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***Haki Yako:***  
**A Client Provider Information,  
Education, and Communication  
Project in Kenya**

*Young Mi Kim*  
*Cheryl L. Lettenmaier*  
*Dan Odallo*

Johns Hopkins Population Communication Services

*Margaret Thuo*  
Family Planning Association of Kenya

*Shanyisa Khasiani*  
Consultant to the Family Planning Association of Kenya

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# Preface and Acknowledgments

The goal of the Kenya Client-Provider Information, Education, and Communication (IEC) project was to increase the new and continued use of modern contraceptive methods among Kenyan couples. This goal was to be accomplished by increasing couples' knowledge of modern methods, encouraging spousal communication, improving providers' communication skills, and promoting providers as well-trained, caring, and trustworthy sources of family planning information and services. The lessons learned in this project can help program planners design further interventions that will continue strengthening the quality of service provided by Kenyan family planning organizations, will raise public awareness, and will increase discussion of family planning.

Many people contributed to the Kenya Client-Provider IEC Project. The Family Planning Association of Kenya (FPAK) under the leadership of Godwin Mzenge, Executive Director of FPAK designed, organized, and managed the project. Pre-campaign baseline surveys were conducted by Olive and Abel Mugenda. Research International East Africa conducted the Omnibus Surveys, and Debbie Gachuhi conducted the observation of community-based trainers in 1991 and 1994. Johns Hopkins Center for Communication Programs (JHU/CCP) staff members Sharon Rudy, Dan Odallo, and Lynne Cogswell provided technical assistance for the project. FPAK staff members Stephen Mucheke and Charles Onoka assisted in data collection and entry. Former FPAK staff members John Nyoike, Kalimi Mworira, and Jennifer Mukolwe assisted in the start-up of the project.

Members of the IEC Working Group contributed in a major way to the success of the project. All trainers, clinic workers, and community-based distribution agents who participated in the study deserve recognition. Maendeleo ya Wanawake, Family Planning Private Sector, the Christian Health Association of Kenya, and the Kenyan Medical Association also contributed to the project.

This report was prepared by Young Mi Kim, Senior Research and Evaluation Officer at JHU/CCP; Cheryl Lettenmaier, Deputy Chief of Party and Communication Advisor, Uganda Delivery of Improved Services for Health project; Dan Odallo, JHU/CCP Resident Advisor for Kenya; Margaret Thuo, Program Manager at FPAK; and Shanyisa Khasiani, FPAK consultant. Susan Atlas and Adrienne Kols, consultants to JHU/CCP, edited this report. Johanna Zacharias, Gary Lewis, Kristina Samson, and Ward Rinehart reviewed the manuscript. Faith Forsythe formatted the manuscript and graphics for publication.

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Phyllis T. Piotrow, Ph. D.  
Director  
Center for Communication Programs  
The Johns Hopkins School of Public Health

Jose G. Rimon II  
Project Director  
Population Communication Services  
The Johns Hopkins School of Public Health

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## Abbreviations

CBD	community-based distribution
CHAK	Christian Health Association of Kenya
FP	family planning
FPAK	Family Planning Association of Kenya
FPPS	Family Planning Private Sector
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
IEC	information, education, and communication
IUD	intrauterine device
JHU/CCP	Johns Hopkins Center for Communication Programs
JHU/PCS	Johns Hopkins University Population Communication Services
KMA	Kenya Medical Association
MCH/FP	maternal and child health/family planning
MOH/DFH	Ministry of Health/Division of Family Health
MYWO	Maendeleo ya Wanawake
NCC	Nairobi City Commission
NCPD	National Council for Population and Development
RTI	reproductive tract infection
USAID	United States Agency for International Development

## Summary

In collaboration with a consortium of family planning organizations, the Family Planning Association of Kenya (FPAK) implemented the Kenya Client-Provider Information, Education, and Communication (IEC) Project, popularly known as the *Haki Yako* campaign, from February 1991 to June 1994. The Kiswahili slogan, *Haki Yako* (in English, “It’s your right”), was used in all the materials and events in the campaign. The two main messages of the campaign were: Spouses and partners should discuss family planning with one another; and modern contraceptive methods are safe to use. Three major interventions made up the project:

- *Kuelewana ne Kuzungumza* (in English, “Discussion Leads to Understanding”), a radio serial drama for the general public,
- Leaflets and posters to be shared by service providers and their clients, and
- Training and reference materials for providers.

The project increased the number of new acceptors at clinics, increased the continued use of modern methods for at least one year, led more couples to discuss family planning, increased the availability and use of educational materials at service delivery points, and improved the public image of family planning providers. Use of most contraceptive methods increased slightly, however, the overall contraceptive prevalence rate did not change substantially.

By 1993, three-fourths of the adult population of Kenya were exposed to at least one *Haki Yako* campaign product. More than half of survey respondents heard the radio drama, and almost two-thirds saw at least one of the two project posters. Nearly half of those who heard the radio program in 1993 took action by either talking with a partner or friend, visiting a family planning service site, or adopting a method. Respondents who listened to the radio drama were more likely to use modern contraceptives than those who did not. New clients cited the radio drama more than any other campaign material as influencing their decision to seek family planning services. Family planning service providers were more positively perceived by respondents exposed to campaign materials than by those not exposed.

During the campaign, clinic statistics from 18 family planning clinics showed that the numbers of new family planning users seen per month increased from 1,500 to 2,000. Survey data show the percentage of current users who reported continuous use of a modern family planning method for at least a year increased slightly from 67 percent to 71 percent between 1991 and 1993.

The campaign substantially increased the availability of most IEC materials at service delivery points between 1991 and 1993. Inspections of 25 service delivery sites found leaflets in 40 percent of sites in 1991 and 68 percent in 1993. In 1991, 28 percent of the sites had flipcharts, by 1993, this figure rose to 58 percent.

The project sought to improve the quality of counseling by training trainers of community-based distribution (CBD) agents and clinic service providers. By the end of the project period, nearly three-fourths of CBD agents were trained by their agencies; however, only one-fourth of clinic service providers were trained. Clients received more complete information from CBD agents in 1993 than in 1991. CBD agents also told clients about a broader range of contraceptive methods and more about pills, Norplant<sup>®</sup> implants, vasectomy, and tubal ligation.

## Chapter I. Background

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Kenya has one of the highest contraceptive prevalence rates in sub-Saharan Africa at 33 percent (Kenya Demographic and Health Survey 1993). Also, almost half of all married Kenyan women of reproductive age have used modern contraceptive methods at some time. Many of these women have discontinued use, however, often because of side effects and health concerns.

In 1989, fewer than one-fifth of all married Kenyan women were using modern contraceptive methods.<sup>1</sup> Rising contraceptive use since then has caused a sharp drop in fertility. Between 1989 and 1993, the total fertility rate decreased from 6.7 to 5.4, and mean ideal family size dropped from 4.4 to 3.7.

Nevertheless, more than one-third of all married women (36 percent) have an “unmet need” for family planning. The term “unmet need” refers to married women of reproductive age who want to limit or space births but are not using contraception. Such data indicate a need for well-designed interventions to promote contraceptive use among women who would be likely to use it. In addition, Kenya has a considerable need for information and services dealing specifically with reproductive tract infection (RTIs) and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS).<sup>2</sup>

### Kenya’s Client-Provider IEC Project

The first phase of the Kenya Client-Provider Information, Education, and Communication (IEC) Project, carried out from February 1991 through June 1994, addressed Kenya’s low contraceptive prevalence rate. On behalf of the National Council for Population and Development (NCPD), the Family Planning Association of Kenya (FPAK) implemented the project in collaboration with a consortium of family planning organizations, which consisted of the NCPD, the FPAK, the Ministry of Health Division of Family Health (MOH/DFH), Maendeleo ya Wanawake (MYWO), Family Planning Private Sector (FPPS), Christian Health Association of Kenya (CHAK), Kenya Institute of Mass Communication, Nairobi City Commission (NCC), Family Life Promotion and Services, Chogoria Presbyterian Church of East Africa, and Kenya Medical Association (KMA). The project was funded by the United States Agency for International Development (USAID), with technical assistance provided by Johns Hopkins University Population Communication Services (JHU/PCS).

**Goals and project objectives.** The major goals of the project were to increase Kenyan couples’ continued use of modern family planning methods by improving the public’s understanding of these methods, encouraging spouses to speak with one another about family planning, and

<sup>1</sup> National Council for Population and Development (NCPD), Central Bureau of Statistics (CBS) (Office of the Vice President and Ministry of Planning and National Development [Kenya]), and Macro International Inc. (MI). 1994. *Kenya Demographic and Health Survey 1993*. Calverton, Maryland: NCPD, CBS, and MI.

<sup>2</sup> Rimon, J.G., Blake, M.S., and Odallo, D., *Strategic Options for IEC Interventions in Kenya: 1995 Update*. Baltimore: The Johns Hopkins Center for Communication Programs, 1995.

promoting family planning providers as caring, knowledgeable, and trustworthy sources of information and services. To accomplish these goals, the project developed four institution-building objectives to strengthen Kenya's family planning IEC infrastructure:

- To improve collaboration among the various Kenyan family planning organizations,
- To improve the ability of FPAK, NCPD, and other organizations to conduct and evaluate audience-based communication activities,
- To improve the ability of FPAK, MOH, and other organizations to train both clinic-based and community-based providers in family planning communication and counseling, and
- To increase the competence of clinic providers and field workers to provide accurate information to current and potential family planning clients.

In addition, the project set two communication objectives:

- To increase the number of client visits to family planning providers, and
- To increase the number of family planning users who continue contraceptive use for at least one year.

**Interventions.** Client-Provider IEC Project interventions were addressed to providers, potential clients, and clients and providers together. An IEC Working Group, chaired by NCPD, with representatives of major family planning organizations in Kenya, was involved in every aspect of the project. This group reviewed all materials, participated in training and research activities, distributed project materials, and organized the *Haki Yako* launch celebrations. Specific activities are listed.

Provider-oriented:

- Development of training curricula in family planning counseling and communication for use by trainers of community-based distribution (CBD) agents and nurses,
- Preparation and distribution of a reference handbook for CBD agents,
- Training of 20 CBD-agent trainers from five organizations,
- Three training-of-trainers (TOT) workshops for participants from all community-based programs, and
- A series of five 1-week workshops led by trained trainers.

Client-oriented:

- Preparation and broadcast of a family planning radio serial drama and 10 radio spot announcements promoting family planning services, and
- Community events in Nairobi, Mombasa, Kisumu, and Nyeri cities.

Provider and client oriented:

- Manufacture and distribution of models of male and female sexual organs and flipcharts with Kiswahili and English text for use by counselors, and
- Preparation and distribution of leaflets for clients and posters for use in clinics and in the community.

A timetable for these activities is shown in Table 1.

**Table 1.**  
**Activities Timetable:**  
**Kenya Client-Provider IEC Project, 1991-1994**

<b>Activity</b>	<b>Time period</b>
IEC Working Group organized	April 1991
Designed CBD training manual	August 1991
Message design for <i>Haki Yako</i> campaign	December 1991
Trained master CBD trainers	January 1992
Master trainers conducted TOT workshops	April - June 1992
Print and radio materials tested	June - October 1992
Radio spots begin broadcasts	January 1993
CBD trainers conduct practicums	February - April 1993
Distribution of print materials begins	April 1993
Mini-launch celebrations in 4 cities	June - July 1993
Distribution of English CBD handbooks	February 1994
<u>Kiswahili CBD handbook printed</u>	<u>June 1994</u>

## **The IEC Campaign**

The campaign slogan, *Haki Yako* (in English, “It’s your right”) appeared on all IEC materials and in all related events. The campaign relied on coordinated efforts on radio, in print, and special events to convey its two main messages:

- Spouses should discuss family planning with each other, and

- Modern contraceptives are safe to use.

**Radio.** The serial drama *Kuelewana ni Kuzungumza* (in English, “Discussion Leads to Understanding”) was produced in Kiswahili and broadcast once a week on the national radio station. The drama followed the lives of several Kenyan families living in the fictional town of Tuliene. Each of the 92 episodes was 30 minutes long. The broadcasts started in November 1992.<sup>3</sup> The radio drama conveyed 10 key messages:

- Family planning gives you control of your life,
- Couples should discuss family planning,
- CBD agents are well-trained to provide family planning,
- People should seek family planning information,
- People should visit a family planning worker or clinic,
- There are several modern family planning methods to select from,
- Modern family planning methods are safe for your health,
- Prolonged use of contraceptive pills will not cause infertility,
- The intrauterine device (IUD) is safe and does not cause long-term problems, and
- Condoms are a good method of family planning for married couples.

