

**End of Project Report**

# **Urban Reproductive Health Initiative II 1999 - 2000**

**Pamela Onyango, Ezri Teri & Rosemary Kamunya**



**Pathfinder  
International**

**PATHFINDER INTERNATIONAL  
AFRICA REGIONAL OFFICE**

# **Urban Reproductive Health Initiative II**

**1999 - 2000**

## **End of Project Report**

**Preventing unintended pregnancy  
and STI/HIV/AIDS in urban slums  
in Kenya and Tanzania**

**Pamela Onyango, LLB, LLM  
Ezra Teri, MBChB, MPH, MPHEd  
Rosemary Kamunya, RN, RM**

**October 2000**

**Urban Reproductive Health Initiative II, 1999-2000:  
End of Project Report**

By: *Pamela Onyango*, independent consultant  
*Dr. Ezra Teri*, Associate Director/Head of Service Delivery, Pathfinder International,  
Africa Regional Office  
*Rosemary Kamunya*, Clinical Services Associate, Pathfinder International, Africa Regional Office,  
Nairobi, Kenya

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**Pathfinder International**

Pathfinder International is a U.S.-based private voluntary organization that provides technical and financial support to reproductive health projects in 22 countries in Africa, Asia, and Latin America. Pathfinder International's mission is to improve access to the fullest possible range of quality information and services to enable individuals and couples to make reproductive health choices. For over 40 years Pathfinder has evolved as a technical organization to keep pace with the most recent developments in the field, responding to a changing environment for population and development work and providing technical leadership to meet emerging reproductive health needs in developing countries. Pathfinder focuses on three core areas: improving access to services, improving service quality, and strengthening institutional capacity.

Currently, Pathfinder International is working in ten countries in sub-Saharan Africa: Botswana, Ethiopia, Kenya, Ghana, Mozambique, Nigeria, South Africa, Tanzania, Uganda, and Zambia. In direct response to the urgent needs of the region, Pathfinder runs five cross-cutting regional initiatives: adolescent reproductive health, emergency contraception, urban quality improvement, post-abortion care, and the integration of STD and HIV/AIDS prevention and care services into family planning programs. Across the continent Pathfinder has been an innovator in multi-sector reproductive health, HIV/AIDS, community mobilization, and development programs targeted to women, disadvantaged families, and youth.

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## LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
CBD	Community-based distribution/distributor
CBO	Community-based organization
CHW	Community health worker
CSW	Commercial sex worker
CTU	Contraceptive technology update
FP	Family planning
FPAK	Family Planning Association of Kenya
HIV	Human immune-deficiency virus
IEC	Information, education, communication
IR	Intermediate result
IUCD	Intra-uterine contraceptive device
MCH	Maternal-child health
MCHA	Maternal-child health assistants
MOH	Ministry of Health
NASCOP	National AIDS Coordination Program
NCC	Nairobi City Council
NGO	Non-government organization
OJT	On-the-job training
PI	Pathfinder International
PLWHA	Person living with HIV/AIDS
RH	Reproductive health
SDP	Service delivery point
STI	Sexually transmitted infections
TBA	Traditional birth attendant
TOT	Training of trainers
URHI	Urban Reproductive Health Initiative
VCT	Voluntary counseling and testing
VSC	Voluntary surgical contraception

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Pamela Onyango  
Ezra Teri  
Rosemary Kamunya

October 2000

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## PREFACE

**A**frica has the highest rate of urban growth of any region in the world. More than one in three Africans lives in an urban setting today, compared with only one in seven in 1950. The United Nations estimates that by 2020, more than half the population of sub-Saharan Africa will live in cities. Both high natural population increase and extensive rural-to-urban migration of Africans seeking greater opportunities and more accessible services drive this rapid urbanization.

Most urban areas will require an enormous expansion of services in all sectors if cities are to be workable living places. Large populations in both capital and secondary cities severely constrain the ability of national and urban governments to plan for and satisfy current and future demand for reproductive health and other services. The advantages of urban living—longer life expectations, lower absolute poverty rates, greater access to education and health care services—are in jeopardy. Indeed, the presumption that urban family planning services have advantages over rural services when it comes to quality of care has proven to be untrue. Nevertheless, donor and technical assistance agencies have tended to focus their attention primarily on rural areas, and until recently few resources were aimed at assisting urban health services.

Municipal and local governments are often overlooked as potential partners in efforts to expand access and improve quality of care in reproductive health services in Africa. These public institutions have become more important during the past decade, as the movement to decentralization leads them to take on greater responsibilities for planning, financing, and delivering health services.

It is against this backdrop that the Urban Reproductive Health Initiative began with a study conducted in 1991/92 and implemented by the SEATS project with support from the Africa Bureau of the U.S. Agency for International Development (USAID). The objective of the study was to determine unmet needs in reproductive health services including HIV/AIDS among the urban populations. Pathfinder International, an international non-government organization with over 40 years experience in quality reproductive health services, was invited to join the initiative in 1996. Starting in Kenya, with nine Nairobi City Council clinics, Pathfinder supported quality services and information with emphasis on promotion of condom use for dual protection. Following an evaluation of this first phase and lessons learned the initiative was expanded to additional local authorities in Kenya (Mombasa) and Tanzania (Arusha) and included local non-government and community-based organizations (NGOs/CBOs) as a bridge. To maximize impact, the approach also shifted to community oriented demand generation while keeping the static clinics as referral points,

The lessons learned from the second phase of the Urban Initiative should be applicable to increasing the ability of city and municipality leaders in their sustainability efforts to meet the growing demand for accessible, high quality reproductive health services in urban Africa.

# EXECUTIVE SUMMARY

The dual dilemma of substantial unmet need for modern family planning coupled with spiraling rates of STI and HIV transmission is facing both Kenya and Tanzania, like many other sub-Saharan African countries. Kenya, considered an African family planning (FP) success story because of the ever increasing use of modern FP methods, has a rate of only 34% for modern method use, meaning that 65% of women are using traditional or no means to space their children and protect their reproductive health. On the issue of STI/HIV/AIDS, Kenya has an estimated 1.4 million persons infected with HIV, of whom 230,000 are living with full-blown AIDS. The situation in Tanzania is similar, where it is estimated that approximately 2.4 million people are HIV positive, almost 8% of the total population. In the majority of big cities in both Kenya and Tanzania, as is the case in other African cities, population growth has far outpaced municipal services and up to 40% of all urban dwellers live in squatter settlements and slums. The urban poor normally have inadequate information about health services, including diagnosis and treatment of STIs.

Through URHI-II, Pathfinder International, with funding from USAID/Africa Bureau, sought to forge partnerships with local implementing agencies and selected slum communities, to provide reinforced and expanded high quality clinic and community based reproductive health services to underprivileged persons with special needs and to promote condom use for dual protection. The project focused on four sites: the Kabiro-Kawangware and Kangemi slum areas in Nairobi (Kenya); Mtongwe in Mombasa (Kenya); and Unga Ltd and Sombetini in Arusha (Tanzania). The main populations targeted were in- and out-of-school youth including matatu touts and loaders; women with multiple partners including commercial sex workers (CSWs), market women, vendors and barmaids; and men with multiple partners including businessmen, *matatu* (mini bus taxi) drivers and conductors (touts), long distance truck drivers (truckers), artisans, and mechanics.

The URHI-II project supported eight clinics (mainly municipal and private clinics) and one pharmacy as a link with the slum communities living around these facilities. The project supported improved service delivery at the referral sites with emphasis on condom use for dual protection aimed at increasing the number of family planning clients using condoms with other FP methods. This approach recognizes the fact that other FP methods do not provide protection against STI/HIV/AIDS. Information, education, and communication (IEC) was conducted to encourage positive behavior change through public community sensitization, media campaigns, and materials development/adaptation. In order to enhance skills and capacities of service providers involved in this project, training was conducted for different categories of service providers.

The initial project implementation period was one year but much of the actual implementation took place in just six months due to the long period of time spent on baseline surveys. This did not allow time for a formal evaluation of project accomplishments and results. The impact of URHI-II in empowering local agencies and communities to continue project activities can only be measured in the coming years if the project is extended, with support of another cooperating agency, or if tagged on to projects with similar objectives or those undertaking other community health or non health activities.

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## Pre-Project Assessments

### *Community Diagnosis*

In order to permit an informed intervention that generated demand for services, a participatory community diagnosis was conducted at the beginning of the project. Data from this survey indicated that formal community structures existed in the form of groups. In most cases these groups had leaders and objectives for their formation that ranged from development and self-help to education of women in community development. The study also showed that community leaders were able to identify health problems afflicting various segments of the populations. These problems included alcoholism, drug addiction, early and premarital pregnancies, abortions, infertility, sexual abuse, promiscuity, STI/HIV/AIDS, non-condom use during casual sex, and ignorance of presence/location of FP/RH services. A high percentage (85%) of communities involved in the study had participated in health related work with organizations working in the area of STI/HIV/AIDS, through community health workers (CHWs), community-based distributors, (CBDs), and outreach activities. However, the actual relationships with these organizations were minimal, with most groups participating only at the implementation level and an almost non-existent participation at the planning and advocacy levels.

The attitudes of community leaders/groups and their receptivity to the proposed activities were also a focus of this study. There was overwhelming support by community leaders for condom use for dual protection, with high percentages ranging from 73% to 93% from all the four sites. As for participation in condom distribution, the study showed that the majority of community groups were willing to act as advocates for condom use. The proportion of groups willing to promote condom use was highest among adult women target groups (80%) and lowest for *matatu* touts (68%). The relatively low percentage of touts approving condom use was not easy to explain. It did, however, demonstrate a gap in IEC. The *matatu* touts perhaps did not perceive themselves at risk. Community leaders also gave their views on the most effective ways to present information about condom use for dual protection. For example, for FP, they suggested sensitization seminars, radio spots/programs, public film shows, pamphlets/posters/brochures, public video shows, public talks by health workers, books/magazines, counseling, and door-to-door campaigns. As for STI/HIV/AIDS prevention, they suggested drama, public video shows, posters/leaflets, community education, mobile film shows, outreach programs, and home visits by health workers.

The community diagnosis also identified possible non-traditional outlets for condom distribution through a cross-sectional survey of 143 business establishments. These included bars, nightclubs, beauty salons/barber shops, and video showrooms. These establishments were found to be usually busy and attracted more youth and adult women and therefore could be integrated into the project as potential condom outlets.

As over 50% of the populations at the four sites were youth, it was important for the URHI-II project to cater for their needs. These needs were identified during the community diagnosis survey through focus group discussions that called for accurate information provision about ways of transmission and appropriate means of protection against infection from STI/HIV/AIDS, use of appropriate information channels such as video shows on HIV/AIDS; demonstration of correct ways to use condoms and making condoms more accessible in social places such as youth clubs, bars, etc.; making existing health services more accessible to youth by having special clinic days offering a range of services to youth; and community education and talks by persons living with HIV/AIDS (PLWHAs).

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### ***Facility Needs Assessments***

This exercise was conducted concurrently with the community diagnosis survey. The purpose of the facility needs assessments was to collect baseline information that would be used to prepare plans for improving/upgrading referral clinics. The assessment focused on availability and quality of services, staff strengths and their willingness to participate in the project, and availability of commodities and equipment. The assessment was conducted in two clinics at each project site. There were similarities in the findings of the assessment at all the clinics:

- The location of some of the clinics was not clearly indicated. The clinics were in bad physical condition and the services offered were not listed. Some of the clinics also did not provide privacy for their clients.
- Although most of the clinic staff had been trained in comprehensive FP/RH and STI management, they had not had updates in the last three years.
- Almost all the clinics had a low average daily client load, including the clinics that had CBD agents attached to them. Even where the client load was slightly higher, return ratio visits remained low.
- In all the clinics, essential equipment was inadequate and non-contraceptive clinical supplies and IEC materials were lacking

The following recommendations were made to address these shortcomings in order to enhance the quality of care in FP/RH service delivery:

- The clinics were to introduce sign posts as well logos and post a list of services offered to make the clinic locations and services known to the catchment area populations. In addition, some of the clinics were to be renovated and partitioned for privacy.
- Staff were to be provided with updates in infection prevention, targeted IEC, and counseling in both FP and STI/HIV/AIDS. Furthermore, staff capabilities were to be strengthened, especially in the area of STI syndromic management.
- A system of follow-up of clients by CBD was to be set up or enhanced to improve the daily average client load, and to improve the ratio of revisits and retention rates.
- The project was to provide minimum equipment such as filing cabinets, display boards for IEC materials, benches or chairs for waiting clients, and essential non-contraceptive supplies.

### **Project Accomplishments**

#### ***Service Delivery***

Pathfinder and coordinators of the selected health facilities conducted a dissemination of the findings of the two studies at the four sites. The purpose of the dissemination was to share and validate preliminary results and also to enhance the target populations' awareness to their problems. Prior to the onset of other service delivery activities, PI and staff from the health facilities also held collaborative meetings with community leaders, including the respective municipal council leaders, to ensure acceptance and support of the project. In addition, a one-day orientation was organized for 60 community leaders. Further orientation seminars were also conducted for clinic service providers and other SDP staff to reinforce support for the project and to enable them to establish effective referral systems. Thus a total of 191 service providers from the four sites were oriented.

Condom distribution, the main service delivery component, was conducted by CBD agents and peer motivators and through referral sites and dispensers. CBD agents and peer motivators were

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provided with bags for carrying condoms, and condom dispensers were placed in strategic places such as bars, shops, and hair salons/barber shops. A total of 300 dispensers were installed. This three-pronged approach resulted in the distribution of 3,558,378 condom pieces during a period of 12 months. This was a tremendous increase over the numbers distributed during the first phase of the project (200,000 for a period of one year).

Tremendous strides were also made with the youth component. In the three project sites, URHI-II worked with youth groups to target youth. These youth groups sensitized their peers at social gatherings and youth centers on FP/RH issues with emphasis on “condom use for dual protection.” The groups also liaised with CBD agents or youth counselors for clinic referrals for those wishing to obtain other contraceptive methods as well as those seeking treatment for STIs. They also distributed non-prescription contraceptives to their peers. Data from one of the sites, Kabiro-Kawangware, indicate that a total of 23,651 youth were thus informed and 4,957 were served with pills, condoms, and foaming tablets. During the last quarter (July–September 2000) the Arusha site launched AYOHEP and MEUMA youth groups to conduct activities among youth. Youth from Mombasa and Nairobi sites also visited Arusha with the aim of sharing ideas and experiences through drama, songs, and other activities used in IEC for in- and out-of-school youth.

### ***Information, Education, and Communication (IEC)***

Several types of activities were undertaken throughout the life of the project. Information, with special emphasis on condom use for dual protection, was provided at youth centers, youth/women clubs, schools, and *barazas* (local community meetings). IEC materials were developed/adapted and distributed to the target audiences. Special community events were conducted and community leaders were sensitized in order to encourage continued support for the URHI activities.

Youth counselors, youth peer motivators, and CBD agents conducted education sessions and activities on STI/HIV/AIDS and unwanted/unintended pregnancies. These service providers used IEC materials, video shows, drama/dance, and puppet shows during social events such as football matches, in-school events, *barazas*, mobile clinic days, and community health events to educate targeted populations.

The IEC strategy also called for the development/adaptation and distribution of IEC materials. Existing IEC materials distributed included 1999 calendars titled “Use a condom to prevent STIs/HIV/AIDS and unwanted/unintended pregnancies”; posters titled “STI may cause ophthalmia neonatrum”; and posters on HIV/AIDS from the MOH. By the end of the project leaflets and more posters were in the process of development.

The IEC activities resulted in information provision to 112,021 people through health education talks, the distribution of 13,700 IEC materials (posters and brochures), and the staging of 128 IEC events including puppet shows, video shows, drama/dance events, and public speeches. Such participatory activities brought the communities together to learn about FP/RH including STIs/HIV/AIDS and to hold discussions with their peers, family, and community members.

### ***Training***

The URHI-II project supported community initiatives in managing health care at the grassroots level. Supervision plays an important role in project success as it forms a link between the beneficiaries and the implementers. One of the purposes of the training was to enhance the capacity of the service providers by strengthening their supervision and monitoring skills in order to

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improve the quality of FP/RH. A total of 24 (12 clinic and 12 CBD) service provider supervisors were trained in facilitative supervision based on quality assurance, CBD back-up, and OJT modules. The training was residential to ensure maximum participation and included field tours to facilitate learning through observation.

With the adoption of a community-oriented approach, it was necessary to strengthen the outreach activities conducted by CBD agents. Thus a total of 83 CBD agents were trained in concepts of integrated RH, principles of IEC, distribution methods, referral methods, definition of STIs and their relationship with HIV/AIDS, contact tracing, dual method use, and the distinction between dual method and double protection to enable them to have a higher impact within their communities. Due to the intensity of the topics covered and because of the different levels of CBD agents at different sites, this training was conducted separately for each site.

Additional training included a one-day on-the-job training for 80 CBD agents and a training for one of the project coordinators.

### **Challenges**

This innovative intervention did not occur without encountering major challenges. The processes that enhance community capacity to mobilize and allow for effective community participation are long term and once started, maintaining momentum becomes a major obstacle. For the condom distribution objective, it was crucial to ensure that a sound management system was in place, from continued availability of sufficient condoms to a smooth flow through clinics, CBD agents, and outlets, to high transmitters. The youth component had to adhere to the prescribed ingredients for youth health and development programming (nurturing a supportive environment, provision of appropriate information, life skills, and services) to ensure success and impact. Information, education, and communication for this kind of intervention needed to go beyond encouraging individual behavior change and move towards creating environmental conditions that would facilitate personal risk reduction. Given the large numbers and different categories of service providers targeted for training, timing for the different training sessions was going to be crucial.

