites; and support to NGOs to develop appropriate (information, education, communication (IEC) materials. The follow-on Kenya AIDS Project continued work in IEC. In addition, the HIV/AIDS work undertaken by other cooperating agencies, including PSI, Population Communication Services (PCS), Pathfinder, FPAK, PATH and contributed to the large, if unorganized, effort to produce materials and change behavior.

- **Implementation of a comprehensive set of activities in a defined geographic area.**

Vision: The district focus, as originally planned, was designed to work in several districts with the overall objective of targeting USAID resources where the needs for strengthened health, family planning and reproductive health services were the greatest in order to generate impact. HIV/AIDS activities were to be a cornerstone of the work to be undertaken in the target districts. In fact, due to cuts early in the APHIA design, the concept of a comprehensive district focus was dropped.

Achieved: As a result of a funding windfall from the USAID/Washington program, the Africa Integrated Malaria Initiative (AIMI), the district focus was transformed into the Bungoma District Initiative (BDI). The focus of BDI was malaria in children and pregnant women. Only in 1999, were explicit HIV/AIDS activities begun under the aegis of PCS. This activity, however, will be completed in June 1999.

III. USAID/Kenya's HIV/AIDS program

In May 1998, USAID reviewed its approach and developed a new HIV/AIDS strategy based on the following emerging issues and critical needs identified by the stakeholders.

A. Needs identified during the 1998 HIV/AIDS strategy development

- Epidemiological evidence indicating increased incidence of HIV infection among adolescents and youth but a lack of effective prevention programs for youth in and out of school.
- A new policy environment created by the 1997 *Sessional Paper Number 4* on HIV/AIDS, but there is a continuing need for strengthened leadership from GOK, MOH and NASCOP.
- Significant knowledge about HIV/AIDS but little evidence of behavior change.
- An increasing demand for high quality, confidential voluntary testing and counseling services.
- The availability of new treatments for STIs and opportunistic infections associated with AIDS as well as short-term retroviral therapy to prevent vertical transmission.
- A growing number of people living with AIDS requiring support and care.
- An increasing number of communities willing to respond to the epidemic but needing support and guidance to get started.
- Increasing evidence about the need to integrate HIV/AIDS and sexually transmitted infection (STI) services with other primary healthcare programs.
- A recognized need for a long-term sustainable approach.

Given the above, USAID/Kenya's new 5-year program was designed to keep the most successful elements of the previous program and add some new elements. Overall, since more than 90 percent of HIV infections are transmitted sexually, USAID will continue to emphasize prevention of sexual transmission through maintaining the successful condom social marketing program, undertaking management of STIs in integrated FP/MCH settings, including the workplace, and taking a new and focused look at behavior change interventions. Support for policy and advocacy interventions will continue. A new direction for USAID support, based on overwhelming stakeholder consensus, was to undertake activities focussing on home-based care and support for those infected with HIV or AIDS and their families. A second new direction for USAID, based on concerns that people need

confidential information about their HIV status, will be to support expansion of voluntary counseling and testing services (VCT) in selected sites.

B. Planned and on-going HIV/AIDS activities

1. Family Health International/IMPACT. This activity will begin in August 1999. It is funded through field support at an anticipated annual level of about \$2.5 million for 5 years. FHI/IMPACT will carry out programs at both the national level and in targeted priority communities. At the national level, programs will include:

- Mobilizing private and parastatal businesses to develop supportive policies and prevention and care programs for workers in the workplace.
- Supporting existing networks to provide leadership for HIV/AIDS prevention and care, including church-affiliated groups or groups representing persons living with HIV/AIDS (PLWHA).
- Improving blood safety through development and dissemination of a national blood policy and support to the MOH to improve the National Blood Transfusion Service.
- Strengthening serological and behavioral surveillance through supporting the MOH to improve the HIV sentinel surveillance system; conducting and disseminating results of behavioral surveillance surveys.
- Improving voluntary counseling and testing (VCT) through developing a training curriculum; assessing and recommending HIV testing protocols for VCT services and updating national guidelines on HIV VCT.
- Supporting prevention and care through small scale grants for research and intervention.

FHI/IMPACT will also undertake intensive programming in selected priority communities which include Western Province (Mumias, Webuye, Busia); Rift Valley Province (Nakuru municipality and outskirts) and Mombasa municipality. Priority community projects will involve both targeted and general population interventions. Target populations will include all sexually active adults and youth. There will be different strategies based on the kinds of socio-cultural, economic and other characteristics within each target site, i.e., sugar plantations, border towns, large factory settings, high rates of commercial sex. In general, interventions in priority communities will include:

- Baseline and follow-up STI prevalence surveys and behavioral data collected from workplace and community-based samples.
- Activities to create a supportive environment for personal behavior change such as locally relevant communication campaigns; increased access to HIV materials and information through local resource centers and

activities to reduce the presence of high risk situations.

- Activities to improve community outreach through peer motivation, participatory meetings and community theater targeting workforces, sex workers, women and youth.

2. Community-based AIDS Prevention, Care and Support Project. This activity will begin in August 1999. The funding level is \$2 million over 3 years. In April 1999, OPH requested applications from local and U.S. NGOs for proposals to undertake a community-based HIV/AIDS prevention, care and support program. Over 100 local organizations submitted proposals. The technical selection of the winning NGO is complete and, pending final contract negotiations, Pathfinder and its collaborating partners, PSI, K-MAP and FPPS, will carry out the program through a direct grant from USAID/Kenya.

Under the program, Pathfinder proposes to improve the ability of local communities to identify their needs and to develop and carry out activities focused on home-based care and support for PLWH/As and their families. Pathfinder will work with local partners in targeted communities to improve their capacity to manage and implement care, support and prevention services. The program activities will be undertaken in Western Province (Siaya, Busia and Kakamega), Central Province (Thika) and Mombasa municipality and environs.

3. POLICY Project. The workplan for this activity runs from August 1998 through September 2000, the scheduled end of the POLICY project contract in AID/W. It is funded through field support at an anticipated annual level of about \$1 million over 2 years. However, part of those funds is earmarked for explicit family planning rather than HIV/AIDS activities.

The POLICY Project HIV/AIDS activities in Kenya are designed to help overcome key policy constraints which might limit or slow down the implementation of the national AIDS control program; to develop institutional capabilities in the National AIDS and STD Control Program and build capacity of AIDS NGOs in analytical and advocacy skills; and to contribute to the strategic planning and implementation planning process in Kenya. Key activities are to:

- Develop an advocacy strategy and training program for promoting HIV/AIDS prevention education for adolescents.
- Support implementation of the *Sessional Paper on AIDS*, including working with parliamentarians and training government leaders and senior officials to present the elements of the Sessional Paper to their colleagues.
- Strengthen the HIV/AIDS sentinel surveillance system to improve monitoring of the epidemic, increase support for the national system and

increase awareness of the HIV/AIDS situation in the districts.

- Build national-level capacity to improve analysis of sentinel surveillance data, prepare advocacy materials and undertake epidemiological projections.
- Build capacity with district-level and networking institutions to provide leadership for AIDS prevention and care.
- Support networking institutions to provide leadership for HIV/AIDS prevention and care.
- Assist the GOK to identify gaps in research and prioritize research needs.

4. Horizons Project. The Population Council's Horizons project is a 5-year, completely core-funded program extending from 1997 through 2002. Horizons seeks to undertake practical, field-based, program-oriented operations research. The research outcome is hoped to be identification of best practices for reducing the risk of acquiring HIV; preventing and managing STIs; developing strategies for policy analysis and advocacy; providing care and support; ensuring community participation and enhancing integration. In Kenya, activities are geared to issues of concern under APHIA and planned in collaboration with the mission. The research underway or planned includes:

- Assessment of counseling and testing as well as care and support centers in Nairobi. This was a joint Horizons/FHI activity, completed in 1999.
- Preventing mother-to-child transmission of HIV through integration of VCT in routine antenatal care services.
- Social marketing of STI drugs.
- Exploring the uptake and utilization of the male condom in Kenya.
- Integrating VCT in adolescent health services in Kenya.
- Collaboration with NASCOP (and the POLICY Project) to develop a national research agenda.
- Exploring community issues that affect demand for VCT.
- Developing standards and guidelines for counseling in VCT.

5. Population Services International. The current cooperative agreement with PSI began in March 1997 and will end in June 2000, when a new mechanism to undertake social marketing in Kenya will be competed. Its funding level is approximately \$1 million/year. The PSI social marketing program began in June 1990 and over the past 9 years has steadily increased the marketing and distribution of TRUST condoms. Genetic advertising to inform people about the safety of condoms and a new "trusted partner" advertising campaign is underway. Currently PSI is marketing condoms nationwide with

sales of about 1 million per month. Other products including hormonals, injectables, bed nets, weaning foods and safe delivery kits are under consideration to be socially marketed. Details on these proposed products and recommendations for USAID/Kenya are found in the MTR issues paper on social marketing.

6. Other activities

a) Centers for Disease Control (CDC)/KEMRI. USAID is providing \$300,000 to CDC/KEMRI in Kisumu to undertake a 2-year follow-on study to ongoing research of placental malaria infection and vertical transmission of HIV. The study will help define for HIV-positive children a number of health care issues which can be addressed in limited resource settings. The study cohort combines information on infant feeding practices, additional HIV transmission occurring through breast milk, growth parameters, and the incidence of diarrheal disease. It therefore provides an excellent setting to further assess the appropriate balance between the potential benefit and risks of breastfeeding compared to alternate infant feeding strategies. This is a key issue which policy makers in many African countries are struggling with as they attempt to make difficult decisions about setting policies for HIV-infected mothers and breastfeeding.

b) Family Health International/Population Program. As HIV/STDs continue to increase in prevalence in Kenya, there have been calls for greater levels of integration between FP and STD services in both clinical and outreach settings. Expanding the contraceptive mix to include a larger array of barrier methods in general and female-controlled methods in particular (such as the female condom, spermicides, and the diaphragm) may enhance the ability of women to protect themselves against unwanted pregnancy and sexually transmitted diseases. FHI is undertaking several activities related to this concern. They include: modeling research on the demographic, epidemiological and cost implications of moving toward a method mix which relies more heavily on barrier contraceptives; research on dual method use; and an intervention trial on the female condom.

C. Emerging issues/concerns

1. Orphans and vulnerable children. Children in Kenya are being affected by HIV/AIDS in a variety of ways: infant and child mortality have increased and are expected to eventually double or triple. Many infants are born HIV positive. Some infants born to HIV positive mothers are abandoned. Approximately 10 percent of all children are living in families where a member is HIV positive. They may eventually need to care for the dying family member and as a result of the death will suffer economic declines, which will affect

their health status and educational possibilities, at a minimum.¹ In cases where the extended family is not able to care for children who lose parents to AIDS or other diseases, these children may end up on the street. The numbers of children needing care and protection is already very large and will grow as AIDS deaths escalate. NASCOP estimates that by 2000 580,000 children will have lost their mothers. Other estimates² suggest that the figure of maternal orphans could reach 780,000 by 2000 and increase to 1.2 million by 2005. Clearly, this is a situation requiring an urgent, concerted response by government and donors.

Based on the emerging crisis in AIDS orphans, USAID/Kenya, working with UNICEF/Kenya, supported an orphans' assessment in March 1999. While recommendations of this assessment have not yet been thoroughly reviewed by OPH, they will be undoubtedly be useful in helping the mission better plan for future activities to address the increasingly difficult issues of AIDS orphans and vulnerable children in Kenya. Further, HIV/AIDS-earmarked funds from USAID/Washington made it possible to increase by \$500,000 the amount available for the community-based RFA recently awarded, raising the total from \$1.5 million to \$2 million. USAID also received HIV/AIDS-earmarked funds for a U.S. NGO (Catholic Relief Services) to provide technical assistance and a \$250,000 grant to a local NGO involved with AIDS orphans. The purpose of the grant is to increase the capacity of the local NGO to work with local communities in caring for orphans and other vulnerable children thereby keeping them out of institutions.

2. Tuberculosis (TB). The co-existence of HIV and TB are a lethal combination, each speeds up the progress of the other. TB is the most common opportunistic infection in developing countries, occurring in 40 to 60 percent of the HIV infected.³ And, according to statistics from the World Health Organization (WHO), TB accounts for almost one-third of AIDS deaths worldwide. This is a serious problem, not only because those HIV positive persons infected with TB are more likely to become seriously ill with TB or other opportunistic illnesses, but also because TB is infectious through casual contact -- which means that HIV uninfected family members are at risk of TB. Further, drug resistant strains of TB are making it more difficult and expensive to treat TB.

To date, USAID/Kenya, has not undertaken programs in TB prevention, monitoring or treatment. However, given the increasing costs, both human

¹Draft report: *Orphan Programming in Kenya: Building Community Capacity to Manage Comprehensive Programmes for Prevention, Care and Support*, USAID/UNICEF Joint Assessment, April 1999.

²POLICY Project, March 1999.

³*Confronting AIDS: Public Priorities in a Global Epidemic*, World Bank, 1997

and financial, of the mounting TB epidemic in Kenya, and USAID's new strategy in community-based care and support, in 1999, USAID has secured funding to support CDC to undertake activities in Kenya targeting TB. Based on the availability of HIV/AIDS funding from USAID/Washington, Kenya will support CDC to continue work in Kisumu on vertical transmission and to begin working with the Ministry of Health in the area of tuberculosis. Specifically, CDC will provide technical assistance, as appropriate, to help the MOH tuberculosis program to evolve a more effective and dynamic role, particularly in developing and implementing policy and in assisting other agencies, both public and private, at the national and local levels, to deal with the increasingly disturbing TB epidemic.

3. Blood Safety. It is estimated that between 5 and 10 percent of all HIV transmissions in developing countries are acquired through blood transfusion. In Kenya the precise numbers are not known. However, as the prevalence rises throughout the country, the need for accurate blood testing becomes increasingly important, both in order to be certain of transfusing only HIV negative blood and in order to be able to give accurate results to those who request HIV counseling and testing.

A key finding of the 1998 HIV/AIDS design was that there is an urgent need for actions to be taken to improve the blood transfusion policies and programs in Kenya. This is not a new finding. As early as 1994, WHO assisted the Government of Kenya to review its blood transfusion activities. The resulting report and subsequent assessments and reports by UNAIDS, CDC and others have reached the same conclusions. However, lack of clear policies, lines of authority, funding and other issues have resulted in almost no improvement. Reforming blood safety in a country as large as Kenya is a costly proposition. Depending on the system adopted, estimates of the cost of blood safety reform have been as high \$10 million over 5 years (about \$2 million a year). Since USAID HIV/AIDS funding was limited, it was decided that USAID initially would only be able to assist the government in taking the first step in addressing the problem: that of developing a blood policy. FHI/IMPACT, under its current workplan will undertake this task.

In addition, as a result of funds made available as a result of the August 1998 bomb blast of the American Embassy in Nairobi, USAID will be able to provide additional support to the GOK in revamping its blood transfusion system. This \$1 million activity, is scheduled to begin in late 1999. Details of implementing and collaborating agencies are still being worked out.

IV. HIV/AIDS issues to be considered through the remainder of APHIA

There were several recurring themes which appear in issues papers written for the MTR which suggest that USAID/Kenya may wish to revisit some

aspects of its current HIV/AIDS strategy.

1. Children affected by HIV/AIDS. The 1998 Kenya Demographic and Health Survey confirms increases in infant and under-five mortality rates. Although NASCOP is said to regard AIDS as the "defining cause of child mortality,"⁴ findings from the MTR field visits noted that "health professionals, in the main, do not regard HIV/AIDS infection in children as an important public health issue."⁵ This curious dichotomy is probably partly related to the lack of information on this issue. Focused research in targeted areas could give information that would be useful for both policy development and intervention programs. Results of USAID's modest ongoing operations research related to mother-to-child transmission should provide information for rational future programming decisions.

Similarly, the skyrocketing numbers of AIDS orphans and street children suggest the need to reevaluate how USAID's current programs may be addressing the problem of vulnerable children. While large scale focus on AIDS orphans is not be feasible for financial reasons, there may be other, less expensive ways to assure that more attention is directed to the issues of children and AIDS. For example, USAID could ask its CA partners such as POLICY to initiate policy and advocacy activities related to welfare of children affected by HIV/AIDS and other vulnerable children. Issues could include working to revise inheritance laws, promoting cost-sharing in the schools and providing medical services to children in need. USAID will look to the recently awarded community-based prevention, care and support project to help clarify the areas where we might appropriately work.

2. Youth. The issues papers confirmed the urgency of assuring that youth receive special consideration in terms of access to information, service delivery, and behavior change interventions. Young women, in particular, are vulnerable to HIV/AIDS infections for a variety of well-known physiological and cultural reasons. While this knowledge is not new -- it was emphasized in the original APHIA design, during development of USAID's adolescent reproductive health strategy and during the HIV/AIDS design -- it reiterates the need to assure that youth are explicitly targeted in the programs undertaken by USAID. Issues papers emphasized the need, for example, to assure that training of service providers was youth sensitive. They acknowledged that this was not merely a question of providing information to service providers about the special needs of youth, but of actually undertaking "values clarification" of service providers.⁶

⁴ *Child Survival Issues Paper* prepared for the MTR, May 1999.

⁵ *Ibid.*

⁶ *APHIA Mid-Term Review Training Issues Paper*, May 1999.

Similarly, the kinds of behavior change which must be adopted by a youthful population in order to stop the spread of HIV should be more consistent, more "hip," and, quite simply, more. All parties acknowledge that it is young people who hold the key to limiting or stopping the spread of AIDS in Kenya. Yet, regrettably, neither the APHIA project nor the GOK has articulated a comprehensive approach to addressing sexual behavior among youth. In addition to looking lessons learned or best practices (as proposed in the HIV/AIDS strategy document), APHIA should work with government and other donors to develop a BCC strategy to help influence critical behavior choices now facing young people in Kenya.

3. Geographic targeting. Several of the MTR issues papers concluded that programs are working better at the local level than nationally. There are still be a number of HIV/AIDS activities that, to be effective, must function at the national level. These include working with national networks, supporting surveillance analysis, and developing VCT or home-based care protocols or curricula. Nevertheless, in the future, many of APHIA's HIV/AIDS cooperating agencies will work in selected geographic focus areas. Undertaking interventions in selected areas with smaller target populations will improve community ownership, sustainability and project impact. If APHIA ultimately moves to a district-based strategy, a key task will be to assure that although there is a reduction in scale, there are concomitant improvements in quality and results.

4. Donor funding. Virtually all issues papers noted the recent decrease in donor commitment to Kenya, particularly in the area of commodities, but in many other areas as well. Many of the recommendations proposed in the issues papers are completely reliant for their success on other donor commitment. For example, condom social marketing, a lynchpin of USAID/Kenya's HIV/AIDS strategy, cannot run without the condoms provided by DFID. Dual method protection for women isn't fully possible if another donor does not procure the male or female condoms. Similarly, USAID programs which target STI clinics can do very little without STI drugs. The issues of logistics have been treated in the MTR issue paper on logistics, but it is worth emphasizing here that without commodities, there will be no HIV/AIDS or reproductive health programs of any kind. Thus, a future role for APHIA will be to continue to support donor collaboration in various fora, particularly in regard to assuring the availability of commodities that are necessary for a complete HIV/AIDS program.

5. Government commitment. All MTR issues papers noted that GOK commitment to undertaking leadership of programs is, with some exceptions, missing. A key assumption of APHIA was that the GOK would implement policies articulated in the 1994 Health Policy Framework. The MTR issues paper on health reforms outlines in detail where the government has fallen short in meeting these expectations. In the area of HIV/AIDS, while there

have been some successes since the beginning of APHIA such as the passage by Parliament of the Sessional Paper, commitment at the implementation level has been lacking.

NASCOP is the government office responsible for leading the national HIV/AIDS program. For a variety of reasons related to staff, technical qualifications, authority, financing, and donor-led priorities, this office has been unable to move forward a dynamic, thoughtful national HIV/AIDS agenda. Even such a relatively straightforward task such as developing a strategy has taken more than two years.

Under APHIA, the USAID response to this governmental disarray has been to increasingly move its HIV/AIDS funding to programs in the private sector. With the exception of a few key policy activities, assistance to NASCOP in analyzing and disseminating surveillance data, helping to develop a research agenda, and working with appropriate agencies on blood safety issues, beginning in 1999, almost all USAID HIV/AIDS contractors will be working with private sector or with selected *local* government entities. This is clearly a loss for HIV/AIDS programs at the national level, but without significant changes in NASCOP's roles, management, and authorities, APHIA's policy of avoiding direct funding of NASCOP is unlikely to change.

IEC ISSUES PAPER

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LIST OF ABBREVIATIONS

AIDSCAP	AIDS Control and Prevention Project
AMREF	Africa Medical and Research Foundation
APHIA	AIDS, Population and Health Integrated Assistance
ARH	Adolescent Reproductive Health
BAT (K)	British American Tobacco (Kenya)
BCC	Behaviour Change Communication
BCI	Behaviour Change Intervention
BDI	Bungoma District Initiative
BIG	Breastfeeding Information Group
CA	Cooperating Agency
CBD	Community Based Distribution
CEDPA	Center for Development and Population Activities
CHAK	Christian Health Association of Kenya
CORAT	Christian Organizations Research Advisory Trust
CPR	Contraceptive Prevalence Rate
CSW	Commercial Sex Worker
DASCO	District AIDS/STD Co-ordinator
DANIDA	Danish International Development Assistance
DC	District Commissioner
DFID	Department for International Development
DHMT	District Health Management Team
DIAC	District Inter-sectoral AIDS Committee
DMO	District Medical Officer
DPHC	Division of Primary Health Care
DSHC	Division of Strategic Health Communication
DTC	District Training College
ECP	Emergency Contraceptive Pill
EU	European Union
FHI	Family Health International
FINNIDA	Finnish International Development Assistance
FLE	Family Life Education
FP	Family Planning
FPAK	Family Planning Association of Kenya
FPSS	Family Planning Support Services
FPPS	Family Planning Private Sector
GOK	Government of Kenya
GTZ	German Technical Cooperation
HAPAC	HIV/AIDS Programs and Activities
HEO	Health Education Officer
IPPF	International Planned Parenthood Federation
IEC	Information, Education & Communication
INTRAH	International Training in Health
JICA	Japan International Cooperation Agency
JHU/PCS	Johns Hopkins University/Population Communication Services

KANCO	Kenya AIDS NGOs Consortium
KAP	Knowledge, Awareness and Practices
KB	Kenya Belgium
KBC	Kenya Broadcasting Corporation
KDHS	Kenya Demographic Health Survey
KIMC	Kenya Institute of Mass Communications
KMA	Kenya Medical Association
KMTC	Kenya Media Training College
KTN	Kenya Television Network
MAP	Medical Assistance Program
MIS	Management Information System
MOE	Ministry of Education
MOH	Ministry of Health
MOH	Medical Officer of Health
MSK	Marie Stopes Kenya
MTR	Mid-Term Review
MYW	Maendeleo ya Wanawake
NASCOP	National AIDS/STD Control Programme
NCPD	National Council for Population and Development
NGO	Non-Governmental Organisation
OJT	On-the-Job Training
PAC	Postabortion Care
PATH	Program for Appropriate Technology in Health
PCIECP	Provider and Client IEC Project
PMO	Provincial Medical Officer
PSI	Population Services International
REDSO/ESA	Regional Economic Development and Services Office/East and Southern Africa
RH	Reproductive Health
SAP	Structural Adjustment Program
SD	Service Delivery
SIDA	Swedish International Development Assistance
STI/STD	Sexually Transmitted Infection/Sexually Transmitted Disease
SWAAK	Society of Women Against AIDS in Kenya
TA	Technical Assistance
TFR	Total Fertility Rate
TOT	Training of Trainers
UNFPA	United Nations Family Planning Association
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations International Children's Education Fund
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YWCA	Young Women's Christian Association

I. INTRODUCTION

This paper was developed as part of the USAID/Kenya's Mid-term Review of the AIDS, Population and Health Integrated Assistance (APHIA) project. The Information, Education and Communication (IEC) team was asked to review the IEC activities carried out under APHIA, focusing particularly on the use of IEC to enhance USAID's programs in family planning and HIV/AIDS. The paper first provides a background that describes the development and changing assumptions guiding IEC for reproductive health in Kenya. This is followed by a review of the achievements and activities under the APHIA project and a situation analysis giving details of projects carried out by USAID and other donors. These sections were developed based on a literature review and interviews carried out by the team in Nairobi and the field, with representatives from government, donors, USAID cooperating agencies and non-governmental organizations.

The paper presents major findings from the situation analysis, identifying strengths and weaknesses in current reproductive health IEC strategy and approaches, and suggests key recommendations for how to redirect IEC in the next five years of APHIA. Background information on donors, collaborating agencies, and media habits in Kenya is provided in appendices.

II. BACKGROUND

USAID's involvement in Kenya's health sector dates back to the early 1970s, with considerable investment in Kenya's Family Planning Program. By the early 1990s, USAID's Support for the National Family Planning program was the largest among donors. In 1982 USAID was also instrumental in the creation of the National Council for Population and Development (NCPD) as a quasi-governmental agency to take the lead in providing guidelines for strategy and priorities in family planning (FP). At inception, one of the objectives was to help NCPD develop core competency in FP analysis and policy advocacy.

Approaches to IEC

Government-owned. Set against its post-independence demographic and health trends, Kenya's IEC programs to support family planning, and later, other reproductive health issues, fall into three broad categories: passive, which relies mainly on dissemination of IEC materials; semi-active, which includes more interaction with target audiences; and highly targeted, which stresses even greater interaction with target audiences and involves more participation from the private sector .

Initial programs developed in the 1970s, after more than a decade of unchecked population growth began straining the economy, adopted the "passive, clinic-era approach."¹ The basic

¹ In Wilbur Schramm's *Communication in Family Planning* (Population Council, 1971), and Everett Roger's *Communication Strategies for Family Planning* (Free Press, 1973).

assumption was that in order to reverse the rapid population growth, all that was required was to make FP services available at health service delivery points. The communication strategies were built on the "large volume" notion, whose thrust was to disseminate as much information as possible, without targeting or segmentation, and with more attention going to materials production and less focus on content. During this period, IEC activities were undertaken on an ad-hoc basis. If there were any, national programs were under-funded, undervalued by policy makers, and largely devoid of strategic thinking.

The biggest flaw of Kenya's initial IEC strategies was their overemphasis on trying to make audiences aware of FP, under the erroneous assumption that awareness and knowledge would automatically lead to persuasion and adoption. The campaigns had the same message for everyone, rather than segmenting audiences according to their varying needs for information and contraception.

“Unsuccessful”². The pioneer FP programs failed to lower fertility rates or increase contraceptive prevalence rates (CPRs). Kenya recorded some of its highest population rates during the 1970s, which are described as the years of Kenya's population boom.³ The messages were ambiguous and lacked a sense of urgency. A typical message asked couples to give birth to the number of children they were able to provide for, while another merely asked couples to *space* their children as a way of *planning* their families. Both messages lacked a call to action. Indeed, heeding these messages, many couples felt emboldened to have as many children as possible, provided there was space between them!⁴ Little wonder that Kenya's efforts to tame runaway population growth rates during the second post-independence decade were typified as largely “unsuccessful”⁵. To some extent, limited availability of commodities also contributed to this state of affairs.

“Moderately strong”⁶. The 1980s and 1990s witnessed a major shift in IEC program design and management and the beginning of Kenya's demographic transition. A “passive approach” was substituted with a “semi-active” field era or “outreach” approach. The key elements of this new design were its stress on tangible interaction with carefully targeted audiences, and an increased role for the private sector. Largely underpinned by a rising CPR, which nearly doubled to 33 percent for all methods between 1978 and 1993, the demographic transition was marked by a dramatic drop in the total fertility rate (TFR), from 8.1 children per woman in 1977, to less than

² Waver J.R McNamara, T.McGinn, and D. Lauro, In “Family Planning Operations Research in Africa:Reviewing a Decade of Experience. *Studies in Family Planning*”

³ Incensed by what he saw a utter insensitivity on the part of Kenyans to the government's “massive” FP campaigns, the then Attorney-General threatened to legalise mandatory birth control to stop Kenyans from “breeding like rates.” Though highly derisive, that single statement precipitated an intense national debate on the “population boom” and galvanised the national psyche around the need for long-term solutions.

⁴ The fact that virtually all public services, including health and education, were free and graduates were assured of automatic employment, compounded the situation. Additionally, the economy was robust, fuelled in the part by the coffee boom of the mid 19970s. Conventional wisdom at the time had it that the economic boon of the 1970s created Kenya's population boom of the same period.

⁵ & ⁶ Ross J. and W. Mauldin, “Family Planning Programs: Efforts and Results, 1972-94” “*Studies in Family Planning* 27(3); also UNFPA's *Population and Development Report*, 1995.

4.7 children per woman in 1998. Overall, the population growth rate declined remarkably, putting Kenya in the league of developing countries that had shown “moderately strong”⁷ signs of having the capacity to check rapid population growth. It is instructive that the TFR declined amidst an economic crisis, partly caused by a serious two-year drought, and the implementation of the first phase of the far-reaching structural adjustment program (SAP).

Strategic thinking. The continuum to provision of services by the private sector accelerated in the 1990s. The key players included the Christian Health Association of Kenya (CHAK), the Young Women’s Christian Association (YWCA), Young Christian Students Association, the Breastfeeding Information Group (BIG), and Maendeleo Ya Wanawake (MYW). The participation of the private sector gave some coherence and integrity to the IEC function in the national FP programs, by infusing some strategic thinking into them. The IEC programs of the 1990s have been designed on the basis of scientifically collected data to achieve measurable objectives, and reach and involve specified audiences. These programs have positioned health practices persuasively as a benefit in the minds of the ultimate beneficiaries. Without a doubt, while a field-outreach approach gained popularity in the 1990s, the informational, awareness-creation approach still remain important. A mix of both approaches will therefore continue to be in demand.

USAID’s contribution to the strategic shift in the IEC paradigm in the 1990s was spearheaded by Johns Hopkins University’s Population Communication Services (JHU/PCS), first under the Family Planning Support Services (FPSS) Project, and then under APHIA. Overall, the two programs, together with scores others supported by many donors, contributed to increased awareness, knowledge and use of reproductive health services. This is borne out by the 1998 Kenya Demographic Health Survey (KDHS), which like the two before it, indicates increased knowledge among Kenyans regarding HIV/AIDS/STIs, and the protective means available to them. The 1998 KDHS, which indicates continued fertility declines, also shows increased use of modern FP methods. Assigning a significant role to IEC in influencing the demographic turnaround in the period to 1996, the Vice-President and Minister for Planning and National Development, Professor George Saitoti, said *“the achievement of the decline in fertility has been possible because of the partnership between the government and NGOS, especially in the area of population IEC.”*

Despite success in creating awareness about health and population issues among Kenyans, several formidable challenges remain. The first is the failure to significantly narrow the knowledge/awareness and practice (KAP) gap. It is clear that interventions at all levels have had limited success in converting awareness among Kenyans to logic⁸ and significantly high levels of practice. The second challenge relates to significant reversals in some basic demographic health indicators. According to the 1998 KDHS, early child mortality conditions worsened in the

⁷ Ross J. and W. Mauldin, 1996

⁸ Refers to the use of socio-cultural values and norms to explain, possibly even justify, proposed behaviour change; the current approach tends to dismiss, even antagonise, existing local logic. A case in point is the tendency by behaviour-change agents to dismiss wife inheritance in Nyanza as “morally repugnant and detrimental to societal well-being”, without attempting to understand the socio-cultural context. Thus, while the change agents’ view sounds nice to them, it doesn’t to the target audience.

1990s, with under-five mortality increasing by 25 percent over the last decade.⁹ Child immunization, steady in the previous decade, has declined significantly from the 79 percent full vaccination coverage recorded in 1993 to 65 percent in 1998. Adding to this grim picture is the HIV/AIDS pandemic, and its deleterious socio-economic impact.

Fundamental shift. There is widespread consensus that the key to confronting head-on the threat posed to Kenya's population by HIV/AIDS and the reversed KDHS indicators lies in a fundamental shift from the long-used IEC model to the more broader Behavior Change Interventions (BCI) model¹⁰, to address key barriers to behavior change, "at the margins"¹¹. JICA's Willy Nyambati, who helped conceptualize NCPD's early population communication interventions, sees the transition from IEC to BCI as inevitable: "the IEC model has almost reached its peak." Besides an overload of IEC materials, a tranquilliser effect has begun to set in, reducing the impact of messages. The next batch of interventions developed to tackle the persistent barriers to behavior change will need to be community-based, culturally rooted, and highly targeted. Special attention will need to be paid to interpersonal channels that build on a particular audience's level of awareness and readiness for change, a key component of the new package being counseling and training in counseling skills.

NCPD IEC Strategy. In 1990, USAID requested JHU/PCS to assist the NCPD to develop a seven year family planning strategy. This collaboration, which started under the Family Planning Support Services (FPSS) Project, was geared toward expanding the FP base. To achieve this strategic objective, JHU/PCS prepared a document, *Strategic Options for IEC Interventions in Kenya* that was to serve as the blueprint for IEC activities during the next seven years. The initial project was a \$300,000 project focusing on continued use of modern family planning - the "Haki yako" [*Your Right*]¹² campaign. In a move that demonstrated the potential for collaboration, this approach brought together all the key organizations doing IEC, to work, in JHU's Dan Odallo's words, "on a project to which everyone could contribute and reap benefits." This project addressed low family planning prevalence rates in Kenya and was to increase user continuity over one-year. JHU collaborated with all major family planning providers including MOH, Family Planning Association of Kenya (FPAK), Family Planning Private Sector (FPPS), Christian Health Association of Kenya (CHAK), Maendeleo ya Wanawake (MYWO), the Kenya Medical Association (KMA) and the Kenya Institute of Mass Communications (KIMC) to execute this campaign. Key activities included production and airing of 76 episodes over two years of a radio soap opera, "*Kuelewana ni Kuzungumza*" (*To Know Each Other is to Talk to Each Other*), ten radio spots encouraging partner communication and emphasizing contraceptive safety, a slogan, "*Haki Yako*" (*It's Your Right*), and promotional events featuring live

⁹ This reversal remains unclear, but antenatal care, malaria and increased poverty, couple with the AIDS pandemic, are obvious contributors.

¹⁰ There are various BCI definitional shades, but as a working definition, this paper views BCI as geared towards the "adoption of a particular behaviours that are pre-identified as promoting public health." This paper makes the point that there is a subtle but very important distinction between IEC and BCI.

¹¹ See footnote 9. This is where both behaviour change agents and their target audience converge in identifying barriers to behaviour change and identify a solution that is mutually satisfying.

¹² The use of Kiswahili is an effective way of reaching the majority of Kenyans

performances of the radio characters. These were complemented by a capacity-building training component for FPAK's community-based distributors (CBDs) of family-planning supplies and services, with materials including four leaflets on family planning, a national CBD training manual, and a CBD reference manual.

Achievements under FPSS. JHU helped introduce some coherence and focus to IEC in Kenya. According to JHU/PCS's evaluation, couple communication on family planning increased from 38 to 42 percent and continued use of FP over one year rose from 67 to 71 percent (short of target). CBD skills improved with 87 percent in 1993 able to explain how FP works, as compared to 43 percent in 1991. This campaign also brought into the open issues that had been taboo to discuss. These included the Kenya Youth Initiative Project, which was implemented at a time when the country's leadership had declared a ban on "sex education". JHU used the project advisory committee comprising 25 organizations; to work in the districts with the health management teams and district development committees to identify and train youth advocates. At the same time, an IEC Project Advisory Committee was formed at national level, and members held meetings with legislators and media personnel. JHU also launched the Vasectomy Promotion Project, and initiated the National Family Planning Logo Project (described more fully below).

The future. A key question in considering APHIA's future investment in family planning is: will present trends persist if declining support for FP IEC continues? Thus far, in the life of the APHIA project, there have been no major family planning IEC campaigns. The "*Haki yako*", Kenya's Client Provider IEC Project was implemented between 1991 and 1994 (before APHIA).

III. SITUATION ANALYSIS

Assumptions

The APHIA Project (1995-2004) was designed with several assumptions, notably that the Government of Kenya would implement policies enunciated in the 1994 Health Policy Framework; and that GOK/donor relations, then at their nadir owing to serious differences over governance issues, would improve and provide an enabling environment for increased, or at least consistent, donor injection of resources (both financial and commodities) into the health sector. The APHIA design assumed donor support would at least remain at the levels indicated in the "Inventory of Donor Assistance to the Population and Health Sector in Kenya".