In addition to the radio drama, the project aired 10 radio spots encouraging partners to discuss family planning, reassuring people that modern contraceptive methods are safe, and pointing out that service providers (especially CBD agents) are well-trained, caring, and trustworthy.

**Print.** Almost all of Kenya’s over 1,500 family planning service points received copies of four leaflets on family planning methods (see Figure 1) and flipcharts in Kiswahili and English to help explain methods. A total of 2,100,000 leaflets were printed and distributed during the project period. Clinics also received two posters, one encouraging spousal discussion and the other assuring clients that modern methods are safe.

<sup>3</sup> The *Kuelewana ni Kuzungumza* drama continued until September 1995, a total of 136 episodes were broadcast (92 during the project period and 44 after).



Figure 1.  
Haki Yako Campaign Leaflets and Poster

**Community events.** During the campaign, celebrations were coordinated to combine speeches by local and national dignitaries, music, dancing, and drama. During these celebrations, master CBD trainers received certificates and radio drama characters made guest appearances at clinics.

A second phase of the campaign, not covered in this report, took place between July 1994 and will continue through July 1995. Activities included: production and broadcast of additional 44 episodes of the radio serial drama, continuous distribution of print materials inside and outside clinics. This report does not present evaluation results of any other activities that occurred during the same project period.

**Training.** The radio drama, print materials, and community events directed clients to consult with caring and competent providers. To meet the audience's rising expectations and demand for improved quality of counseling the project included a provider training component. There were three primary training objectives:

- To upgrade the training of CBD trainers and CBD agents,
- To develop a national CBD training curriculum and a CBD reference handbook; and
- To make provider support materials available at service sites.

To enhance CBD trainers' and CBD agents' skills, four 1-week workshops were conducted with master trainers between March and April 1993. The training was coordinated and implemented by the FPAK, MYWO, and CHAK. FPAK organized two of these workshops, one in Busia and the other in Kikuyu. MYWO organized one in Kakamega and CHAK in Maseno. Workshop participants came from the MOH, FPPS and African Medical Research Foundation. In all, 99 CBD agents, 21 CBD trainers, and eight master trainers attended the four workshops.

During June and July 1993, two 1-week workshops for clinic nurses were conducted, one in Mombasa and the other in Nakuru. A total of 21 nurses were trained with several master trainers. For these two workshops, clinic providers and trainers of NCC and NCPD also participated. After these workshops the project shifted its financial support from provider training to indirectly supporting organizations by developing a training curriculum and clinic

IEC materials. Each organization was thereafter responsible for using the new curriculum to train its own providers.

Thus, a major contribution of this project to provider training is the development of a national CBD training curricula and a reference handbook for CBD agents. The fact that all the major family planning organizations in Kenya now have a uniform CBD training curriculum and reference handbook represents a major advance for sustainable training capabilities. The contents of the CBD curriculum include interpersonal communication, counseling, contraceptive updates, human anatomy and physiology, referral, use of audio visual aids, AIDS/STDs, and record-keeping.

## Chapter II. Evaluation Methods

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### Overall Evaluation Design and Objectives

To assess the impact of the project on Kenya's population, three distinct types of studies were conducted (see Tables 2 and 3):

- **Clinic studies.** The clinic studies consisted of observation of counseling sessions with “new acceptors” and “continuing users,” interviews with new acceptors and continuing users, interviews with providers, inventories of IEC materials at study sites, and service statistics.<sup>4</sup>
- **Omnibus surveys.** The omnibus surveys included both an Adult Survey and a Housewives Survey.
- **Observations of CBD trainers.** The observations of CBD trainers included review of the training materials, observations of training sessions using structured checklists, interviews with trainers and managers, and focus-group discussions with trainees.

**Table 2.**  
**Evaluation Methodologies,**  
**Kenya Client-Provider IEC Project (1991-1994)**

<b>Study</b>	<b>Description</b>
<b>Clinic Studies</b>	
New Acceptors Observations	Observations of 181 (1991) and 178 (1993) counseling sessions involving new acceptors and either clinic staff or CBD agents.
Continuing Users Observations	Observations of 214 (1991) and 191 (1993) counseling sessions between continuing users and clinic staff or CBD agents.
New Acceptors Interviews	Interviews with 158 (1991) and 174 (1993) new acceptors.
Continuing Users Interviews	Interviews with 202 (1991) and 188 (1993) continuing users.
Providers Interviews	Interviews with 56 clinic providers and 48 CBD agents in 1991 and 68 clinic providers and 57 CBD agents in 1993.
Site Observations	Inventories of IEC materials at 25 service sites in 1991 and 1993.
Service Statistics	Monthly service statistics for new acceptors and family planning methods dispensed for in 1991 and 1993. Statistics from May 1992 to July 1993 are used in this report.
<b>Omnibus Surveys</b>	
Adult Omnibus Survey	Surveys with 2,000 adults in 1992, 1993, and 1994.
Housewives Omnibus Survey	Surveys with 1,000 housewives in 1991 and 1993.
<b>Observation of CBD</b>	<b>Observations of trainers' skills during several CBD training</b>

<sup>4</sup> “New acceptors” and “continuing users” are terms used by the Kenyan family planning program. A new acceptor is a first-time user of modern contraceptives. A continuing user is anyone who has ever used, including current users and past users, regardless of their method source.

The objectives of the *overall evaluation* were to measure:

- Any improvement in providers' family planning counseling and other interpersonal communication skills,
- Any improvement in CBD trainers' counseling training skills, and
- Overall reach and impact of the *Haki Yako* campaign on the public as indicated by exposure to the campaign, partner communication, public perception of family planning providers, and continuation of contraceptive use.

**Table 3.**  
**Timetable for Evaluation Studies,**  
**Kenya Client-Provider IEC Project, 1991-1994**

<b>Study</b>	<b>Date</b>
Baseline Clinic Observations	August 1991
Baseline Clinic Interviews	August 1991
First CBD Trainer Observation	November 1991
First Housewife Omnibus Survey	August - September 1991
First Adult Omnibus Survey	February - March 1992
Clinic Service Statistics	April 1992 - July 1993
Second Housewife Omnibus Survey	September - October 1992
Second Adult Omnibus Survey	September - October 1992
Follow-up Clinic Observations	October 1993
Follow-up Clinic Interviews	October 1993
Second CBD Trainer Observation	February - April 1994
Third Adult Omnibus Survey	April - May 1994

## Clinic Studies

Between 1991 and 1993 clinic studies were conducted in the central, coastal, and western regions of Kenya using three types of data collection methodologies: baseline and follow-up observations of client-provider interactions, baseline and follow-up client interviews, and clinic statistics. Data collected using these methods allowed for the assessment of family planning service providers' counseling and communication skills, IEC materials used at service delivery points, clients' sources of information and referral to services, and the numbers of new acceptors and continuing users of family planning at each service delivery site. Additional information was obtained from interviews with service providers and inventories of the IEC materials available at service delivery sites.

**Sample design and selection.** To assure adequate participation by family planning agencies and geographic representation, a 2-stage purposive sampling frame was developed for the clinic studies. A master list of all established family planning clinics and CBD agents throughout Kenya was compiled from information provided by the collaborating organizations. Family planning service delivery sites included MOH clinics, private doctors' offices, nongovernmental

family planning clinics, and CBD sites. Some of these service delivery sites are clinic only, CBD only, or a combination of clinic and CBD. There were more than 1,500 family planning service points on the master list.

A total of 25 service delivery points were selected for the study. First, representative urban and rural locations were proportionally selected in three of Kenya's four main geographic regions. The north-east region was omitted because of its long distance from Nairobi and relatively sparse and nomadic population. Second, service delivery sites were randomly selected within the chosen locations (see Appendix A for the distribution of service delivery sites by region).<sup>5</sup> The distribution of the service points, by organization, in 1991 and 1993 is shown in Table 4.

**Table 4.**  
**Number of Service Points and Providers, by Organization:**  
**Clinic Studies, Kenya, 1991 and 1993**

Organization	Service Points		Service Providers Interviewed			
	1991	1993	1991	1993		
				Total	Untrained	Trained
MOH	7	5	23	16	16	0
KMA	4	3	4	5	5	0
FPAK	6	7	34	44	27	17
FPPS	3	3	14	10	5	5
CHAK	2	3	13	17	12	5
MYWO	3	4	17	29	0	29
<b>TOTAL</b>	<b>25</b>	<b>25</b>	<b>105</b>	<b>121</b>	<b>65</b>	<b>56</b>

SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).

**Observation and interview instruments.** Seven study instruments were developed for use in the various clinic studies and were pretested at nonstudy family planning delivery sites. With minor adjustments, the same instruments were used for both the 1991 and 1993 studies. These instruments included:

- Observation checklist for interaction between new family planning acceptors and service providers,
- Observation checklist for interaction between continuing family planning users and service providers,
- Interview schedules for new family planning acceptors,
- Interview schedules for continuing family planning users,
- Interview schedules for service providers,
- Inventory of study site IEC materials, and

<sup>5</sup> Kenya Medical Association (KMA) physicians were not sampled in rural areas since they operate mostly in cities and not in rural areas.

- Service statistics data collection form.

Supervisors—either university lecturers or candidates for advanced degrees in medical education or population studies—and research assistants conducted the field work. Both research assistants and supervisors participated in five days of training. The field staff then spent 10 to 12 days observing and interviewing providers and clients at study sites. One assistant collected data for each study site and took inventory of all the IEC resources found at each service delivery point. Research assistants worked at sites in their home areas because of their familiarity with local languages and cultures.

Each research assistant observed at least eight interactions between service providers and new acceptors, and eight interactions between service providers and continuing users (see Table 5). Research assistants attempted to interview the clients and service providers they had observed but were not always successful; some clients did not consent, usually for lack of time. Research assistants tried to observe interactions with clinic providers and CBD agents at sites served by both. For the follow-up evaluation, researchers interviewed as many trained personnel as possible to enable comparisons with trained and untrained service providers. Supervisors coordinated the field work and gave on-site feedback to the research assistants. They also checked and reviewed the completed instruments, did general troubleshooting, and requested additional observations and interviews when necessary.

**Table 5.**  
**Number of Clients Observed and Interviewed, by Organization:**  
**Baseline and Follow-up Clinic Studies, Kenya, 1991 and 1993**

Organizati on	New Acceptors				Continuing Users			
	Observed		Interviewed		Observed		Interviewed	
	1991	1993	1991	1993	1991	1993	1991	1993
MOH	54	31	54	31	59	40	57	40
KMA	4	9	4	9	7	15	7	15
FPAK	74	63	54	59	70	60	60	57
FPPS	20	20	19	20	31	24	31	24
CHAK	9	24	8	24	24	24	24	24
MYWO	20	31	19	31	23	28	23	28
TOTAL	181	178	15	174	214	191	202	188
			8					

SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).

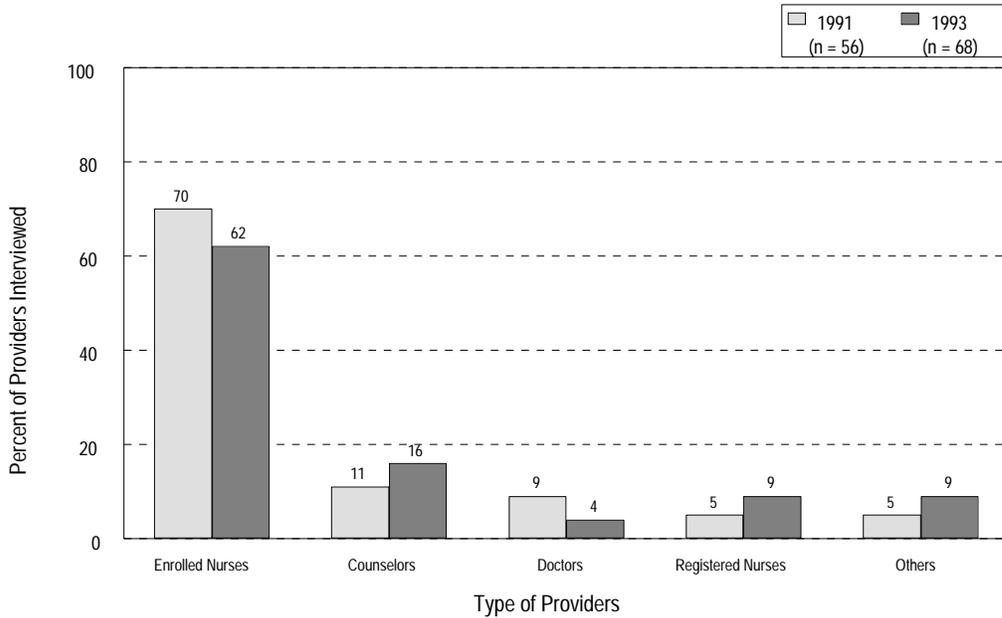
**Sites.** With minor adjustments, the same sites from the 1991 baseline clinic study were selected for the 1993 follow-up study. To assure inclusion of CBD sites, the number of MOH sites was reduced and the number of other agency sites was increased. Another site was substituted for one MOH site that closed for renovations during the 1993 study period.