### **Lessons Learned and Recommendations**

Pathfinder and the implementing agencies identified the following lessons learned as a result of the implementation of this project:

#### ***Partnership with Local Organizations***

- Working with existing organizations such as municipalities and private entities in FP/RH is generally more effective than setting up new ones. These organizations are more able to respond to changing community needs than ones created in response to an intervention. Partnership with such organizations is therefore more likely to increase community participation.
- A systematic planning process with targeted communities (sensitization prior to community diagnosis, participation during the exercise, dissemination of findings for validation, orientation of leaders on proposed activities) articulates a clear vision for a project and encourages valuable collaboration among communities and organizations.
- However, community involvement and participation processes take time to put in place and should therefore be implemented in phases to attain the desired progress/impact.

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### ***Condom Distribution***

- Extending condom distribution beyond clinics and CBD agents to other non-traditional outlets makes condoms more available and accessible to individuals who are likely to use them in high risk situations.
- Involving communities in project planning by getting their views on proposed activities such as condom distribution helps interventions to cross cultural barriers that may otherwise hinder effectiveness of an intervention.

### ***Establishment of Youth Services***

- Community members should be presented with accurate and up-to-date information about health problems afflicting youth in their areas, and to create an understanding about what health care providers/services can and should do about the problems. Community members are more likely to support youth problems when they fully understand the value of promoting and safeguarding young people's health.
- Despite some of its shortcomings, peer to peer education has been found to be an effective way of providing information to youth. Young people are always willing to share information among themselves.
- Public health workers can be oriented to acknowledge the need to remove barriers to the delivery of services to youth and to the use of such services.

### ***Information, Education, and Communication (IEC)***

- Peer educators/motivators, CBD agents, and clinic staff should be trained not only to create awareness but also to provide information that is likely to cause individuals to move to other stages of behavior change.
- Although some IEC messages and materials have universal appeal, the communities should be involved in formulating and testing messages in order to achieve in materials more suitable for their circumstances.
- Given the varying levels of literacy of the target population, events such as video shows and puppet shows are more appropriate media for passing messages as they entertain and at the same time educate the target audience.

### ***Training***

- All future training might be better conducted at the project site (catchment area) where the participants are likely to be at the same level in terms of background and familiar working environment, so that they can translate knowledge into real life experience.
- Training needs to be conducted at the beginning of the project and a feedback loop set up so that refresher training can be conducted to address subsequent recommendations.
- A lot of time spent on planning project activities leaves inadequate time for implementation in terms of creating an effective human resource base and therefore implementation issues are not addressed on a timely basis.

# 1

## PROJECT DESCRIPTION AND DESIGN

**A**frica is becoming increasingly urban. The United Nations has projected that Africa's urban population will reach 400 million by 2005 and will double its current figure by 2025. Poor urban dwellers may be as disadvantaged as their rural counterparts in terms of health care services in the face of health problems often associated with urban living. In the overwhelming majority of African cities, population growth has far outpaced municipal services and up to 40% of all urban dwellers live in squatter settlements and slums. The urban poor normally have inadequate information about health services, especially family planning and other reproductive health services, including treatment of sexually transmitted infections (STIs). In sub-Saharan Africa, the average contraceptive prevalence is 11% as contrasted with 51% worldwide, and the average total fertility is six children per woman, the world's highest.

In the context of elevated levels of STI/HIV/AIDS, one of the most pressing challenges for reproductive health programs in Africa is to meet the increasing demand for quality reproductive health services. The technical challenges implied in combining family planning with STI/HIV/AIDS services include those associated with the promotion of condom use in order to simultaneously address the goals of disease prevention and unwanted pregnancy.

### 1.1 Project Context

Kenya and Tanzania, like most of their neighbors in sub-Saharan Africa, face the dual dilemma of substantial unmet need for modern family planning coupled with spiraling rates of STI and HIV transmission. Kenya, considered an African family planning (FP) success story because of the ever increasing use of modern FP methods, has a rate of only 34% for modern method use, meaning that 65% of women are using traditional or no means to space their children and protect their reproductive health. In Tanzania, an estimated 13% use modern contraception and at least 56% would like to space or limit births, resulting in substantial unmet need.

RH strategies have been transformed in both countries due to the extraordinarily rapid spread of STIs and HIV/AIDS. In Kenya, it is estimated that 1.4 million persons—or one of every eight adults—are infected with HIV, of whom 230,000 are persons living with full-blown AIDS (NASCOP, AIDS Survey, 1997). Prevalence rates range from 5–15% in rural areas to 20–30% in urban areas. It is projected that over 2 million Kenyans will be HIV positive by the year 2005. In spite of condom logistics and distribution efforts, condom use remains low and HIV infection rates continue to escalate. A similar situation exists in Tanzania, where it is estimated that approximately 2.4 million people are HIV positive (almost 8% of the total population). AIDS is decimating the most productive ages in both countries (15–45 years), resulting in enormous

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strain on the health systems and social structures. Equally important, it is estimated that of those who are HIV positive, only 10% know they are infected.

## **1.2 Project Summary**

In response to this situation, the Urban Reproductive Health Initiative (URHI) was started in 1997, as a partnership project between REDSO/ESA, SEATS, and Pathfinder International with financial support from USAID/Africa Bureau. URHI intended to improve the quality of RH services in urban settings starting with five cities: Lusaka (Zambia), Bulawayo, Gweru, and Chitungwiza (Zimbabwe), and Nairobi (Kenya). The initiative provides men, women, young adults, and individuals at high risk for STI/HIV/AIDS and unwanted pregnancy with information on condom use for dual protection, dual method use, family planning methods, and management of STIs including HIV infection.

During Urban Reproductive Health Initiative Phase I (URHI-I), Pathfinder International collaborated with REDSO/ESA to work with Nairobi City Council and Crescent Medical Aid in Kenya to enhance condom use for dual protection in six clinics in Nairobi. Over 72 service providers were subsequently trained in CTU management of STIs, and appropriate IEC techniques, and all service delivery staff were oriented on the job. The training also focused on youth friendly services, "Condom use for dual protection" aimed at increasing the number of young people requesting services, and education on increased use of condoms. The service providers drew up site implementation plans of action for each clinic that were to be shared with other service providers at their respective work sites. Nearly 200,000 condoms were distributed during the one-year period. "Dual method use for dual purpose," aimed at increasing the number of FP clients using condoms with other FP methods, was promoted. This approach recognizes that other FP methods do not provide protection against STI/HIV/AIDS.

From the analysis of lessons learned during the first phase, it was determined that improved and higher quality clinical reproductive health services needed to be reinforced and expanded, especially to reach high transmitters and to increase impact. Among the lessons learned were that clinics were not providing adequate services to the catchment area populations; clinics were not reaching high transmitters and other groups at risk because they lacked skills and logistics; and the negative attitudes of service providers discouraged the surrounding communities from attending the clinics and certainly precluded certain target groups such as young men and other high transmitters from frequenting these clinics. During the second phase of URHI, the project built on the achievements of phase I and intensified its activities through a broader community approach. In order to achieve its goals of reaching more people, the project shifted from the clinic-based mode to a community oriented demand generation approach. This approach was considered as having potential for high impact and focused on innovative prevention activities while maintaining the curative services. Project activities were directed to areas where high transmitters naturally congregated. Participatory approaches were adopted to ensure involvement of community leaders and representatives of target groups in joint planning, implementation, and monitoring/evaluation of the interventions.

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Efforts were made to reach high transmitters in clubs, brothels, shops, *jua kali* (informal sector artisans) locations, etc., through IEC for behavior change. Pathfinder International worked with women, men, and youth groups to undertake community mobilization and ensured participation of the communities and their leaders in the project activities. Furthermore, community groups were involved in message formulation and dissemination, and condom distribution using various modes of service delivery, for example community-based distribution (CBD), and market-based, work-based and depot holders. Baseline surveys including community diagnosis and rapid facility assessments were conducted prior to start-up of the project. Other activities conducted included public sensitization, identification of collaborating agencies, and development and distribution of existing IEC materials, as well as establishment of a system to sustain the project.

The purpose of the URHI phase II project was to improve the quality of reproductive health services provided to underprivileged persons with special needs and to promote condom use for dual protection in urban slums—Nairobi and Mombasa in Kenya and Arusha in Tanzania—through multiple service delivery approaches, information, education, and communication (IEC) on family planning, STI/HIV/AIDS prevention, and condom use. The project was designed to adopt the community approach by ensuring community participation and effective involvement.

This second phase of the project was designed for one year (April 1, 1999 – March 31, 2000) and budgeted at US\$259,861. Activities were concentrated in four sites: Kabiro-Kawangware and Kangemi slum areas in Nairobi (Kenya); Mtongwe in Mombasa (Kenya); and Unga Limited and Sombetini in Arusha (Tanzania).

The main groups targeted by the project in the four sites included:

- In- and out-of-school youth, including *matatu* touts and loaders.
- Women with multiple partners, including commercial sex workers (CSW), market women, vendors, and barmaids.
- Men with multiple partners, including businessmen, *matatu* drivers, long distance truck drivers (truckers), artisans, and mechanics.

The major components of this project were:

- Community mobilization and participation through established community partnerships.
- Improved service delivery through assessment and upgrading of referral sites.
- Information, education, and communication (IEC) for behavior change.
- Training of health care providers.
- Installation of condom dispensers in strategic places and condom distribution through existing community health care providers.
- Monitoring and evaluation.

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## 1.3 Objectives and Indicators

Under the new USAID system of monitoring and evaluation of results package, USAID/ Washington specified objectives to be reached through the achievement of one intermediate result (IR) by March 2000.

*Intermediate Result:* To enhance community mobilization and participation in activities that will reduce the incidence and prevalence of STI/HIV/AIDS and unwanted/unintended pregnancies among community residents and high risk groups.

There were process indicators articulated for specific objectives to be used to measure this intermediate result. These are itemized below.

### 1.3.1 Service Delivery

- Conduct and disseminate results of the baseline surveys for of four communities to youth and other leaders.
- Distribute 4,000,000 condoms in the four identified communities (two communities in Nairobi, one in Mombasa, and one in Arusha).
- Serve an estimated total of 20,000 condom clients in the four identified communities within the project period.
- Renovate two referral clinics per site and provide minimum equipment and supplies to enhance quality of care.
- Establish “youth friendly” corners in four facilities (one per site) and establish mobile or other youth services in the four communities, (e.g., STI treatment to tout stands).
- Conduct one health fair per site per year.
- Procure and install condom dispensers in four facilities throughout the four targeted communities.

### 1.3.2 IEC

- Inform 120,000 people (at youth centers, youth/women clubs, drama groups) about condom and dual method use at the four sites during the project period as shown in the table below:

Kangemi	Kabiro-Kawangare	Mtongwe	Unga Ltd/Sombetini
30,000	40,000	40,000	10,000

- Develop/adapt two posters and two leaflets with messages on condom use for dual protection and distribute 4,000 posters and 120,000 leaflets (60,000 each of two types).
- Hold community events (e.g., puppet shows, video film shows, drama/dance, public speeches, “Messages of Hope”) for a total of 48 events (once a month per site).
- Conduct two 2-day site orientation sessions for 24 community leaders (six per site) on FP/STI/HIV/AIDS and the importance of condom use for dual protection.
- Conduct at least three sensitization and consultative seminars for community leaders at each of the four sites.

### 1.3.3 Training

- Improve and support URHI service delivery and other activities by conducting training and seminars as shown in Table 1.
- Train 12 CBDs/service providers (2 per site) on community mobilization skills

**Table 1. URHI-II training objectives**

<b>No. of providers to be trained</b>	<b>Types of people and training topics</b>	<b>PHT</b>
40	Conduct on the job training for 40 participants (10 per site) on: <ul style="list-style-type: none"> <li>• “Youth friendly” services</li> <li>• Referrals for voluntary counseling and testing (VCT)</li> <li>• Condom Promotion</li> <li>• Recognizing the special needs for men</li> </ul>	(3 hours per session) 1,920
12	Conduct one 5-day practicum TOT for 12 clinic based supervisors on QA, CBD backup, OJT modules	960
12	Conduct one 5-day practicum TOT for 12 CBD supervisors on effective supervision and improved counseling (2 from each site) using OJT modules	960
120	Conduct two 5-day training sessions for 80 CBD agents and 40 peer counselors	9,600
<b>Total trained</b> <b>184</b>		<b>Total PHT</b> <b>13,400</b>

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## 1.4 URHI Phase II - Project Timeline (April 1, 1999 – March 30, 2000)

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1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
<ul style="list-style-type: none"> <li>• Orient staff at CB services/static sites</li> </ul>	<ul style="list-style-type: none"> <li>• Install condom dispensers in high volume locations</li> </ul>	<ul style="list-style-type: none"> <li>• Continue training activities to include Arusha</li> </ul>	<ul style="list-style-type: none"> <li>• Complete training and trainee follow up</li> </ul>
<ul style="list-style-type: none"> <li>• Conduct 6 baseline surveys</li> </ul>	<ul style="list-style-type: none"> <li>• Provide guidelines, IEC materials</li> </ul>	<ul style="list-style-type: none"> <li>• Institute pilot "B"</li> </ul>	<ul style="list-style-type: none"> <li>• Hold 4 project consultative meetings</li> </ul>
<ul style="list-style-type: none"> <li>• Hold 3 sensitization meetings to:               <ul style="list-style-type: none"> <li>- Disseminate baseline diagnosis</li> <li>- Identify key groups /leaders</li> <li>- Jointly identify appropriate activities/strategies/priorities</li> <li>- Create monitoring processes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Implement training plan               <ul style="list-style-type: none"> <li>- Conduct TOT for 12 CBD supervisors</li> <li>- Provide training for 12 clinic staff</li> <li>- Conduct training for 40 peer counselors/educators</li> <li>- Conduct training for 80 CBDs</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Conduct 3 community events (e.g., health fair, folk media presentations, dramas)</li> </ul>	<ul style="list-style-type: none"> <li>• Implement pilot project "C"</li> </ul>
<ul style="list-style-type: none"> <li>• Conduct training/clinic needs assessments</li> </ul>	<ul style="list-style-type: none"> <li>• Hold 3 consultative community meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Hold a community leader symposium for dialogue with high transmitters in 3 communities. Provide materials on community mobilization</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct 1 community event for Arusha</li> </ul>
<ul style="list-style-type: none"> <li>• Develop training systems and schedules (training follow up, OJT, management)</li> </ul>	<ul style="list-style-type: none"> <li>• Institute pilot project "A" (male or youth friendly services)</li> </ul>	<ul style="list-style-type: none"> <li>• Continue upgrading clinics</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct end of period review meeting with representatives of the communities and facilities</li> </ul>
<ul style="list-style-type: none"> <li>• Identify/select/reproduce IEC materials</li> </ul>	<ul style="list-style-type: none"> <li>• Arusha start-up               <ul style="list-style-type: none"> <li>- Conduct 1 sensitization meeting for Arusha</li> </ul> </li> <li>- Begin upgrading of referral clinic sites</li> </ul>		<ul style="list-style-type: none"> <li>• Conduct regional end-of-project dissemination meeting outlining lessons learned, best practices, models</li> </ul>
			<ul style="list-style-type: none"> <li>• Review sites for next period if funds available</li> </ul>

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# 2.

## SUMMARY OF COMMUNITY DIAGNOSES AND FACILITY ASSESSMENTS

The two studies, participatory community diagnosis and facilities assessment, helped to identify existing active and potential structures that could be used as vehicles to gain support for the URHI-II, through community mobilization and participation. They also gave insight into an informed intervention that would create demand for services. (The full report of the studies is contained in the Appendix.)

### 2.1 Community Diagnoses

Opinions of community leaders on community group participation in health related work were documented, particularly in the area of HIV/AIDS control and prevention, and the presence of CHW/CBD agents and outreach services. Community leaders' attitudes toward condom use for dual protection, and their receptivity to condom distribution and information provision about condom use for dual protection were assessed and documented. Focus group discussions for youth group were also conducted to identify their needs.

#### 2.1.1 Existing Active and Potential Structures

Community structures were found to be formed along social or traditional lines with recognized leaders elected by the general community or installed on the basis of the person who initiated the idea. In most cases these groups had objectives for the formation of their groups or organization which ranged from development and self-help, to education of women in community development. Through the facility assessments, two facilities at each site already involved in a limited way in FP/RH activities were identified as links between the project and the communities.

#### 2.1.2 Identified Health Problems

Community leaders identified health problems afflicting various segments of the population: adolescents of both sexes, adult women, adult men, *matatu* drivers/touts, and commercial sex workers (CSWs). Most of the problems were predominantly related to or were the cause of RH complications. These problems ranged from alcoholism and drug addiction, to early and premarital pregnancy, abortions, infertility, and sexual abuse. Also prominent among the problems were promiscuity, STIs/HIV/AIDS, non-condom use during casual sex, and ignorance of presence/location of FP/RH services.

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### **2.1.3 Participation in Health Related Work**

A high percentage (85%) of communities involved in the study had participated in health related work with organizations working in the area of STI/HIV/AIDS, through CHWs, CBDs, and outreach activities. The actual relationships with organizations involved in STI/HIV/AIDS work was minimal, however. The lower percentages in some of the sites could be explained by the fact that the presence of some of the programs was not made known to the members of the communities. Most of the groups participated at the level of activity implementation, but participation in planning and advocacy was very low.

### **2.1.4 Attitudes toward Condom Use and Provision of Information on Condom Use**

In terms of condom use for dual protection from unwanted/unintended pregnancies and prevention of STIs/HIV/AIDS, there was an overwhelming support by community leaders, with percentages ranging from 73% to 93% from the four selected sites. The majority of community groups were also willing to act as advocates for condom use. The proportion willing to promote condom use was highest among adult women target group (80%) and lowest for *matatu* touts. The *matatu* touts did not perhaps perceive themselves at risk, which could indicate a gap in IEC, i.e., this target group was not being reached by appropriate FP/RH information.

As for the expansion of condom distribution to non-traditional outlets, a cross-sectional survey of 143 business establishments indicated that quite a number of these business establishments had potential as condom outlets. These included bars, nightclubs, beauty salons/barber shops and video showrooms. These establishments were found to be usually busy and attracted more youth and adult women than other types of business, hence their potential as condom outlets.