Since then, the landscape has changed for the worse. For one, SIDA, which had focused on provision of oral contraceptives for 12 years, was in 1996, unable to procure these supplies as earlier anticipated. Internal problems between 1997 and 1998 severely disrupted UNICEF's focus on the improvement of child health and the reproductive health needs of the youth. An agreement between the World Bank and the GoK on condom procurement remains deadlocked. The MOH's inability to cultivate trust among key donors has been evident in recent months. The Netherlands has withdrawn its support to the sector; support from DANIDA remains uncertain. Over the coming year (1999-2000) commodity supplies, particularly condoms, are precarious, threatening significant advances recorded in recent years. Overall, the goal of shifting emphasis

from donor funding and creating mechanisms to ensure sustainability--particularly with respect to procurement of contraceptives and other commodities--remains elusive. Nearly five years after the start of APHIA, the health sector is still heavily donor funded, and governance issues are still critical. These underlying issues will affect USAID's ability to achieve its overall objectives, and will affect choices of future strategy, including the IEC strategy.

Donor Support

The major donor agencies, in addition to USAID, currently directly or indirectly supporting significant health communication activities are the World Bank (through NASCOP), UNFPA, the European Union, DFID (through the Futures Group UK/ HAPAC project), SIDA, CIDA, FINNIDA, GTZ, JICA, UNICEF, WHO, Belgium and UNAIDS. At the governmental level, the principal partners are NCPD, NASCOP, DHSC, and the DPHC. Donor co-ordination remains a challenging task

KDHS Data on Fertility and Media Habits

Positive turnaround. The 1998 KDHS data indicate that fertility continues to decline in Kenya. At current fertility levels, a Kenyan woman will bear 4.7 children in her life, down 30 percent from the 1989 KDHS and 42 percent since the 1977/78 Kenya Fertility Survey (KFS) when the total fertility rate (TFR) was 8.1 children per woman. *It should be noted, however, that fertility did not decline among the youngest women, ages 15-19.* Modern contraceptive use has risen sharply since the early 1980s and 39 percent of married women in Kenya are currently using a method of contraception. Use of modern methods has increased from 27 percent in the 1993 KDHS to 32 percent in the 1998 DHS. The survey also indicates that 24 percent of married women have an unmet need for family planning (either for spacing or limiting births). This group comprises married women who are not using a method of family planning, but either want to wait two years or more for their next birth (14 percent) or do not want any more children (10 percent).

Basic knowledge of family planning is nearly universal among Kenyan women, as 97 percent of who have heard of at least one contraceptive method. Nearly two thirds of currently married women in Kenya have had experience in using family planning methods at some time in the past, up 9 percent from 1993.

Exposure to Family Planning Messages on Electronic Media. Radio and television are the major potential electronic sources of information about family planning. In Kenya more men than women are exposed to electronic media. Nearly one half of the female respondents, and only 29 percent of male respondents reported they had not heard or seen a family planning message on radio or television, during the six-month period prior to the interview. Sixteen percent of women and 30 percent of men have heard a family planning message on the radio and seen a family-planning message on the television in the last month. Sharp contrasts in access to media messages are observed between urban and rural residents.

Almost two-thirds of women without an education have no exposure to radio and television, compared to only 30 percent of women with a secondary education. This suggests that other

forms of communication are needed to reach these women who have the lowest levels of contraceptive use.

Acceptability of Electronic Media to Disseminate Family Planning Messages. Overall, the large majority of men and women interviewed reported that it was acceptable to use radio or television to air family planning messages and radio is slightly more acceptable. Acceptability of radio and television as a source of information is highest among men and women ages 20 - 29 and relatively low among ages 15-19.

Exposure to Family Planning Messages from other Media. Only 25 percent of women reported no exposure to a message about family planning on non-electronic media such as newspapers, magazines, billboards, live drama or other community events during the six months prior to the interview. Overall, radio is the most commonly reported source of FP information (52 percent), followed by billboards (45 percent), newspapers/magazines (28 percent) and community events (24 percent). Young and more educated women and those living in Western Province are disproportionately more likely to have had exposure to family planning information through live drama and community events.

Discussion about Family Planning between Spouses. Twenty-seven percent of married women who know about family planning had not spoken with their husband over the past year about family planning.

Attitudes of Male and Female Respondents Toward Family Planning. Approval levels and patterns of family planning are very similar to those from the 1993 KDHS. There have been little changes in attitudes since the 1993 KDHS.

Family Planning and Youth. The KDHS asked respondents if they thought it was acceptable for young persons (under age 18) to be provided with a) information and b) services related to family planning. Seventy-nine percent of women reported that family planning information should be made available to persons under 18, but only half (52 percent) believed that the services themselves should be available. This data is very similar to the 1993 KDHS. Men tend to be more liberal towards making information and services available.

Why FP uptake rates are slowing is a matter for conjecture, but it certainly raises serious concern. While trends have generally been improving, this has not happened at the same rates as in other periods of time between DHS's. The key concern is whether and when there will be a tapering-off of such a rapid fall what impact USAID's investment (or lack thereof) in IEC will have.

IV. APHIA ACTIVITIES AND ACCOMPLISHMENTS

The specific activities carried out and achievements under this contract with JHU/PCS and other APHIA projects are described below, together with observations about opportunities for further action in support of these IEC interventions.

1. Johns Hopkins University/Population Communication Services (JHU/PCS)

Under APHIA, JHU was contracted to:

- Strengthen mechanisms and structures for the development of a national IEC strategy and co-ordinated implementation,
- Provide technical assistance and services to planners and implementers to develop effective IEC messages and campaigns keyed to target audiences such as couples with an unmet need for FP, and people at risk of HIV/AIDS/STD infection, including the youth,
- Assist a Kenyan institution to develop the capacity to become a lead technical resource to planners and implementers in the research, design, production, implementation and evaluation of IEC programs, and
- Develop and launch a FP logo.

Kenya National Family Health Logo Project (1994 -1999). The National Family Health Logo was developed with technical assistance from JHU to act as a marker for the family health services being offered by the government and NGOs in Kenya. The logo has gone through different phases. It was first developed prior to APHIA as a "Family Planning Logo"¹³. Due to the reform process and the shift from curative to preventive health service delivery, the logo was later repositioned as the "Family Health Logo"¹⁴ and now integrates the various components of a FP/RH program, including family planning, safe motherhood, child immunization, STD treatment and HIV/AIDS counseling and services. The original Family Planning Logo was launched on World Population Day in 1997. After the shift from family planning to family health, the logo was press-launched in March 1999 with GTZ funds. APHIA is also funding the production of a thirty-second radio spot (to be aired over four months), 526 small logo signboards to be placed at all district hospitals and some health centres, 5250 large wall stickers for all government service delivery points, 10,000 door stickers to be placed on the doors of facilities offering specified services, and 50,000 posters to be placed outdoors in the community.

Opportunity. Given that many service delivery points do not have the full complement of reproductive health (RH) services available, there is need for service personnel at such delivery points to be oriented and trained on a single but effective referral system.

Ministry of Health, Division of Strategic Health Communication (MOH/DSHC) National Health Communication Strategy (launch set for June 1999). Despite marked health and demographic achievements morbidity figures have remained unacceptably high. The biggest threat stemmed from morbidity associated with prolonged and obstructed labour, malaria, diarrhoea and STDs and HIV/AIDS. "These diseases," concluded the MOH in 1997, "are primarily preventable through proper and timely information, education and communication that promote health-seeking behaviors".

¹³ The project was undertaken in 1992 by the Embassy of Netherlands and updated in 1995 by USAID

¹⁴ Service providers met during the MTR stressed the need to expedite the dissemination of the logo.

Opportunity: The MOH/DSHC has the opportunity to leverage the formal adoption of this strategy to:

- Forge partnerships with other health care providers,
- Gain legitimacy and build funding to position itself at the forefront of IEC in the country,
- Establish itself as a resource for technical expertise, and
- Facilitate the increased ability of private/public sector groups to conduct IEC activities.

Challenge. For the MOH in general and the DSHC in particular, the key challenge is how to build credibility to mobilize donor support successfully, and popularize a strategy that is perceived to be based on the waning “IEC model”. An additional challenge is posed by the existence of two other national IEC strategies, each of which is competing for recognition as *the* national IEC strategy. But the competition between the MOH/DHSC, NCPD and NASCOP goes beyond the national strategy. The central question is: of the three governmental agencies, which is best suited, equipped and strategically positioned to lead the country in confronting the AIDS scourge among other health challenges.

Increased IEC capacity among a growing number of FP NGOs. Building capacity in IEC skills was a specific APHIA objective, and was carried out for both GOK and NGO staff. In addition to its direct partners, JHU's technical assistance under APHIA contributed to capacity building within many other agencies, which have recognized JHU's role in creating linkages between GOK and the private sector in the provision of RH services. This strengthening of IEC capacity is also an element in the Mission's HIV/AIDS program.

The JHU/PCS program in family planning trained 78 Health Education Officers (HEOs) in communication skills in two initial workshops, before a cutback in funding levels forced JHU to abandon the training, which originally targeted 350 HEOs. There appears to be continued need for training for district and regional level health officers in IEC skills. During the recent field visits by the APHIA MTR team, the DASCOS and HEOs expressed a strong need for technical training in IEC. PATH trained representatives from 20 NGOs in materials development, using a job-release approach in which the participants worked together in teams over a six-month period to design, pre-test and produce a set of materials.

Challenge. While IEC capacity has been enhanced through APHIA, the challenge is how to deepen the focus in community efforts to meet an ever growing demand for IEC interventions. Many acknowledge that this shift in focus calls for enormous resources and expertise, both of which they lack.

2. Population Service International's (PSI's) Social Marketing Program: Increased Condom Uptake.

Increased uptake of condoms has been a significant achievement under the APHIA program. At APHIA's inception, one of the expected results was that the social marketing program (implemented by PSI) would have pushed condom sales nationally from 6 to 10 million

annually, accounting for about 8 percent of all condoms distributed in the country. As at the time of the MTR, this goal was on track. From approximately 2.4 million in 1995, *Trust* sales have risen to over 10.3 million in 1998. PSI's strategy had a strong IEC component, which involved complementing their expanded distribution with a carefully planned and targeted media campaign for urban youth, supported by special events. While this rise in condom uptake is a huge success, there is still a long way to go in accessing socially marketed condoms to the community level.

3. HIV/AIDS Activities

A 1998-2002 USAID/Kenya strategy for HIV/AIDS has been developed which includes a discussion of behavior change and IEC issues, focusing particularly on behavior change. This section briefly reviews BCI/IEC activities on HIV/AIDS carried out by USAID/Kenya immediately prior to and during the first years of the APHIA project. The team considers that these interventions represent a considerable contribution by USAID, and should be seen as complementary to FP IEC interventions. In addition, opportunities to harmonize FP and HIV/AIDS message delivery and to reduce duplication of effort should be identified in future planning.

IEC and behavior change interventions were carried out both as part of integrated reproductive health communication and as interventions specifically aimed at reducing the incidence of HIV/AIDS. The interventions used a range of channels and approaches, including mass media, materials development and dissemination, capacity building through training in IEC skills, use of community-level media, and interpersonal communication through peer education and counseling. USAID, and later, DFID and the Kenya Belgian AIDS/STD Project, have been major donors in supporting IEC related to HIV/AIDS; JICA and the EU have also provided project funding. The GOK has also supported limited national IEC as part of NASCOP's activities under the GOK/World Bank STI Project. Despite the individual success of several of these interventions, this report concludes that their potential impact was limited by the lack of co-ordinated planning between the different projects.

Mass media interventions since 1995 have mainly targeted the youth, with some additional activities aimed at the general public. Overall, results have been rewarding, though the interventions are expensive. Three different models were used to target the youth. Under APHIA, USAID supported one of the most successful IEC campaigns in Kenya: PSI's *Trust* condom campaign that targeted urban youth aged 15-24, as part of the social marketing project. The campaign used TV and radio spots, billboards and special sporting and musical events to reach urban youth, aiming for a spillover effect to youth nation-wide. These targeted activities were supported by an aggressive media relations intervention that used radio and the press to counteract condom misinformation and to publicize AIDS issues.

Youth were also targeted in two other mass media interventions: the Youth Initiative Project carried out by JHU and initially funded by USAID; and the "*Jisimamie*" ["*Stand Up For Yourself*"] campaign in Nyanza, funded by the Belgian government. The Youth Initiative addressed HIV/AIDS and STIs within a reproductive health context. Rather than focus on

specific brand or behavioral messages, it used a weekly radio and press magazine format to stimulate discussion by and for youth on RH issues; and facilitated the airing of problems in an anonymous public forum. The project worked in collaboration with Kenya Broadcasting Corporation (KBC) to produce the weekly *Youth Variety Show* on radio, supported by a weekly newspaper column for youth.

The "*Jisimamie*" campaign in Nyanza focused on HIV/AIDS prevention using special events, radio spots, and supportive materials to deliver the message "*Stand up for yourself*". One significant aspect of this intervention was the training component, as the Regional Health Education Officers were involved in each stage of the project development. The campaign planners intended to link mass media and special events through distributing supportive materials to enhance community-level education and interpersonal discussion. Constraints in distributing the materials at local levels, however, resulted in limited use at community level.

Another mass media intervention directed at youth is the "*Straight Talk*" supplement in *The Standard* funded by UNFPA and produced by the Kenya Association of Professional Counselors, as one aspect of a RH initiative that also reaches youth at the community level. In discussion before and during the MTR field visit, there were strong indications that the "*Jisimamie*" campaign worked very well, in part due to what the Futures' Group's Richard Odindo, described as "very good conceptualization and development." Odindo, who was in the thick of the campaign (it was reviewed by JHU/PCS) also gave part of the credit to effective collaboration with District AIDS Committees in the target areas.

Mass media was also used to reach the general public, with the objectives of creating awareness, counteracting myths, and modelling different options for responding to the epidemic. The APHIA-funded "*Maajabu*" ["*Wonders*"], a weekly radio soap opera that was produced in five local languages, was used to model responses to HIV/AIDS issues and stimulate awareness among rural communities. USAID also funded the weekly newspaper column "AIDSWATCH" in the *Sunday Standard*. Both activities were popular, with approximately 2000 letters a month written in response to the radio program; and AIDSWATCH being highly rated as among the most popular columns in a *Standard* reader survey. While this response implies they achieved their objective to increase awareness of a broad range of AIDS issues, the need to support similar activities in future is questionable, given the urgency of switching gear to more impactful behavior change interventions.

USAID supported several successful interventions to support behavior change at the service delivery level. These included peer education and training of trainers (TOT) targeted at youth, workplace populations and church pastors. Youth peer educators at university and college campuses were trained by both Pathfinder on integrated reproductive health, and Family Health International /AIDSCAP¹⁵ with Family Planning Private Sector (FPPS) focusing on HIV/AIDS. A comparison of the curriculum and results from the two models would be useful, and the lack of this points to the need for improved coordination between programs. APHIA targeted men through work-site or occupation based interventions. AIDSCAP through FPPS and PATH

¹⁵ The AIDS Control and Prevention (AIDSCAP) Project was implemented by Family Health International (FHI) between 1991-97, and subsequently extended to the Kenya Aids Program (KAP).

trained peer educators in 23 worksites; a pilot project targeting matatu "touts"/operators was also launched. The worksite project included a gender component that highlighted the issue of how gender stereotypes could be inadvertently reinforced in peer education programs. The GOK consulted with the USAID-funded worksite project in designing the GOK worksite intervention in Nyanza. United Nations AIDS (UNAIDS) has also expressed interest in supporting interventions in the work-site. These community-level interventions were supported by training for the peer educators in the use of folk media (provided by FPPS) and theatre and puppet performances (Mijiza Players and FPPS).

These initial interventions tested and validated several needs relating to policy issues, sustainability of programs and motivation of peer educators, and gender issues. Given the current need to scale up the response to HIV/AIDS at community-level, USAID should systematically analyze the details of these approaches and ensure that lessons learned about the best and worst practices inform future programs. APHIA did not fund peer education for high-risk populations (Commercial Sex Workers (CSWs), and their clients, long distance drivers), based on the perception that Canadian International Development Agency's program with the University of Nairobi and GOK interventions with CSWs were providing adequate coverage of these populations.

MAP International's comprehensive program for church groups included the use of radio, video, film, mobile vans, materials development, and a training program for church pastors that resulted in over 500 prevention and care interventions at the community level.

Much groundwork was laid pre-APHIA and in its first years (1995-98) by USAID programs that contributed to the softening of the public climate to allow controversial topics, like condoms, to be discussed on public media. This potential for continuing to influence public opinion through open discussion of sexual behavior and HIV/AIDS can now be used to support targeted IEC campaigns around specific behavioural messages.

4. Materials Development

Both USAID and other donors developed curriculum for health providers that addressed HIV/AIDS issues. USAID supported FPPS through AIDSCAP to develop a curriculum for training health providers in HIV/AIDS prevention counseling, which was used to train health providers in FPPS clinics. CEDPA, INTRAH and Pathfinder also developed, with USAID support, integrated curricula for health providers that included HIV/STI modules. The Kenya Belgian STD/AIDS Project funded a recently completed distance education curriculum to upgrade the skills of clinical officers that includes modules on sexuality and communication. The different curricula inevitably overlap and duplicate each other to some extent, illustrating once again that better co-ordination between the different donors and agencies is needed to reduce duplication, minimize resource wastage, and ensure consistent training.

Several APHIA-supported projects developed HIV/AIDS materials. Under APHIA, PATH developed a series of materials for different target groups as part of their IEC skills training project, a package of materials for work-site peer educators. The later use of the PATH materials

by the NASCOP/STI Project as national billboards displayed in different regions unfortunately demonstrated the dangers of transferring materials pre-tested with geographically and culturally specific audiences to a national level. One of the most successful materials developed during this period was a video *"the Silent Epidemic"*, which dealt with STIs. Produced by ACE Communications, the video was funded by several donors including USAID/REDSO, FFI/AIDSCAP's regional office, UNDP, and UNFPA. It continues to be in high demand. UNICEF also addressed HIV/AIDS issues in the integrated set of materials developed by the Sara Project targeted at the girl-child.

V. MAJOR FINDINGS

As a result of document review, interviews with key informants (including a focus group) and conclusions from the field visits, the following were identified as the major findings.

The existing USAID strategy is based on an IEC paradigm.¹⁶

The team defined an "IEC paradigm" as an approach to public health communication that has as its objective informed choice by the client from a selection of options and that tends to focus attention on Information and Education, rather than Communication. In addition, an "IEC approach" may think of communication as primarily occurring in a clinic setting and runs the risk of focusing on materials production and distribution. A "BCC paradigm" has as its objective adoption of particular behaviors that are pre-identified as promoting public health. BCC tends to attach more importance to interpersonal communication, outside as well as within a clinic setting, as a major element in the strategy of any communication program. The difference is important because using an IEC or a BCC perspective can influence the relative amount of resources put into different channels of communication.

Co-ordination in IEC at all levels is lacking, resulting in overlapping strategies and guidelines.

There is no overall co-ordination of a national IEC strategy by the Government of Kenya, and the Ministry of Health lacks the capacity and the will to take on this role. There is some co-ordination and exchange of information about IEC strategies between donors, but this usually occurs in the design stage, when donors will consult each other, and is seldom maintained throughout implementation of different projects. APHIA's cooperating agencies have also failed to establish a mechanism for ongoing co-ordination that could enhance their individual programs.

It is generally agreed that good communication programs need to use different channels at different levels to put across messages most effectively. Thus the lack of co-ordination within and between different levels weakens the potential strength of IEC programs. As one of the major donors supporting FP and HIV/AIDS programs, and a donor that has provided continuing support to capacity building in IEC, USAID has a comparative advantage in pushing for synergy.

¹⁶ This definition expresses the team's consensus and is intended to suggest differences in emphasis that may result from the use of these labels for a communication program.

One approach could be for USAID to take the lead in presenting the need for co-ordinated IEC priorities to the donor community. Co-ordination and clarity of roles between different levels is also lacking. A first step in planning IEC activities is for USAID to determine what results can be expected from using national, regional, or community-level IEC interventions, in order to determine which mix is the most appropriate and which channels should be used to convey which messages. This calls for an internally generated IEC strategy.

The Family Health Logo was being displayed in some, but not all, facilities visited.

Posters were displayed in some facilities, and some health workers saw the logo as a good way to remind clients of the range of services available to them. No supporting materials were available¹⁷, which raises the questions of the best approach to publicizing the meaning of the logo to a wide audience and whether USAID should fund this.

There are still many constraints to behavior change.

Perhaps the most predictable comment about HIV/AIDS and behavior in Kenya is that behavior has failed to change, despite high levels of knowledge about AIDS. The team gathered interesting insights into how to approach this block, from the focus groups and field trips. Respondents called this "knowledge" highly superficial: people can recite the three means of transmitting AIDS and ways of preventing AIDS but this hides the extent of ignorance and stigma that still exists. Many people still do not fully understand exactly how AIDS is transmitted by sexual behavior. There is also denial of personal risk and lack of internalization and personalization of the dangers of HIV, even though a high percentage of people now report knowing someone with HIV (1998 DHS). Stigmatization of people with HIV/AIDS continues, increasing the likelihood of denial.

Cultural practices and norms, including gender issues and power relations, reinforce the barriers to change (particularly to condom use). These norms include adult attitudes towards youth from parents, church leaders, and health providers. The less than committed leadership at many levels of society does not provide a motivating force to counteract this weight of influences that conspire to continue Kenyan society's denial of the socio-economic and personal impact of the epidemic.

Field interviews indicated community representatives think more would be achieved if IEC interventions were more responsive to a particular local environment and language. There is also need to target institutions or cultural gatekeepers that constrain behavior change, as well as at the individual him/herself. But isn't there also need for a more realistic time frame and more realistic expectations of change? Many projects last for two years: what can realistically be the expected achievement within such a short period of time? To what extent do our project designs establish the stage of change reached by a particular target audience and then design the project to move them to the next stage of change?

Response to reproductive health issues in different regions is uneven.

¹⁷ The RH guidelines developed by the DPHC with JHU technical assistance are yet to be distributed to the community, yet they constitute very valuable information for health providers.

The teams were struck by the varied IEC emphasis on reproductive health issues in the different regions. In Nyanza Province, for example, the emphasis is on AIDS, and IEC for malaria is down (and perhaps as a result, malaria incidence is up, contributing to child mortality); in Central Province, there is little focus on HIV/AIDS¹⁸. What are the implications of these gaps? In Nyanza, would more IEC on malaria improve child survival? Does the lack of programming in Central Province entrench an unfounded feeling of safety about HIV/AIDS, and isn't this a recipe for disaster, as the false sense of security created may lead to risky behavior? This uneven response raises the issue of balancing the need for integrated RH messages for long-term health promotion, against an IEC response to emergencies. Teams also noted that the availability and quality of materials varied considerably between regions visited.

Interventions need to be more community-owned and community-specific.

Many health providers and community representatives in the field made strong, consistent statements about the need for representation and local involvement in designing national programs, and in better understanding the local barriers to change. They need more local level data, community structures to implement programs, better skills (particularly in peer education, counselling, and care and support) and better and more local materials. One intervention that was seen as insensitive was the national billboards on HIV/AIDS, which some communities found linguistically and culturally unacceptable. A respondent in one region said that the poster asking men to protect their families encouraged men to be unfaithful by implying that extra-marital sex was the norm. Whether or not this is the case in that region, these respondents thought they should have been included in further pre-testing of the materials before putting up the billboards.

USAID has been successful in using national organizations or networks (such as FPAK, MAP, Pathfinder through Maendeleo ya Wanawake) to provide training and interventions at the community level. Future interventions should continue to identify similar organizations that have the potential for the greatest national coverage.

Cash flow problems hamper implementation.

Plans and skills exist at district level, but GOK operationalization is hampered by cash flow problems. The issue is the extent to which HEOs and DASCOS can overcome this by using other local resources. The HEOs and DASCOS are acknowledged to play a critical role in community-based interventions and are not fully realizing their capacity.

There is high visibility of Trust condoms and recognition of media campaign.

The field visits reinforced the data from Population Services International's distribution figures on the success of the condom marketing campaign and suggested that promoting *Trust* condoms is also having a spillover effect on public condoms. The few bars and kiosks visited reported that they were selling more condoms than a year ago. What was perhaps more striking was the ease with which bar and kiosk staff discussed condoms with no embarrassment, and the unanimous praise for the *Trust* radio and TV spots, especially TV. The success of this campaign in towns has implications for the use of social marketing techniques, not only for other products

¹⁸ One argument is that the region has good enough an infrastructure to support health-seeking behaviour, without using IEC, compared, say, to Nyanza

but also to market norms and specific preventive behaviors. That in turn will require co-ordination so those community-level programs reinforce national messages as far as possible.

Condom discussion is virtually non-existent: "dual protection" is seldom promoted.

A major issue in evaluating the on-site performance of health providers is their attitude to demonstrating and discussing condom use. Field visits suggested that condom discussion is still very low, and for adolescent clients, virtually non-existent. Health providers interviewed in one USAID funded RH/FP private clinic only discussed condoms with clients who had had an STD. So, given the advanced stage of the AIDS epidemic in Kenya, should USAID advocate more aggressively for condoms? Should this be the key message? Should dual protection be promoted, through using the male or female condom for all sex acts? The IEC team was divided on this issue, and divided on internal cultural lines. One section of the team, and most respondents in the field, did not support condom promotion for all sex acts, as this conflicts with cultural norms about the meaning and value of sex between couples, and may lead to a potentially dangerous situation, because of the implied lack of trust. Another section of the team saw this as an opportunity to promote a new norm of condom use, unrelated to fear or distrust in a particular relationship - the approach taken by PSI in its "trusted partner" campaign.

Capacity building and training have shown successes but more remains to be done. Despite the cutback in funds for IEC skills training for the Health Education Officers, USAID has achieved considerable success in capacity building among many private sector organizations. Pathfinder and FPAK both included training for IEC in their work with clinic-based staff and CBDs; training in IEC skills is included in the six-week in-service FP provider-training course. Several USAID-funded NGOs working in HIV/AIDS (PATH, Pathfinder, and FPPS) trained peer educators, and trainer of trainers to communicate FP and HIV/AIDS prevention messages to their colleagues. MAP trained pastors in HIV prevention and counseling skills and developed a curriculum for theological colleges to institutionalize this training. But there are still huge training gaps.

In the field interviews the team heard that there is a need for training in peer education, counseling, and IEC skills, and communication skills for facility managers. Clinicians need training in the proper procedure for referral for voluntary counseling and testing (VCT) since they may refer patients for an HIV test without pre-test counseling. DASCOS and Health Education Officers, and health workers reported they need more IEC skills. Before planning any additional training in IEC for DASCOS, however, this should be co-ordinated with the STI Project, which had planned to fund this. In addition, it is difficult to know which curricula exist for some types of training, such as peer educator training for HIV/AIDS, and there are no nationally approved guidelines for this training. It would be helpful to collect existing curricula and identify successful models.

There are unmet needs among specific target groups, in both FP and HIV/AIDS.

The most striking gaps in services and IEC support are for youth (all services), men (information about FP), families affected by HIV, and services for emerging groups at risk, e.g. AIDS orphans. Several field providers said VCT is needed nation-wide as part of the response to HIV/AIDS, with training needed for health providers and clinicians.

There are mixed perceptions of the adequacy and relevance of materials.

In some areas visited, there were almost no FP client materials, but in others there was an overload of materials displayed, resulting in weak and confused messages. Some materials were outdated. There is a lack of materials on certain topics: for example, there is little or no information on HIV/AIDS care and support, and no guidance or sample materials to help in local-level advocacy. And despite annual cholera outbreaks there are no materials available. Many messages still focus on awareness and information, not a call for action. HIV/AIDS messages for youth (including interpersonal messages) do not target postponement of sex, an approach that has been successfully used in Uganda. Local access to materials is uneven; with some regions having good and easily accessible sources, others being underserved.

Media coverage has improved, but media personnel still need continued training in technical areas.

USAID has clearly contributed to the change in the amount and quality of media coverage of reproductive health over the past five years. Without conscious co-ordination, the different media projects have reinforced and built on each other. Early training for media representatives from FHI was followed by support for the weekly column *AIDSWATCH*, press supplements for youth under the Youth Initiative Project, and media training and press articles by the Kenya AIDS NGOs Consortium. For the last two years, PSI has had an aggressive and highly successful media relations campaign that is ensuring expanded coverage of AIDS issues on radio and in the press and is a model for other countries.

But reporters and editors need more technical training in covering reproductive health. Editors have a bias against coverage of local, mostly political, stories and so miss the opportunity to inform the public about the extent of the epidemic. A common, though somewhat valid, sentiment from media editors who “spike” (not totally dismiss) AIDS stories, is that they lack punch, are repetitious and give no new information. How to “liven-up” the AIDS story in a way that continuously engages the Kenyan public on such a grave health issue remains a real challenge to the country’s media practitioners.

Political goodwill is woefully inadequate.

The current situation is in many ways a paradox. At the peak of the population boom in the 1970s, a culture of silence and inaction had enveloped the Kenyan public, which seemed oblivious of the threat posed by the demographic trend¹⁹. The roles have clearly been reversed. Calls for a resounding and an unequivocal Government articulation of the enormity of the health crisis now crippling Kenya have only met deafening silence from the government. Leadership at the political level is lacking, and needs to be ignited. Brutal frankness from Uganda’s President Yoweri Museveni, and his being an indefatigable supporter of openness, is one reason Uganda has made significant strides in demystifying AIDS and promoting behavior change among Ugandans.

Research, monitoring and evaluation require more effort.

¹⁹ See footnote 3, page 1

More attention could be paid to measuring the quantity and quality of USAID's varied behavior change interventions, to help determine if the program is making the right use of media resources and better practices²⁰. The APHIA document sets out the IEC component as a national campaign and national-level training and institutional strengthening, yet APHIA projects carried out many other behavior change activities. USAID therefore underestimates its total investment in IEC. Dissemination and use of research and evaluation to improve interventions at local level is limited. Guidelines and training in using rapid techniques to inform local interventions and assess their success would be helpful.

Experience in reproductive health and family planning has shown that when awareness is not qualified by non-stigmatizing attitudes and a readiness to change behavior, it may be counter-productive. Research needs to be carried out to assess the duration required for behavior change to be effected in particular contexts, as well as provide crucial leads on when and how to measure expected results. However, even though there is little guidance on the optimum length of time for behavior change programs, USAID should consider extending programming periods to maximum limits in order to take into account the time required to influence the dynamics leading to behavior change.

VI. CROSS CUTTING ISSUES

While most other cross cutting issues (for example, the youth, and gender concerns) have been discussed in this paper, the issue of governance cuts deeper. It is clear that the GOK/donor gridlock, which is governance-rooted, has hampered the development of an effective national IEC strategy. Looking to the future, the worst-case scenario is that external support to the health sector will continue to diminish, with serious implications for service delivery and health communication. The best-case scenario is that GOK/ donor relations will soon be on the mend and support for the health sector reinstated to reasonable levels. Gauging from the current sentiment within the MOH on recent personnel changes there, prospects of a new positive direction appear real.

Uncertain commodity supplies over the next year pose serious challenges to service delivery and, by implication, effective communication, particularly emerging IEC needs. It is a truism that service delivery (SD) is the bedrock of FP/RH programs. People, no matter how motivated, cannot, for instance, use FP without service providers and commodities. Thus, the shape and direction of Kenya's communication strategy in the coming year and beyond will be defined by how accurate an assessment there will be of the services available nationally, in different organizations and locations.

VII. CONCLUSIONS

Need for a new emphasis.

Interpersonal intergenerational communication

²⁰ For a profile of media usage in Kenya, see appendix A.

Many of our contacts proposed a shift in the emphasis of communication programs. This proposed shift is premised on the firm belief that the strongest influence on people's behavior in Kenya, as it is with other African countries, is interpersonal communication. The Futures Group's Donald Dickerson and NASCOP's Meshack Ndolo converge on the view that the next break-through in Kenya's health communication arena will need to come from a fundamental change in the behavior of individuals and couples in the private spheres of sexual, reproductive, family life.

Legitimizing the role of mass media

While interpersonal communication will be the main focus in the new BCC era, mass media interventions will continue to play a critical role. Kenya's media has clearly been key in catalysing more open discussion of formerly taboo topics, such as sex, thereby greatly reducing the embarrassment of talking with friends or family members about RH issues. Information gleaned from both electronic and print media has been the subject of community meetings, and at the interpersonal level. Thus, mass media will retain its very strategic role of facilitating interpersonal communication, and giving visibility to role models, who are particularly important to the youth. Youth listen to radio (rural youth more than urban) and watch TV (urban youth more than rural because it is an urban-peri-urban luxury). The radio reaches more than 90 percent of Kenyans. It has enormous multiplier effects.

Social marketing, the new frontier

Defined as "the design, implementation, and control of programs calculated to influence the acceptability of social ideas and involving considerations of product, planning, pricing, communication, distribution, and marketing research,"²¹ Kenya's social marketing program has successfully been used to promote the Trust condom. Building on experience gained, the program is to be expanded to a new product range. The Trust condom campaign owes its success to the effective use of marketing and advertising skills to promote health-seeking behavior; and to the entereducate approach, which combines educational health messages with popular culture (entertaining songs, dance, and drama). Equally important has been the use of rigorous audience research, audience segmentation, and the establishment of market niches for specific methods to address the unmet needs of specific audiences. In the coming few months, Population Services International (PSI) plans to introduce a Trust brand targeting Kenya's lowest income strata.

Coordination: the national strategy

There is clearly an urgent need to develop a national framework with set minimum standards for IEC, without stymieing creativity. There is consensus that the current situation - far too many players with different IEC strategies - is distorting and does not give room for optimal use of diminishing resources. While there is agreement that a national IEC strategy can serve to coordinate the IEC effort, there are divergent views on which agency should provide leadership. While the government, through the MOH, is seen as playing a predominant role in health issues,

²¹ As with BCC, there are many definitions on social marketing and this is just one such definition. All, however, stress that the ultimate result (behaviour change) is dependent on the ultimate beneficiary, who adopts the proposed change on their own terms, and when it is compatible with their own perceptions, is realistic and sufficiently convenient in the context of their lives. It cannot be forced.

NGOs view themselves and are viewed as excellent advocates for policy review and reform issues.

Though it sees itself as having been mandated by government to oversee the national IEC strategy, the National Council for Population Development (NCPD)²² is identified as having evolved by far the best policy advocacy mechanisms, rather than as the national IEC leader. Both the National AIDS/STD Control Programme (NASCOP)²³ and the Division of Strategic Health Communication (DSHC)²⁴, but increasingly the latter, promote themselves as being the best suited to provide national IEC leadership. There is evidently a long-standing but subtle turf war between NCPD on the one hand, and DSHC and NASCOP on the other. Efforts to promote a single national IEC strategy must first resolve these differences. While a few donors and agencies were ambivalent on the issue of leadership, the majority were explicit in their support for one or the other government agency. In general, however, the common view was that substantial resources have in the recent past been invested to enhance the DSHCs²⁵ capacity to facilitate the implementation of a national RH strategy, and that it would be imprudent to invest in another structure.

Co-ordination: donors, government agencies, and CAs²⁶

Two reasons are advanced to explain the historic lack of co-ordination between donors and government. The first is that both sides deeply mistrust each other. While a preponderant number of donors view government systems as inept and opaque (lacking transparency and accountability), government regards a majority of donors as “overbearing”. But more fundamentally, government is critical of what it perceives as unwillingness by donors to develop structures necessary for effective co-ordination. The MOH, and the DSHC in particular, moans what it terms “impatience” on the part of USAID for having discontinued support to the Division just when it was beginning to gain recognition from other MOH entities. In addition the donors feel that the government should be playing a stronger leadership/co-ordination role.

Co-ordination of donor inputs from USAID and other key players (UNFPA, DFID, GTZ, DANIDA, CIDA, FINNIDA, UNICEF, JICA, WHO, Belgium and the World Bank) at the national level has proven elusive. However, there have been flashes of success at the project level, or where there have been specific issues to address, such as AIDS. In pursuing tangible collaboration with other partners, USAID should build on the linkages it already has with GTZ (both co-funded the design and launch of the family health logo), DFID (presently co-funding the Trust social marketing program), JICA under the US/Japan Common Agenda, and UNFPA.

²² These views were collated during discussions with all APHIA collaborating agencies in IEC, some non-APHIA NGOs (Care, Freedom From Hunger), donors with significant IEC components, and key governmental agencies, notably DSHC, NASCOP, NCPD and the Division of Primary Health Care (DPHC).

