

Extending Service Delivery Project
Best Practices Series Report #2

**USAID AMKENI Integrated Model in
Reproductive Health Programming in Kenya**

A Promising Practice Model

June 2007



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The Extending Service Delivery (ESD) Project, funded by USAID's Bureau for Global Health, is designed to address unmet need for family planning (FP) and increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, to improve health and socioeconomic development. To accomplish its mission, ESD strengthens global learning and application of best practices; increases access to community-level RH/FP services; and improves capacity for supporting and sustaining RH/FP services. ESD works closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associate Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

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ACRONYMS AND ABBREVIATIONS

AKHS	Aga Khan Health Services
BCC	Behavior Change Communications
BP	Best Practices
BTL	Bilateral Tubal Ligation
CAI	Community Aid International
CBO	Community-Based Organization
CDF	Constituency Development Fund
CIM	Community Involvement and Mobilization
CO	Clinical Officer
COPE	Client-Oriented Provider Efficiency
CPR	Contraceptive Prevalence Rate
CS	Child Survival
C/S	Caesarean Section
CLUSA	Corporate League of the USA
CTS	Clinical Training Skills
CTU	Contraceptive Technology Update
DCO	District Clinical Officer
DHC	Dispensary Health Committee
DHMT	District Health Management Team
DMOH	District Medical Officer of Health
DMS	Director of Medical Services
DPHN	District Public Health Nurse
DRH	Division of Reproductive Health
DRHT&SS	Decentralized Reproductive Health Training and Supervision System
DTSS	Decentralized Training and Supervisory Systems
ECN	Enrolled Community Nurse
EH	EngenderHealth
EMOC	Emergency Obstetric Care
EOP	End of Project
ESD	Extending Service Delivery
FBO	Faith-Based Organization
FHOK	Family Health Options Kenya
FHI	Family Health International
FP	Family Planning
FPAK	Family Planning Association of Kenya
FS	Facilitative Supervision
GOK	Government of Kenya
HCDC	Health Center Development Committee
HFMC	Health Facility Management Committee
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illnesses
IP	Infection Prevention
IST	In-Service Training
IUCD	Intrauterine Contraceptive Device

KDHS	Kenya Demographic and Health Survey
KECN	Kenya Enrolled Community Nurse
KMFF	Kenya Music Festival Foundation
KMTC	Kenya Medical Training College
KRCHN	Kenya Registered Community Health Nurse
LATF	Local Authority Transfer Fund
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MO	Medical Officer
MOH	Ministry of Health
MTC	Medical Training College
NASCOP	National AIDS and STD Control Programme
NGO	Nongovernmental Organization
OJT	On-Job-Training
PAC	Postabortion Care
PATH	Program for Appropriate Technology in Health
P/BPs	Promising and Best Practices
PGH	Provincial General Hospital
PHMT	Provincial Health Management Team
PHO	Public Health Officer
PHT	Public Health Technician
PI (A)	Performance Improvement (Approach)
PMO	Provincial Medical Officer
PMTCT	Prevention of Mother-to-Child Transmission
PNO	Provincial Nursing Officer
QI	Quality Improvement
RH	Reproductive Health
SDP	Service Delivery Point
SO	Strategic Objective
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TA	Technical Assistance
TOT	Training of Trainers
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VSC	Voluntary Surgical Contraception

EXECUTIVE SUMMARY

Kenya has seen an improvement and subsequent decline in reproductive, maternal and child health indicators over the last several decades. The contraceptive prevalence rate (for all methods among married women) rose from 10% in 1984 to 39% in 1998 but had reached plateau at 39% between 1998 and 2003, causing a significant unmet need for family planning (FP). The infant mortality rate is currently 77 deaths per 1,000 births, while under-five mortality rate is 115 deaths per 1,000 live births. While the maternal mortality ratio was reported at 414 per 100,000 live births, registering a slight improvement from the previous 1998 figure of 590 per 100,000 live births, it is still too high and is probably an underestimation in view of other worsening indicators. According to the Kenya Demographic and Health Survey, the HIV prevalence rate among Kenyan adults was 6.7%, compared to 10% in the 1990s.¹

To address the remaining reproductive health and family planning (RH/FP) challenges, the United States Agency for International Development (USAID) Kenya bilateral project, AMKENI, was implemented (2001-2005) to increase the use of sustainable, integrated, comprehensive reproductive health, family planning and child survival (RH/FP/CS) services, including HIV/AIDS prevention services at the community level. It had specific objectives and strategies to meet this goal. AMKENI, which means “awakening” in Swahili, was implemented in ten districts in the Western Province and Coast Province. It involved 97 health facilities (48 in Coast and 49 in Western) distributed as follows: 30 dispensaries and clinics, 39 health centers, 11 nursing and maternity homes and 17 hospitals. Facilities were managed by private organizations or individuals, nongovernmental organizations (NGOs) and the Ministry of Health (MOH).

Over five years of implementation, the project developed a number of good practices in RH/FP programming and service delivery that resulted in improved access to services—especially to underserved communities.

In a country where the contraceptive prevalence rate (CPR) had hit a plateau, the trends in FP acceptors in AMKENI sites demonstrated an increase in users of different FP methods and improvements in the overall uptake of FP clients since the project’s inception. In 2001, 127,740 clients accepted short-term methods in comparison to 173,606 in 2004. The increase represents 36% more usage than reported post-baseline. For long-term methods, at baseline, 2,335 clients adopted FP methods in comparison to 3,758 acceptors in 2004. This difference was 61% higher than baseline data. The total number of acceptors in the three-year period increased by 36%, from 130,075 acceptors to 177,364.²

ESD commissioned a study covering the period of May 8 through June 5, 2006, to document the experiences and practices that were undertaken by USAID/AMKENI to achieve those results.

The documentation team used a participatory rapid appraisal approach to obtain, analyze and document promising and best practices. Key informants provided the main source of data. The

¹ Kenya Demographic Health Survey, 2003.

² End of Project Evaluation Report, May 2005.

team interviewed the following individuals: representatives from the MOH and the Division of Reproductive Health (DRH), the Provincial Medical Officer (Coast), the Provincial Coordinator of Reproductive Health Services (Coast), the District Medical Offices of Health, officials at facilities at the provincial district hospital, health providers in health center and dispensary levels and USAID/AMKENI staff at the headquarters in Nairobi and in the area offices.

The documentation team identified the AMKENI Project model as a best practice model. This report describes the key elements (practices) that made the model a success.

Following are the key elements within each thematic area within the project:

1. Partnership

- a. Community Involvement and Mobilization (CIM) achieved through fostering community groups and creating supportive environment for individual and community change.
- b. Involvement and participation of the MOH and other government agencies in project activities. The director of RH/FP served in the project management board; MOH and other agencies shared performance indicators and participated in joint planning and project performance reviews at district level.

2. Capacity Building

- a. Standardization of Reproductive Health and Family Planning Training Curricula through an all inclusive participatory approach in development and training of trainers in the use.
- b. Linking pre-service (PST) and in-service training (IST) through standardization of RH/FP curricula and building the capacity of the two institutions in use of performance improvement approach (PIA) to identify and address root causes of problems at service delivery and training systems.
- c. An On-the-Job Training (OJT) system that facilitated recognition of staff conducting the training and the achievement of the trainee through certification was established. This approach to training increased the number of service providers trained.

3. Supervision

- a. Decentralized Reproductive Health Training and Supervision System (DRHT&SS) was put in place. Provincial, district and facility supervision sub-systems were developed and staff were active in facilitative and supportive supervision for quality improvement at all levels.

4. Service Access

- a. Health facilities were upgraded to offer higher level RH/FP/CS health care services. The project carried out renovations and supplied equipment to improve the health delivery care environment. In addition the project expanded provider skills and MOH increased staffing, All these improved the quality of services hence attracted users and some of the facilities were able to provider additional services.

5. Repositioning the Intrauterine Contraceptive Device (IUCD) as a Major Family Planning Method in Kenya: the IUCD Re-Introduction Initiative

- a. Advocacy activities were carried out at policy level towards creation of an IUCD re-launch strategy in conjunction with other agencies..
- b. Implementation of the National IUCD Re-launch strategy BCC activities including re-launch of the strategy at community and training of service providers

6. Integration of FP into HIV/AIDS Services

A promising practice emerged in this project in the integration of Family Planning into HIV services. The integration strategy identifies four levels of integration offered at different service delivery levels. Different levels offer voluntary counseling and testing (VCT), assessment of pregnancy and STI risks, provision of information and counseling on contraceptive methods and referral for methods or services that are not available.

INTRODUCTION

Background

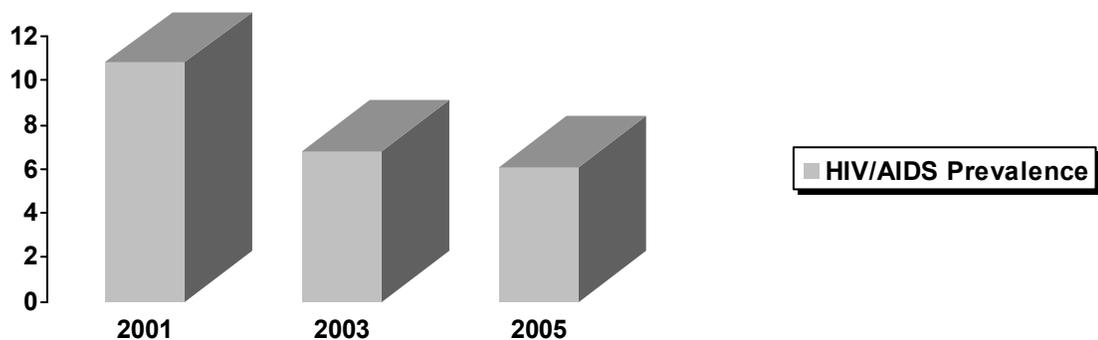
The Extending Service Delivery (ESD) Project works to expand access to RH/FP services among poor and underserved groups, including the urban poor at the community level. ESD is mandated to identify, document and disseminate Promising and Best Practices (P/BPs) in RH/FP for application at the community level and to provide avenues for broader communication about P/BPs. In consultation with USAID/Kenya, the ESD Project identified the USAID/AMKENI Project model as a potential best practice model that needed further documentation.