Community leaders also gave their views on the most effective ways to present information about condom use for dual protection. For family planning, they suggested sensitization seminars, radio spots/programs, public film shows, pamphlets/posters/brochures, public video shows, public talks by health workers, books/magazines, counseling, and door-to-door campaigns. For STI/HIV/AIDS prevention, they suggested drama, public video shows, posters/leaflets, community education, mobile film shows, outreach programs, and home visits by health workers. The majority of these communication channels were incorporated into the URHI-II project design.

### **2.1.5 Identification of Youth Needs**

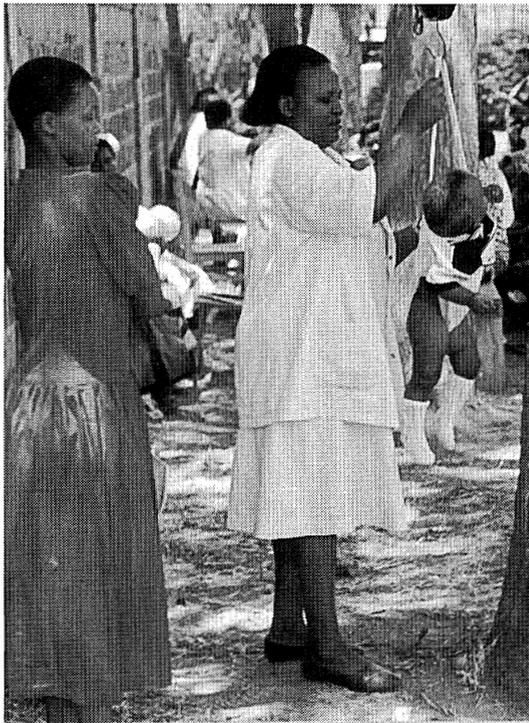
As over 50% of the populations at the four sites were youth, it was important for URHI-II to cater for their needs, identified through focus group discussions as: need for information preferably at youth centers, which in most cases did not exist; need for accurate information about ways of transmission and appropriate means of protection against STI/HIV/AIDS; educating youth on the effects of drug abuse, alcohol consumption, family planning, and control of sexually transmitted infections; making the existing health services more accessible to youth by having special clinic days offering a range of services to youth and by using the services of appropriately trained health care providers on adolescent health; using appropriate information channels such as video shows

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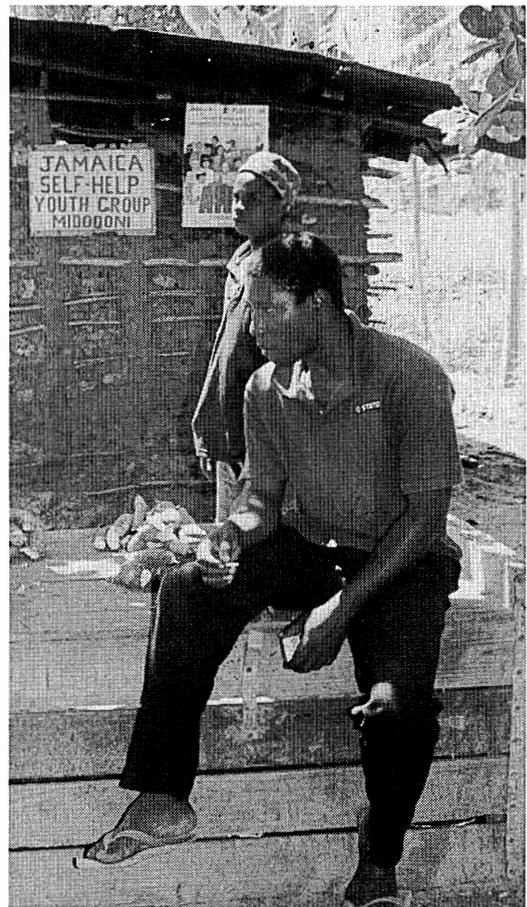
on HIV/AIDS, demonstrations on the correct way to use condoms, community education and talks by persons living with HIV/AIDS; making condoms more accessible in social places such as youth clubs and bars.

## 2.2 Facility Assessments

A number of gaps were identified in selected health facilities, including the need to enhance the skills of clinic staff and CBD agents through training and CTU, IEC on condom use for dual protection and community mobilization. The clinics also needed upgrading in terms of additional equipment and non-contraceptive clinical supplies. And finally, the clinics needed to be reorganized in terms of services they provided.



Arusha, Tanzania - Service provider (clinic based) at work in one of the referral sites.



Mtongwe, Mombasa, Kenya  
Rehabilitation of drug/substance abusers through  
Mtongwe Bamako Initiative.

# 3. PROJECT IMPLEMENTATION, ACTIVITIES, AND OUTCOMES

Community mobilization and participation in FP/RH activities were the major thrust of the URHI phase II project. The major goal was to enhance community mobilization for “condom use for dual protection” in order to reduce the incidence and prevalence of STI/HIV/AIDS and unwanted/unintended pregnancies among community members and high-risk groups. Community participation implies that where a program is introduced from outside, efforts are made to sensitize the community about program objectives to enable its members to understand these objectives in order to make informed choices. It reconciles outside objectives with local priorities and builds a sense of ownership and hence a supportive environment for community mobilization that eventually ensures active and sustained participation.

Basing its approach on this principle and in response to the identified gaps, Pathfinder in partnership with municipalities and private clinics within the selected municipalities conducted a wide range of activities. Community leaders and service providers were oriented about project objectives and activities and community diagnoses were conducted and disseminated at the four project sites. Training was subsequently conducted for CBD agents as well as peer counselors on contraceptive technology updates (CTU), STI and HIV prevention, and condom use for dual protection.

IEC activities through health education talks, video shows, drama, in-school visits, and community health events were also conducted to educate the communities on prevention of STI/HIV/AIDS and unwanted/unintended pregnancy. A number of existing and adapted IEC materials were distributed. Condoms were also distributed through community health care workers/community based distributors and condom dispensers installed in strategic places in the project areas, i.e., shops, bars, kiosks, hair salons/barber shops, restaurants, etc. These and other activities are described in detail in the following sections.

## 3.1 Service Delivery

### 3.1.1 Dissemination of the Baseline Surveys and Community Orientation

#### *Accomplishments*

Recognizing the crucial role of a supportive environment for the success of such an intervention, Pathfinder and the coordinators from the health facilities disseminated the findings of the two studies at the four selected sites. The dissemination was at two levels: 1) with local community

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structures, outlets, and partners, and 2) with community-based service providers and peer educators. The purpose of the dissemination was to share and validate the preliminary results of the studies, but more importantly to enhance the target populations' awareness of their problems and to take action with support from Pathfinder.

In addition, and prior to the onset of the activities, Pathfinder and the staff of the selected health facilities held collaborative meetings with community leaders, including the respective municipal council leaders. The purpose of these meetings was to ensure their involvement and participation in the planning and implementation of the proposed project activities. To further solidify acceptance and support of the project by the respective communities, a one-day orientation was specifically organized for 60 community leaders on URHI-II. Additional orientation seminars were conducted for clinic service providers and other SDP staff to ensure support for the project and to enable them to establish effective referral systems.

Orientation was conducted for staff as follows:

<u>Site</u>	<u>City</u>	<u>Participants</u>
Kangemi	Nairobi	48 service providers
Kawangware	Nairobi	35 service providers
Mtongwe	Mombasa	68 service providers
Unga Ltd/Sombetini	Arusha	40 service providers

Indications were that community groups, community leaders and service providers were receptive to the proposed activities.

### ***Challenges***

Challenges may be identified in the areas of community mobilization processes, the need to maintain momentum, and the importance of sustainability.

- Processes that enhance community capacity to mobilize and allow for effective community participation should be undertaken in phases to bring about the desired impact. The fact that the community leaders were receptive to the proposed activities did not mean that the project would automatically achieve its objectives. This is because community norms and values that govern how certain things are done are not easily changed. Therefore any program implicitly involving community participation would take longer than a year to have the desired effect.
- Once the processes begin, the next major obstacle is maintaining momentum. With the realization that the communities targeted by URHI-II have a myriad of more immediate problems, comes the challenge of maintaining the enthusiasm, energy, and commitment that is driving the project. Program managers need to find ways to reduce burnout among those directly involved with the communities whose work is difficult and often discouraging and to document slow but real progress of the implementation of the intervention, in order to convince government and donors of the importance of continued support.

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- Perhaps the greatest challenge facing those managing the URHI-II project is sustainability. Stronger partnerships among the communities, government, donors, NGOs/CBOS, and private sector are needed to sustain such projects as URHI. Strengthening existing community structures and fostering greater community ownership of the project would also increase their sustainability by reducing dependence on outside donors. However, strengthening community structures and subsequent fostering of ownership is a long-term undertaking.

### ***Lessons Learned***

- Working with existing organizations such as municipalities and private entities such as Kabiro Health Care Trust, or even the Bamako Initiative, is generally more effective and sustainable than setting up new ones. Organizations already working in these communities are better able to respond to changing community needs than ones created in response to an intervention, because they are better placed to nurture partnerships with communities. Partnerships with such organizations are therefore more likely to increase community participation .
- A systematic planning process with targeted communities (sensitization prior to the community diagnosis, participation during the exercise, dissemination of the findings for validation, orientation of leaders on proposed activities) articulates a clear vision for a project, provides a framework for implementation, and makes it easier to assess project progress. Joint planning by all community groups that will be involved in implementing a project results in stronger projects and encourages valuable collaboration among communities and organizations.
- However, community involvement/participation processes takes time to put in place and should therefore be implemented in phases in order to attain the desired progress/impact, to enable momentum to be maintained, to create a sense of community ownership of the project, and to eventually ensure sustainability.

### **3.1.2 Condom Distribution**

The component had the following specific objectives:

- Procure and install condom dispensers in four facilities in the four targeted communities
- Distribute 4,000,000 condoms in the four identified communities (two in Nairobi, one in Mombasa, and one in Arusha)

In order to achieve these objectives, condoms were distributed by CBDs for the adult population, by peer motivators targeting youth, and through referral sites and installed dispensers at strategic places. All CBD agents received shoulder bags for easy distribution of condoms, with a total of 120 bags provided to the CBD agents by their supervisors and by the referral sites. Condom dispensers were also placed in strategic outlets (bars, restaurants, shops, video show rooms, hair salons/barber shops, *matatu* stages, referral sites, etc.). Condom dispensers were refilled on a regular basis by staff of the referral sites. Anecdotal information suggests that those manning the outlets also collected condoms whenever the stocks in the dispensers were exhausted prior to

the date scheduled for refills. This seems to suggest that members of the communities were no longer embarrassed to get condoms from health facilities.

### Accomplishments

Condom dispensers were distributed in strategic outlets in the four sites as follows:

- Kangemi 66 dispensers
- Kawangware 50 dispensers
- Mtongwe 84 dispensers
- Unga Ltd/Sombetini 100 dispensers

Figures 1–4 illustrate the condom distribution per site during the period from October 1999 to end September 2000, through the dispensers, referral sites, and CBD agents.

Figure 1. Kangemi site: Condom distribution (N = 686,867)

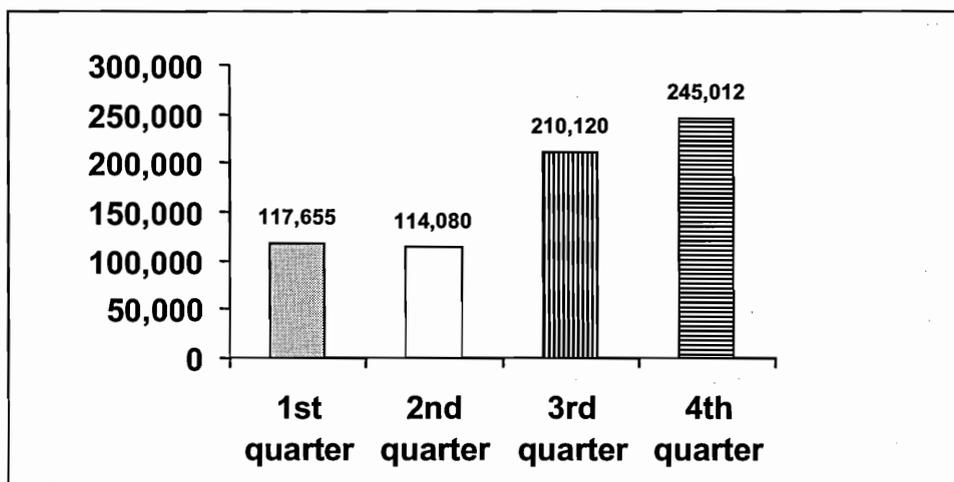


Figure 2. Kawangware site: Condom distribution (N = 1,371,605)

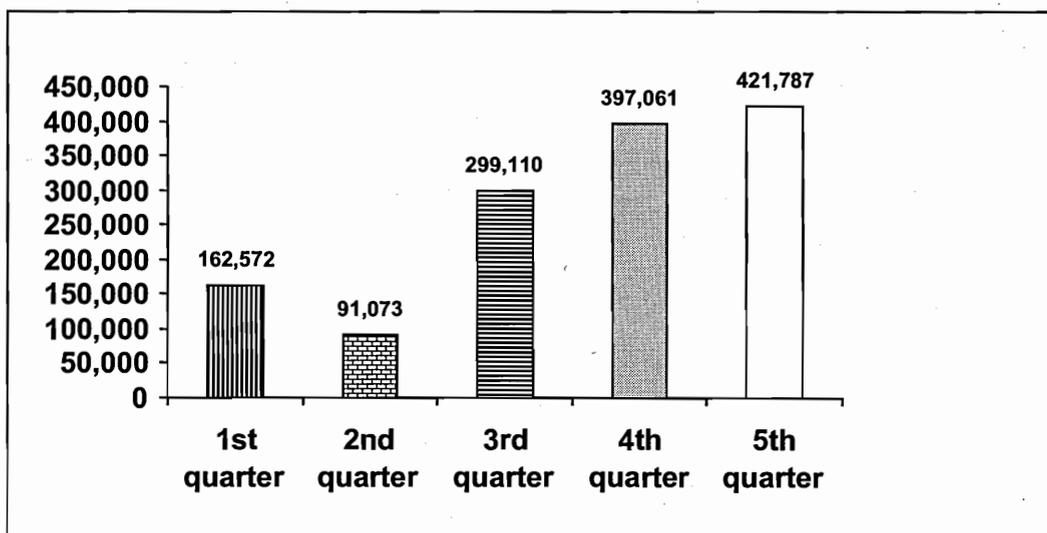


Figure 3. Mtongwe site: Condom distribution (N = 958,367)

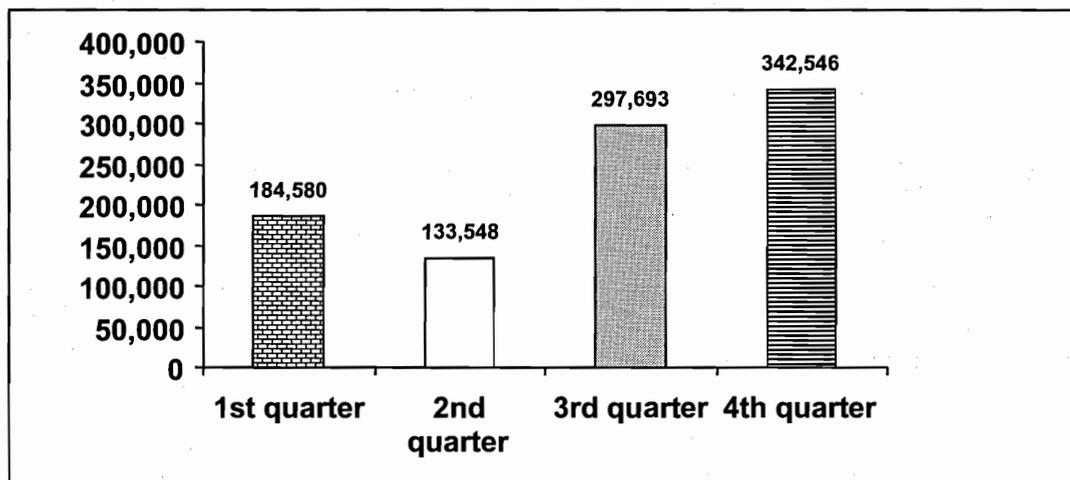
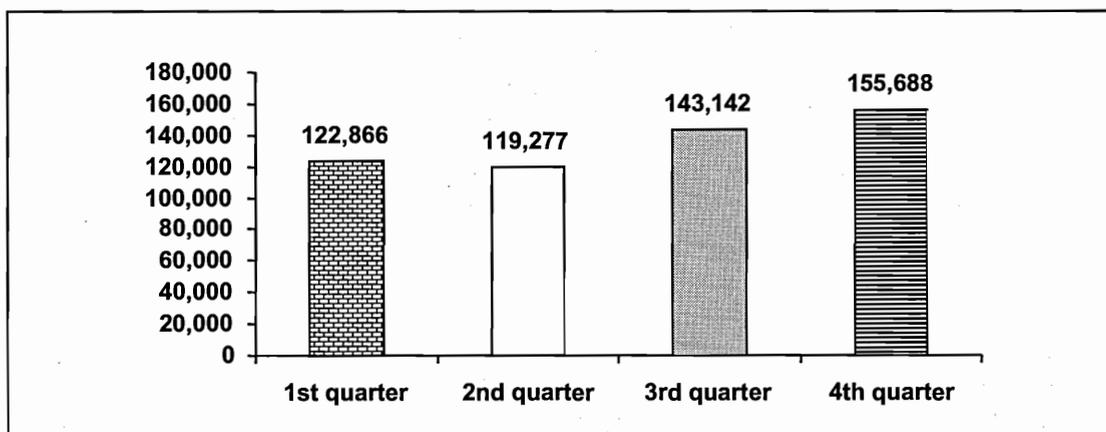


Figure 4. Unga Ltd/Sombetini site: Condom distribution (N = 541,519)



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This three-pronged approach to condom distribution has definitely contributed to the increase in the number of condoms distributed. Within a period of 12 months the URHI-II project had distributed a total of 3,558,378 condoms at the four sites, almost reaching the targeted number of 4,000,000. This was a tremendous increase compared with the numbers distributed only through clinics (200,000 had been planned for the first phase). For most of the sites, there was clearly an upward progression in the numbers of condoms distributed, particularly with the installation of dispensers at the referral sites, bars, hair salons/barber shops, video show rooms, etc., which began during the month of October 1999 for three sites (Kangemi, Mtongwe, Unga Ltd/Sombetini) and Kawangware, which began its distribution in July 1999. Although a slowdown can be noted during the second quarter beginning January 2000, this can be explained by the fact that in December most slum dwellers go to their rural homes and on return during the month of January most do not have money to frequent the establishments. In the case of Arusha, condom distribution began to pick up during November and December 1999 at both the clinics and through CBD agents and dispensers, but then began to slow down mainly due to logistics problems and particularly to a generalized condom stock-out. However, a steady flow is noted during the third and fourth quarter year 2000. The summary is shown in Figure 5.