²³ For NCPD's profile and views, see appendix B

²⁴ For NASCOP's profile and views, see appendix C

²⁵ Formely the Health Education Division, now the Division of Strategic Health Communication.

²⁶ Brief donor profiles are attached as appendix D

Internally, USAID also had a tested, albeit discontinued, mechanism for co-ordinating its CAs. Established in 1993 to plan for and manage the integration of HIV/AIDS with FP programs, the USAID CAs' "Kenya Integration Group" (co-ordinated by Pathfinder) has been mentioned favorably as one that should be revived to push for a synergistic approach to all of APHIA activities. Experience with the CAs IEC Working Group, however, suggests that it is difficult for one CA to coordinate others, and that this role needs to be assumed by USAID/Kenya. In particular, it is difficult to develop a mechanism that will allow CAs to share responsibility for deliverables and will divide program funds and overhead equitably between different CAs.

Timeframe

There is need to recognize that behavior change is as much a societal process as it is an individual decision-making process. BCI must therefore have a long-term perspective. Kenyan societies have undergone fundamental changes over the last five years, and not just in the area of reproductive health. Only five years ago, for instance, no media organisation in the country was willing to carry material explicitly discussing sexuality, particularly condoms; in virtually all households and religious institutions, this subject was taboo. The lesson from this is that use of strategic communication to change fertility behavior requires adequate funding over a sustained period.

VIII. KEY RECOMMENDATIONS

Background

APHIA's contract with JHU/PCS ends in June 1999 and PSI's in June 2000. USAID's overall strategic framework is set for a review/redesign by the end of 2000. The current MTR is expected to inform USAID's re-energized overall framework, particularly in pointing out specific places where synergy can be created. In view of current funding constraints, allocative efficiency will mean that IEC will, perhaps justifiably, continue to receive less attention, with the limited resources being allocated to interventions that yield immediate and discernible/quantifiable results. From this MTR, it has become patently clear that, unlike in the past, the desired behavior change approach will be driven by interventions seeking to enhance capacity and sustainability, optimize resource use, and maximize desired results among target audiences.

New policy directions

Over the next few months, the national IEC strategy developed by the Division of Strategic Health Communications (DSHC) will be launched and disseminated as the MOH's IEC blue print to "guide the individuals and organizations involved in providing health communication and related services" in Kenya. The government, with support from the World Bank, has committed to the creation of a National AIDS Council, whose mandate, as distinct from that of NASCOP, remains unclear. There are also strong indications that, in a bid to "streamline donor activities", the government plans to create Ethical Review Committees at the provincial and district levels to review proposed donor interventions and "direct" them towards "difficult areas that have tended to be ignored".²⁷

Taking into account the government's intention to improve co-ordination and the imminent launch of the national IEC strategy, the IEC MTR team recommends the following:

1. Government Leadership

Issue: The lack of clear leadership at the national level has severely eroded the potential impact of IEC strategies through to the community level.

Recommendation: Despite the difficulties resulting from lack of clear leadership and of co-ordination between the different agencies involved in national IEC, APHIA should continue to explore ways of working with government institutions to support the implementation of a national IEC strategy. While the leadership gap continues, USAID's most practical strategies could be to:

- Support improved co-ordination among donors and at the CA level, and
- Continue to improve national capacity to deliver high-quality behavior-change interventions and to transfer these skills to the district level.

²⁷ From Dr. Misore, Nyanza Provincial Medical Officer, and Dr. Sam Ochola, Siaya MoH, though put differently.

2. Improved co-ordination of BCC/IEC interventions

Issue: BCC/IEC activities are being funded by several donors, and implemented by a variety of cooperating agencies and NGOS. Donors have differing agendas, which at worst may result in conflicting messages. Improved co-ordination is needed to ensure that these different behavior change interventions reinforce each other.

Recommendations:

a) APHIA should take the lead in presenting the need for co-ordinated IEC priorities to the donor community and relevant government departments.

USAID should leverage its comparative advantage to facilitate a meeting of the National IEC Working Group, expanded to tap private (business) sector representation, to explore the creation of a Social Marketing/Behavior Change Foundation/Advisory Board to serve as a credible vehicle for generating lasting behavior change through a cross-sectoral approach. This could, for example, include advocating for behavior change relating to a host of public health issues ranging basic family health (child survival, FP, STD prevention) to road safety, drug abuse, to anti-smoking campaigns. There is overwhelming support from key donor agencies for such an initiative, whose mandate goes beyond health. To prepare the groundwork for the proposed meeting and initiative, USAID should mobilize a core committee of like minds.

USAID can also enhance a coordinated and informed approach to BCC/IEC through ensuring that the existing Policy Project intervention to develop a database on HIV/AIDS research includes strategies to disseminate the availability and relevance of the data to agencies planning IEC interventions.

b) APHIA should develop internal mechanisms for more effective coordination and exchange of information between current CA-based IEC programs.

APHIA should support the development of a management information system and reporting protocols, to facilitate continuous information flow between APHIA and its CAs. The system, in addition to establishing concrete milestones for the CAs, will facilitate maintenance of an IEC materials audit, and enable documentation of "best" and "worst" practices. Better mechanisms are also needed to ensure that CAs complement each other's work in behavior change communication and that all CAs have systems in place to monitor the quality of interventions at field-level. It would also be helpful to develop some common indicators for interim stages of behavior change that can be shared across CAs.

One option would be to revive a CA IEC Working Group, led by one of the CAs. Experience with this mechanism has however shown that it is difficult for an individual CA to take on this role: the team recommends that USAID/Kenya assign someone on staff to co-ordinate CA BCC/IEC activities. In addition, USAID should ensure that its considerable investment in

reproductive health IEC/BCC is fully documented and recorded, including all community-level interventions carried out by the CAs.

3. The need for continued national IEC campaigns

Issue: As demonstrated by PSI's successful condom social marketing campaign, national media campaigns have huge potential for affecting the behavior of key sectors the community - and changing the national sense of which topics are appropriate for public discussion.

Recommendation: APHIA should champion national campaigns - identified to be seriously lacking - as one way of both contributing to behavior change, and of building project or issue based coalitions among key players in the health sector.

The National Family Health Logo/guidelines (and possibly the DSHC IEC Strategy) provide some opportunity. The huge cost factor of such campaigns could be addressed through the proposed consortium model, to involve several donors in, for example, supporting an campaign targeted at youth addressing reproductive health issues. To avoid past failures, the planning of such national campaigns must be sensitive to domestic political events and trends.

4. The need to channel and focus available resources.

Issue: Given the limited funds available, IEC resources should be prioritized and focused on key target groups and issues.

Recommendation: APHIA should channel available resources for both national and CA-based IEC programs to focus on the youth, promotion of "dual-protection", and advocacy to increase the level of political response and commitment to the country's health challenges.

This limited focus should create an early opportunity to establish a mechanism for synergizing APHIA's activities to link with other USAID SO areas, as recommended at the MTR synthesis meeting, particularly in interacting with the governance and democracy SO to address advocacy issues. Particular groups that could be targeted include Permanent Secretaries and Parliamentarians. APHIA should champion national campaigns--identified to be seriously lacking--as one way of building project or issue-based coalitions among key players in the health sector.

5. Capacity-Building in BCC/IEC Skills

Issue: On of the most-frequently stated issues during the MTR field trips was the need for training in BCC/IEC skills for government personnel and NGOs.

Recommendation: USAID should fund continued skills training in behavior change communication for DASCOS and Health Education Officers.

It is also worth noting that Kenya has no professional association of behavior change professionals that encourages specialists to share knowledge and incorporate new findings into intervention design. APHIA could explore ways of supporting a new consciousness of this professional identity in Kenya.

6. Community Level Interventions

Issue: Another significant issue identified through field trips and other key informant interviews was the barriers to behavior change at community level.

Recommendation: Increased emphasis should be placed on involving the community in designing behavior change interventions, in order to strengthen their relevance to the local situation.

APPENDICES

Appendix 1: Collaborating Agencies/NGOS/Government Agency/Donor Overviews

FAMILY PLANNING ASSOCIATION OF KENYA (FPAK)

Formed by a group of individuals from various parts of Kenya to popularize family planning in response to problems posed by large families, especially on family health and stability, FPAK was registered in Kenya and affiliated to the International Planned Parenthood Federation (IPPF) in 1962. FPAK is the pioneer family planning movement in Kenya. The Association has 17 clinics countrywide, a large CBD program serving over 5000 clients. FPAK is a nation-wide, volunteer based, non-profit, non-governmental organization. FPAK believes that planned parenthood is a fundamental human right and that voluntary family planning is an important health measure and recognizes that clients have the right to be treated with dignity and complete confidentiality. The IEC strategy is intended to ensure a systematic and harmonious approach to dissemination of population related messages. Its aim is to provide a reference point to implementers of all FPAK projects with an IEC component in order to avoid unnecessary overlapping and contradictions. It provides a framework within which IEC and advocacy activities are developed.

Provider and Client IEC Project (PCIECP): Conceived after the 1989 Kenya Demographic and Health Survey (KDHS), which revealed that although the level of awareness on FP was very high, practice was as low as 27 percent or less. FPAK was then charged with providing family planning information. Research was carried out to understand why:

- The levels of awareness and knowledge did not match.
- The typical medical care provider was rude, insensitive and uncaring.
- Different institutions/ organizations had entered the market at the same time; these had trained their service providers in different areas using different curricula. This gave rise to different levels of knowledge and different approaches to the same basic issues.
- Lack of spousal communication in family planning matters is low.

FPAK's partners in this project were Maendeleo ya Wanawake, FPPS, CHAK, Nairobi City Council and CORAT and AMREF. It had two components - training of service providers and IEC. A national training manual was developed for CBD agents. The MTR team received very positive comments on the manual, which is now widely used by non-APHIA supported CBDs, most notably GTZ, which puts its national CBD network at 12,000. Joseph Cheruyot, coordinator of the European Union supported Freedom From Hunger Council's Siaya program, called the training manual "a worthwhile investment". All of the programs CBD Supervisors and trainers use the manual.

In all, PCIECPs successes included:

- Increased couple communication on matters of FP through radio campaigns.
- Different agencies formed a "rapid relationship", demonstrating potential for collaboration at project level
- Uniformity in FP information being communicated to the public
- Training skills stepped up and maintained

- Facilitative supervision skills improved

MARIE STOPES KENYA (MSK)

One of the 30 Marie Stopes International affiliates, MSK was established in 1986. Currently running four full-fledged nursing homes and 12 clinics around the country, the agency implements two outreach projects, including the Voluntary Surgical Contraceptive (VSC) Program and the USAID education and service project. The MSK/USAID project provides integrated RH services to women and men who fall within the catchment areas of 120 selected private practitioners. Ten MSK community health workers are attached to each selected private practitioner, with RH services emphasizing effective and personalized STI and HIV/AIDS home care, counseling and referrals. For the moment, MSK has virtually frozen its IEC program, opting instead to develop a clearly thought-out strategic plan that will help the organization effectively use communication to create demand for its services. This unique approach was quite visible at most MSK clinics visited. In a number of such clinics in Nyanza, where the norm is to plaster clinics with print materials, the material on display -- the Family Health logo, the JHU/PCS flipchart and MS International's overarching logo ("Caring for Your RH Choice") -- were strategically situated to add to knowledge after service. MS Kisumu's clinic in-charge, Richard Olewe and Doctor-In-Charge, Peter Waweru explained it thus: "Posters detract when not displayed strategically." Their plan is to adopt the model used by multinational companies (Coca-Cola etc), which have perfected the art of "renewing" their products by constantly reviewing their message before the tranquilizer effect sets in.

FAMILY HEALTH INTERNATIONAL (FHI) Population Division.

Family planning and contraceptive technology research. This is a program that looks to address research questions relating to contraceptive technology and the provision of quality family planning services around the world. FHI works with the testing and approval of new contraceptive technologies, improvement of family planning services, specifically addressing barriers to access; looking at the non-contraceptive risks; and benefits of family planning services and contraceptive technology; training and dissemination of technical information.

FHI is also involved in the area of barrier contraception, especially focusing on the female condom and female-controlled methods. There is a large community intervention trial funded by USAID Washington and USAID Kenya. Studies are also being carried out on the diaphragm, investigating whether or not it provides protection against cervical infections. There is also an ongoing study in Coast, Eastern and Central Provinces, looking at the ability and willingness to pay for family planning services. Findings from this study are to be distributed to donors and the government.

IEC focus: FHI IEC activities in population would be categorized as technical information. FHI produces technical materials for providers of reproductive health services. The emphasis is to bring the most up-to-date information to them in a format that can be understood by providers. In Kenya FHI is working with AMREF to link up with their CBD system to disseminate a network edition that is coming out to deal with CBD. FHI is not involved in mass IEC.

FHI's HIV/AIDS Division: The IMPACT Project. FHI has been managing AIDS prevention projects for USAID since 1988. From 1988-92, USAID funded 16 sub-projects through the AIDSTECH Project. The main focus was HIV/AIDS prevention education, including pilot projects targeting commercial sex workers and truck drivers, and training and materials development for health providers. Other issues addressed were reducing blood transmission, upgrading STD services, surveillance, an MIS system for the National AIDS Control Program, and an assessment of the economic impact of HIV.

AIDS prevention activities continued under the AIDSCAP program and its extension as the Kenya AIDS Project. AIDSCAP primarily implemented its projects through subcontracts with Kenya NGOS. AIDSCAP funded 27 subprojects, 14 of which were related to behavior change communication. The primary target audiences were men and workmen at work-sites, clients seeking STI services, family planning clients, and students in institutions of higher education. Interventions were carried out at the national level and in three urban settings: Eldoret, Nairobi, and Mombasa. The target audiences of workers and students were selected because of their current and future importance to the economy and their perceived role as influencers in their communities. AIDSCAP, through FPPS, also developed a training curriculum for family planning health providers, in order to integrate HIV and STI prevention education into clinic services.

The strategic approach of the communication projects was to deliver interpersonal interventions at work-sites and colleges, reinforced by drama performances. This was supported by mass media coverage in the press and on radio, aimed at the general public, to create awareness, provide information, promote discussion, and model behaviors. Working with FPPS, AIDSCAP/KAP trained peer educators at 17 work-sites in Mombasa, Eldoret, and Nairobi and at 10 colleges. PATH was subcontracted to provide training of trainers in five security guard companies, and a pilot project provided life skills training to *matatu* (public service vehicle) drivers and touts. A training curriculum and supportive materials were developed for the security guards, a curriculum for the *matatu* intervention; and materials packages for peer educators in work-sites and colleges.

Media activities included a weekly column in the Sunday Standard; and Maaiabu, a radio soap opera in five local languages. AIDSCAP supported a professional drama group, the Miujiza Players; and a project that used drama to motivate youth at the community level, through an AIDS Week drama competition and festival.

AIDSCAP also supported two major interventions with national NGOS, MAP International for work with church organizations and the Kenya AIDS NGOs Consortium to develop a Resource Center on HIV/AIDS and reproductive health issues. The KANCO intervention was later expanded to provide training for staff in charge of selected district health information centers. In addition, IEC capacity was increased for the staff of 20 NGOS, trained by PATH in materials development and production techniques.

Although AIDSCAP's primary focus in Kenya was on project implementation, there were four research projects: into the efficacy of voluntary counseling and testing; issues surrounding

communication for safer sex between steady partners; Communication between mothers and daughters; and factors promoting the adoption of the female condom. USAID will start a new two-year program with the IMPACT Project later this year. IMPACT will revise tile approach to behavior change interventions, by targeting persons at high risk of infection and their surrounding communities through combined service delivery, behavior change, and condom promotion. The approach will be highly participatory, involving the communities in these interventions.

KENYA AIDS NGOS CONSORTIUM (KANCO)

Initially formed by about six individuals working for some key NGOS, KANCO was motivated by a desire to fully integrate HIV/AIDS into existing programs. In September 1994, with funding from USAID through AIDSCAP, the Secretariat was formed and reproductive health services offered. To date membership stands at about 450 registered members - individuals, community societies, government departments and the private sector. KANCO's overarching objective is to strengthen organizational capacity among its members through resource networking.

IEC Component. USAID has been the main donor, initially through AIDSCAP/FHI. This support lapsed in June 1996. DFID through Futures Group International sought to identify the gaps in the IEC area in Nyanza province as a whole. Initially, leaders at the provincial level met and an AIDS assessment was carried out. From MOH, KANCO has received assistance in the form of IEC materials. KANCO has also worked closely with PATH International, which, being an expert in training in IEC materials, has helped KANCO NGOs develop AIDS-specific IEC materials targeting the youth.

Advocacy for HIV/AIDS Issues. During the period, KANCO held four provincial workshops covering 20 districts. For two days, the trainees went through an AIDS situation analysis in their respective areas and nationally, they were able to identify the key pressing issues. Papers were prepared for key policy makers to provoke a critical analysis of these issues for implementation at the national level. Three of these included:

- HIV/AIDS - education for Kenyan youth
- Discrimination
- Reduction of stigma to enhance home based care.

Three other areas around which activities are being developed include testing and counselling, access to treatment and management of HIV and orphan support

Achievements. From evaluation, it was felt that the establishment of the resource center was timely. It was seen as appropriate for those involved in HIV/AIDS to access the relevant information because there was no other library in Kenya providing specialized HIV/AIDS information. The center is gradually evolving into a fully-fledged, one-stop resource on HIV/AIDS.

Media Involvement. Initially, three media workshops were held at which it was evident that the media and those in the field of HIV/AIDS and RH did not have a close relationship. Through these meetings, a formal understanding evolved between the two and the media took the resource center as a reference point. Since then, there has been an increase in media reporting of HIV issues. Reporting has also been more informed and accurate. Airtime allocation at KBC has also increased, offering an important forum to publicly address these issues. KANCO-member NGOs provided valuable input into Sessional Paper No. 4, of September 1997 on AIDS in Kenya, indicating governments recognition of the consortium mandate.

Impact. Measuring impact is difficult. But past evaluation suggests that although some level of behavioral change has been achieved, a lot still has to be accomplished. The level of awareness is quite high but a few gaps exist in the way of misconceptions and negative attitude. The challenge going forward is to create fora to mobilize communities to discuss their fears, and design more effective interventions to achieve behavioral change.

POPULATION SERVICES INTERNATIONAL (PSI)

PSI has been in Kenya since 1990. PSI is primarily involved in the social marketing of goods for health, with a communications component. PSI tries to do generic or non-trust (non-branded) communications to address key problems. The vast majority of PSI work is branded. PSI operations are currently involving the social marketing of *Trust* condoms. Sales volumes are estimated at one million units per month (average for the three months), with 1998 sales estimated at about 10 million. The target for 1999 is to sell 14-15 million condoms and at the time of the review (March/April, 1999) this seemed to be right on track.

Next phase. PSI is planning to launch hormonal contraceptives, both pills and injections. Research in preparation for the development of a brand has been completed. An advertising brief has been conducted and has been submitted to five advertising agencies. PSI also has a minuscule unfunded program in Kilifi, which is all about re-dipping bed nets.

IEC strategy. The bulk of PSI work is brand marketing; to sell *Trust* condoms. PSI does not really have much of a mandate for generic communications. PSI has identified through a survey that there is a huge behavioral problem that is not being addressed, namely the trusted partner issue. A survey in Western and Coastal Kenya and in Nairobi, covering 1500 people, identified the main barrier (addressed by 15-25 year olds) to more widespread use as trust of one's partner. The new *Trust* campaign will be a combination of brand and generic marketing. The latter will not mention *Trust*.

PATHFINDER INTERNATIONAL

Pathfinder delivers comprehensive reproductive health services and works closely with NGOs to deliver these services. Pathfinder's mandate is to strengthen partner NGOs and institutions and to provide them with funds/grants to provide their services. The goal is to increase access to and quality of reproductive health services and to improve institutional sustainability. Pathfinder has no clinics or sites but works through such NGOs as Maendeleo ya Wanawake, which receive TA aimed at enhancing their capacity to deliver service.

Their main area of interest is community-based programs. Pathfinder has about 2000 community based workers. Pathfinder is also working on postabortion care (PAC) with the University of Nairobi and peer education for youth at Egerton and Kenyatta universities. It is also involved in other innovative activities like the introduction of the emergency contraceptive pill (ECP). Pathfinder is therefore a service delivery CA that has been in the field since 1969 and registered as an NGO in Kenya in 1974. They were involved in introducing CBDs. Initially a family planning organization, Pathfinder is now moving to more reproductive health issues, integrating HIV/AIDS, STDs and safe motherhood into service delivery programs.

Impact. The CBDs have contributed to increased awareness and acceptance of HIV/AIDS, family planning and use of the condom. They are now being trained to be vocal messengers to enhance and encourage behavior change. They are invited by chiefs and sub-chiefs to talk on family planning at "barazas". This is also advocacy. Pathfinder is concerned about the tendency to under-invest in IEC, which undermines its importance and impact.

Pathfinder's Charles Thumbi, sums it thus: "In order to effect behavior change, the new BCC on family planning should be localized/community based. The use of mass media should also be strengthened. It should however be culturally sensitive and targeted. In-service training on counselling should also be emphasized to enhance IEC."

MAP INTERNATIONAL. The regional office of MAP was established in 1984, at which time the focus was primary health care. The distribution of medicines is now MAP International's main activity. Locally, MAP's focus is primary health care. The organization seeks to tackle health issues through the church, which they view as a very sustainable institution. Their focus is to enhance the capacity of the churches to deal with health issues. Their programs include: A program that seeks to supply essential drugs to all church health units, a program that seeks to increase the capacity of the church to intervene in peace and reconciliation issues with special emphasis on the Great Lakes Region, and an HIV/AIDS prevention program.

Since the early 1990s, MAP changed its focus to address the issue of HIV/AIDS. They started by bringing church leaders together, to consolidate efforts, and it became apparent that there was a very negative approach towards HIV/AIDS prevention. Most churches were in denial; they did not want to appear to be involved in the campaign because at the time AIDS was viewed as a "sinner's disease".²⁹²⁸ Using a biblical basis, however, MAP sought to unite the church efforts in the campaign, and challenged them to action. As a result of this, a change of attitude and perception in the church was evident. In 1994, MAP organized a church and AIDS consultation in Kampala from which MAP sought to understand how the churches could best be equipped to communicate effectively. They indicated a lack of capacity to respond, a lack of information and a need for further education on HIV/AIDS. After this meeting, MAP embarked on designing materials to help bridge the gap.

²⁸ This was pretty much the message in the first campaigns of the early 1990s. The message purveyed in these campaigns, unwittingly or otherwise, was that all but prostitutes and drug addicts were safe from the disease.

In 1996 a policy workshop was held where the church leadership was encouraged to develop policies to address the issue of HIV/AIDS. At the workshop, the church leaders signed a document detailing the areas they felt needed urgent attention. The AIC church for example, has made significant progress in addressing some of these issues, including convening regular communication workshops for its clergy to impress on them the impact of HIV/AIDS.

MAP's collaboration with the church begins with top leadership in order to receive an endorsement/blessing to ensure that the message will penetrate to the laymen and congregations. Beyond this, MAP has representatives in Mombasa, Machakos, Kisumu and Nakuru. They work through the parishes in the various provinces and have strong links with health coordinators and education department leaders. MAP has been very successful in the production of educational materials from a biblical perspective. MAP's core competence is its partnership with the church, although they also work with other non-religious organizations. Being a Christian organization, MAP is not currently working with the Muslim community but is exploring that area of collaboration.

The church needs to have effective programs to address issues relating to youth sexuality, peer pressure and reproductive health. MAP has succeeded in coordinating the campaign among the different church groups because the organization has remained neutral in its role. MAP's materials for communication are largely representative of their constituencies - affiliated church organizations. They address all the issues together with possible solutions and leave the decision to the individual.

In 1994, MAP conducted a baseline study polling church leaders and the youth (19-25 years), to obtain their knowledge, attitudes, practices and behaviors towards HIV/AIDS. A survey of the church was carried out to find out what was lacking to make the church more effective.

Materials were then developed together with a working group consisting of representatives from other organizations CHAK, KANCO and other health professionals. It is MAP's intention that the design of the materials reflects the accepted approaches. MAP has produced materials that have been quite successful. These include:

Helpers for a Healing Community - a pastoral counselling manual specifically for HIV/AIDS for church leaders and health workers. MAP uses this manual in pastoral training. It has also been cited by WHO as a best practice manual in that it reflects a pastoral-counselling manual for community level training.

Growing together - a parenting youth guide. It challenges parents on parenting approaches from infancy. About 7000 copies of this book have been distributed in Mombasa, Nakuru, Kisumu, Machakos and Kakamega.

Choosing hope - a pastoral training module. It is designed for use by theological and pastoral training institutions. It is an accurate presentation that serves to educate and inform those in theological colleges about HIV/AIDS. Workshops have also been held with curriculum developers of these institutions on how they can integrate the campaign into their institutions.

AIDS in Kenya - the churches challenge and lessons learned is designed specifically for policy leaders. It attempts to share what MAP has learned through its work with various church organizations, areas of emphasis, how to develop policy and other recommendations. It has been distributed to all bishops in Kenya.

NATIONAL COUNCIL ON POPULATION AND DEVELOPMENT (NCPD).

NCPD's Dr Linus Etyyang sees the major communication challenge now as the need "to intensify education for behavioral change including the promotion of condom use, involving and mobilizing the community to take responsibility in the provision of care of people with HIV/AIDS and early diagnosis and treatment of STDs." The interventions that have been employed against HIV/AIDS have mainly focussed on education, blood screening and surveillance. Yet STDs have a serious impact on RH. They make it easier for HIV infection to take place, while in people with HIV infection other STDs may be more resistant to treatment. STDs, other than HIV/AIDS, have not received much attention in the area of population and health, particularly as far as IEC efforts are concerned.

IEC Strategy: The IEC strategy was developed through wide consultation with public and private sector groups and individuals, including JHU/PCS, CHAK, FPAK, government ministries including Health, Education and Information, among others. Successful implementation of the strategy is dependent on the effectiveness of the institutional framework and mechanisms set up to effectively coordinate NGOS, government ministries, the private sector and donor agencies. The strategy as it is developed is designed to:

- Provide a reference point and guidelines to government institutions, NGOS, donors and other agencies involved in population advocacy and IEC in order to avoid unnecessary overlapping and contradictions
- Provide a framework within which advocacy and IEC programs can be developed

NCPD's mandate is to coordinate all advocacy and IEC activities in Kenya. This involves reestablishing, strengthening and expanding the technical advocacy/IEC working groups in specific health areas, such as HIV/AIDS, youth, and contraceptive drop-outs. Together, the working groups will form a much broader group to critique and coordinate IEC activities. It will also involve reestablishing and strengthening the advocacy/IEC standing committee, which will serve as a final screening and vetting ground for IEC materials. The committee should meet on a quarterly basis.

In addition there is need to develop a supply system that distributes materials to service providers and establish an inventory and materials collection center with samples of all advocacy/IEC materials used in Kenya. This will assist NCPD in providing leadership in the development of new materials and avoid duplication and waste of resources. A directory of advocacy and IEC population experts is also needed, and research activities in population, advocacy and IEC should be coordinated.

IEC activities should be framed in the context of rigorous audience analysis and aimed at:

- Increasing the target group's knowledge and understanding of an issue
- Changing their attitude to an issue through developing a more critical awareness of it
- Precipitating a specified behavioral change amongst the target group

The NCPD holds regular meetings (quarterly progress review committees) with participating agencies to assess progress and discuss issues. The agencies communicate on what activities they are involved in, share their experiences and look for new areas of collaboration with each other. The NCPD however experiences problems of funding/delays in funds disbursement and lack of equipment.

NCPD works closely with other agencies, such as FPAK and NASCOP. There is division of labor between NCPD and NASCOP. An NCPD Officer, Mr. Muindi, who represents the NCPD director, is attached to NASCOP. Together NCPD and NASCOP are involved in the development of seminars and programs to develop FP projections for the year 2000 and beyond.

NCPD feels that the universities should be involved in the national IEC strategy. This is because as institutions of higher learning they have the resources and ability to provide wider/broader thinking on issues. University personnel could also be used in research and to assess the impact of programs/interventions.

The NCPD argues that they have to contend with retrenchment of staff, which has left them overburdened. The fact that they operate at the national level also makes it that much more difficult to achieve results comparable to those of NGOs who operate within much smaller geographical areas. NCPD is satisfied with the existing structure of leadership of a national IEC strategy. It recommends that an empirical assessment of NGOs participating in the area of IEC be conducted and documented. This will make it easy to compare strategies, avoid duplication and allow for shared experiences where the best or most effective strategies would be adopted.

NATIONAL AIDS/STD CONTROL PROGRAMME (NASCOP). Partners - NASCOP works together with NGOs and the private sector at the national, provincial and district levels. NASCOP is a division of the MOH, which provides oversight and works in partnership with all actors in Kenya. Its principal donors are UNAIDS and the World Bank. NASCOP works mainly in the areas of epidemiology, surveillance, care and support for the infected, counselling, testing, blood safety and IEC. It feels that there are very many actors in IEC. NASCOP also works in the area of advocacy. They target specific programs at the youth, both in and out-of-school, address gender issues and provide community based education. It is very important that leaders be involved in health programs and for this reason advocacy is a principal component of NASCOP's IEC strategy.

NASCOP's IEC strategy is implemented through the health care delivery infrastructure down to the community level. The strategy works within the framework of the MOH framework by emphasizing the decentralization of decision making and resource utilization. At the district level NASCOP works through the DHMT and DASCO on STI programming and implementation. It is also involved in the promotion of health education. At the district level, NASCOP generates workplans with an IEC component detailing the target groups as defined in

their strategy. For example, IEC for the youth contains workplan details on the methods to be used to reach the group with information, education and supportive RH services. NASCOP facilitates funding from the Ministry of Health courtesy of existing projects. NASCOP also interacts with CBOs in capacity building.

NASCOP also works through the District Intersectoral AIDS Committees (DIACS) at the district level. DIACs exist in every district and are chaired by the DC, with a secretariat led by the MOH. The DIACs have a very broad composition, including NGOs and CBOS, representatives of religious organizations and the private sector; they are responsible for reviewing programming and implementation, processes and challenges and monitoring activities at the district level. NASCOP has fostered the DIACs' capacity through training and providing terms of reference for their activities. It is now working on the creation of divisional inter-sectoral committees to counter myths and rumors and popularize RH programs at the divisional level. NASCOP intends to use the participatory process to involve target groups.

Through reporting mechanisms/systems consisting of process indicators and benchmarks, NASCOP is able to monitor the impact of its interventions in the district/divisional level. This is a very effective method of monitoring and obtaining feedback from the district level. They are now working towards working with the community health committees. Regular meetings are held at which project objectives and challenges faced are discussed and successful projects are replicated. NASCOP receives proposals from CBOs and NGOs to collaborate in interventions. It recommends the identification and use of CBOs which have the capacity to reach specific target groups, e.g. youth clubs, to target out-of-school youth through sports, music and other social activities. The CBOs are chosen depending on their leadership structures and the commitment/ obligation of the leadership to the CBO. Weaknesses are identified through record keeping, documenting such items as materials/condom distribution and accounting systems. The CBOs are also encouraged to engage in income generation activities to empower them to take the lead in health communication and social marketing of condoms. There is a complete/intertwined relationship between IEC programs and those intended to empower the CBOs themselves to implement IEC activities. The biggest challenge facing NASCOP is the dissemination of materials. Infrastructural resources to reach people at the community level are limited as are other resources such as finances and manpower

NASCOP is supported by the World Bank through the STI project. Donor funding on AIDS programs stopped after 1993 when the Global AIDS Programme of the World Health Organization, which used to be the channel through which donor funds were channelled, was disbanded. NASCOPs activities are also funded by other donors including DFID (Nyanza province), Kenya-Belgian Project (IEC), the European Union (facility-based IEC on STDs), the UN (through UNAIDS, WHO, UNICEF, UNDP) and CIDA (program targeting youth training institutions, such as KMTC).

In terms of coordination, NASCOP hopes that the National AIDS Council, which is in the process of being formed, will provide coordination in IEC in the country. With funding from the World Bank under the STI project, NASCOP supported the preparation of the DSHC's (formerly HED) health communication strategy, which has been finalized and is due to be launched in June

this year. DSHC staff (Mwongera, Willy Njoroge) are seconded to NASCOP to cement the link between the two. The head of DSHC is a member of NASCOP's AIDS Committee and one of NASCOP's offices is based at DSHC.

Because of the close link between FP and AIDS, NASCOP was also involved in the national FP/IEC strategy prepared by NCPD. An NCPD official is a member of the NASCOP AIDS Committee. NCPD operates under the Ministry of Planning and National development while NASCOP is a Division of the MOH.

Gaps in IEC. Meshack Ndolo says "focussing on CBOs is not an easy task. Most of our activities are health facility based; they go for outreach. If these activities were to be embedded within the community development programs, the IEC need would easily be fulfilled." It is at this level, he adds "where we will be able to determine the problem of the linkage between knowledge and behavior change. This gap is a huge one and can only be solved at the community level through countering rumors and myths and bringing down cultural barriers."

Ndolo's view on the MOH's role in a national strategy is this: "While government structures may not be very efficient, they are there and are an effective means of reaching the community through the DC, DASCO, District Committee Development Officers and District Social Development Officers, who will always be there. We should make use of them. The Sessional Paper on AIDS provides for a national structure. The community is the one unit that knows the effect/cost of AIDS and it is the community that will determine the next course of action. Government will always be critical in efforts to reach the community."

THE WORLD BANK.

The World Bank activities on HIV/AIDS in Kenya seek to:

- Support all the basic interventions - AIDS & STD education, STD care, condom promotion, blood supply protection, care of opportunistic infections, and mitigation of AIDS consequences and they provide the necessary resources to expand these interventions to scale. Meet national needs for commodities: condoms, diagnostics, and drugs to treat STDs, tuberculosis, and other opportunistic infections
- Design and incorporate national evaluation strategies to measure the impact of interventions strengthen the skills of public and private personnel in program management

The Bank supports Kenya in strengthening programs leading to the adoption of healthy sexual behaviors and practices. Three separate tasks built on the Bank's cooperative advantage in policy dialogue and sector work are proposed to strengthen capacity in this field

- Establish a National AIDS Council to organize analytical work and behavioral change programs in Kenya for better change. The group will bring together prominent spokespersons from various backgrounds to explore, promote, and give direction to other Kenyans, the Bank and international partners on the many facets of changing behavior.
- Design and undertake a comprehensive review of the progress to date and challenges ahead in changing risky practices and adopting safe behaviors in Kenya.
- Augment Bank initiatives to strengthen public and private institutions, and community based organizations currently involved in behavioral interventions. These organizations

will serve as national and regional centers of expertise for building the capacity of professional and community leaders in improving health practices.

THE UNITED NATIONS CHILDRENS FUND (UNICEF).

Since the mid-1980s, UNICEF has actively supported the fight against HIV infection. All programs supported by UNICEF adhere to WHO's Global AIDS strategy. UNICEF'S support takes several forms:

- AIDS prevention education activities, through health education, school curricula, and other outlets, to reach women and children at risk
- Orientation & training for those likely to come into contact with AIDS patients or their relatives Advocacy, towards government, donors, NGOS, and the general public, to raise awareness and mobilize resources
- Co-operation with NGOs directly involved in caring- for those with AIDS or affected by it Expansion of PHC networks and child survival initiatives, including extra attention to sterilization of medical equipment
- Exchange of scientific and technical information to provide effective programming through funding conferences, workshops and study tours

UNICEF and AIDS Prevention. The importance of awareness building cannot be over-stated. UNICEF has helped develop information and education materials about AIDS - posters, pamphlets, cartoon strips, videos, radio spots - for use with a wide range of audiences.

Youth: UNICEF intends to reach those in their early youth before they become sexually active. Schools, youth clubs, and other environments in which young people can be reached with messages about AIDS prevention are a natural UNICEF target.

Women of childbearing age: Much of AIDS education effort has been directed at women of child bearing age (15-49), through primary healthcare networks and through regular communications outlets. UNICEF has been actively involved in the preparation of manuals and brochures for the training of health workers in AIDS prevention.

Support for families, especially orphans: The impact on families and communities of the loss of key economic providers to AIDS is of growing concern. UNICEF is now urgently examining how to care for the growing number of AIDS orphans. The challenge is to find ways of helping them economically, socially and psychologically without distancing them from the normal context of their lives. UNICEF also participates in national and local studies to determine the nature and magnitude of the problems concerning children whose parents have been lost to AIDS.

Priorities until the year 2000: Over the coming decade, UNICEF's main priority within AIDS prevention will continue to be to spread information among key audiences, by offering technical and material support to government ministries, NGOS, and all kinds of social and community groups undertaking AIDS-related programs.