**Family planning service providers.** The ratio of clinic-based family planning service providers to community-based providers was similar over the course of the study. Clinic providers were 53 percent of the 105 service providers in 1991, and 54 percent of the 121 service providers in 1993. The percentage of service providers with less than two years of experience decreased from 30

percent to 12 percent between 1991 and 1993. Only one-fourth of the clinic providers sampled in 1993 had received any training within the last year; in contrast, almost three-fourths of CBD agents had been trained.

Most clinic providers in both 1991 and 1993 were enrolled nurses (see Figure 2), although fewer enrolled nurses were observed in 1993. A smaller number of providers were doctors in 1993 than in 1991, while a larger number were counselors and registered nurses.

Figure 2.  
Family Planning Clinic Providers Interviewed, by Type of Provider:  
Providers Interviews, Kenya, 1991 and 1993



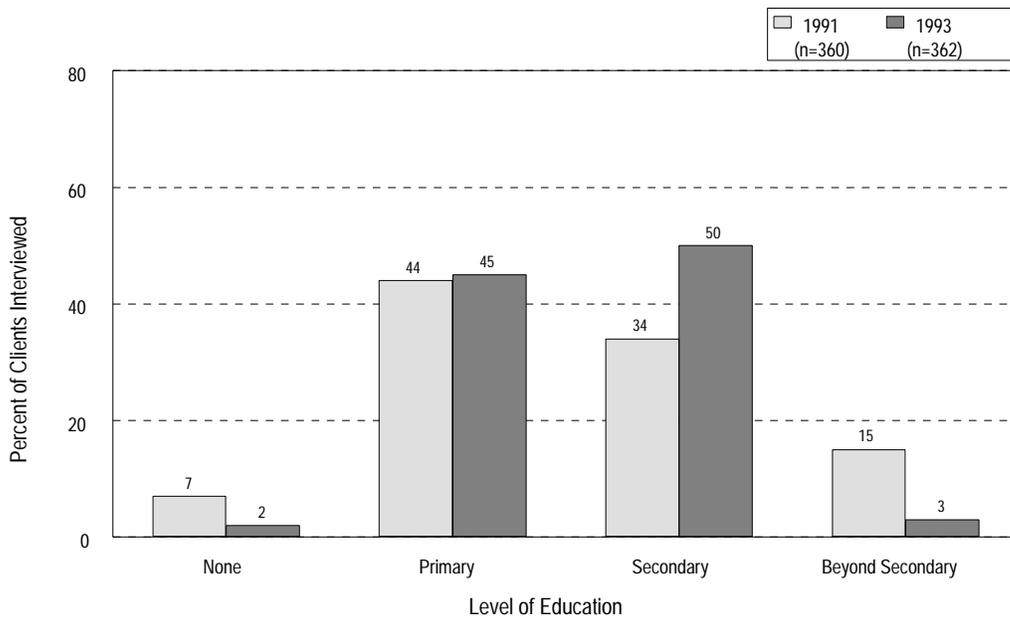
SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).

**Data analysis.** Univariate and bivariate analyses were done using STATA 3.1 statistical software. The numbers of clients observed with each service provider varied, and so data were adjusted to standardize the influence of each service provider’s behavior on the outcome. For instance, if a service provider was observed with four clients, each of the four clients was given a weight one-fourth that of a single observation.

**Service statistics.** Monthly service statistics for new family planning acceptors were collected from the 18 clinics at which the information was available. Information was also obtained on the family planning methods dispensed over the project period.

**New acceptors and continuing users of family planning.** The average age of new acceptors was 27 years old in 1991, and 26 years old in 1993. The average age for continuing clients was 29 years old in 1991, and 28 years old in 1993. The percentage of clients with no education decreased from 7 to 2 percent between 1991 and 1993, and those who had secondary education rose from 34 to 50 percent over the same period (see Figure 3). The pill was the most popular modern family planning method among new acceptors in both 1991 and 1993 (see Figure 4).

Figure 3.  
Education Level of New Acceptors and Continuing Users of Family Planning Interviewed:  
New Acceptors and Continuing Users Interviews, Kenya, 1991 and 1993

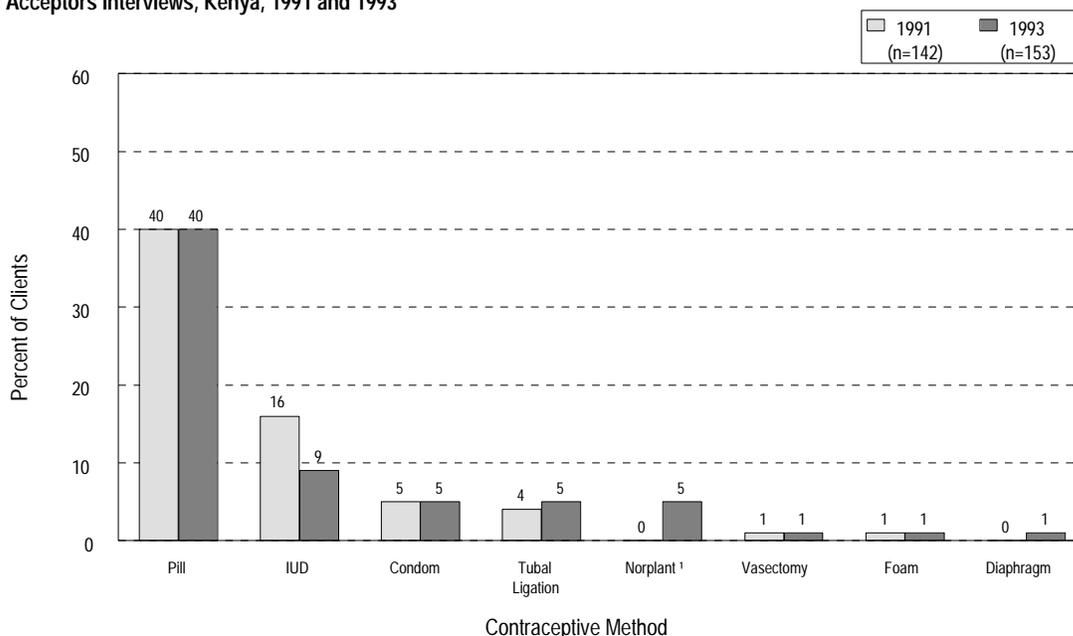


SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).

The re was a significant decrease in the percent of new acceptors choosing the IUD and an increase

in the percent choosing Norplant® implants.

Figure 4.  
 Contraceptive Methods Chosen by New Acceptors:  
 New Acceptors Interviews, Kenya, 1991 and 1993



SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).  
 NOTE: <sup>1</sup> Norplant not available in 1991.

## Omnibus Surveys

To assess project impact in the population, questions were included in three surveys of adult men and women and two surveys of housewives conducted in selected households throughout the project by the research firm Research International. The surveys included different questions on family planning at specific times to measure various aspects of campaign impact. Each survey included specific questions to assess impact of materials according to specific campaign objectives (see Table 6).

**Table 6.**  
**Questions Included in Adult and Housewives Omnibus Surveys:**  
**Kenya, 1991-1994**

Question Subject	Adult Omnibus Surveys			Housewives Omnibus Surveys	
	1992	1993	1994	1991	1993
Continued use of modern family planning method				X	X
Partner communication about family planning	X		X		
Exposure to campaign materials		X	X		
Opinion of family planning service providers		X			
Specific knowledge of and attitudes toward family planning messages			X		

SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).

**Sample design and selection.** For the Adult Omnibus Survey, interviews were conducted with 2,000 randomly selected Kenyans ages 15 years and older, residing in three of Kenya's four major districts. The data were divided into two main strata, urban (1,000 respondents) and rural (1,000 respondents). Within each stratum, sampling points were selected for every district according to district population. The sampling points were sub-locations selected at random within districts. Ten households (one adult per household) were selected within each sampling point, and overall quotas based on national levels were used to ensure coverage by socio-economic status, age, and gender.

For the Housewives' Survey, interviews were held with 1,000 housewives from the same districts interviewed in the Adult Survey. (A housewife is defined as the person primarily responsible for making purchases and organizing housework and cooking, and may be male or female. A household is defined as a group of people, not necessarily related, who live together and share at least one meal a day.) The districts surveyed contain 94 percent of the adult female population of Kenya. The sampling procedure used was similar to that of the Adult Survey, but each group was half the size of that in the Adult Survey.

**Continued use of modern family planning methods.** Data from the Housewives Omnibus Surveys conducted in 1991 and 1993 was used to assess contraceptive use. However, due to data analysis limitations<sup>6</sup>, the contraceptive use data was used only to measure trends and levels rather than to evaluate project impact. The Housewives Omnibus Surveys rather than the Adult Omnibus Surveys yielded the most accurate data on contraceptive use, therefore it is on the Housewives Omnibus survey that observations on contraceptive use are based. Respondents were asked whether they or their partners were currently using any of the methods on a list of modern contraceptives. If they were using a method listed, they were asked how long they had

<sup>6</sup> Research International provided FPAK with analysis results by each contraceptive method, however, this included users of multiple methods. Thus, a reliable contraceptive prevalence rate was not available to the analysis.

been using it without interruption. If they were not currently using a modern method, they were asked whether they had used a method in the past 12 months.

**Partner communication about family planning.** The Adult Omnibus Surveys conducted in 1992 and 1994 included questions to monitor any changes in partner communication about family planning. Respondents were asked, “Have you spoken with your spouse about family planning in the past six months?”

**Campaign exposure and agreement with messages.** To monitor exposure to campaign materials and their impact, questions about the radio drama, *Kuelewana ni Kuzungumza*, and print materials were also included the 1992 and 1994 Adult Omnibus Surveys. Respondents were asked whether they had seen or heard campaign materials and whether they agreed with their key messages.

**Service provider image by campaign exposure.** Secondary univariate and bivariate analyses of the 1993 Adult Omnibus. Differences in image of service providers among persons exposed to IEC materials and among those not exposed were analyzed by means of a logistic regression model. Variables included in the model were age, gender, socioeconomic status, marital status, urban *versus* rural, and current use of modern contraception.

## Observations of CBD Trainers

The training skills of CBD trainers were assessed before and after they were instructed on how to use the new CBD curriculum. Assessment included a review of the training materials, observations of training sessions using structured checklists, interviews with trainers and managers, and focus-group discussions with trainees.

CBD trainers from three nongovernment family planning organizations—FPAK, CHAK, and MYWO—were observed by a consultant and a research assistant while they conducted refresher training and during the training of new CBD agents. In addition, 15 trainers and three service provider managers were interviewed. Small focus-group discussions were also held with a total of 30 CBD trainees.



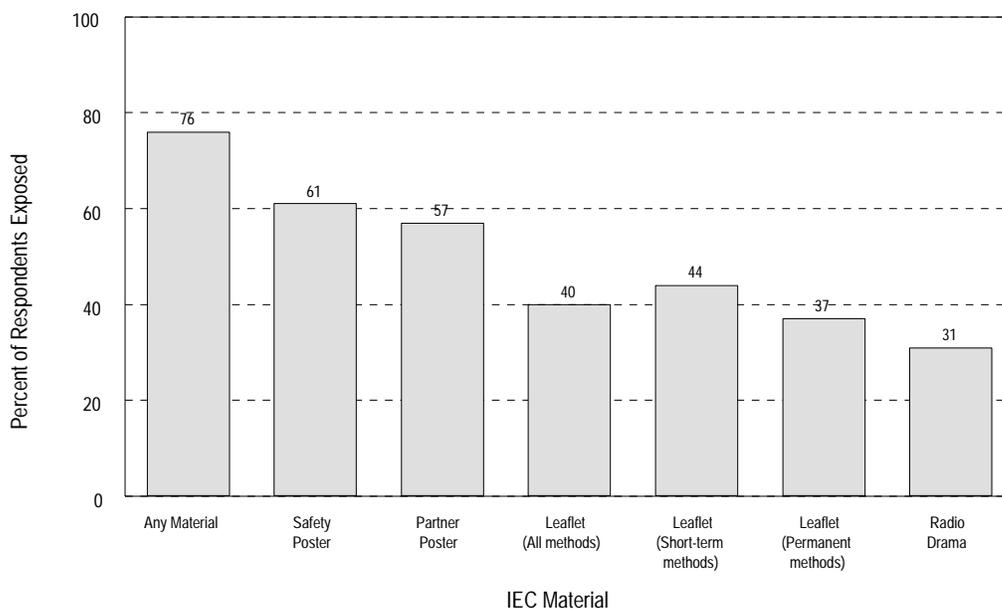
## Chapter III. Results of Campaign Exposure

The use of multiple data sources is a common practice in evaluating JHU/PCS IEC campaigns. The multiple data sources allow evaluation of different campaign objectives and compensate for the limitations and biases of any one data source. The findings are presented here topically, but each topic is covered by one or more data sources. To understand the nature of the findings fully, the reader is reminded to consider the sources of data carefully (see Chapter II for descriptions of survey methodologies).