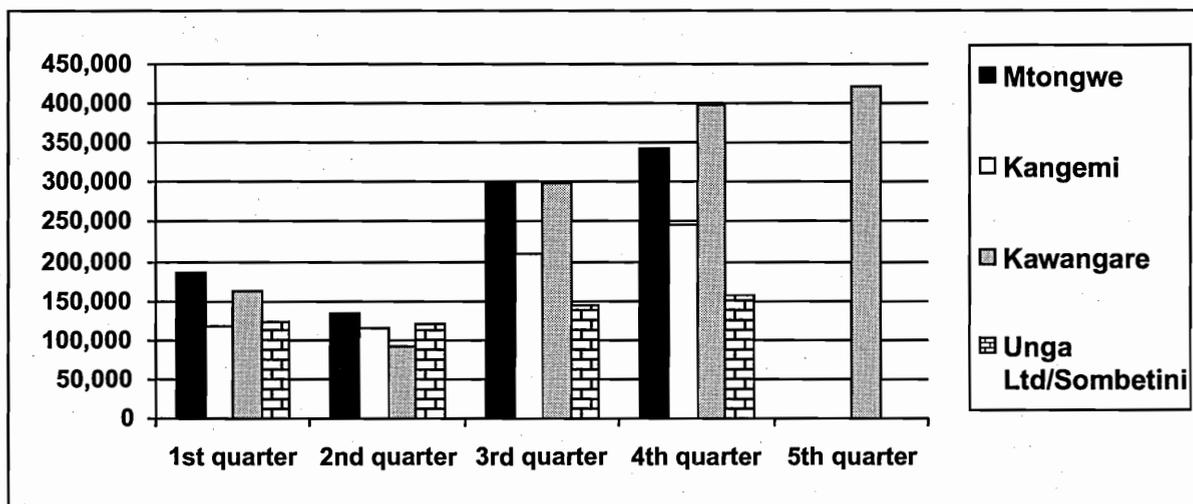
### ***Challenges***

- Ensuring that a sound condom management system is in place, from continued availability to a smooth flow through the clinics, CBD agents, and outlets, to high transmitters.
- Condom dispensers distributed to the sites need to be of durable material given the nature of some of the condom distribution outlets. Some the project staff indicated that some of the dispensers had broken up, resulting in lower numbers of condoms distributed in some of the outlets. Health providers resorted to using baskets, etc., as dispensers.

### ***Lessons Learned***

- Extending condom distribution beyond clinics and CBD agents to other non-traditional outlets such as bars, video show rooms, hair salons/barber shops and even bus/*matatu* stages makes condoms available and more accessible to individuals who are likely to use them in high risk situations. Distribution through clinics and CBDs can be more efficient if properly managed, including attitude change by the service providers, but is much less likely to provide access to condoms at times and in locations where high transmitters congregate or where people usually engage in high risk sex.
- Involving communities in project planning by getting their views on proposed activities such as condom promotion, and distribution, which would otherwise be opposed for traditional or religious reasons, has gone a long way to gain/reinforce support by the targeted communities for condom distribution, particularly in non-traditional outlets.

Figure 5. Illustrative summary of condom distribution progression and slow down during the six-month period



### 3.1.3 Establishment of Mobile and Other Youth Services in the Targeted Communities

In three of the sites the URHI-II project worked or started work with youth as follows:

- Kangemi Anti-drug youth group and touts (now called “Living Youth”)
- Kawangware Peer counselors and motivators
- Mtongwe Bamako Initiative youth groups
- Arusha AYOHEP and MEUMA youth group

#### *Accomplishments*

The specific accomplishments at each of the four project sites are described below.

**Kangemi Site.** The Living Youth group consists of four *matatu* touts and eight youth members who were former drug addicts. This group mainly created awareness among fellow youth during social gatherings, football matches, and other community mobilization events such as general cleaning exercises. They also visited youth in secondary schools and sensitized them on FP/RH issues with emphasis on condom use for dual protection and consequences of drug and substance abuse. This youth group liaised with CBD agents for referrals to the Kawangware site’s two clinics and for those wishing to obtain other contraceptive methods as well as those seeking STI treatment. They also distributed non-prescription contraceptives including condoms to their peers.

**Kabiro-Kawangware Site.** This site had 25 peer motivators, representing each of the catchment area zones who were supervised by seven youth counselors. The peer motivators worked with adolescents below the age of 19 years. They conducted IEC on adolescent RH and distributed foaming tablets, pills, and condoms to their peers. The peer motivators made referrals to youth counselors for counseling; any referrals to the youth clinic nurse were made by the peer counselors. The youth motivators met regularly with the CBD agents to coordinate other IEC activities such as video and puppet shows, as well the daily mobile clinic. The youth motivators worked four hours a day, 3–4 days a week. This schedule was not necessarily adhered to as they had set monthly targets to meet. They got support from community leaders who were aware of their activities, having been sensitized about the youth activities and informed of their recruitment as motivators.

**Mtongwe Site.** This coastal site had two youth groups operating through the Bamako Initiative project: The Jamaica Youth Group consisting of approximately 100 members, and Asali Tamu (“sweet honey”), consisting of approximately 87 members. All group members were former drug addicts. The Bamako Initiative project has been working with them through a conversion project supported by UNICEF and Action Aid. The project provided them with small parcels of land through the community to enable them to earn a living. The URHI dovetailed on to this project by using them as peer educators/motivators. Members of these youth groups conducted IEC among fellow youth in conjunction with the catchment area CBDs and also distributed foaming tablets and condoms to other youth. The youth group members collected condoms from condom dispensers located in the youth groups’ executive offices, which were in turn supplied by the Bamako Initiative pharmacy.

**Unga Ltd/Sombetini Site.** During the last quarter, the Arusha site launched AYOHEP and MEUMA youth groups. It is planned that some members of the youth groups will be trained as peer educators/motivators to conduct IEC activities among their peers and also to distribute non-prescription contraceptives even after the project ends. The youth motivators were extremely active at this project site. Some of their accomplishments included providing information to a total of 23,651 adolescents during a period of six months (October 1999 – March 2000). Distribution of contraceptives in conjunction with the CBDs for the same period is shown in Table 2. During the last quarter there was an impressive increase in both new and revisit clients, particularly condom clients.

**Table 2. Unga Ltd/Sombetini site: CBD and youth program**

Methods	Achieved			
	October – December 1999		January – March 2000	
	New	Revisit	New	Revisit
Pills	647	777	1,359	2,009
Condoms	1,027	916	1,882	2,049
Foaming tabs.	11	0	31	5
<b>Total</b>	<b>1,685</b>	<b>1,693</b>	<b>3,272</b>	<b>4,063</b>

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### ***Challenges***

- The prescribed ingredients for youth health and development programming are supportive environment, information, life skills, and services.
- Even when community support has been achieved, there is need to sustain this interest in order to maintain a conducive environment.
- There are often major limitations to what the provision of information alone can achieve. Providing clear, accurate information about health topics of interest to young people is essential to programming, but knowledge alone is inadequate to help young people develop and sustain healthy behavior concerning sex.
- Even when services are available, youth are often unable or unwilling to use them. Various barriers hinder youth's access to and use of health services, including not knowing where, and under what conditions, health services are provided, fearing that services are provided in places where they could be seen by people who know them, which would compromise discretion, worrying that health workers may ask difficult and embarrassing questions and put them through unpleasant and painful procedures, and being unable to afford to pay for the services they need.

### ***Lessons Learned***

- Community members should be presented with accurate and up-to-date information about health problems faced by youth in their areas in order to create an understanding of what health care providers/services can and should do about the problems. Community members are more likely to support youth health services when they fully understand their value in promoting and safeguarding health, and the consequences of not making services available to youth.
- Although many questions remain about what works best in effective provision of information, it is clear that efforts should be made to exploit the various ways of reaching young people, especially by involving them directly. Despite some shortcomings, peer-to-peer education has been found to be an effective approach to sharing information. Young people are always willing to share information. When young people state support for and model important prevention behavior (such as thinking about making personal choices before starting sexual relationships or using a condom) this can create and strengthen positive group attitudes towards healthy behavior. As role models, peers can be very effective in enhancing information sharing.
- Public health workers can be oriented and trained to acknowledge the need to remove barriers to the delivery of health services to youth and to the use of such services. The emphasis should be on the importance of understanding the concerns and needs of young people and to address them systematically.

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## 3.2 Information, Education, and Communication (IEC)

The goal of the URHI-II IEC strategy was to enhance RH/FP services among the targeted population in order to reduce the incidence and prevalence of STI/HIV/AIDS and unwanted/unintended pregnancies. Three objectives were identified in order to attain this goal:

- Increase the demand for and utilization of condoms for dual protection.
- Increase the demand for the treatment and prevention of STIs.
- Reinforce community support for activities to prevention STI/HIV/AIDS and unwanted/unintended pregnancies.

Several types of activities were undertaken throughout the life of the project to achieve these objectives: information at youth centers, youth/women clubs, schools, *barazas*, etc., about condom and dual method use; development/adaptation of IEC materials with messages on condom use for dual protection and distribution of these materials; and organization of community events and sensitization of community leaders.

### 3.2.1 Information Provision

The URHI-II project used youth counselors, youth peer motivators, and CBD agents to conduct education sessions and activities on STI/HIV/AIDS and unwanted/unintended pregnancies, as one of the main strategies of the IEC component. The counselors, peer motivators and CBD agents conducted education sessions using IEC materials, video shows, drama, and puppet shows, during social events such as football matches, in-school events, at *barazas* (meetings of community leaders with impact on local policy), during mobile clinic days, and at community health events. Through the different forums, URHI-II was able to spread the message about the health benefits of the prevention of STI/HIV/AIDS and unwanted/unintended pregnancies and elicit their participation in the URHI activities, particularly in the promotion of condom use for dual protection. In addition, these peer educators and the CBDs encouraged the communities to modify their behavior in order to reduce the risk of infection and unwanted/undesired pregnancies and provided information and/or means to protect themselves (information on where to go for treatment of STIs and condom distribution).

#### *Accomplishments*

Although only two project sites met and even surpassed the set targets (Mtongwe and Unga Ltd/Sombetini) for health education talks, a total of 112,021 people were reached within the 12-month project period, which represents 93% of the total target set of 120,000 people to be informed during the period. Table 3 has the site details.

**Table 3. Number of people informed per site for the period**

Kangemi	Kabiro-Kawangware	Mtongwe	Unga Ltd/Sombetini
30,120	18,151	44,030	19,740

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### 3.2.2 IEC Materials

The IEC strategy also called for the development/adaptation of two posters and two leaflets with messages on condom use for dual protection and also distribution of 4,000 posters and 120,000 leaflets (60,000 each of two types).

#### *Accomplishments*

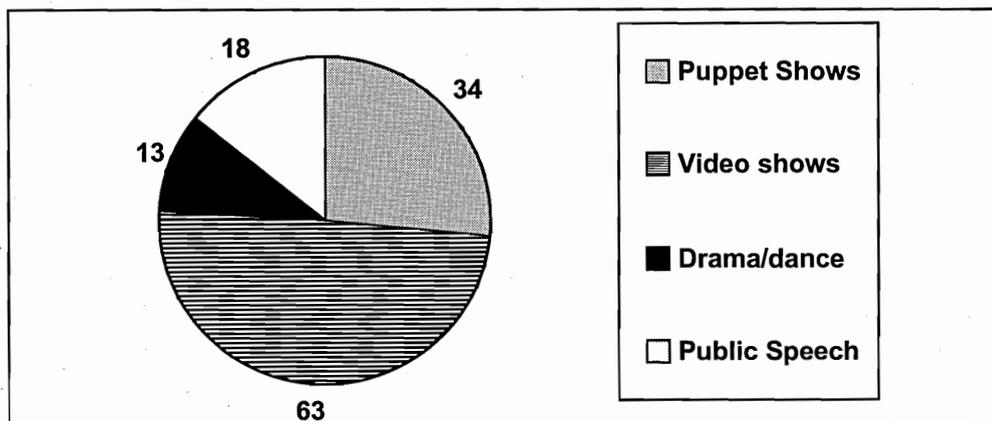
At the Kangemi and Kawangware sites in Nairobi, 800 calenders for 1999 titled “Use a condom to prevent STIs/HIV/AIDS and unwanted/intended pregnancies” were distributed. A total of 100 posters titled “STI may cause ophthalmia neonatrum” were distributed to the CBD agents. Finally, the project distributed posters on HIV/AIDS from the Ministry of Health (MOH) at the rate of 100 per site for a total of 800 posters. During the last quarter, a total of 12,000 Kiswahili posters and brochures were distributed. Thus, during the 12-month project period a total of 13,700 different type of IEC materials were distributed. At the end of the project more leaflets and posters were in the process of development.

### 3.2.3 IEC Events

In order to reinforce the use of IEC materials, a number of IEC events were planned including puppet shows, video shows, drama/dance, and public speeches at schools. Figure 6 indicates the number of events conducted for the four sites.

The URHI-II project conducted a total of 128 community events at all the four project sites over a period of six months. This figure surpassed the set objective of 45 events for all the four sites during the life of the project.

**Figure 6. IEC events conducted at the four sites during a period of six months**



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### *Challenges*

- The number of participants attending health education talks was not recorded systematically and this made it difficult to quantify exactly the number of people attending. It was almost as if creating awareness was not an important part of the behavior change continuum.
- IEC should go beyond encouraging individual behavior change. It should help create environmental conditions that facilitate personal risk reduction.
- Given the different levels of literacy and the different cultural mix of the target populations and the communities living in these slum areas, the IEC materials used needed to be culturally sensitive and appropriate by involving of the communities in their development/adaptation.

### *Lessons Learned*

- Peer educators/motivators, CBD agents, and clinic staff should be trained not only to provide awareness but also information that is likely to cause individuals to move to other stages of behavior change: knowledge, risk perception, intention to act, and action.
- Although some IEC messages and materials have universal appeal, the communities should be more actively involved in formulating and testing messages so that materials will be suitable for their circumstances. However, before creating new materials, a project such as URHI should consider whether existing materials from other programs—even from other countries—might fit their needs. These materials should always be pre-tested with representatives of the target audience before production to determine whether they are appropriate and to identify any revisions that may be necessary.
- Given the varying literacy level of the target populations, events such as drama/dance, video shows, and puppet shows are more appropriate medium for passing messages as they entertain and at the same educate the target audience.

### **3.2.4 Orientation and Seminar Sessions**

As part of the IEC strategy, it was also planned that a two-day orientation session for 24 community leaders (six per site) on FP/STI/HIV/AIDS and the importance of condom use for dual protection be conducted.

### *Accomplishments*

In order to ensure acceptance and support of the project by the respective communities, a one-day seminar was conducted, prior to the onset of activities, to orient 60 community leaders on the objectives of the URHI project. The emphasis was on FP/STI/HIV/AIDS and the importance of condom use for dual protection. Furthermore, and to ensure the crucial link between the service providers and the communities and support for the project, additional seminars were conducted for service providers and other SDP staff. Other objectives of these seminars were to enable service providers to mobilize their communities and to establish effective referral systems. Thus, the URHI-II project went further than the set objective.

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## Challenges

As mentioned earlier, the major challenge will be maintaining the momentum in the form of enthusiasm, energy, and commitment that had begun to drive the project. The current project managers/coordinators need to find ways to reduce burnout among service providers who are directly involved with these communities and whose work is often difficult and discouraging.

## Lessons Learned

Sensitization and consultative meetings between communities and service providers should be an ongoing process in order to ensure the communities' continued support and effective participation in the activities started under URHI-II or any similar follow-on activities.

## 3.3 Training

The goal of training was to improve and support URHI service delivery and other supporting activities. Training needs were identified during the facility assessments conducted prior to project start-up. Service providers targeted by the training sessions were community based reproductive health service provider supervisors and the service providers themselves.

## Accomplishments

Table 4 shows the number of service providers trained, types of service providers, training topics, and the duration of the training.