ESD uses the following definitions for P/BPs, which take into consideration definitions established by other projects and collaborating agreements, such as Advance Africa, the Implementing Best Practices/WHO consortium and USAID/Washington:

- **Best Practice:** A specific action or set of actions with proven evidence of success and the ability to be replicated or adapted. Evidence of success is demonstrated through qualitative and quantitative information regarding the practice.
- **Promising Practice:** A specific action or set of actions that has the potential of becoming a BP but requires further evidence of success.³

Over the last several decades, Kenya has seen improvement and then deterioration in reproductive health, child health and HIV/AIDS. Sentinel surveillance system data indicates that HIV/AIDS prevalence peaked in the 1990s at around 10% for adults and that the prevalence rate has since declined to 7%, according to the 2003 Kenya Demographic and Health Survey (KDHS). There are currently 1.1 million adult Kenyans infected with HIV. Almost two-thirds of those infected are women, and twice as many urban residents as rural residents are infected.

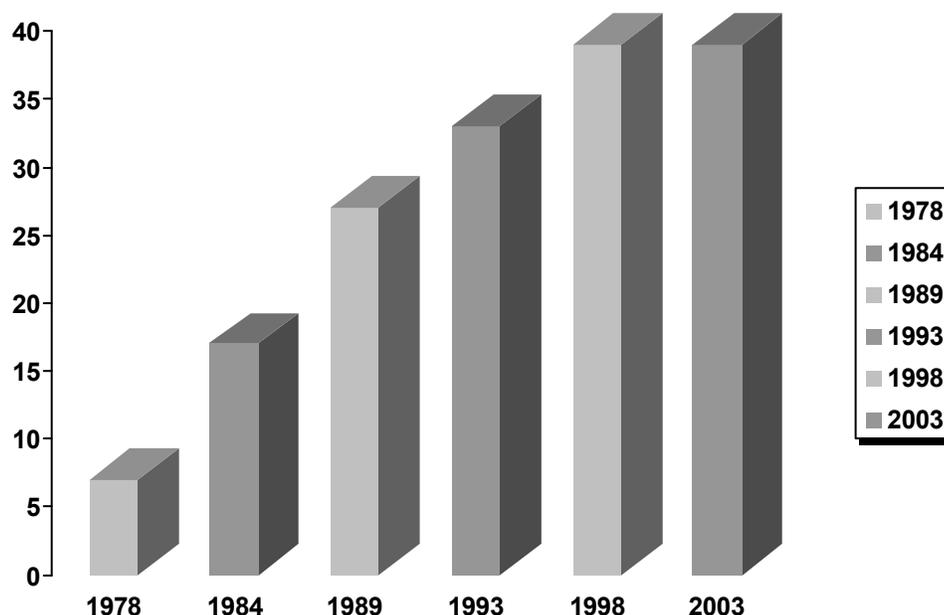
Figure 1: HIV/AIDS among Adult Population



³ According to ESD's definition, "a specific action or sets of actions" may include program models as well as technical guidelines and protocols.

The contraceptive prevalence rate (CPR) increased steadily from 10% in 1984 to 39% in 1998 before plateauing at this level between 1998 and 2003 (see Figure 2 below). Despite the remarkable growth in FP use since the 1980s, significant unmet need for FP remains in Kenya. Overall, 20% of births are unwanted, and an additional 25% are mistimed.

Figure 2: Contraceptive Prevalence Rates



Source: KDHS 2003

Currently, the infant mortality rate is 77 deaths per 1,000 live births, and the under-five mortality rate is 115 deaths per 1,000 live births. Vaccination coverage declined significantly between 1998 and 2003 from 65% to 57%.

According to the KDHS, the maternal mortality ratio improved from 590 per 100,000 live births in 1998 to 414 per 1,000 live births in 2003. This ratio is very high and is probably an underestimate, since most other health indicators have worsened during the same time period.

In response to the worsening health indicators in the country, USAID/Kenya developed a new health and population strategy in 2000. The Strategic Objective (SO) 3 was prepared as part of the USAID/Kenya Integrated Strategic Plan for 2001-2005 with the aim “to reduce fertility and the risks for HIV/AIDS transmission through sustainable, integrated family planning and health services.” In December 2000, EngenderHealth (then AVSC International) and its partners—Program for Appropriate Technology in Health (PATH), IntraHealth International, Cooperative League of the USA (CLUSA) and Family Health International (FHI)—were awarded the AMKENI Project to increase the use of sustainable, integrated, comprehensive reproductive

health, family planning and child survival (RH/FP/CS) services, including HIV/AIDS prevention services at the community level.⁴

Two overarching objectives of the USAID/AMKENI Project were identified:

- Increase access and quality RH/FP/CS services, including HIV/AIDS prevention services
- Encourage healthier behaviors among the population and increase demand for services.

These two objectives formed the foundation of the project, which aimed to link communities with service facilities.

The following strategies were applied to meet these objectives:

- Improve the capacity of health facilities to provide RH/FP/CS services—including HIV/AIDS related services—through training, expanding the range of services provided, strengthening supervision and increasing service outreach.
- Work through communities to encourage healthier RH/FP/CS behaviors and demand for services by fostering preventive health care seeking behavior and community groups in order to create a supportive environment for individual and community change.
- Strengthen the Ministry of Health's (MOH) decentralized training and supervisory systems (DTSS) for RH service providers through the establishment of the MOH's decentralized training and supervision system; update and strengthen the teaching skills of public-sector pre-service and in-service trainers and supervisors; and facilitate the application of the performance improvement approach.

The AMKENI Project was implemented in ten districts in Western Province and Coast Province. It involved 97 health facilities (48 in Coast and 49 in Western) distributed as follows: 30 dispensaries and clinics, 39 health centers, 11 nursing and maternity homes and 17 hospitals. Facilities were managed by private organizations or individuals, NGOs and the MOH.

The roles and focus of the four principal partners were as follows:

As USAID/AMKENI managing partner, EngenderHealth provided technical assistance to the MOH in FP/RH counseling, emergency obstetric care, postabortion care, child survival, facilitative supervision and quality improvement. FHI and IntraHealth also provided TA to the MOH. FHI supported HIV/AIDS and STI prevention and treatment as well as HIV/STI RH service integration. IntraHealth supported the development of sustainable performance improvement, public-sector training and supervision systems and integrated PI approaches into RH/FP/CS services.

PATH provided TA to a range of community organizations, developing capacity in the areas of behavior change communications, community mobilization and community involvement in health interventions.

CLUSA served as the community agency implementing partner by leading community mobilization, involvement and response efforts to increase community ownership of health

⁴ Final Evaluation of the AMKENI Project, April 2005, EngenderHealth.

problems and solutions and strengthen local groups' ability to manage health care and invest in health facilities.

Initially, the project was designed to provide services to the community and program support to NGOs and FBOs to improve and expand RH/FP services. It was envisioned that some of these local service providers would serve as centers of excellence; however, after the midterm review, the team recommended that USAID/AMKENI find new ways to involve the MOH. The Division of Reproductive Health was incorporated as a principal partner of the project and worked in collaboration with multiple development partners. Also, several local implementing partners worked with USAID/AMKENI at the community level.

Working in a consortium helped each member achieve its objectives—the user of services benefited and the MOH advanced its goals. The jointly-developed Management Agreement set clear roles and responsibilities, including full and equal participation in the management committee, which provided overall strategic direction in developing the decision-making project framework.

The competencies were overlapping and synergistic since each partner contributed their particular technical skills and organizational strengths. Throughout the study, there was evidence of consistent, mutually respectful relationships. Because of clear leadership in each of the technical components, the partners had well-delineated and widely accepted roles laid out in the Management Agreement. The common challenges of unhealthy competition and duplicating efforts that accompany agencies working in the same geographical region neither affected nor undermined the partners' collaboration or, ultimately, the program.

Over the past five years (2001-2005), the USAID/AMKENI Project generated a number of good practices in RH/FP programming and service delivery that resulted in improved access to services—especially in underserved communities. In a country where the CPR hit a plateau, the trends in FP acceptors in AMKENI sites demonstrated an increase in users of different FP methods as well as improvements in the overall uptake of FP clients since the project's inception.

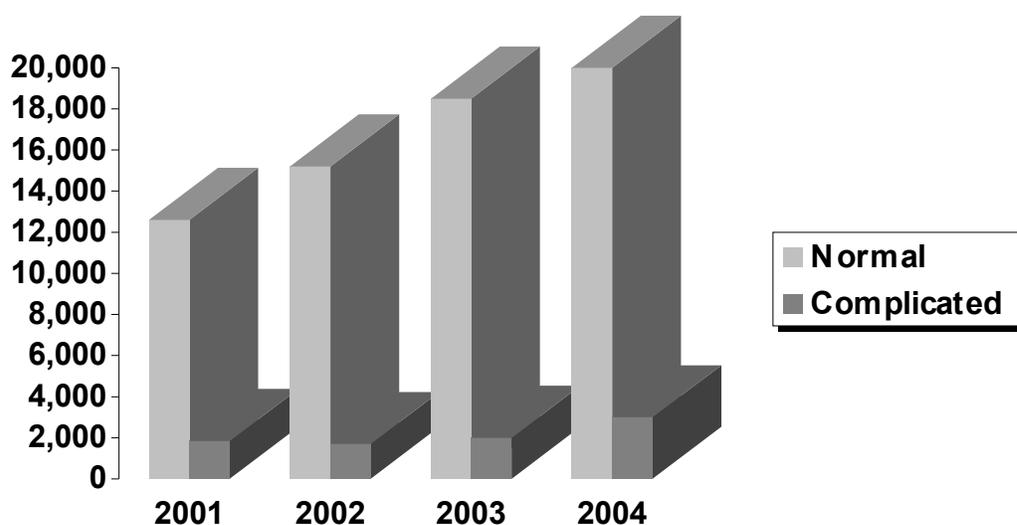
Table 1: Trends in Family Planning Acceptance⁵

Methods acceptors	Baseline (2001)	2004	Percent Change
Short-term methods	127,740	173,606	+36
Long term & permanent methods	2,335	3,758	+61
Total acceptors	130,075	177,364	+36

The following monitoring and evaluation reports show that this project was successful in achieving its goals. See the following tables adapted from the end-of-project (EOP) report.