### IEC Campaign Reach

The September/October 1993 Adult Omnibus Survey found that more than three-fourths of adult Kenyans had been exposed to at least one of the *Haki Yako* campaign materials, and 31 percent had heard the radio drama (see Figure 5). This survey was conducted one year after *Kulewana ni Kuzungumza* began broadcasting, and six months after posters and leaflets were distributed. Six months later, the April/May 1994 Adult Omnibus Survey found that 56 percent of the population had heard the radio program—a substantial increase from 1993 (data not shown).

Figure 5.  
Adult Population Exposed to Haki Yako Campaign Materials:  
Adult Omnibus Survey, Kenya, 1993

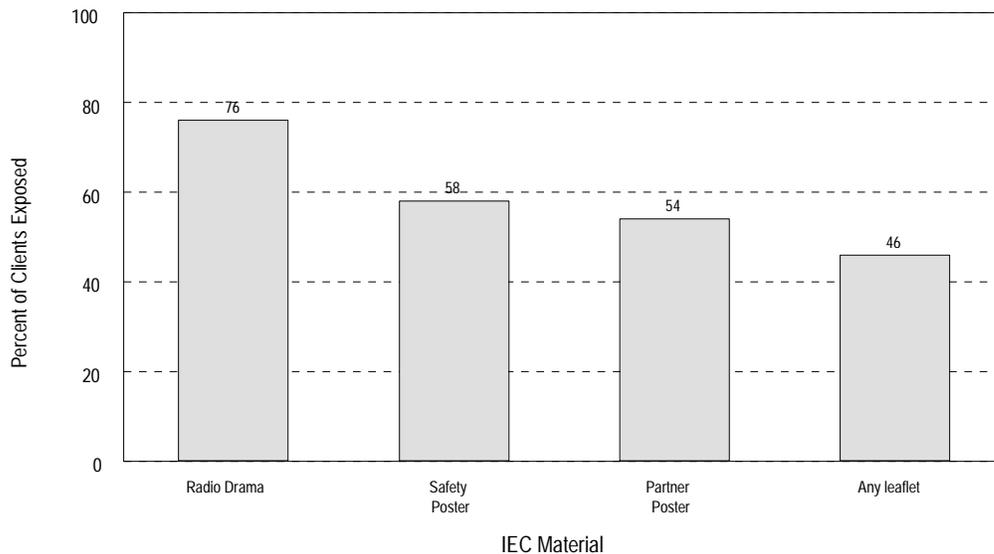


SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).  
NOTE: n=2,000

More men than women respondents in the 1993 Adult Omnibus had heard *Kulewana ni Kuzungunza*. A comparison of the Adult Omnibus survey findings and interviews with new acceptors at clinics show that a larger proportion of female clinic clients had heard the radio drama than had women in the Omnibus Survey. Results from the Omnibus Survey show that fewer than one-third of adult women (28 percent) had heard the drama while fully three-fourths (76 percent) of women who were family planning clients in 1993 had heard the program (see Figure 6).

By September/October 1993, more than half the general adult population had seen either the “safety” poster (61 percent) or the “partner” poster (57 percent), and approximately 40 percent had seen at least one of the leaflets (see Figure 6). Six months later (April/May 1994), levels of exposure to these print items had not changed appreciably (safety poster, 64 percent; partner poster, 61 percent; any leaflet, 39 percent). Further, the follow-up new acceptors interviews found that exposure to print media among family planning clients in 1993 (safety poster, 58 percent; partner poster, 54 percent; any leaflet, 46 percent—see Figure 6) was similar to exposure among the general adult population.

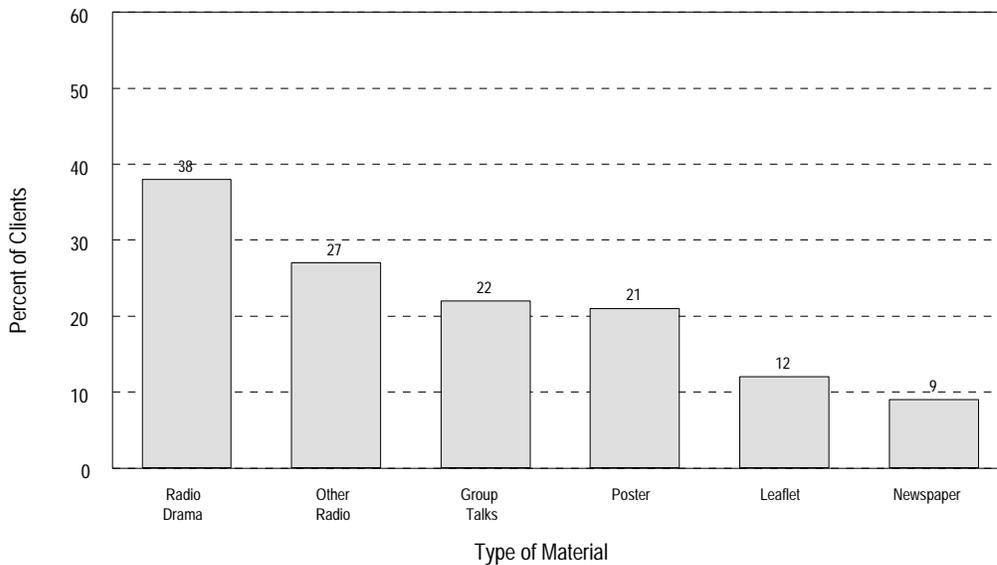
Figure 6.  
New Acceptors' Exposure to Radio and Print Materials:  
New Acceptors' Interviews, Kenya, 1993



SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).  
NOTE: n=172

Clients are referred to family planning services either through personal contact or the media. The radio serial drama also proved to be an effective media source of referral for new acceptors. Over one-third of new acceptors reported the media as a source of referral and specifically said that *Kulewana ni Kuzungumza* was a source of referral to the clinic (see Figure 7). A smaller percentage reported that leaflets or newspapers were their source of referral.

Figure 7.  
 New Acceptors Who Cite Mass Media as Referral Source, by Specific Media Material:  
 New Acceptors Interviews, Kenya, 1993

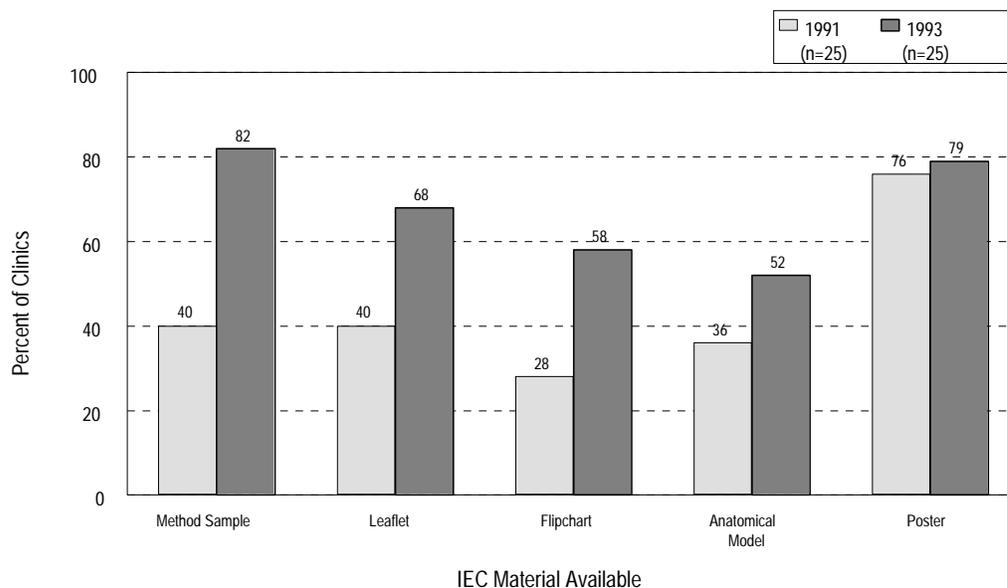


SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).  
 NOTE: n=172

## Clinic Counseling Materials—Availability

At service delivery sites the campaign substantially increased the availability of various IEC materials for providers to use with clients (methods samples, flipcharts, and anatomical models) and for clients to see (posters and leaflets)(see Figure 8). Method samples, which were displayed on a board or shown individually to clients, were found in more than twice as many sites after the campaign than beforehand (82 percent compared with 40 percent). Substantial increases were also seen for leaflets (from 40 percent to 68 percent), flipcharts (28 percent to 58 percent), and anatomical models (36 percent to 52 percent). Only the numbers of posters, which had been available at more than three-fourths of the service points before the campaign, did not increase much (76 percent to 79 percent). Interviews with providers found that a larger proportion of clinic providers than CBD agents had received flipcharts and anatomical models (more than 60 percent compared with less than 20 percent). There was much less difference with printed materials.

**Figure 8.**  
Availability of IEC Materials in Family Planning Clinics, by Type of Material:  
Site Observations, Kenya, 1991 and 1993



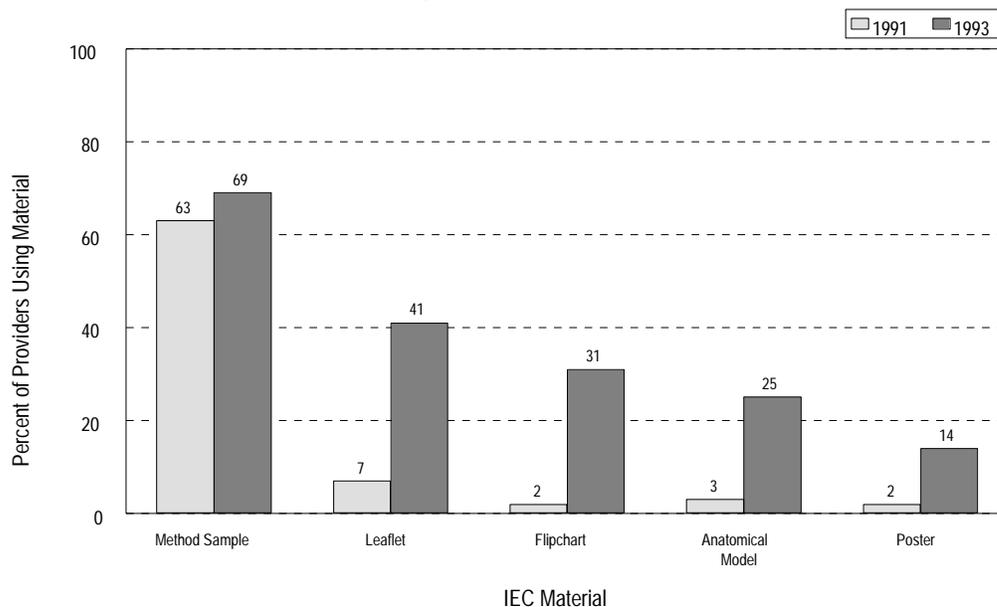
SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).

## Clinic Counseling Materials—Providers' Use

The fact that materials are available in a clinic or other service delivery site does not ensure they will be used. This project also sought to increase providers' use of project materials, such as flipcharts, anatomical models, and leaflets. These materials can improve the quality of counseling by helping service providers to explain contraceptive methods better and by helping clients to understand their options better.

More service providers used IEC materials in their interactions with new acceptors after the campaign than before (see Figure 9). Methods samples were widely used to introduce contraceptives both in 1991 and 1993 (in 63 percent and 69 percent of observations, respectively). Service providers greatly increased their use of leaflets (7 percent to 41 percent), flipcharts (2 percent to 31 percent), and anatomical models (3 percent to 25 percent). Even in 1993, however, these materials were used in fewer than half the interactions.