**Table 4. Service provider training under URHI-II**

# of service providers trained by site	Types of service providers	Training topics	Duration
24 providers: 4 – Kangemi 6 – Kawangware 9 – Mtongwe 5 – Unga Ltd/Sombetini	Clinic supervisors and community based service providers	Facilitative supervision based on QA, CBD back-up, OJT modules; developing viable partnerships including building bridges, networking, community mobilization	5 days
	Community- based reproductive health service providers	Concepts of integrated RH, concepts and principals of IEC, distribution methods, emergency contraception, referral methods, definition of STIs and the ir relationship with HIV/AIDS, contact tracing, dual method and distinction between dual method and double protection, referrals and follow-ups	5 days for Kangemi 5 days for Kawangware 5 days for Mtongwe
80 providers 20 – Kangemi 20 – Kawangware 20 – Mtongwe 20 – Unga Ltd/ Sombetini	CBD agents and clinic health workers	Youth friendly services, referrals for voluntary testing and counseling (VCT), dual method use (DMU), condom promotion including condom negotiation, recognizing special needs and information and services for men.	5 days for Unga Ltd/Sombetini 1 day on-the-job training for a total of 4 days for the four sites

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### ***Challenges***

- One of the major challenges of training to improve the quality of services is the timing, particularly for a project of such short duration. The planning of such training is important earlier at the beginning of the project especially given the level of participants and also the numerous topics to be covered.
- Although the training for clinic supervisors and CBD agent supervisors was combined, perhaps because of time constraints, it is not evident that this approach was effective, given the different levels of the two groups.
- While training in residence, outside of the catchment areas, has its advantages in making sure that all the participants fully attend all the sessions, such training can end up being heterogeneous because the background and experience of participants vary. This makes harmonization of thinking and a unified approach difficult and may compromise effectiveness.

### ***Lessons Learned***

- Future training might be better conducted at the project sites (or catchment areas) where the participants are likely to be at the same level in terms of background and familiar working environment so that they can quickly translate knowledge into real life experiences.
- Training needs to be conducted at the beginning of a project and a feedback loop set up so that refresher training can be conducted to address subsequent recommendations. A lot of time spent on planning project activities including gaining community support, leaves inadequate time for implementation in terms of creating an effective human resource base and therefore implementation issues are not addressed on a timely basis.

#### **3.3.1 Training for Community-Based Reproductive Health Service Provider Supervisors**

The URHI-II project supported community initiatives aimed at managing health care at the grassroots level. Supervision plays an important role in project success as it forms a link between the beneficiaries and the implementers. The purpose of the training was, therefore, to enhance the capacity of service providers by strengthening their supervision and monitoring skills in order to improve the quality of FP/RH services. As is shown in Table 4, URHI-II met the set objective of training 24 service providers' supervisors in facilitative supervision based on QA, CBD backup, and OJT modules. The training was residential in Mombasa to ensure maximum participation and participants were also able to conduct field tours to Mtongwe clinic, Shika Adabu clinic, and the Bamako Initiative pharmacy.

The purpose of the field tours was to learn through observation how supervision is done, in order to compare knowledge gained at the workshop with practical experience. Participants also observed use of outreach services as a strategy to improve condom distribution, and the use of condoms as a method for protection against unwanted/unintended pregnancies and prevention of STI/HIV/AIDS. Other important aspects of clinic services observed were improving client flow by increasing

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the inflow of clients, using flex time for the convenience of clients, and using data to determine the level and quality of services. At the end of the training the following areas were identified for action planning:

- Supervision scheduling
- Networking
- Stakeholder mapping
- Team building
- Assessing customer needs
- Outreach strategies
- Staff motivation
- Data collection and report writing
- Capacity building

The participants evaluated the training and some of the recommendations included the fact that training should have been conducted at the beginning of the project to allow for follow-up training.

### **3.3.2 Training for Community-Based Reproductive Health Service Providers**

Because of the different levels of CBD agents at different sites and due to the intensity of the topics to be covered, this training was conducted for each of the three sites separately for a total of 15 days. The URHI-II project trained a total of 83 participants as shown in Table 4, slightly surpassing the set objective. A post training evaluation was conducted and the outcome indicated that the highest knowledge gained was 48% and the lowest was 1%. This implies that an urgent follow-up training was imperative for this group of service providers to enhance their knowledge and improve their skills to the required level. The following areas were identified for action planning for these service providers:

- IEC strategies
- Condom use for dual protection
- Improvement of referral systems
- Effective distribution systems
- Management of outreach activities

## **3.4 Other Accomplishments**

Placement of recommended equipment was completed and clinic renovation started during the beginning of the last quarter (July–September 2000) and is expected to continue until November 2000.

# 4. CONCLUSIONS AND RECOMMENDATIONS

In terms of quantitative outputs, URHI-II distributed 3,558,378 condoms through CBD agents, referral sites, and condom dispensers placed in various non-traditional outlets; educated 105,941 adults and 23,651 adolescents, with emphasis on condom use for dual protection; adapted/developed and distributed 1,700 different types of IEC materials; and trained 187 service providers. During the project period, the community-oriented demand generation approach adopted by Pathfinder and its municipal government partners had begun to show potential as being effective.

While municipal governments had proven, in URHI-I, that they could take on greater responsibilities for health infrastructure and personnel, they were confronted with a reduction in resources to solve the increasing challenges of expanding access to and improving the quality of FP/RH services for growing populations. With URHI phase II, Pathfinder and its implementing partners were convinced that self-governance was key to effective participation by community residents in resolving their health problems. For this reason community mobilization and participation was placed at the center of this project phase. Enhancing community capacity for engaging in participatory planning, problem solving, monitoring, resource mobilization, and development processes became key. The communities from the four selected sites thus became vital resources representing part of the unfunded involvement required.

## 4.1 Conclusions

A review of how the municipal governments in collaboration with their communities involved in URHI-II achieved the results that they did and the challenges that faced presents lessons on how municipal authorities could increase their capacity to meet the growing demand for high quality reproductive services needed to reach high transmitters that would subsequently have impact.

### 4.1.1 Establishing Tangible Partnerships with Local Communities

Municipal governments often focus on national government resources to solve ongoing health problems including RH. This results in neglect of local institutions and even existing community structures. With support from Pathfinder, municipal governments from the three selected cities, Nairobi and Mombasa, Kenya, and Arusha in Tanzania, opted to form coalitions with local organizations and local community structures. Through participatory community diagnoses and

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facilities assessment preceded by sensitization, current data on the communities' priority areas in FP/RH became available and appropriate strategies that would address these priority areas were defined. Dissemination of the findings of the studies to the communities and their leaders, to share and validate the preliminary results, had the effect of enhancing target populations' awareness of their problems and their willingness to take action. Thus a project that would ensure community participation was designed.

#### **4.1.2 Empowering Local Communities and Engendering Sustainability**

During the community diagnosis survey, community leaders came up with responses that they considered appropriate for their FP/RH issues and categorized target populations (youth and men and women) that these responses were to address. These priorities were not necessarily those of Pathfinder or the municipal governments. The community leaders also suggested how some of the proposed strategies could best be implemented. For example, in the area of IEC, particularly promotion of condom use for dual protection, the community leaders gave their views on the most effective ways to present information on this strategy. Reaching compromises with the community leaders on their priorities reinforced their position as stakeholders in the subsequent intervention. Pathfinder and municipal governments, recognizing the importance of joint problem solving, also built into the project design consultative meetings with community leaders to review project progress.

The process of resource mobilization is an important ingredient for sustainability. Two aspects of resource mobilization emerged from URHI-II. Although still nascent at the end of the project, the initiatives were already showing promise. The two initiatives were a) reinforcement of existing community structures, and b) strengthening of the capacity of available human resources.

##### ***Reinforcement of Existing Community Structures***

Working with existing organizations or structures is generally more effective and sustainable than creating new ones. Also, community-based groups with little or no previous experience in FP/RH can be mobilized to support FP/RH activities including STI/HIV/AIDS control and prevention in their communities if the process is kept simple and participatory. Pathfinder and its partners built on the existing community groups and outlets to undertake outreach activities, thus ensuring the requisite trust from the communities. This reinforcement and fostering of community ownership through community groups is likely to increase sustainability in time and thus reduce donor dependence.

##### ***Strengthening of the Capacity of Available Human Resources***

Through URHI-II, Pathfinder provided technical assistance in intensive training geared towards enhancing the capacity of non health facility service providers within the catchment areas. The training targeted CBD agents and peer motivators who have a broader outreach and are expected to remain the link between the communities and the initiative. The challenge, as stressed elsewhere in this report, remains that of maintaining momentum. Municipal government program managers need to find ways to reduce the burnout among those directly involved with the communities

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whose work is difficult and often discouraging and to document slow but real progress in implementing this kind of intervention, in order to convince the national government and the communities of the importance of continued support.

### **4.1.3 Improving Access to Reproductive Health Services**

In the face of increasing poverty in sub-Saharan Africa, informal settlements within the urban areas continue to grow. Improving access to quality FP/RH services becomes a challenge for local authorities in African cities. As demonstrated by this intervention, improving access includes working beyond static clinics and expanding activities into the communities. And this implies getting the communities involved in the process of formulating strategies. By applying some of these jointly formulated strategies the URHI-I project used various community resources to expand access in the selected catchment areas. Among other things:

- Some communities mobilized anti-drug youth groups to provide information and education on condom use for dual protection to their peers during social community events and in schools. These youth groups also made referrals for other methods as well as the STI cases to the static clinics and distributed contraceptives such as condoms and foaming tablets.
- Involving non-traditional health sectors not usually associated with health service delivery such as recreation provided critical new resources for service expansion. For example, extending condom distribution beyond clinics and CBD agents to other non traditional outlets such as bars, video show rooms, hair salons/barber shops, and even bus stages made condoms available and more accessible to individuals who are likely to use them in high risk situations. The dramatic increase in the number of condoms distributed can be attributed to the expansion to non-traditional outlets.

Building on the achievements of URHI-I, which upgraded clinics and service provider skills, URHI-II adopted a community-oriented demand generation approach, to enhance the target communities' capacity to engage in participatory planning, problem solving, monitoring, and resource mobilization. This implementation strategy offered community residents and their leaders opportunities to develop experiences through learning by doing. Further, the strategy that residents themselves, if provided with organizational tools to enable them to take responsibility for their own health status and advancement, constitute primary resources for effective implementation.

To build this capacity, Pathfinder took the following steps:

- Consulted with local implementing partner managers and community leaders prior to the onset of the project and continued this consultation during project implementation.
- Jointly conducted community diagnosis with target communities.
- Jointly facilitated the enhancement of community structures in the community setting.

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- Worked with local implementing partners to ensure joint ownership and community level accountability

## 4.2 Recommendations

The approach of extending efforts into urban communities and the use of community involvement and participation processes have the potential to help municipal governments to ensure that all their inhabitants, especially the urban poor and youth, have access to high quality reproductive health services. However, it must be pointed out that these processes take a long time to put in place and a longer period of time was needed for desired impact.

In order not to lose the accomplishments thus far achieved, it is proposed that:

- The URHI-II current activities be extended, not necessarily through Pathfinder but another cooperating agency or donor agency. This would give the project time to mature, have a greater impact, and perhaps attain sustainability.
- The project be tagged on to other projects with similar objectives or even to other health or non health community projects.
- The model be scaled up to meet the needs of similar populations in other urban municipalities in both Kenya and Tanzania.



Mtongwe, Mombasa - CBD agents display their CBD bags, which are their tool kits.

## **APPENDIX: RESULTS OF BASELINE SURVEYS OF COMMUNITIES AND FACILITIES**

The first few months of Urban Initiative phase II were devoted to baseline surveys of two types: 1) community diagnoses, which was used to inform the URHI program design, and 2) clinic needs assessments, which were used to prepare plans for improving the referral clinics as well as for future evaluation of progress.

Drawing from lessons learned during phase I, including inadequate service provision by clinics to catchment area populations, clinics not reaching high transmitters due to lack of skills and logistics, and negative attitudes by service providers vis-a-vis target groups such young men, the start of the project's phase II began with the redesign of the URHI to reinforce and expand the improved clinical services that resulted from activities in phase I.

Because of the different emphasis in phase II, Pathfinder International's first step was to develop site selection criteria. These communities are urban slums with similar health and socioeconomic problems, including abject poverty. The community diagnoses were conducted in four selected areas: Kabiro-Kawangware (population approximately 300,000) and Kangemi (population of 70,000) in Nairobi, Mtongwe in Mombasa (population 42,000–65,000 in 9 villages), and Unga Ltd/Sombetini (population just over 65,000) in Arusha, Tanzania. The community diagnoses focused on identifying priority community health problems, placement and types of community-based RH activities that would have the greatest impact among the target groups, organizations, or groups most likely to participate in project activities, and receptivity to certain proposed activities.

### **1. Community Diagnoses**

Specific objectives of the community diagnosis were:

- To assess availability of community structures and resources that could be used/pooled in support of community based FP/RH/STI/HIV/AIDS programs (such as health facilities, schools, significant shops and kiosks, leaders, women and youth groups, centers, bars, brothels and hotels).
- To identify major health problems afflicting selected communities.
- To assess community leaders' attitudes toward and willingness to provide FP/STI/HIV/AIDS services to community members including youth.

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- To assess community members attitudes to condom use, STI/HIV/AIDS, and abortion, and willingness to sell condoms in the communities.

Qualitative and quantitative data were collected to enable URHI-II to build on the existing community structures for full implementation of the planned activities. The groups involved in this study were:

- Adolescent girls and boys aged 14–18
- Young women and men aged 19–25
- Adult men and women
- Men and women community group leaders

Information about the existence of community structures for improving reproductive health services, including family planning and STI/HIV/AIDS, as well a identification of other issues was obtained from study groups through interviews and focus group discussions.

### **1.1 Findings from Interviews with Community Members and Community Leaders**

The community diagnosis data presented in this section are organized according to:

- Availability of structures and resources that can be used to support FP/STI/HIV/AIDS activities
- Identification of major health problems within the selected communities
- Participation in health related activities by communities or community groups
- Levels of participation or involvement in health work by communities or community groups
- Receptivity to certain proposed activities

#### ***Availability of Community Structures and Resources***

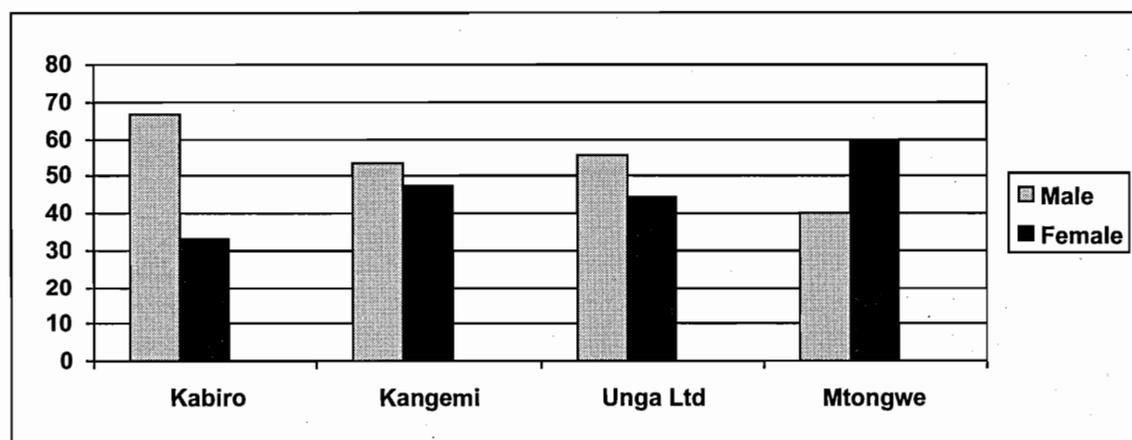
It emerged from the study that community structures (groups) are formed along either social or traditional lines. All community group leaders are elected by the general community or installed to leadership positions on the basis that the person who initiated the idea of forming the local community group automatically became the leader. A total of six specific types of community structures were identified. The distribution of existing groups is shown in Table A1.

It is of interest to note that all of the 83 group leaders of the local community groups mentioned at least one objective for the formation of their group or organization. These objectives ranged from development, employment, and self-help, to the education of women in community development and the provision of security to leisure groups. As for the length of their existence or period of functioning, the mean length of time ranged from a low of 3.1 years at one site to 7.1 years at another site.

**Table A1. Distribution of existing local community groups by site**

Group type	Kabiro		Kangemi		Mtongwe		Unga Ltd		Total	
	No.	%								
Women groups	5	23.8	6	35.3	10	37.1	7	38.8	28	33.7
Youth groups	2	9.6	6	35.3	12	44.4	2	11.1	22	26.4
Touts groups	1	4.8	0	0.0	1	3.7	0	0.0	2	2.4
Microenterprise	4	19.0	1	5.9	0	0.0	0	0.0	5	6.0
NGO	0	0.0	1	5.9	0	0.0	1	5.6	2	2.4
CBO	5	23.8	1	5.9	1	3.7	5	27.8	12	14.5
Other groups	4	19.9	2	11.7	3	11.1	3	16.7	12	14.5
<b>Total</b>	<b>21</b>	<b>100</b>	<b>17</b>	<b>100</b>	<b>27</b>	<b>100</b>	<b>18</b>	<b>100</b>	<b>83</b>	<b>100</b>

Over half (54.2%) of the community structure/organization leaders interviewed in this study were men—both young and adult—in three of the study sites: Kabiro-Kawangware, Kangemi (Nairobi), and Unga Ltd. (Tanzania). In Mtongwe (Mombasa), 60% of the community structure leaders were women. These results are presented in Figure A1.

**Figure A1: Distribution of local community structure leaders by gender, August 1999**

With the exception of Mtongwe site in Mombasa, there was little difference in the distribution of local community structures with respect to age. The mean age of leaders was 36.4 years in Kabiro-Kawangware, 35.2 years in Kangemi, and 33.8 years in Unga Ltd/Sombetini, which were all significantly different from the mean age of community leaders in Mtongwe (26.5 years). These results are presented in Table A2.