UNICEF is working closely with the DSHC and the national IEC working group. Lack of co-ordination in implementing strategies lies chiefly in the inability of DSHC to move on -- mainly because it lacks resources and capacity. UNICEF has prepared a draft document on a national IEC strategy. This was developed at a one week seminar attended by key players including ministries (Health, Information) and relevant departments within these ministries and NGOs (CHAK, FPAK).

UNAIDS.

The role of UNAIDS is to co-ordinate the HIV/AIDS efforts/activities of UNICEF, UNDP, UNFPA, UNHCR, WHO AND UNESCO. Through the provision of technical assistance and funding, UNAIDS also helps governments respond to the epidemic. UNAIDS is not involved in the design or development of IEC programs/activities, but rather provides funding and technical assistance to NASCOP in IEC. The organization advises on target group identification, IEC, counselling, condom promotion, HIV testing, safety of blood transfusions and surveillance. In so doing, the goals of UNAIDS are twofold: 1)prevention of further spread of the epidemic and 2)mitigation of the socio-economic impact of HIV/AIDS.

NASCOP's IEC activities in the area of HIV/AIDS are mainly targeted at two groups;

Youth - especially the girl child. UNAIDS recommends reaching the in-school youth through the teachers who should be provided with FP, RH and life skills education during their years in teacher training colleges to enable them to teach these to in-school youth. Out-of-school youth are targeted through community leaders, such as church leaders or chiefs.

Women - especially commercial sex workers (CSWs). This is mainly through the promotion of condom use.

UNAIDS feels that NCPD should exercise leadership in IEC conception and design but not in implementation. The NCPD has done a poor job of coordinating IEC activities in Kenya due to lack of qualified personnel and inadequate financing. UNAIDS feels that these issues of capacity and institutional building if addressed, could transform the NCPD into a more qualified authority to handle and coordinate IEC in Kenya.

UNAIDS recommends that leadership in IEC in Kenya should be left to an organization that is not affiliated with the government and also one that has linkages at the grassroots to be able to effectively reach rural communities. UNAIDS feels that the NCPD lacks this and proposes the Kenya Catholic Secretariat, which manages at least 400 schools across Kenya. It also identifies KANCO as an organization that can be used to vet NGOs operating in the country through which donors can channel funding for IEC activities.

UNAIDS also recommends that implementing partners in IEC be identified from their networking capabilities (capacities), availability of infrastructure, mechanism and resources. It identifies the District AIDS Committees for example who have the mandate but lack the tools/finances with which to effectively carry out the mandate. As part of its advocacy

component, UNAIDS funded and participated in the Nyanza leaders focus meeting in December 1998.

UNFPA

Overall Objective

- To increase the accessibility and quality of RH programs

Strategy

- Support the implementation of the National Strategy for Reproductive Health and Health Policy reform
- Strengthen the management of the RH program at national and district levels including the health information system
- Establish reliable procurement and distribution procedures and systems for commodities and supplies
- Strengthen capacity at all levels to deliver quality RH services and to manage the program
- Establish mechanisms and procedures to promote and safeguard women's sexual and reproductive rights within the context of reproductive health care

Objective

- To improve the reproductive and sexual health of adolescents

Strategy

- Advocate for policies, strategies and programs that respond to the needs of adolescents both in-school and out-of-school

Objective

- To arrest the spread of STDs and HIV/AIDS and mitigate their impact on families, communities and the population at large

Strategy

- Integrate the management of STDs at all levels of health service delivery
- Intensify advocacy, IEC and social mobilization interventions to empower and mobilize segments of the population to deal with the STDs, HIV/AIDS pandemic
- Strengthen community-based initiatives for prevention care and support for HIV/AIDS
- Train service providers in the prevention and diagnosis and management of HIV/AIDS

- Expand the availability and accessibility of condoms to under-served groups including adolescent and youth for the prevention of STDs and HIV/AIDS
- Strengthen and expand the syndromic approach for STD case management at all levels of health delivery
- Provide appropriate equipment and drugs for diagnosis and treatment of STDs

Advocacy and IEC

Objectives

To improve the institutional and operational mechanisms for coordination, supervision, monitoring and evaluation of population advocacy and IEC activities in order to avoid duplication and wastage, assure quality, effectiveness and cultural relevance and facilitate collaboration among government, donors and NGOs

Strategy

- Build on the foundation of the NCPD's current efforts to coordinate and monitor advocacy and IEC activities and to assure their quality.
- Involve implementers and other stakeholders in coordination through fostering consortiums or coalitions to undertake specific advocacy and IEC activities in support of RH
- Decentralize advocacy and IEC implementation to the district level. District and zonal population officers are expected to play a key role in establishing, monitoring and mobilizing technical support for advocacy and IEC activities at this level

Objective

- To bring about positive attitude and behavior changes among in-school adolescents on issues of adolescent reproductive and sexual health, family life, and gender relations by increasing their access to appropriate information and counselling services

Strategy

- Foster or strengthen coalitions that agitate for the provision of information, education and counselling services to in-school adolescents
- Engage in dialogue and negotiate with institutions opposed to providing information on reproductive and sexual health to in-school adolescents
- Provide information, education and relevant skills training to in-school adolescents through innovative counselling and co-curriculum activities to enable them to cope with reproductive and sexual health problems
- Disseminate relevant research data to inform and educate parents and other significant adults about the reproductive and sexual health needs of adolescents and provide them with the skills to communicate with their adolescents

Objective

- To increase male involvement in RH decision-making, and encourage responsible behavior among men in matters relating to sexual and reproductive health

Strategy

- Support and expand IEC programs that target men in working places and other organized settings
- Inform and educate men about their responsibility in RH through mass media and social mobilization activities
- Equip RH service providers and educators with skills to address the RH information, education and counselling needs of men
- Support and expand IEC programs that promote spousal communication on RH issues To improve the quality of information and counselling provided to RH clients at service delivery points
- Collaborate with the MOH and its partners, key donors and technical assistance agencies in developing standard training manuals and protocols in inter-personal communication and counselling for RH service providers
- Collaborate with the MOH and its partners, key donors and technical assistance agencies in producing/procuring print and audio-visual support materials to support counselling and interpersonal communication, and to educate clients

Objectives

- To increase the awareness of the general population about new and emerging issues in population, particularly the new orientations in RH and gender
- To bring about changes in the attitudes, beliefs, values and norms of individual and communities that foster promotion of the status of women and girls and the eradication of harmful traditional practices

Strategy

- Information and education through mass media, community and institution based IEC
- Support and strengthen coalitions working at the community level for the eradication of harmful practices
- Support coalitions working at the central level to change legislation and policies that discriminate against women and girls

Objective

- To bring about positive attitude and behavior changes among in-school adolescents on issues of ARH and sexual health, family life, and gender relations by increasing their access to appropriate information and counselling services

Strategy

- Support coalitions that agitate for the provision of information, education and counselling services to in-school adolescents
- Assist the Ministry of Education (MOE) to review current strategies to reach in-school adolescents with population and FLE. In particular MOE should consider institutionalized collaboration with MOH and youth serving NGOs to establish innovative counseling and co-curricular activities for in-school adolescents
- Assist NGO coalitions to expand ongoing activities to re-package and disseminate research data on ARH and sexual health to parents, policy makers and community leaders.
- Assist NGO coalitions to expand ongoing interventions to provide RH and sexuality information to out-of-school youth through the mass media and participatory enter-educate interventions.

GERMAN TECHNICAL COOPERATION (GTZ).

“IEC components and implementation programs tend to suck up a lot of resources human and financial and sometimes even material, argues Henri van der Hombergh. "The inputs and methodologies are often based on long-existing concepts. Very often however, the implementers of these IEC inputs have no more time, money or energy left to measure the impact on IEC." The GTZ project makes a calendar each year for distribution and use by its 12,000-plus CBDs. As Dr. van der Hombergh says a lot of thought is invested on the message development process. Research has revealed that most recipients remember the picture and not the words.

In Dr. van der Hombergh's opinion, "IEC is very important but it is also very over-rated. It often gets inordinately high budgets." IEC on health should not be an issue that comes from health workers, but rather "from those people/sectors in society from whom the young people traditionally get their information on life education. The initial implication of social misbehavior is not health, it is socio-economic." IEC is not effective if there is conflicting information. "We need to adapt our methodologies to our target groups to be successful."

GTZ's strategy is not to create messages but to use pictures. Explains Dr. van der Hombergh: "We distribute these pictures to the people who then tell us what they have understood from them and from these we formulate a message. We have learned from the calendars that people make their own messages when they look at a picture. If the pictures transmit the right message, they will remember it but if the message is different from the pictures, then they remember only the picture. There are not enough people with the conviction that IEC has to be targeted towards public health goals."

The lack of a national strategy, argues Dr. van der Hombergh, partly owes to the fact that the one common/binding factor is the ministry, which lacks the capacity to provide leadership, to

orchestrate for joint donor support. Reason: "This is very difficult to do because the ministry has no idea what messages it would like to send out, nor do they have a research strategy for health. Donors are thus forced to develop their own means of investing in IEC." But are there any prospects for synchronizing of individual donor IEC strategies? Dr. van der Hombergh says this can only be done if donors use their counterparts as a channel. "A common IEC strategy of donors in the health sector is not really achievable."

Appendix 2: Media Habits in Kenya

Radio: There has been a steady increase in the number of radio receivers from 39 /1000 in 1980, to 81/100 in 1985 and 96/1000 in 1995. (UNESCO 1997 Statistical Yearbook)

Television: In 1980 there were 3.7/1000 inhabitants, in 1990 there were 10/1000 and in 1995 there were 18 per 1000 inhabitants. (UNESCO 1997 Statistical Yearbook). According to the 1997 World Guide to Television, there are 390,000 television households in Kenya, 400,000 televisions present in Kenya and VCR penetration is 21 percent.

Newspapers and Magazines: In 1980 there were three dailies, in 1990 there were five and in 1995 there were still five. Circulation was 13/1000 in 1980, 14/1000 in 1990, and 17/1000 in 1995. In addition there has been a significant decrease (nearly half as much) in the number of imports of books and pamphlets and newspapers and periodicals over the last fifteen years. (UNESCO 1997 Statistical Yearbook)

Results of a National Information, Communication and Education Situation Survey carried out by JHU/PCS. The data, which was collected in late 1994, was the APHIA baseline data.

Media Habits

- 73 percent of adult males said they read the newspaper, 34 percent of adult women reported reading newspapers
- Most readers only read a paper one to three days a week, 33 percent of adult men read a paper daily 70 percent of readers read The Nation
- Two thirds to three fourths of all respondents resided in households that had a radio, and one to two thirds of the sample listened to radio every day. Prime listening times were from 6 p.m onwards and 75 percent of listeners tune into the KBC Swahili station. News was the most popular program across all age groups.
- 14 percent of respondents resided in households that had a television set. Regardless of whether they lived in a household that had a TV or not, 30 percent of the sample said they watched television. Television viewership was less frequent than radio listenership, and less than 11 percent watched daily. Among those who watched, 90 percent watched KBC and less than 25 percent watched KTN. The majority watched TV from 7-9 pm.
- **Exposure to FP in the mass media**
- When asked where they heard about FP, most adult males and adolescent male and females said radio; while adult women cited health workers. Schools were an important source of information for adolescents.
- When asked directly if they had heard family planning information in the mass media in the six months preceding the survey, over 60 percent of adolescents and 75 percent of adults said that they had. Adult males were more likely to report exposure to FP messages, regardless of the medium.
- 78 percent of adult men and 68 percent of adult women had heard the USAID funded family planning radio drama *Kuelewana ni Kuzungumza*. Over 60 percent of adolescents reported on hearing the program as well.
- 34 percent of the adult males had seen the vasectomy advertisements in newspapers.

Appendix 3: Persons Contacted

National Government

Dr. Linus Ettyang, NCPD
Jane Gitonga, MOH
Dr. Bilha Hagembe, NASCOP
Meshack Ndolo, NASCOP
Dr. Gordon Nyanjom, KB STD Project, NASCOP
Dr. Margaret Makumi, DPHC, MOH
Dr. Tom Mboya Okeyo, NASCOP

Provincial and District Government

Mr. Lims, Provincial Commissioner, Coast Province
Dr. John Adungosi, PMO's Office, Mombasa
Dr. Chidagaya Jamanda, DMO Mombasa
S.M. Mwota, DASCO, Mombasa
Mrs. Agatha Ruria, Health Education Officer, DHMT, Mombasa
Dr. Misore, PMO, Nyanza
Robert Ayisi, MOH, Bungoma
DHMT, Bungoma District
James Nakitare, District Public Health Nurse, Bungoma
Simon Danda, Health Education Officer, DASCO, Bungoma
Hezron Ngugi, BDI
Sam Makama, BDI
Dr. Sam Ocholo, MOH Siaya District
Clement Were, District Health Education Officer/DASCO, Kakamega
Anthony M. Gateru, Karatina Municipality
Josephat M. Murai, Karatina Municipality
Wilson Kibethi Muriuki, Chief, Cheru/Kianganaru Sub-Location
Dr. Eliud Mwangi, Provincial Medical Officer, Nyeri
Dr. Eliud Ritho, Deputy PMO, Provincial Pediatrician, Nyeri
Joshua King'ori, Provincial Public Health Officer, Nyeri
V.M. Karioki, Provincial Personnel Officer, Nyeri
Ruth Macharia, Provincial Nursing Officer, Nyeri
Karuga Karioki, Provincial Health Education Officer, Nyeri
Charles Chiuri, Provincial Health Information System, Nyeri
Njeru Muriuki, District AIDS/STD Coordinator, Nyeri
Dr. Rachel Kamau, MOH, Nyeri District
Dr. Peter Ndagwa, MOH, Murang'a District
Francis Kamau Gitau, District AIDS/STD Coordinator, Murang'a

Provincial Hospitals

Dr. Esther Getambo, Coast General Hospital
Mrs. Wamugunda, Coast General Hospital

George Lipesa, Kakamega Provincial Hospital
Grace Mokune, Kakamega Provincial Hospital
Mrs. Catherine Mkanyika, Health Educator, Coast Provincial Hospital
Veronica Okoti, Provincial Matron, Kakamega Provincial Hospital
Mrs. Washika, District Public Health Nurse, Kakamega Provincial Hospital
Cyrus Kagathi, Provincial Hospital Secretary, Nyeri Provincial Hospital
Mrs. Martha Muriithi, District Supervisor, Nyeri Provincial Hospital
Mrs. Rose Gichuki, FP Coordinator/Trainer, Nyeri Provincial Hospital
Priscilla Njagi, Nurse, Adolescent Reproductive Health Clinic, Nyeri Provincial Hospital

District Hospitals

Dickson Ombima, Busia District Hospital
Mrs. Okumu, Busia District Hospital
Mrs. Oboya, District Public Health Nurse, Busia
Mr. Sirigwa, In-Charge, Busia District Hospital
Mr. Wesonga, Nursing Officer, Busia District Hospital
Mr. Otonyo, Nursing Officer, Busia District Hospital
Dr. Ibrahim Shivalo, Slaya District Hospital
Mary Wanjora, OJT Trainer, Murang'a District Hospital
Mary Njoroge, DTC Coordinator, Murang'a District Hospital
Tabitha Gathitu, DPHN, Murang'a District Hospital
Margaret Macharia, Nursing Officer in Charge, Murang'a District Hospital
John Wachira, Hospital Accounts Officer, Murang'a District Hospital

Health Centers

Consolata Ochieng, Tin'wangi Health Center, Siaya
Alberta Nyakine, Tin'wangi Health Center, Siaya
Wekano Onjoma, Tin'wangi Health Center, Siaya

Academic Institutions

Immanuel Abala
Eunice Obingo, University of Nairobi
Prof G.N. Lule, University of Nairobi
Pauline Masitsa, Maseno University
Maseno University Peer Educators Club

NGOs

Joe Muriuki, Kenya AIDS Society
Esther Gatchua, KANCO
Michael Wamae, Map Intl.
Joseph Kiprono, Kenya Freedom from Hunger Council
Dr. Peter Waweru, Marie Stopes, Kisumu
Richard Olewe, Marie Stopes, Kisumu
Mr. Saidi, Marie Stopes, Murang'a
Charity Njoki Kimotho, Nyeri

Peter Njuguna Mohamed, Karatina Home Based Care and Counseling Clinic
James Muievu, Eleka Counseling Center
Nellie Kigonde, Eleka Counseling Center
Alexander Kalama, COBRA Development Agency
Rose Ochieng, SWAAK
Anne Mbogholi, Women's Network Center
Mary Stevens, K-MAP
Maggie Mutungi, SWAAK
Maryrose Ikumi, Artnet Waves Communication
Gathecha Kamau, Artnet Waves Communication
Jane Jilani, Eleka Trust, SWAAK
Ms. Henrietta Windindi, FPAK, Kakamega
Stephen Mucheke, FPAK, Nairobi
Filberts Oluouch, FPAK, Mombasa
Geoffrey Menego, FPAK, Kakamega
Masibo Wamalwa, FPAK, Kakamega
CBD Agents, FPAK, Kakamega
Nzloki Kingata, FPAK, Kisumu
Joan Odouri, FPAK, Kisumu
Genya Nyalle, Plan International

Donors

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Roberto Esposito, EU
Dr. K.M. Ongawe, GTZ
Njeri Mukoma, GTZ
Dr. Henri Van der Hombergh, GTZ
Willy Nyambati, JICA
Jayne Kariuki, UNICEF
Dana Vogel, USAID
Neen Alrutz, USAID

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Minor Issues Paper
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Kenya APHIA Mid-Term Review

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
APHIA	AIDS, Population & Health Integrated Assistance
CPR	Contraceptive Prevalence Rate
DANIDA	Danish International Development Agency
DFH	Division of Family Health
DFID	Department for International Development, UK
DPHC	Division of Primary Health Care
DRP	Distribution Resource Planning
EDs	Essential Drugs
EDP	Essential Drugs Project
FP	Family Planning
FPLM	Family Planning Logistics Management
GOK	Government of Kenya
HESSP	Health Sector Support Project
HIS	Health Information System
JICA	Japanese International Cooperating Agency
KDHS	Kenya Demographic and Health Survey
KEPI	Kenya Expanded Programme on Immunization
LMIS	Logistics Management Information System
LMU	Logistics Management Unit
LTA	Long Term Advisor
MIS	Management Information System
MOH	Ministry of Health
MSCU	Medical Supplies Coordinating Unit
NDC	National Distribution Center
NDP	National Drug Policy
PHC	Primary Health Care
PHN	Center for Population, Health and Nutrition, USAID/Washington
PSI	Population Services International
QA	Quality Assurance
REDSO	Regional Economic Development Services Office: East & Southern Africa
RH	Reproductive Health
RLI	Regional Logistics Initiative
PSI	Population Services International
SDP	Service Delivery Point
STI	Sexually Transmitted Infections
TA	Technical Assistance
TAR	Technical Assistance Record
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
USD	U.S. Dollars
WB	World Bank
WHO	World Health Organization

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1. Executive Summary

This *Minor Issues Paper* looks at the status of Reproductive Health (RH) Logistics Management in Kenya, and is a component of the overall APHIA mid-term review exercise which was held in-country during April, 1999 under USAID/Kenya's leadership. AIDS, Population and Health Integrated Assistance (APHIA), is USAID/ Kenya's umbrella project for all Population and Health activities in Kenya. It is a ten-year, \$132 million USD effort, which runs from 1995 – 2005. The purpose of the project is to reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services.

The purpose of this paper is three-fold: a) to document the accomplishments of Reproductive Health Logistics Management efforts undertaken by the JSI/Family Planning Logistics Management (FPLM) project in conjunction with the Logistics Management Unit (LMU) of the Division of Primary Health Care (DPHC) within the Ministry of Health (MOH) during the first four years of APHIA (1995-1999); b) highlight the most pressing issues currently facing USAID, the Government of Kenya (GOK) and other donors in the area of availability of RH commodities (including contraceptives) and maintaining the RH logistics management system; and c) to provide a series of forward-looking recommendations for USAID's focus during the remaining six years of APHIA, through 2005.

USAID-funded logistics assistance provided to the GOK through the FPLM project dates back to the mid-1980s. However, despite important initial steps taken by FPLM to improve the logistics management information system (LMIS) as a means of increasing the availability of contraceptives nation-wide, family planning logistics remained a low priority within the MOH. There were no systems for local distribution within the districts to Service Delivery Points (SDPs); in general distribution of contraceptives was sporadic and unreliable. The consequence was prolonged stockouts in some districts but overstocking to expiry in others. The system was also characterized by a lack of accountability and was unable to track contraceptive donations from the various donors. There was no way of documenting for USAID and other donors how their commodity donations were contributing towards the overall improvement in reproductive health status of Kenyans.

In 1991, the Logistics Management Unit (LMU), which is managed through the Division of Primary Health Care (DPHC), initiated a new distribution system for family planning commodities. This system, considered radical and innovative at the time, facilitated the transformation of a system plagued by stockouts and lack of information to one through which clients all over Kenya now have reliable access to contraceptives at their SDPs. Facilitated by a strong LMIS which has improved forecasts, procurement, inventory control and distribution, the system now reports that stockouts of contraceptives are rare throughout the country.

The 1998 Kenya Demographic and Health Survey (KDHS) reports one of the most dramatic declines in total fertility rate (TFR) ever recorded from 6.7 children in 1989 to

4.7 children in 1998; and an increase in contraceptive prevalence rate (CPR) from 27 percent in 1993 to 32 percent in 1998. Although direct attribution or causality can not be made between the improved availability of family planning commodities and a sharp decline in TRF, there is a strong association between these factors given that they occurred over the same period of time.

Kenya's success in the area of RH logistics management comprises a number of important elements including a sustained and long-term commitment by USAID/Kenya to improving the system. USAID/Kenya has taken the lead among the donor community in recognizing how a strong logistics system contributes both to the overall improvement of RH status within the country, as well as towards protecting GOK and donors' commodity investments. Other elements of this success have included a commitment from within the MOH and the LMU to dedicate human resources towards this effort, and the establishment of a powerful, locally designed and maintained LMIS which monitors and tracks the overall system. The highlight of this system is the Distribution Resource Planning (DRP) component which prevents shortages and eliminates stockouts while ensuring maximum utilization and efficiency of distribution vehicles and routing.

Through its strength in successfully managing family planning commodities, other donors have come to rely on USAID's logistics management system to track their own commodity donations. Other donors have come to recognize how the system provides a means towards greater accountability of their donations through accurate tracking of information. In addition, for the first time they are able to quantify the impact their contribution is having on Kenya's RH program. Donors have also come to rely on USAID and FPLM to take the lead in forecasting national contraceptive requirements and coordinate the donor community to provide what is needed.

Over time donors have come to consider logistics management one of USAID's major comparative advantages. As demand increases, however, USAID will not be able to continue subsidizing the full cost of maintaining the logistics management system on behalf of all donors, and will require outside contributions to keep the system working. FPLM actively lobbies donors to contribute 15 percent of the value of their commodity donations towards maintenance of the logistics system upon which they have come to rely.

Based on the success in handling family planning commodities, FPLM has been asked by donors to integrate other RH commodities into the logistics system. The first request came in 1995. It was for FPLM to handle other RH products came from DFID for Sexually Transmitted Infections (STI) drugs, which play an important role in reducing HIV transmission. FPLM successfully adapted its LMIS to include these supplies, and was able to stretch DFID's investment to cover over 500 SDPs instead of the originally projected 163. Coverage was also extended to cover a two-year period instead of only one year as originally planned. FPLM is currently negotiating contracts with KfW and DFID (through The Futures Group International) to distribute RH commodities.

USAID through FPLM is now involved in an effort to restructure the Medical Coordination Supplies Unit (MSCU), the central system which is being designed to procure and distributes all drugs (including contraceptives) and supplies to outlets around the country. This restructuring is a key component of health sector reform efforts in Kenya. In this context, FPLM undertook a consultancy supported by DANIDA to design an action plan for the restructuring process including the implementation of a new logistics management system. It was decided that this new system would be based on the successful RH logistics management system. If the restructuring of the MSCU is successful, it will constitute an important contribution to the overall improvement of public health status of Kenyans by making supplies available to them on a reliable and more sustainable basis. In order for this restructuring to be successful however, DANIDA, the principle funder of this effort, will need to demonstrate a sustained commitment over the long-term. However, DANIDA recently reported that its support to Kenya's health sector will be suspended, if withdrawn altogether. Although the World Health Organization (WHO) is prepared to make a significant contribution to the restructuring process, it will require additional donors to make similar contributions for this process to be successful.

Enticed by Kenya's successful RH logistics management system, other countries in the region have begun to take notice of what Kenya has to offer and wish to learn from Kenya's achievements. Prompted by a joint effort supported by REDSO/ESA and USAID's Africa Bureau, Kenya's logistics management success has taken on regional significance through an effort which has come to be known as the Regional Logistics Initiative (RLI). The purpose of the RLI is to operationalize the concept of cross-boarder exchange by distilling and disseminating lessons learned within the region. The RLI carries out activities in four principle areas: a) capacity building; b) integrated logistics system development; c) documentation and dissemination of logistics better practices in the region; d) and advocacy for logistics investment as a means of improving quality of care. The RLI is currently working through a network of logistics colleagues in twelve countries.

Most donors involved in Kenya's health sector have flat-lined their budgets. In some cases donors are planning "low-case scenarios" or suspending activities altogether. This makes the future of RH commodity supplies uncertain. Further, most donors perceive that USAID is handling the logistics management responsibilities, and have no plans to contribute to these costs themselves. The result is that as the logistics management system integrates more products and assumes greater responsibility for family planning and other RH commodities and essential drugs, USAID may be left bearing most of the logistics burden on behalf of the GOK and other donors. USAID will not be able to sustain this full burden, and will need other donor support to maintain the system.

The future of contraceptive supplies is uncertain in Kenya, and the country faces serious deficits over the next five years. Neither the donors nor the GOK has a clear strategy to secure reliable sources of these supplies for the long term. In particular, Kenya faces an anticipated deficit in its condom supply. In Kenya's context of limited resources amidst

increasing demand for family planning contraceptives and the HIV epidemic, resolving these supply issues is a priority for the GOK and donors.

Recent policy decisions made by the MOH have had a major impact on the number of condoms required to serve its clients. Although there are differences of opinion within the donor and Cooperative Agency (CA) communities regarding exactly how many condoms will be needed over the next five years, all parties agree that Kenya will face serious deficits if plans to secure condom (and other contraceptive) donations are not put into place in the immediate future. USAID should undertake a *Condom Study* to get an independent determination of national condom requirements, and should use this study as the basis of developing a *National Condom Strategy* that can address long and short term scenarios and provide proposed solutions.

Similar to the situation with contraceptives and condoms, reliable sources for STI drugs, essential drugs and vaccines also do not exist and future donations are uncertain. Again there is no long-term plan to secure these important items for Kenya over the next five years. It is critical that the GOK and donors find a way for these drugs be widely available and easily accessible if Kenya has any hope of controlling the HIV/AIDS epidemic and improving the overall public health status of its citizens.

The maintenance and sustainability of the successful RH logistics system is highly dependent on donor support. In order to prevent collapse of the system, USAID, with the support of other donors, will need to continued its sustained commitment to supporting the system. The GOK and the donor community need to better understand what the negative consequences and public health implications would be if the logistics system were allowed to collapse. In the context of Kenya's already declining health indicators (as reported in the 1998 KDHS), the country can not afford to be without this vital system. USAID/ Kenya must work in a more intensive and sustained way with its partners to leverage contributions to assure continuation of the important program element.

Finally, as Kenya's success in RH logistics management becomes more widely known and relevant within the Africa region through the RLI and other work, Kenya will need to protect its human and financial resources needed to maintain and grow its own logistics capacity. While USAID/Kenya has negotiated an equitable cost-sharing arrangement with the RLI partners (REDSO and USAID's Africa Bureau), the Mission will need to monitor the situation closely to make sure that Kenya's program is not compromised at the expense of admittedly important regional work. Kenya can not afford to sacrifice its investments and hard-earned successes, and has much internal work yet to accomplish.

2. Purpose and Background

This *Minor Issues Paper* looks at the status of Reproductive Health (RH) Logistics Management in Kenya, and is a component of the overall APHIA mid-term review exercise which was held in-country during April, 1999 under USAID/Kenya's leadership. AIDS, Population and Health Integrated Assistance (APHIA), is USAID/ Kenya's umbrella project for all Population and Health activities in Kenya. It is a ten-year, \$132 million USD effort, which runs from 1995 – 2005. The purpose of the project is to reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services.

The purpose of this paper is three-fold: a) to document the accomplishments of Reproductive Health Logistics Management efforts undertaken by the JSI/Family Planning Logistics Management (FPLM) project in conjunction with the Logistics Management Unit (LMU) of the Division of Primary Health Care (DPHC) within the Ministry of Health (MOH) during the first four years of APHIA (1995-1999); b) highlight the most pressing issues currently facing USAID, the Government of Kenya (GOK) and other donors in the area of availability of RH commodities (including contraceptives) and maintaining the RH logistics management system; and c) to provide a series of forward-looking recommendations for USAID's focus during the remaining six years of APHIA, through 2005.

USAID-funded assistance to the Government of Kenya (GOK) through technical assistance (TA) provided by FPLM in the area of contraceptive logistics management dates back to the mid-1980's. Despite important initial steps taken by FPLM to improve the logistics management information system (LMIS) as a means of increasing the availability of contraceptives nation-wide, family planning logistics remained a relatively low priority within the MOH at the time.

There were serious problems in terms of availability of contraceptives at the district level and at Service Delivery Points (SDPs). Donors and the GOK alike were generally unaware of what quantities of donated commodities were available at the Medical Stores Coordinating Unit (MSCU), the central warehouse of the GOK. Reconciling inventory levels and estimating requirements was virtually impossible because records and reporting forms did not exist or were not maintained throughout the delivery system. There were no systems for local distribution within the districts to SDPs. In general, distribution of contraceptives was sporadic and unreliable.

It was difficult to assure space for contraceptives on vehicles moving from the MSCU to the districts because hospital equipment and essential drugs (EDs) were always given higher priority over contraceptives. Only if excess space was available on a given truck leaving the MSCU would contraceptives be added, without knowing what was actually needed in the field. The distribution system was uneven and haphazard. The consequence was widespread stock outs in some districts, but overstocking to expiry in others. The system was also characterized by a lack of accountability, and was unable to track contraceptive donations from the various donors. There was no way of

documenting for USAID and other donors how their commodity donations were contributing towards the overall improvement in reproductive health status of Kenyans. ¹

3. Accomplishments of the Reproductive Health Logistics Management System

3.1 Development of a Successful Family Planning (F.P.) Logistics Management System

In 1991, the Logistics Management Unit (LMU), which is managed through the Division of Primary Health Care (formerly the Division of Family Health (DFH)), initiated a new distribution system for family planning contraceptives. This system, along with a significant commitment and sustained investment on USAID's behalf to strengthen reproductive health logistics management, facilitated the transformation of a system plagued by stockouts and lack of information to one through which clients all over Kenya now have reliable access to contraceptives at their SDPs. Information available from a variety of sources indicates that stockouts of contraceptives are now rare in Kenya.

The automated Logistics Management Information System (LMIS) has facilitated improved forecasts, procurement, inventory control, and distribution. Improvements associated with this information system have increased precision and created an impressive level of credibility and accountability, both within the MOH and with other donors. The system's current ability to be precise diminishes waste and loss, therefore keeping overall procurement costs down and closer to the actual client demand. ²

The 1998 Kenya Demographic and Health Survey (KDHS) preliminary report indicates that the contraceptive prevalence rate (CPR) has increased from 27 percent of currently married women in 1993 to 32 percent in 1998. Kenya has also experienced a dramatic decline in its total fertility rate (TFR) from 6.7 children in 1989 to 4.7 children in 1998, one of the most dramatic declines ever recorded. ³ Although direct attribution or causality can not be made between the improved availability of family planning commodities and improvements in the CPR and TFR indicators, there is a strong association between these factors, given that they occurred over the same period of time. Improvements achieved in the area of logistics management have significantly contributed to reducing fertility and to improving the overall reproductive health status of Kenyans.

Chart 1 in Annex A illustrates the association of increased contraceptive prevalence with decreased contraceptive stockout rates in Kenya from 1989 through 1998.

¹ Logistics Management Unit, Division of Family Health, "Kenya FPLM II Final Report 1991 – 1995: A Summary of Major Activities and Accomplishments", June, 1996.

² Olson, Gachara and Ophwette, "Evaluation of Logistics Improvements in Kenya" JSI/FPLM, Oct. 1996

³ 1998 KDHS Preliminary Report, Macro International

3.2 Important Elements, Factors and Tools Contributing to the Success of the F.P. Logistics Management System

Kenya's success to date in the area of logistics management comprises a number of important elements, factors and tools. The first among these has been a recognition on USAID/Kenya's behalf of how important it is for a country to have a functioning and accurate logistics system. USAID/Kenya has taken the lead in among the donor community in understanding how a strong logistics system contributes both to the overall improvement of RH status in the country, as well as protecting GOK and donors' commodity investments over time. For USAID/Kenya, this has translated into a sustained and long-term commitment to support and finance the improvements in RH logistics management. USAID is one of the only international donors in Kenya (with the exception of DFID and KFW) which has embraced the strategy of improving the national availability of RH commodities through an improved logistics management system.

The second element of success involves both USAID and the DPHC being willing to take programmatic and financial risks over time. These have included assuring dedicated space for contraceptives at the Central Medical Stores, creating radically different and innovative systems, insisting on improved storage conditions for contraceptives and the maintenance of a separate transportation fleet. In the beginning, each of the components of this new system met with organizational resistance, as many in the MOH would have preferred that contraceptives remain a fully integrated, low-priority commodity. Having dedicated warehousing space, innovative systems, and upgraded storage conditions however, proved important factors in elevating the importance of family planning logistics in making contraceptives available.

The third element of success lies in the investment in human resources to develop and maintain a working system. In 1991 USAID placed a Resident Advisor to guide FPLM/Kenya's activities and began to hire a permanent and competent staff. The MOH also demonstrated its commitment to improving the logistics management system by establishing a Logistics Management Unit (LMU) within the Division of Primary Health Care (DPHC), and staffing this unit with a full time logistics advisor and other counterparts. The FPLM project is located within the LMU and works in collaboration with them under their direction. This close coordination between FPLM and the LMU has been key. The commitment to retain the key LMU logistics advisor and counterparts over long periods of time has also been very important. The continuity of these human resources has greatly facilitated coordination, communication and implementation over time. A large effort and investment was also made to provide competency-based logistics management training important to store managers and service providers alike throughout the pipeline.

The fourth, and perhaps most important technical contribution to the overall success of Kenya's Family Planning Logistics Management system, has been the establishment of the logistics management information system (LMIS). The LMIS is a locally developed and maintained software program which is used to monitor and track the overall logistics system and ensure adequate contraceptive supplies are maintained throughout the

country. The LMIS has four modules: *Forecast*, *Inventory Control System (ICS)*, *Distribution Resource Planning (DRP)* and *PreSent*. *Forecast* projects commodity requirements and identifies funding gaps, facilitating donor coordination and regulation of stock levels; *ICS* tracks commodities and stock levels at the Central Warehouse, facilitating execution of the First-Expiry-First-Out (FEFO) principle and minimizing expiries; *DRP* prevents shortages and eliminates stockouts while ensuring maximum utilization and efficiency of distribution vehicles and routing; and *PreSent* features graphic presentations of LMIS data on commodity availability and requirements for use with Programme Managers, Policy Decision Makers and Donor.⁴⁵

3.3 Other Donors Recognize USAID’s Comparative Advantage in RH Logistics Management and Rely on USAID’s Donor Coordination Leadership

Through its strength in successfully managing family planning commodities and increasing the reliability of having contraceptives available around the country, other donors have come to rely on USAID’s-supported logistics management system to track their commodity donations. In addition to logistics information and the ability to deliver necessary requirements to districts around the country, other donors recognize how USAID’s/FPLM’s system provides a means towards greater accountability of their donations through accurate and timely tracking of information. In addition, for the first time, they are able to quantify the impact their contribution is having on Kenya’s RH program.

Donors also look towards USAID and FPLM as the leader in coordinating the donor community to meet the supplies requirements of the country. FPLM provides the MOH with the capability to make reliable projections of national contraceptive requirements five years into the future on an on-going basis. FPLM periodically organizes formal Logistics Coordination Meetings with the donors and MOH to discuss sourcing “pledges” to match these requirements. In addition, FPLM has dedicated much effort towards continuous dialogue and coordination with individual donors on a one-to-one basis. Largely due to donor confidence in the logistics system, USAID has been able to facilitate sustained donor input and commodity donations over the past eight years.