Fig 3: Annual Number of Deliveries from All AMKENI-Supported Facilities

⁵ Final Evaluation of the AMKENI Project, April 2005



Source: AMKENI Profiles, January 2005.

Table 2: Trends in PAC Services in USAID/AMKENI sites

	2002	2003	2004
# of PAC clients	661	1,641	1,880
# of facilities providing PAC services	43	62	65
Average # of PAC clients per facility	15	26	29

Table 3: VCT Services

	Number
Health facilities offering voluntary counseling and testing (VCT) services	73
VCT services initiated with AMKENI support	37
Total VCT clients counseled and tested	46,959*
Monthly average, July-Sept 2004	4,672*

*Figures include clients served at all VCT sites since 2002.

Source: EOP Evaluation Report

Table 4: PMTCT Services

	Number
Health facilities offering prevention of mother-to-child transmission (PMTCT) services	75
PMTCT services initiated with AMKENI support	43
Total antenatal care (ANC) clients counseled and tested	21,509*
ANC clients who tested positive	1,595*
ANC clients who received Niverapine	451*

*Figures include clients served at all PMTCT sites since 2002.

Source: USAID AMKENI EOP Report

DOCUMENTATION PURPOSE AND OBJECTIVES

Given the positive results achieved by the project, a study was undertaken between May 8 and June 5, 2006, by the ESD Project to document the experiences and practices that were undertaken by USAID/AMKENI to achieve those results.

This report describes the process and the specific activities undertaken by USAID/AMKENI to improve RH/FP/CS services, including HIV/AIDS prevention services at the community level, and focuses on identifying characteristics that make the model a best practice.

DOCUMENTATION STRATEGIES AND ACTIVITIES

The team used a participatory rapid appraisal approach to obtain, analyze and document P/BPs.

The following data sources were used: key informants from the MOH and the DRH, the Provincial Medical Officer (Coast), the Provincial Coordinator of Reproductive Health Services (Coast), staff members from the District Medical Offices of Health and facilities at the provincial district hospital, health center and dispensary levels and AMKENI staff at the headquarters in Nairobi and area offices. A full list of persons interviewed is included in Annex II.

The other sources of data include planning and implementation documents as well as quarterly and other reports. A bibliography is included in Annex I.

Data collection instruments were used by consultants who used interview guides, direct observation guides, and data abstraction forms. A copy of the interview guide is included in Annex V.

DOCUMENTATION FINDINGS: BEST PRACTICE PACKAGES

The study team identified several promising and best practices, which are organized into packages or thematic areas. With each practice, the key elements that made the practice successful are listed and followed by a detailed description of the intervention/practice.

I. Partnership

It is essential that community members actively participate in their own health, in the decisions that affect their health and in the implementation of these decisions.

A. Community Involvement and Mobilization (CIM)

Key Success Factors:

- Engaging in participatory needs assessments and stakeholder forums
- Building on existing social networks and organizational capacities
- Linking communities with local funding sources

- Linking project goals and activities with community interests (leading to community volunteerism)
- Building capacity
- Establishing a dialogue between local groups, government, implementing organizations and community representatives to give community members a sense of ownership as well as empower them to seek services and mobilize resources.

Activity Description: Three strategies were used in USAID/AMKENI’s work with communities to adopt healthier behaviors and increase demand for RH/FP/CS/AIDS services:

- Encouraging preventive and health-seeking behavior
- Fostering community groups (also known as change agents)
- Creating a supportive environment for individual and community change.

A variety of partners and approaches were used to reach women, youth and men served by the target facilities. Some of the local implementing agencies that were used in both Western Province and at the Coast included: Aga Khan Health Services (AKHS), Community Aid International (CAI), CLUSA, Family Planning Association of Kenya (FPAK), which was recently renamed Family Health Options of Kenya (FHOK), Kenya Music Festival Foundation, Uzima Foundation and World Relief.

Using existing groups in the community as well as other social networks—such as village health committees, women’s groups, youth groups and provincial administration—it was possible to reach different segments of the community. In the Coast Province, the project relied heavily on facility management committees; in Western Province, it placed greater emphasis on community structures (village health committees and sub-location coordinating committees). These institutions acted as effective entry points and links to the communities.

With these agencies, communities were mobilized at locational and sub-locational⁶ levels. Initial meetings involving seminars were held to bolster support and to provide information, education and communication (IEC) materials for behavior change in RH/FP/CS to these change-agents.

Once these agents were enlisted, appropriate messages were developed that focused on different aspects of RH/FP/CS/AIDS, such as VCT, tubal ligation, PMTCT and HIV/AIDS. The Chief’s *barazas* (public meetings) were useful for reaching community members, especially men. Other avenues for information dissemination were village health committees, provincial administration, women’s groups and community-based organizations (CBOs).

Communities also were empowered to participate in the management of health facilities through representation in the Dispensary Health Committees (DHC) and Health Facility Management Committees (HFMC). USAID/AMKENI helped build the capacity of facility committees so that they understood their roles in financial management. USAID/AMKENI also supported facilities in developing and functioning effectively.

⁶ Locational refers to cluster of villages; sub-locational refers to one village.

The sense of ownership was so strong that community members found solutions to their problems, such as the continuation of cost sharing. Even though the MOH abolished cost sharing by individuals, community members organized themselves and mobilized resources to help those in need so that they could finance their RH services. A Senior Medical Officer informed the researchers that he knew of places where community members continued cost sharing. Whenever he questioned the practice, he was informed that the initiative was a community affair and had nothing to do with the MOH or the government.

The impact of community involvement was demonstrated in different ways. Community members were identified and trained to assume multiple leadership roles such as women's agency coordinators, facilitators, and animators. Trainings included mentoring and outreach which led to more equitable representation of women (48%) and youth (22%) within village health committee. Activities implemented with CLUSA assistance CLUSA reached a total of 728 villages: community assessments and health action plans; advocacy efforts around health issues; and improved governance practices. Community members indicated that they benefited from the project through health education related to RH, HIV/AIDS, VCT and PMTCT. Information sharing led to behavior change in the community as indicated on Tables 2 and 3. Over 5,000 effective referrals were made for RH services quarterly in 24 health facilities, further underscoring this result. Community members continued to request and seek preventive services.⁷

This local initiative contributed to an increase in the utilization of RH services in Malindi District Hospital, Kwale Sub-District Hospital, Gongoni Dispensary, Chwele Health Center, Jibana Health Center and Diani Dispensary, among others. Improved RH practices are reflected by increased antenatal attendance, increased number of traditional birth attendants accompanying women to the health facilities for deliveries and increased utilization of delivery services, PMTCT and VCT services.

Results from the needs assessment helped to enlist government as well as community support and ensured that USAID/AMKENI staff and community representatives were knowledgeable of and sensitive to local needs. Follow-up actions from the assessment resulted in USAID/AMKENI helping communities mobilize resources by linking them to local funding sources such as the Local Authority Transfer Funds (LATF), Constituency Development Fund (CDF) and various NGOs. USAID/AMKENI trained community leaders on how to write simple proposals and apply for funding or assistance for needs outside of the USAID/AMKENI mandate, e.g., to cover electricity, water, roads and for income generation.

Besides the MOH, USAID/AMKENI's other stakeholders were instrumental in establishing the Stakeholder Forums at provincial and district levels, which met twice a year to share experiences. Examples of partnerships and improvements triggered by the capacity building activities supported by the USAID/AMKENI included the following: Ndalua Health Center acquired solar power, Malava Health Center obtained a water supply, and Lunga Lunga Health Center secured electricity. USAID/AMKENI also made efforts to identify the different NGOs

⁷ Thinking Locally to Improve Health Outcomes: Best Practices from the Kenya AMKENI Project for Strengthening Community Responses to Health Priorities, CLUSA Presentation to USAID Global Health Bureau, December 14, 2006.

who were working in overlapping areas and had similar activities in order to avoid conflicts and negative competition.

B. Active Involvement of the Ministry of Health, Other Government Ministries and Private Organizations Concerned with Health (working within existing structures)

Key Success Factors:

- Involving MOH in management activities and placement of MOH officials in key positions to maintain good relations and strengthen collaborative efforts
- Maintaining MOH presence on the project's management board
- Using joint planning, performance review and implementation meetings for project staff, MOH and public health staff
- Staying in tune with the need for improving relationships among implementing partners
- Involving public- and private-sector providers in multi-stakeholder meetings
- Sharing performance indicators, peer performance reviews and constructive recommendations with all participants, and aiming at improving the quality of RH/FP services.

Activity Description: The mid-project review was conducted in April and May 2003. This Extended Management Review or project evaluation recommended greater involvement of the MOH, with the core recommendation being to strengthen collaboration with MOH staff. In response, USAID/AMKENI re-aligned the project activities with those of the Ministry. The project started involving the MOH staff at various levels: the Director of Medical Services (DMS), the Provincial Medical Officer (PMOs), the District Medical Officer of Health (DMOHs), the managers and supervisors. USAID/AMKENI invited the head of the DRH, who was the custodian and key implementer of the Kenya Reproductive Health Strategy, to become a member of the Project Management Board. The DRH fully identified with the USAID/AMKENI project objectives, mobilized district and provincial teams and worked through the Decentralized Training and Supervision Teams (described later) in the two provinces. There was joint planning, joint development of action plans and joint implementation at all levels.

The leadership exhibited by the head of DRH motivated teams at the provincial and district levels as well as garnered support for USAID/AMKENI project trainees and trainers. At the community level, USAID/AMKENI utilized public health officers (PHOs) and public health technicians (PHTs) of the MOH to disseminate RH messages. The PHOs included the Public Health Inspector, Sanitary Inspector and Sanitarian, while PHTs included the health assistants. This approach of integrating health initiatives into non-health activities maximized the use of existing channels to disseminate vital health information.