**Figure 9.**  
Clinic Providers and CBD Agents Observed Using IEC Materials to Counsel New Acceptors, by Type of Materials Used: New Acceptors' Observations, Kenya, 1991 and 1993



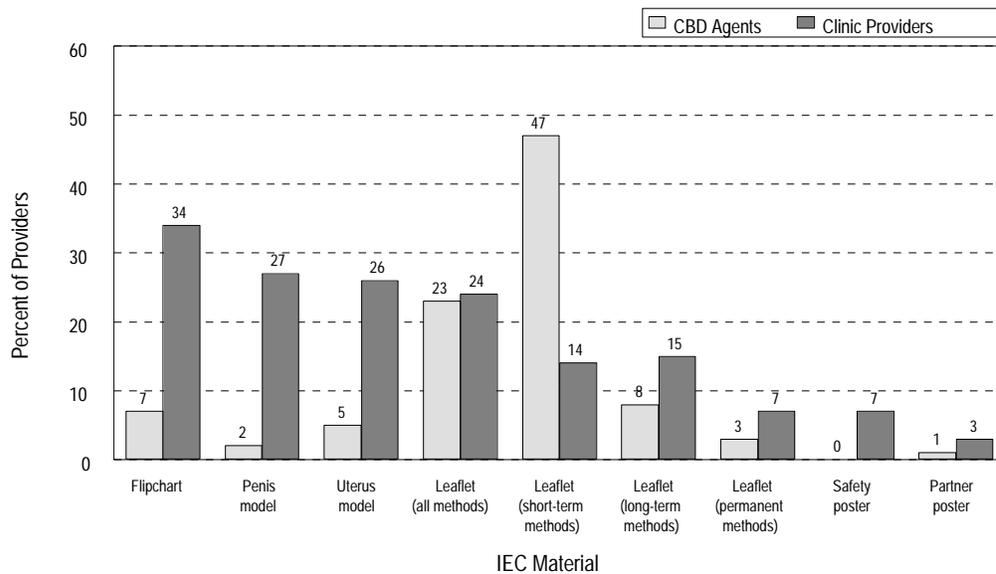
SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994)

NOTES: Where multiple sessions were observed for a single provider, data are averaged across the number of observed sessions.

1991: No. of sessions (Ns) =182; No. of providers (Np) =25; 1993: Ns =171; Np =53

**CBD agents compared with clinic providers, 1993.** Generally, clinic providers used IEC materials with clients more than CBD agents did (see Figure 10). CBD agents, however, used the leaflet describing short-term methods more extensively. This was expected, since these are the methods CBD workers could actually provide during home visits.

**Figure 10.**  
**CBD Agents and Clinic Providers Observed Using IEC Materials, by Type of Materials Used:**  
**New Acceptors and Continuing Users Observations, Kenya, 1993**



SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).  
 NOTES: Where multiple sessions were observed for a single provider, data are averaged across the number of observed sessions.  
 CBD agents: Ns =101; Np =20; Clinic providers : Ns =67; Np =28

**Clinic providers, 1991 and 1993.** A larger percentage of clinic providers used some IEC materials during counseling sessions in 1993 than in 1991. The use of method samples by these providers, however, decreased over the two years (77 percent to 65 percent). This is probably because by 1993 providers had other materials, especially flipcharts with method descriptions, available for explaining methods to clients. Even after the campaign, however, fewer than half (43 percent) were using materials other than method samples.

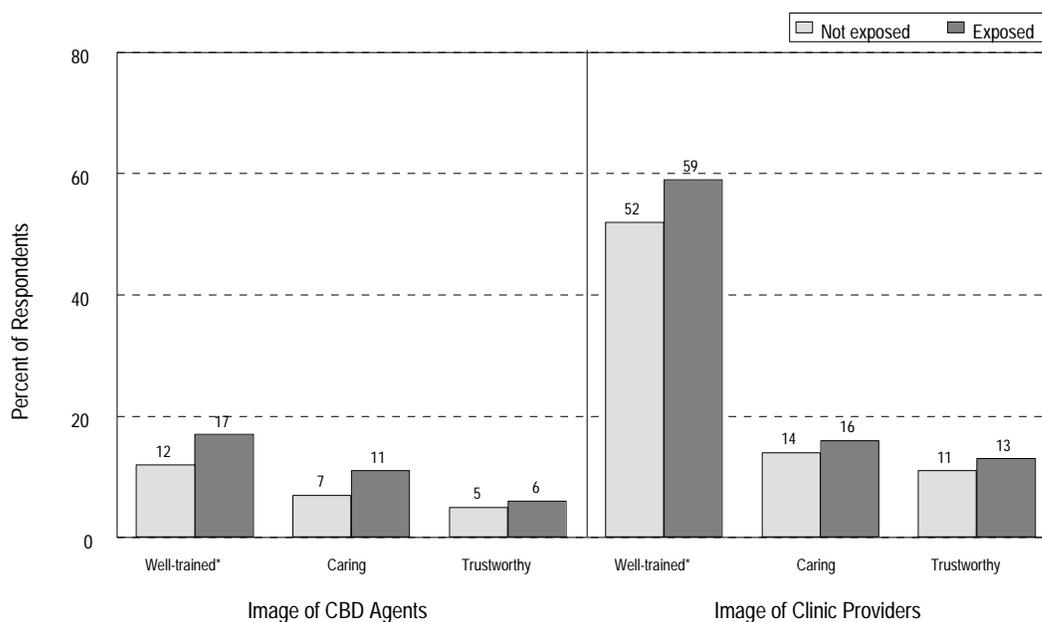
**CBD agents, 1991 and 1993.** The percent of CBD agents using method samples to introduce contraceptives increased from 53 percent in 1991 to 74 percent in 1993. A substantial increase from 1991 to 1993 was observed in CBD agents' use of leaflets (4 percent to 47 percent), and anatomical models (3 percent to 15 percent). Since flipcharts were unavailable in 1991, their use increased from 0 percent in 1991 to 17 percent in 1993. These levels would have been even higher had more CBD agents had access to models and flipcharts. It is interesting to note that among

CBD agents who received training between 1992 and 1993, only 45 percent said that the use of visual aids was included as a topic in the training (see Appendix A).

## Service Providers' Image

Adults interviewed in the Adult Omnibus Survey who heard the radio drama *Kulewana ni Kuzungumza* had a more positive image of CBD agents and clinic providers than those who had not been exposed (see Figure 11). Those who had seen *more* print materials generally also had a more positive image of these family planning providers (see Figure 12). Still, the image of providers (among clients) is quite poor, suggesting the need for future campaigns to improve providers' image and the quality of care. Clinic-based providers have a better, more professional image than do CBD agents.

Figure 11.  
Image of CBD Agents and Clinic Providers by Exposure to Radio Drama:  
Adult Omnibus Survey, Kenya, 1993

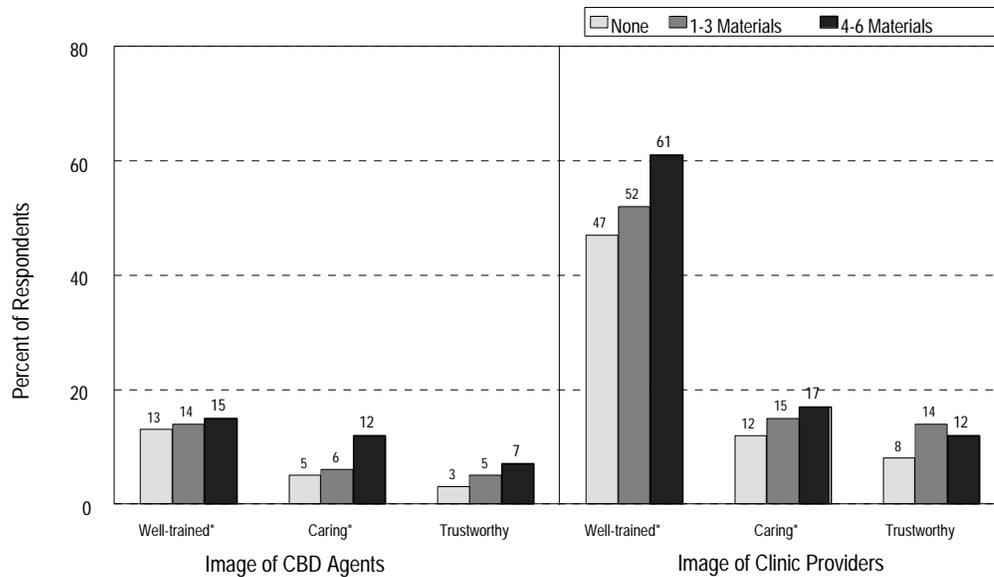


SOURCE: JHU/CCP and FPAK Kenya Client- Provider IEC Project (1991-1994).

NOTES: n=2,000

\* Difference significant at p<0.01.

**Figure 12.**  
**Image of CBD Agents and Clinic Providers by Exposure to Number of Print Materials:**  
**Adult Omnibus Survey, Kenya, 1993**



SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).

NOTES: n=2,000

\* Difference significant at p<0.01.

## Chapter IV. Provider Counseling Skills and CBD Training

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The effectiveness of the *Haki Yako* campaign in improving family planning counseling was assessed according to the “the GATHER approach.” Devised by JHU/PCS to train counselors in the interactive communication essential to serving clients effectively, “GATHER” provides both a useful mnemonic for guiding counselors and offers a rational basis for evaluating counselors’ performance. The GATHER approach is applicable to both community-based and clinic counseling. Its six steps are:

- G** - Greet clients and make them comfortable;
- A** - Ask clients about themselves;
- T** - Tell clients about available family planning methods;
- H** - Help clients choose an appropriate method;
- E** - Explain how to use the chosen method; and
- R** - Recommend and schedule a return visit or refer to other services if needed.

Under the project, about 200 trainers of clinic staff and CBD agents from family planning organizations were trained. Each organization was then responsible for all aspects (including funding) of training their own providers. By 1993, three-fourths of CBD agents, but only one-fourth of the clinic providers, had been trained in counseling according to the GATHER approach. The CBD agents were trained in 1992 or 1993; thus the effectiveness of their training could be measured by comparing their skills in the baseline (1991) and follow-up (1993) clinic studies. Since such a small percentage of clinic providers received training in GATHER, their skills are reported for 1993 only to provide a baseline description of counseling skills for future comparison.<sup>7</sup>

Counseling skills were assessed by trained observers who sat in on counseling sessions. It should be noted that such “cross-sectional” observations reveal only a small part of a dynamic, continuing counseling process. This limitation is especially obvious in this study that takes place over many contacts between CBD agent and client, where “before and after” comparisons of the counseling skills of CBD agents are made. Because CBD agents are residents of the community they serve, they may visit clients periodically to educate, serve, or motivate them. As a consequence, the observations made at only one counseling session captures only a small part of all counseling and will miss what has been covered previously.<sup>8</sup> The observation method was used because it provides an excellent measure of skills used during actual service delivery.

<sup>7</sup> Note that none of the providers at a MOH or KMA sites received counseling training under the project.

<sup>8</sup> In a forthcoming study by Kim *et al.*, a content analysis of almost 200 counseling sessions also notes the difference between observations of one-time clinic-based counseling sessions and CBD agent counseling sessions. When compared on information content, CBD agents scored lower than clinic-based providers. In contrast, when the extent of the interaction between client and provider was measured, counseling sessions with CBD agents were found to have much higher levels of positive interaction than those involving clinic-based providers. (Interactions were considered to be more positive if the client spoke more, asked questions, expressed concerns, and shared desires.) The greater interaction between CBD agents and clients—and possibly also the lower information content in a single session—may reflect recurring contacts.

## CBD Agents' Counseling Skills Using GATHER

**Greeting.** The greeting skills of CBD agents were high in both the baseline and follow-up evaluations. In both 1991 and 1993, CBD agents received their clients professionally and put them at ease. They used language that was easy for their clients to understand, and they spoke distinctly and pleasantly.

**Asking.** CBD agents' ability to ask clients for necessary information (medical history, and previous family planning experience) declined between 1991 (80 percent) and 1993 (60 percent; see Figure 13). This decline may not, however, reflect a decrease in asking skills, but instead suggests that CBD agents may already know this information through previous counseling or observation.