One example of FPLM’s successful donor coordination effort was in the early 1990s when SIDA was on the verge of not continuing their contraceptive donations to Kenya because they could neither track their product, nor say what impact their donation was having. Due to the quality of FPLM’s information, donor coordination and negotiation efforts, however, FPLM and the MOH were able to convince SIDA to continue its contraceptive donations to Kenya. With the logistics information, SIDA is now accountable for its contribution and can demonstrate what impact its donation is having

⁴ Logistics Management Unit, Division of Family Health, “Kenya FPLM II Final Report 1991 – 1995: A Summary of Major Activities and Accomplishments”, June, 1996.

⁵ Personal Communications, John Wilson, Resident Advisor, JSI/FPLM Kenya, Apr., 1999

on the overall country program. Not only does the quality of the logistics system appear to be a key factor in convincing donors to continue their commodity donations, it has also brought new donors “to the table”, including UNFPA and KfW.

Over time, donors have come to consider logistics management as one of USAID’s major comparative advantages. They have come to rely on USAID’s sustained commitment to continue supporting and funding this important aspect of their collective effort to improve the RH status of Kenyans. Donors recognize that with USAID’s support of this system, their donations would not otherwise reach clients around the country and would be a wasted effort.

As demand increases, however, USAID will not be able to continue subsidizing the full cost on behalf of all donors, and will require outside contributions to maintain the system itself. FPLM actively lobbies donors to contribute 15 percent of the value of their commodity donations towards maintenance of the logistics management system that they rely on to deliver and track their donations. To date two donors, DFID and KfW, have recognized the importance of contributing to this expense as a means of protecting their own investments. USAID, both through FPLM and on its own, will need to continue efforts to have others support this important component of the program on a long-term basis.

3.4 Requests from Other Donors to Distribute and Track Additional Reproductive Health Commodities

Based on the LMU’s successful track record in creating and maintaining a well functioning logistics management system for family planning commodities, both the MOH and other donors began to express interest in having FPLM introduce other RH commodities into the system.

The first formal request to include additional RH commodities in the system came through DFID in 1995. Understanding the important role early prevention and treatment of sexually transmitted infections (STIs) plays in reducing HIV transmission, DFID agreed to donate STI drugs and HIV/AIDS testing reagents to Kenya as an interim measure until the World Bank (WB) got its project to procure these supplies up and running. DFID turned to FPLM and requested that the project handle the distribution and tracking of their supplies to districts and Service Delivery Points (SDPs) around the country. FPLM successfully adapted its LMIS to include these supplies. Due in large part to the efficiencies of the LMIS system, DFID’s investment stretched to cover over 500 SDPs instead of the originally projected 163. DFID was also able to extend coverage requirements for a full two-year period instead of only one year, as originally projected.

Chart 2 in Annex A shows planned (in green) vs. actual (in red) scope of the DFID STI project utilizing standard drug kits. DFID was able not only to make its initial investment go twice as far as expected, but was also able to document programmatic impact, thus helping to secure future commodity donations to Kenya.

FPLM is currently finalizing contracts with KfW and DFID (through The Futures Group International) to distribute STI drugs. The WB is currently in the tendering process for logistics support for its own STI project. JSI/FPLM has submitted an expression of interest and is in a good technical position to carry out this work.⁶

3.5 Restructuring of the Medical Supplies Coordination Unit (MSCU) in the Context of Health Sector Reform and Integration

As a key component of health sector reform efforts in Kenya, the MOH and health sector donors have recognized the need for restructuring of the MSCU. It has recently been acknowledged that changes in the management and supply of drugs for the public health system need to be made, and that these changes should be in line with implementation of the health sector reforms taking place nationwide in Kenya.

The MSCU restructuring exercise is seen as a major component of the Kenya National Drug Policy (NDP) that emerged in 1993 with the goal of: *“use[ing] available resources to develop pharmaceutical services to meet the requirements of all Kenyans in the prevention, diagnosis and treatment of diseases, using efficacious, high quality, safe and cost effective pharmaceutical products”*.

As noted in a 1994 Interim Report, the major constraints experienced by the MSCU in its current organization include: inappropriate policies; poor implementation of procurement policies; inefficient management and administration; lack of resources (funds, manpower, materials and infrastructure); and inadequate security.

The major objective of the MSCU restructuring plan is to establish an autonomous, self-financing organization to take responsibility for procurement, storage, stock control and the distribution of drugs and other supplies throughout Kenya.

In the short term, the GOK budget increments in the drug budget cannot keep pace with the increasing population's drug requirements, and the MOH must rely on donor support to supplement GOK resources.

In the longer term, however, the MOH has developed and introduced an ambitious Health Sector Reform Programme, that in addition to including the NDP, includes strategies to develop new sources of revenue to finance health services. These include cost sharing and cost recovery mechanisms, and the establishment of a revolving fund to finance drug supplies. Through these mechanisms, the MOH intends to support the cost of drug procurement through user fees, while ensuring that those clients who are unable to pay can still obtain adequate services.

In agreement with the NDP, objective #11 is to *“ensure the constant availability of safe and cost effective drugs to the Kenyan population”*. In order to achieve this ambitious

⁶ Personal Communications, John Wilson, Resident Advisor, JSI/FPLM Kenya, Apr., 1999

goal, the MOH requires an efficient and effective logistics system to ensure that drugs are available where and when needed around the country.

The MOH recognized that the Division of Primary Health Care (DPHC), in collaboration with FPLM, has developed and implemented an innovative and efficient logistics system for family planning commodities and STI drugs. This system ensures both continuous availability of supplies at the health facility level as well as accountability to the MOH and international donors. What was once viewed back in 1991 as a radically new and innovative system for family planning commodities has now come to be considered *state-of-the-art*, and has become the model for MSCU's future restructuring objectives.

During a workshop held in Nairobi in 1996 to discuss the DANIDA-supported Health Sector Support Programme, FPLM demonstrated the RH logistics system to key decision makers within the MOH. Based on this demonstration and subsequent discussion, it was agreed that a similar system should be developed to integrate essential drugs, vaccines and RH commodities (including contraceptives) into a single, integrated, logistics system.

As a result, FPLM undertook a consultancy supported by DANIDA to design an action plan for the restructuring process including the implementation of a new logistics management system based on the successful family planning logistics system. This new system will include Distribution Resource Planning (DRP) for essential drugs. The four key objectives of this consultancy included plans to: a) establish an autonomous National Distribution Center (NDC); b) improve the physical facilities and working environment of the current warehouse; c) improve productivity and efficiency of the National Distribution Center; and d) increase sustainability of the national medical supplies system. It is hoped that vaccines will be phased in and included at some point in the future.

The restructuring of the MSCU and adaptation of the RH logistics system to include essential drugs and vaccines is significant undertaking. If successful, this effort will constitute an important contribution to the overall improvement of public health status of Kenyans by making supplies available to them on a reliable and more sustainable basis.⁷

In order for this restructuring to be successful however, DANIDA, the principle funder of this effort, will need to demonstrate a sustained commitment over the long term. However, DANIDA recently reported that it will suspend its support for the health sector, if not withdraw it altogether. Although the World Health Organization (WHO) is prepared to make a significant contribution to the restructuring process, it will require additional donors to make similar contributions for this process to be successful. USAID/Kenya will need to monitor events and guide FPLM's actions so as not to jeopardize significant achievements already made in RH logistics for Kenya at the expense of a highly complex MSCU restructuring effort.⁸

⁷ JSI FPLM/Kenya, "Implementation Plan: Restructuring the Medical Supplies Co-ordinating Unit", December, 1997.

⁸ Personal Communications, John Wilson, Resident Advisor, JSI/FPLM Kenya, Apr., 1999

3.6 Regional Significance and the Regional Logistics Initiative (RLI)

Enticed by Kenya's successful RH Logistics System, other countries in the region have begun to take notice and wish to learn from Kenya's achievements. Kenya's RH logistics system has taken on relevance in the region. Prompted by this interest and initiative to share lessons learned within the region, REDSO/ESA, USAID's Regional Economic Development Services Office for East and Southern Africa, and USAID's Washington-based Africa Bureau established and now jointly fund what has come to be known as the Regional Logistics Initiative (RLI).

Carried out by FPLM in collaboration with USAID's Rational Pharmaceutical Management (RPM) Project, the RLI operationalizes the concept of cross-boarder exchange by distilling and disseminating lessons learned within the region, and adapting proven logistics techniques and technologies to meet specific needs in a coordinated and cost-effective manner. The vision is to establish an on-going network of managers and practitioners in public health logistics programs who can promote and facilitate the continuous sharing of experiences, skills and lessons learned within the region. The RLI has established an overall Secretariat and full-time Documentation/Dissemination Officer to share logistics better practices and lessons learned throughout the region.

The RLI carries out activities in four principle areas: a) capacity building; b) integrated logistics system development; c) documentation and dissemination of logistics better practices in the region; and d) advocacy for logistics investments as a means of improving quality of care. The RLI has provided technical assistance in Ghana, Jordan, Mozambique, Uganda, Kenya, Zambia, and Eritrea; and is networking with logistics colleagues in an additional five countries in the region.^{9 10}

This regional initiative has a been a "feather in Kenya's cap" as other countries are acknowledging Kenya's achievements and leadership in logistics management, and wish to emulate its success in this important area.

⁹ FPLM/RLI: "Regional Logistics Initiative; Investing in Logistics for Quality of Care Improvements"; Nyali Beach Hotel, Mombassa, Kenya, Workshop Feb 16-20, 1998.

¹⁰ FPLM/RLI, Quarterly Performance Report; Oct. – Dec. 1998, RLI Secretariate, JSI/FPLM/Kenya, 1998.

4. Issues and Recommendations; Looking Forward through the Remainder of APHIA

4.1 Donor Contributions and Plans

Most donors who are involved in the health sector in Kenya have flat-lined their budgets. In some cases, donors are planning “low-case scenarios” or suspending activities altogether. This is in large part due to political concerns over good governance, accountability and humanitarian issues. There are no donors who plan to increase funding levels for technical assistance to sustain the logistics management system or RH commodity donations in the near future. This makes the future of reproductive health commodity supplies for Kenya uncertain.

A handful of donors are contributing on a relatively steady basis with donations of RH supplies, including contraceptives. Most donors, however, perceive that USAID/Kenya is handling the logistics management responsibilities have no plans to contribute to these costs themselves (there are only two, DFID and KfW who have invested in the logistics management system). The result is that as the logistics management system takes on more products and assumes greater responsibilities for not only family planning commodities, but also STI drugs, essential drugs, supplies and vaccines, USAID/Kenya may be left bearing most of the logistics burden on the GOK and other donors’ behalf. USAID/Kenya will not be able to sustain this full burden, and will need other donor support to maintain the system.

Chart 3 in Annex A shows a history of RH commodity donations by donors from 1995 – 1998.

Following is the situation of other donors in relation to their plans to continue donations of reproductive health commodities, and their plans for supporting the logistics management system.

4.1.1 DFID

DFID has just issued its new Kenya strategy document which will run from 1998 through 2001. DFID is committed to continuing their work with the GOK, provided the GOK is willing to develop economic strategies to establish “pro-poor” policies. DFID’s overall annual Kenya budget is approximately USD \$36 million per year; 30-40% of this total is dedicated to health activities.

DFID has historically provided injectables (Depo Provera) and Orals, and supplies 20 percent of the public sector condom requirements. DFID has two main HIV/AIDS projects, under which they have provided STI kits and all of the social marketing condoms handled by Population Services International (PSI), approximately 10 million condoms per year. DFID plans to sustain its condom donations to the Kenya program in the future.

DFID has been one of the only donors to invest in the RH logistics management system for distribution and tracking of its donations. It has contributed 3 vehicles to the system for STI kit distribution. DFID intends to continue supporting the logistics system as long as it continues to provide supplies. DFID looks to FPLM to take the lead in forecasting RH commodity requirements, and have been impressed with FPLM's work; the Department understands that investing in logistics management is an important component of protecting their donations. USAID and FPLM have well-coordinated and strong working relationships with DFID.

DFID is very concerned about the upcoming condom deficit facing Kenya, and hopes to work in collaboration with USAID and other donors to address and resolve this issue on a long-term basis.

DFID has expressed a willingness to step in and help out in the vaccine crisis facing Kenya (with DANIDA pulling out of vaccine support), but indicates that this responsibility needs to be a shared one with other donors and the GOK.

4.1.2 World Bank (WB)

The World Bank has provided injectables in the past, and after years of delay, successfully procured a total of 66 million condoms (under its POP IV Project) working through GTZ as the GOK's procurement agent. The WB also provided MCH equipment this past year, the specifications of which did not necessarily reflect the country's needs. In addition, WB has provided gloves and foaming tablets.

Historically, Kenya's experience of WB-funded commodity procurements has not been problem-free. The WB provides loans to host countries, and leaves the execution of procurement actions in the hands of their host government. The WB exercises minimal control over important components of a given procurement such as the selection and tendering process, development of specifications and timing. Delays in deliveries have caused near stockouts and have prompted emergency donations by other donors so that the country won't be caught short. This derails careful forecasting efforts and causes additional logistics resources to be used for in-country redistribution.

Examples of problematic WB procurements have included two separate "one-time" WB-funded procurements of injectables which arrived without needles and syringes; one of the products was an unknown injectable in Kenya. The situation caused other donors to "to rescue" the WB procurement by finding the needles and syringes to administer the contraceptive to clients and needed to be accompanied by an introduction letter to providers and clients alike about the new injectable.

A second example was a long-standing commitment by the WB to procure condoms. This activity was delayed for over 6 years. In the end GTZ was contracted by the MOH as the procurement agent, and delivered 66 million condoms to the country all at once, instead of in a phased manner. This overload of condoms was handled successfully by FPLM, but not without emergency and costly measures to distribute them.

This overload of condoms all at once prompted the DPHC to institute a policy that condoms should be delivered to bars and lodgings. Although FPLM took action to curtail delivery to bars and lodgings where PSI condoms were already being sold, anecdotal evidence from the APHIA mid-term review field trips revealed that both public sector and PSI condoms are available in these establishments. This is an unfortunate duplication of efforts and the situation should be examined further.

After a two-year delay, the WB has just procured STI drugs under its \$26 million dollar STI project. FPLM is working hard to distribute them in a rational manner around the country, but may have instructions to deliver them to SDPs which have not yet been trained in their proper use. This too is a one-time procurement, and is anticipated to last 2 years. Delivery scheduling has again been a major problem, with large quantities of kits arriving in a single consignment. The MOH's position is that these drugs are to be used in all facilities throughout Kenya (regardless of whether service delivery staff have had training in syndromic management), and that these drugs can be used to treat multiple diseases, including STIs. In consonance with the move towards decentralization and empowerment of the districts to manage their own health services, these drugs will be delivered only to the district stores, and responsibility for delivery to the SDPs now rests with the district MOH. In FPLM's judgement, no systems have been established to track these drugs below the district store.

Under DFID funding, the LMU has been servicing 530 sites on a direct-delivery basis in order to provide adequate logistics and clinic management support in order to maximize rational drug use and accountability for the drugs to the donor. With the arrival of the WB drugs, FPLM will now stop its support to all district sites and will only continue to service approximately 90 municipal and large-NGO sites utilizing KfW-financed drugs. As this donor requires accountability down to the client level, FPLM will continue to utilize its DRP and monitoring support for these sites.

The WB is an important source of RH commodity financing, however, there is a lack of coordination on specifications, quantities needed with the logistics management unit. This, coupled with a lack of rational delivery scheduling has resulted in huge quantities being delivered at one time, creating serious storage problems for the MSCU (including the WB having to finance additional warehousing space) and the distribution teams. USAID and other donors should work together with the WB through the LMU to develop an alternate, workable procurement system with this important source of financing; one that both conforms to WB procurement regulations and meets Kenya's RH commodity needs.

4.1.3 JICA

JICA and USAID work collaboratively in a number of developing countries, including Kenya, under the *Common Agenda*. In its work, JICA has traditionally supported major structure building (hospitals) or infrastructure (roads), but not historically provided commodity donations to Kenya or other developing countries. During the past year,

however, JICA has been considering donating condoms to a number of countries, including Kenya.

The DPHC has recently submitted to JICA a request for \$19 million USD worth of condoms, plus an addition 15% for logistics support, totaling \$22.5 million USD. In the context of Kenya's pending condom deficit problem it is important to pursue this potential donation of condoms from Japan (see Section 4.3 for additional information on the anticipated condom deficit situation).

USAID should get access to a copy of this request, and find out what priority it has been given by the DPHC in the context of other requests to JICA it may have already submitted. If it has been ranked a high priority (which it should be), USAID/Kenya should work with USAID/Washington's *Common Agenda* Coordinator to track the request. USAID should write a letter to JICA explaining Kenya's pending condom deficit situation and express support for this donation as an important component of our collective international efforts to control the HIV/AIDS epidemic in Kenya. USAID can also share DPHC's request with other donors (e.g., UNFPA, DFID and others), and ask them to write similar letters of support to JICA.

JICA has no current plans to donate other RH commodities to Kenya, nor does it plan to support the logistics management system.

4.1.4 SIDA

In June, 1999 SIDA will end its current contract. Its next contract will extend from 1999 through 2002 and will have the same level of overall funding at approximately 30 million Swedish Crowns for the whole period.

SIDA has supplied the majority of Kenya's public sector Orals, spending approximately \$1 million USD per year on these commodities. They have flatlined their budget for Orals, despite increasing overall demand.

SIDA relies on FPLM's system for contraceptive forecasts and on the RH logistics system for distribution of their Orals donations.

SIDA views handling of logistics management as one of USAID's comparative advantages, and neither has plans to contribute to financing the system, nor does it plan to financially support the restructuring of the MSCU.

4.1.5 UNFPA

UNFPA has a long-term political commitment to the GOK, and plans to continue its support in the health sector. At the same time, UNFPA is exploring new directions with other partners and is diversifying its portfolio to include support to a variety of NGOs and community groups.

UNFPA has supplied condoms and gloves, but does not currently have plans to donate any more condoms or other contraceptives. UNFPA did not include commodity donations in its current project, and considers it difficult to modify plans to include them now. UNFPA is looking to other donors to provide RH commodities, including contraceptives, and views USAID as having a comparative advantage in logistics management. They have no plans at this time to fund any of the logistics management work.

4.1.6 KfW

KfW has not historically donated contraceptives, but has recently come in with a total of 8 million cycles of Orals to cover the gap left behind by SIDA as it flatlined its donations in a context of increasing national demand.

KfW has also donated a year's worth of STI kits, and is in the process of negotiating with FPLM for a contract to distribute them through the RH logistics system.

4.1.7 DANIDA

DANIDA has historically provided vaccines to Kenya for the Kenya Expanded Program on Immunization (KEPI), and has supported many of the health sector reform activities, including undertaking the restructuring of the MSCU (see Section 3.5 for additional information).

DANIDA has recently announced plans to suspend its health sector activities in Kenya, thus withdrawing its vaccine donations and putting plans to restructure the MSCU on hold. The restructuring of the MSCU and its adjunct systems is a complex and risky undertaking, but one that if successful, can have a significant impact on improving the public health status of Kenyans. In order for this effort to be successful, DANIDA will need to "come back to the table" and demonstrate a sustained commitment over the long term. Without DANIDA's financial and technical support, the restructuring effort may be at risk. USAID and FPLM need to monitor DANIDA's plans closely, so as not to jeopardize Kenya's hard earned achievements in RH logistics management at the expense of a complex restructuring effort.

4.1.8 USAID

As described in detail in Section 3 above, USAID has sustained a long-term commitment to improve and maintain the RH logistics management system in Kenya. This has been its major contribution towards assuring that contraceptives are made available to clients nationwide. This is an unprecedented commitment, which no other donor has taken on in Kenya to date.

In addition, USAID has historically provided IUDs to the public sector and is committed to continuing this donation through 2000. Unfortunately, IUD services are one of the weakest components of Kenya's family planning service delivery program. This is largely due to provider bias, as well as lack of supplies (gloves and sterilizing solution) that clients have to purchase on their own and bring with them to the clinic. Demand for IUDs has also declined primarily due increased demand for injectables, as well as increased demand for implants, condoms and female sterilization.¹¹

Given the situation with IUDs, USAID/Kenya should re-examine its decision to have its contraceptive donation be that of IUDs versus another contraceptive. If USAID/Kenya is recommitted to providing IUDs, it should work with the DPHC through its Cooperative Agencies (CAs) to try to reinvigorate IUD services and promote the method as an attractive long-term option. Overall, the program should work with providers and policy makers to improve the sustainability and cost-effectiveness of Kenya's method mix with the inclusion of stronger IUD services and other long term methods. If the IUD component is to succeed, IUDs should be packaged with the necessary expendable items. Should a client request an IUD from a Community-Based-Distribution (CBD) worker, the worker should refer clients to clinics which have trained providers in IUD insertion (i.e., preferably AVSC supported clinics).¹²

4.2 Contraceptive Security for Kenya

Achieving contraceptive security refers to assuring a reliable and adequate supply of contraceptives to meet the family planning requirements of a given country. Although Kenya has been very successful to date in coordinating contraceptive donations over time from a variety of donors to meet these needs, the country now finds itself in a situation of increasing contraceptive requirements in a context of limited resources. The future of contraceptive supplies in Kenya is uncertain and the country faces serious deficits. Neither the GOK nor the donors has a clear strategy for addressing the issue.

The biggest concern is how to sustain the contraceptive pipeline, which to date has been 100 percent donor driven. There is no line item in the GOK budget for procurement of contraceptives. In the current economic environment it is not realistic to think the GOK will procure a proportion of the country's contraceptive requirements in the near future. The 1998 KDHS indicates that demand for family planning is increasing due to large cohorts of women entering reproductive age. Twenty-five percent of women still have unmet contraceptive needs in Kenya. Just to maintain achievements made in CPR and TFR since 1993, an overall increase of 16 percent per year of contraceptives will be required.

¹¹ Kenya Demographic and Health Survey (KDHS) Preliminary Report, Macro International, 1998.

¹² Personal Communications, John Wilson, Resident Advisor, JSI/FPLM Kenya, Apr., 1999

Although long term plan for restructuring of the MSCU hold some hope in its cost recovery strategy for the GOK to become less dependent on donors in the future, the government will need to rely on contraceptive donations for the foreseeable future. Further, despite all cost recovery schemes, there will always be a segment of the population that will need subsidized family planning services and contraceptives.

According to FPLM's contraceptive forecasts (based on historical distribution data and the KDHS data, taking into account anticipated policy and programmatic changes), Kenya is facing a funding shortfall of over \$46 million USD from 1999 through 2003. \$15 million USD of this figure represent the condom funding shortfall. Chart 4 in Annex A shows the DPHC's Funding Shortfall Summary Report. Chart 5 in Annex A shows detail of DPHC's funding history and projected shortfalls from 1994 – 2003, by product.

The GOK and other donors have come to rely on FPLM and USAID's on-going leadership coordinating donors to secure donations of required contraceptives. USAID and FPLM need to assume this responsibility and leadership role once again to address Kenya's long-term contraceptive requirements through the end of APHIA. Stakeholders need to come together and jointly ensure contraceptive supplies are available.

USAID should use the forum of upcoming donors meetings to present the contraceptive security problem facing Kenya for the next years. FPLM should lead parallel and coordinated work in its logistics coordination meetings.

4.3 Anticipated Condom Deficit

As with contraceptives, Kenya's projected condom supply is also facing a serious potential deficit by the end of 1999. Without additional pledges from donors of condom donations in the near future, it is estimated that Kenya will stock out altogether by the middle of 2000. Recent policy decisions made by the MOH have had a major impact on the number of condoms required to serve clients in Kenya. The anticipated condom deficit will have an impact on the family planning program; 5 percent of all public sector condoms distributed are used for family planning.

More seriously, however, based on reports in the KDHS of up to 9 percent of all Kenyan adults being infected with the HIV virus, and up to 22 percent of ante-natal women in Nairobi (and a reported 49 percent in some parts of western Kenya) being infected in some provinces, condom stockouts would spell a deepening of Kenya's major public health disaster. Apart from behavior change, which is slowly coming about but is extremely difficult, having condoms widely available and promoting their consistent and correct use is the only concrete tool we have to prevent HIV transmission and the worsening of this epidemic. The GOK, and the donors who support it, simply can not allow for condoms to stockout in this country. Condom demands are increasing as information about HIV becomes more widely known and individuals become frightened of contracting the virus. The KDHS reports a 43 percent relative increase in condom use

with non-regular partners, a large proportional increase from previous years. Community leaders, traditionally the most conservative of groups, are desperate to make condoms available to their people. Finding a way to sustain the condom pipeline on a long-term basis is critical and must be addressed collectively.¹³

Indeed, there are differences of opinion within the donor and CA communities regarding precisely how many condoms will be needed over the next few years. FPLM's projections indicate a projected deficit of \$15 million USD through 2003 to meet the condom requirements. This estimate is based on a working assumption of 16% increase in distribution per year, which is in turn based on distribution history and the KDHS. FPLM distributed a total of 80 million public sector condoms in 1998, and suggests that their estimate through 2003 may in fact be conservative (see Chart 5 in Annex A for detailed condom projection information).

Others, at USAID/Kenya and within the CA community, perceive that FPLM's estimates may be high and challenge the assumptions upon which they are based.

Despite differing opinions, however, all parties agree that Kenya will face a serious condom deficit unless plans are put into place to secure condom donations in the immediate future. All express concern and see the issue as an urgent one that needs to be addressed and resolved.

To begin addressing this anticipated national deficit, the GOK and donors need a common point of departure; a commonly accepted estimate of projected condom requirements over the next five years. USAID should facilitate identifying this common point of departure. As a first step, USAID/Kenya should have one of its CAs (the Policy Project or another appropriate group) undertake a *Condom Study*. The purpose of this study would be to come to an independent determination of how many condoms Kenya will need over the next 5 years. The next step would be to use results of the study to bring donors together to address the situation jointly.

In order to conduct such a study, the MOH will need to define its target group. Without such a definition, it will be difficult to usefully determine how many condoms are needed. The MOH may also need to reassess its target group in relation to the availability of resources to procure condoms. Also needed would be a calculation of how many sex acts per year need to be protected based on use history and rate of behavior change. The study should also assess how many condoms are on the market, what are the roles of PSI's successful social marketing vs. public sector distribution should be. It should explore how many are used for STI/HIV prevention versus for family planning, and to what extent individuals are prepared and able to pay for condoms. It should provide recommendations on how to best strategically cover condom distribution for bars and lodgings. The study should also look to answer the questions: what was the family planning effect of the 80 million public sector condoms distributed in 1998 and how many of the distributed condoms were actually used.

¹³ Personal Communications, John Wilson, Resident Advisor, JSI/FPLM Kenya, Apr., 1999

Once this study is complete, USAID/Kenya in collaboration with FPLM, should lead a dialogue with the GOK and other donors to develop a *National Condom Strategy* for Kenya with short and long term scenarios and proposed solutions. Development and implementation of such a strategy needs to be a collective effort of all the donors. Neither the GOK nor one donor can shoulder the full burden alone.

Without a concerted, immediate and collective effort to address the anticipated condom deficit situation now facing Kenya, control and resolution of the serious public health threat posed by the HIV/AIDS epidemic will not be achieved.

4.4 The Future of Reliable and Continuous Sources of RH Commodities and Essential Drugs

The lack of reliable sources for STI drugs, essential drugs and vaccines is similar to the uncertain situation of contraceptives and condoms. DANIDA, historically the provider of vaccines to Kenya, has recently suspended vaccine donations, leaving other donors and the GOK to scramble for alternate sources. There is no long-term plan or strategy for how to secure these important items for Kenya over the next five years. It is critical that the GOK and donors find a way for these drugs be widely available and easily accessible if Kenya has any hope of controlling the HIV/AIDS epidemic and improving the overall public health status of its citizens.

The GOK and the donor community must come together and create a plan to secure reliable sources of these products. Donors must also invest a portion of the value of their donations to support the logistics management system upon which nation-wide distribution of these drugs will depend; USAID will not be able to shoulder the entire logistics burden alone as the system takes on more and more products.

Currently the GOK procures 60 percent of Kenya's essential drugs; donors provide the balance of 40 percent. The precise national requirements of essential drugs are not fully known, since distribution has historically been based on a rationed system. However, we do know that if essential drugs can be successfully integrated into the well-functioning RH logistics system, the drugs that are available in Kenya have a much better chance of stretching further than they currently do. The strength of the logistics system could greatly increase coverage without having increased actual quantities procured.

The current system for drugs is one in which many never reach their intended destinations. The system is not set up to fully track or account for all the products it handles. Donors and the GOK alike find it difficult to quantify the programmatic impact that their donations and procurements of essential drugs are having. An improved logistics system for these products would give Kenya a better chance to improve impact and secure future donations from external sources. Kenya's plan to restructure the MSCU and try to apply what has been learned about RH logistics management to essential drugs (and eventually vaccines) lends strong potential to overhauling the

pipeline of the country's public health system. Although the restructuring plan is highly complex risky, the potential payoff in terms of improved quality of care, sustainability and overall enhancement of public health is worth it.¹⁴

4.5 Sustainability of the RH Logistics System

The maintenance and sustainability of the RH logistics system is currently highly dependent on donor support. FPLM should be acknowledged, however, for working consistently over time to develop local capacity within the LMU to run many parts of the system. Although the system is primarily financed by donors (principally USAID), a significant proportion of its functions are maintained by local LMU staff. All routine distribution and monitoring functions, including clinical supervision for STI sites, is carried out exclusively by MOH staff.

In order to prevent collapse of the RH logistics system, USAID, with the support of other donors, will need to continue a sustained commitment to supporting and maintaining the system. The system is currently as sustainable as the national RH program is. As long as donors are willing to donate contraceptives and other RH commodities, USAID should continue to advocate for them to apportion 15 percent of the value of their donations to support the logistics costs they have come to depend on to distribute and track their products. If donations dry up, Kenya will neither have a reliable source of RH commodities, nor the logistics system to distribute them.

Donors across the board perceive that the RH logistics system is one of USAID's strongest comparative advantages. USAID has taken the lead in this area and now other donors are asking USAID to take on the responsibility of maintaining the system. This is a tall and expensive order, but one that it is important for USAID/Kenya to assume. However, one donor alone can not undertake it; others will need to contribute as the system expands.

The GOK and the donor community need to better understand what the negative consequences and public health implications would be if the logistics system were allowed to collapse. In the context of Kenya's already declining health indicators, the country can not afford to be without this vital system.

So far, USAID/Kenya has assumed the burden and financial and technical responsibilities of maintaining the system. In the context of Health Sector Reform and its accompanying push towards integrated services, the burden on this system is likely to increase many fold. Although USAID/Kenya has been willing to invest thus far in the creation and maintenance of the RH logistics system, it will not be able to continue to carry this burden on its own; the burden needs to be shared. USAID/Kenya must work in a more

¹⁴ Personal Communications, John Wilson, Resident Advisor, JSI/FPLM Kenya, Apr., 1999

intensive and sustained way with its partners to leverage their contributions to assure the continuation of this important program element.

4.6 Continuation of USAID-Supported Technical Assistance and Financing

4.6.1 Sustained USAID Commitment

It is important for USAID/Kenya to sustain its commitment to supporting the RH logistics system. Much has been achieved in a relatively short number of years. The potential consequences of having the logistics system collapse would be devastating to the country.

4.6.2 Strengthening Local Capacity

USAID through FPLM should continue working to strengthen local capacity to maintain the logistics system. Much has already been achieved in this area, and Kenyans are handling a good portion of the system themselves. Continued efforts to strengthen local capacity in this area at all levels of the system is an important process. Logistics systems improvement is a long-term, dynamic and increasingly complex process, especially in the context of health sector reform.

4.6.3 Training

USAID has supported FPLM's efforts to train central and district-level staff. In 1994-95, 2300 providers and product managers in district stores were trained. When sampled recently, however, 50 percent of those previously trained has been transferred out of their posts (a system-wide problem). Due to cost constraints, FPLM has shifted to on-the-job (OJT) trainings for providers at 500 SDPs and districts.

It is now time to conduct necessary refresher training for those providers who remain, and first-time training for new staff and new districts that have been created over the last couple of years.

Investing in training is an important element of developing local capacity and maintaining a well-functioning system. USAID should support upcoming necessary training expenses.

4.6.4 Vehicle Fleet

One of the keys to success of the RH logistics system has been the maintenance of a separate vehicle fleet upon which the system can rely. Although many of the vehicles in the fleet are over 7 years old and have clocked over ¼ million kilometers, FPLM has maintained the fleet well. In the near future, however, this aging fleet will become more expensive to maintain and operate. Other donors including UNFPA and DFID have provided vehicles, (UNFPA has provided 2 pick-ups and 1 truck, and DFID has provided 3 vehicles for STI drug distribution).

Within the next year or two, the LMU will require new vehicles to replace some of its aging fleet, and USAID/Kenya should consider providing some of these vehicles.

USAID/Kenya should also coordinate with its partners for their contribution to this important resource.

4.6.5 Resident Advisor

An important element of the system's success has been USAID's sustained investment in a Resident Advisor. Having an ex-patriate oversee systems development and logistics operations has been critical in realizing significant logistics system improvements. Although there has been a considerable amount of capacity building within the MOH, particularly through the development of the LMU, continued oversight by a long-term advisor (LTA) will continue to be needed and will safeguard USAID's investments to date. Although costly, this investment will ensure viability of the system in an increasingly complex environment.

4.6.6 Resources

From April, 1999 through the end of the FPLM contract in September, 2000, FPLM will need approximately \$1,656,000 USD to maintain its operation. This is based on a fully loaded burn rate of approximately \$92,000 per month, times the remaining eighteen months of the contract.

Donor support necessary to maintain the logistics system over the remaining years of APHIA is likely to require similar funding levels. USAID/Kenya needs to intensify its advocacy role among donor partners so that they start to invest in logistics systems as a critical component of overall commodity procurement. This is particularly important given the potential for improved public health impact that the MSCU restructuring process offers.

4.7 How to Protect the Successful RH Logistics Management System in the Context of Integration?

Under APHIA, the LMU and FPLM have successfully created and maintained a well functioning family planning logistics system which now delivers contraceptives, including condoms, to SDPs nation-wide. The system has also proven robust enough to integrate STI drugs and reagents, expanding the system from one which originally handled only family planning commodities to one which now handles a wider range of reproductive health commodities. For the first time, this expansion has greatly enhanced the country's ability to distribute, track and be accountable for donations of STI drugs.

As the logistics management system integrates more products, USAID and its partners will have to monitor the viability of the currently successful RH logistics management system. USAID/Kenya and the GOK can not afford to let achievements in RH logistics management be compromised by taking on a fully integrated system which tracks multiple products. Nor will USAID/Kenya through its APHIA program be able to sustain the full financial burden of a fully integrated logistics management system. Other donors and the GOK itself will need to contribute to ensure long-term and continued success.

4.8 Regional Success and Expansion

As Kenya's success in RH logistics management becomes more widely known and relevant within the Africa region through the RLI and other work, Kenya will need to protect its human and financial resources used to maintain and grow its own logistics capacity. One can anticipate that the techniques and technologies which have proven successful in Kenya will become more and more in demand in the region. While USAID/Kenya has negotiated an equitable cost-sharing arrangement with the RLI partners (REDSO and USAID's Africa Bureau), the Mission will need to monitor the situation closely to make sure that Kenya's program is not compromised at the expense of admittedly important regional work. Kenya can not afford to sacrifice its investments and hard-earned successes, and has much internal work yet to accomplish.

In order to ensure adequate human and financial resources are dedicated to both Kenya and regional work, USAID/Kenya must continue to coordinate with REDSO, USAID's Africa Bureau and USAID's Center for Population, Health and Nutrition (PHN). In the future, meeting both Kenya and region-specific requirements may necessitate expansion of financial and human resources. Implementing partners may need to explore bringing on another ex-patriate to support the regional work, along with the possibility of using core funds.

4.9 Persons Contacted

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ANNEX A

APHIA MID-TERM REVIEW

ISSUES PAPER

ON

REPRODUCTIVE HEALTH SERVICE DELIVERY

Submitted by Dr Aloys Ilinigumugabo: May 6th, 1999

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EXECUTIVE SUMMARY

The AIDS, Population and Health Integrated Assistance (APHIA) project supported both the Ministry of Health (MoH) and the private sector in providing integrated reproductive health services. The Ministry of Health received support to improve access and quality of facility-based services while the funding given to NGOs was mainly invested in promoting community-based services.