The other stakeholders, with whom good relations were maintained, were private health facilities and staff at the different levels of the health pyramid: provincial, district, health center, dispensary and community.

Regular project review and consultation meetings were held with support from and/or involvement of the DRH, PMO and DMOH. During these meetings, district health plans were

discussed and developed with USAID/AMKENI project staff representation. The MOH staff actively participated in quarterly meetings to discuss performance. Staff from various facilities in the district (with support from USAID/AMKENI) shared performance indicators and conducted peer performance reviews. These meetings had a tremendous impact on improving the quality of RH services. The ongoing exchanges fostered ownership by different health providers at different levels of health care.

A health care provider from a private health facility in Watamu, Malindi, had this to say about these meetings:

“As opposed to the previous situation when public- and private-sector used to view each other with suspicion and negative competition, we now are working together and, at times, sharing resources. We were able, for the first time, to share and compare ourselves—those of us in private sub-sector with those from public health facilities. In this way we were able to improve our services. We were also able to see exactly how others are doing and where we stand alongside them, below or above them as far as providing services were concerned. It really helped.”

There also was an increased recognition of the need to promote RH as a primary part of health care. During the life of the project, for the first time, a dedicated line item budget was assigned by the MOH for implementation of RH services. USAID/AMKENI was one of the stakeholders who advocated for inclusion of this budget line item.

II. Capacity Building

A. On-the-Job-Training (OJT) for Clinical Service Providers

Key Success Factors:

- Linking certification with on-site training requirements
- Relationship-building between facility-based providers, local organizations and the community as a whole through concurrent training activities
- Utilizing local institutions and creating links to medical training colleges
- Achieving joint curriculum development between MOH and USAID/AMKENI
- Garnering political support of training
- Motivating newly trained health providers to train colleagues at health facilities.

Activity Description: The most important resource in the provision of quality RH/FP/CS/HIV/AIDS care services is appropriately trained, skilled and motivated health care providers. However, most of the health care providers were not adequately prepared to provide services, especially at the health center and dispensary levels. One reason for this may be the previous lack of emphasis on RH at pre-service training levels and/or on focused in-service training in this area. Since the majority of patients were managed at the lower levels of the health care delivery system, i.e., dispensaries and health centers, there was a particular need to improve

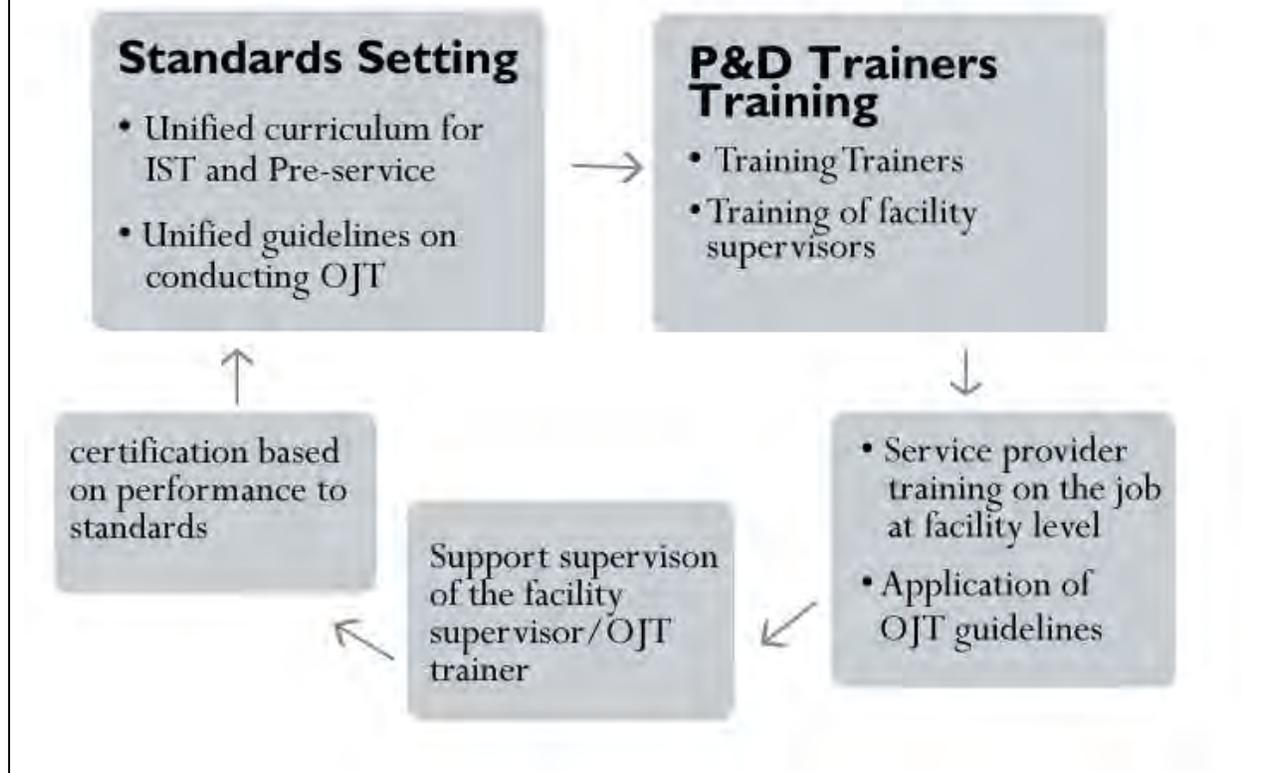
the knowledge, skills and attitudes of health care providers at that level of the service delivery system.

The USAID/AMKENI Project conducted a clinical hands-on training as well as a training of trainers. Providers at all levels were trained. The courses consisted of 26 themes in accordance with service delivery needs. Some of the topics or areas of training were: essential/emergency obstetric care, including focused antenatal care, management of PET/Eclampsia, antepartum hemorrhage, delivery care and abnormal labor including obstructed labor; complicated deliveries, including vacuum extraction delivery; syntocinon induction and augmentation in postnatal care (including PPH); neonatal care and resuscitation; PAC, manual removal of placenta and FP, including vasectomy, bilateral tubal ligation (BTL), Norplant and IUCD; PMTCT, including Nevirapine administration; voluntary counseling and testing; blood transfusion; anesthesia; laboratory for ectopic pregnancy repair of ruptured uterus; repair of cervical tear; and repair of perineal tear. The selected health providers were also trained to train others in all these areas. Workshop-based training and on-the-job training (OJT) were the two main methods of training used.

Although workshop-based training is effective with large groups such as those needing clinical practicum, disadvantages of workshop-based training abound. Workshop-based trainings keep staff away from their work stations, incur high costs because trainings are conducted off-site and pose challenges in securing dates and maintaining attendance through the completion of sessions. OJT has the advantage of imparting skills to staff members at their work stations, which allows them to learn in a familiar environment and often maneuver around more convenient times. Because of the cited disadvantages of workshop-based trainings, the MOH and its stakeholders, with USAID/AMKENI assistance, developed OJT guidelines, a curriculum and an accompanying certification process. The Director of DRH observed training sessions and issued certificates for successful OJT trainees. Thus, OJT had support from the highest level, receiving recognition as an official training approach. As a result, the MOH promoted its scale-up in the country.

The MOH, USAID/AMKENI and other stakeholders developed a National OJT Manual, Facilitative Supervision Manual and a certification process for Kenya, alongside the DRHT&S system.

On-the-Job Training System Development



*IST= in-service training; P&D= provincial and district; and OJT=on-the-job training.

To ensure sustainability, a certificate was awarded only upon completion of a training requirement. A trainee was also required to train three colleagues at his/her job site. The training of colleagues in the new clinical skills thus became a strategy for expanding the reach of the initial training program and the skills of additional health workers. Table 5 shows the numbers of people trained at the end-of-project review period in May 2005. At that time, OJT had not been developed or accepted as a structured system, and training was primarily workshop based with facilitative follow-up supervision. However, 60 personnel were trained using the OJT methodology and, thereafter, the scheme was adopted. Standardized and structured OJT was initiated only in the last months of the USAID/AMKENI Project. USAID/AMKENI trained more than 4,700 health workers at all levels and 240 tutors from medical training colleges (MTCs) throughout Kenya during the duration of the project.

Health providers at various levels reported that one of the lasting benefits they received from the project was relevant skill development that enabled them to perform their duties better and to provide quality care to community members.

Health care providers also learned new skills through training in quality “customer care,” management and leadership. Public health technicians, who were particularly useful in community mobilization, were trained in communicating RH messages, which enabled them to perform their public health duties better, including those related to water and sanitation.

Local implementation partners, who were involved in training health providers, also benefited as their visibility in the community increased. Their presence in the community helped many individuals and respective groups gain a greater level of acceptance because of the relationships developed through interactions with community members.

OJT expanded to other provinces outside USAID/AMKENI provinces because of the support it received from the providers and trainers, endorsements from the MOH, and from AMKENI.

Table 5: Service Providers Trained in RH/FP/CS and HIV/AIDS Skills at End-of-Project Evaluation

Skills	Numbers Trained
Clinical Skills Training	241
Contraceptive Technology Update	244
Facilitative Supervision	304
FP Counseling	203
IMCI	91
Infection Prevention	229
IUD Insertion and Removal	171
Norplant Insertion and Removal	526
On-the Job-Training Methodology	60
Postabortion Care	102
PIA Training and Orientation	422
PMTCT	171
STI Syndromic Management	199
STI/HIV/AIDS Counseling	53
Total	3,016

Linking pre-service (PST) and in-service training (IST)

USAID/AMKENI strategically linked the PST and IST institutions by improving performance of trainers, service providers, and managers.⁸ Four hundred and twenty-two trainers, service providers, MOH heads of departments, Kenya Medical Training College heads of departments, and provincial heads from the project provinces were trained using real situations to perform root cause analysis and plan for interventions. As a result of this skills development, all concerned developed an ownership of the PIA process, adopted the PIA principles, and identified additional trainees and long-term support to trainees in district health facilities. In addition, facility level training in PIA helped identify areas for improvement such as infection prevention, provision of wider range of contraceptive methods, improved morale, client congestion, and better immunization rates. Unlike the interventions in service delivery, which were focused on two provinces, interventions with pre-service institutions were at the national level. To address the learning needs of the tutors (identified during the root cause analysis), 250 tutors/trainers from 18 Kenya Medical Training Colleges countrywide were trained in FP/RH/CS and HIV/AIDS.

