FAMILY PLANNING PROGRAM BRIEF

Afya Pwani’s Technical Approach to Reducing Unmet Need for Family Planning Services in Kilifi County
BACKGROUND

Women of reproductive age (WRA) constitutes 25% of Kilifi county's nearly 1.5 million people (KNBS 2019)\(^1\). In 2014, the county recorded a high fertility rate of 5.1, a low modern contraceptive prevalence rate (mCPR) of 33%, and a high unmet need for family planning (FP) of 21.8%. The rate of teenage pregnancy was 22% (KDHS 2014)\(^2\). The low mCPR in Kilifi county was attributed to a wide range of demand-side barriers including poverty; literacy; and socio-cultural factors like male dominance in reproductive health decision making, religious beliefs, gender inequity, and gender-based violence (GBV), and supply-side barriers including geographic access to health facilities, inadequate community-facility linkages, gaps in health care worker knowledge and skills, commodity stockouts, provider bias, and low data quality for decision making.\(^3\)

THE AFYA PWANI APPROACH AND IMPACT

The USAID Afya Pwani project (2016-2021), led by Pathfinder International in partnership with Palladium and Plan International, strengthen delivery of HIV and reproductive health services and - the capacity of the health systems in five counties in Kenya—Lamu, Kilifi, Mombasa, Kwale, and Taita Taveta. In its family planning (FP) programming, Afya Pwani's goal was to increase demand, access, and quality voluntary FP services to improve the modern contraceptive prevalence rate (m-CPR) and reduce unmet need among adolescents, youth, and women of reproductive age in Kilifi County. The project worked to achieve this goal by aiming to meet the following objectives: expanded contraceptive awareness and acceptance; increased FP access at the community level; improved quality of voluntary FP services; and strengthened capacity of county and subcounty health management teams to plan, implement, and coordinate FP services.

Expanded contraceptive awareness and acceptance

To generate demand for voluntary FP, Afya Pwani implemented several social behavior and change (SBC) strategies:

- Advocacy to encourage investment and commitment from political and social leadership;
- Social mobilization with religious and community leaders for broader participation, coalition building, and ownership;
- Behavior change communication using mass and social media, community-level activities, and interpersonal communication to change knowledge, attitudes, and practices among specific audiences.

The project engaged local leaders and national administrators to dissuade communities against retrogressive practices, a barrier to the utilization of sexual and reproductive health (SRH) services in Kilifi County. The project initiated a transformative empowerment approach, “Utawala

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\(^{3}\) County government of Kilifi county Family Planning costed Implementation Plan (2017 – 2021)
na Afya,” to trigger community-led solutions to positively influence their health and standards of living incognizant of the power held by communities and the existing structures. The forum ensured collaboration between the National Government Administrative Office (NGAO)—representing the voice of the community members and the County health leadership to ensure the upholding of patient rights and responsibilities at the health facility and community levels, respectively. Through this approach, the national administrators promoted good health-seeking behavior among communities, while the health department ensured quality services for all clients. The project further leveraged crucial influencers—male champions, traditional leaders (Kaya elders⁴), community-based distributors, religious leaders, and traditional birth attendants, supporting them to be transformative change agents by training, sensitizing, and equipping these key influencers with job aids to guide messaging.

Afya Pwani expanded discussions and dialogue about FP among community members through an elaborate network of community-based resource persons (1,070 community-based distributors, 400 male champions, 183 Kaya elders, 400 traditional birth attendants, 121 religious’ leaders, and 180 Utawala na Afya champions), reaching cumulatively 904,545 people with FP messages and services at the community level (670,727 women older than 25 and 212, 261 women 24 or younger). There was also increased male involvement as shown by the round seven PMA 2020 survey report⁵; about 9 in every 10 women using a modern, female controlled contraceptive method reported that their partners knew they were using a method of family planning and half of the women decision to use family planning was made jointly with the husband.

**Increased family planning access at the community level**

To increase community-level access to FP services, Afya Pwani strengthened community-based distribution, targeted integrated outreach, and door-to-door FP services. It also leveraged community events like edutainment, sports, community meetings (Baraza), and other public events to provide FP services. The project trained 1,070 community-based distributors, equipping them with job aids and tools.