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**Table A2: Distribution of local community structure leaders by average and median age, August 1999**

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Site	No. Observations	Mean age	Standard deviation	Median age
Kabiro	21	36.4	10.8	34
Kangemi	15	35.2	12.9	33
Mtongwe	28	26.5	11.7	27
Unga Ltd.	21	33.8	12.8	36

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***Major Health Problems within the Communities***

Leaders of the community groups listed in Table A2 were able to identify what they perceived as major health problems affecting populations in their communities:

**Young women/girls:**

- Induced abortions
- Early and premarital pregnancy
- Sexual abuse
- Alcoholism and drug abuse
- Prostitution
- HIV/AIDS/STD

**Young men/boys:**

- Drug and alcohol abuse
- Sexually transmitted diseases
- HIV/AIDS

**Adult women:**

- Prostitution—increasing numbers of commercial sex workers (CSWs) due to economic hardships
- Drug and alcohol abuse
- Infertility
- Malaria
- Poor nutrition

**Adult men:**

- Alcohol and drug abuse
- Sexually transmitted diseases
- HIV/AIDS
- Malaria
- Lack of health care services

***Matatu drivers/touts:***

- Drug and alcohol abuse
- STD/HIV/AIDS

- Premarital sex and promiscuity
- Ignorance of presence/location of health services particularly FP/RH services
- Non-use of condoms during casual sex

**Commercial sex workers (CSWs):**

- Gonorrhoea (STDs)
- HIV/AIDS
- Promiscuity (multiple sexual partners)
- Infertility
- Drug and alcohol abuse

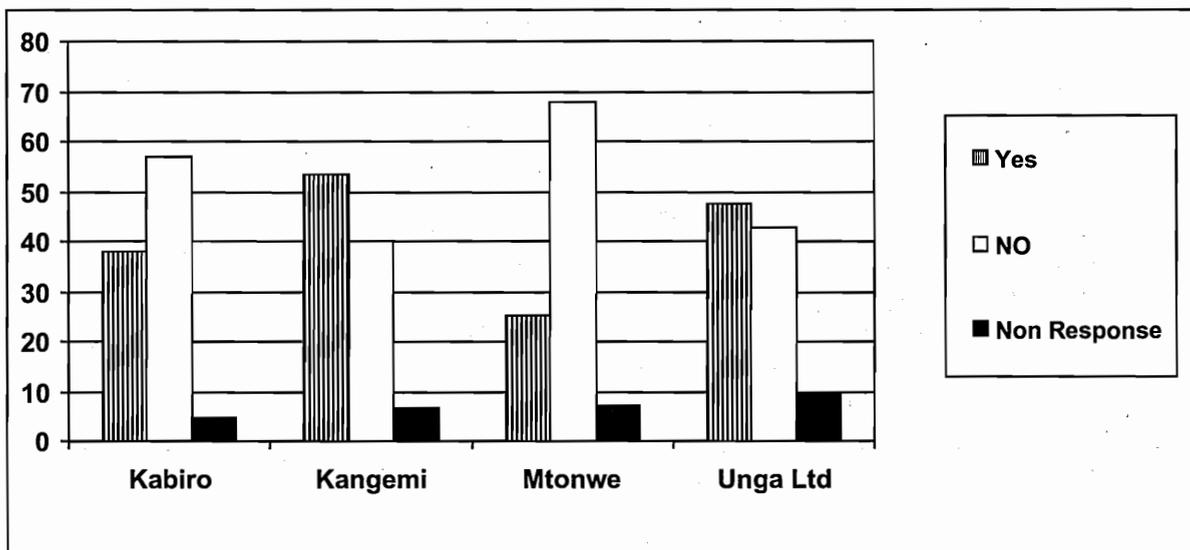
**Other problems believed to contribute to poor health:**

- Lack of family planning services
- High cost of health services
- Lack of maternity services
- Physical abuse
- Poor hygiene
- Illiteracy and ignorance

**Participation by Community Groups**

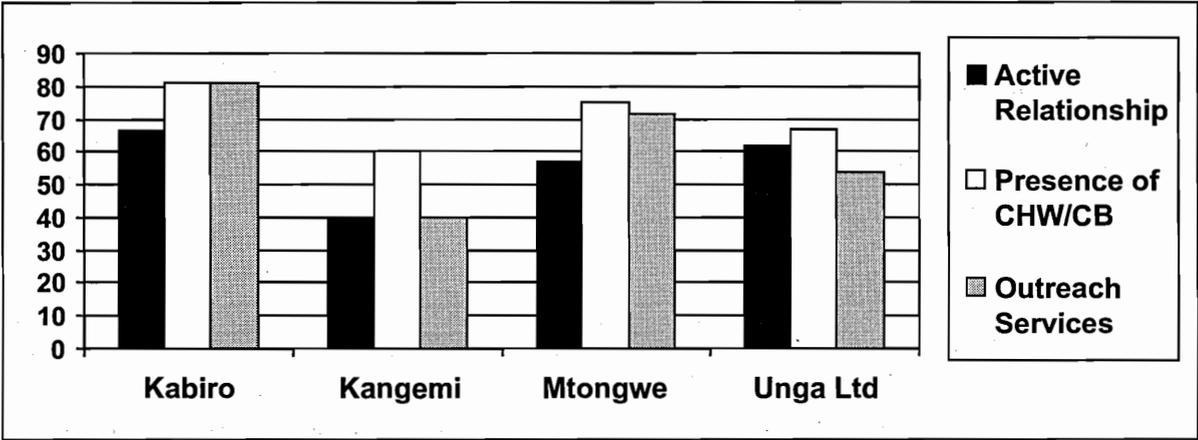
Three out of five community group leaders from the four sites reported having been involved in mobilizing their communities to change or improve a situation. The community groups were mobilized to promote environmental hygiene, as well as informal education of communities on communicable diseases and health promotion, including immunizations. The participation of community groups in health related activities is shown in Figure A2.

**Figure A2. Community group participation in health related activities**

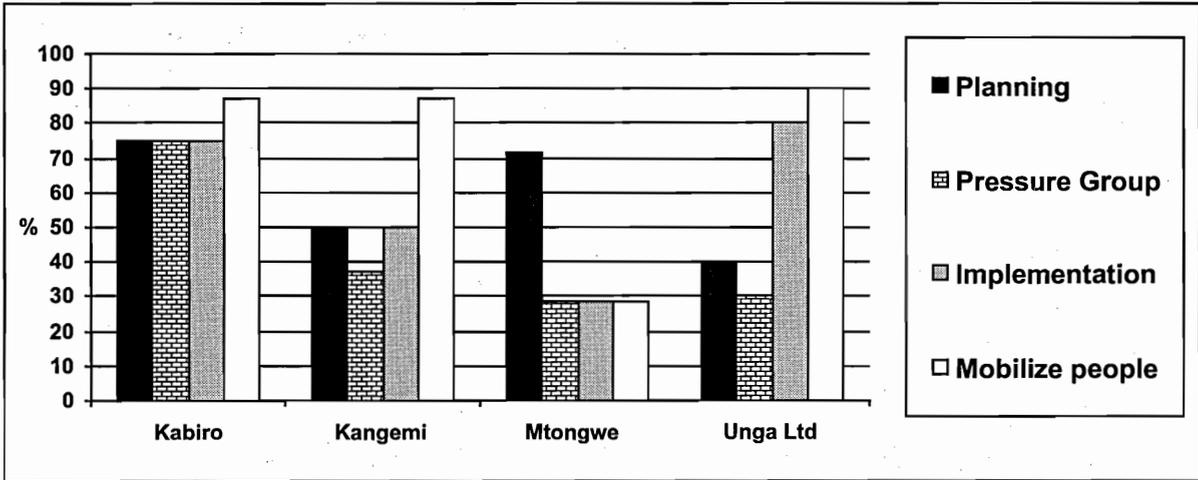


From Figure A2 it is clear that there was a wide variation in the percentage of group participation in health related work among the study sites. The differences varied from 53.3% in Kangemi in Nairobi to 25% in Mtongwe, Mombasa. More specifically, there was an insignificant presence of groups or organizations working or participating in STI/HIV/AIDS prevention and control in the four selected sites. Some community leaders, however, said they had active relationships with local NGOs in the fight against HIV/AIDS. Similarly, the community groups had community health workers or community-based distributors who conducted outreach activities within their communities (as illustrated in Figure A3).

**Figure A3. Community groups' relationship with organizations working in HIV/AIDS control and prevention: Presence of CHW/CBD and outreach services**



**Figure A4. Community groups by levels of participation**



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In total, 85% of communities involved in this study participated in health related work through partnerships with organizations working in the area of STI/HIV/AIDS, through community health workers, CBDs, and outreach activities. In terms of relationships with organizations involved in STI/HIV/AIDS, the percentages were very low with 12.2% in Kangemi and 33% in Mtongwe. The percentages of CHWs and CBDs were higher, however, with 60% in Kangemi and 81% in Kabiro-Kawangware. The presence of outreach activities varied with each study site in relative terms, being highest in Kabiro with 81% and lowest in Kangemi with 40% (Figure A3). The lower percentages in some of the sites could be explained by the fact that members of these communities had not been made aware of some of the ongoing projects. For example, greater publicity about the presence of a CBD agent or community health worker and their work within a given community would increase the number of people who use them for information and services.

### ***Levels of Participation or Involvement in Health Activities***

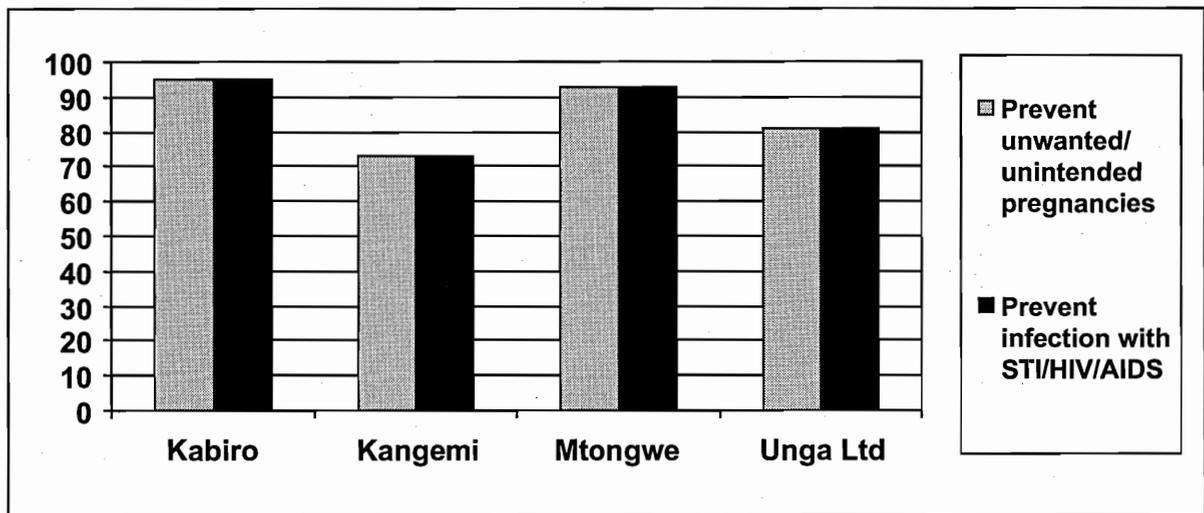
Levels of participation or involvement in health work were classified into four distinct categories: 1) planning, 2) power or pressure group, 3) implementation, and 4) mobilizing people for community work. The various levels are shown in Figure A4.

Of the 33 leaders whose groups' ever participated in health related activities, over 75% affirmed that their groups were involved in mobilizing people for communal work. More than 60% of the community groups participated in health work at the level of activity implementation. However, at the level of planning only 55% said they had participated and at the level of advocacy (pressure group) only 42% affirmed to have participated. Despite the presence of ongoing projects, such as the Kabiro Health Project in Kawangware and the Bamako Initiative Project in Mombasa, that mobilized their communities in health related work, these low percentages seem to imply that until recently these disadvantaged communities were perceived as needing help. Most, therefore, remained at the level of recipients with no participatory role or mere provision of labor as opposed to involvement in identifying and prioritizing needs, planning strategies to overcome problems, and getting involved in the implementation and subsequent evaluation.

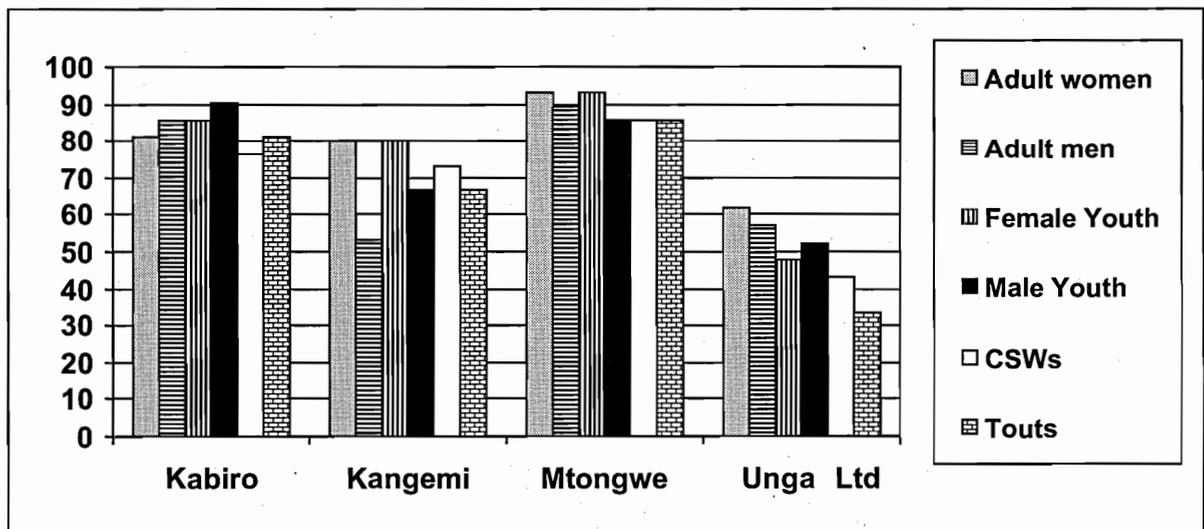
The community diagnosis also examined community leader knowledge and attitude towards condom use for dual protection. The percentage of community leaders who knew that condoms were used both to prevent unwanted/unintended pregnancies and to prevent STI/HIV/AIDS infection in the four sites was highest in Kabiro-Kawangware (91%) and lowest in Kangemi (67%). The lower percentages could be due to insufficient previous presentations made about condom use for dual protection.

This section of the community diagnosis survey examined community leaders' support for condom use for dual protection, and ways to present information about condom use for prevention of unwanted/unintended pregnancy and STI/HIV/AIDS. In terms of support for condom use for dual protection, the percentages remained high, as shown in Figures A5 and A6.

**Figure A5. Community leaders supporting condom use for prevention of unwanted pregnancies and STI/HIV/AIDS**



**Figure A6. Community groups willing to promote condom use**



More than 95% of the community leaders in Kabiro-Kawangware and 93% in Mtongwe supported condom use for prevention of unwanted/unintended pregnancies as well as prevention of STIs/ HIV/AIDS. This compares with 81% in Unga Ltd and 73% in Kangemi.

A few of the leaders (9.4%) opposed the display of information about condom use for dual protection for the following reasons:

- Display of information would promote immorality, as people would feel free to practice sex indiscriminately.

- Information about condom use was not needed as most members of the community groups are married couples.
- Display facilities were lacking.

Community group leaders gave their views on the most effective ways to present information about condom use for the prevention of unwanted/unintended pregnancy as well as STI/HIV/AIDS. These are compiled into the list shown in Table A3.

**Table A3. Community leaders' suggestions for ways to present information to the communities about condom use for prevention of unwanted/unintended pregnancy and STI/HIV/AIDS**

No	For family planning	For STI/HIV/AIDS prevention
1.	Sensitization seminars	Drama
2.	Radio spots/programs	Video shows
3.	Public film shows	Posters/leaflets
4.	Pamphlets/posters/brochures	Community education
5.	Video shows	Mobile film shows
6.	Public talks by health workers	Outreach programs
7.	Books/magazines	Home visits by health workers
8.	Counseling	
9.	Door-to-door campaigns	

### ***Receptivity to Certain Proposed Activities***

This section of the community diagnosis deals with the communities' willingness to participate in condom distribution including distribution in non-traditional outlets.

**Participation in Condom Distribution.** The study revealed that various community groups were willing to act as advocates for condom use. As shown in Figure A6, more than 90% of group leaders in Kabiro-Kawangware, compared with a low of 18% in Unga Ltd/Sombetini, indicated that their community groups were willing to participate in condom distribution activities. In addition, 85% of groups were willing to show videos on condom use so that their community members might learn how to practice safe sex. The various community leaders and groups wanted video shows that would particularly pass messages about the ways HIV/AIDS is transmitted as well as soliciting compassion for persons living with HIV/AIDS (PLWHAs).

The proportion of groups willing to be involved in the promotion of condom use was highest among the adult women target group (80%) and lowest for *matatu* touts (68%). The relatively low percentage of touts approving condom use is not easy to explain. *Matatu* touts as a group are considered to be at high risk of STI/HIV/AIDS because of the nature of their occupation and their sexual behavior. Their attitude could be linked to their own of perception. Perception influences people's attitudes and also their behavior. The process of perceiving allows individuals to receive information and to understand and appreciate that information. Before a person can choose to reduce their personal risk of HIV infection, they must first perceive that they are at risk, and understand the factors that put them at risk. The *matatu* touts perhaps did not perceive themselves at risk.

**Possible Expansion of Condom Distribution to Non-Traditional Outlets.** In order to reinforce the concept of “Condom use for dual protection” it was envisaged that condoms needed to be made more available through non-traditional condom outlets within the communities. During the community diagnosis a cross-sectional survey of 143 business establishments was conducted to determine potential non-traditional condom outlets as shown in Table A4.