⁸ AMEKENI End of Project Report, 2005.

The end project evaluation concluded that the USAID/AMKENI's training and supervision interventions were highly successful and were valued by trainees and stakeholders.

Community-Based Organization and District Health Committees

The acquisition of skills was not confined to health care providers but extended to members of the community as well. Different skills were acquired by beneficiary trainees at different levels; for example, CBOs, DHCs and HCDCs acquired financial management and record keeping skills, and animators (facilitators) in Western Province received communication and counseling skills. Other skills included technical information on HIV/AIDS and PMTCT as well as CIM skills. In building the capacity of existing community groups and structures, new skills were utilized to seek assistance from other partners and NGOs, which ensured that these groups and members of the community could sustain their activities.

B. Standardization of Reproductive Health and Family Planning Training Curricula

Generally, projects develop their own curricula, but that results in many curricula on the same content area in one country, i.e., duplication of curricula. Although the USAID/AMKENI Project was implemented in three out of the eight provinces in the country, one national RH/FP curricula and training materials were developed, tested, and adopted for national use.

Key Success Factors:

- Using standardized training curricula and approaches
- Creating two training manuals for trainers and trainees to acquire multiple skills
- Building partnerships in the development of the curriculum
- Ensuring the ability of the MOH and USAID/AMKENI to stay tuned to the need for improvements in the training curricula and program
- Maintaining cooperation and flexibility of stakeholders in the development of the curricula.

Activity Description: There are usually many challenges in successfully implementing multifaceted training activities, such as ensuring adequate and appropriate representation and involvement of stakeholders in curriculum development, training and adaptation of materials. USAID/AMKENI respected the official mandate of the MOH to spearhead these activities and understood its facilitative role.

In response to training needs identified from the assessments, a decision was made to standardize training and use approaches that facilitate skills acquisition and uniformity. A three-phase process in curriculum development began with the initial brainstorming sessions involving a cross-section of stakeholders. During this phase, key issues were identified, and the content was consolidated into training modules.

During the second phase of interactive group planning and content revision, a series of workshops were held (in Nyeri, Embu and Nakuru) to clarify the module's content. Discussions also were held to provide input on the MOH Strategy for RH training, which was being developed simultaneously. Ideas were consolidated through technical and financial support from USAID/AMKENI. There was continuous consultation between USAID/AMKENI and the DRH, whose vision was incorporated throughout these processes.

In the final phase, a working group of seven people convened to pre-test the curriculum. These representatives incorporated recommendations from the pre-testing exercise into the revised curriculum. USAID/AMKENI also held meetings with trainers from the focus districts. The feedback from their discussions on their pre-testing experiences provided valuable information that was incorporated into the final curriculum. This forum contributed to the success of the development of the final curriculum.

The consensus reached by the different DRH staff, training institutions and other stakeholders was that two manuals were needed. This realization demonstrated the flexibility of the participants actively involved in the process. The core national RH curriculum for all cadres was produced into two volumes, i.e., Trainer's Manual and Trainee's Manual. The difference between cadres will only be in scope and depth of the content.

III. Training and Supervision System

Prior to the USAID/AMKENI Project, two systems existed for supervision. Provincial RH supervisors supervised project-specific activities, and their role was not officially recognized outside the project. The MOH had a national RH training unit that consisted of a team of trainers at a central level and at satellite facilities based in the provinces. The satellite trainers were managed from the central level. The USAID/AMKENI Project spearheaded the amalgamation of the two systems.

A. Decentralized Reproductive Health Training and Supervision System

Key Success Factors:

- Assuring formation of training and supervision teams at district, provincial and facility levels
- Building the capacity of health providers within the existing decentralized operating system
- Adopting RH training and supervision materials in pre- and in-service trainings
- Developing a decentralized health system that provides an enabling environment for identification of trainees at the facility level and facilitation of trainings at district, provincial and national levels.

Activity Description: The DRHT&SS was a result of an initiative led by the MOH and USAID/AMKENI to form reproductive health training and supervision (RHT&S) teams at provincial and district levels. The USAID/AMKENI Project was involved in several consensus-building activities between 2001 and 2002. This resulted in the Director of Medical Services issuing a directive requesting the establishment of a decentralized system that covered national, provincial, district and facility levels in November 2002. The decentralized system brought together two independently operating sub-systems that existed at the time and developed the capacity of the teams to carry out effective facilitative supervision.

Between 2003 and 2004, USAID/AMKENI assisted the MOH to pilot-test the implementation of the system at provincial, district and facility levels in Coast and Western Provinces. The two provincial, ten district and 16 facility-based RH training and supervision teams were trained in clinical training skills (CTS) methodology and facilitative supervision skills to enable them to

implement training programs and supervise health staff at provincial, district and facility levels with guidance and oversight at the national level.

To assist in the implementation of the RHT&S Initiative, USAID/AMKENI facilitated the trainings of the initial provincial RHT&S teams in CTS and facilitative supervision; the district RHT&S teams in clinical skills training, facilitative supervision and OJT; and the facility teams in facilitative supervision and OJT. Several other trainings facilitated by USAID/AMKENI included EOC, PMTCT, infection prevention (IP) and use of quality improvement tools such as the client oriented provider efficient (COPE) tool.

The developed training materials were and continue to be used by the RHT&S teams and for general use in both pre- and in-service training (see Service Access).

With a decentralized supervision system in place, it is possible to “think nationally but act locally.” The provincial and district teams mobilized resources to finance RH activities in the province to train and supervise district RH teams. Other activities included efforts to strengthen RH data collection, analysis, storage, retrieval and use at district facility levels, in addition to training and ongoing supervision of facility-based RH teams. The RH teams were then able to arrange for assessment and certification of RH service providers trained at their facilities. They also provided supervision to RH service providers at all facilities in the district (both public and private) and monitored the quality of the RH services provided within the district.

The teams at the facility level conducted OJT for service providers within the health facility and encouraged the use of performance improvement approaches (PIA) to increase the quality and utilization of RH services. Representatives also strengthened RH data collection, analysis, storage, retrieval and use at the facility level. They endorsed community participation and involvement in identifying and addressing RH needs. Community needs were identified through the initial needs assessments.

Decentralized training and supervision teams ensured standardized, sustainable training programs that are effective and efficient. These trainers and managers also coordinated activities to avoid duplication of efforts and wasting resources.

According to Professor Japhet Mati and Dr. Jacob Mwangi, who conducted an evaluation of the health system in mid-2005, the system was “versatile enough to make it feasible for the core skills (clinical skills training, OJT, facilitative supervision and specific RH skills) to be transmitted by teams at the three levels: provincial, district and facility. It is not only a self-replicating mechanism for sustainable training and supervision,” but also one “which has a cascade effect that adds value to the sustainability of the system.” The success of the RHT&SS, according to the Kilifi RH T&S team, lies in “commitment, initiative, and team work.”

Within the newly established supervision system, the project supported the use of ***Facilitative Supervision***, which has been documented by a number of agencies as a practice that brings out the best results in service delivery. Previously, traditional supervision in most districts took the form of a lone member from the District Health Management Team (DHMT) who visited health facilities under his/her jurisdiction. In most cases, the focus was on critique and criticism. The

USAID/AMKENI Project strengthened the DRHT&S teams' skills in facilitative supervision, which assisted in improving the quality of services.

Facilitative and supportive supervision has been embraced by provincial health management teams (PHMTs) and DHMTs in the focus districts. Previously, the District Public Health Nurse (DPHN) had multiple tasks and was expected to handle them alone. Now, a supervision team performs the tasks. With the newly added responsibilities, the team provided capacity building on leadership and management skills—resulting in more health staff trained in the technical components.

In the words of a nurse: *“After facilitative supervision training, we are more receptive to supervisors from Bungoma (District DRHT&S team). We never used to like their visits. But in the last year or so we have come to appreciate the value of these visits. Previously, they jumped out of the vehicle fierce and harsh. We used to lock ourselves in the toilet the moment we saw the blue uniform (of the DPHN). Of course, the problems at our health center would not be solved, but we would have saved ourselves the harassment and embarrassment.”*

The supervisors themselves felt more confident as a result of the training in facilitative supervision, and according to a clinical officer (CO) in a health center:

“Training in facilitative supervision has been very helpful. I had not been prepared to run a facility and to relate to other staff—some much older than I am. I wish facilitative supervision could be introduced in the pre-service curriculum.”

IV. Service Access

Upgrading Health Facilities to Offer a Higher Level of RH/FP/CS Health Care Services

Key Success Factors:

- Improving existing health facilities through supportive renovations and the supply of essential equipment
- Expanding health services through EMOC and other RH training of health workers
- Linking rehabilitation of health clinics to community mobilization activities
- Elevating select health centers to a higher designation by improvements in quality and range of services
- Ensuring MOH commitment to hiring new staff and assisting in their placement
- Capacity building of the community to support the health facilities
- Improving facility management by the community health committees.

Activity Description: Many health facilities that have the potential to increase the range and number of services that they provide could not because of inadequate space and lack of equipment and supplies. Many times, with just simple modifications to the use of space, there can be a positive impact in the provision of services.

To extend the range of RH services provided in USAID/AMKENI-supported health facilities, it was necessary to physically improve some of the facilities. In Kenya, health care services are organized in a pyramidal or tiered system with community-based services at the bottom,

followed by services at the dispensary/clinic, health center, nursing home/maternity district and sub-district hospital, then provincial hospital, and finally the national referral hospital. The range of services increases from the bottom to the top of the pyramid.

USAID/AMKENI focused on the lower level of the health care pyramid. Of the 97 facilities supported by the project, both in the public and private sector, 30 were dispensaries with a clinic level of service, 39 were at the health center level, 11 were at the nursing or maternity home level, and 17 were at the district or sub-district hospital level. There was no direct support at the provincial hospital level, but training of health providers at this level took place. The provincial level facilities also were used for facilitation of training and for supervision of other facilities.