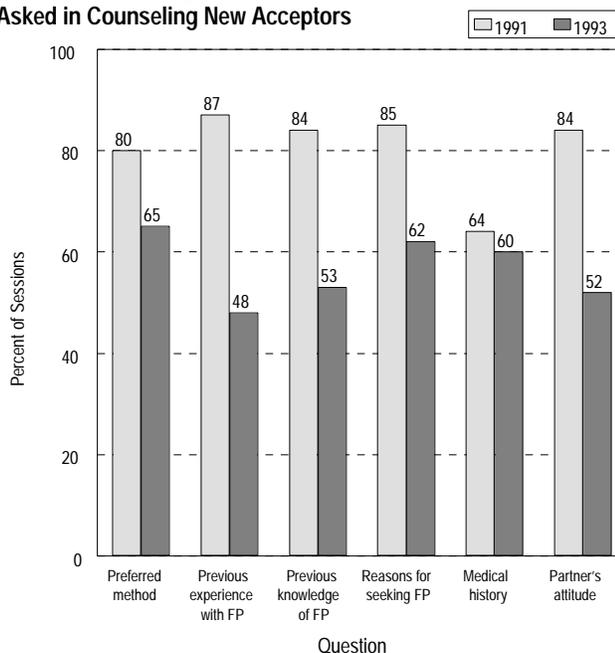
**Telling.** CBD agents told clients about a wider range of methods in 1993 counseling sessions than in 1991 (see Figure 14). Fully 90 percent of counseling sessions touched on some aspect of pill use in 1993—a substantial increase from 1991. Norplant implants were not widely available in 1991 but were discussed with one-third of new acceptors in 1993. Presentation of the diaphragm, tubal ligation, and vasectomy improved substantially after the campaign.

**Helping.** CBD helping skills were generally high, although there was some decline in several areas between 1991 and 1993 (see Figure 15). In 1993, fewer CBD agents asked about client concerns, gave clients a chance to express their concerns, or explained why a particular method was inappropriate.

**Explaining.** Also notable, providers' explanations about family planning improved between 1991 and 1993 (see Figure 16). CBD agents were more proficient at explaining how the clients' chosen methods work. They also showed correct use and mentioned possible side effects more often in 1993 than in 1991. In 1993, CBD agents also were better at assessing whether clients understood instructions.

**Recommending.** There was a big improvement in scheduling return visits in 1993 compared with 1991 (see Figure 17). CBD agents referred more than twice as many clients for family planning service in 1993 than in 1991. This increase may be the result of more clients' choosing long-term and permanent methods, which CBD agents cannot provide.

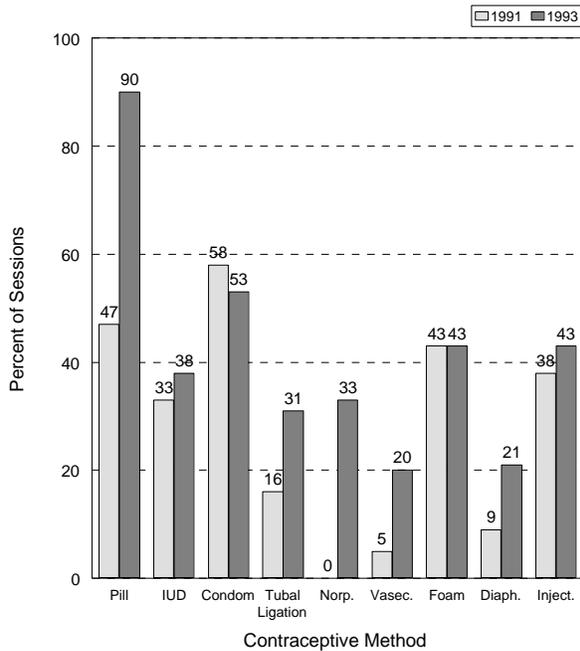
Figure 13.  
CBD Agents' Asking Skills--Observed Questions  
Asked in Counseling New Acceptors



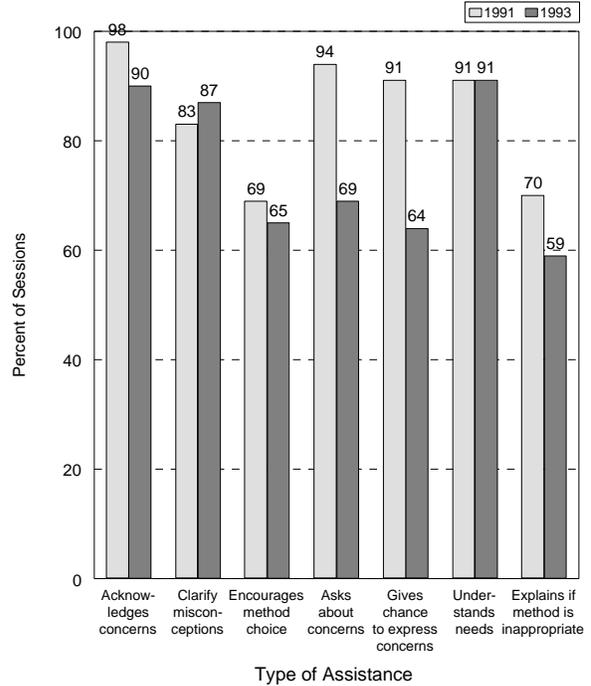
SOURCE: New Acceptors Observations, Kenya, 1991 and 1993.  
JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).

NOTES: Where multiple sessions for a single provider were observed, data are averaged across the number of observed sessions.  
(Ns=49; Np=30; 1993: Ns=50; Np=31)

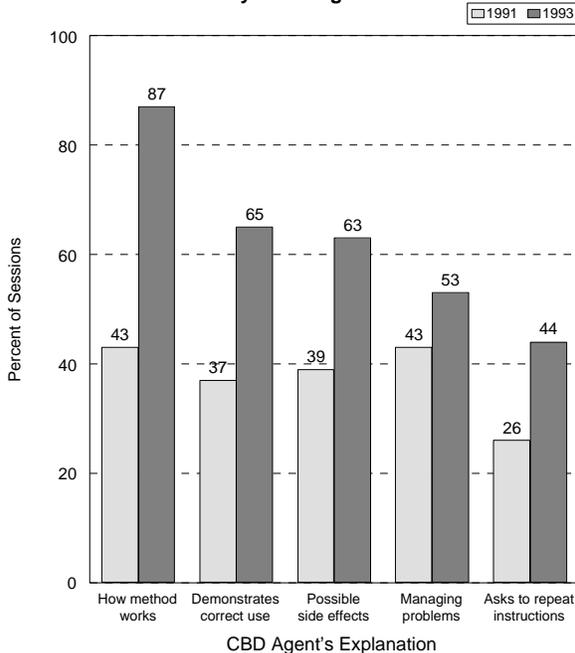
**Figure 14.**  
**CBD Agents' Telling Skills--Observed Contraceptive Methods Discussed with New Acceptors**



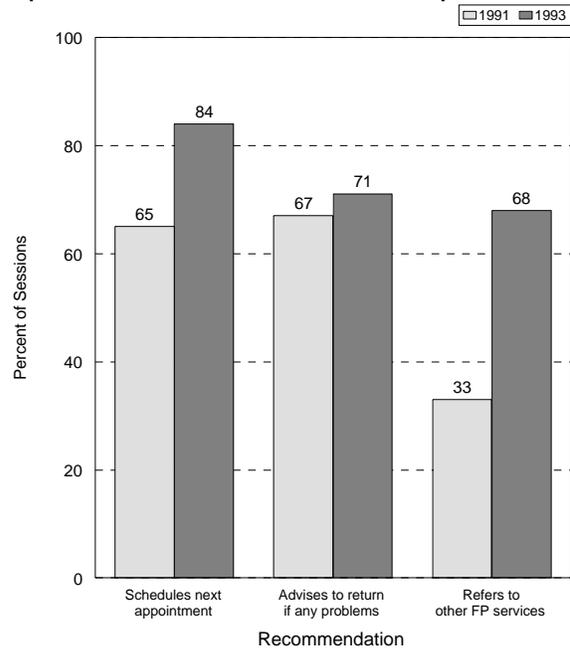
**Figure 15.**  
**CBD Agents' Helping Skills--Observed Assistance to New Acceptors in Choosing Methods**



**Figure 16.**  
**CBD Agents' Explaining Skills--Observed Explanations of Client's Chosen Family Planning Method**



**Figure 17.**  
**CBD Agents' Recommending Skills--Observed Setting Up of Return Visits or Referrals for New Acceptors**



SOURCE: New Acceptors Observations, Kenya, 1991 and 1993. JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).  
 NOTES: Where multiple sessions for a single provider were observed, data are averaged across the number of observed sessions.

(1991: Ns=49; Np=30; 1993: Ns=50; Np=31)

## Clinic Providers' Counseling Skills Using GATHER

As stated earlier, clinic providers' counseling skills assessed in 1991 cannot be compared with their skills in 1993 because only a small percentage of them received GATHER training. The findings of clinic providers' skills for 1993, however, can be valuable baseline information for developing future training strategies.

**Greeting.** Like those of the CBD agents, the greeting skills of clinic providers were excellent: 89 percent of clients were greeted. Clinic-based providers' respect of the client's privacy, however, could be improved. In only 43 percent of sessions observed did clinic-based providers respect their client's privacy.

**Asking.** Clinic providers were skilled at obtaining information needed to counsel clients effectively (see Figure 18). Approximately 90 percent of providers asked about the preferred method, previous experience with family planning, or previous knowledge of family planning (see Figure 18). Only about one-half of the clients, however, were asked about the attitude of their partner toward family planning.

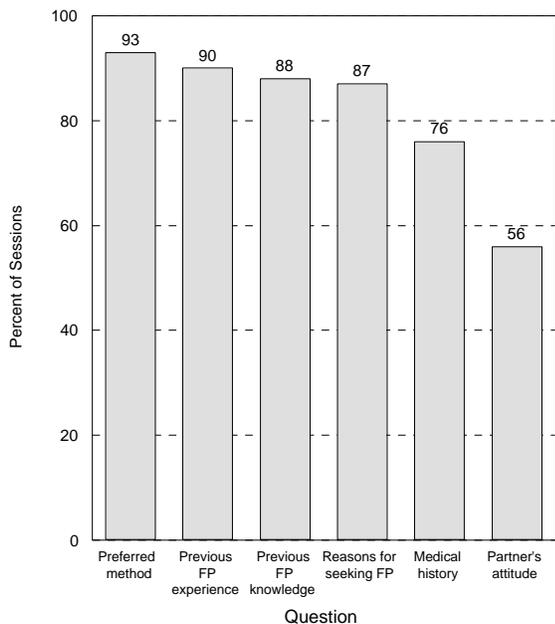
**Telling.** Clinic providers informed their clients about the range of modern family planning methods (see Figure 19). Not surprisingly, clinic providers mentioned long-term methods more frequently than CBD agents did, as clinic providers can dispense these methods, while CBD agents must refer (see also Figure 14).

**Helping.** Clinic providers had well-developed helping skills (see Figure 20). Providers encouraged method choice more than 80 percent of the time. Even the least common skill—explaining why a particular method was inappropriate—was evident in nearly three-fourths of the interactions with new acceptors. When clients expressed concerns or misconceptions, in more than 90 percent of the cases, clinic providers acknowledged and clarified these issues during the session.

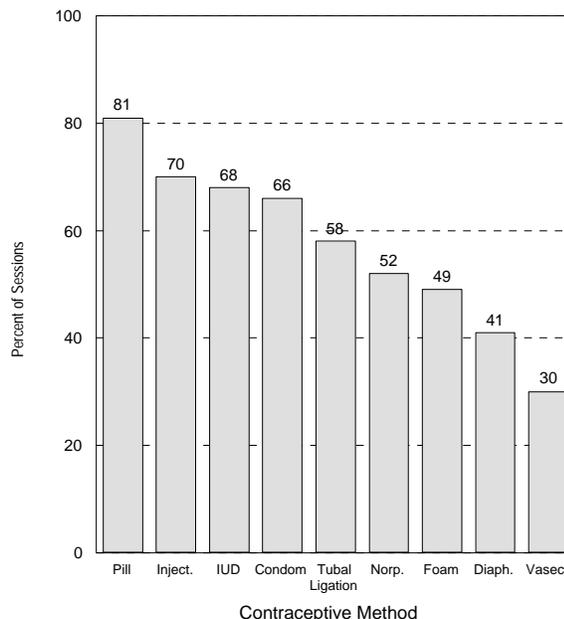
**Explaining.** Clinic providers were conscientious at explaining how a method works, demonstrating correct use, and managing problems (see Figure 21). They were less likely, however, to check for comprehension by asking clients to repeat instructions.

**Recommending.** Clinic providers provided most clients with a follow-up appointment and were told to return if there were problems (see Figure 22). This skill is important in encouraging clients to continue using the method they have chosen or in determining if there are problems with the method and offering an alternative.