**Table A4. Distribution of 143 potential condom outlets by study site**

Establishment type	Kabiro		Kangemi		Mtongwe		Unga Ltd		Total	
	N	%	N	%	N	%	N	%	N	%
Video showroom	8	21.1	2	4.6	5	17.2	6	18.2	21	14.7
Hotel/lodge	2	5.3	0	0.0	1	3.4	2	6.1	5	3.5
Restaurant/café	0	0.0	3	7.0	3	10.3	1	3.0	7	4.9
Pharmacy/Chemist	0	0.0	1	2.3	1	3.4	1	3.0	3	2.1
Supermarket	5	13.2	2	4.6	0	0.0	0	0.0	7	4.9
Salon/barber shop	7	18.4	10	23.3	4	13.8	9	27.3	30	21
Shop	3	7.5	5	11.6	9	31	6	18.2	23	16.1
Bar/Night Club	7	18.4	9	20.9	3	10.3	8	24.2	27	18.9
Service bureau	0	0.0	2	4.6	0	0.0	0	0.0	2	1.4
Others	6	15.8	9	20.9	3	10.3	0	0.0	18	12.6
Total	38	100	43	100	29	100	33	100	143	100

From the study, and as reflected in Table A4, there were numerous business establishments that had potential as condom outlets. These included bars, nightclubs, hair salons/barber shops, and video showrooms. These establishments are usually very busy and attracted more youth and adult women than other types of business hence had potential as condom outlets. The study further revealed that every establishment surveyed received a mixture of customers. These customers were pre-classified as female youth, male youth, female adult, and male adult. More than 80% of the owners of the establishments said the pre-classified customers frequented their business. Consequently, video show rooms, hair salons/barber shops, grocery shops, bars/night clubs, and other places such as tout stands were identified as appropriate outlets for condom distribution, to be incorporated into the URHI-II project design.

**Willingness by Owners to Participate in the Promotion of Condoms in Their Establishments.**

Nearly 78% of the respondents were willing to make condoms available in their establishments and the majority preferred to distribute condoms for free. The majority of the establishments willing to distribute free condoms required condom dispensers (82.2%). A high percentage of owners or caretakers of the establishments were willing to allow information on condom use for dual protection to be displayed in their establishments, with the highest being Mtongwe (89.7%), and the lowest being Unga ltd with 72.7%.

There were, however, those respondents who were reticent about making condoms available in their establishments. Among the reasons given were:

- 
- Their religion did not allow them to promote condom use.
  - It was not good for the image of the business to sell or provide free condoms.
  - People were generally shy to ask for condoms in the presence of others who may be known to them, while other respondents said that most of their customers were married couples and therefore did not require condoms.

## **1.2 Youth Focus Group Discussions**

The youth groups (young men and women) discussed adolescent attitudes towards sexual practices, condom use, and knowledge about sexually transmitted diseases including HIV/AIDS. They also talked about ways of prevention, prevalence of teenage pregnancy, abortion, and the needs of young people and organizational structures.

Adolescent young women and men reported initiating into sex at an early age (10–14 years). The sexual negotiation process was nearly always driven by payment of cash or gift. Young women's willingness to exchange sex for gifts was blamed on poverty and lack of economic opportunities for young women. The predicament of young women is compounded by the fact that they are sought out by older men in the belief that they are free of HIV/AIDS.

### ***Condom Use***

Nearly every young man or woman participating knew about and had seen a condom. In terms of condom use, young men were willing to use them but were shy to purchase them. In addition, whatever little money they had, their preference was to purchase cigarettes or alcoholic drinks. On the other hand, young women had some concerns about condom use:

- Condoms might remain inside them.
- Young men might intentionally poke holes in the condoms.
- Condoms are believed to be laced with the HIV virus.

These misconceptions require correction with accurate and appropriate IEC messages specifically designed for youth.

### ***Current Knowledge about STI/HIV/AIDS***

Focus group discussions further revealed that young men and women knew that STIs are contracted through sexual intercourse and were able to identify some sexually transmitted diseases such as gonorrhea and syphilis. With regard to HIV/AIDS, young men participating were able to cite opportunistic diseases such as TB, diarrhea, and skin infections as symptoms of the disease. The participants mentioned more than one mode of prevention:

- Use of condoms during every act of sexual intercourse
- Abstaining from sex altogether
- Sticking to one partner
- Being faithful to each other

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Of concern was the fact that young men felt that having AIDS was like “catching a common cold,” while young women took it more seriously because “AIDS finishes you.” Both groups were concerned about not being able to tell whether a potential partner is infected. But more serious was the attitude of young men of not being disposed to inform their sexual partner if they were infected with STIs or HIV/AIDS. In general, men blame women for spreading AIDS. Here again there appears to be a problem of perception of risk. The process of risk perception allows individuals to receive information, to understand and appreciate that information, and to form an opinion and be prepared to respond to the information.

### ***Unwanted/Unintended Teenage Pregnancy and Abortion***

Both groups acknowledged that premarital pregnancy is not desirable. Yet for the young women, teenage pregnancy was the most common health problem in these communities. For example, pregnancy occurred in adolescents as young as 14 years at Mtongwe site, Mombasa. Young women blamed unwanted/unintended pregnancy on peer pressure pushing them to early sexual initiation, lack of information from parents and community at large, and men who lure them into sex in exchange for gifts. More critical, however, was that these pregnancies ended in abortions, most often botched from dubious services, to avoid shame/stigma and for fear of being left with the burden of dealing with the consequences of the pregnancy after they are abandoned by their partners.

### ***Identified Needs for Young People in the Communities***

- Most young people need information on various health issues currently affecting them. Some of the participants expressed concern about lack of community centers where youth can meet and receive information and general health education including family planning and other reproductive health issues.
- Young people need to be given accurate information about ways of transmission and appropriate means of protection against infection from HIV/AIDS and other sexually transmitted diseases.
- Youth need to be educated about the effects of drug abuse, alcohol consumption, family planning, and control of sexually transmitted diseases.
- Condoms should be made available to adolescents at an affordable price and HIV testing and counseling should be made locally available on request.
- Existing health services should be made more accessible to the youth by having special clinic days offering a range of services to the youth and by having health care providers appropriately trained on adolescent health.
- With emphasis on the impact of poverty on health, there was need to establish vocational training and income-generating activities.
- On ways of improving information to increase awareness, the young men suggested video

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shows on HIV/AIDS, drama competitions, demonstrations on the correct way to use condoms, community education, and talks by people living with AIDS.

- The limitations of written materials were also mentioned, as very few people could read. The youth suggested seminars/workshops on reproductive health for the youth within their communities, peer counseling, and mobile large screen film shows within the community.
- Accessibility of condoms in social places such as youth sports clubs and bars was desirable, as opposed to classic outlets such as shops and pharmacies that closed on regulated hours.
- More information on condoms was a requirement such as disposal by burning or burying in pit latrines after use to minimize dangers posed to unsuspecting children.

### ***Major Constraints in Undertaking Community Work***

Lack of resources, especially locally generated funds, was cited as a constraint for these less advantage communities in undertaking community work. However, the main problems perceived by local community group leaders as adversely affecting the communities at the study sites were:

- High cost of health care services, making these services financially inaccessible to the majority of these poor populations.
- Non-existence of comprehensive health services. Such services were often located far away from the communities and did not provide a whole range of services such as laboratory and maternity care.
- No free services were available even at the municipal or city council health units.
- Drugs were not available in most public health care facilities.
- There were no traditional birth attendants (TBAs) who could provide substitute maternity services.
- The communities lacked clean drinking water, sanitation and drainage systems, and garbage collection.

### **1.3 Programmatic Issues Emerging from the Community Diagnosis**

There were two categories of programmatic response emerging from the community survey: those for young people and those for community leaders and adult men and women.

#### ***Programmatic Issues for Youth***

For this category, the following issues were identified:

- 
- Creating a forum for young women and men, parents, and members of the community groups that would ensure their involvement in identifying and defining community problems as well as designing and implementing solutions.
  - Creating strategies that would increase economic opportunities for the youth who have dropped out of school such as establishing vocational training facilities within the communities.
  - Targeting STI/HIV/AIDS education efforts towards young men's and young women's realities and including young married adolescents in community education efforts.
  - Selecting a couple of youth for training as youth peer educators to reach out with information on STIs/HIV/AIDS and family planning.
  - Establishing regular mobile large-screen cinema/film shows on STI/HIV/AIDS, family planning, and a whole range of reproductive health issues within the communities.
  - Making condoms more accessible to youth and involving youth in their promotion by emphasizing correct use and addressing fears, concerns, and misinformation as well as negotiation skills/issues.
  - Establishing and promoting community-based sexual and reproductive health education and counseling to deal with negotiation skills within relationships among the youth.
  - Establishing community-based distribution outreach programs using peer educators and CBDs.
  - Introducing special clinic days exclusively for youth to receive IEC and treatment of their medical conditions in public health facilities.

***Programmatic Issues for Community Leaders and Adult Men and Women***

For this second category the following issues were identified:

- Forming village or community health committees at each project site and defining the composition, functions, roles, and responsibilities for the implementation of a sustainable reproductive health initiative project.
- Developing community-based distribution programs that will enable members of the community to be trained as distributors and establish outreach activities through community organizations in the areas, e.g., Bamako Initiative project in Mtongwe.
- Integrating family planning, STIs, and other reproductive health services into community-based health programs.

- 
- Providing information, education and communication (IEC) in reproductive health, including STI/HIV/AIDS, to community leaders and adult men and women.
  - Providing free condom dispensers in popular places frequently visited by sexually active segments of the population, such as bars, lodges, guesthouses, and health facilities, to promote greater condom use.
  - Introducing cost-sharing into the project for a long-term sustainability of health services. There was an overwhelming support for cost sharing from the communities in the study sites.

## **2. Clinic Facility Needs Assessments**

The community oriented approach of URHI-II, while focusing on innovative prevention activities, was to maintain curative services at clinics that would provide referral points and backup for community-based services. This exercise was conducted concurrently with and as part of the community diagnosis survey. The purpose of the facilities needs assessment was to collect baseline information that would be used to prepare plans for improving/upgrading referral clinics. More specifically, the assessments focused on:

- Availability and quality of services
- Staff strengths, needs, and willingness to participate in the project
- Availability of commodities and equipment

The assessments were conducted at two clinics in each of the project sites.

### **2.1 Kangemi Site, Nairobi**

The Kangemi NCC Clinic and Mawamu Medical Clinic, both situated in Kangemi Location of Nairobi City, serve a population of 60,000 people, consisting of 20% women of reproductive age and over 50% youth. Both clinics offer curative, preventive, and promotive services. Both clinics are easily accessible by the target population. The Kangemi NCC clinic operates from five rooms (two of which are reserved for MCH/FP services), has electricity, running water, logo, and signpost, but lacks partitions for privacy. Mawamu has two rooms (one reserved for MCH/FP), electricity, and running water, but has neither a logo nor a signpost. The clinic operates five days a week. Neither of the two clinics had a list of services they provide. However, interviews with senior clinic staff revealed that services provided included family planning (with VSC clients being referred to Kenyatta National Referral Hospital and Family Planning Association of Kenya), immunization (mother and child), counseling for infertility, STI prevention and management, AIDS counseling, treatment of minor ailments, and laboratory services.

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### **Staffing**

Although Kangemi clinical staff were trained in comprehensive RH/FP and STI management assessment they had not had updates during the previous three years. The clinic also supervised 40 CBD workers located in the Kangemi catchment area. (See Table A5.) The CBDs distributed non-prescription contraceptives including condoms and conducted IEC and community mobilization for RH/FP services within the communities they served. As for Mawamu clinic, out of the three clinical staff only one was trained in RH/FP. This clinic, however, had no CBDs.

**Table A5. Kangemi site: Staffing**

Types	Kangemi NCC Clinic	Mawamu Med. Clinic	Total
Clinical	9	3	9
CBD	40	0	40
Total	49	3	49

### **Service Delivery**

There were no CBD clients at either Kangemi or Mawamu clinics (Table A6). This would imply that the CBD agents attached to the Kangemi clinic were not making any referrals. During the examination of clinic records neither referral cards nor returned referral cards were seen at the two clinics. Of note here is the fact that the figures in Table A6 were randomly selected and should not be linked to the figures in Table A7.

**Table A6. Kangemi site: Summary of service delivery during a period of three months**

Total # of clients served	Kangemi NCC Clinic	Mawamu Medical Clinic
Clinic Services		
1 <sup>st</sup> visit	343	20
Return visit	1963	150
Return ratio: Revisits/ New	5.7	7.5
Average daily client load	6	2.4
CBD	0	0

**Table A7. Kangemi site: Clients served by method in each clinic for a period of three months**

Method	Kangemi NCC Clinic	Mawamu Medical Clinic	Total Clients
Pills	725	31	756
Condoms	150	10	160
Injectables	1606	92	1698
IUCDS	0	3	3
Others	141	13	154
Total	2622	149	2771

Table A7 illustrates that condom distribution was at a very low level. It could be surmised that the clinic was not sufficiently promoting condom use at the clinic level or through community promotion of RH/FP by the CBDs. Both clinics had regular supplies of contraceptives including condoms. Any contraceptives not in stock, e.g., foam tablets and jelly, were not available at the

Ministry of Health, the main supplier. On the other hand, most non-contraceptive supplies such as cotton wool, antiseptic lotion, draw sheets, disposable gloves, surgical gloves, drugs for RX of STI, etc., were lacking in both clinics.

### ***Clinic Equipment***

During the visits to these clinics, it was observed that the two clinics lacked essential equipment and where the equipment was available it was inadequate. Table A8 shows the required equipment.

**Table A8. Kangemi site: List of requirements**

Items	Requirements per clinic		Total Required
	Kangemi NCC	Mawamu	
Torch	1	1	2
Sphygomometer	1	1	2
Stethoscope	1	1	2
Oral thermometers	2	2	4
Galipots	0	4	4
Adult scale	1	1	2
Adjustable stool	1	1	2
Cheatle forceps	2	2	4
Medium drums	1	1	2
Kidney dishes	2	4	6
Pedal bin	1	1	2
IUCD kits	3	3	6
Autoclave	1	1	2
Sterilizer	1	1	2
Scissors, 8-inch	6	4	10

### ***Recommendations***

The service providers cited the following major problems as affecting their performance and preventing them from achieving their goals: lack of commodities and supplies, inadequate staff, inadequate skill/training, lack of equipment and IEC materials/strategies, and lack of financial resources. The following recommendations were made to address their concerns:

- That FP rooms at Kangemi clinic be renovated and curtains provided to ensure privacy. The Mawamu Medical clinic needed to put up signposts and a logo as well as a comprehensive list of available services. Both clinics needed to have in place a system of referrals and follow up of defaulters and also get involved in community mobilization to gain support for the project. It was further recommended that service providers start supportive supervision, document results, and provide necessary protocols and guidelines to ensure quality services.
- That staff capacity to participate be enhanced. Staff at both clinics were willing to participate in the URHI project but needed updates in infection prevention, targeted IEC, and counseling for FP/STI/HIV/AIDS. Staff capabilities also needed to be strengthened specifically in STI syndromic management.

- That the project provide furniture such as filing cabinets, display boards for IEC materials, and benches or chairs for waiting clients. In addition, minimal equipment as listed in Table A8 was to be provided to enhance the quality of care in RH/FP service delivery. The required supplies were to be furnished to both clinics.

## 2.2 Kawangware Site, Nairobi

The Kawangware site included Kabiro Health Care Trust, situated in Kawangware Location, and Riruta Health Center, a Nairobi City Council clinic, in the Riruta slums, both in the City of Nairobi. Together the two clinics serve a population of 204,632 people, 20% of whom are women of reproductive age and over 50% youth. The clinics are easily accessible to the target population and offer curative, preventive, and promotive health services. In addition, Kabiro clinic has a youth center that caters for youth from the slum areas. Kabiro clinic has one room for MCH/FP services and does not have a partitioned area for privacy. Riruta operates from two rooms for similar services. Both clinics have FP logos as well as signposts, running water, and electricity. They both provide the following services: integrated FP with other activities, FP services (with VSC clients being referred to FPAK clinics), immunizations (mother and child), counseling for infertility, STI diagnosis and treatment, HIV/AIDS counseling, treatment of minor ailments, and limited laboratory services.

### *Staffing*

The two clinical staff at Kabiro clinic were trained in comprehensive RH/FP. The clinic supervised 20 CBD agents, 20 peer counselors, and 10 youth motivators, all located in the catchment area, with a primary responsibility of distributing non-prescription contraceptives and conducting IEC including community mobilization for RH/FP services within the communities. On the other hand, out of a total of 15 staff at Riruta clinic, only 2 were trained in RH/FP service delivery. The Riruta clinic had no CBD agents, youth counselors nor motivators. Table A9 shows the staff breakdown by cadre.

**Table A9. Kawangware site: Staffing**

Type	Kabiro Health Care Trust	Riruta NCC Health Center	Total
Clinical	2	15	17
CBD	20	0	20
Peer Counselors	20	0	20
Youth Motivators	10	0	10
Total	52	15	67

### *Service Delivery*

As shown in Table A10, both clinics had a high average daily client load, with Riruta having the highest. Kabiro had very low return ratio revisits. This could imply poor record keeping or ineffective IEC. The daily client load for CBD agents in Kabiro was high but the return ratio revisit was extremely low. This would mean that follow-up system by the CBD agents was inadequate. As for Riruta, there were no CBD clients. This implies that there were no linkages between the two

clinics in terms of referrals made by the CBDs attached to the Kabiro clinic. Of note here is that the figures in Table A10 were randomly selected and therefore have no bearing on the figures shown in Table A11.

**Table A10. Kawangware site: Illustrative summary of FP service delivery during a period of three months**

Total # of clients served	Kabiro Health Care Trust	Riruta NCC Health Center
<b>Clinic services:</b>		
1 <sup>st</sup> visit	702	256
Return visits	1,102	3,681
Return ratio: Revisits/New	1.6	14.4
Average daily FP client load	27	55.7
<b>CBD services</b>		
1 <sup>st</sup> visit	2,266	0
Return visits	1,347	0
Return ratio: Revisit/New	1	0
Average daily FP client load	55	0

Table A11 shows relatively low condom use by clients at the Kabiro clinic, given that this was an ongoing project. The low condom use in both clinics could not be attributed to stock-outs since this clinic received regular supplies including condoms from the Ministry of Health. Kabiro did not show clear signs of condom promotion in spite of the fact that it had CBD agents whose major responsibility was to distribute non-prescription contraceptives including condoms and to conduct IEC including community mobilization for RH/FP services. In addition, the Kabiro clinic offered STI diagnosis and treatment (one of the four Cs' of syndromic management of STI being condom use). There appeared to be no linkages between the two clinics in terms of referrals made by the CBD agents attached to the Kabiro clinic.