By improving the physical infrastructure and/or supplying equipment and other commodities, USAID/AMKENI improved maternal care by improving antenatal care, normal and complicated deliveries, PAC and child survival, as well as FP and HIV/AIDS services. PAC services also were made available through renovation of and equipping PAC rooms. Some of the support given by USAID/AMKENI in this area included improved maternity services such as helping to renovate maternity units and equipping them with delivery beds, baby incubators and resuscitation equipment for newborns. Some health facilities received operation tables and other theater equipment.

As a result of these improvements and other program components, deliveries of babies from USAID/AMKENI-supported facilities rose from 15,117 in 2001 to 27,762 in 2005, an increase of 83%.

Other services that increased were FP with total acceptors increasing by 36% between 2001 and 2004; and VCT clients served increased almost from zero to 46,959.

On May 24, 2006, the documentation team visited a hospital that was “resurrected from the dead” by USAID/AMKENI. The team spoke with Dr. Boniface Kahindi, the Medical Officer in charge of the facility, along with Sister Maurene Leseni, the nursing officer in charge. According to Dr. Kahindi, “This was a dilapidated hospital that serves a poor community that cannot afford to pay for services.” According to EngenderHealth (See Annex V to read the whole story), USAID/AMKENI staff provided St. Luke's with essential equipment and supplies, allowing the hospital to become functional again. The medical staff participated in training workshops led by AMKENI staff on topics such as IP, EMOC, FP and voluntary counseling and testing for HIV infection using the COPE® (client-oriented, provider-efficient services) process developed by EngenderHealth.

As a result of USAID/AMKENI's support, the number of clients visiting St. Luke's increased dramatically. At the end of 2003, the hospital had 60 in-patient visits per day as compared with four per day in 2002. The operating theater was completely renovated, and surgeries were occurring on a regular basis for the first time in many years. In addition, the number of women coming to St. Luke's for services almost tripled, from ten a month at the beginning of 2003 to nearly 30 a month as of April 2004. The hospital began implementing voluntary counseling and testing for HIV as well as services aimed at PMTCT of HIV.

Many dispensaries and some health centers were not handling deliveries in the supported districts prior to the USAID/AMKENI Project. A major outcome of the project was enabling these facilities to conduct normal deliveries and, thus, reach more women.

Some of the facilities that are now able to provide a wider range of services and a higher level of care were promoted to a higher designation by the MOH. Some dispensaries were designated as health centers, while some health centers were designated as sub-district hospitals.

Examples of facilities that had a positive impact as far as RH/FP/CS/HIV/AIDS services are concerned are cited on page 27.

GEDE DISPENSARY IS DESIGNATED A HEALTH CENTER BY MOH

Gede Health Center, previously a dispensary, was upgraded to conduct deliveries. The effort started by training staff in EOC, IP, contraceptive technology update (CTU), FP and sexual reproductive health (SRH), FS/QI, implanting IUCD, PAC, PMTCT, VCT and others. The facility was then provided with one delivery bed, one baby resuscitator, two bay incubators, an oxygen concentrator, six oxygen flowmeters, two autoclaves, two high-level disinfection boilers, a vacuum extractor and one suction machine, among other equipment. Renovations were done in the laboratory, and an incinerator was constructed. As a result, the numbers of deliveries increased sevenfold in the 12 months from January to December 2003. Gede recorded 74 deliveries for the year ending September 2004 compared to 45 in the previous year. Family planning acceptors shot from 133 in July 2000 through June 2001 to 352 in October 2003 through September 2004. PMTCT and VCT services were also introduced. BCC activities involved women's groups, youth, drama, choirs, public health technicians and a number of volunteer field agents.

With this improvement, it is envisaged that community mobilization of Gede will continue to increase utilization of delivery and other services in this health center. According to Ms. Emily Karisa, in charge of nursing and midwifery at Gede, "AMKENI has opened our eyes."

MALAVA HEALTH CENTER BECOMES A HOSPITAL

Malava Sub-District Hospital in Western Province, which previously functioned as a health center, was enhanced by the AMKENI Project, and now provides comprehensive obstetric care and other RH services. Using the three-prolonged strategies of training, improving range and quality of services and community mobilization for demand creation, AMKENI contributed significantly to the elevation of Malava into a sub-district hospital. Staff was given the necessary training; the MOH posted two doctors and a CO anesthetist; renovations were done in the theater, VCT, and the whole hospital was given a new coat of paint. The necessary equipment was supplied, and a reliable water supply was installed. Malava now functions as a comprehensive EMOC facility (hospital) and provides all methods of FP, PMTCT, VCT and other services. Total FP acceptors increased threefold from 3,119 in the baseline year to 8,691 by September 2004. The number of deliveries more than doubled from 151 to 369 during the same period.

MOH PROMOTES MARIAKANI HEALTH CENTER (IN KILIFI, COAST PROVINCE) TO A SUB-DISTRICT HOSPITAL

Using similar strategies, AMKENI assisted in upgrading former Mariakani Health Center on the Mombasa-Nairobi highway to a sub-district hospital. By the end of 2004, the normal deliveries more than doubled while assistance for complicated deliveries increased sixfold. The Medical Officer in charge was upbeat about AMKENI. He said, “AMKENI updated us and gave us the tools, and this combined with demand creation in the community and outreach has raised staff morale.” The PMTCT uptake is 99% to 100%. They now conduct approximately 80 deliveries a month and are able to do caesarean sections (C/S) when indicated.

V. IUCD Re-Introduction Initiative

The Kenya MOH and other FP stakeholders expressed concern about the trend of the method mix over the last two decades. There has been a decline in the use and availability of long-term and permanent methods as well as oral contraceptives and the injectables (see Figure 3 below).

Key Success Factors:

- Influencing policy through workshops and other dissemination activities targeting key decision makers and communities
- Building on advocacy efforts through an educational campaign that reintroduces the intrauterine contraceptive device
- Linking facility-based training to a community-based behavior change communications program
- Ensuring contribution of community representatives and development partners to the initiative at a variety of levels from educational and communication campaigns.

Activity Description: Implementation of National IUCD Re-launch

In response to reduced IUD uptake, the MOH, FHI and other stakeholders started a series of meetings/activities to re-launch the IUCD and popularize or increase its usage. A pre-conference symposium during the 5th East, Central and Southern African Obstetrics and Gynecological Society Conference—hosted by the Kenya Obstetrics and Gynecological Society in February 2003—became the national and regional forum for the re-launch. The conference was well attended by Kenyan, regional and international delegates who discussed evidence-based information about the advantages of the IUCD. Presenters included Professor David Grimes, an internationally renowned RH authority and advocate.

Following the pre-conference symposium, a series of activities followed that consisted of several workshops to disseminate evidence-based information on the benefits of the IUCD to policy makers, trainers, managers, supervisors and providers. As a result of these meetings, a national strategy to re-launch the IUCD was developed.

The USAID/AMKENI Project was identified as a major implementer of this campaign. For USAID/AMKENI, increasing the use of IUCD—an effective, safe and long-term method of FP—was an integral part of its strategy to expand the range of family planning services in its target areas. With the launch of this campaign in mid-2003, USAID/AMKENI redoubled its efforts in 2004. The disseminated IUCD provider trainings, educational sessions and brochures constituted the multiple interventions undertaken. These activities contributed to the increase in use and availability of the IUCD. See Table 6 and Figure 3 below.

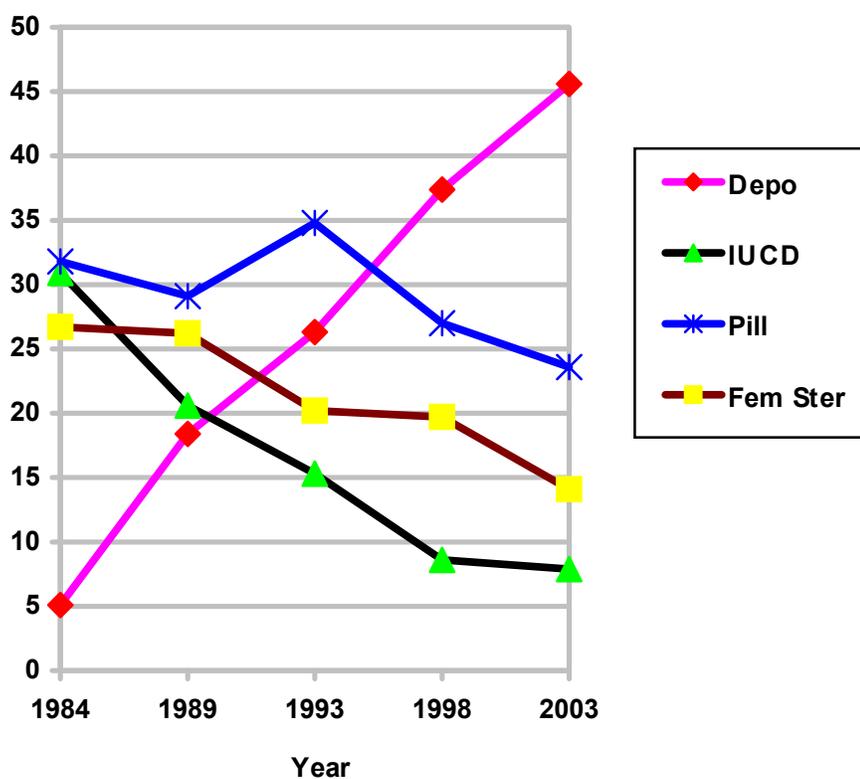
Table 6: IUCD Interventions and Results

INTERVENTIONS	CALENDAR YEARS				
	2001	2002	2003	2004	TOTAL
IUCD trainees (Total)	0	32	69	70	171
IUCD trainees (AMKENI HF)	0	6	38	56	100

INTERVENTIONS	CALENDAR YEARS				
	2001	2002	2003	2004	TOTAL
BCC information sessions	Not tracked			1,807	1,807
Persons reached in sessions	Not tracked			55,899	55,899
Brochures distributed	Not tracked			11,150	11,150
RESULTS					
Total IUCD acceptors	510	643	908	1,570	3,631
Percent annual increase		26.1%	41.2%	72.9%	
# of HF's reporting IUCD acceptors	34	55	51	71	
Aver. IUCD per HF providing service	15	12	18	22	
# HF with more than four clients/month	2	2	5	11	
# HF with more than two clients/month	7	3	10	19	

Source: USAID/AMKENI Highlights - the IUCD Re-introduction Campaign

Figure 1: FP TRENDS OVER TIME (Source: KDHS 1984, 1989, 1993, 1998, and 2003)



Before the initiative (2001-2003), USAID/AMKENI trained 101 providers and supervisors nationally in IUCD insertion and removal. Forty-four of them worked in USAID/AMKENI-supported facilities, and the remaining trainees worked in other MOH, private or NGO facilities. As a part of the IUCD re-introduction initiative, USAID/AMKENI supplied an IUCD insertion kit in each facility where staff was trained. This was coupled with IUCD information that was included in BCC activities in communities in the catchment areas of the USAID/AMKENI-supported facilities to create demand. Some minor improvements were made to provide more privacy in the FP room for IUCD insertion. As a result of these interventions, the total number of acceptors rose from 510 in 2001 to 643 in 2002 (a 26% increase) and to 908 in 2003 (a 41.2% increase) as shown in Table 6.