Currently, the USAID Kenya office of Population and Health is supporting six organisations with a total of 1983 CBD agents and 1200 community health workers. The FPAK and Pathfinder CBD programmes generated annually an average of 127,540 couple-year protections (CYPs) over the last four years. The Marie Stopes Kenya (MSK) project is only 7 months old and has not yet started producing information.

The performance of CBD programmes supported by APHIA recorded a downward trend during the last four years as a result of the USAID funding cuts. The funding provided to FPAK was reduced by almost a half in 1996. To meet this unexpected reduction of funding, the Association retrenched almost all the staff supervising the CBD programmes at all levels and also cancelled the allowances given to CBD agents. Half of CBDs dropped out from the programme in 1998. The CYPs declined from 60,700 in 1995 to 6,340 in 1998. Pathfinder programmes also experienced a funding decline. The allocations to Kenyan programmes declined from \$ 1,000,000 in the 1995/6 financial year to \$ 591,104 in 1998/9 financial year. Pathfinder grantees reacted to these funding cuts by reducing the number of CBD agents and training activities. The CYPs dropped from 177,661 in 1995/6 financial year to 145,615 in 1997/8 financial year. Both FPAK and Pathfinder grantees introduced a fee-for-service and started income generating activities for CBD groups in order to sustain their programmes.

In the period of 1995-1999, AVSC provided support to 80 facilities in providing permanent and long-term methods. The 80 facilities include 52 public hospitals, 11 FPAK clinics and 17 CHAK clinics. AVSC provided training in technical skills, expendable supplies, and funds for the supervision of activities, equipment, and some minor facility renovations. The number of procedures reported by grantees to AVSC dropped drastically between 1995 and 1998. The reasons for this downward trend are not well known.

Since last year, AVSC, INTRAH/PRIME and Pathfinder started initiatives to introduce postabortion care services in some Kenyan facilities. AVSC introduced these services in 20 public and private facilities. Pathfinder did the same in three public facilities. INTRAH/PRIME has already assisted 22 facilities operated by nurse midwives in establishing postabortion care services. INTRAH will increase this figure to 40 facilities by July 1999.

APHIA supported two successful programmes. The Family Planning Logistics Management (FPLM) has drastically reduced contraceptive and STI drug stock-outs. 90 percent of all district stores have a three-month supply of contraceptives and STI antibiotics. The computerisation of the Medical Stores Coordinating Unit is also advanced. The second successful programme is the PSI social marketing for promoting condom use. The monthly paid sales have grown from 150,000 in 1995 to one million in 1998. PSI will launch social marketing for promoting pill use by the end of the year.

The important achievement of FP programmes over the last five years is that the fertility rate continues to decline in Kenya. The 1998 KDHS survey indicates that the total fertility rate has dropped from 5.4 children in the 1993 to 4.7 children in 1998. The CPR for modern methods has risen from 27 percent in 1993 KDHS to 31 in the 1998 KDHS. Based on KDHS data, condom use is much less common during sex with spouse for both women (3 percent) and men (7 percent) as compared to sex with regular partners or casual partners. For men, 42 percent of last sex with regular partner and 43 percent with casual partners involved use of a condom. For women, the figures are 16 and 15 percent.

Community-based programmes have attracted many donors such as GTZ, DFID, EU and Sida while USAID is the only donor who supports the provision of facility-based services and has developed unique expertise in the area. The 1998 KDHS data indicates that 91.4 percent of modern contraceptive users were supplied through facility-based services. Only 3.4 percent of contraceptive users were getting supplies through CBD agents. Furthermore, the performances of the USAID supported CBD programmes indicated a downward trend over the last four years and cover only about 10 percent of the estimated total number of CBD agents countrywide. This analysis suggests that APHIA supported CBD programmes generate a little added value to the national family-planning programme. We therefore recommend that APHIA focuses on improving access and quality of facility-based services and advocates for additional support for CBD programmes from other donors.

1. Introduction

USAID has supported Kenya's family planning programme since 1972. By the mid-1980s, USAID was the lead donor, providing an average of \$17-20 million annually through bilateral and central projects. During the early 1990s, USAID continued to be the lead donor in family planning and provided one-quarter of HIV/AIDS prevention programme expenditures.

In 1995, USAID approved a five year AIDS, Population and Health Integrated Assistance (APHIA) Project. APHIA was approved as a five-year, \$ 60 million results package. The purpose of the project was to reduce fertility and the risk of HIV/AIDS transmission through sustainable integrated family planning and health services. The project set up four objectives:

- Reduce fertility
- Reduce the risk of HIV/AIDS transmission
- Sustain reductions in fertility and HIV/AIDS transmission beyond the year 2000
- Support related policies and programmes upon which sustained reductions in fertility and HIV/AIDS transmission rely

To achieve these objectives, the project focused on five major components, namely FP service delivery, training, IEC, child survival and health sector reform

In January 1999, APHIA was extended at a level of \$132 million over 10 years. After four years of APHIA implementation, USAID/Kenya decided to conduct a mid-term review to assess the progress against the objectives and suggest any appropriate adjustments.

This issues paper is a review of the service delivery component of APHIA. The paper provides a summary of the activities accomplished, the project achievements and proposes the way forward in the service delivery for the five coming years.

2. Review of USAID-supported Programmes

The APHIA project provides support to both the Ministry of Health (MoH) and the private sector for providing integrated reproductive health services which include family planning (FP), maternal and child health (MCH) and STI/HIV/AIDS services. The Ministry of Health received support to improve access and quality of clinic-based services while the funding given to NGOs was mainly invested in promoting community-based services.

2.1. CBD programmes

Over the past decade Kenya developed and implemented community-based distribution programmes (CBD), as part of the national family planning programme. The CBD system relies on community members, as providers of family planning information and services to men and women at convenient locations, such as markets, barazas and homes. Even though there have been efforts to create guidelines to co-ordinate all CBD activities, there still is no formal government policy. Thus, the programme is characterised by a diversity of approaches. Currently there are over 25 organisations with 20,000¹ CBD agents throughout Kenya.

Currently, the USAID Kenya office of Population and Health is supporting six organisations with a total of 1983 CBD agents and 1200 community health workers.

(i). The Family Planning Association of Kenya (FPAK): is a non-governmental and non-profit organisation that provides reproductive health services in Kenya. Member of IPPF since 1992, FPAK CBD activities cover 35 divisions (31 rural and 4 urban) within 18 districts. The 475 CBD agents and 110 volunteer workplace motivators are attached to 13 conventional, 3 male only and one sub-static clinics.

(ii). Pathfinder International is a US based NGO that helps NGOs and the GOK in the development and the strengthening of the CBD activities. Pathfinder provides sub-grants to the following organisations:

- *Maendeleo ya Wanawake Organisation (MYWO)* is the largest nation grassroots women's organisation in Kenya and has been in existence for more than 20 years. MYWO provides reproductive health services through CBD activities. The CBD programme has 1228 CBD agents and 80 field supervisors. Since MYWO does not have its own clinics, clients are referred to the nearest health facility. The MYWO CBD programme operates in 10 districts.
- *Kabiro Kawangware*, is a community-based integrated health care project initiated by the residents of Kawangware in 1979. The purpose of the project is to address societal problems such as high unemployment, extreme poverty, high infant mortality, and high fertility. The Kabiro clinic, located in one of Nairobi's largest peri-urban slums, provides integrated health services with emphasis on reproductive health services for women. Other services provided by the clinic are vocational training, a primary

¹ Kenya Country Position Paper on population and Development, Presentation to the International Conference on Population and Development, 5th-13th September 1994, CAIRO, Egypt

school, and various income generating activities. Currently, Kabiro has 30 part-time volunteer CBD agents.

- *Mkomani Clinic Society*, is the only non-profit, community-based organisation in Coast Province that offers both integrated MCH/FP and CBD services. It provides these services at two clinics, and supports community activities through 25 CBD agents
- *Anglican Church of Kenya (ACK)* supports CBD activities at two locations (Maseno West and Eldoret) in Western Kenya. The two have a total of 225 CBDs.

(iii) Marie Stopes Kenya

(MSK) was established in 1986. It is one of the 30 affiliates of Marie Stopes International. It currently runs 4 full-fledged nursing homes and 12 clinics including two clinics recently established with support from USAID. MSK also implements two outreach projects, which include the Voluntary Surgical Contraceptive (VSC) Programme and the USAID education and service project. The MSK/USAID project provides integrated reproductive health services to women and men who fall within the catchment areas of 120 selected private practitioners. Ten MSK Community health workers are attached to each selected private practitioner and provide integrated reproductive health services with an emphasis on effective and personalised STI and HIV/AIDS home care, counselling and referrals.

Roles and Responsibilities

All the CBD programmes listed above provide integrated family planning services, MCH and STI/ HIV/AIDS education and counselling to clients in remote areas. This is done through community-based distributors. The CBD agents are elected and respected by people of their community. The basic responsibilities of the CBD include the following: motivation, counselling, distribution of non-clinical contraceptives (condoms and pills), referral of clients, IEC activities, reporting, records keeping, collaboration and networking, follow-ups and home visits. Each of the CBDs is assigned a specific area called a “catchment area”(300-800 households). They are responsible for visiting each of the homes in this area on a regular basis. In addition, CBDs commonly hold barazas and meetings to educate the community as a group.

Marie Stopes Kenya recruits existing community health workers and trains them in provision of integrated reproductive health services. All MSK community health workers provide HIV/AIDS home-based services over and above the common CBD services described above. Some Pathfinder supported programmes have also started providing training and support to caregivers of people with AIDS (PWAs).

Quality of Care

From the documents reviewed (trip reports, Population Council and Pathfinder reports), it is clear that at the community level, community members see CBD agents as acceptable sources of information about FP, STDs, HIV/AIDS, child survival, safe motherhood, and other reproductive health issues affecting that particular community.

FPAK and Pathfinder CBD programmes have recently initiated mobile services to provide injectables to clients in their catchment areas. The CBD supervisors are nurses trained in provision of family planning services. In response to the increase demand of injectable contraceptives, the CBD supervisors are providing these services during their scheduled supervisory visits. The injections are usually given in a home of one of the CBDs or in any other public facilities within the catchment area.

CBD integrated services

All the CBD are trained in providing information, counselling and referrals for STI and HIV/AIDS. MSK community-based health workers provide comprehensive PWA home-based care. They give basic care and support to people infected and affected by HIV/AIDS. They also establish contact between the PWAs and the private practitioner and facilitate the re-supply of prescribed drugs.

Pathfinder has also initiated home-based care services in some sites as a pilot project. The Pathfinder trained CBDs provide mainly counselling and support to PWAs' caregivers. The initiative is new and a small percentage of the CBDs have been trained.

CBD Supervision

In Pathfinder programmes, management and supervision systems are in place and functioning. Overall, all Pathfinder programmes have a four-layer system of supervision: Project Manager, Zonal Supervisors, Senior CBDs, and CBD agents at the grassroots. The majority of the CBD supervisors make an individual visit with each of the CBDs at least once a month while Senior CBDs make many contacts a month.

The CBD supervisors are trained nurses who can also provide injectables to clients during their monthly visits. Each of the supervisors is assigned to a group of CBDs (usually not more than 15). They are responsible for checking records and collecting reports, holding monthly meetings with the entire CBD group, meeting each CBD at least once a month to assist in developing monthly work schedules and ensuring effective coverage. They also have to provide continuous on-the-job training to CBDs, attend IEC activities, collect fees for service, and distribute supplies.

Before 1997, FPAK had the same supervisory system as Pathfinder grantees. Following the restructuring, almost all the CBD programme officers, CBD

supervisors and fieldworkers were retrenched. Currently, clinical nurses are expected to hold monthly meetings with the entire CBD group of their sites. The nurse meets the CBD on the field. With the nurse's clinical workload and lack of training in CBD supervision, the support provided to CBD agents is minimal.

The MSK project funded by USAID is only 7 months old. However, it has a functioning supervision system in place. The zonal supervisor holds monthly meetings with each of the private practitioners. During the visit, the supervisor attends IEC activities and makes arrangements to meet the community health workers of the catchment area at their homes. The private practitioner meets regularly with the CHWs, especially for the follow up of PWAs.

Support to CBDs

Inadequate Training: According to evaluation reports reviewed and the interviews, training and supervision for all CBD programmes have been negatively affected by budget cuts. Before budget cuts, each NGO provided three weeks of training for new CBD staff. Refresher training for current CBDs took place within a group setting for at least one day (number of days varied across programmes) each year. Currently, many CBD agents have not received refresher training for a number of years. For example, the last time MYWO conducted initial and refresher training for both CBDs and their supervisors was back in 1994. Often, new CBDs are trained on the job by overworked supervisors, who have not received adequate training themselves. Poor supervision, inadequate training and reduction of incentives are the main reasons for CBD poor performance and dropouts.

Reduction of support from the Supervisors: The decline in supervisory staff has also been an area of concern for CBD organisations. Before budget cuts, CBD supervisors could attend barazas and visit homes to educate people about the benefits of family planning. Currently, the number of supervisors has declined, or the recruitment of additional supervisors has not taken place. The remaining supervisors are often overworked and unable to complete their assigned duties.

A recent study done by the Population Council² suggests that a strong supervisory system is a key determinant of the performance of CBD agents. Most successful CBD programmes globally have strong management teams and efficient supervision systems. Supervisors provide motivation, training, supplies of contraceptives, and help the CBD agents with any questions, conflicts or concerns.

Promotion of income generating activities (IGAs): In response to the decrease in funding, a number of small CBD groups were formed and they started IGAs. Typically each of the members contributes a small amount each month. This can

² Chege J. N., Askew I. (1997) "An Assessment of Community-based Family Planning Programmes in Kenya", Africa OR/TA Project II, Population Council, page 32

either be used to purchase materials for the whole group to start a project (sunflower oil, pig farming, selling maize and beans) or it can be given to one person in the group on a rotational basis so that they can purchase some essentials for the home (merry-go-round). In both cases, many of the groups have established banking accounts and are generating enough income to start small businesses and assist each other financially. The FPAK experience in provision of seed money for IGAs was not successful. The association experienced difficulties in monitoring and co-ordinating these activities.

Fee for Services: Due to the cut back in funding and the decrease in CBD allowances, all the CBD groups have started “fee for service” programmes. The fees vary amongst programmes. Generally, CBDs are charging for a cycle of pills (Kshs 5-20) and injectables (Kshs 30-40). Condoms are free. At this point, the CBD supervisors are collecting the fees for service from each of the CBDs and keeping track of how much each CBD makes. This is then being charted in the district office and put into a general fund for the entire programme. A few programmes such as FPAK have started to give the CBDs a percentage of the total that they personally earn as an incentive to get more clients.

Services for youth

According to our interviews, the majority of CBD agents are beyond the reproductive age. The older CBD agents are hesitant to provide reproductive health services to unmarried youth particularly condoms. The informants thought that the generation gap and the lack of training in sexuality and reproductive health for the youth might be the reasons for negative attitudes of CBDs towards the provision of services to youth. The 1997 Population Council study³ found that only 26 percent of CBDs would provide contraceptives to an unmarried girl who has not yet had a child or become pregnant.

USAID supported initiatives to provide community-based services for youth are limited. Pathfinder has developed peer counselling in Kenyatta and Egerton Universities only. Trained students organise IEC activities and provide counselling services on integrated reproductive health including STIs and HIV/AIDS. However, the student counsellors do not distribute contraceptives because of the stigma associated with FP methods in the campuses. The students who want contraceptives are referred to hall cleaners who act as FP depot holders or the university health centre for clinical contraceptives. The peer counsellors receive on-site back up from a lecturer specialised in counselling.

FPAK is running two youth centres providing integrated reproductive health services. The centres use Friends of Youth who act as CBD agents for adolescents and the unmarried. The project is funded by UNFPA.

³ Chege J. N., Askew I. (1997) op cit.

Services for Men

The majority of the CBDs are women and are not adequately catering for men. The recent Population Council studies in the region have shown that female agents are more effective at reaching female pill clients while male agents are more effective at reaching male condom clients. Increasing men involvement in reproductive health has been a concern for FPAK and some Pathfinder grantees. FPAK and ACK Eldoret have developed workplace motivator programmes in male dominated firms operating in their project sites. The trained workplace motivators are responsible for IEC activities, counselling and distribution of contraceptives in their respective firms as depot holders.

2.2 Clinic-based services

APHIA project supports both the public and private sector health facilities in provision of reproductive health services.

Improving access to FP methods

In the period 1995-1999, the total number of sites supported by AVSC which are providing permanent and long-term methods has increased from 70 to 80. This increase of ten sites occurred in 1997 in the MoH, which currently has 52 hospitals active in providing permanent and long-term methods. Within the NGO and private sectors, numbers of sites have remained static. FPAK has 11 sites and CHAK has 17 sites.

Some Pathfinder grantees as well as FPAK and MSK receive support from USAID to provide integrated reproductive services in their own clinics. CBD agents refer the majority of the clients to these clinics.

AVSC provided support to the MOH, FPAK, CHAK and for-profit private sector providers expendable supplies, funds for supervision activities equipment, some minor renovations of facilities, and technical support.

AVSC has also continued to support the development of increased capacity to provide permanent and long-term methods. The corps of trained providers have steadily increased with the introduction of whole-site training and on-the-job training.

A particularly important source of increased capacity for service provision, and therefore access to service, has been the training of nurses to do the NORPLANT insertions and removals, under the supervision of doctors. The nurses are providing NORPLANT services in private sector only (30 sites). The MOH has completed a pilot project to test the provision of NORPLANT services by trained nurses. The study demonstrated that trained nurses can provide those services at acceptable level of quality. However, the Nursing Council has not yet issued the formal approval for nurses to provide NORPLANT services.

Counselling

A very recent assessment conducted by AVSC⁴ and our interviews indicated that clients are treated with respect in AVSC sites. Privacy is generally ensured during counselling although interruption by other staff may occur in few instances. New clients are provided with information on all the methods. Providers also assess the clients' knowledge and past use of family planning. However, vasectomy is not routinely presented as one of the family planning methods. After clients choose the method they want, they are further informed on its mechanism of action, side effects, and how to use the method. Most counsellors encourage clients to ask questions and sometimes ask clients questions to ensure that they have understood the information provided. Clients are also encouraged to return to the clinic if they have any problems.

AVSC has assisted most of its sites to establish a voluntary surgical contraception unit that provides NORPLANT and sterilisation services. At these sites, clients who choose surgical methods are referred to these units for further counselling and documentation of informed consent.

Recent AVSC and Population Council studies revealed that STI/HIV transmission is rarely discussed during counselling for family planning in Kenyan health facilities.

The following family planning methods are provided at most of the health facilities supported by USAID: condoms, pills, spermicides, injectables, IUCDs, NORPLANT and female sterilisation.

Supervision

The 1999 AVSC mini-assessment noted that MOH regional supervisors had introduced and implemented quality approaches and tools at the sites where they are based. However, they had not yet begun to introduce these tools to other institutions in their regions. The regional supervisors were beginning to use these approaches and tools during their supervisory visits.

The AVSC assessment also indicated that COPE and on-the-job training (OJT) were being implemented at the sites visited, but not the whole-site training and in-reach. The documents reviewed suggested that the use of QI approaches is at different stages amongst provinces.

OJT is on-going at most sites supported by AVSC. Staff receive OJT in a variety of skills including NORPLANT insertion and removal, counselling, customer care, infection prevention, etc.

⁴ Bettie K. et al., (1999) "AVSC International Kenya Programme Evaluation 1995-1999"

Documents reviewed and our interviews suggested that facilitative supervision, quality improvement approaches and tools have been introduced throughout FPAK, MSK, CHAK and Pathfinder grantees.

Integration of STI/HIV and MCH/FP Services

The Ministry of Health has adopted new guidelines for providing reproductive health services, which require the integration of STI/HIV/AIDS control in MCH/FP programmes. All service delivery facilities have integrated the provision of family planning services with STI/HIV/AIDS control. Overall, the MCH/FP clinics use the following prototype model for integration:

- Case finding and treatment of asymptomatic women, women with but not recognising and/or reporting RTI symptoms, and those that report symptoms
- HIV/AIDS testing and counselling through referral to specialised centres and IEC on prevention of transmission.
- Finding and treating maternal syphilis
- Information and education to prevent new infections and to improve health seeking behaviour

Recent operations research studies from Population Council and FHI have demonstrated that implementing an integration model which emphasises syndromic approach to STI management in MCH/FP programmes presents many challenges. The operations research studies⁵ pointed out the following findings:

- Cervical infections used to decide treatment approaches in syndromic management of vaginal discharge account for less than one quarter of RTIs among MCH/FP clients
- Women's knowledge of common STI symptoms is poor, therefore, they are unlikely to report symptoms even when present.
- Syndromic approach to prescribing antibiotics leads to many women without infection being exposed to antibiotic therapy and those with infection missing treatment
- Partner notification and treatment is problematic given that women who fear discussing with their partners are the primary contacts at MCH/FP
- Return for follow-up is poor, therefore it is difficult to assess effectiveness of the approach and to change clients to more appropriate therapy when required
- Service providers have not been adequately prepared to provide STI services and many have reservations about discussing sexual behaviour with clients. Therefore, they are unlikely to perform adequate STI/HIV risk assessment and counselling for clients

⁵ Maggwa B. N., Askew I. (1997) "Integrating STI/HIV Management Strategies into Existing MCH/FP Programmes: Lessons from Case studies in East and Southern Africa", Africa OR/TA Project II, The Population Council

- Current syndromic approach does not lead to a diagnosis of RTIs even when MCH/FP clients have clinical signs suggestive of an infection.

The above results were confirmed by FHI research mining on the integration of STI/HIV/AIDS in family planning services. These studies recommended further research to assess the cost effectiveness of the syndromic approach compared to other interventions. For HIV/AIDS, studies suggested counselling for all clients and the promotion of condom use.

Postabortion Care services

Post-abortion care (PAC) services were introduced in Kenya by Ipas and Population Council through an experimental study for testing approaches to creating linkages between incomplete abortion treatment and family planning services in Kenya. PAC consists of three elements:

- Emergency treatment services for complications of spontaneous or unsafely induced abortion
- Postabortion family planning counselling and services
- Links between emergency abortion treatment services and comprehensive reproductive health care

AVSC originally began working in only 4 pilot sites in assisting with PAC services. This has now expanded from these 4 sites to include a total of 20 sites. AVSC's support includes providing replacement MVA instrument and training updates to staff. Some sites were assisted to move the provision of PAC services from the main theatres.

In 1998, Pathfinder also expanded postpartum and postabortion services to three public hospitals – Machakos (Eastern Province), Mombasa (Coast Province), and Eldoret (Rift Valley Province).

INTRAH/PRIME is implementing a pilot project to establish postabortion care (PAC) services at 30 private facilities operated by nurse midwives. The project trains two nurses by facility and provides a MVA kit for starting the provision of PAC services immediately after the training. The project started in February 1999 and has already introduced PAC services at 22 facilities in Nairobi, Central and Rift Valley provinces. Each facility receives a facilitative supervision visit three weeks after the training from INTRAH trainers. The information collected during these visits shows that the 22 facilities had already provided PAC services to 114 clients during a period of three weeks.

Youth-friendly reproductive health services

The High Risk Clinic (HRC) of Kenyatta National Hospital is the only USAID-supported facility providing youth-targeted services. The main objective of the HRC was to improve the reproductive health of young unmarried women through

prevention of recurrent unintended pregnancies. The Department of Obstetrics and Gynaecology of the University of Nairobi established HRC in 1991 with support from Pathfinder International. The clinic provides reproductive health services to young women admitted to the KNH with complications associated with incomplete or septic abortion. This clinic, which is the only one of its kind in Kenya, has become a crucial health service and resource center for young women, not only in Nairobi but also from the surrounding areas.

The High Risk Clinic provides the following specific services:

- Education and counselling on reproductive health issues, including STD/HIV/AIDS, to young adults
- Provision of family planning services to post-abortion and postpartum patients in order to prevent recurrent unintended pregnancies
- Follow-up of the patients
- Reducing existing barriers to access to reproductive health information and service for youth
- Maintaining a telephone “hot-line” for young women seeking anonymous counselling on reproductive health issues.

HRC experience is successful. The 1997 evaluation of the clinic indicated that more than half of the HRC clients (54 percent) accepts a family planning method. For the period of July 1st 1995 to December 31st 1998, the clinic provided family planning services to 7,366 new clients and 10,539 old clients made revisits. The clinic also referred 759 clients for implant (725) and female sterilisation (32).

Men-friendly services

Increasing access to reproductive health services for men has been a concern for some USAID-supported NGOs. FPAK has established three male only clinics with the support of IPPF. Some Pathfinder grantees such as Mkomani Clinic Society and Kabiro Kawangware project have started to open their clinics Saturdays and Sundays for providing male-only services. The NGOs use male service providers for offering male-friendly services. The male clients pay the same fees as females receiving the same services. According to our informants, these interventions are successful. However, there is a need to assess the merits of the male-only services versus other interventions.

2.3 Logistics Management

The FPLM project has been providing long-term technical assistance to the Ministry of Health in Kenya since 1991 for institutionalising logistics management systems through the creation of the Logistics Management Unit of the Division of Primary Health Care.

The FPLM has successfully designed and implemented logistics management for both family planning and STI drugs. Commodity management, distribution and tracking is facilitated by an electronic Logistics Management Information System (LMIS).

The availability of commodities is critical to achieving and sustaining high quality of care. Unless commodities are available in the clinic, clients do not come to the clinic. The FPLM ensures high quality commodities are available in the right place, at the right time, in the right quantities.

The project has increased the volume of contraceptive commodities distributed by more than 200% with a constant operational budget. The high performance was the result of improved efficiency within the distribution system. The FPLM success in improving the FP distribution system was recently replicated in developing the STI drugs distribution system. The computerisation of the Medical Stores Coordinating Unit (MSCU) is at an advanced stage. The system will provide up-to-date data on commodity stocks and issues, facilitate efficient distribution scheduling, and generate national forecasts of drug and commodity requirements.

2.4 Social Marketing for Reproductive Health

The PSI Trust Social Marketing Project in Kenya began in 1993 and has been active in promoting use of Trust condoms focusing on HIV/AIDS prevention among young people. PSI's intensive campaign to popularise Trust condoms through radio, television, posters, point of purchase (POP) materials and other channels, continue to operate concurrently with a condom distribution system that has increasingly expanded into non-traditional retail outlets, particularly in urban areas. It is through this product-delivery system that distributors and wholesalers have been strengthened to avail Trust condoms at the closest level to the consumers. Non-traditional outlets are the principal retail points from which consumer products are served to urban consumers in Kenya, a majority of whom earn low incomes.

Trust condoms were launched in October 1993, followed by an extensive radio campaign, which resulted in high brand recognition. Sales increased dramatically to approximately 500,000 per month. However, 60% of these were credit sales and the money was never collected.

In 1995, the entire sales department was re-organised and all the regional sales managers were replaced. Over the next year, PSI subdivided the sales zones, creating 10 zones from five and added a retail sales force, which sold directly to kiosks, dukas, bar/lodgings and other non-traditional outlets. Creating this new layer of sales force has been a key component in the improvement in sales and they continue to play a crucial role in expanding Trust condoms availability. There are currently 55 Retail Sales Force Agents (RSFs) who buy product from

sub-distributors and sell to retailers, keeping a profit margin of 33 Ksh per dispenser. Some of the agents are provided with bicycles.

The RSFs are supposed to open new outlets, service existing retail customers and do some merchandising. The first RSFs were salaried, but performance was not satisfactory. PSI then switched to commissions only. This did not provide sufficient incentive and there was a high turnover of staff. PSI now has a hybrid system: if the RSF sells 17 cartons in a month, they will receive a Kenya shillings 3500 bonus in addition to the profit made on each dispenser sold. The bonus serves as a salary of sorts, although it is not guaranteed unless the target of selling 17 cartons is reached. This new incentive system is working well.

RSFs are “micro-distributors” and sign a contract with PSI/Kenya and the sub-distributor. The sub-distributor is supposed to keep a record of RSF sales. Retail Sales Force Supervisors, whose job description emphasises providing management and oversight of the RSFs in his/her region, manage the newly created zones. They are responsible for selling to wholesalers, and earn 64 Kshs per carton sold in commissions. PSI now works with a network of approximately 50 distributors and 15 wholesale pharmacies spread across the country. The sales have reached one million condoms per month. PSI has decided to launch social marketing for promoting pill use by July 1999.

3. Service delivery related activities supported by other donors

According to our interviews, seven donors other than USAID provide support for service delivery. Four of them support FP commodities and STI drugs. Table 1 below shows that DFID/EC is the lead donor in procuring commodities. It contributed 38 percent of the total FP commodities and STI drugs distributed during the period 1995-98. The second donor in provision of commodities was the World Bank (26%) followed by Sida (14%). USAID and UNFPA contributed 12 and 10 percents respectively. Table 1 also presents the types of contraceptives supplied by each of the donors.

Table1: Contribution to Family Planning commodities and STI drugs for the period 1995-98

Donor	Funding for the period 1995-98	Percentage	Types of contraceptives supplied
DFID/EC	\$ 12,367,538	38	Injectables condoms, STI drugs
UNFPA	\$ 3,217,296	10	Pills, condoms
USAID	\$ 3,848,502	12	Condoms, IUDs
World Bank	\$ 8, 489,464	26	Condoms, NORPLANT, STI drugs
Sida	\$ 4,631,151	14	Pills
Total	\$ 32,553,951	100	

Source: FPLMU MIS

Programmes:

Sida promotes the development of youth friendly services through IEC activities and an adolescent centre in Siaya district. It provides funding for MVA procurement and training of service providers in postabortion care. Sida also supports the safe motherhood initiative through TBAs training and kits, and mothers' cards.

WHO helped the MOH in establishing youth-friendly services in Nyeri Provincial General Hospital and trained staff from Nakuru General Hospital in youth-friendly services. WHO assisted in developing the action plan for elimination of Female genital Mutilation (FGM) and provided mother- baby package training to District Health Management Teams (DHMTs).

UNFPA provided support for strengthening RH management capacity through Provincial Health Management Teams (PHMTs) and DHMTs. The latter will in turn train health facilities committees (health centres and dispensaries). UNFPA assisted in developing the national five-year plan for reproductive health and is about to start a comprehensive reproductive health programme in eight districts.

Belgian GADC assists the MOH in implementing a comprehensive reproductive health programme in Makueni district.

DFID and EU are supporting a joint Kenya Family Health Programme (KFHP). The project is managed by GTZ and has five components:

- Procurement of contraceptives (80% and 20% of the national requirement for injectables and condoms respectively)
- Support of eight NGOs in provision of reproductive health services (AMREF, FPAK, CARE International, NCCK, KCS, Kenya Freedom from Hunger, CCF and Marie Stopes). These NGOs are using the DFID/EU funds in carrying out community-based programmes.
- Promotion of the private sector through training services and procurement of equipment at subsidised price
- Establishment of a service quality unit in the Division of Primary Health Care (DPHC/MOH)
- Operations Research in reproductive health

KfW is implementing two projects. The first project will assist the Ministry in designing and procuring MOH brand pills. The second project will develop the MOH social marketing strategy for contraceptives

GTZ in collaboration with the Ministry of Health is implementing the largest CBD programme in Kenya. This Germany-supported project covers 20 districts in Western, Nyanza and Eastern provinces. It started in 1990. GTZ has trained 12,000 CBD agents for the whole project life with about 9,000 agents who are still

active. Elected by the community, GTZ CBD agents work on a volunteer basis. The CBDs receive a two-week training at the beginning and biannual refresher courses of a single day. The CBD agents cover a catchment area within a project site surrounding a public health facility. The CBD supervisors are trained nurses providing services at the public health facility used by the supervised CBD agent as a referral point. The CBD agents are expected to meet their supervisor in group once a month at the health facility. Table 2 presents the project outputs for the last four years. The table shows that the number of new clients recruited by GTZ during the last four years has significantly been increasing. The number of new acceptors had an increase of 78 percent. The cycles of pills distributed have doubled while the condom distribution raised by 238 percent.

Table 2: GTZ community-based programme outputs for the period 1995-98

Year	New clients	Referrals	Nordette	Migrogynon	condoms
1995	212856	19945	7299	517797	4807178
1996	306998	21245	525020	257977	8066156
1997	333901	24900	991360	9088	10063959
1998	377865	25479	938500	180553	11443824

Source: GTZ project MIS

The GTZ project in collaboration the MOH is implementing a pilot project in Karachuonyo district for testing different approaches to introducing fees for CBD service.

4. USAID supported Programme performances

FPAK, Pathfinder and AVSC programmes have not met the planned annual targets over the last four years while the PSI social marketing programme has been performing well.

FPAK: The performances of FPAK programmes have drastically declined over the last four years. Tables 3 and 4 present the performances of FPAK for the period 1995-98. Table 3 shows that the CYPs distributed by the FPAK CBD programme has decreased from 60,700 in 1995 to 6,340.32 in 1988 while the number of new acceptors declined from 87,525 to 11,706 over the same period. The utilisation of FPAK clinic services also declined. Both the number of new acceptors and the CYPs distributed decreased by half from 1995 to 1998.

According to documents reviewed and our interviews, the reduced performance in the CBD programme seems to be related to the retrenchment at FPAK and in the programme in particular. Between June 1993 and December 1997, a total of 233 people were made redundant. Many of these included CBD programme officers, CBD supervisors, and field workers. At the same time many benefits which CBD agents used to enjoy, such as allowances, were withdrawn. These two factors explain the drop of the CBD programme performance. The

retrenchment of CBD programme staff was mainly a result of the USAID funding cuts in 1996. Table 3 shows that the grant from USAID was almost reduced by half in 1996 compared to the previous year. The funding decline continued during the following two years, but at a lower rate.

FPAK introduced integrated reproductive services in its clinics since 1996. Table 3 indicates that the management of STIs increased from 551 cases in 1996 to 2036 in 1998. However, the utilisation of FPAK MCH services is still very low. The 13 FPA clinics provided services to 149 mothers seeking antenatal and postnatal services while 149 children were seen for well baby growth monitoring and immunisations. The under-utilisation seems to be related to the lack of publicity. FPAK clinics are known for providing family planning only. The Association needs to develop a marketing strategy. It could also explore the possibility to expand the services and provide comprehensive health services.

Table 3: FPAK FP performances for 1995-1998

Year	Grant from USAID Ksh.	Clinic-based Services		CBD Services		
		New Acceptors	CYPs	New Acceptors	Referrals	CYPs
1995	64347526	11,427	108,646	87,525	43,507	60,700
1996	36762612	7,094	75,175	43,736	21,914	29,677
1997	34702046	5,808	65,362.5	22,920	30,620	17,038.64
1998	28388496	5,137	53,676.19	11,706	11,716	6,340.32
TOTAL		29,466	891,122	165,887	107,757	113,756

Source: FPAK MIS

Table 4: Other services offered in FPAK Clinics for 1995-1998

Service	1995	1996	1997	1998
Pap Smear	15,443	11,731	11,033	11,446
Management of RH infections	974	418	558	558
STI management	0	551	1,655	2,036
Pregnancy Test	1,636	1,918	1,805	1,710
Emergency Contraception			24	194
Ante natal	0	33	62	149
Child	0	77	326	140
TOTAL	18,053	14,728	30,191	16,233

Source: FPAK MIS

Pathfinder: The performances for Pathfinder grantees have been declining from 1995 to 1998 in terms of CYPs. Tables 5 and 6 present a summary of the outputs for all Pathfinder supported programmes. Table 5 shows that the CYPs dropped from 177,661 in 1995/6 to 145,615 in 1997/98. However, the number of new acceptors indicates a different pattern. The number of new acceptors declined from 1995 to 1996 and started to gain momentum last year. The figures for new acceptors recruited through CBD programmes increased by 33 % last year. The clinics supported by Pathfinder registered an increase of 5% for new acceptors over the same period. According to our interviews, these fluctuations are associated with the introduction of fee-for-service and the retrenchment of CBD agents. Programmes experienced a decrease of clients when they introduced the fee-for-service for a while until the clients realised that the CBD services were still cost-effective compared to public services that required walking to the health facility. All Pathfinder grantees have started reducing the number of CBD agents as a result of the USAID funding decline. The total number of CBD agents supported by Pathfinder dropped from 1829 in 1996 to 1508 in 1998. The allocations for Pathfinder grantees also declined from \$ 1, 021,824 in 1996/7 financial year to \$ 797,376 in 1997/8 financial year. The budget for the current financial year was reduced to \$591,104.