**Improved quality of voluntary family planning services**

Afya Pwani increased access to and use of voluntary FP services by supporting the county to improve service providers’ skills and competencies; expand service delivery; improve quality; and strengthen commodity and equipment security.

**Capacity strengthening**

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⁴ Traditional Mijikenda (consists of the 9 tribes of the coastal community) leaders who are well respected in the community and hold spiritual tenets, values and beliefs of the community

⁵ PMA, Kilifi, Phase 2, Cross-Sectional, 2020 results accessed on 8/6/2021 from https://www.pmadata.org/sites/default/files/data_product_results/Kenya%20KILIFI_Phase%202_XS_Results%20Brief_Final.pdf
In partnership with the county and subcounty health management teams (S/CHMT), the project conducted a blended capacity-strengthening approach that encompassed face-to-face training, continuous medical education, on-the-job training, structured mentorship, whole-site sensitization, and virtual training. The whole-site orientation sessions equipped all facility staff (clinical and non-clinical) with FP knowledge. County capacity development was also enhanced by the development and implementation of a competency-based mentorship program for health care workers. Afya Pwani sensitized 35 mentors, established a county mentorship coordination structure, and supported the mentorship of 486 mentees on provision of LARCs and PPFP. The project further supported the county in establishing and equipping reproductive, maternal, newborn, child, and adolescent health (RMNCAH) decentralized training centers equipped with training models to mitigate know-do gaps among service providers, improve quality of training, sustain competency, create a learning culture, and strengthen sub-county-led capacity-building programming.

At the facility level, the project trained 106 health care workers: 80 on provision of long-acting reversible contraceptives (LARCs) and 26 and postpartum family planning (PPFP) methods. The project also sensitized 161 health care providers on commodity forecasting quantification, documentation, and reporting with the contraceptive Facility Consumption and Data Report & Request (FCDRR) -reporting tool.

**Service delivery**

Afya Pwani expanded FP services by integrating them with critical service delivery points, including gynecology outpatient clinics, postpartum clinics, child health clinics, and HIV comprehensive care centers, using the Family Planning High Impact Practices (HIP) guidance. The project also included FP services in the group antenatal and postnatal care model, incorporated healthy timing and spacing of pregnancy (HTSP) messages during pre-pregnancy counseling, antenatal care, delivery, and post-pregnancy care. Before initiating PPFP, the project conducted facility assessment, identified gaps and provided the county government technical assistance to address the gaps. It supported the facilities with equipment, job aids, and

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7 A peer-support structure made up of different cohorts of pregnant women (both with and without HIV; both first-time mothers and experienced mothers). Each group consists of 5 to 30 women, who are grouped based on their gestation at first ANC visit.
guidelines. The project strengthened FP integration in 60 comprehensive care centers and institutionalized PPFP in maternity and postnatal clinics. It enhanced the continuum of care using a holistic approach to HTSP in Group ANC and PNC, commonly known as Mama Kwa Mama (MKM) and Binti Kwa Binti (BKB) groups. These were vital avenues to integrate clinical services with tailored group educational activities and peer support, which boosted retention in care, improved MNCH outcomes and increased uptake of family planning. The project implemented the group model in 93 health facilities reaching 11,169 women in 339 groups with FP messages. At the end of the project, 4,767 women had completed 13 monthly visits. The groups enhanced retention of enrolled women over 13 months - with monthly clinic visits, achieving 96% overall retention in cascade, 97% uptake of skilled deliveries, and 86% uptake of voluntary family planning (FP) services in the postpartum period.

Kilifi County made great strides in increasing the mCPR among women in the union from 33.44% in 2014 to 49.75% in 2020, and reducing the unmet need for child spacing from 36.22% in 2014 to 19.55% in 2020 (PMA 2020). Project efforts enabled supported facilities in Kilifi to offer quality voluntary FP services, reaching 895,469 women of reproductive age during the implementation period, contributing to 498,885 couple years of protection.