USAID/AMKENI conducted 1,800 BCC sessions, reaching almost 56,000 people, and 11,150 brochures were distributed. In one year of implementation, the number of acceptors of IUCD increased another 73% to 1,570 new users. The number of health facilities providing the service increased from 55 in 2002 to 71 in 2004.

In 2004, as a part of its contribution to the National IUCD Re-introduction Campaign, USAID/AMKENI trained 56 additional staff from its supported facilities. USAID/AMKENI also conducted a six-month information campaign for community education on the IUCD and other FP methods as part of its BCC component in villages, with women's groups, at work sites and in churches in different catchments areas. These activities increased people's knowledge about the IUCD as well as the likelihood for women to seek and utilize this contraceptive method. Table 7 provides more detailed information on the performance of 11 health facilities supported by AMKENI. In the first quarter of 2005, 375 IUCD acceptors were reported from 52 USAID/AMKENI-supported facilities.

Periodic stock-outs of commodities, including IUCD, have been a major problem in Kenya. To sustain this national initiative, the DRH/MOH has been working with development partners to ensure adequate procurement and availability of commodities.

Table 7: The Best Performing USAID/AMKENI-Supported Facilities in IUCD Insertions in 2004

Rank	Health facility	District/Province	# IUCDs inserted
1	Malava Sub-District Hospital	Kakamega, Western	173
2	Webuye District Hospital	Bungoma, Western	111
3	Ndalu Health Center	Bungoma, Western	99
4	Likoni Health Center	Mombasa, Coast	95
5	Kimilili Sub-District Hospital	Bungoma, Western	80
6	Mkomani Bomu Clinic	Mombasa, Coast	74
7	Kilifi District Hospital	Kilifi, Coast	69
8	Chwele Health Center	Bungoma, Western	58
9	Lugulu Mission Hospital	Bungoma, Western	57
10	Mbale Rural Health Training Center	Vihiga Western	57
11	Port Reitz District Hospital	Mombasa, Coast	54

Source: USAID/AMKENI Highlights - the IUCD Re-introduction Campaign

VI. Integration of FP into HIV/AIDS Services

A new dimension of the AMKENI model is the integration of FP into HIV services. The strategy identifies four levels of integration depending on services available. Levels will offer voluntary counseling and testing (VCT), assessment of pregnancy and STI risks, provision of information and counseling on contraceptive methods and referral for methods or services that are not available. Although the initiation of integrated FP-HIV services has shown promise, more evidence is required as it emerges to qualify as a BP.

CHALLENGES AND LESSONS LEARNED

Challenges

Some of the most important challenges the USAID/AMKENI Project faced included:

- **Abolishing of cost sharing by MOH**
“This was the single most important development, which seriously affected access and quality of services in USAID/AMKENI-supported facilities. The policy has been erroneously equated to free services and the initial reaction to the directive was overwhelming to the few staff at the facilities. The result was the preventive services, e.g. RH/FP, VCT, and PMTCT, tended to be relegated to the back seat. The policy change is also having a serious detrimental effect on quality of services since the facilities are now lacking the funds to hire additional staff and purchase essential commodities and supplies.”⁹
- **Long-term sustainability**
Although communities consider USAID/AMKENI as their project and there is evidence of significant community involvement and active participation, sustainability remains a major challenge. A case-in-point is sustaining bilateral tubal ligation surgical contraception services. USAID/AMKENI used to provide transportation for clients to the facilities for surgery and then transport them back home. Health care managers and providers reported that these services already have decreased due to the ending of USAID/AMKENI’s continued support. The Coast area manager informed the ESD documentation team that with only one vehicle now available for the project, USAID/AMKENI is no longer able to provide transport. The Ministry is also unable to provide alternative arrangements. Additionally, sometimes USAID/AMKENI provided extra surgeons from the private sector or other public hospitals, but the communities can no longer afford the cost of transportation and allowances for the surgeons.

Lessons Learned

The major lessons learned that are highlighted by the documentation team included:

- **Integrated approach:** Applying a multisectoral and integrated approach allowed AMKENI to reach its program goals and objectives.
- **Constant engagement and involvement of the community:** Involving the community at all stages of the project’s phases (design, planning and implementation) was crucial to the success of the intervention. The project involved the community by starting with a needs assessment and later included local community groups in project implementation activities.
- **Ability to adapt activities rapidly to meet community needs helped build support for the project.** Facility upgrades were not part of the AMKENI Project; however, when

⁹ AMKENI End of Project Report, May 2005.

need arose, the project improved the infrastructure of the facility and provided equipment and commodities resulting in improvement of maternal care, antenatal care, normal and complicated deliveries, postabortion care and child survival in addition to FP and HIV/AIDS services.

CONCLUSION

The USAID/AMKENI approach is a best practice given the evidence in increased service access, community mobilization and involvement. It was unique because it turned a project that was initially designed as a predominately private-sector family planning project into an integrated community-level public/private-sector RH/FP and HIV/AIDS program that was able to:

- Respond to the realities in the field as well as the needs of the communities and the MOH
- Evolve to include HIV/AIDS services where needed in public and private sectors and communities.

Sensitivity and responsiveness to on-going project reviews are the key to offering a successful service program that meets community needs and that encourages community ownership. Sheila Macharia of USAID Kenya stated, “This evolution of the USAID/AMKENI Project qualifies as a best practice.”

The following “blue prints” serve as a guide for application of the model elsewhere. The guide is based on the USAID AMKENI experiences and practices in developing and successfully implementing a best practice model, the following “blue prints” serve as a guide for application of the model elsewhere.

1. Partnerships

A. Community Involvement and Mobilization

- Using participatory needs assessments and stakeholder forums
- Building on existing community groups and organizational capacities
- Linking communities with local funding sources
- Linking project goals and activities with community interest (leading to community volunteerism) and capacity building.

B. Active Involvement of the Ministry of Health and Other Government Ministries and Private Organizations Concerned with Health (working within existing structures)

- Inclusion of MOH in management activities and placement of MOH officials in key positions to maintain good relations and strengthen collaborative efforts
- MOH serving on the project’s management board
- Utilization of joint planning, performance review and implementation meetings for project staff, MOH and public health staff

- Ability to stay attuned to the need for improved relationship among implementing partners
- Involvement of public- and private-sector providers in multi-stakeholder meetings
- Efforts to share performance indicators, peer performance reviews/and constructive recommendations across participants aimed at improving the quality of RH/FP services.

2. Capacity Building

A. Standardization of Reproductive Health and Family Planning Training Curricula

- Using standardized training curricula and approaches
- Creating two training manuals for trainer and trainee to acquire multiple skills Partnerships in the development of the curriculum
- Ensuring cooperation and flexibility of stakeholders in the development of curricula.

B. Linking Pre-service and In-service Training Systems Through the Performance Improvement Approach (PIA)

- Skills development among the heads and faculty of training institutions at both district and national levels; service supervisors and managers trained in application of performance improvement approach to training and service improvements.
- Promoting ownership and adoption of PIA as a way of identifying needs and priorities in service delivery and training programs
- Application of standardized curricula and approaches for both pre- and in-service training programs.

C. On-the-Job-Training for Clinical Service Providers

- Linking certification with on-site training requirements
- Building relationships between facility-based providers, local organizations and the community as a whole through concurrent training activities
- Utilizing local institutions and creating links to medical training colleges
- Building political support of training and motivation of newly trained health providers to train colleagues at health facilities.

3. Institutionalizing Training and Supervision System

A. Decentralized Reproductive Health Training and Supervision (DRHT&S) System

- Forming training and supervision teams at district, provincial and facility levels
- Building the capacity of health providers within the existing decentralized operating system
- Adopting reproductive health training and supervision materials in pre- and in-service trainings
- Developing a decentralized health system that provides an enabling environment for the identification of trainees at facility level and facilitation of trainings at district, provincial and national levels.

4. Improving Service Access

A. Upgrading Health Facilities to Offer Higher Level FP/RH/CS Health Care Services

- Improving existing health facilities through supportive renovations and the supply of essential equipment
- Expanding health services through emergency obstetric care and other RH training of health workers
- Linking rehabilitation of health clinics with community mobilization activities
- Promoting select health centers to a higher designation by improvements in quality and range of services
- Building the capacity of the community to support the health facilities and improving facility management by the community health committees
- Ensuring MOH commitment to hire new staff and assist in their placement.

5. Re-introduction of IUCD

A. Advocacy

- Influencing policy through workshops and other dissemination activities targeting key decision makers and communities
- Building on advocacy efforts by way of an educational campaign to reintroduce the intrauterine contraceptive device
- Linking facility-based training to community-based behavior change communications program.