In response to these drastic funding cuts, Pathfinder grantees maintained the CBD supervisory system. However, they reduced the number of CBD agents receiving allowances and froze training activities. Overall, the strategy adopted by Pathfinder grantees did not affect the CBD motivation, but in the long run, it may reduce the quality of services provided by CBD agents. Often, new CBD agents are only trained on the job by CBD supervisors.

MCH services of Pathfinder-supported clinics are utilised at an acceptable level. In average, each clinic provided services to 16 children and 14 mothers per day. The clients seeking STI/HIV/AIDS services in clinics supported by Pathfinder raised precipitously from 4528 in financial year (FY) 1995/6 to 30,249 in FY 1997/8.

Table 5: Pathfinder Grantees' FP performances for 1995-1998

Year	Grant from USAID	New acceptors in Clinics	New Acceptors in CBD	Referrals	CYPs
7/01/95-6/30/96	\$1,000,000	35,328	199,078	137,916	177,661
7/01/96-6/30/97	\$1,021,824	25,415	182,090	131,820	176,635
7/01/97-6/30/98	\$ 797,376	26,610	241,432	171,370	145,615
TOTAL		87,353	622,600	441,106	499,911

Source: Pathfinder MIS

Table 6: Other services offered by Pathfinder Grantees for 1995-1998

Service	1 July 1995- 30 June 1996	1 July 1996- 30 June 1997	1 July 1997- 30 June 1998
Child	372,417	335,009	316,330
Mother	249,124	246,288	189,791
Pap Smear	2,903	1,676	1,495
STD/AIDS	4,528	12,007	30,249
Other	43,382	32,080	61,605
TOTAL	672,354	627,060	599,470

Source: Pathfinder MIS

The MSK project funded by USAID is 7 months old. MSK has not started to generate service statistics for the project. However, table 7 presents the outputs for the entire MSK programmes. The number of clients has been increasing over the last five years. The CYP declined slightly in 1997 and increased by about 9.3 % last year. According to our informants, this fluctuation was a result of the workplace motivator project, which came at the end of the year 1996. The project sites were closed and the number of condoms and pills distributed dropped.

Table 7: MSK performances for the period 1995-98

Year	No of clinics & nursing homes	No. of Nursing Homes	Total clients	%FP	CYP
1995	10	1	131,103	35	217,900
1996	10	2	131,258	51	250,000
1997	12	3	139,234	50	185,296
1998	13	3	147,503	51	202,662
TOTAL			549,098		855,858

Source: MSK MIS

Performance of AVSC-supported services: The numbers of procedures reported by grantees to AVSC dropped dramatically between 1995 and 1998. Table 8 presents the results of AVSC interventions in terms of clients served. The analysis of these data shows that the total number of clients has declined for all long-term and permanent methods in the sites supported by AVSC over the period 1995-98. A 1999 AVSC mini-assessment indicated that MOH and FPAK figures for 1998 are about 50% of the 1995 figures. CHAK has seen a slightly less dramatic decline, and the private sector figures are somewhat erratic, though possibly increasing.

The 1999 AVSC mini-assessment and our interviews suggested three possible reasons for this downward trend:

- The consequences of the year-long strike by doctors
- The uncertainties brought about by a transition to decentralised management and the economic and resource constraints that Kenya experienced in the past five years, especially for the utilisation of Private clinic services.
- The accumulated demand for sterilisation procedures from older or high parity women may have been met by 1995/1996

Table 8: Number of Clients provided with Permanent and Long-term methods by AVSC Grantees

Year	Tubal Ligation	Vasectomy	Norplant	PPIUD	Postabortion Care
1995	13,733	147	11,207	5,846*	
1996	8,188	69	8,326	6,359*	
1997	7,400	58	7,671	270	
1998	6,079	129	7,511	323	2,689
TOTAL	159,000	403	34,715	12,798	2,689

- Please note that the IUD procedures for 1995/1996 include both postpartum and non-postpartum procedures. From 1997, AVSC takes into account only PPIUD procedures since AVSC's site level support is mainly postpartum IUD only.

Source: AVSC MIS

PSI Social Marketing Performance: Paid sales have grown from approximately 2.4 million in 1995 to 4.2 million in 1996 to 7.83 million in 1997 and finally to 10.323 million in 1998. The programme has reduced the cost per condom sold from approximately \$0.42 in 1995 to \$0.10 in 1998

Table 9: PSI Social Marketing Performance for 1990-1998

Year	Annual paid sales	Approx. annual programme cost	Cost per condom sold
1990-2	540,000	\$1,000,000	\$1.85
1993-5	2,400,000	\$1,000,000	\$0.42
1996	4,179,000	\$1,000,000	\$0.24
1997	7,830,000	\$1,000,000	\$0.13
1998	10,323,000	\$1,000,000	\$0.10

Source: PSI MIS

The 1998 marketing research conducted by PSI revealed the following findings:

- Twenty-six (N=952) of all retail outlets (N=3703) and 18 percent of all wholesale outlets (N=303) visited were currently selling the Trust condom. The bulk of the outlets selling Trust were Non-traditional outlets (74 percent) i.e., bars, lodgings, kiosks, dukas, and street vendors.
- Retailers sold a mean of 3 Trust dispensers, translating into 216 units while wholesalers sold a mean of 39 Trust dispensers (2808 units) per month. Bar/Lodgings accounted for the highest mean sale of 244 units of Trust condoms among the non-traditional outlet stratum. The Trust dispenser was visibly displayed in the bulk of retail (84 percent) and wholesales (94 percent) outlets.
- Only 5% of retailers and a negligible percent of wholesalers (0.7%) had another type of condom in stock other than Trust (both commercial and public sector). Of the 5% non-Trust condoms available in retail outlets, the Government supplied 2% and commercial firms supplied 3%.

5. Impact of Family Planning Programmes

Fertility Decline: USAID has been the leading organisation in providing support to the national family planning programme in Kenya. The important result of FP programme over the last five years is that fertility continues to decline in Kenya. The 1998 KDHS survey indicates that the total fertility rate has dropped from 5.4 children in 1993 to 4.7 children in 1998. The fertility has fallen recently at every age. However, the total fertility rate is higher in rural areas (5.2 children per woman) than in urban areas (3.1 per woman). This pattern of higher rural fertility is evident at every age. The fertility also varies widely across the provinces, ranging from a low of 2.6 children per woman in Nairobi to over 5 children in Western, Rift Valley and Coast provinces.

Knowledge and use of contraception: The contraception prevalence rate (CPR) for Kenya was 39 percent in 1998. Most current users of contraception are using a modern method. The CPR for modern methods was 31 percent while 8 percent of current married women were using traditional methods. Contraceptive use, especially modern methods, has risen sharply since the early 1980. It is probably the principal cause of the fertility decline described in the previous section. The CPR for modern methods has risen from 27 percent in 1993 to 31 in the 1998. However, the rate of increase in uptake of contraception has slowed. Between 1984 and 1993, nearly 2 percentage points were added to the contraceptive prevalence rate for modern methods each year. This has slowed to less than one percentage point per year between 1993 and 1998.

The current method mix indicates a shift in contraceptive behaviour of Kenyan women. The use of injectables increased from 7 percent in 1993 to 12 percent in 1998 and became the predominant method. The use of implants, condoms and female sterilisation has risen over the inter-survey period while the use of pills and IUD dropped.

The knowledge of family planning methods is nearly universal, with 96 percent of all women aged 15-49 and 98 percent of all men aged 15-54 knowing at least one method of family planning. Married women and men know an average of 7.2 and 7.6 methods respectively, compared to 7.2 and 6.8 methods for unmarried sexually active women and men.

Awareness of STD/HIV/AIDS and Use of Condoms: In Kenya, one in 11 adults is infected with HIV, the virus that causes AIDS. It is estimated that over 240,000 people in Kenya have already developed AIDS since 1984. Currently, it is estimated that about 1,325,000 adults and 90,000 children are HIV infected.⁶

The 1998 KDHS shows that HIV/AIDS is widely known among both women and men in Kenya. The most frequently cited means to prevent getting AIDS was through condom use with forty nine percent of men and 38 percent of women. This represents an increase since the 1993 KDHS when 36 and 21 percent of men and women respectively cited condom use to avoid AIDS.

According to the same survey, condom use is much less common during sex with spouse for both women (3 percent) and men (7 percent) as compared to sex with regular partners or other (casual) partners. For men, 42 percent of last sex with regular partner and 43 percent with other partners involved use of a condom. For women, the figures are 16 and 15 percent. Married men when engaged in outside marriage use condoms 60 percent of the time compared with 7 percent condom use with wives.

Source of family planning methods: The 1998 KDHS data showed that public (government) facilities provide contraceptives to 58 percent of users, while 33 percent are supplied through private medical sources, 5 percent through commercial outlets and friends, and 3 percent through community-based distributions. This represents a significant shift away from public sources, down from 68 percent in the 1993 KDHS. The contribution of medical private sector in providing contraception has risen from 24.7 percent of users in 1993 to 33.4 percent in 1998. The private sector has attracted more pills and injectable users than public facilities. However, public facilities continue to provide about two-thirds of IUD insertions and female sterilisation.

Although the number of CBD agents increased to about 14,000 countrywide, their contribution in supplying contraceptives did not increase much. The proportion of condom users who were supplied by CBD agents slightly changed from 3.2 percent in 1993 to 3.9 percent in 1998. The percentage of pills users whose source is CBD agents has risen from 6.3 percent to 10.9 percent in 1998 according to KDHS data.

⁶ Okeyo T.M. et al. (1998) "AIDS in Kenya: Background, Projections, Impact and Interventions, NASCOP, Fourth Edition

Social marketing efforts have successfully increased the condom supplies through commercial outlets. The 1998 DHS data indicate that the percentage of condom users who got supplies through shops increased from 9.2 percent in 1993 to 33.2 percent in 1998.

Need for Family planning services: Twenty-four percent of married women in Kenya have an unmet need for family planning services, fourteen percent for spacing purposes and 10 percent for limiting births. This represents 33 percent decline in unmet need since it was estimated in 1993 KDHS (36 percent). Combined with the 39 percent of married women who are currently using contraceptive method, the total demand for family planning now comprises about two-thirds of married women in Kenya.

In 1998, 63 percent of potential demand for family planning in Kenya was being satisfied compared with 47 percent in 1993 . Unmet needs for spacing purposes is higher among the younger women, while unmet need for limiting childbearing is higher among the older women. The level of unmet need is also much greater among rural women than among urban women, and tends to be higher among women with less education. Provincial differences are noteworthy with unmet need ranging from lows of 11 to 13 percent in Central and Nairobi Province to 32 percent of married women in Western Province.

Contact of Non-users of Family Planning with Family Planning Providers:

The 1998 KDHS data revealed that 82 percent of non-users had been neither visited by a CBD agent nor discussed family planning at a health facility. About one-third of women (31 percent) were not visited by a CBD agent, but did go to a health facility and were not contacted about family planning while at the facility. This shows a high level of missed opportunities to inform non-contracepting women about their reproductive options.

The woman's age is an important determinant of receiving FP contact, either through a CBD agent or at a health facility. According to the 1998 KDHS data, only 4 percent of adolescents (woman aged 15-19) were visited by a CBD agent and only 3 percent were contacted at a health facility about FP. For these adolescents, the low level of FP contact at health facilities is not only because they attend facilities less frequently. A much smaller percentage of women aged 15-19 than women at older ages who did attend a facility received some FP contact. Around 1 in 10 women aged 15-19 who attended a health facility received FP contact as compared with about 1 in 3 women aged 20-24 and 1 in 2 women aged 25-44.

6. Findings and Conclusions

PSI has developed a very successful social marketing programme for promoting use of Trust condoms focusing on HIV/AIDS prevention among young people. The annual paid sales have grown four times from 1995 to 1998.

The family planning Logistics Unit has greatly improved access to reproductive health services countrywide through the drastic reduction of contraceptive and STI drug stock-outs.

The performance of USAID-supported CBD programmes has been declining over the last four years as a result of USAID funding cuts. However, the level of the decline varies among the supported organisations. FPAK has experienced a high decrease of CBD productivity compared to Pathfinder grantees.

NGOs have introduced fees for service. They also mobilised CBD agents to develop income-generating activities (IGA). However, the current fee structure is not enough to cover the programme costs. Given that the MOH programmes still provide family planning free of charge for both CBD and clinic-based services, NGOs can not establish fees meeting their actual costs. The fees for service vary widely between NGOs and some times within the same organisation. There is a need for standardised fee-for-service guidelines, preferably from the Ministry of Health

The integration of STI/HIV/AIDS in FP clinics is limited. Many service providers have not been adequately prepared to provide STI services and have reservations about discussing sexual behaviour with clients. There is a need for improving FP service providers' skills and attitude toward promoting dual protection.

The facilitative supervision has not yet been institutionalised by the Ministry of Health. The use of COPE at site level and the facilitative supervision for regional supervisors are outcomes of AVSC efforts in improving quality of services in the sites supported. There is a need to continue and expand AVSC efforts in providing clinic-based services of high quality

There is a lack of coordination and collaboration between organisations providing reproductive health services at the district level. In some areas, USAID-funded NGOs are competing between themselves or with MOH/GTZ project.

Interventions to reach men and adolescents with appropriate information and services in reproductive health incorporating STI/HIV/AIDS treatment and prevention are very limited.

Community-based programmes have attracted many donors such as GTZ, DFID, EU and Sida while USAID is the only donor who supports the provision of facility-based services and has developed unique expertise in the area. The 1998 KDHS data indicates that 91.4 percent of modern contraceptive users were supplied through facility-based services. Only 3.4 percent of contraceptive users were getting supplies through CBD agents. Furthermore, the performances of the USAID-supported CBD programmes indicated a downward trend over the last four years and cover only about 10 percent of the estimated total number of CBD agents countrywide. This analysis suggests that APHIA-supported CBD

programmes generate a little added value to the national family-planning programme. We therefore recommend that APHIA focuses on improving access and quality of facility-based services and advocates for additional support for CBD programmes from other donors.

USAID has invested a lot in its CBD programmes and the majority of them are implemented in sparsely populated communities living in remote areas far from the nearest health facility. These communities still need CBD services. APHIA should ensure a smooth transition through technical assistance to the current grantees for strengthening their sustainability and developing strategies to diversify the source of funding.

7. Recommendations to USAID/APHIA

- To focus on improving access and quality of facility-based services and advocate for additional support for CBD programmes from other donors
- To provide technical assistance to CBD programmes for developing sustainability strategies and diversifying the sources of funding
- To facilitate the review of CBD programmes by the stakeholders in order to assure that programmes are implemented in appropriate areas
- To explore the possibility of promoting experience sharing between Kenya and Asia countries with advanced community-based programmes (e.g. Indonesia, Bangladesh)
- To provide assistance to the Ministry of Health for developing and implementing national reproductive health fee-for-service guidelines
- to provide assistance to NCPD for strengthening the coordination of reproductive health interventions at the district level
- To assure continued supply of commodities through the donors, and government coordination and continued sustained commitment to logistics management
- To explore the possibility of promoting the use of long-term and permanent contraceptive methods
- To reinforce the support for an effective integration of MCH/FP/STI/HIV/AIDS, especially the promotion of dual protection and postabortion care
- To start implementing the USAID/Kenya HIV/AIDS strategy
- To continue and extend the capacity-building in provision of long-term and permanent methods, postabortion care, facilitative supervision and quality improvement approaches
- To explore the possibility of expanding the use of social marketing to promote a large range of reproductive health services
- To explore the possibility of promoting reproductive health youth-friendly services

- To support research to clarify the role, merits, cost and training needs of CBD agents and their link to clinical facilities

Appendix 1:Acronyms

AIDS:	Acquired immune Deficiency Syndrome
AMREF:	African Medical Research Association
APHIA:	AIDS, Population and Health Integrated Assistance
AVSC:	Association for Voluntary and Safe Contraception
Belgian GADC:	Belgian General Administration for Development Co-operation
CBD:	Community-based Distribution
CHAK:	Christian Health Association of Kenya
COPE:	Client-Orient, Provider-Efficient
CPR:	Contraceptive Prevalence Rate
CYP:	Couple-Year Protection
DFID:	Department for International Development
DHMT:	District Health Management Team
EU:	European Union
FHI:	Family Health International
FP:	Family Planning
FPAK:	Family Planning Association of Kenya
FPLM:	Family Planning Logistics Management
FY:	Financial Year
GOK:	Government of Kenya
GTZ:	German Agency for International Development
HIV:	Human Immunodeficiency Virus
IEC:	Information, Education, and Communication
IGA:	Income Generating Activities
INTRAH:	Program for International Training in Health
IPPF:	International Planned Parenthood Federation
IUCD:	Intra-uterine Contraceptive Device
KDHS:	Kenya Demographic and Health Survey
KNH:	Kenyatta National Hospital
MCH:	Maternal and Child Health
MIS:	Management Information System
MOH:	Ministry of Health
MSK:	Marie Stopes Kenya
MVA:	Manual Vacuum Aspiration
NCKK:	National Christian Council of Kenya
NGO:	Non-Government Organisation
PAC:	Post-abortion Care
PHMT:	Provincial Health Management Team
PSI:	Population Services International
PWA:	People with AIDS
QI:	Quality Improvement
RSF:	Retail Sales Force
RTI:	Reproductive Tract Infection
Sida:	Swedish International Development Agency
STI:	Sexually Transmitted Infections

UNFPA: United Nations Population Fund
USAID: United States Agency for International Development
WHO: World Health Organisation

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Appendix 3: People interviewed in Nairobi

Population Council:

- Mr Lewis Ndhlovu
- Dr Jane Chege
-

Pathfinder International:

- Mr Charles Tube
- Ms Pamela Onduso
- Mr Gilbert Magiri
- Ms Irene Mwaponda

Family Planning Association of Kenya:

- Mr Mucheke
- Dr George Muriithi
- Mr Siniwa

Family Health International:

- Dr Welch

Family Planning Logistics Management Unit:

- Mr John Wilson
- Mr David Karite

Division of Primary Health Care:

- Dr Margaret Makumi

GTZ Project:

- Dr Sabine Berkermann

Population Services International:

- Mr John Berman
- Ms Veronica Musembi
- Ms Dorothy Hodson

AVSC:

- Mr Feddis Mumba

INTRAH/ PRIME:

- Ms Rose Wahome

Marie Stopes Kenya:

- Mr Charles Nyaberi
- Ms Martha Mutunga

Participants who attended Focus Group Discussion on Service Delivery

Name	Organisation
1. Irene Mwaponda	Pathfinder International
2. Pamela Onduso	Pathfinder International
3. Kimeli Chepsiror	NCPD
4. Ian Askew	Population Council
5. Stephen Mucheke	FPAK
6. Charles B. D. Nyaberi	Marie Stopes Kenya
7. Dorcas Amolo	MYWO
8. Scott Radloff	USAID
9. Emma Njuguna	USAID
10. Tim Takona	USAID
11. Maureen Kuyoh	FHI
12. Donald W. Dickerson	Futures/ DFID
13. Dr Margaret Makumi	MOH/DPHC
14. Malaika Imani	PSI

Appendix 4. Field discussion guide

1. What types of interventions are supported by USAID?
2. What geographical areas do you cover? Why those areas?
3. What are the target groups of your different interventions? Why those?
4. What are the major achievements of USAID supported initiatives from 1995 (improving quality of care, integrating HIV/ AIDS, accessibility and utilisation of services, impact on the beneficiaries) ? Please provide the statistics on:
 - **Annual program performances (new acceptors, referrals, CYPs) per type of interventions (CBDs vs Clinic-based services) for 1995, 1996,1997 and 1998**
 - **Annual CBD agent performances- an average productivity of a CBD agent (new acceptors, referrals, CYPs) for 1995, 1996,1997 and 1998**
 - **Annual clinic performances - an average productivity of a clinic (new acceptors, referrals, CYPs) for 1995, 1996,1997 and 1998**
 - **The average cost of a CYP in CBD programs compared to the average cost of a CYP in clinic-based services.**
5. What services are provided in the different interventions (CBDs, clinic-based services, adolescence initiatives, and male involvement initiatives)? For clinical based services could you provide description of services following the patient flow ?.
6. What initiatives/interventions were made to improve quality of services (Community-Based and Clinic based services) over the last 4 four years?
7. What support is given to Community-Based Distributors? Service providers? (Describe the supervision and training systems for the two types of programmes)
8. How the programme is monitored (Describe the service statistics system, indicators, and MIS)?
9. What make Pathfinder /FPAK/MSK/ AVSC/INTRAH/PSI service special compared to others?
10. What strategies are implemented to sustain Pathfinder /FPAK/MSK/ AVSC/INTRAH/PSI services? How effective are they? Are they compatible with the quality of services.
11. What geographical areas need more attention in reproductive health in your catchment areas? in the country? Why? How can they be served?
12. What sub- populations need more attention? Why? How can they be served?
13. How Pathfinder/ FPAK/MSK/ AVSC/INTRAH interventions are integrating STI/HIV/AIDS in the services?
14. What is the cost-effective approach between CBD and clinics? What approach should be given priority? why
15. What services do you provide to adolescents? Are your adolescent approaches effective? Can they be improved? Do adolescents' friendly clinics work?

16. What services do you provide to men? Are your men involvement approaches effective? Can they be improved? Do men only clinics work?
17. Do you think that Pathfinder/ FPAK/MSK/ AVSC/INTRAH/PSI services have benefited from USAID research activities funded? How?
18. What are the gaps /weaknesses in Family Planning/Reproductive Health services provided by Pathfinder/ FPAK/MSK/ AVSC/INTRAH/PSI? How the organisation is planning to overcome them
19. What can be done to improve FP/RH services in the country?
20. How reproductive health services/organisations are coordinated at country, provincial, and district levels
21. What new directions/ innovations the organisation is planning to undertake in near future in provision of services?
22. What are your donors for the service delivery component? How do they coordinate their efforts? What are the levels of their financial support?
23. Are there policies/ guidelines that are needed to facilitate the provision of FP/RH quality services? If yes, can you describe them?

Focus group discussion Themes

1. Role of CBD agents in the future
2. Role of private sector in reproductive health
3. Strategies for sustaining reproductive health services (both CBD and facility-based services)
4. Strategies for promoting safe motherhood
5. Integration of FP/MCH/STI/HIV/AIDS services (both CBD and facility-based services)
6. Quality of reproductive health services

ISSUES PAPER ON SOCIAL MARKETING

Prepared for the APHIA Mid-term Review

May 1999

**Mike Strong
Office of Population and Health
USAID/Kenya**

APHIA Mid-Term Review Minor Issue Paper

Social Marketing

Summary of Major Issues and Challenges

Introduction

In their Health Communications book Piotrow *et al.* (page 19) present two definitions of social marketing. The first, from Kolter (1971) defines it as “the design, implementation, and control of programs calculated to influence the acceptability of social ideas and involving considerations of product, planning, pricing, communication, distribution, and marketing research.” More recently Andreason (1995) defines it as “the application of commercial marketing technologies to the analysis, planning, and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of their society

As part of its HIV/AIDS prevention activities USAID/Kenya has used Population Services International (PSI) to socially market condoms in Kenya. USAID is currently interested in expanding the number of products socially marketed in Kenya, and in increasing local capacity and ownership of social marketing activities. As a contribution to the USAID Mid-Term Review of the APHIA project, this paper looks at past and current social marketing activities, and possibilities for the future.

Social Marketing Under APHIA in the Past

PSI is a non-profit, non-governmental organization based in the US. PSI began activities in Kenya in June 1990 with the dual objectives of slowing the spread of HIV/AIDS and reducing the population growth rate through the social marketing of condoms and oral contraceptives. During the period 1990-93 PSI provided technical assistance to a local distributor who was responsible for marketing and distribution. Sales performance was poor: condom sales in 1992 were 44,000, or .02 per capita. This was primarily due to an inefficient distribution system that failed to extend beyond traditional outlets such as pharmacies and supermarkets. (In other successful programs in the region non-traditional outlets, such as kiosks, dukas, bars, and lodgings accounted for a majority of sales.)

In 1993 the decision was made to focus social marketing exclusively on AIDS prevention. Oral contraceptives were dropped, PSI took responsibility for sales and marketing, market research was conducted to develop a new condom brand, and Trust was launched in October 1993. Sales increased dramatically, to 500,000 per month. However, 60% of these sales were made on credit, resulting in large inventory build-up. By mid-1995 over-due credit was Ksh 7 million. Sales to non-traditional outlets was still not identified as a priority, sales managers had no incentive to collect outstanding credit, and sales staff were poorly supervised and performed poorly.

Current Social Marketing Activities

Objectives

Encouraging safe sexual practices, such as the use of condoms, is the key to slowing the spread of HIV/AIDS in Kenya. To ensure consistent and correct use of condoms PSI/Kenya has the following objectives: ensure that condoms are accessible; promote condom use; and assure the sustainability of condom social marketing in Kenya. An additional objective is now to explore the social marketing of hormonal contraceptives.

Product and packaging

PSI/Kenya currently distributes Suretex condoms, which are manufactured in India and provided through DFID. They are locally packaged into a cardboard pack containing 3 condoms. The package design was introduced in 1997 after pre-testing with focus groups of people from the intended market, 15-24 year olds. Dispensers holding 24 3-packs (72 condoms) are distributed to the retail level. Dispensers and 3-packs use the same design. Cartons holding 12 dispensers (864 condoms) are distributed to the wholesale level.

Distribution and sales force

PSI has divided Kenya into 10 sales zones. The sales department consists of the National Sales Manager, an assistant, and 10 Regional Sales Managers (RSMs). They work with a network of about 60 sub-distributors and 15 wholesale pharmacies throughout the country. Orders are processed and shipped within 48 hours from Nairobi using Securicor, a courier company, relieving PSI of having to provide transport. There have been very few problems maintaining regular supplies of Trust.

Wholesale pharmacies distribute Trust condoms to retail pharmacists and chemists as they do with other products stocked by these outlets. The 60 sub-distributors work with about 120 retail sales Micro-Distributors (MDs). These MDs have a contract with PSI and with their sub-distributor. They operate on a commission/bonus system. For example, if an MD sells 20 cartons in a month he receives a Ksh 4,000 bonus in addition to the profit margin made on each dispenser sold (Ksh 7,920 income for 20 cartons). MDs buy condoms from sub-distributors and sell them to kiosks, dukas, bars, and other non-traditional outlets in their areas. RSMs are eligible for two types of incentives, group awards and individual awards. They earn between Ksh 14,000-18,000 per month; hitting the sales target can more than double monthly income.

Pricing

The pricing structure is shown in Annex 1. The consumer price of a packet of 3 condoms is Ksh 10. A retailer, who buys a dispenser of 24 packets for Ksh 185, makes a margin of Ksh 55, a 30% mark-up which is higher than most other goods a small retailer sells. Competition ranges from "free" un-branded public sector condoms (which are sometimes sold for a small amount) to commercial for-profit sector condoms which sell for Ksh 50-150 for a packet of 3.

Target market

The target market for Trust condoms are 15-24 year old males and females living in urban and peri-urban areas earning under Ksh 10,000 per month. They fall into marketer's "C1-D" socioeconomic group (middle managers through semi-skilled). They aspire to become materially established, especially through car and home ownership. They are light to heavy current condom users, and are aware and informed about the product and reasons for using it. For them price is key to the purchasing decision. The 1998 Consumer Profile found that of those who had used a condom in the last year 92% had used Trust and 60% had used public sector condoms. 95% of those interviewed recognized the Trust condom brand, and most Trust users were in the target audience.

Advertising and promotions

PSI runs an advertising campaign which targets their 15-24 year old target audience. The campaign is "hip" and encourages youth to talk about their options for avoiding HIV/AIDS. Advertisements feature attractive young couples, contemporary music, and bold layouts. Trust messages are disseminated through both electronic and print media. PSI is currently preparing the next phase of their communications campaign which will include both branded Trust commercials as well as generic TV and radio spots which address key obstacles to condom use among the 15-24 year old group.

Mass media activities are supported by Trust special events and merchandising at the "grass roots" level. The special events campaign consists of both sporting and musical activities. Sporting events include both local and national level soccer tournaments and cycle races. The events are important because many people in PSI's target audience participate in or actively follow sports.

Merchandising activities consist of the distribution of point of purchase materials and outdoor advertising. Point of purchase materials currently in circulation include: *Trust Sold Here* stickers, bumper stickers, t-shirts, caps, wallets, shelf stickers, drink coasters and posters. Outdoor advertising consist of billboards which are positioned along strategic routes, wall paintings, and metal signs fixed to kiosks and dukas.

Media Relations

The media department plays an important and innovative role in the program. The full-time media liaison person regularly meets with journalists, editors, and managers of all the major media in order to assure that HIV/AIDS messages are accurately and adequately reported. The media strategy has proven to be extremely effective at reducing the misinformation that was previously disseminated about condoms. The media department also assures that Trust special events are covered in the mass media. This has the effect of amplifying small, local events into national events seen or heard by millions of Kenyans nationwide. Finally, the media department has succeeded in securing free or highly concessional air and production time from media.

Results

- Trust sales

Average monthly paid sales have grown from 175,000 units in 1995 to 348,000 units in 1996 and 652,181 in 1997. This represents 98% and 87% growth in 1996 and 1997 respectively. In 1998, average monthly sales of Trust Condoms increased by 31% to 840,000, or 70% of the old target. PSI believes that the old target was probably over-optimistic, since it was based on the rapid growth which was made when the project was starting. Current targets have been revised to reflect a more realistic annual growth rate of 40% with respect to the 1994 base. International comparisons of social marketing programs indicate that the average annual sales growth for mature projects is approximately 15%.

- brand loyalty

Trust condoms are now known and available throughout Kenya, as shown in the 1998 KDHS and various PSI surveys. After a hiatus of 26 months, from late 1995 through early 1998, they are once again advertised on national TV and radio. According to the most recent distribution survey they are being sold in 26% of all retail outlets in urban and peri-urban areas. Among 15-25 year old condom users, 61% use Trust all or most of the time, showing youth's loyalty to the Trust brand.

- revenues

PSI's 1999 goal is to sell 13.2 million condoms. PSI sells to the sub-distributor at Ksh 135 per dispenser, or Ksh 5.625 per three pack. At 13.2 million units per year, annual revenue would be \$375,000 (at Ksh 66 per US\$1).

- KDHS

The 1998 Kenya Demographic and Health Survey asked a number of questions regarding condom use, both in the family planning and in the AIDS sections. It included a question specifically on Trust condoms. Condom use by married women is fairly low (1.3%, compared with 11.8% for injectable contraceptives). Use by men, and by sexually active unmarried men and women, is much higher. Among unmarried, sexually active people 15-19 years old 11.3% of women and 42.6% of men reported condoms as their contraceptive method. Two thirds of all men 15-54 interviewed knew the Trust condom brand, especially those 20-24 (84%) and those in urban areas (82%). Twenty-four percent of men, however, didn't know of a source of condoms and 21% had used a condom during the last sexual intercourse before the survey (42% with a partner other than their spouse).

Possibilities for the Future

Condom social marketing program

Recommendation

USAID should continue its support to the Trust social marketing activity, encouraging the social marketing organization to expand sales as quickly as possible. Competition with public sector condoms is probably not a factor limiting sales. The need for condoms among the target audience is far from met. PSI should increase the number and efficiency of its Micro-Distributors, increase the number of outlets, and increase the turnover per outlet. This will require significant demand creation activities as well as improving the distribution system.

New Products

- Oral contraceptives (OCs)

Discussion

Under its current grant from USAID PSI plans to socially market oral contraceptives through approved pharmaceutical outlets (doctors, pharmacists, and chemists). A feasibility study conducted by PSI/Kenya in October 1997 concluded that conditions were ripe for such an activity. PSI recognizes that OCs must be marketed and distributed in different ways than condoms. It plans to create a separate Hormonals Product Team, including a new detailing force to call on doctors and pharmacists, and will target advertising to this group and to their clients.

Commodities are being provided by DFID. They have purchased 1 million OCs, which will be in the PSI warehouse shortly. This amount should be sufficient through the end of 2000.

Recommendations

USAID should continue support to this activity, carefully monitoring sales, commodity support, and possibilities for the for-profit private sector to assume responsibility should the GOK decide to begin charging for public sector OCs. PSI should continue to work with the MOH as the latter develops a family planning commodity strategy. USAID and PSI should request a clear commitment from other donors or the government regarding commodity supplies for a multi-year period.

- Injectable contraceptives

Discussion

Under the hormonals grant discussed above, PSI plans to socially market injectable contraceptives through approved pharmaceutical outlets (doctors, pharmacists, and chemists). The new Hormonals Product Team will handle injectables as well as OCs.

The 1997 feasibility study concluded that conditions were also ripe for this activity. As with OCs, the study addressed the problem of competition from free public sector injectables, and reached similar conclusions: the growing trend toward using private providers for contraceptive supplies, combined with the assurance of regular supplies and quality provider training, would help offset this competition.

Commodities are being provided by DFID. They have purchased 200,000 injections (with gloves, syringes, and swabs), which will be in the PSI warehouse shortly. This amount should be sufficient well into 2001.

Recommendations

USAID should continue support to this activity, carefully monitoring sales, commodity support, and possibilities for the for-profit private sector to assume responsibility should the GOK decide to begin charging for public sector commodities. PSI should continue to work with the MOH as the latter develops a family planning commodity strategy. The MOH is concerned about the introduction of injectables (due to needle and syringe disposal problems, need for side effects counseling, and since they are a prescription drug). PSI must remain aware of these sensitivities and work closely with the MOH in introducing this product. As with OCs, USAID and PSI should request clear commitments, for a multi-year period, from other donors and government regarding commodity supplies.

- Rural brand of condom

Discussion

NASCOP has asked PSI to develop a less expensive condom brand primarily for distribution in rural areas by CBD workers. It is unclear, however, if there is a real market for another socially marketed condom; to what extent Trust is already being sold in rural areas; and what the source and quality of these condoms would be. Alan Ferguson's 1994 "Willingness to Pay for CBD Commodities" study indicated that significant numbers of people were willing to pay for condoms. The PSI distribution survey, and special tabulations of the 1998 KDHS, should help resolve questions about current condom distribution in rural areas. (For example, 20% of rural men used a condom during last sexual intercourse compared with 23% of urban men, and almost half of rural women and two-thirds of rural men had heard of Trust condoms.)

Recommendations

A second brand of condoms is not a high priority for USAID at this time. Sales of Trust need to be expanded first, and a second condom could take away from this effort. Before a second brand is launched, market research indicating a clear second market would have to be completed and a long-term source of supply identified. In the meantime efforts could be made to market Trust in what are thought to be underserved rural areas.

- Bednets

Discussion

Malaria is one of the leading causes of mortality and morbidity in Kenya, especially on the coast and in the western parts of the country. The MOH considers malaria to be a very high priority. At the 1998 Arusha Social Marketing Conference, the Kenya country team (composed of MOH, PSI, and USAID representatives and other donors) agreed to support a social marketing program to increase access to and use of insecticide treated nets. The MOH was to be the lead implementing organization, with assistance from

PSI. PSI/Kenya has experience with this product through its participation in the UK-lead malaria research activities in Coast province. The current USAID agreement with PSI does not fund insecticide-treated materials (ITMs), but contains language easily allowing funding of this activity. ITMs, however, are an expensive product, one which has a small but perhaps growing and sustainable private sector supply.

Options:

USAID, through a social marketing project, has these options:

1. Heavily subsidize nets, achieve rapid coverage and impact, but potentially damage private sector suppliers, creating future sustainability issues.
2. Sell nets at or near cost, with sales growing slowly and perhaps plateauing (with the saturation of a small, wealthier market). This may have less immediate impact, but could create a stronger private sector.

Recommendations:

USAID should quickly examine the ITM experience in other countries (e.g., Malawi), review the current net and insecticide private and public sector supply situation in Kenya, and then decide on a model.

- STI kits

Discussion

NASCOP has been interested in a project to socially market antibiotics to treat STIs, initially focusing on male urethritis. Both NASCOP and the DPHC are concerned about this project, since it seems to provide powerful antibiotics to pharmacists without a guarantee that proper prescription practices would be followed. The Kenya team at the Arusha conference noted that there are questions regarding whether there is a role for social marketing in this area. Thus there is a need to proceed cautiously and include stakeholders in all discussions. It was suggested that DFID's HAPAC project, the lead agency in this activity, broaden the group of stakeholders and carefully start needed background studies about the current situation.

Recommendations

PSI, and USAID, should let HAPAC take the lead in this activity. At the earliest, a pilot social marketing test could be undertaken in 2000, more operations and marketing research done in 2002, and a national program started (if warranted) in 2004.