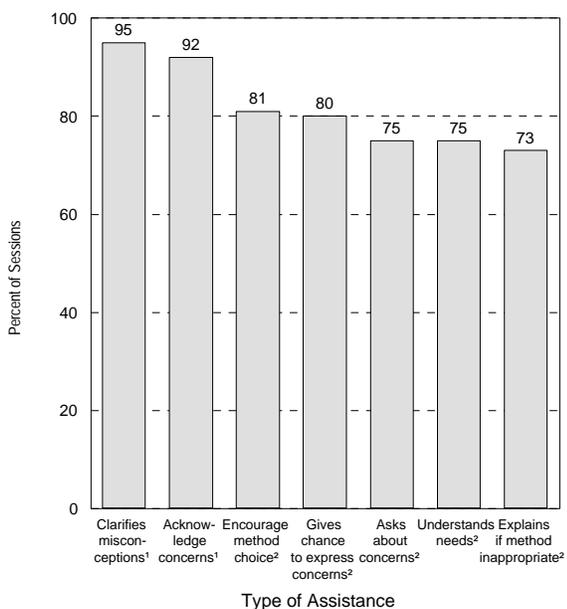
**Figure 18.**  
**Clinic Provider's Asking Skills--Observed Questions**  
**Asked in Counseling New Acceptors**



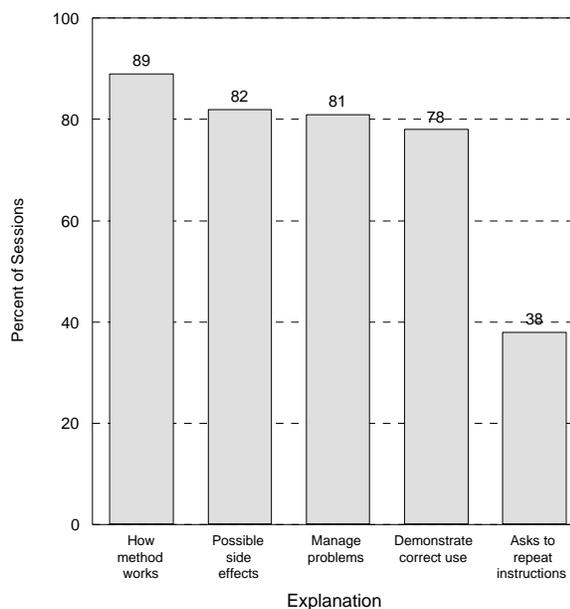
**Figure 19.**  
**Clinic Provider's Telling Skills--Observed Contraceptive**  
**Methods Discussed with New Acceptors**



**Figure 20.**  
**Clinic Provider's Helping Skills--Observed Assistance**  
**to New Acceptors in Choosing Methods\***



**Figure 21.**  
**Clinic Provider's Explaining Skills--Observed Explanations**  
**of Client's Chosen Family Planning Method\*\***

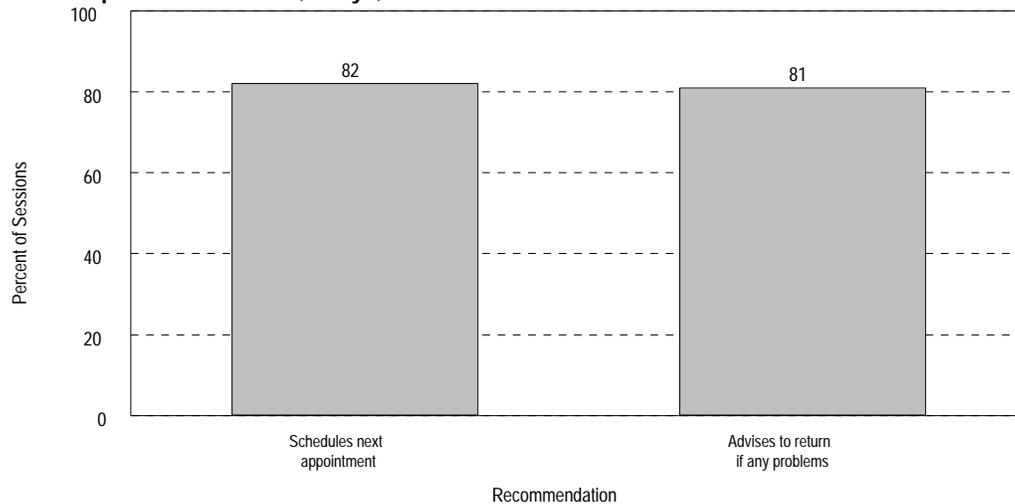


SOURCE: New Acceptors Observations, Kenya, 1993. JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).  
 NOTES: Where multiple sessions for a single provider were observed, data are averaged across the number of observed sessions.  
 (Ns=101; Np=20)

\*Fig. 20. ¹ Numbers vary because of the structure of the observation. Providers cannot "acknowledge" or "clarify" unless

the client had "concerns" or "misconceptions." Ns=69; Np=13; <sup>2</sup> Ns=101; Np=20)  
\*\*Fig. 21. Ns=92; Np=19

**Figure 22.**  
**Clinic Providers' Recommending Skills--Observed Setting Up of Return Visits**  
**for New Acceptors and Advising to Return:**  
**New Acceptors Observations, Kenya, 1993**



SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).  
 NOTES: Where multiple sessions for a single provider were observed, data are averaged across the number of observed sessions. (1991: Ns=49; Np=30; 1993: Ns=50; Np=31)

## CBD Training Evaluation

One important component of the project was to improve the quality of training of service providers by developing a national training curriculum and CBD training manual. A baseline observation of training skills was conducted in 1991. After the training of trainers, a follow-up observation was done in 1994 to assess the skills of master trainers and determine the efficacy of the project. The objectives of the study were to determine how well trainers were using the CBD training manual and to learn if their training skills had improved. The follow-up evaluation included a review of training materials, observations of CBD training sessions using structured checklists, interviews with trainers and program managers, and focus-group discussions with trainees.

Although the study sample was small, training of CBD trainers appears to have had a positive effect. Trainers were better organized than they were before training. Most had objectives for their sessions, prepared lesson notes, and had handouts for the trainees. Trained trainers kept to the schedule and handled the teaching aids effectively. Overall, trained trainers are doing a excellent job of training CBD agents. Aspects of training still needing improvement include: use of the audio/visual equipment, skills in facilitating interactions, and record-keeping.

Trainees thought that the trainers were knowledgeable and communicated their subject matter well. Trainees felt they had benefitted from the training and were eager to receive further

training. Many trainees thought that the refresher training sessions were too short and that there was insufficient time to absorb all the material.

## Chapter V. Impact on Family Planning Attitudes and Practices

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### Family Planning Attitudes and Knowledge

**Attitudes toward family planning.** The April/May 1994 Adult Omnibus Survey measured attitudes toward modern family planning by asking respondents whether they agreed or disagreed with campaign messages.<sup>9</sup> The survey results revealed that:

- 91 percent of respondents agreed that “Family planning helps couples be in control of their lives;”
- 84 percent of respondents agreed that “There are many modern family planning methods to select from;”
- 31 percent of respondents agreed that the IUD is safe and does not cause long-term problems;
- 38 percent of respondents agreed that modern family planning methods are safe for a woman's health; and
- 53 percent of respondents agreed that the pill does not cause infertility.

**Family planning knowledge.** By asking if a number of statements about modern contraceptives were true or false, the 1994 Adult Omnibus Survey assessed family planning knowledge on four subjects, as follows:

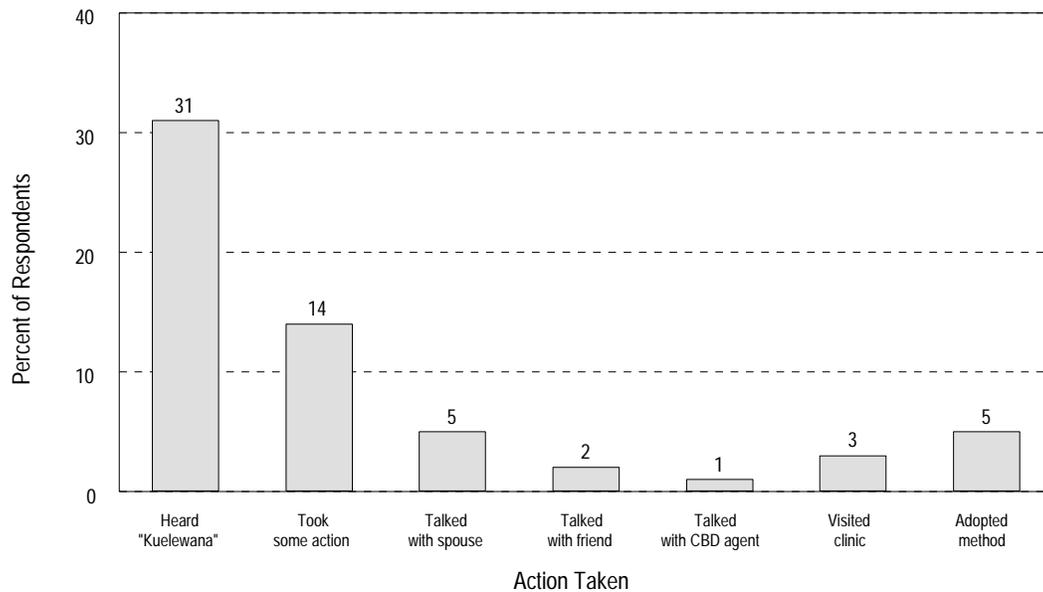
- 60 percent of respondents knew that tubal ligation is a permanent method;
- 42 percent of respondents knew that vasectomy cannot easily be reversed;
- 45 percent of respondents were aware that breastfeeding women can safely use the pill once their babies are six weeks old; and
- 22 percent of respondents were familiar with Norplant implants.

<sup>9</sup> These numbers do not reflect a comparison of pre- and post-campaign attitudes, and therefore, cannot be used to assess campaign impact.

**Couple communication about family planning.** One of the major goals of the Client-Provider IEC Project was to increase couple communication about family planning. The Adult Omnibus Surveys reported attitudes and actions involving couple communication about family planning:

- In 1994 almost all adults (94 percent) agreed with the statement: “It’s important to discuss family planning with one’s spouse;”
- Between 1992 and 1994 the percentage of adults who reported *speaking to their spouses or partners about family planning within the last six months* rose from 38 percent to 42 percent;
- In 1993 “talking with their spouse” was the action most commonly reported by adults exposed to campaign materials. Among those who heard the radio program and took action, 36 percent spoke to their spouses about family planning (see breakdown in Figure 23).

Figure 23.  
Self-Reported Actions Taken as a Result of Listening to "Kuelewana ni Kuzungumza:"  
Adult Omnibus Survey, Kenya, 1993



SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).  
NOTE: n=2,000

## Family Planning Practice

One major goal of the IEC project was to increase the continued use of modern contraceptives. In 1991, before the campaign started, 67 percent of the Housewives Omnibus Survey respondents already using modern methods reported continued use for at least one year; in 1993 after the campaign had been in progress for a year, this figure had risen to 71 percent. The contraceptive prevalence rate was not used in this study because the contraceptive method use data included users of multiple methods.<sup>10</sup>

Also, adults who listened to the radio drama or had seen a leaflet or poster were more likely to use modern family planning methods than those who had not (see Figure 24). For instance, 56 percent of those who heard the radio program used modern methods compared with 38 percent of those who had not heard it.