ANNEXES

Selected Reference Documents

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Annex II: Work Plan for Documentation of AMKENI's Best and Promising Practices

By Prof. Joseph Karanja, Team Leader, and Dr. Boaz Otieno-Nyunya, Team Member

Day	Date	Place	Activity
Sunday	5/7/06	Nairobi	Dr. Otieno-Nyunya travels to Nairobi
Monday	5/8/06	Pathfinder	Debriefing with Dr. Orero, Pathfinder
Tuesday	5/9/06	Pathfinder	Planning and team building meeting with Dr. Orero
Wednesday	5/10/06	Pathfinder	Planning and preparation meeting/documents review
Thursday	5/11/06	Nairobi	Document search and review
Friday	5/12/06	Nairobi	Document search and review
Saturday	5/13/06	Nairobi	Interview Dr Solomon, DRH, Documents review
Sunday	5/14/06	-----	-----
Monday	5/15/06	AMKENI offices/ DRH	Interviews at AMKENI Offices: Drs. Obwaka/Karanja Mbugua/Oyoo Dr. M. Solomon, Mrs. Ann Njeru, Ms. E. Kamanthe
Tuesday	5/16/06	Nairobi – Eldoret	Dr. Nyunya travels to Western Kenya Consultants continue document review
Wednesday	5/17/06	Western Province	Field work/interviews at Likuyani SDH, Webuye DH, Pan Paper Health Center (HC)
Thursday	5/18/06	Western	Visits/interviews, Malava District Hospital, Kakamega AMKENI Area Office, Pathfinder Kakamega office, Mbale Training Health Center, Vihiga District Hospital
Friday	5/19/06	Kisumu	Consultants meeting to collate data/information from Western Province Professor Karanja travels to Nairobi in evening. Further review of documents
Saturday	5/20/06	Kisumu – Nairobi	Dr. Otieno-Nyunya travels to Nbi, both plan Coast trip, discuss documents
Sunday	5/21/06	Nairobi- Mombasa	Consultants travel to Coast
Monday	5/22/06	Mombasa “ “	Pathfinder and AMKENI offices, Mombasa (logistics), planning meeting; AMKENI area staff, Provincial Medical Officer, Provincial Nursing Officer, Dr. Othigo, Dr. Marjan, District Medical Officer, District Health Management Team and staff at Port Rietz. Hospital Meeting /interview Dr. Chamia of Jocham Hospital
Tuesday	5/23/06	Mombasa- Malindi	Consultants travel to Malindi Meetings/interviews with DMOH, Nurse Officer in Charge and staff Malindi District Hospital, Field visits to Gongoni HC, Gede HC, Watamu M&NH (private provider) Spend night in Mahindi

Day	Date	Place	Activity
Wednesday	5/24/06	Kilifi	Meeting and interviews District Medical Officer and Nurse Officer in Charge, Kilifi Distr. Hospital, field visit St. Luke Kaloleni, Bamba HC and Mariakani Sub-District Hospital
Thursday	5/25/06	Kwale	Visits and interviews with District Clinical Officer Kwale, Diani Dispensary, Ukunda Medical Center, Msabweni DH and Lunga HC
Friday	5/26/06	Mombasa	Visit and interviews at Coast Provincial General Hospital- Director, deputy director, and Dr. Ali and Dr. Kosgei, and at MCH: Ms. Kinuthia and Josephine, Garize Nursing Officer in Charge
		Likoni	Field visit to Likoni HC and interviews with Clinical Officer in Charge, Nursing Officer in Charge and staff
Saturday	5/27/06	Mombasa	Consultants travel to Nairobi
	5/27/06	Nairobi	Meeting to discuss and collate Coast data/information
Monday	5/29/06	Nairobi	Further review of relevant documents Plan draft report, interviews
Tuesday	5/30/06	Nairobi – Eldoret	Further review of documents, Plan draft report. Dr. O–Nyunya travels Togo HC (Western) and interviews staff; Consultants continue collating info and developing draft report
Wednesday	5/31/06	Nairobi – Eldoret	Consultants continue collating info and developing draft report
Thursday	6/1/06	Nairobi	Revision of draft and review of documents
Friday	6/2/06	Nairobi	Consultants continue collating info and developing draft report
Saturday	6/3/06	Nairobi	Consultants continue collating info and developing draft report
Monday	6/5/06	Nairobi	Revision of draft; writing final draft
Wednesday	6/7/06	Nairobi	Discussion with Dr. Orero
Thursday	6/8/06	Nairobi	Final draft writing

Annex III: Key Informants and Health Facilities Visited

Ministry of Health, Nairobi

Josephine Kibaru, Head of the Division of Reproductive Health
Dr. Marsden Solomon, Deputy Head of the Division of Reproductive Health
Mrs. Anne Njeru, Program Officer, Division of Reproductive Health

AMKENI Nairobi Office (headquarters)

Dr. Job Obwaka, Project Director
Dr. Chris Oyoo, Service Delivery Advisor
Dr. Linda Archer, Monitoring and Evaluation Director
Dr. Karanja wa Mbugua, Policy and Systems Advisor

Western Province AMKENI Office, Kakamega

Moses Lukhando, Area Manager
Cornelius Kondo, Service Delivery Coordinator
Joyce Wafula, Community/Women's Agency Coordinator

Likuyani Sub-District Hospital

Moses Segu, Public Health Officer
Nelson Simiyu, Hospital Administrator
Sostena Bugu, Registered Clinical Officer
Rosbetta Asota, KECN/FP/VCT Counselor
Florence Mutura, Nursing Officer

Webuye District Hospital

Samuel S Walukano, Nursing Officer
Yucabeth K Onchar, ECN (an AMKENI alumnus)
Anne W Chicole, ECN

Malava Sub-District Hospital

Dr. Wilson Bett, Medical Officer in Charge
Mr. Joseph Kimani, Health Administrator

Pathfinder Area Office, Kakamega

Mr. Alex Muyonga, PI
Vihiga District Hospital
Mr. Vincent Kavole, Nursing Officer
Mr. Mohammed Wanga, KECHN Student
Sister Sangoro Medsar, Nursing Officer

Tigoi Health Center

Mr. Albert Vuhasho Lumasai, Clinical Officer in Charge

Coast Province

PMO's Office and Provincial General Hospital, Mombasa
Dr. Anderson Kahindi, Provincial Medical Officer
Dr. Janet Othigo, Provincial RHT&S Coordinator
Dr. Sekeley, Chief Administrator, Coast Provincial General Hospital
Dr. Mwangi, Deputy Chief Administrator, Coast Provincial General Hospital
Provincial Nursing Officer
Josephine Garise, Matron in Charge, Coast Provincial General Hospital
Ms. Kinuthia, MCH/FP Clinic, Coast Provincial General Hospital
Dr. Habbib Hussein, Medical Officer, Coast Provincial General Hospital

Dr. Rose Kosgey, Medical Officer, Coast Provincial General Hospital

Coast Province AMKENI Office, Mombasa

Feddis Mumba, Area Manager

Patience Ziro, Service Delivery Coordinator

Jocham Hospital

Dr. John Chamia, Director and Consultant, OB/GYN

Mombasa

Dr. Ramadhan Marjan, Consultant OB/GYN, private practice, trainer for AMKENI

Malindi DMOH Office and District Hospital

Anisa Omar, District Medical Officer/Medical Superintendent, Malindi

Esther Mwema, Hospital Matron, Malindi DH

Asafa Komora, DPHN, Malindi District

Port Rietz MOH Office and District Hospital

Dr. David Wanjalla, District Medical Officer Mombasa (outgoing)

Dr. Samuel Kadivane, DMOH Mombasa (incoming)

Juliet Kanumi, DPHN

Margaret Berube, NO in Charge of the district hospital

Likoni Health Center

Fatuma Ali, CO in Charge

Raymond Ngwai, NO I/i

Joyce Osore, Adherence Counselor

Eunice Omondi, Pharmacy Technologist

Gongoni Health Center

Caroline Mulunda, CO in Charge

Watamu Maternity and Nursing Home

Joseph Katore Katana, KEN/M, Proprietor and Nurse Midwife in Charge

Gede Health Center

Timothy Nyamai, CO in Charge

Emily Karisa, in charge of nursing/midwifery services

Kilifi DMOH Office and District Hospital

Dr. Philip Masaulo, DMOH, Kilifi District

Ms. Pamela Kibibu, NO in Charge

St. Luke's Hospital, Kaloleni

Dr. Boniface Kahindi, Medical Officer in Charge

Sr. Mauren Lezeni, Matron in Charge

Bamba Health Center

Mr. Kenneth Dena, Co in Charge

Mr. Keya Baltaza, NO in Charge

Mariakani Sub-District Hospital:

Dr. Zebedee Akanga, Medical Officer in Charge

Ms. Halima Hassan, Nurse /Midwife

Kwale DMOH Office and Health Center

Ms. Esha Yahya, DCO, Kwale District

Diani Dispensary
Stanley Chepkirwok, CO in Charge
Johns Mwakoma, Nurse /Midwife
Ukunda Medical Center
Ms.Triza Ileri, KRCHN, Counselor/Administrator
Msambweni District Hospital
Ms Tima Bwana Bwanadi, Nurse/Midwife
Lunga Lunga Health Dispensary
Ms Dorah Dawida, Nursing Officer in Charge
Shaaban S. Mwatenga, Public Health Officer in Charge, Lunga Lunga Division

Annex IV: Interview Guide

Interview guide for Ministry of Health staff (HQ/DRH), USAID/AMKENI and its partners, health care providers and other stakeholders

1. What role do you play in RH/FP/CS/HIV/AIDS in Kenya/province/district/facility?
2. Tell us what your own role is/was in the AMKENI Project.
3. How did AMKENI work with MOH and partners/stakeholders during the project period?
4. How was the AMKENI Project different from other projects?
5. What good things in particular do you think about AMKENI Project?
6. Do you think this project should be scaled up?
7. If yes or no, explain why.
8. What changes, if any, would you recommend?
9. Are there any aspects of this project that you think should be copied by other projects or countries? Please explain.
10. What, in your opinion, are the best and promising practices of this project that should be documented for others to adopt/adapt?
11. Tell us more about AMKENI.

Contacts:

Professor Joseph Karanja: jkaranja@wananchi.com and karanjajg@yahoo.com

Dr. Otieno Nyunya: nyunya@mtrh.org