- Female condoms

Discussion

Female condoms are almost certainly a small niche product. If this market can be clearly targeted then social marketing could be an appropriate way to proceed. If female condoms are heavily subsidized there is a danger to the overall program of substituting them for cheaper male condoms with no improvement in protection, as was the case in Thailand. The MOH is keen to get female condoms into the system, especially along truck routes. FHI is doing trials in plantations in the Kericho/Nandi Hills area, and soon will undertake a study of core transmitters using both male and female condoms.

Options:

1. Wait for FHI core transmitter study, perhaps by the end of 2000.
2. Try test marketing among core transmitters along truck route ("Trust for Her " in Voi, for example)

- Weaning foods

Discussion

REDSO, the LINKAGES project, UNICEF, WFP, and PSI/Washington are concerned about weaning practices that can lead to malnutrition. They have identified a fortified complementary food product and a Kenyan producer, the House of Manji. They plan a three-phase procedure: 1) conduct a literature review of consumption and food purchasing patterns; 2) qualitative research on feeding practices and commercial alternatives; and 3) project design. To initiate the process REDSO has allocated \$250,000 over two years, with more funding potentially available from LINKAGES core.

Childhood nutrition appears to be better in Kenya than in several other countries in the region. For example, the percentage of children 6-11 months old below -2SD height-for-age was 17.5 in Kenya (1998), 26.5% in Uganda (1995) and 26.6% in Tanzania (1996). Nutrition is not currently a high priority for USAID/Kenya. However, we will be interested in the outcome of the proposed study.

Options:

1. Have PSI start socially marketing weaning foods. This would be a new product area, and would be a way of testing PSI's "product team" approach, with one new product manager handling this product.
2. Have PSI/Kenya help Manji or others do it. This would be a similar undertaking without as much product distribution and other logistics and supply activities.
3. Have another organization work with Manji to socially market weaning food.

[SEE NEEN]

- Safe delivery kits

Discussion

This is another product which has been recommended for social marketing. There is first a need to investigate whether clean delivery a problem (Low tetanus and neonatal death rates suggest not). However, since most women get antenatal care they could be fairly easily reached. This would be a new market and distribution channel for social marketing. The kits would probably be locally assembled or manufactured.

Recommendation:

USAID should work with the Maternal and Neonatal Project and determine how this fits into current USAID strategies and the likelihood of co-funding. Intervention should probably not be attempted before 2001.

Commodity supply

- Condoms: the latest batch of 30 million from DFID is sufficient through about November 2000. A new order should be placed soon. If a second “rural” brand is to be launched an assured multi-year source of supply of quality condoms is essential.
- OCs: being provided by DFID. They have purchased 1 million OCs, which will be in the PSI warehouse shortly. This amount should be sufficient through the end of 2000. A further commitment is essential, probably before going to scale with sales.
- Injectables: also being provided by DFID. They have purchased 200,000 injections (with gloves, syringes, and swabs), which will be in the PSI warehouse shortly. This amount should be sufficient well into 2001. As with OCs a further commitment is needed soon.
- ITMs: availability is a major factor in deciding whether to start this activity or not.
- STI kits: not a pressing issue as taking this product to scale is several years away. World Bank funded STI drugs are a possibility.
- Female condoms: as these are expensive supplies, either for a marketing trial or for subsequent large-scale marketing, substantial donor commitments would be needed.
- Weaning foods: REDSO has funds for the start-up phase only. By working closely with the manufacturer/distributor and selling nearby there is the potential to make this a self-sustaining product.
- Safe delivery kits: procurement sources would need to be explored.

New Activities

Elsewhere in the Mid-Term Review possibilities are discussed for broadening the scope of social marketing, for example into demand creation for child survival services and commodities. As one of the few successes in the area social marketing is seen as fitting into a broader IEC strategy. In addition, new partnerships have been proposed, such as with company managers (for workplace activities) and with NGOs (for CBD outreach).

Recommendation

Social marketing is merely a tool, a set of methodologies for encouraging behavioral, purchasing, and consumption changes to improve individual and community health and wellbeing. Use of this tool has been frequently misunderstood by NGOs, the government, and others who do not understand the complexities of selling products and ideas. PSI needs to more clearly articulate how commercial marketing technologies work for this audience not used to working in a market environment.

Local Ownership

In its 1999 workplan PSI intends to complete the registration process to form a local entity, the Social Marketing Initiative of Kenya (SMIK), and to continue to transfer managerial capacity to local staff. This will be a significant step towards the goal of becoming a sustainable local social marketing organization.

If Trust condoms were the only product to be socially marketed this process would be

straightforward. An impressive PSI staff has been assembled who could take on this task fairly soon. USAID and others, however, are requesting expansions new products, new markets, new distribution channels, and innovative activities.

This may require the type of technical assistance which USAID's CAs provide, and which is relied upon by Kenyan partners and by the donor community.

Recommendation

As stated in the 1998 Assessment Report, PSI should work with USAID and DFID (and other stakeholders) to "clearly articulate its vision, objectives, and plans for building local organizational capacity... (and) to articulate the relative importance of this effort vis-à-vis developing, launching, and marketing new products." This should take place in the near future, probably before additional products or messages are added to the menu.

Annex 1 – Pricing Structure for Trust Condoms

	price per carton	price per dispenser	price per pack	price per condom	margin (%)	income per pack	income per dispenser	income per carton
Sub-distributor	1620	135	5.63	1.88	12.6	0.71	17	204
Wholesaler	1824	152	6.33	2.11	21.7	1.38	33	396
Micro-Distributor	1824	152	6.33	2.11	21.7	1.38	33	396
Retailer	2220	185	7.71	2.57	29.7	2.29	55	660
Consumer	2880	240	10.00	3.33				

USAID
APHIA MID-TERM REVIEW
TRAINING
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ACRONYMS

AIDS	-	Acquired Immuno-deficiency Syndrom
APHIA	-	AIDS, Population and Health Integrated Assistance
AVSC	-	Association for Voluntary Surgical Contraception
CBD	-	Community Based Distributor
CHW	-	Community Health Worker
CO	-	Clinical Officer
DHMT	-	District Health Management Team
DON	-	Division of Nursing
DPHC	-	Division of Primary Health Care
DPHN	-	District Public Health Nurse
DTC	-	Decentralized Training Center
FP	-	Family Planning
FPAK	-	Family Planning Association of Kenya
GOK	-	Government of Kenya
GTZ	-	German Technical Cooperation
HIV	-	Human Immuno-deficiency Virus
IEC	-	Information, Education and Communication
INTRAH	-	Program for International Training in Health
IUCD	-	Intrauterine Contraceptive Device

JHPIEGO	-	Johns Hopkins Program for International Education in Reproductive Health
JICA	-	Japanese International Cooperation Agency
KMTC	-	Kenya Medical Training College
MCH	-	Maternal & Child Health
MIS	-	Management Information System
MOH	-	Ministry of Health
MTR	-	Mid-Term Review
NASCOP	-	National AIDS and STI Control Program
NCK	-	Nursing Council of Kenya
NGO	-	Non-Governmental Organisation
OB/GYNAE	-	Obstetrics and Gynaecology
OJT	-	On-the-Job Training
PAC	-	Postabortion Care
PHMT	-	Provincial Health Management Team
PMO	-	Provincial Medical Officer
RH	-	Reproductive Health
RHTC	-	Rural Health Training Center
SIDA	-	Swedish International Development Agency
STIs	-	Sexually Transmitted Infections
TOT	-	Training of Trainers
WHO	-	World Health Organization

- UNFPA** - United Nations Population Fund
- UNICEF** - United Nations Children Fund
- USAID** - United States Agency for International Development

I. EXECUTIVE SUMMARY

Under the USAID/APHIA Project, JHPIEGO has been working since 1995 with the Ministry of Health (MOH), Division of Primary Health Care (DPHC), Nursing Council of Kenya (NCK) and the Division of Nursing (DON) to pioneer the development of an integrated clinical training system used for both pre-service and in-service family planning training. By developing a core group of trainers, tutors and preceptors and by supplying training materials to clinical facilities that can be used for both student and participant training, JHPIEGO and its partners have strengthened both in-service and pre-service training. Training has been decentralized from the national level Division of Primary Health Care (DPHC) to the decentralized training centers (DTCs) so that more effective family planning training is conducted each year.

In addition, APHIA has supported AVSC to provide training for permanent and long-term methods, on-site problem solving and quality improvement at the facility level. APHIA is currently supporting INTRAH/PRIME to train 60 private/nurse midwives to improve postabortion skills.

The APHIA mid term review (MTR) looked at the training progress in Kenya. During the MTR process, the team reviewed documents, interviewed key stakeholders including MOH/DPHC, donors and collaborating agencies, held a focus group to discuss emerging training issues, visited field sites to verify key findings and synthesized the information to develop recommendations for USAID/Kenya (see Appendices 1 B 4).

It has become clear during this process that despite the many advances made in training under APHIA, reproductive health training is in jeopardy. Gains made will not be sustained without a real commitment from the highest levels in the GOK to support the reproductive health training system both financially and politically. USAID can not support the training system on its own. It is essential that the GOK takes the lead in organizing all stakeholders to support reproductive health training. USAID should not continue to spend money on training when there is not sufficient commitment and cooperation to support it.

The foundation of service delivery consists of three components without which there are no services. These are: 1) guidelines and standards, 2) trained service providers and 3) drugs, contraceptives and supplies. It is the hope of the MTR team that the above constraints can be overcome so that this essential element of service provision can go forward. Therefore, the following issues and recommendations are dependent upon high level GOK tangible commitment and support.

There are three over-arching recommendations. They are:

- Certain training activities must remain at the central level, but for any training implementation, APHIA should adopt a geographic focus

- Dual protection should be the key reproductive health message in the RH training system
- Ways must be explored to create a practical and realistic training focus on youth

In addition to these over-arching recommendations, there were six key training issues that emerged and were examined during the MTR. The analysis of each issue resulted in a number of specific recommendations for improving the training component under APHIA. The issues and recommendations are as follows:

Issue 1: Coordination of Training Programming

There is a lack of effective communication and collaboration between all partners and stakeholders supporting training for reproductive health.

Recommendations:

- USAID/Kenya should facilitate the development, organization and coordination of a stakeholders group in support of training with a core committee to operationalize it
- Expand and better operationalize the computer database on trainers/trainees and their deployment at all levels
- Consider making the need to aggressively confront the selection and deployment process a center piece of the next APHIA work-plan
- Rethink performance measurement indicators for training results (e.g. shift measurement from quantitative to qualitative indicators)

Issue 2: Effectiveness of Training Methods and Approaches

There is a need for continued advancement in the development, promotion and use of practical and simple training techniques that are effective.

Recommendations:

- APHIA should support a content specific analysis to determine the cost effectiveness of each of the training methods and approaches currently being used

Issue 3: Critical Links Between Training and Supervision

There are inadequately trained supervisors, lack of support for supervision and weak supervisory linkages between training and the DHMT (no one on the DHMT is responsible for supervising training activities in the District).

Recommendations:

- Focus on skills training for supervisors as a priority for reproductive health
- Include a trainer on the DHMT (where possible)
- Aggressively advance supervision skills within existing curricula

Issue 4: Improvement of the coordination and implementation of policies, standards and guidelines

Even when guidelines and standards are developed, they are often not disseminated or

utilized effectively.

Recommendations:

- APHIA should support the facilitation of a stakeholders meeting to review the recently developed “National Reproductive Health Training Plan” and solicit commitment and funding for it
- APHIA should support follow-up actions through the development of a implementation schedule for the National Training Plan with all partners
- Assess the current use/status of the “National Reproductive Health Guidelines and Standards” and implement ways to better expand the operationalization of these.

Issue 5: Training in the face of HIV/AIDS

There is an overwhelming need to continue strong family planning training as we confront the training issues raised by HIV/AIDS. It is irresponsible to deliver female methods without counselling about and promoting the use of condoms. Dual protection is essential in the Kenyan environment.

Recommendations:

- Aggressively promote condoms along side female methods
- Aggressively adapt, develop and expand the use of curricula and follow-up supervision to:
 - promote values adjustment and clarifications
 - enhance individual introspection of attitudes and applications for service providers
- Facilitate formal training links between DPHC and NASCOP

Issue 6: Improvement of Incentives and Motivation

Although an incentives/promotion system has been developed within health sector reforms, it has yet to be operationalized. “Favouritism” continues to interfere in the selection process and deployment.

Recommendations:

- Explore ways to improve the standardization and certification process currently being used
- Explore ways to better implement a promotion system based on accrued training

II. INTRODUCTION

USAID/Kenya has supported Kenya's family planning program since 1972. Since the mid-1980s, USAID has been the lead donor providing Kenya with both technical and financial assistance in family planning. In 1990, USAID commissioned the DPHC to conduct an evaluation in order to document the quantity and quality of the training which had already been accomplished and to make recommendations for further activities. This evaluation identified several areas that required strengthening and revision including: inadequate facilities at the decentralized training centers, the lack of a standardized training approach, the inability of the DPHC to make long-range manpower projections, the trainers' need for updated training skills, the lack of a training-of-trainers curriculum for instructing new clinical trainers, and the lack of specialized job responsibilities among DPHC staff. Following this evaluation, USAID requested that JHPIEGO assist the DPHC to review and improve training needs and provide financial support and technical assistance.

Between 1990-1995, JHPIEGO worked closely with the DPHC to revise the in-service family planning curriculum strengthen the DPHC training body (trainers), support the decentralization of training to the DTCs and ensure that adequate numbers of service providers were trained. Some other accomplishments include: the development of a competency-based six week family planning certificate course, an introductory family planning course for nurses working at the dispensary level and a training information system that prioritizes the selection of trainees on the basis of geographical staffing needs.

When USAID funding for Kenya was severely reduced in 1995, JHPIEGO and USAID/Kenya decided that the medical program (training of doctors and medical interns) was adequately institutionalized to continue without further USAID funding and decided to shift focus to nursing in-service and pre-service training. With consultation from DPHC, Division of Nursing (DON) and the Nursing Council of Kenya (NCK), JHPIEGO shifted to a more balanced pre-service/in-service mix from a strategy focused primarily on in-service training.

III. BACKGROUND

Since APHIA was initiated in 1995, training efforts have focused on developing training capacity, institutionalizing the training and enhancing opportunities for sustainability.

A. Accomplishments Under USAID/APHIA Project (1995-1999)

1. A Decentralized Reproductive Health Training System has been Established

The focus with the DPHC Training Unit has been to help them transform from a unit that primarily conducts RH training to a body that sets clinical and programmatic standards, develops curricula, insures that trainers have standardized clinical skills and monitors the quality of clinical training.

JHPIEGO assisted the Ministry of Health (MOH) to decentralize clinical and training expertise from the DPHC to the DTCs. At each DTC, one trainer has been selected to attend a central-level course in a specific technical area. Following the course, the DTC trainers co-train this course with a DPHC or JHPIEGO trainer. DPHC trainers continue to co-train and “co-supervise” with the DTC trainers until they are proficient in both the technical content and training skills. Using this strategy, the 13 DTCs have provided courses in infection prevention, family planning counseling, contraceptive technology and clinical training skills for all staff or faculty in training either nursing students or in-service participants.

In addition, the DTCs and training sites have been given support in the form of training materials, equipment and models to facilitate training and renovations have taken place, when necessary.

Finally, JHPIEGO developed a computer-based training information monitoring system (TIMS) that helps ensure that at each site, the most appropriate person is being trained.

Summary of Participants Trained by Participant Type for Calendar Years 1995-1999

Participant Type	1995	1996	1997	1998	1999 (Qrt 1)
Service Providers	270			12	
Trainers		10	139	46	7
Preceptors	200	6	584	122	95
Tutors			135	37	17
Other			9		105
Total	470	16	867	271	224

Total Trained 1995-1999 = 1794

JHPIEGO MTR Report 3/99

2. A Wide Range of Curricula and Supporting Materials have been Developed

In 1995, JHPIEGO assisted the DPHC and the Department of Obs/Gynae, University of Nairobi, to revise the national FP/RH service delivery guidelines to incorporate World Health Organization (WHO) standards. The new National Service Delivery Guidelines and Standards were developed by DPHC with JHPIEGO= and DFID= technical and financial support. They were published in mid-1997 and disseminated at national meetings in 1997 and 1998. To-date, the “Guidelines” updates have been conducted during on-going meetings for key administrators, educators and service providers, but have yet to be distributed to all service delivery points.

In 1999, JHPIEGO, the Department of Obs/Gynae, DPHC and UNFPA, using the “Kenya Reproductive Health Sector Assessment” (RHSA) as well as the “Evaluation of the Maternal, Child Health, and Family Planning In-Service Training Program”, developed a country training strategy for Kenya. The overall goal of the RH Training Strategy is to ensure health personnel are in adequate numbers at all appropriate levels and have the knowledge, technical skills and positive attitudes to handle reproductive health issues within a comprehensive and integrated system of reproductive health care, offered by the public, NGOs and private sectors.

In addition to the National Guidelines and Standards and the National Reproductive Health Training Strategy, APHIA has supported the development, testing and dissemination of a wide range of quality training materials which include: resource manuals, training packages and modules, classroom instruction and clinical instruction guidelines for both in-service and pre-service training, student clinical placement guides and on-the-job training (OJT) guidelines.

3. Innovative and Effective Training Approaches and Methodologies have been Developed

In 1996, a “Pre-Service Nursing Training Needs Assessment” revealed the need for moving away from the largely theoretical training methods to skill oriented, more practical approaches. The following are examples of innovative training approaches that have recently been developed:

- **On-the Job Training (OJT)** for infection prevention, family planning counseling and IUCD insertion. This approach helps insure that trainees in IUCD insertion have ample opportunity to practice clinical skills under supervision
- **Interactive Training Techniques** including roles plays, case studies and coaching exercises to name but a few
- **Demonstrations** including practicums and use of anatomical models
- **On-Site Training** including COPE, In-Reach and facilitative supervision training. This approach allows the clinic/facility to identify their problems/constraints and develop an appropriate plan of action based upon their situation.

4. A Preceptorship System for Supervising Trainees has been Institutionalized

JHPIEGO worked with the DPHC and the clinical sites to establish “clinical preceptors”. Preceptors are designated service providers whose duties include clinical training and supervision of their peers. The result is that clinical supervision is strengthened and standardized through the preceptorship program. Since the preceptors conduct regular RH/FP training updates to service providers at the facility level, the preceptorship program enables many more services providers to gain necessary clinical skills. Currently, DPHC and JHPIEGO are assisting NCK and DON to establish a formal system of “preceptorship” that will help ensure that clinical trainers, once trained, will not be deployed to other health services where they will not be able to use their clinical training skills.

B. Other Donor Contributions to Training

The MTR team was able to meet with a number of donor agencies to discuss reproductive health training activities. Following is a recap of other donor contributions to training in Kenya.

GTZ

GTZ is working with the Ministry of Health in 4 Provinces and 20 districts (mostly Western). GTZ focuses on capacity building training with the District Health Management Teams (DHMT). This approach incorporates training in service management, reproductive health and facility improvement.

GTZ also facilitates the training of community-based distributors (CBDs) who are recruited and selected by the village. The CBDs are supervised and trained by District Public Health Nurse (DPHN). The training covers family planning, community mobilization, report writing and record-keeping, data collection, referral system and counseling for family planning and STIs/HIV/AIDS.

JICA

In addition to rehabilitating the Coast Provincial General Hospital to facilitate better health services provision, JICA supported renovations and facility improvements at selected Kenya Medical Training Colleges. These renovations have facilitated the expansion of training processes in the College and several of its constituent Colleges where pre-service and in-service of all service providers at certificate and diploma levels takes place.

UNFPA

UNFPA's five year development plan (1997-2001) is a \$20 million plan with 3 major components (reproductive health, population development strategies and advocacy). Under reproductive health, UNFPA is working to strengthen the MOH's capacity to deliver services and draw strategies for RH design and implementation. UNFPA was the lead donor for the development of the National Reproductive Health Strategy. UNFPA is currently in the process of implementing the next stage of their development plan which will establish and support the integration of reproductive health service in eight Districts. Prior to this initiative, UNFPA will fund Pop/Council to perform a major baseline survey to inventory existing health care services. This survey will provide direction and guidance for the training piece of the intervention. Realizing that they will not be able to cover all the gaps identified in the survey, UNFPA is hoping that other donors will contribute to this project.

Following is a chart from the newly developed National Reproductive Health Training Strategy that indicates donor-supported programs.

	Donor Agency	RH Area of Interest	Location of Projects	Period and Cost
	SIDA	Safe Motherhood: PAC Adolescent Health	Siaya, Machakos all Districts Machakos and Kajiado	1997-98 KShs.78m
	SIDA/PATH	Gender (FGM)	Kajiado	?
	AVSC/USAID	FP & related issues PAC Facility Improvement COPE, Facilitative Supervision	50 hospitals Busia, Gatundu Homa Bay	1997-99 US\$336,900
	WHO	Safe Motherhood Adol Health Gender (FGM)	6 Provinces	?
	JHPIEGO/USAID	RH training (FP OJT In-service & Pre-service	13 DTCs 6 sites	1996-99 US\$2m
	UNFPA	RH Training Plan Planning, SMU Management, RH	All districts	1998-2001 US\$1,701,105
	GTZ	FP Training CBD Training	Eastern, Western, Nyanza	US\$1.1m
	DFID	Safe Motherhood		
	World Bank	STIs/HIV/AIDS	Through NASCOP	
	BADC	RH STIs/HIV/AIDS	Makueni Kajiado, Kisumu, Gilgil	1998-2002 Belg.Fr.80m
	UNICEF	Safe Motherhood, Child Survival		1998-2003 US\$8.03m
	KFHP/EC/DFID	FP		1997-2002 27.5m ECUs
	UNAIDS	STIs/HIV/AIDS	Through NASCOP	
	DANIDA	STIs/HIV/AIDS	CHAK, AMREF	
	CIDA	STIs/HIV/AIDS	KMTC	
	JICA	MIS Strengthening MTC	Through NCPD	
	USAID	AIDSF		

from MOH "National Reproductive Health Training Plan 1999-2003"

IV. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

A. Over-arching Issues

It has become clear during this process that despite the many advances made in training under APHIA, reproductive health training is in jeopardy. Gains made will not be sustained without a real commitment from the highest levels in the GOK to support the reproductive health training system both financially and politically. USAID can not support the training system on its own. It is essential that the GOK takes the lead in organizing all stakeholders to support reproductive health training. USAID should not continue to spend money on training when there is not sufficient commitment and cooperation to support it.

Secondly, the MTR training team realizes that the current training supported by APHIA can not adequately reach and meet the needs of the whole country. It recognizes that some of the activities must remain at the central level, but for any training implementation, APHIA should adopt a geographic focus. At central level, the team believes that the continuation of the development and refinements of standards, guidelines, protocols, teaching materials and curricula is necessary. In addition, policy development and influence supported by APHIA should also remain at the central level. All implementation of OJT, training updates, interactive training, on-site/whole-site training, preceptor training and training of trainers/tutors should be implemented in targeted geographic areas. The MTR training team strongly recommends that reproductive health training be implemented in the same geographic areas as USAID's AIDS community-based strategy.

Thirdly, there are many missed opportunities within the training system to promote dual protection against unwanted pregnancy and STIs/HIV. The team strongly recommends that as part of all reproductive health training, condom promotion needs to have a very high profile.

Lastly, there are many missed opportunities in providing reproductive health to youth. Therefore, the team recommends a careful analysis be conducted to make training "youth friendly" and to make youth a major focus of reproductive health training.

B. Emerging Major Issues

There were six key training issues that emerged and were examined during the MTR. The analysis of each issue resulted in a number of specific recommendations for improving the training component under APHIA.

Issue 1: Coordination of Training Programming

There is a lack of effective communication and collaboration between all partners and stakeholders supporting training for reproductive health.

Key Questions:

How can we improve donor/project/MOH discussion and coordination on training programs?

What are the weakest links between training and the results of training?

What are some practical support solutions?

Recommendations:

USAID/Kenya should facilitate the development, organization and coordination of a stakeholders group in support of training with a core committee to operationalize it
Expand and better operationalize the computer database on trainers/trainees and their deployment at all levels

Consider making the need to aggressively confront the selection and deployment process a conditionality of the next agreement mechanism

Rethink performance measurement indicators for training results (eg shift measurement from quantitative to qualitative indicators)

Issue 2: Effectiveness of Training Methods and Approaches

There is a need for continued advancement in the development, promotion and use of practical and simple training techniques that are effective.

Key Questions:

Under what circumstances is traditional in-service (classroom/practicum) training appropriate?

Under what circumstances is OJT more advantageous?

How can we better promote OJT?

Recommendations:

APHIA should support a content specific analysis to determine the cost effectiveness of each of the training methods and approaches currently being used

Issue 3: Critical Links Between Training and Supervision

There is inadequately trained supervisors, lack of support for supervision and weak supervisory linkages between training and the DHMT.

Key Questions:

How can we best support linkages between supervision and training?
What are these links?

Recommendations:

Focus on skills training for supervisors as a priority for reproductive health
Include a trainer on the DHMT (where possible)
Aggressively advance supervision skills within existing curricula

Issue 4: Improvement of the coordination and implementation of policies, standards and guidelines

Even when guidelines and standards are developed, they are often not disseminated or utilized effectively.

Key Questions:

What is the status of the National Reproductive Health Training Plan?
What is needed to formalize this plan?
What are the specific steps that should be taken to formalize the plan?
What is the status in terms of the dissemination and utilization of the National Reproductive Health Standards and Guidelines?

Recommendations:

APHIA should support the facilitation of a stakeholders meeting to review the recently developed National Training Plan and solicit commitment and funding for it
APHIA should support follow-up actions through the development of a implementation schedule for the National Training Plan with all partners
Assess the current use/status of the “National Reproductive Health Guidelines and Standards” and implement ways to better expand the operationalization of these.

Issue 5: Training in the face of HIV/AIDS

There is an overwhelming need to continue strong family planning training as we confront the training issues raised by HIV/AIDS. It is irresponsible to deliver female methods without counselling about and promoting the use of condoms. Dual protection is essential in the Kenyan environment.

Key Questions:

What more should we be doing in addition to what we are already doing to improve training and training results for the mitigation of HIV/AIDS?

Recommendations:

Aggressively promote condoms alongside female methods

Aggressively adapt, develop and expand the use of curricula and follow-up supervision to:

- a) promote values adjustment and clarifications
- b) enhance individual introspection of attitudes and applications for service providers

Facilitate formal training links between DPHC and NASCOP

Issue 6: Improvement of Incentives and Motivation

Although an incentives/promotion system has been developed within health sector reforms, it has yet to be operationalized. "Favouritism" continues to interfere in the selection process and deployment.

Key Questions:

How much of an incentive is training now?

What can be done to minimize favouritism?

What can be done to improve motivation after training?

Recommendations:

Explore ways to improve the standardization and certification process currently being used

Explore ways to better implement a promotion system based on accrued training

C. Significant Changes in Relevant Expectations since the APHIA Design

Based on the team's review of the APHIA project paper (PP) "results and sustainability status by the year 2000", it was noted that there have been only a few deviations from the expected training results. Due to financial constraints, the MOH has not achieved the rehabilitation of the network of seven rural health training centers (RHTC) to convert them into permanent residential facilities for integrated reproductive health training and replace the 13 decentralized training centers currently operated by the DPHC, nor have cost recovery plans for financial self-sufficiency been developed.

The other four expected results have been achieved and JHPIEGO and its training partners have exceeded the project paper's expectations particularly in curricula, methodology and materials development. These are:

- Pre-service teaching institutions will have added integrated reproductive health training to their teaching curricula
- The Division of Nursing (DON), DPHC and the University of Nairobi Department of Obs/Gynae will be coordinating activities related to in-service training of doctors, nurses and clinical officers in integrated family planning/reproductive health

- The MOH will have developed a national integrated in-service training manpower information and planning system administered at provincial and district levels in consultation with the Division of Nursing
- The DPHC and DON will have jointly established a formal structure and regular activities for district and sub-district level supervision of integrated family planning/reproductive health activities

D. Cross Cutting Issues

The relevant cross cutting issues have been addressed throughout this report. Specifically within the issues and recommendations section. However, gender has not been explicitly integrated into the discussion.

Gender

The reproductive health training materials do address important gender issues such as the reduction of medical barriers for men and youth, female genital mutilation and early marriage. However, there is a need to strengthen (wherever possible) the training system to better and more effectively combat gender bias. There is a long way to go in influencing service providers to change their own attitudinal barriers.

V. APPENDICES

Appendix 1: Nairobi Contacts/Interviews - Training

1. Ministry of Health/Division of Primary Health Care
Jane Gitonga - Senior Trainer
Melissa Mulimba - Trainer
2. Division of Nursing
Margaret Ngure - Chief Nursing Officer
Esther Kwinga - Reproductive Health Coordinator
3. Nursing Council of Kenya
Janet Mwamuye - Registrar
4. JHPIEGO
Pamela Lynam - Country Representative
Nancy Toroitich - Program Manager
Dorothy Andere - Training Coordinator
Tamara Smith
5. AVSC
Theodora Bwire - Program Officer
6. INTRAH/PRIME
Pauline Muhuhu - Regional Coordinator
Rose Wahome - Project Coordinator
Florence Githiori - Project Coordinator
Collette Aloo-Obunga (IPAS) - Training Coordinator
7. Family Planning Association of Kenya (FPAK)
Rosanna Simwa - Assistant Program Officer
George Muriithi - Program Officer
8. Population Services International
Veronica Musembi - National Sales Manager
Dorothy Hodson
Judy Kunyiha-Karogo - Female Hormonal Project Coordinator
9. UNFPA
Sheila Embounou - Reproductive Health Program Officer
Charlotte Larsen - Junior Program Officer
10. GTZ (interviewed by Helena Kithinji)

Appendix 2: Focus Group List - Training

Facilitators: Sarah Kaviti, Melinda Wilson and Liz Kizzier

1. Dr. Job Obwaka - AVSC
2. Anne K. Njeru - MOH/SIDA
3. Peris Muriuki - MOH/UNFPA
4. John Baptist Muchiri - Clinical Officers Association
5. Tamara Smith - ex JHPIEGO
6. Jane Gitonga - MOH/DPHC
7. Pamela Lynam - JHPIEGO
8. Nancy E. Williamson - FRONTIERS Project (Pop Council/FHI)
9. Pauline Muhuhu - INTRAH/PRIME
10. Joyce Musandu - University of Nairobi/Department of Nursing
11. Robert Osiemo - Clinical Officers Council
12. Barbara Dickerson - MTR Team Leader
13. Dana Vogel - USAID/Kenya

Appendix 3: MTR Questionnaire to Assess Training Programs in Kenya

Instructions: Please complete questionnaire - THIS IS ONLY A GUIDE

Name of Person Being Interviewed _____

Institution _____ Province/Town _____

Name of Interviewer _____ Team _____

Date of Interview _____

I. Background information

- What are your responsibilities in this institution?
- How long have you been in this institution?
- What are your qualifications?
- What training have you received for your current position?
- When were you trained?
- Where were you trained?
- When was your last update?

II. Coordination for Infrastructure

- a) What do you feel are the weakest links in the training system?
- b) What are some practical support solutions?
- c) What are some ways that we could improve coordination?

III. Effectiveness of Training Methods and Approaches

- a) What type of training do you feel is the most effective and why?
- b) When is the in-service/classroom approach more advantageous? OJT?

III. Critical Links between Training and Supervision

- a) Are you a supervisor? What was your last supervisory visit?
- b) Where did you go? When? How did you get there?
- c) When did your supervisor last visit?
- d) What did you discuss with your supervisor during the last visit?
- e) Do you use a record book for supervision visits? If yes, can I look at it?

V. Improvement of the Coordination and Implementation of Policies, Standards and Guidelines

- a) How do you measure the standards being practiced?
- b) Do you have a standardised training curriculum? YES NO
- c) Which curriculum do you use?
- d) When was the last time that it was revised?
- e) Are you familiar with the *“Reproductive Health/Family Planning Policy Guidelines and Standards for Service Providers”*?
- f) Do you have a copy? Can you show it to me?

VI. Training in the face of HIV/AIDS

- a) What is the HIV/AIDS situation in your area?
- b) What services are currently available for HIV/AIDS clients?
- c) Do you distribute condoms? Where are they?
- d) What are the attitudes of the community about sex, AIDS and condoms?
- e) How does the service provider handle these attitudes?

VII. Improvements of Incentives and Motivation

- a) Why did you decide to become a nurse/health care service provider?
- b) How are nurses selected for training? What is the criteria?
- c) What can you suggest to improve the selection process?
- d) What are the incentives for a nurse to receive additional training?
- e) What can be done to improve motivation after training?

VIII. Additional Comments

Appendix 4: Field Visit Contacts - Training

I. KAKAMEGA/BUSIA

1. MOH/Busia
2. DHMT/Busia
3. DHMT/Bungoma
Terrie Wafwafwa - Nutrition Advisor
Hasea Orone - Clinical Officer
4. Matayos Health Center (Busia)
Rukia Kaseke, ECHN
Christine Ojiambo
Jacob Asangai
5. AMREF (Bungoma)
Hezron Ngugui

II. NYERI/MURANG'A

1. Provincial Health Management Team (PHMT) - Nyeri
Dr. Eliud Mwangi - Provincial Medical Officer
Dr. Eliud Ritho - Deputy PMO/Provincial Pediatrician
Joshua King'ori - Provincial Public Health Officer
VM Karioki - Provincial Personnel Officer
Ruth Macharia - Provincial Nursing Officer
Karuga Karioki - Provincial Health Education Officer
Charles Chiuri - Provincial Health Information System
Cyrus Kagathi - Provincial Hospital Secretary
2. Provincial General Hospital - Nyeri (focus group)
Anne Nzimbi - Nurse/Administrator
Dr. Githiru - Medical Superintendent/ Regional RH Supervisor
Rose Gichuki - FP Coordinator/Trainer
Gladys Muthengi - FP Trainer (OJT)
Martha Muriithi - District Supervisor
Jedidah Ndegwa - Nurse/AVSC Coordinator
Lucy Mwogo - In-charge Maternity Unit/FP Trainer (OJT)
Naomi Kituku - Nursing Officer
Penina Ndegwa - Nurse Tutor
Ruth Macharia - Provincial Nursing Officer

Humphrey Kariuki - In-charge Psychiatric Unit/Continuing Education Coordinator

3. Karatina District Hospital
 - Teresa Mugambi - OJT Trainer
 - Mary Muriithi - Public Health Nurse/In-charge MCH
 - Lucy Gichuki - Deputy District Public Health Nurse
4. Othaya Sub-District Hospital
 - Rose Miriti - FP Nurse
5. Murang'a District Hospital - DHMT
 - Dr. Peter Ndegwa - MOH
 - Mary Wanjora - OJT Trainer
 - Mary Njoroge - DTC Coordinator
 - Tabitha Gathitu - DPHN
 - Margaret Macharia - Nursing Officer In-charge
 - John Wachira - Hospital Accounts Officer
 - Mary Chege - DTC trainer
 - Elizabeth Gitau - Principal Nurse Tutor
6. Marie Stopes - Murang'a
 - Mr. Saidi - Clinic Coordinator

III. MOMBASA/TIWI/KWALE

1. Provincial Medical Office
 - Dr. Andogasi - Deputy PMO
2. Coast Provincial General Hospital
 - Dr. Getambo - Chief Administrator
3. Mkomani Clinic
 - Mrs. Anjarwallah - Director
 - Shakeel Rahemtula - Project Manager
 - Stella Kilalo - Community Nurse
4. Family Planning Association of Kenya (FPAK)
 - Margaret Beja - Sub-Regional Manager
 - Mr. Kimeu - Clinic In-charge
 - Juma Mwatsefu - Youth Clinic Coordinator
5. Rural Health Training Center (RHTC) - Tiwi
 - Kissingu Mutinda - Clinical Officer
 - Halima Mwangutsi - Deputy Matron

6. Aga Khan Health Services
 - Salim Sohani - Director
 - Henry Nyamu - Project Coordinator

7. DTC/MTC/Preceptor Focus Group at CPGH
 - Flora Ali - DTC Coordinator
 - Jasper Mbungu - MTC Tutor
 - Naomi Ndaa - MTC Tutor
 - Lily Oyangi - Nurse Trainer/Preceptor
 - Jephris Omuka - PAC/Preceptor
 - Susan Mbunda - Nurse MCH/FP/Preceptor
 - Susan Ngwai - Maternity/Preceptor

IV. KISUMU/SIAYA

** See IEC Report for Field Contacts

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