*Figure 1. CYP trends in Afya Pwani-Supported Sites June 2016 to December 2020*

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8 A peer-support structure made up of different cohorts of pregnant women (both with and without HIV; both first-time mothers and experienced mothers). Each group consists of 5 to 30 women, who are grouped based on their gestation at first ANC visit.

9 A subset of the Mama group, comprising young girls and women younger than 24, and focused on ensuring quality integrated services for adolescent girls and young women who are either pregnant or breastfeeding. The BKB offers a targeted approach that focuses on adolescent and youth-friendly services.

Figure 2. Contraceptive Method Mix Trends in Afya Pwani-Supported Sites in Kilifi County from 2016-2021

Quality improvement

At baseline, Afya Pwani identified sub-optimal quality of care in FP counseling, documentation, and data use for decision-making. The project addressed the above gaps by strengthening the county's capacity to offer quality FP services, training health care providers on quality improvement and sensitizing and scaling up the Kenya Quality Model of Health (KQMH). The project also supported the county to establish quality improvement structures including institutionalization the County Quality Improvement Technical Working Group (CQI-TWG). The project provided technical assistance to the county CQI-TWG to continuously sensitize health care providers on quality improvement, and establish work improvement teams in health facilities. Cumulatively, 116 health facilities set up quality improvement structures and teams.

Commodity and equipment security

FP commodity stockouts are a critical barrier to access to FP services. Afya Pwani strengthened county commodity and equipment commodity security by strengthening capacity in forecasting, quantification, documentation, reporting, and inventory management. It further strengthened county commodity security by improving coordination and monitoring through FP and commodity technical working groups. The project also supported the county in conducting targeted FP commodity distribution and redistribution to ensure access to an expanded contraceptive method mix.

Strengthened county and subcounty health management team capacity to plan, coordinate, and implement family planning services

Afya Pwani strengthened the capacity of the C/SCHMTs to plan, coordinate, and provide quality FP services by providing technical assistance during co-creation, planning, and implementation of the FP program. The project contributed to the development, implementation, and midterm review of the Kilifi FP Costed Implementation Plan (CIP, 2017-2021). The CIP guided FP
programming by clearly defining the FP program's strategies, activities, and cost, thus supporting advocacy for increased resource allocation for FP. The project also reinvigorated the FP technical working group, an avenue for strengthened coordination and collaboration. The project further supported harmonizing the RMNCAH supportive supervision tool, developing RMNCAH dashboards, and holding review meetings. Finally, the project strengthened the capacity of the county, sub-county, and facilities leadership in the development of work plans, performance reviews, and supportive supervision and program monitoring tools.

LESSONS LEARNED AND RECOMMENDATIONS

- The project implemented the group ANC/PNC model in 93 out of 155 public health facilities, documenting increased uptake of PPFP among the girls and women engaged. To further increase uptake of PPFP among women and girls, the county should scale up this model in all the facilities and among all pregnant women.
- Post-training and structured mentorship in LARC and PPFP provision leads to sustained competency.
- Expanding community discussion on contraceptives/FP through community-based resource persons help to address myths, misconceptions, and social-cultural barriers.
- Tapping into the national government administration office through the county commissioner and providing a structured engagement "Utawala na Afya" provides a platform for increasing demand and access to voluntary FP services. To sustain the gains, the county department of health should institutionalize collaboration with the National government administrative office and the local leaders.

RECOMMENDATIONS

- The county needs to weave male champions, traditional birth attendants, community champions, and other essential lay health workers into the existing community health strategy.
- The Community based distribution program provided a critical role in providing information, commodities, and referral for family planning. To further expand access to family planning, future programming can sensitize the CBDs on selfcare to increase the contraceptive mix.
- The county government should increase FP allocation and streamline FP commodity procurement to ensure uninterrupted commodity supply.
- All FP training should include values clarification and attitude transformation to address provider bias and balanced counseling for the provision of quality FP services.
- The county should implement the Community Health Strategy bill to achieve universal health coverage and increase access to FP services.