**Table A11. Kawangware site: Clients served by method in each clinic during a period of three months**

Method	Kabiro Health Care Trust	Riruta NCC Health Center	Total clients
Pills	2,787	346	3,133
Condoms	2,154	1,600	3,754
Injectables	27	150	177
IUCDs	367	4	371
Others	7	0	7
Total	3,403	2,100	7,442

### ***Clinic Equipment***

It was observed that both clinics lacked essential equipment. Table A12 shows the requirements of the clinics.

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**Table A12. Kawangware site: Clinic requirements**

Item	Required equipment per clinic		Total required
	Kabiro	Riruta	
Oral thermometers	24	12	36
Instrument tray	2	2	4
Adult scale	1	1	2
Adjustable stool	2	2	4
Cheatle forceps	2	2	4
Medium drums	1	1	2
Pedal bin	1	1	2
IUCD Kits	2	2	4
Autoclave	1	1	2
Sterilizer	2	2	4
Scissors 8-inch	6	4	10

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In terms of non-contraceptive supplies it was observed that Kabiro clinic had most of the essential supplies, while Riruta lacked most of them.

### ***Recommendations***

Service providers at both Kabiro and Riruta clinics cited five major problems affecting their performance and preventing them from achieving their goals: lack of commodities and supplies, lack of adequate staff, need for skill enhancement and training for staff, lack of IEC materials and strategies, lack of equipment, and inadequate financial resources. The following recommendations were made to address their concerns and improve clinic performance:

- That the FP room at Kabiro clinic be renovated and curtains provided to ensure privacy.
- That although Kabiro had a system of follow up using CBD agents, and peer and youth motivators through home visits, the system should be enhanced to improve the ratio of revisits and retention rates. As for Riruta clinic, the staff in charge should establish a follow-up system, conduct community mobilization, and document the outcomes to see impact.
- That staff capacity be enhanced. Staff at both clinics were willing to participate in the URHI project but needed updates in infection prevention, targeted IEC and counseling in FP/STI/HIV/AIDS. Staff capabilities also needed to be strengthened through training in STI syndromic management.
- That the project provide minimal equipment (as listed in Table A12), as well as filing cabinets, display boards for IEC materials, and benches or chairs for waiting clients, in order to enhance the quality of care in RH/FP service delivery. The required clinic non-contraceptive supplies were also to be furnished to both clinics.

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## 2.3 Mtongwe Site, Mombasa

Both Shika Adabu Municipal Council Clinic and Mtongwe Municipal Council Clinic are situated in Mombasa municipality within Mtongwe and Likoni divisions, respectively. The two clinics serve a population of approximately 65,000 people, consisting of 20% women of reproductive age and over 50% youth. Both clinics offer curative, preventive, and promotive services and are easily accessible to the target population. The two clinics procure their contraceptive provisions and other drugs including STI prescription drugs from the Ministry of Health. The Shika Adabu clinic operates from four rooms (two were reserved for MCH/FP services), it has a FP logo but lacks a signpost and has curtains for privacy. The clinic has running water but no electricity, although the wiring has been done.

Mtongwe clinic uses one room for MCH/FP. The clinic has 40 Bamako Initiative members who operate from one room assigned to the Bamako Initiative pharmacy. Unlike Shika Adabu clinic, the Mtongwe clinic and the pharmacy have no FP logos or signposts. Both Mtongwe clinic and the Bamako Initiative pharmacy have running water and electricity. None of the clinics had a list of services they provide, but interviews with senior clinic staff revealed that services included family planning services (with VSC clients being referred to FPAK clinics and Mkomani clinic), immunization (mother and child), counseling for infertility, STI prevention and management, AIDS counseling, treatment of minor ailments, and laboratory services.

### *Staffing*

Mtongwe site staffing is shown in Table A13. All the five Shika Adabu clinical staff were trained in comprehensive RH/FP and STI management. The three Mtongwe clinical staff had also had similar training. The FP experience of these staff ranged from one to four years but none of the eight service providers had had infection control/prevention training in the last three years. Only three had received clinical FP/contraceptive technology up-dates. The Mtongwe clinic acted as a backup for the 40 Bamako Initiative community health workers.

**Table A13. Mtongwe site: Staffing**

Type	Shika Adabu clinic	Mtongwe clinic	Total
Clinical	5	3	8
CHW	0	40	40
Total	5	43	48

### *Service Delivery*

The high numbers of return visits shown in Table A14 makes it clear that both clinics had a follow-up system using the CHWs (BI members) through home visits. However, a referral system did not appear to be in place as the table shows no CHW clients for either of the clinics. During the examination of clinic records neither referral cards nor returned referral cards were seen at either clinics. Of note here is that the figures in Table A14 were selected randomly and have no bearing on the figures in Table A15.

**Table A14. Mtongwe site: Illustrative summary of FP service delivery during a period of three months**

Total # of clients served	Shika Adabu clinic	Mtongwe clinic
<b>Clinic services</b>		
1 <sup>st</sup> visit	590	79
Return visit	6,980	2,004
Return ratio: Revisits/ New	11.8	25.4
Average daily client load	115	32
<b>CHW</b>	0	0

From Table A15, condom distribution appears to be at a very low level. It can be concluded that the clinics as well as the Bamako Initiative pharmacy were not sufficiently promoting condom use at the clinic level or through community mobilization in RH/FP by the community health workers (also members of the Bamako Initiative). Both clinics had regular supplies of contraceptives including condoms from the MOH. Any contraceptive not in stock, e.g., foaming tablets and jelly, were not available at MOH, the main supplier. Most non-contraceptive supplies such as cotton wool, antiseptic lotion, draw sheets, disposable gloves, surgical gloves, and prescription STI drugs were lacking in both clinics.

**Table A15. Mtongwe site: Clients served by method in each clinic during a period of three months**

Method	Shika Adabu clinic	Mtongwe clinic	Total clients
Pills	269	229	498
Injectables	275	318	593
IUCD	0	0	0
Condom	39	38	77
Others	7	1	8
<b>Total</b>	<b>590</b>	<b>586</b>	<b>1,176</b>

### ***Clinic Equipment***

During the assessment exercise, it was observed that the two clinics lacked essential equipment and where the equipment was available it was found to be inadequate. Table A16 shows the clinics' requirements.

### ***Recommendations***

Service providers at the Mombasa clinics had similar problems as those of other sites: inadequate staff, need for skills enhancement and training for staff, lack of equipment, lack of IEC materials and strategies, lack of commodities and supplies, and lack of financial resources. The following recommendations were made to address these concerns and improve clinic performance:

- That although the physical conditions of the two clinics were reasonably good, both clinics required minor renovations and curtains to ensure privacy. Also, since the Bamako Initiative pharmacy was busy, it needed to be renovated to provide extra room. The directors of both clinics should introduce signposts as well as FP logos and make available a comprehensive list of services offered by their clinics. Both clinics needed to put in place referral systems and enhance follow-up systems using Bamako Initiative CHWs through home visits.

- That service providers from referral sites be trained in areas such as infection prevention, IEC/ Basic FP counseling, and STI/HIV/AIDS counseling. Staff capabilities also need to be strengthened through training in STI management.
- That the project provide basic furniture such as filing cabinets for better storage of clinic records, display boards for IEC materials, and benches or chairs for waiting clients, as well as with non-contraceptive clinic supplies. In addition, minimum equipment as listed in Table A16 should be provided by PATHfinder to enhance the quality of care in RH/FP service delivery.

**Table A16. Mtongwe site: Clinic requirements**

Items	Requirements per clinic		Total required
	Shika Adabu clinic	Mtongwe clinic	
Privacy screen	4	4	8
Trolley torch	4	2	6
Instrument trolley	1	1	2
Sphygmono. BP	2	2	4
Oral thermometers	12	12	24
Instrument tray	4	4	8
Swabs dressing jar	2	2	4
Galipots	4	4	8
Adjustable stool	2	2	4
Cheatle forceps	4	4	8
Medium drums	1	1	2
Kidney dishes	4	4	8
Pedal bin	4	3	7
IUCD Kits	2	2	4
Autoclave	1	1	2
Sterilizer	1	1	2
Scissors, 8-inch	4	4	8

## 2.4 Unga Ltd/Sombetini Site, Arusha

Ngarenaro Reproductive Child Health Clinic is situated in Unga Ltd ward of Arusha Municipality, while the second clinic observed, Upendo Charitable Medical Center, is located in Sombetini Ward also of Arusha Municipality. Both clinics serve a population of over 200,000 people, 20% of whom are women of reproductive age and over 50% youth. The clinics are accessible to the target population and offer curative, preventive, and promotive health services. Ngarenaro clinic uses two rooms for MCH/FP services and Upendo clinic has two rooms for similar services. Both clinics have electricity and running water. Ngarenaro has a family planning logo but no signpost while Upendo has a signpost but no logo. Neither clinic has a list of services they provide. Interviews conducted with clinic staff, however, revealed that the two clinics provide the following services: integration of FP with other activities, FP services (with VSC clients being referred to Mt. Meru Regional Hospital and Marie Stopes Health Services), immunizations (mother and child), counseling for infertility, STI prevention and management, AIDS counseling, treatment of minor ailments, and laboratory services.

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### **Staffing**

Table A17 shows the staffing pattern at the Arusha clinics. All five clinical staff at the Ngarenaro clinic were trained in comprehensive RH/FP. The clinic supervised 20 CBD agents located in the catchment area, who had the primary responsibility of distributing non-prescription contraceptives and conducting IEC including community mobilization for RH/FP services within the communities. At Upendo, only one of the three clinical staff was trained in RH/FP service delivery. The Upendo medical center had no CBDs but had maternal child health assistants (MCHA) who assisted the trained clinical staff.

**Table A17. Unga Ltd/Sombetini site: Staffing**

Types	Ngarenaro Clinic	Upendo Clinic	Total
Clinical	5	3	8
CBD	20	0	20
Total	25	3	28

### **Service Delivery**

Table A18 summarizes service delivery at the two clinics. For Ngarenaro the CBDs had an average daily client load of seven whereas at Upendo there were none. This means that there were no linkages between the two clinics in terms of referrals made by the CBDs. Very few referrals appeared to have been made at Ngarenaro clinic to which the CBDs were attached. Of note here is the fact that the figures in Table A18 were selected randomly and have no bearing on the figures in Table A19.

**Table A18. Unga Ltd/Sombetini site: Illustrative summary of service delivery during a period of three months**

Total # of clients served	Ngarenaro clinic	Upendo clinic
<b>Clinic services:</b>		
1 <sup>st</sup> visit	5,739	18
Return visits	15,515	126
Return ratio: Revisits/New	2.7	7.0
Average daily client load	322	2.2

Table A19 illustrates a very low condom use by the clients. The low condom use could not be attributed to stock-outs since the two clinics received regular supplies of contraceptives including condoms from the Ministry of Health. Even Ngarenaro clinic did not show any signs of condom promotion, despite having CBDs whose major responsibility was to distribute non-prescription contraceptives and conduct IEC including community mobilization for other RH/FP services. In addition, the two clinics offered STI management (one of the “four Cs” of syndromic management of STI being condom use). Upendo clinic did not have CBDs or any system of community mobilization for RH/FP services.

**Table A19. Unga Ltd/Sombetini site: Clients served by method in each clinic during a period of three months**

Method	Ngarenaro clinic	Upendo clinic	Total clients
Pills	601	28	639
Condoms	54	6	60
Injectables	3,786	109	3,895
IUCDs	34	0	34
Others	7	0	7
<b>Total</b>	<b>4,482</b>	<b>143</b>	<b>4,625</b>

### ***Clinic equipment***

In terms of non-contraceptive supplies, Upendo clinic seemed to have most of the essential supplies while Ngarenaro lacked most of these supplies. During the rapid assessment exercise, it was observed that both clinics lacked essential equipment. Table A20 shows the requirements of the clinics.

**Table A20. Unga Ltd/Sombetini site: Clinic requirements**

Item	Required equipment per clinic		Total required
	Ngarenaro	Upendo	
OB/Gyn. Table	2	2	4
Privacy screen	10	3	13
Torch	4	2	6
Instrument trolley	4	3	7
Sphygmomanometer	10	5	15
Oral thermometers	24	12	36
Instrument tray	4	4	8
Swabs dressing jar	0	4	4
Galipots	0	7	7
Adult scale	6	4	10
Adjustable stool	4	3	7
Cheatele forceps	4	6	10
Medium drums	4	3	7
Kidney dishes	6	4	10
Pedal bin	4	3	7
IUCD kits	2	5	7
Autoclave	1	1	2
Sterilizer	2	2	4
Scissors, 8- inch.	6	4	10

### ***Recommendations***

Service providers at the Arusha clinics had similar major problems as those of the other sites e.g., lack of adequate staff, need for skills enhancement and training for staff, lack of equipment, lack of IEC/strategies, lack of commodities and supplies, and inadequate financial resources. The following actions were recommended:

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- That the Arusha Municipal Council and the director of Upendo Charitable Medical Clinic introduce signposts and logos, respectively, and a comprehensive list of services offered by their clinics. Ngarenaro FP rooms should be renovated and curtains/partitions provided to ensure privacy. Both clinics need to put in place referral systems and not use client's record cards.
  - That service providers from referral sites receive training in areas such as infection prevention, IEC/basic FP counseling, and counseling in STI/HIV/AIDS. Staff capabilities also need to be strengthened through training in STI management.
  - That the project provide furniture such as filing cabinets, display boards for IEC materials, and benches or chairs for waiting clients. In addition, the minimum clinic equipment should be provided to both clinics enhance the quality of care in RH/FP service delivery.

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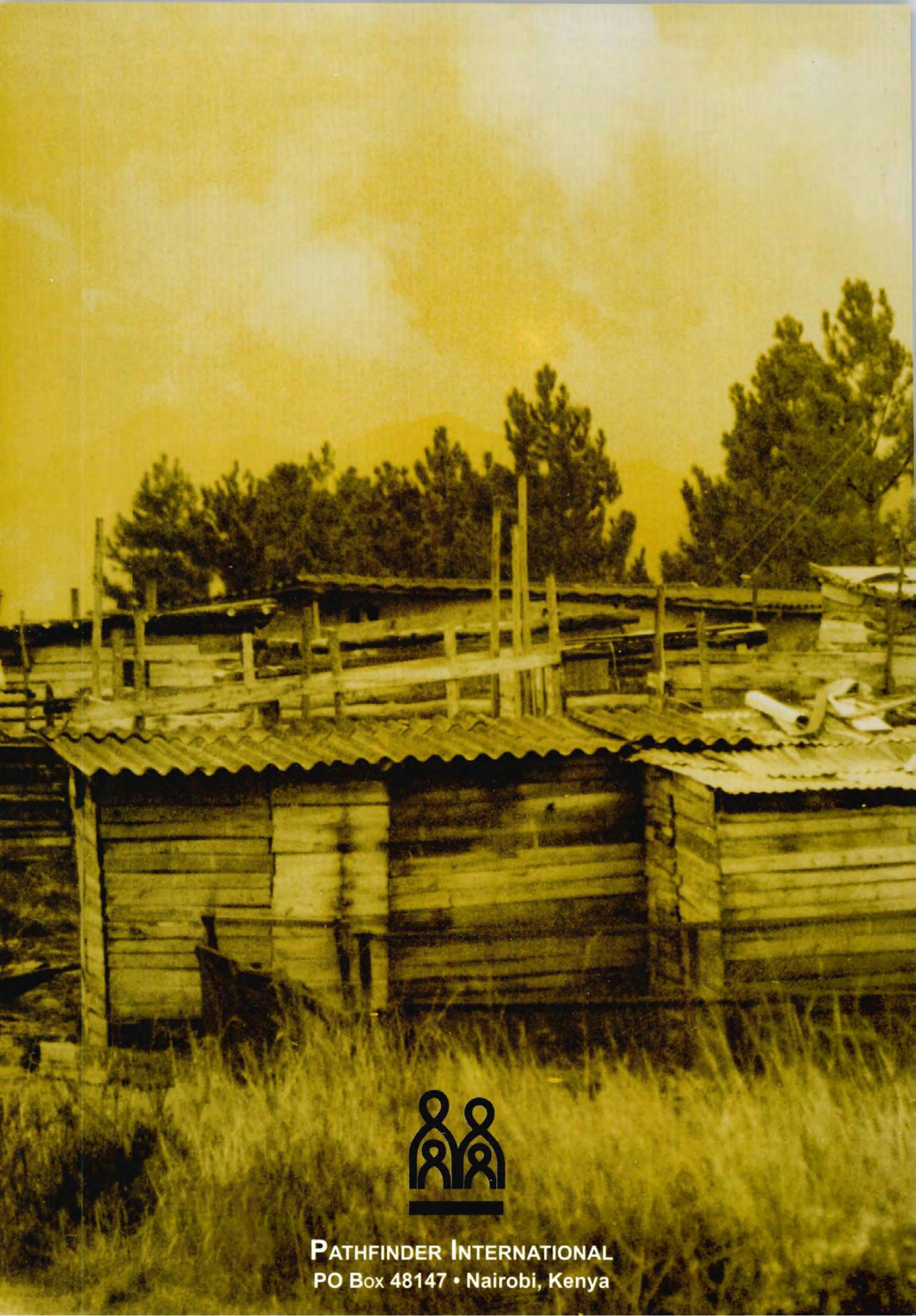
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**PATHFINDER INTERNATIONAL**  
PO Box 48147 • Nairobi, Kenya