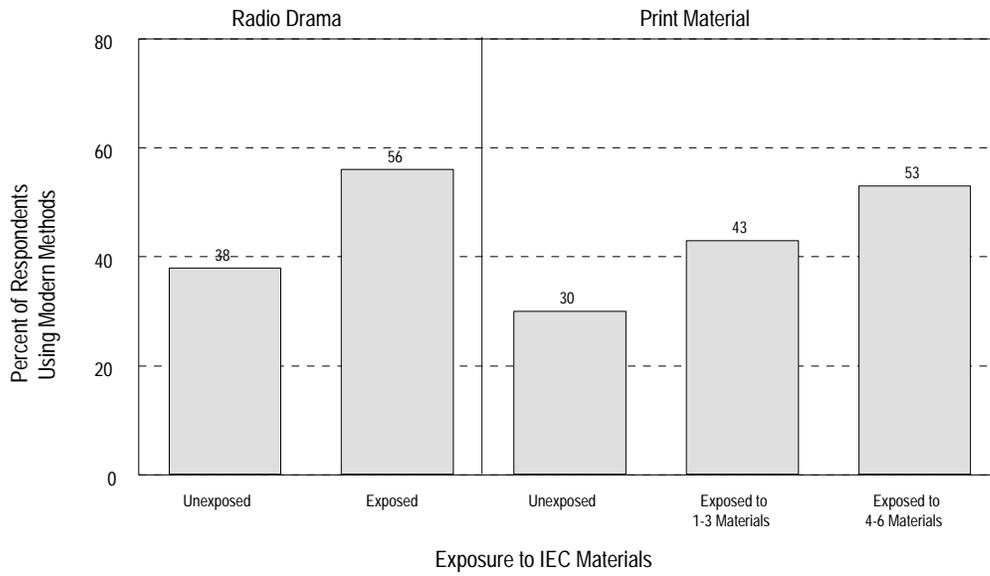
Another report corroborating this result uses data from the Kenya National IEC Situation Survey conducted by NCPD and JHU/PCS in Kenya in 1994.<sup>11</sup> That survey found that 54 percent of the 4,000 respondents had heard the radio drama *Kuelewana ni Kuzungumza*. Modern contraceptive use was twice as common among those who had heard the drama than among those who had not heard it. Similarly, greater exposure to print materials was associated with greater likelihood of using a modern contraceptive. For example, among those who saw no print materials, 30 percent used modern methods. Among those who saw one to three leaflets or posters, 43 percent used modern methods. Among those who saw four to six leaflets or posters, 53 percent used modern methods. In both studies, however, it is difficult to know whether exposure to campaign materials encouraged use of modern methods; whether use of modern methods made people more aware of or receptive to campaign materials; or whether people saw these materials when they visited providers to obtain methods.

Numbers of new acceptors per month seen at family planning service sites increased during the campaign (see Figure 25). The increase was particularly dramatic over the spring and summer of 1993, following distribution of campaign print materials in the clinics as well as in the community. While the data in this paper do not provide conclusive evidence as to whether provider training resulted in either an increased number of new clients or an increase in continued use, they do provide a basis upon which the quality and delivery of services may be improved.

<sup>10</sup> The 1991 and 1993 Housewives Omnibus data showed that injectable use increased from 7 to 9 percent, IUD use from 4 to 5 percent, tubal ligation use from 2 to 3 percent, and condom use from 3 to 5 percent. However, pill use decreased from 16 to 13 percent.

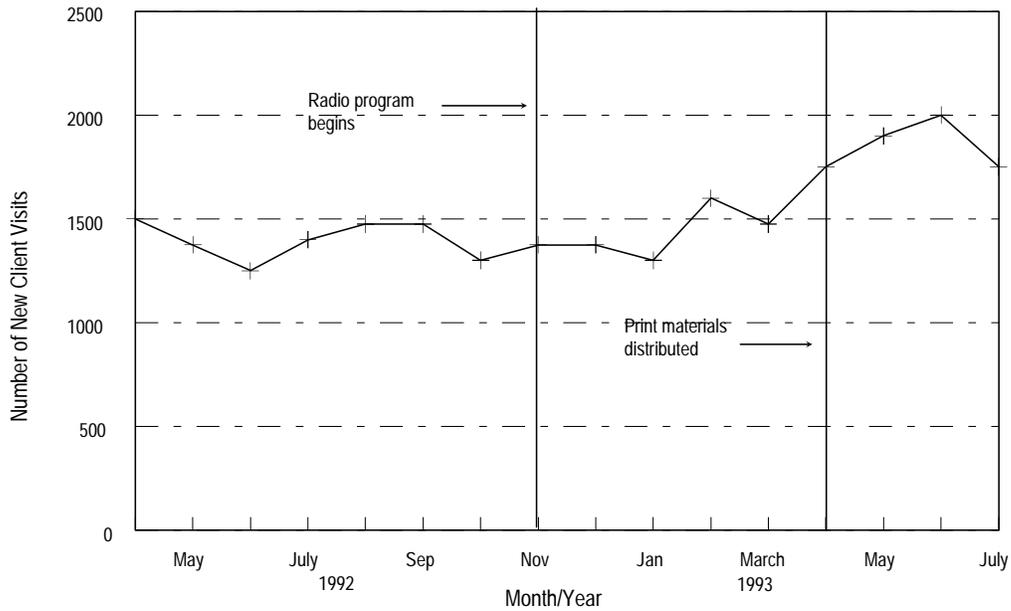
<sup>11</sup> Kincaid, D.L. Research Methods for Evaluating the Impact of Population-Based Communication Programs: Lessons from Family Planning and Public Health. Presented at a symposium on Communication and Empowerment: Uses of Media and Information Technologies in Developing Countries, University of Southern California, April 1996.

**Figure 24.**  
**Use of Modern Family Planning Methods, by Exposure to IEC Materials:**  
**Adult Omnibus Survey, Kenya, 1993**



SOURCE: JHU/CCP and FPAK Kenya Client-Provider IEC Project (1991-1994).  
 NOTE: n=2,000

**Figure 25.**  
**New Acceptor Visits at 11 Sentinel Clinics:**  
**Clinic Statistics, Kenya, 1992-1993**



SOURCE: JHU/CCP and FPAK Client-Provider IEC Project (1991-1994).

## Chapter VI. Conclusions and Recommendations

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The Kenya Client-Provider IEC Project resulted in improved counseling and interpersonal communication between providers and clients, increased availability and use of educational materials at the service delivery points, and widespread exposure to campaign materials among the general population. The numbers of new acceptors of family planning per month seen at 18 family planning delivery sites increased from 1,500 to 2,000 during the campaign.

The *Haki Yako* campaign reached more than three-fourths of Kenyan men and women. This success could be partly the result of the simplicity and appeal of its slogan, *Haki Yako* (“It’s your right”). The slogan communicated a sense of empowerment to people wanting more control over their own lives. The simplicity of the messages—modern contraceptives are safe, service providers are well-trained, and partners should discuss family planning—made them more memorable. A much greater percentage of people who heard the radio serial drama knew that family planning methods are safe and, despite widespread rumors, do not cause infertility. Still, although the message that couple communication about family planning was widely aired, there was but a small increase in the proportion of the population that reported speaking to their spouses or partners about family planning within the past six months.

Radio drama appears to be an effective way to encourage Kenyan women to go to family planning service providers, however. High family planning use among listeners, compared with women in the general population, and clients’ reports of referral sources confirm this. This high level of exposure to the radio drama suggests that future campaigns should use radio broadcasting as a major communication channel.

In addition to the conclusions mentioned above, other recommendations can be made on expanding and improving the IEC project, media campaign clinic IEC material distribution, provider training, and institutional coordination for the next project phase. These recommendations and the findings on which they are based are described below.

### Media Campaign

■ **Finding:** The radio serial drama—heard by 56 percent of the general adult population—proved to be an effective means of attracting new family planning acceptors (76 percent of new acceptors listened to the program; 38 percent said the program influenced them to visit the clinic).

**Recommendation:**

Continue to use radio drama or other programming to reinforce the messages of partner communication and safety of modern contraceptive use. Make more effort to improve the images of providers as competent and trustworthy. Investigate ways to increase listenership.

■ **Finding:** Using several communication channels (radio, posters, leaflets, community events) reached three-fourths of the adult population of Kenya. In fact, the overlapping coverage of various media increased the level of exposure and had a reinforcing effect on those exposed.

**Recommendation:**

Use multi-media campaigns for any communication interventions in which reaching a large audience is an objective.

■ **Finding:** Posters and leaflets reached much of the intended audience but were available mostly in clinics, limiting access for much of the population.

**Recommendation:**

Increase general exposure to posters and leaflets by distributing them in public gathering places such as banks, kiosks, and hair dresser shops, as well as clinics.

■ **Finding:** The use of the *Haki Yako* slogan tied various components of the project together and increased recall and awareness of the primary issues.

**Recommendation:**

Use a unifying theme for IEC campaigns.

## Clinic IEC Material Distribution

■ **Finding:** Although most IEC materials were more widely available at service delivery sites during the campaign than before, materials were still unavailable in one-third of the 25 study sites.

**Recommendation:**

Develop a better distribution and inventory system for IEC materials.

## Provider Training in Counseling

■ **Finding:** Training of CBD trainers improved CBD performance.

**Recommendation:**

Provide refresher training for CBD trainers to maintain and improve the quality of training.

- **Finding:** Since the training portion of the project focused on training CBD agents, limited numbers of clinic providers received training.

**Recommendation:**

Seek resources to allow other organizations to establish regular counseling training for clinic-based service providers.

- **Finding:** CBD agents and clinic providers were more likely to use IEC materials during counseling sessions after the campaign. However, only 41 percent of service providers who had leaflets actually used them in counseling sessions.

**Recommendation:**

Explore the reasons that some providers are not using the IEC materials and design interventions to increase use of the materials. Conduct training of CBD trainers to encourage trainers to use visual aids and show them how.

- **Finding:** Clinic providers generally had better asking skills than CBD agents, but both often failed to ask about partners' attitudes.

**Recommendation:**

Continue to emphasize asking skills in provider training and link them to the importance of identifying needs, screening for appropriate methods, dealing with misinformation, and inquiring about partners' attitudes.

- **Finding:** More family planning methods were discussed with clients during the campaign than before; some methods were discussed with fewer than 40 percent of clients, however. These methods include long-term and permanent methods such as IUD, Norplant implants, tubal ligation, and vasectomy. For example, young women do not get information on these methods because providers "pre-screen" clients, making assumptions about which methods are appropriate for young women. The selective provision of information may be a mechanism for dealing with crowded conditions and a shortage of time.

**Recommendation:**

Identify why CBD agents and clinic providers are less likely to discuss long-term and permanent methods. Providers need to be trained to balance quality and quantity of information provided to fit a variety of counseling situations.

- **Finding:** Service providers did not assess whether clients understood instructions.

**Recommendation:**

Explore different ways of assessing clients' comprehension; then investigate different approaches to training providers how to test client comprehension.

- **Finding:** CBD agents scheduled return visits more often in 1993 than in 1991. Further improvement is needed, however.

**Recommendation:**

Re-emphasize during training that new acceptors should routinely be scheduled for a follow-up visit or referred to the clinic if they have chosen a method that calls for such services.

- **Finding:** Family planning service providers were not viewed as very competent, caring, or trustworthy by the general population.

**Recommendation:**

Conduct additional studies to determine the reasons for the public's poor opinion of family planning providers, continue to improve the quality of service, and let the public know that service has improved. Encourage dialogue between providers and the communities they serve to identify problems.

## **Program Management Issues**

- **Finding:** While improving the quality of services will increase use of facilities in the long run, the effect is much quicker when the training is linked to publicity about trained providers.

**Recommendation:**

Promote trained providers to create an image of them as competent, caring, and trustworthy.

- **Finding:** There was a lack of materials related to some reproductive health issues available to service providers.

**Recommendation:**

Provide support materials covering of reproductive tract infections and HIV/AIDS.

- **Finding:** The IEC Working Group consists of representatives from different organizations. Coordination by the IEC Working Group resulted in more effective nationwide distribution of IEC materials through their organizations.

**Recommendation:**

Use the IEC Working Group mechanism for coordinating and implementing IEC projects.

## Appendix A. Additional Tables

**Distribution of study sites by regions.** The number of MOH sites studied was decreased and other agencies' sites increased, between 1991 and 1993, to ensure sufficient representation of CBD sites.

**Appendix Table 1.**  
**Distribution of Study Sites, by Region**

Region	Organization											
	MOH		FPAK		FPPS		CHAK		MYWO		KMA	
	1991	1993	1991	1993	1991	1993	1991	1993	1991	1993	1991	1993
Coast/ Eastern	1	1	-	2	2	2	1	1	-	-	-	-
Central/Nairobi	3	2	3	2	-	-	1	1	3	1	1	2
Rift	3	2	3	3	1	1	-	1	1	3	2	1
Valley/Western												
<b>TOTAL</b>	<b>7</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>3</b>	<b>3</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>4</b>	<b>3</b>	<b>3</b>

SOURCE: JHU/CCP & FPAK Kenya Client and Provider IEC Project (1991-1993).

**Service provider program training—1993.** The training program included the GATHER method of counseling, vasectomy and Norplant implants use, use of visual aids, new regulations for pill distribution, and other topics. Note that relatively few service providers received training in use of visual aids.

**Appendix Table 2.**  
**Percent of Trained CBD Agents and Clinic Providers**  
**Who Were Trained in Specific Training Topics**

Training Topic	CBD Agent (n=31)	Clinic Provider (n=11)
GATHER	62.9	81.8
Vasectomy	61.3	66.7
Norplant	61.3	54.5
Visual aids	45.2	28.6
Pill distribution	73.2	16.1
Other	54.2	66.7

SOURCE: JHU/CCP & FPAK Kenya Client and Provider IEC Project (1991-1993).